Policy for the Development and Implementation of Procedural Documents

(Previously 'Policy on Policies')

Solent NHS Trust policies can only be considered to be valid and up-to-date if viewed on the intranet. Please visit the intranet for the latest version.

Purpose of Agreement	To outline the standard format of Policies and Standard Operating Procedures and approval routes.
Document Type	[X] Policy [ ] SOP [ ] Guideline
Reference Number	Solent NHST/Policy/GO 01
Version	15
Name of Approving Committees/Groups	Policy Steering Group, Assurance Committee, Board
Operational Date	September 2017
Document Review Date	September 2020
Document Sponsor (Name & Job Title)	Chief Executive Officer
Document Manager (Name & Job Title)	Company Secretary
Document developed in consultation with	Policy Steering Group, Equality & Diversity Lead
Intranet Location	Solent Policies; Operational Policies
Keywords (for website/intranet uploading)	Policy, policies, Standard Operating Procedure, SOP, procedures,

Review Log

Include details of when the document was last reviewed and summary of amendments:

Version Number	Review Date	Name of reviewer	Ratification Process	Reason for amendments
4	24/04/2007	RG	N/A – document review	
5	16/08/2007	RG	N/A – document review	
6	30/11/2007	RG	N/A – document review in light of CFT application withdrawal	
7	26/05/2009	RC	Document Steering Group Provider Management Board Trust Board	Reviewed to take into consideration recent organisational changes and inclusion of Standard
8	10/05.2010	KB SL	Policy & NHSLA Group Assurance Committee Trust Board	Reviewed to take into consideration recent organisational changes
9	20/01/2012	SL RT	Policy & NHSLA Steering Group	Biennial review
10	31/03/14	SL RT	Policy & NHSLA Steering Group	Biennial review
11	01/03/2016	Rachel Cheal	Policy Steering Group	Complete policy review following expiry.
12	08/12/2016	Rachel Cheal		Amendment to Policy Template to ref: Equality, Diversity and Human Rights Policy
13	30/08/2017	Rachel Cheal	Policy Steering Group	Amendment to include requirement to notify if a service cannot comply with policies (and associated Appendix 5). Minor other updates re: job titles

Amendments Summary:

Amend No	Issued	Page	Subject	Action Date
1	Feb 2018	17	Amended standard Scope wording as agreed at the PSG Jan 2018	Feb 2018
2	Feb 2018	19	Amended EIA template as agreed at the PSG Jan 2018	Feb 2018
3	Nov 2018		Deletion of term 'Governor' from Scope wording	Nov 2018 (Version 14)
4	April 2019	5	Amended location of term 'bank staff' within scope wording	April 2019

SUMMARY OF POLICY

Policies must follow a **standard format** and in some sections contain standard wording - a template is available (see **Appendix 1**).

All policies must be **developed in consultation** with others/key subject matter experts before being reviewed by the **Policy Steering Group**. The Policy Steering Group, a multidisciplinary group including corporate (which includes Human Resources and staff-side representation) as well as clinical representation, will ensure that the standard policy template has been followed. The Group will approve policies and recommend ratification by the Assurance Committee.

For **Standard Operating Procedures /Guidelines**, whilst there is no set format for the content, a template guide is available (see **Appendix 2)**.

All procedural documents, regardless of type, must consider equality issues. An **Equality Impact Assessment** is included within the policy template.

For queries relating to policies, please liaise with:

Corporate Affairs Administrator (Policy Steering Group administrator and maintains the Policy Register)
Associate Director of Corporate Affairs and Company Secretary (Policy Steering Group Chair)
Head of Professional Standards and Regulation (Policy Steering Group Deputy Chair)

POLICY FOR THE DEVELOPMENT AND IMPLEMENTATION OF PROCEDURAL DOCUMENTS

CONTENTS

POLICY FOR THE IMPLEMENTATION AND DEVELOPMENT OF PROCEDURAL DOCUMENTS

1. INTRODUCTION AND PURPOSE

1.1 Organisations need formal written documents which communicate standard organisational ways of working. These help clarify strategic, regulatory and operational requirements and bring consistency to day to day practice.

1.2 A common format and approval structure for such documents helps to reinforce corporate identity and, more importantly, helps to ensure consultation (and not isolation) and reflect national, organisational and best practice approaches.

2. SCOPE AND DEFINITIONS

2.1 This policy applies to locum, permanent, and fixed term contract employees (including apprentices) who hold a contract of employment or engagement with the Trust, and secondees (including students), volunteers (including Associate Hospital Managers), bank staff, Non-Executive Directors and those undertaking research working within Solent NHS Trust, in line with Solent NHS Trust's Equality, Diversity and Human Rights Policy. It also applies to external contractors, agency workers, and other workers who are assigned to Solent NHS Trust. It also applies to external contractors, Agency workers, and other workers who are assigned to Solent NHS Trust.

2.2 All policies must follow the template provided in Appendix 1 which includes the standard required wording.

2.3 As the content of Standard Operating Procedures and Guidelines can be varied, there is no strict format however the template in Appendix 2 should be used to ensure a standard approach.

2.4 For the purposes of this Policy, the term "procedural document" refers to (and therefore this Policy applies to) the following document types:

Type	Definition
Policy	• A policy is a specific statement of principles • It formally documents a Trust approved standard or procedure, often based on statutory legislation and/or NHS mandatory objectives that must be followed, • Non-compliance could expose the Trust and its staff to unacceptable risk. • An effective policy should therefore describe **what** is to be achieved by **whom**. Trust wide policies can only be authorised by the Trust board or a subcommittee of the Board with specific delegated authority.
Procedure/ Standard Operating Procedure (SOP)	• A procedure often supports a policy in that it sets out a series of steps that must be followed to deliver specific aspects of the policy. • Procedures can usually be mapped using a flowchart. • An effective procedure should describe **how** to achieve the required standards. • It provides individuals with information to perform a task properly and

	facilitates consistency in the quality and integrity of an end result. • A procedure/SOP specifies **what** should be done, **when**, **where** and by **whom**.
Guidance/ Guidelines	• Guidance/Guidelines are a general rule, principle or piece of advice • A 'clinical guideline' is an evidence-based statement used to assist clinicians in the decision making process for the diagnosis, interventions, timescales and expected outcomes for appropriate management of a specific condition • Where possible, Trust staff are asked to follow guidelines, but there may be instances where professional judgement may differ from guidance. In these cases, Trust staff must record (either within clinical notes if a clinical issue or in minutes of meetings if a corporate/operational issue) where they have not followed the Trust approved guidance, outlining the rationale for doing so.

2.5 The following terms are also defined.

Document Manager	• The person who is the author / subject matter expert • The person who is responsible for reviewing/revising the document • The person who responsible for ensuring the document is implemented
Document Sponsor	• The Executive Lead who has overarching accountability for the document

3. DEVELOPING A NEW DOCUMENT

3.1 All documents must follow the below checklist:

☑ Check there isn't a **similar/same document** already in existence beforehand

☑ Use the **templates** (Appendix 1 for Policies, Appendix 2 for SOPs/Guidelines)

☑ Use a minimum font **size 11 calibri** and be concise and clear, using unambiguous terms and language.

☑ **Number all sections** sequentially including paragraphs and Appendices.

☑ Include a **footer** (title of the document, the page numbers and number of pages and version number)

☑ **Abbreviations** – only to be used after the first full reference and include a **glossary** at the end of the document.

☑ Pay special consideration to **Adult & Child safeguarding issues, mental capacity** and **information governance**

☑ **Consultation** – key groups/individuals consulted with must be referenced,

including the name and date of where a group agreed the document.

- ☑ **Training** – any training needs to implement the policy/procedure and any on-going training commitments must be considered in consultation with the Learning & Development Team.

- ☑ **Resource implications** – consider any resource implications for your policy to be implemented successfully. Ensure that the relevant parties have been consulted with, for example, the finance team, and agreement reached if funding is required.

- ☑ Consider **version control** even during drafting - with the Records Management & Lifecycle Policy, section 9 Effective Records Management. Once approved for the first time the policy will be known as version 1. As the policy is subsequently reviewed and re-approved the version number will be advanced (eg version 2). Policies under development or review will have a draft number against 'version' (eg version 2, draft 1).

- ☑ **Equality Impact Assessment and Mental Capacity Act** - equality and diversity issues must be considered in the development of documents. All public bodies have a statutory duty under the Race Relation (Amendment) Act 2000 to "set out arrangements to assess and consult on how their documents and functions impact on race equality".
  It is also necessary to assess the document against the requirements of the Mental Capacity Act (MCA) 2005 during document development. The MCA 2005 ensures that the rights of patients are supported during any time when they are temporarily or permanently unable to make a decision. An impact assessment must be completed for all policies - For further information and access to Impact Assessment Guidance please refer to Appendix 6 and the Equality and Diversity Policy or contact the Trusts Equality Lead.

- ☑ For **joint documents** - it will be necessary to include the logo for the partner organisation on the left hand side of the front cover. It should be noted that joint documents will require approval/ratification by all partner organisations concerned prior to implementation.

- ☑ For **external policies** – (such as Department of Health or other national body policies) these do not need to be rewritten if the organisation is intending to adopt them without change. However, a front cover sheet, as per the first page of Appendix 1, should be attached to the beginning of the document.

4. UPDATING EXISTING DOCUMENTS

4.1 All documents must follow the below checklist:

- ☑ All documents must be **reviewed within the stipulated timescales** to take into account changing circumstances, including regulation changes. Policies must be reviewed within a three year period.

- ☑ The updated document will be allocated the **next sequential version number** and the previous version must be removed from the intranet and archived.

☑ Document Managers should ensure that any **references or hyperlinks** used within the document are still relevant and current

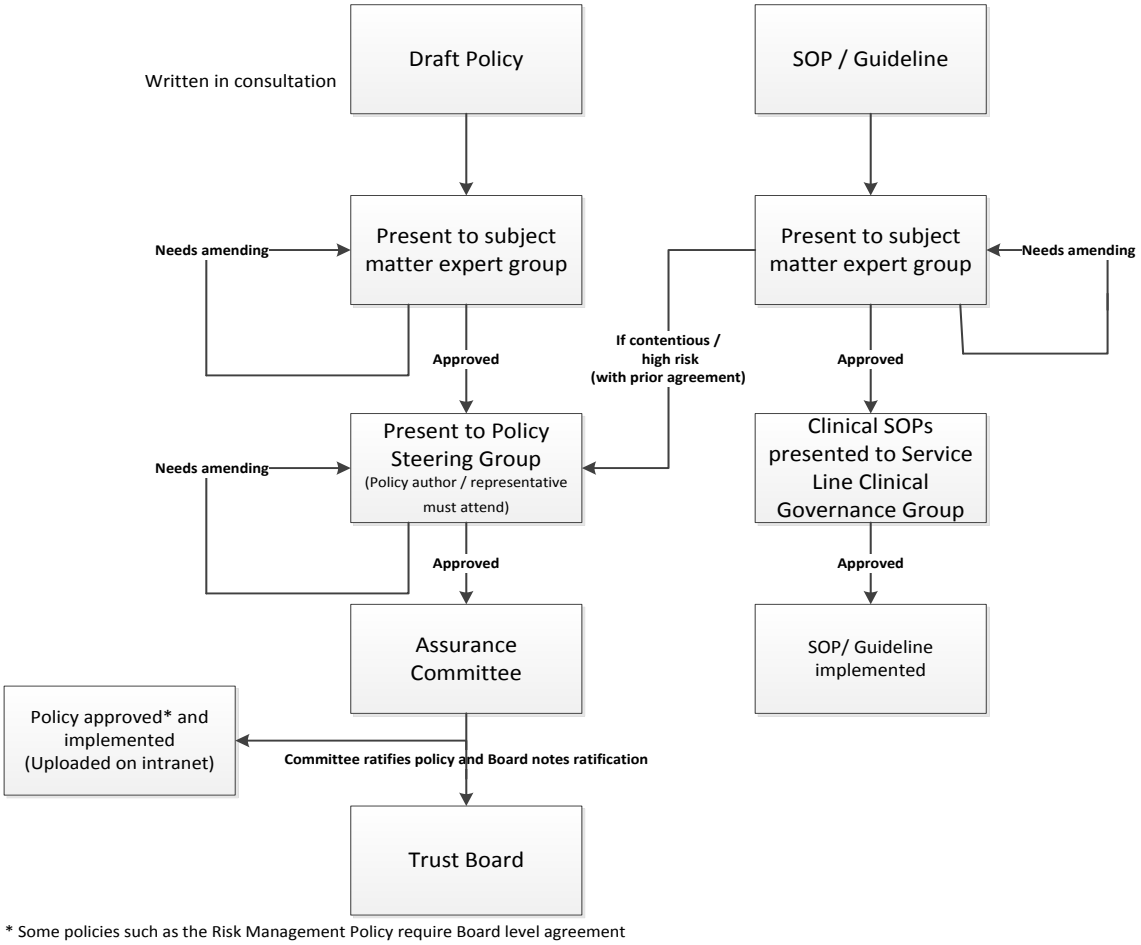
☑ For policies;
- All policies must be **represented** to the Policy Steering Group **for re-approval.**
- If there are **non-material changes only** (e.g. minor changes that do not impact on the content of the policy) it may not be necessary for the policy to go through the full approval route again –in which case **liaise with the Chair of the Policy Group.**

☑ **Highlight any changes** made in the policy so that people reviewing / approving the changes can clearly see the difference(s) from the original version. (Once approved ensure any highlights / tracked changes are removed and a 'clean' copy is published).

5. APPROVAL ROUTES

5.1 The below summarises approval routes.

5.2 Whislt it is not necessary for SOPs/ Guidelines to be reviewed and approved via the Policy Steering Group, it may be appropriate for contentious or high risk documents to be considered by the Group, with prior agreement or referral from another Committee. In such cases, document managers are asked to seek clarification/liaise with the Policy Steering Group Chair/Deputy Chair.



* Some policies such as the Risk Management Policy require Board level agreement

5.3 The policy author or their representative must attend the Policy Steering Group meeting to present the policy.

6. PROCESS AFTER APPROVAL

6.1 Once a policy is ratified, the Policy Steering Group Administrator will:

- ☑ Notify the document manager and request that they provide a summary (no more than 3-4 bullet points) to assist in the communication of the policy and to identify any key changes to staff where the policy has been revised/amended.
- ☑ Notify the communications team –who will include an item in the next issue of Staff News
- ☑ Arrange for the policy to be uploaded onto the intranet
- ☑ Archive any previous approved versions of the policy and make appropriate arrangements to withdraw from circulation
- ☑ Update the Policy Register

7. DOCUMENT CONTROL AND ARCHIVING

7.1 Under the HSC 1999/053 and the Document Retention Schedule, all policies must be retained for permanent preservation. It is, therefore, the responsibility of the Document Manager to ensure previous versions are appropriately archived electronically in a central/accessible location (which is accessible to the wider service team and not just in a restricted folder owned by the individual).

7.2 It is paramount that Document Managers or another responsible person ensures appropriate communication of any amended documents or revisions to the relevant service areas within the organisation.

7.3 Any subsequent versions should be documented on the front cover and a new version number must be given to the document for tracking and audit purposes.

7.4 All policy documents are listed on the Policy Register, maintained and kept up to date by the Policy Steering Group administrator.

7.5 The Policy Steering Group administrator will allocate a unique identifier to each new document created. All versions of documents on the same subject will keep the same unique identifier, with a different version number being used for each update.

8. ROLES AND RESPONSIBILITIES

8.1 Chief Executive

8.1.1 The Chief Executive has ultimate accountability for the strategic and operational management of the organisation, including ensuring all policies are adhered to. Operational accountability for policy management is delegated to the Associate Director of Corporate Affairs and Company Secretary.

8.2 Document Sponsor (Executive Lead)

8.2.1 The Document Sponsor is responsible for ensuring that:

- A Document Manager (Author) has been identified to carry out regular review and revision of the document
- Documents originating from their areas of responsibility are reviewed within the stipulated timescales

8.3 Document Managers

8.3.1 Document Managers are responsible for ensuring the following:

- That documents they are responsible for (as determined by their role) are appropriately developed in consultation, reviewed and maintained
- That the policy is appropriately communicated with the relevant staffing groups
- That documents are uploaded to and accessible on the intranet
- Policies that they are personally responsible for are formally approved following the correct procedures
- That all documents follow the corporate format
- That the implementation and effectiveness of the document is monitored and evidenced

8.4 The Policy Steering Group Administrator

8.4.1 The Policy Steering Group Administrator is responsible for the following tasks including:

- Maintaining the Policy Register
- Liaising with the Corporate Support Manager regarding agreement by the Assurance Committee, ratification by the Board as appropriate.
- Checking with the Document Author that amendments at approval have been actioned
- Issuing a review reminder to a Document Manager three months prior to review date and escalating policies that have expired to the Policy Steering Group Chair as appropriate
- Uploading the policy, after approval onto the intranet
- Providing a summary of policies ratified by the Assurance Committee to the Communications Team for inclusion in the next staff wide communication
- Archiving previous approved versions of documents and taking necessary steps to remove these from circulation
- Maintaining a log of service policy non-compliance (in accordance with section 10.3)

9. TRAINING

9.1 There are no specific training requirements in respect of this policy. However, managers may request advice from the Chair of the Policy Steering Group and / or the Policy Steering Group administrator on request.

9.2 For the purposes of this Policy the Equality & Diversity and Mental Capacity Act Impact Assessment (IA) was conducted and no negative impact was highlighted. A copy of the IA for this Policy is attached as Appendix 3

10. SUCCESS CRITERIA / MONITORING COMPLIANCE – INCLUDING NON-COMPLIANCE

10.1 Compliance with Solent NHS Trust Policy is a requirement of staff contracts. Non-compliance, other than that in the following section and reported as such, may result in disciplinary action.

10.1 Individual's non-compliance with policy

Non-compliance introduces risk for the individual, organisation and service user. In rare circumstances, if staff members are **unable** to follow Trust policies, as the policy requirements cannot be applied in a specific set of circumstances, this must immediately be reported to the Line Manager who must consider what remedial steps will be taken to manage risk. The Non-Compliance Form (Appendix 4) must be completed. This may prompt an early review of the policy.

10.3 Service non-compliance with policy

On occasions, it may not be possible (for example due to differing commissioning models and requirements) for services to comply with a Trust Policy. In such cases the Policy Steering Group Chair must be informed and the details must be logged centrally (the log is held by the Policy Steering Group administrator). Where a service cannot comply, a clear justification must be provided and alternative practice (for example, the development of a SOP) must be implemented – such practice must be developed in conjunction with and with approval of the Policy Document Manager and / or Subject Matter expert. The Non-Compliance Form (Appendix 5) must be completed.

10.4 With regard to this policy, the Policy Steering Group are responsible for ensuring compliance with this policy and the template in Appendix 1. Policies not conforming will be rejected and asked to be represented prior to approval.

11. REVIEW

11.1 This document may be reviewed at any time at the request of either staff side or management, but will automatically be reviewed 3 years from initial approval and thereafter on a triennial basis unless organisational changes, legislation, guidance or non-compliance prompt an earlier review. This policy will remain in force until such time as a new one is formally agreed.

12. LINKS TO OTHER DOCUMENTS

- Disciplinary Policy
- Equality & Diversity Policy
- Deprivation of Liberty Safeguards and Mental Capacity Act Policy

Appendix 1 – POLICY TEMPLATE

Insert Policy Title

Solent NHS Trust policies can only be considered to be valid and up-to-date if viewed on the intranet. Please visit the intranet for the latest version.

Purpose of Agreement	Summarise v. briefly what this document is about
Document Type	☐ Policy
Reference Number	Solent NHST/Policy/ Insert unique document number
Version	Insert version number
Name of Approving Committees/Groups	Xxxxxx, Policy Steering Group, Assurance Committee
Operational Date	Insert date of when document was ratified
Document Review Date	Insert the review date. This date is usually 3 years after operational date.
Document Sponsor (Job Title)	Insert the job title of the Executive Lead
Document Manager (Job Title)	Insert the job title of the person responsible for writing/reviewing
Document developed in consultation with	List the main groups/staff that were consulted with during development
Intranet Location	Insert the location of the document on the intranet
Website Location	Insert the location of the document on the FOI Publication Scheme
Keywords (for website/intranet uploading)	Insert the metadata/keywords that will be used to locate the document on the intranet / website

Amendments Summary:

Please fill the table below:

Amend No	Issued	Page	Subject	Action Date

Review Log:

Include details of when the document was last reviewed:

Version Number	Review Date	Lead Name	Ratification Process	Notes

SUMMARY OF POLICY

In no more than 2 pages summarise the key points of the policy (this should form an executive summary of the policy)

All policies must have a summary that staff can refer to in an 'easy read' version.

Table of Contents

Insert table of contents here. This table is provided just for easy use.

Note: This template follows the rule of sequential paragraph numbering for every paragraph in the main body. Therefore the following numbering style for sub numbers is recommended. Font must be 'Calibri' 11.

1. AAAAAAAAAA

1.1 aaaaaaaaaaa

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3. AAAAAAAAAA

Please delete this page. This is just for information

INSERT DOCUMENT TITLE

1. INTRODUCTION & PURPOSE

1.1 Insert text

1.2 Insert text as required

2. SCOPE & DEFINITIONS

2.1 This policy applies to ** locum, permanent, and fixed term contract employees (including apprentices) who hold a contract of employment or engagement with the Trust, and secondees (including students), volunteers (including Associate Hospital Managers), bank staff, Non-Executive Directors and those undertaking research working within Solent NHS Trust,* in line with Solent NHS Trust's Equality, Diversity and Human Rights Policy. *It also applies to external contractors, agency workers, and other workers who are assigned to Solent NHS Trust.*

2.2 To be used if the document applies to patients/clients/service users:
"Solent NHS Trust is committed to the principles of Equality and Diversity and will strive to eliminate unlawful discrimination in all its forms. We will strive towards demonstrating fairness and Equal Opportunities for users of services, carers, the wider community and our staff.

2.3 Insert any definitions for any terms used. A glossary must be used where there are many acronyms used.

3. PROCESS/REQUIREMENTS

3.1 This is the main body of the document. There is no prescriptive way of detailing this section and the main body of the document will be unique depending on the subject matter. Include subsections/ change numbering as required.

4. ROLES & RESPONSIBILITIES

4.1 Outline here (subsections may be necessary) the different roles and responsibilities staff / users and committees/groups may have in relation to this document. Detail where ultimate responsibility lies within the organisation.

5. TRAINING

5.1 Outline here any training implications or issues as a result of this document. The Document Manager must ensure that the Learning & Development Team have been engaged in the development of the document where any learning or training needs have been identified.
Attendance at any training session carried out as a consequence of the document implementation must be formally recorded and documented.

6. EQUALITY IMPACT ASSESSMENT AND MENTAL CAPACITY

6.1 Include a statement summarising the outcome of the Impact Assessment that was conducted in relation to this document, making reference to the Impact Assessment form which must be appended to the document. (See Appendix A).

7. SUCCESS CRITERIA / MONITORING EFFECTIVENESS

7.1 The Document Manager must be able to demonstrate the effectiveness of the document at the point of review, for example by; carrying out audits, reviewing incidents that may have occurred related to the document, discussing the document at team meetings. Any subsequent issues/findings resulting from the review should be incorporated in the new version of the document.

7.2 This section should include details of the following (in accordance with NHSLA best practice);

- When will implementation be reviewed
- who will carry out the review
- using what tool (attach as an appendix) and, where applicable, sample size
- where will results be presented
- how will actions be monitored
- how often will a review take place

7.3 State that non-compliance must be reported.

7.4 Give consideration to including an Evaluation Standard - a basic tool drawing out the main points of the document, in the form of questions, which can be used by managers to easily and quickly assess the implementation of the policy.

8. REVIEW

8.1 All policy documents must include the following statement:
'This document may be reviewed at any time at the request of either staff side or management, but will automatically be reviewed 3 years from initial approval and thereafter on a triennial basis unless organisational changes, legislation, guidance or non-compliance prompt an earlier review.'

9. REFERENCES AND LINKS TO OTHER DOCUMENTS

9.1 Where applicable, the document must contain a section detailing *the* Research/ Evidence/ References that were used to assist with the development of the Document. Some of this information may be included at the beginning of the document as way of an introduction but should be referenced in full at the back of the document. The Harvard Referencing System should be used as standard.

9.2 Signpost the reader to other relevant and supporting Trust policies / Standard Operating Procedures. (Ensure these are cross referenced within the main body of the document where appropriate). Check that any links to policies / web links exist before listing them.

10. GLOSSARY

10.1 Insert a glossary of abbreviations / acronyms used

Appendix: A Equality Impact Assessment

Step 1 – Scoping; identify the policies aims	**Answer**		
1. What are the main aims and objectives of the document?			
2. Who will be affected by it?			
3. What are the existing performance indicators/measures for this? What are the outcomes you want to achieve?			
4. What information do you already have on the equality impact of this document?			
5. Are there demographic changes or trends locally to be considered?			
6. What other information do you need?			
Step 2 - Assessing the Impact; consider the data and research	**Yes**	**No**	**Answer** (Evidence)
1. Could the document unlawfully discriminate against any group?			
2. Can any group benefit or be excluded?			
3. Can any group be denied fair & equal access to or treatment as a result of this document?			
4. Can this actively promote good relations with and between different groups?			
5. Have you carried out any consultation internally/externally with relevant individual groups?			
6. Have you used a variety of different methods of consultation/involvement			
Mental Capacity Act implications			
7. Will this document require a decision to be made by or about a service user? (Refer to the Mental Capacity Act document for further information)			
External considerations			
8. What external factors have been considered in the development of this policy?			

9. Are there any external implications in relation to this policy?			
10. Which external groups may be affected positively or adversely as a consequence of this policy being implemented?			

If there is no negative impact – end the Impact Assessment here.

Step 3 - Recommendations and Action Plans	**Answer**
1. Is the impact low, medium or high?	
2. What action/modification needs to be taken to minimise or eliminate the negative impact?	
3. Are there likely to be different outcomes with any modifications? Explain these?	
Step 4- Implementation, Monitoring and Review	**Answer**
1. What are the implementation and monitoring arrangements, including timescales?	
2. Who within the Department/Team will be responsible for monitoring and regular review of the document?	
Step 5 - Publishing the Results	**Answer**
How will the results of this assessment be published and where? (It is essential that there is documented evidence of why decisions were made).	

****Retain a copy and also include as an appendix to the document****

Appendix 2 – SOP /GUIDANCE TEMPLATE

NHS Solent NHS Trust

Insert title of Standard Operating Procedure/ Guideline

Solent NHS Trust procedures can only be considered to be valid and up-to-date if viewed on the intranet. Please visit the intranet for the latest version.

Purpose of Agreement	Summarise v. briefly what this document is about
Document Type	☐ SOP ☐ Guideline
Reference Number	Solent NHST/SOP/GUIDANCE / Insert unique document number
Version	Insert version number
Name of Approving Committees/Groups	Insert name of groups presented
Operational Date	Insert date of when document was ratified
Document Review Date	Insert the review date. This date is usually 3 years after operation date.
Document Sponsor (Job Title)	Insert the details of the Executive Lead
Document Manager (Job Title)	Insert the details of the person responsible for writing/reviewing
Document developed in consultation with	List the main groups/staff that were consulted with during development
Intranet Location	Insert the location of the document on the intranet
Website Location	Insert the location of the document on the FOI Publication Scheme
Keywords (for website/intranet uploading)	Insert the metadata/keywords that will be used to locate the document on the intranet / website

Amendments Summary:

Please fill the table below:

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Table of Contents

Insert table of contents here. This table is provided just for easy use.

Note: This template follows the rule of sequential paragraph numbering for every paragraph in the main body. Therefore the following numbering style for sub numbers is recommended. Font must be 'Calibri' 11.

Use a logical structure throughout your document.

Appendix 3 - Equality & Human Rights and MCA Impact Assessment (for this policy)

Step 1 – Scoping; identify the policies aims	Answer
1. What are the main aims and objectives of the document?	To outline the process for creating, reviewing and ratifying policies and standard operating procedures within Solent NHS Trust
2. Who will be affected by it?	All staff who are developing internal control documents
3. What are the existing performance indicators/measures for this? What are the outcomes you want to achieve?	n/a
4. What information do you already have on the equality impact of this document?	No
5. Are there demographic changes or trends locally to be considered?	n/a
6. What other information do you need?	N/a

Step 2 - Assessing the Impact; consider the data and research	Yes	No	Answer /evidence
1. Could the document unlawfully discriminate against any group?		x	
2. Can any group benefit or be excluded?		x	Applies to all staff groups
3. Can any group be denied fair & equal access to or treatment as a result of this document?		X	N/A
4. Can this actively promote good relations with and between different groups?		X	N/A
5. Have you carried out any consultation internally/externally with relevant individual groups?	X		Current Policy Steering Group members consulted and wider groups represented by PSG members.
6. Have you used a variety of different methods of consultation/involvement	X		Via email and face to face meetings
Mental Capacity Act implications			
7. Will this document require a decision to be made by or about a service user? (Refer to the Mental Capacity Act document for further information)	X		Does not apply to patients
External considerations			
8. What external factors have been considered in the development of this policy?			Consideration of the types of people affected by this policy
9. Are there any external implications in relation to this policy?		X	N/A
10. Which external groups may be affected positively or adversely as a consequence of this policy being implemented?		X	N/A
If there is no negative impact – end the Impact Assessment here			

Step 3 - Recommendations and Action Plans	Answer
1. Is the impact low, medium or high?	
2. What action/modification needs to be taken to minimise or eliminate the negative impact?	
3. Are there likely to be different outcomes with any modifications? Explain these?	

Step 4- Implementation, Monitoring and Review	Answer
1. What are the implementation and monitoring arrangements, including timescales?	
2. Who within the Department/Team will be responsible for monitoring and regular review of the document?	

Step 5 - Publishing the Results	**Answer**
How will the results of this assessment be published and where? (It is essential that there is documented evidence of why decisions were made).	

Appendix 4 - Non Compliance Form (Staff Member)

Please complete this form to notify the organisation of non-compliance with approved Solent NHS Trust policy, where the policy requirements cannot be applied to the specific set of circumstances experienced by the individual.

Policy name:	
Policy reference number:	
Policy Document Manager:	
Date of non-compliance:	
Service:	
Site:	
Concerning (staff name, if appropriate)	

Please state the section(s) of the policy which cannot be applied and detail the policy requirements.
Please detail the reason(s) why compliance cannot be achieved in this instance

Is this likely to happen again?	**YES**	**NO**
In your opinion, does the policy need to be reconsidered to meet the specific circumstances of your service?	**YES**	**NO**

Please detail the risk posed by non-compliance, any action taken in this instance (including completion of an Incident form) and any steps to minimise risk from non-compliance in the future.

Incident form reference:	
Alternative course of action authorised by:	
Please sign:	
Please print name:	
Please print designation:	
Form completed by:	
Please sign:	
Please print name:	
Please print designation:	
Please date:	

Please send copies of this form to the Policy Document Manager and to the Policy Steering Group Administrator at Solent NHS Trust Headquarters, Highpoint Venue, Bursledon Rd, Southampton, SO19 8BR

Appendix 5 - Non Compliance Form (Service)

Please complete this form to notify the organisation of non-compliance with approved Solent NHS Trust policy, where the policy requirements cannot be applied to the specific set of circumstances experienced by the service.

Policy name:	
Policy reference number:	
Policy Document Manager:	
Date of non-compliance:	
Service:	
Site:	

Please state the section(s) of the policy which cannot be applied
Please detail the reason(s) why compliance cannot be achieved
Please detail the risk posed by non-compliance, any action taken to mitigate / minimise the risk, including details of alternative procedures / practices being implemented. *If an alternative SOP has been developed please confirm that the Policy Document Sponsor / and or subject matter expert have been consulted with and have approved the SOP*.

Please print name:	
Please print designation:	
Please date:	

Please send copies of this form to the Policy Document Manager and to the Policy Steering Group Administrator at Solent NHS Trust Headquarters, Highpoint Venue, Bursledon Rd, Southampton, SO19 8BR

APPENDIX 6 - Equality & Human Rights and Mental Capacity Act Impact Assessment

Implications for developing Policies

Q1. What is an Impact Assessment?

"Impact Assessment is a systematic way of finding out whether a document, function or service (or one which is proposed) affects different groups differently. It should be part of normal document making process" (Commission of Racial Equality 2003).
Equality & Human Rights Impact Assessment therefore focuses on systematically assessing the likely impact of a document. It anticipates the consequences of the impacts identified on people with the aim to eliminate or minimise any negative consequences, at the same time creating opportunities for ensuring equality in service provision and delivery as well as in employment.

The Mental Capacity Act (MCA 2005) ensures that the rights of patients are supported during any time when they are temporarily or permanently unable to make informed decisions

Q2. Why do we need to do an Impact Assessment?

The duty to undertake Impact Assessments is a legal duty under the race, disability, gender and human rights legislation.
You will be required to demonstrate evidence that an Impact Assessment has been carried out in relation to your document development.

Q3. What does it cover?

An Impact Assessment should cover the following six areas of equality; Age –
Disability – Gender – Race – Religion/Belief – Sexual Orientation
It is also necessary to ensure that the document will not negatively impact on individuals under the MCA 2005

Q4. But many of our policies are national requirements based on national guidance – so why do we have to do a separately Impact Assessment?

It is true in some cases that our policies will be written in accordance with National Document or Guidance and that an impact assessment may have already been considered; however, it is essential that local consideration is given to the six equality areas to ensure that the document is not discriminating or disadvantaging our local stakeholders (i.e. staff or patients etc).

Q5. How do I carry out an Impact Assessment?

All Document Managers should refer to the 'Equality & Human Rights Impact Assessment' document which is located on the intranet for further information. All Document Managers of new policies must complete the standard impact assessment template, append it to the document and retain a copy as evidence.
It is essential that the relevant groups of stakeholders are consulted in the development of policies and that the impact assessment is carried out as part of the
document development with stakeholders. Every time a document is reviewed it is essential that the Impact Assessment is also reviewed. The template to complete is located within Appendix A or the Policy Template (Appendix 1 of the Policy on Policies).
Document Managers will be asked to discuss the Impact Assessment at the Policy Steering Group meeting.