Management of Care and Clinical and Non-Clinical Documents Policy

Including strategies, policies, standard operating procedures, clinical guidelines, clinical protocols and other Trust documents

Document Information

This is a controlled document. It should not be altered in any way without the express permission of the author or their representative. On receipt of a new version, please destroy all previous versions.

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Author:	Company Secretary			
Director Responsible	Corporate			
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Approved By:			**Date Approved:**	
Executive Team			12 May 2020	
Links or overlaps with other policies:				

Amendment History

Issue	Status	Date	Reason for Change	Authorised
v0.1	Draft	October 2016	Re-write post ICO	Corporate Governance Team
v 0.2	Draft	February 2017	Revised	Senior Nursing Team
v0.3	Draft	February 2017	Revised	Senior Nursing Team
V1	Current	25 April 2017	Approved	Executive Team
V1.1	Draft	September 2018	Revised	Medical Director and Chief Nurse
V1.2	Draft	April 2020	Revised/updated re governance changes	Executive Team
V1.3	Draft	March 2021	Revised/ templates added	Risk Group

Contents

1. Introduction

In this policy the word 'document(s)' refers to strategies, policies, standard operating procedures, clinical guidelines, clinical protocols and other documents, as defined in Appendix 1. The purpose of this policy is to ensure a structured and systematic approach to the development, review, ratification and archiving of these documents.

1.1   It will support the evidence process for external and internal assessments e.g. Care Quality Commission (CQC) inspections, NHS Resolution and Information Governance Toolkit to ensure that all documents:

- are of a consistently high standard;
- are up-to-date and based on current best practice;
- are accessible to all staff,
- meet operational, legal, insurance and statutory obligations; and
- are approved by the appropriate committee/group as well as implemented, monitored and evaluated on a regular basis.

2. Policy Statement

2.1   This policy will apply to all documents as defined in appendix 1 that are produced by and for Torbay and South Devon NHS Foundation Trust (hereby known as 'the Trust') staff or for use within the Trust.

2.2   The implementation of this policy will ensure all ratified documents are compliant, consistent, fit for purpose and where applicable suitable for public access.

3. Responsibilities

3.1   The effective management of Trust documents ultimately lies with the Chief Executive Officer. The Trust has a responsibility to ensure that documents are a key part of the Trust's internal controls and processes.

3.2   Day-to-day responsibilities relating to all staff, line managers, document owners/authors/originators, Clinical Effectiveness Department, Company Secretary, corporate document database administrator and ratifying committee/group administrator are outlined in appendix 2.

4. Writing, Reviewing, Ratifying and Monitoring

Documents Writing Documents

4.1   The development of all documents must involve, where appropriate consultation of one or more of the following:

Patients, clients, service users, carers, relevant members of staff who hold key knowledge in subject area, stakeholders and/or partners including outside agencies.

4.2   Documents must not discriminate any person by gender, sexual orientation, marital status, race, religion, colour, age or disability and have been through an Quality and Equality Impact Assessment (QEIA) prior to being presented for ratification.

4.3   All documents will be presented in a standard structure and format and be written in a clear, concise and easy to read style. The templates that are used on ICON are locked down to ensure that only the correct formatting can be used. Any documents not in the correct template will not be ratified. For care and clinical documents, the clinical effectiveness department will support with formatting. Acronyms should be avoided or clearly referenced where appropriate. All documents are to be created in black, Arial font size 11 text throughout unless referring to a link or a diagram or using footnotes etc.

4.4   All documents must be marked clearly with a 'draft' watermark until ratified by the appropriate committee/group and follow version control guidance. The 'draft' watermark must be removed once ratified and before being sent for upload to ICON and the website.

4.5   Associated or linked documents that may support or impact the policy must be listed in the 'document information' section under the heading 'links or overlaps with other policies'.

4.6   Any material/sources used in writing a document must be appropriately referenced by clearly marking the reference and then including the source and date in either the footer of that page, or as a separate section at the end of the document.

4.7   For care and clinical documents where hyperlinks are required for internal documents, these will be activated by the clinical effectiveness department. For external hyperlinks the date last accessed must be recorded on the document by the author.

4.8   Document authors MUST NOT post ratified documents on any departmental or team intranet sites. Links can be used for this purpose through liaison with the document librarians.

Reviewing Documents

4.9   Documents must be reviewed by their review date, and a new review date set, which should be agreed by the ratification committee/group. A reminder system is in place to provide designated ratifying committees/groups with regular reports on the documents that are due for review or are out-of-date.

4.10   If there are no changes to the document, the review date will be moved forward as agreed by the ratification committee/group and the amendment history is completed.

4.11   If there are minor changes to the document before a formal review, e.g. correction of spelling mistakes, change of staff roles or addresses, etc. which do not have an effect on care or clinical services, staff, users, financial or training implications the author will inform the document librarian and keep the review date as set.

4.12   If a document has major changes then it should be treated as a new document and consulted on appropriately.

4.13   The ratification committee/group must record in the minutes/notes from each meeting all documents which have been ratified.

Ratifying Documents

4.14 Documents should be ratified by an appropriate committee/group before being implemented within the Trust. A list of documents and the committees/groups that can ratify documents is listed in appendix 6.

4.15 The ratification committee/group must include within their terms of reference the responsibility for ratification of relevant documents. A record in the minutes/notes from each meeting must be made for all documents which have been ratified.

4.16 The ratification committee/group will determine if a document is **NOT** suitable for publication on the Trust public website and the chair will inform the document librarians.

Adopting External Documents

4.17 In some instances, the Trust will adopt documents from external organisations / professional regulatory bodies and/or other recognised Groups where the document sets out best practice as agreed by a broad expert group e.g. Peninsula Neonatal Network, Safeguarding Boards, Chartered Society of Physiotherapy.

4.18 On occasions urgent patient presentations may require clinicians to adopt a clinical guideline from a specialist centre of excellence to ensure immediate patient safety. On such occasions the clinicians would be required to record the source of the guidance followed.

Implementing and Monitoring Documents

4.17 Approved documents will be distributed and implemented via the Trust's public website and ICON; additional awareness can be raised through the staff bulletin. Documents that are not suitable for the public facing website will be published on ICON only.

4.18 Audit checks will be undertaken on a regular basis by the Clinical Effectiveness Department and Corporate Document Database Administrator to ensure all ratified documents are available and accessible to staff.

4.19 All new policy documents will be reviewed within two years in the case of non-clinical documents and three years in the case of clinical documents, unless indicated otherwise. The subsequent review period will be determined according to the nature of the document. No review date should extend longer than within two years in the case of non- clinical documents and three years in the case of clinical documents.

4.20 Policies must be reviewed when there is a change to the organisation structure, legislation, evidence or best practice. This will ensure that documents are up-to-date and relevant at all times.

4.21 All draft copies of the documents should be destroyed by the author, once the document has been ratified.

4.22 Previous documents will be archived for future reference in accordance with the Trust's retention and disposal schedule.

Flowcharts

4.23 The process for the:

- creation and review of **non-clinical** documents can be found as at appendix 3;

- production of **care and clinical** documents and review of existing **care and clinical** documents can be found as at appendix 4; and

- review and revision of published **care and clinical** guidance can be found as at appendix 5.

5. Training and Awareness

5.1 Advice and support for authors of care and clinical documents will be provided by the Clinical Effectiveness Team (contact details as at section 7) in the developing, reviewing and ratifying of documents.

5.2 Training, advice and support for **non-clinical documents** will be provided by the Foundation Trust Office (contact details as at section 8) to support staff in developing, reviewing, ratifying and publishing documents on ICON and the Trust's public website.

5.3 The corporate document database administrator (CDDA) will raise awareness of this policy through the publication of information on ICON and advise staff of changes through the staff bulletin and various ratification committees/groups.

6. Monitoring, Auditing and Review of this Policy

6.1 The use of this policy for the development of documents will be monitored by the Foundation Trust Office in collaboration with the Clinical Effectiveness Department through the ratification procedure and the internal audit programme.

6.2 This policy will be reviewed by the Company Secretary after one year and then every three years or earlier if working practices change. This policy document will be approved by the Executive Team.

7. Distribution

7.1 This policy document will be made available to staff via ICON, the Trust Website and signposted in the Staff Bulletin.

7.2 Awareness will be raised through Equality Impact Assessment training, all ratifying committees/groups, policies and procedures training and ICON.

8. Key Contacts

Care and Clinical documents	Clinical Effectiveness Team	01803 655802
Non-clinical documents	Foundation Trust Office	01803 655705

9. Appendices

Appendix 1   Definitions

Appendix 2   Responsibilities

Appendix 3   Creation and review of **non-clinical** documents

Appendix 4   Process for production of **care and clinical** documents and review of existing **care and clinical** documents

Appendix 5   Process for review and revision of published **care and clinical** guidance

Appendix 6   Committee/group ratification structure

Appendix 7   Rapid equality impact assessment

Appendix 8   Blank policy template

Appendix 9   Standard operating procedure (SOP) template

Appendix 1

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Definitions

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Strategy
- Defines an overall outline and direction that will help co-ordinate long term planning and decision making;
- Supports an overarching NHS or Social Care Strategic Plan and presents what is to be achieved;
- Is time limited, although the time line can be decades and the strategy can be reviewed at any time;
- Usually has an action plan and identifies risks to the organisation.

Policy
- Is an overarching statement of intent which explicitly states who is responsible and accountable for the subject of the policy;
- It states how to comply with relevant legislation, guidelines and good working practices;
- It may include specific expectation of what is to be achieved and why.
- It may include a plan or course of action that is intended to influence and determine decisions, actions;
- It provides a safe environment for individuals or specific groups to work within
- It is not open to interpretation or professional judgment and it is non-negotiable.

Standard Operating Procedure (SOP)
- Is the way that a named policy is implemented;
- Can cover one aspect of care;
- Is a step-by-step method of how to do something;
- Based on best practice;
- Provides clarity and consistency;
- Deviation is not an option although alternatives may be specified.

Code of Practice
- Supports a named policy;
- Is a documented procedure operated by public bodies to enable them to comply with legislation e.g. NMCs Code of Professional Practice.

Clinical Guideline/Guidance
- The term 'guideline(s)' is intended when it is recognised that there is not an exclusive course of action to take, but they represent known best practice and compliment any existing standard.
- Supports the named policy or strategy;
- Is not prescriptive;
- Is a systematically developed evidence-based statement;
- Is flexible and acts as a support and guide;
- Allows individuals to use their professional judgement and decision-making skills concerning the appropriate care or delivery of service;
- Supports the improvement of care in all aspects of the service;
- Is prescriptive when used by unregistered health and care staff as the registered member of staff retains accountability and they alone can change the guidance.

Clinical Protocol
- Written as a practical education resource for health professionals and as a core component of disease management initiatives;
- Does not allow deviation, except by registered staff if the action and reason is clearly documented and based on an evidence base;
- Shows delegation and clear accountability;
- Standardises a safe approach to a task or intervention related to specific skills and knowledge required;
- Is designed to protect both staff and patients.

NB: It is important when using a protocol or guideline to document clearly any reason why in the case of an individual patient/client/service user it has not been followed. They should be developed using the current available evidence, expert opinion or accepted current best practice.

Standard
- Underpins a procedure, guideline or protocol;
- Is a minimum performance/outcome which is widely recognised or employed because of its level of excellence or attainment;
- Is sometimes included as part of a policy, procedure, guideline or protocol.

Competency Frameworks

- Defines the knowledge and practical experience required to be demonstrated by a Healthcare Professional to undertake a specific intervention. In some cases it acts as the assessment documentation/evidence of competence.

Care Pathways

- A hybrid document combining sequenced clinical guidance/actions, with areas for clinical recording for the management of a specific disease or condition, along an anticipated pathway of care.

  Like a Clinical Protocol it does not allow deviation, except by registered staff if the action and reason is clearly documented and based on an evidence base and clinical judgement relating to the clinical situation.

Clerking Proformas

- A document for clinical recording for the management of a specific disease or condition in an emergency situation, along an anticipated pathway of care. It may have some clinical guidance, but in a much more limited format than the Care Pathway.

Patient Group Direction (PGD)

- Definition in (Patient Group Directions Policy ref 1782)

  "A PGD is a specific written instruction for the supply or administration of a licensed named medicine including vaccines to specific groups of patients who may not be individually identified before presenting for treatment".

  Health Service Circular 2006 https://www.nice.org.uk/guidance/mpg2 *(updated March 2017)*

Patient Specific Direction (PSD)

- A Patient Specific Direction (PSD) is a written instruction, signed by a prescriber for medicines to be supplied and/or administered to a named patient after the prescriber has assessed the patient on an individual basis. In practice, a PSD is may be referred to as a "prescription" by those who write and follow them because this indicates that it is written by a prescriber.

https://www.rcn.org.uk/clinical-topics/medicines-management/patient-specific-directions-and-patient-group-directions

Appendix 2

Responsibilities
(Day-to-day responsibilities for all staff, line managers, document owners/authors/ originators, Clinical Effectiveness Department, company secretary, corporate document database administrator and ratifying committee/group)

All Staff

Have a responsibility to:

- read and understand and align working practice with all documents relating to their areas of work and role.
- report any changes relating to best working practice to their manager, so that the document can be reviewed and updated.

All Line Managers

Have a responsibility to ensure staff have:

- access to all relevant documents
- working environments, processes and practices that meet the requirements of the documents
- received any relevant training and education to support them in aligning their work with Trust documents
- a responsibility for ensuring that staff who are authorised for developing documents are fully trained and aware of this policy and the process involved (appendix 5).

Document Owner/Author/Originator

Have a responsibility to:

- ensure that the document does not exceed its review date and undertaking any creations, reviews or amendments, ensuring that the document is fully consulted upon and meets with the current document format;
- supply information source references as required
- submit an "Quality and Equality Impact Assessment Form" (QEIA) prior to its ratification
- liaise directly with the Trust Equality and Diversity Lead in relation to any potential impact identified through the QEIA form.
- ensure that documents are presented for ratification two weeks prior to relevant ratification committee/group meeting. Once ratification has been completed, documents can be published in accordance with appendix 3.
- For non-clinical documents follow guidance in Appendix 3. For care and clinical documents follow guidance in Appendix 4.

For Care and Clinical Documents

- The ratification process for care and clinical documents includes approval by directorate meeting e.g. cardiology, specific group e.g. Infection Prevention and Control Group or Trust wide Care and Clinical Policy Group.
- Signature approval is also required from the relevant Clinical Director/Committee Chair and/or Executive Level sign off.
- Additional ratification is required from the Director of Pharmacy if the content makes reference to the use of drugs or drug dosages.
- Ratified documents require a 2 yearly review and the Clinical Effectiveness Department inform the relevant Integrated Service Unit (ISU) and department 4 months in advance of the review due date. Re-ratification will then be required with the exception of date change only and/or logistic changes e.g. telephone contact details.

The Clinical Effectiveness Department

Have a responsibility to:

- support the document originator in the formatting of new and revised documents into the agreed Trust format
- maintain a publication history of the document with version numbering
- publish new and revised ratified documents onto the intranet and public websites on a weekly basis, and also publish notification of changes to all relevant staff groups
- maintain the metadata related to each document
- notify originators of the requirement to review their documents (every 3 years, unless otherwise agreed) approximately 4 months prior to the review date; and
- manage and report monthly on the notification of documents to ISU or relevant department which remain un-reviewed post expiry, and the escalation of these to the executive.

Company Secretary

Responsible for the management of the corporate records system and has responsibility for overseeing corporate document creation, review, ratification and publication for all corporate documents. The Company Secretary will produce reports to ratifying committees/groups identifying documents due for review in the next three months and for those that are out of date and may pose a risk to the Trust.

Corporate Document Database Administrator (DDA)

Has a responsibility to create and publish reports from the document database for the ratifying committees' librarians, uploading ratified documents to the database and ensuring it is maintained.

All documents will be published on the Trust public website as part of our responsibilities under the Freedom of Information Act 2000.

There will be a small number of documents which will not be suitable for public viewing; these will be agreed by the ratification committee/group. These will be made available on the Trust's intranet site.

Ratifying Committee/Group Administrator

Have a responsibility to:

- receive a monthly report from the DDA identifying documents due for review in the next three months and/or overdue to ensure that these have been allocated a document owner/author for review;
- identify any areas of risk relating to the document and record there on the risk register; and
- assist the Chair of the committee/group to ensure all documentation is in the correct format/template and are fit for purpose before ratification and publication through the DDA.

Appendix 3
Creation and review of <u>Non-Clinical</u> Documents

Step 1

Identification of need

Step 2

Document owner, author and working group identified

Step 3

Document owner drafts document using the correct template and format

Step 4

Author sends document out for consultation with a set timescale for working group to provide feedback. Author incorporates feedback and makes necessary amendments to the document

Step 7

The author completes and submits the ratification sheet and document to the appropriate committee/group to go on to the next agenda (document must be sent at least two weeks prior to next committee)

Step 6

Author completes EIA form and sends to Trust's Equality and Diversity Lead

Step 5

Where appropriate the document is viewed by a third party for verification

Step 8

Document is represented by its author at the appropriate committee/group for approval

Not Ratified

Ratified

Ratified With Conditions

Step 9

Document sent to document database administrator to upload to ICON and website with copy of ratification and EIA

Step 8a

Document is amended or viewed and reviewed following the conditions of the ratification committee/group

Step 8b

Document reviewed by Chair of the ratification committee/group for approval with regard to the conditions of the ratification

Step 10

Three months prior to the documents review date, go back to **step 3** and follow process

Appendix 4

Process for Production of <u>Care and Clinical</u> Documents and Review of Existing <u>Care and Clinical</u> Documents

NB. Patient Group Directions (PDG) are also published by the Clinical Effectiveness Group onto the intranet, in conjunction with Pharmacy, who manage the production of these documents and ratification through the Medicines Management Group.

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                         ( New Document )
                                │
                                ▼
┌───────────────────────────────────────────────────────────────────────┐
│ Originator will:                                                        │
│     Prepare wording / flowcharts etc / evidence / references, and agree │
│     content with peers.                                                 │
│ Then -                                                                  │
│     Email the document to the Clinical Effectiveness Department (CED)    │
│     with the following information:                                     │
│     1.  Person responsible for review                                   │
│     2.  Evidence base / references                                      │
│     3.  Classification – see categories in policy – appendix 1          │
│     4.  Key search terms                                                │
│     5.  Completed Rapid EQIA.                                           │
│ Template documents are available from the Clinical Effectiveness         │
│ Department, or their website                                            │
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          ┌──────────────────────────────────────────────────┐
          │ Clinical Effectiveness Department will:          │
          │   1.  Allocate a temporary number for draft       │
          │       purposes                                    │
          │   2.  Register on database                         │
          │   3.  Prepare document in standard Trust format    │
          │   4.  Return to originator for confirmation        │
          │       document is correct                          │
          └──────────────────────────────────────────────────┘
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              │   On confirmation document is correct  │
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                                ▼
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              Yes      ╱ discuss / recommend  ╲      No
           ┌─────────◄   drugs and or dosages? ►─────────┐
           │          ╲                       ╱          │
           ▼           ╲                     ╱           ▼
   ┌──────────────┐                              ┌────────────────────┐
   │ CED forwards │                              │ CED forwards       │
   │ document to  │                     Yes      │ document to        │
   │ Pharmacy for │              ┌─────────────► │ relevant Department │
   │ approval     │              │               │ Group Meeting for   │
   └──────────────┘              │               │ approval            │
           │                     │               └────────────────────┘
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      ╱ Approved? ╲──── Yes ─────┘                         ▼
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    No │                                       │ Approving Department│
       ▼                                       │ Meeting notifies    │
 ┌──────────┐                                  │ outcome to CED and  │
 │ Return to│                                  │ evidences via       │
 │ Originator│                                 │ signature of Group  │
 │ for rework│                                 │ Chair or extract    │
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                                          Yes            ▼         No
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 │  Clinical Effectiveness Department will:          │      │ Return to│
 │                                                   │      │ Originator│
 │   1.  Allocate a permanent reference number       │      │ for rework│
 │   2.  Initiate version history                    │      └──────────┘
 │   3.  Make document available on the intranet /   │
 │       public website as indicated                 │
 │   4.  Assign a next review date                   │
 │   5.  Notify publication of document              │
 ╰──────────────────────────────────────────────────╯
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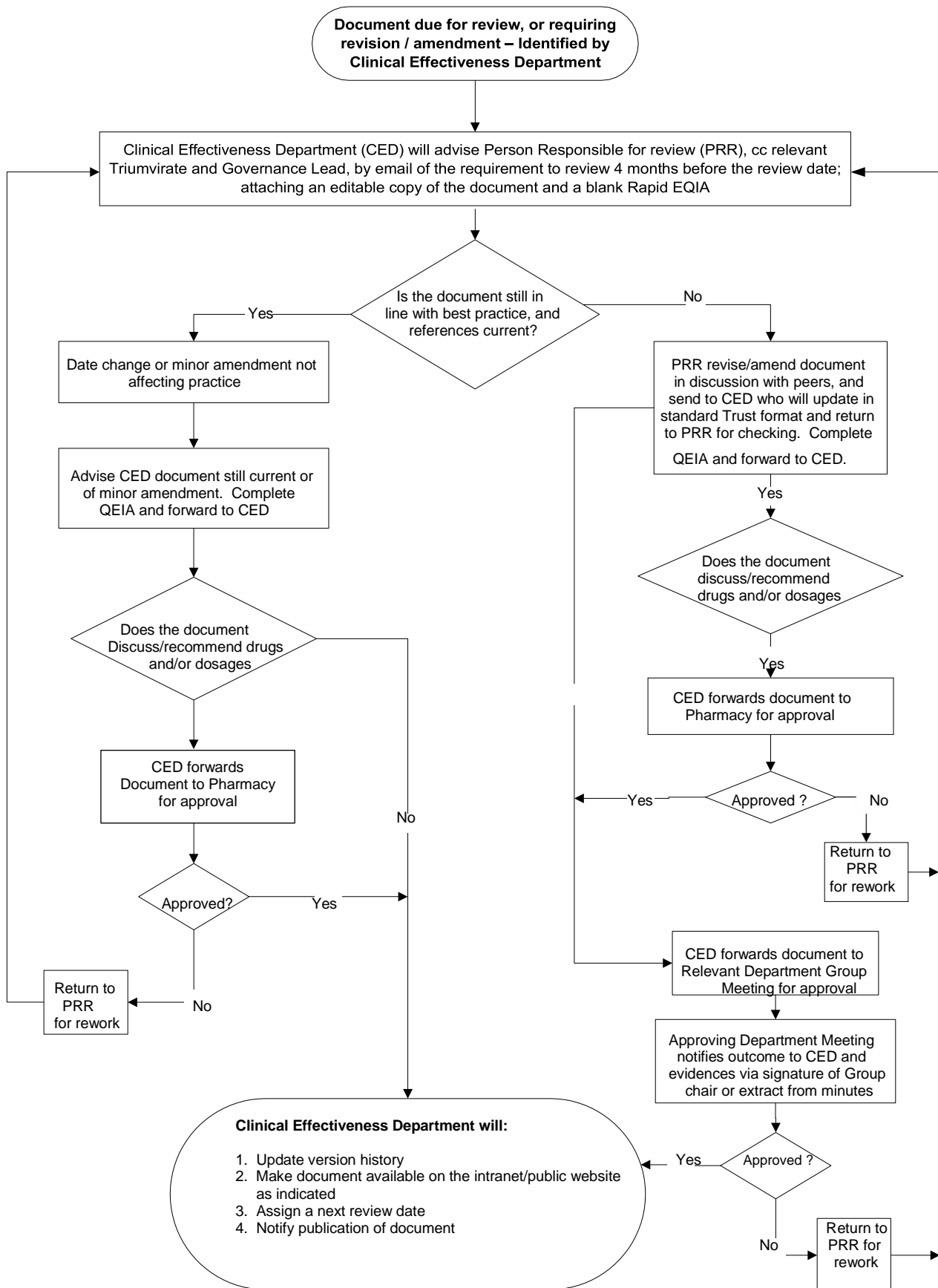
Appendix 5

Process for Review and Revision of Published Clinical Guidance

Document due for review, or requiring revision / amendment – Identified by Clinical Effectiveness Department

Clinical Effectiveness Department (CED) will advise Person Responsible for review (PRR), cc relevant Triumvirate and Governance Lead, by email of the requirement to review 4 months before the review date; attaching an editable copy of the document and a blank Rapid EQIA

Is the document still in line with best practice, and references current?

Yes

Date change or minor amendment not affecting practice

Advise CED document still current or of minor amendment. Complete QEIA and forward to CED

Does the document Discuss/recommend drugs and/or dosages

No

CED forwards Document to Pharmacy for approval

Approved?   Yes

No

Return to PRR for rework

No

PRR revise/amend document in discussion with peers, and send to CED who will update in standard Trust format and return to PRR for checking. Complete QEIA and forward to CED.

Yes

Does the document discuss/recommend drugs and/or dosages

Yes

CED forwards document to Pharmacy for approval

Yes   Approved ?   No

Return to PRR for rework

CED forwards document to Relevant Department Group Meeting for approval

Approving Department Meeting notifies outcome to CED and evidences via signature of Group chair or extract from minutes

Yes   Approved ?

No

Return to PRR for rework

Clinical Effectiveness Department will:

1. Update version history
2. Make document available on the intranet/public website as indicated
3. Assign a next review date
4. Notify publication of document

Process for management of <u>care and clinical</u> documents overdue for review:

- Responsibility for the management of care and clinical documents falling overdue for review rests with the triumvirate* of the ISU in which the author of the document is located.
  *(Triumvirate consists of the ISU System Director; the Associate Director of Nursing and Professional Practice and the relevant System Medical Director).

- The Clinical Effectiveness Department holds the responsibility of maintaining records relating to the progress of documents through the notification of requirement to review, updating of documents, and progress through approval and ratification. From this information a suite of reports and tools are supplied on a monthly basis to the ISU triumvirate and governance leads to enable their management of documents.

- The ISU should review the risk and impact of the out of date documentation being made available on the intranet (and in some cases public website), and consider adding to their ISU risk register.

Appendix 6

Ratification Structure

All documents should be ratified as set out below unless there is a requirement for the document to be ratified by the Board of Directors.

Please note that policies should be passed through the relevant steering/working groups for comment prior to submission to the ratification committee/group.

Documents will be categorised as follows:

Category	Area	Consultation Groups	Ratification
Strategy	All strategies which are developed due to national policy and/or legislative requirement and relevant for more than three years to be ratified by the Board of Directors. All other strategies to be ratified as per list below.	• Directors • Head of services/directorates • Professional leads • Managers • Appropriate working /steering groups	• Board of Directors
	Human resources, volunteers, workforce and education strategies.	• Joint Consultative and Negotiating Committee (JCNC)	• People Committee
	Quality related strategies which relate to care and treatment e.g. quality strategy and end of life strategy.	• As appropriate including Quality Improvement Group	• Quality Improvement Group plus • Quality Assurance Committee as appropriate.
	Partnership agreement.	• As appropriate	• Board of Directors
	Learning disability strategy.	• Head of services/directorates • Professional leads as appropriate	• Safeguarding / Inclusion Group
Care and Clinical	Care and clinical quality related documents.	• Head of services/directorates • Professional leads • Care governance groups • Care teams affected by the document.	• ISU specific Integrated Governance Group Speciality specific - Specialties/ Directorates meetings/ committee • Trust wide – Care and Clinical Policy Group
Estates and Facilities	All documents that relate to estates and facilities excluding health and safety and security (please see Health and Safety section below)	• Head of services/directorates • Infection Prevention and Control Group • Professional leads • Authorising Engineers • Estates and Facilities Team	• Capital Investment and Delivery Group • Estate Performance and Compliance Group • Health and Safety Committee

Category	Area	Consultation Groups	Ratification
		• Joint Consultation and Negotiating Committee	• Infection Prevention and Control Group
Finance	All documents that relate to financial systems and processes for the Trust.	• Head of services/directorates • Finance team • Internal and external auditors	• Finance, Performance and Digital Committee
Human Resources	Policies relating to the employment of staff.	• Managers and appropriate working groups.	• Joint Consultative and Negotiating Committee
Health and Safety including security	Documents relating to health and safety related issues including security.	• Head of services/directorates • Professional leads • Appropriate working group • JCNC • External experts	• Health and Safety Committee
Safeguarding / Inclusion	Safeguarding of adults and children as well as more widely applied equality and disability discrimination acts.	• Adult Safeguarding Group • Children's Safeguarding Group • Dementia Group • Disability Awareness Action Group • Domestic Violence Group • Experts by Experience Group • Joint Equalities Cooperative • Serious Case Review Group	• Safeguarding / Inclusion Group
Corporate policies	Policies that do not fall into any of the above categories e.g. IT, information governance, etc.	• Head of services/directorates • Care teams • Appropriate working groups, committees	• Information Management and Technology Group • Executive Team
Corporate procedures, guidelines etc.	Documents that do not fall into any of the above categories e.g. ICT, information governance, etc.	• Head of services/directorates • Care teams • Appropriate working groups, committees	*To appropriate steering/working group. See list below.*

Corporate procedures, guidelines, protocols, standards, etc. which
sit under a ratified policy can be ratified by one of the appropriate groups, subject to
appropriate consultation, as listed below.

Documents	Ratification
Estates and Facilities	Capital Investment and Delivery Group Estate and Performacne and Compliance Group
Finance	Finance, Performance and Digital Committee
Health and Safety including Security	Health and Safety Committee (reports to Risk Group)
Human resources/Workforce	Joint Consultative and Negotiating Committee and/or People Committee
Infection prevention and control	Infection Prevention and Control Group
Information Management and Information Technology (IM&IT)	IM&T Group
Information governance	Information Governance Steering Group and/or IM&T Group
Resuscitation	Resuscitation Group
Risk management	Risk Group
Safeguarding / Inclusion	Safeguarding / Inclusion Group

If your document does not fit into one of the above categories or are unsure as to where it
should go for ratification, please contact the Corporate Document Database Administrator
on 01803 654630 / Internal 54630. For Care and Clinical documents please contact the
Clinical Effectiveness Team on 01803 655802.

Appendix 7
Rapid Equality Impact Assessment *(for use when writing policies and procedures)*

Policy Title (and number)	*Management of Care and Clinical and Non-Clinical Documents Policy*	Version and Date	*V1.3 March 2021*
Policy Author	Company Secretary		

An equality impact assessment (EIA) is a process designed to ensure that a policy, project or scheme does not discriminate or disadvantage people. EIAs also improve and promote equality. Consider the nature and extent of the impact, not the number of people affected.

EQUALITY ANALYSIS: How well do people from protected groups fare in relation to the general population?
PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below

Is it likely that the policy/procedure could treat people from protected groups less favorably than the general population? (see below)

Age	Yes ☐ No☒	Disability	Yes ☐ No☒	Sexual Orientation	Yes ☐ No☒
Race	Yes ☐ No☒	Gender	Yes ☐ No☒	Religion/Belief (non)	Yes ☐ No☒
Gender Reassignment	Yes ☐ No☒	Pregnancy/ Maternity	Yes ☐ No☒	Marriage/ Civil Partnership	Yes ☐ No☒

Is it likely that the policy/procedure could affect particular 'Inclusion Health' groups less favorably than the general population? (substance misuse; teenage mums; carers[1]; travellers[2]; homeless[3]; convictions; social isolation[4]; refugees)	Yes ☐ No☒

Please provide details for each protected group where you have indicated 'Yes'.

VISION AND VALUES: Policies must aim to remove unintentional barriers and promote inclusion

Is inclusive language[5] used throughout?	Yes ☒ No☐
Are the services outlined in the policy/procedure fully accessible[6]?	Yes ☒ No☐
Does the policy/procedure encourage individualised and person-centered care?	Yes ☒ No☐
Could there be an adverse impact on an individual's independence or autonomy[7]?	Yes ☐ No☒

If 'Yes', how will you mitigate this risk to ensure fair and equal access?

EXTERNAL FACTORS

Is the policy/procedure a result of national legislation which cannot be modified in any way?	Yes ☐ No☒

What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?)

To facilitate a standardized approach to policy documents across the Trust

Who was consulted when drafting this policy/procedure? What were the recommendations/suggestions?

ACTION PLAN: Please list all actions identified to address any impacts		
Action	**Person responsible**	**Completion date**
N/A		

AUTHORISATION:
By signing below, I confirm that the named person responsible above is aware of the actions assigned to them

Name of person completing the form		**Signature**	
Validated by (line manager)		**Signature**	

Any issues Please contact Diversity & Inclusion Lead
Debbie Maynard on Debbie.maynard@nhs.net or *Mobile Number 07976895349*

[1] Consider any additional needs of carers/ parents/ advocates etc, in addition to the service user
[2] Travellers may not be registered with a GP - consider how they may access/ be aware of services available to them
[3] Consider any provisions for those with no fixed abode, particularly relating to impact on discharge
[4] Consider how someone will be aware of (or access) a service if socially or geographically isolated
[5] Language must be relevant and appropriate, for example referring to partners, not husbands or wives
[6] Consider both physical access to services and how information/ communication in available in an accessible format
[7] Example: a telephone-based service may discriminate against people who are d/Deaf. Whilst someone may be able to act on their behalf, this does not promote independence or autonom

Policy Title

Document Information

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Date of Issue:		Next Review Date:	
Version:		Last Review Date:	
Author:			
Director Responsible			
Approval Route			
Approved By:		**Date Approved:**	
Links or overlaps with other policies:			

Amendment History

Issue	Status	Date	Reason for Change	Authorised

Contents

1. **Introduction**

1.1

2.

2.1

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4. **Distribution**

4.1 This policy document will be made available to staff via ICON, the Trust Website and signposted in the Staff Bulletin.

4.2 Awareness will be raised through Equality Impact Assessment training, all ratifying committees/groups, policies and procedures training and ICON.

5. **Key Contacts**

6. Appendices

Appendix 1: Rapid Equality Impact Assessment

Appendix 2

Appendix 3

NHS
Torbay and South Devon
NHS Foundation Trust

Appendix 1
Rapid Equality Impact Assessment *(for use when writing policies and procedures)*

Policy Title (and number)			**Version and Date**		
Policy Author					

An equality impact assessment (EIA) is a process designed to ensure that a policy, project or scheme does not discriminate or disadvantage people. EIAs also improve and promote equality. Consider the nature and extent of the impact, not the number of people affected.

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Document type	Standard Operating Procedure (SOP)
Document title	
Version number*	
Author	
Date issued	
Interim review date	
Scheduled review date	

Standard Operating Procedure

Title (Reason for the SOP and what it is outlining)

1.

2.

3.

.