Lincolnshire Partnership NHS Foundation Trust (LPFT)

Corporate Documents and Policies Procedure

DOCUMENT VERSION CONTROL	
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Author:	**Trust Secretary**
Approving Body:	**Audit Committee**
Approval Date:	**January 2018**
Committee, Group or Individual Monitoring the Document	**Audit Committee**
Review Date:	**January 2021**

Contents

Equality Statement

Lincolnshire Partnership NHS Foundation Trust (LPFT) will develop and implement business plans, project initiation documents, service change, service delivery and provision and policies and other corporate documents that meet the needs of the local community. They will take account of the provisions outlined in the Equality Act 2010, to eliminate discrimination, harassment and victimisation, promote equality of opportunity and build on good relations between the diverse communities.

The aim is to ensure no individual receives less favourable treatment on the grounds of age, disability (learning disabilities), sex (gender), race, gender reassignment, sexual orientation, religion and belief, marriage and civil partnership and pregnancy and maternity.

LPFT will have due regard to the different needs of those listed as the 'protected characteristics' and those not listed to ensure dignity and respect, leading to a fair and equitable service for all.

1.   **Introduction**

There is a duty on LPFT to comply with legislative requirements. Over and above what is legally required of the Trust and of its staff there are standards that the Trust aspires to and/or expects. Staff within the Trust need to know what standards are expected of them and where necessary the processes they are expected to follow in order to achieve these standards. Corporate governance documents policies and procedures provide this framework of standards and expected behaviour. Large organisations have a variety of policies and procedures governing various aspects of their work. It is important that these policies are developed following a standard format. This helps with uniformity and aids the auditing process. It is also important that the policies staff are expected to follow are relevant, achievable, approved, monitored and reviewed.

For a variety of reasons older versions of policies may be required. It is therefore important that policies are archived in an appropriate manner and are accessible easily when required.

The regulators of health care all set standards and expectation that require the Trust to have in place a robust policy and procedure for the management of corporate documents.

2.   **Purpose & Scope**

For the sake of brevity any reference to "policy" in the table below includes: corporate governance documents, policies and procedures.

Target/Standard	Reason for Target/Standard
For all policies to receive Executive Director sign-off for initial creation/ review	To ensure that all policies are relevant and necessary
For all policies to be benchmarked against other organisations or against national standards	To determine if the standards we are setting are in line with other organisations
For all policies to be in a standard format	To aid staff understanding the policy and to aid auditing.
For all documentation to have an Equality Analysis carried out.	To comply with the Equality Act 2010 and eliminate/reduce barriers and access to services.

For all new/substantially revised policies to undergo consultation	To ensure all staff/stakeholders who may be impacted by the policy have a chance to express any thoughts or concerns.
For all new/revised policies to be approved and ratified by the appropriate Executive Committee on behalf of the Board of Directors.	To ensure sign-up to the policy at the highest level of the Trust
For all policies to be easily accessible to staff	To enable staff the most up-to-date information regarding the standards expected
For all affected staff to be informed in a timely manner of any changes to policy	To ensure the best use of staff time
For all policies to be monitored for their effectiveness and improvements made where shortcomings are identified.	To ensure that the Trust is meeting the standards set by the policies.
For all policies to be regularly reviewed	To ensure information is up-to-date with current legislation/guidance
For older versions of policies to be easily identifiable and accessible	To aid with any investigations into incidents, complaints or claims.

The procedure at **Appendix 1** will apply to all corporate governance documents, policies and procedures (hereafter in this document referred to as policies) produced by Trust staff for use within the Trust and wherever the Trust carries responsibility for the staff it employs, including seconded, agency and bank staff.

This Policy and the procedure at **Appendix 1** will apply to staff involved in developing or writing policies/procedures and to anyone who has any responsibility for the control, management, implementation or dissemination of policies/procedures.

In the case of policies that are developed in collaboration with other agencies or where the Trust signs up to the procedures of another organisation the standards detailed above are still applicable, although it may not be achievable that these documents are in a standard format. The procedure at **Appendix 3** should be followed

This policy and procedure **does not apply** to Clinical Protocols and Clinical Guidelines, which will be developed through Specialist Clinical Practice Committees, nor to other Trust guidance documents and strategies.

3.   **Duties**

3.1.1   **The Board of Directors (the Board)** has a legal responsibility for Trust policies and for ensuring that they are carried out effectively.

3.1.2   **Board Committees** have a responsibility for development, implementation, review and monitoring effectiveness of all policies. Each Committee will approve relevant policies and procedures on behalf of the Board.

3.1.3   **Executive Directors** will be responsible for:

- Sanctioning the development of new policies
- Identifying a Policy Lead
- Signing off Checklist for Review and Approval

- Presenting policies or procedures, with implementation plans, to the approving committees
- Reviewing whether practices are in line with policy

3.1.4 **Executive/Associate/Deputy/Assistant Directors and Divisional Management Teams** are responsible for:

- Ensuring that comprehensive arrangements are in place regarding adherence to this policy and how policies and procedures are managed within their own Division or Service in line with the guidelines in this policy.
- Ensuring that team managers and other management staff are given clear instructions about policy arrangements so that they in turn can instruct staff under their direction. These arrangements will include:

  - o Keeping informed of any changes to policies
  - o Ensuring that all members of staff have access to up to date policies through the internet
  - o Maintaining a system for recording that changes to policies and procedures have been noted by staff and that necessary arrangements have been made in line with the implementation plan in each policy.

3.1.5 **Managers and Team leaders** will be responsible for:

- Ensuring that policies and procedures are followed and understood as appropriate to each staff member's role and function. This information must be given to all new staff on induction. It is the responsibility of local managers and team leaders to have in place a local induction that includes relevant policies and procedures
- Ensuring that their staff know how and where to access current policies and procedures via the internet
- Ensuring that a system is in place for their area of responsibility that keeps staff up to date with new policies and policy changes

3.1.6 **Policy Author / owner** will be responsible for:

- Drafting (or arranging the drafting) of the new policy or procedure following the template at **Appendix 2**. The template provides an indication of the minimum contents and headings of the policy. Policy leads can add other headings where necessary.
- Ensuring that the policy or procedure complies with all relevant legislation and Codes of Practice. (The rationale for any deviation from guidance must be clearly stated.)
- Identifying any implementation or training programme and lead responsibilities.
- Collating consultation feedback and providing a rationale for incorporation/non-incorporation.
- Liaising with the Trust Secretary's Office as per the procedure detailed at **Appendix 1**

3.1.7 **Trust Secretary**

On behalf of the approving committees, the Trust Secretary's Office is the central control point for administering the distribution of all policies and maintains a database of all Trust policies and procedures. The Trust Secretary will therefore be responsible for:

- Co-ordinating and managing the creation, consultation, approval, ratification, review and archiving processes for all Trust-wide policies.
- Ensuring that a master copy is kept of all Trust-wide policies and procedures for the life of the organisation plus 6 years in line with the guidance set out in [Records Management Code of Practice For Health and Social Care 2016](#)
- Maintaining a single register of all Trust-wide policies.
- Ensuring that policies follow the prescribed format.
- Ensuring that policies are kept under review.
- Being the main authority in all but rare circumstances for the inclusion of new policies or procedures on the Internet (in the interests of continuity, version control and security).
- Ensuring that the dedicated Corporate Governance Documents, Policies & Procedures pages of the Internet are regularly kept up to date.
- Ensuring that staff are informed regarding any policy updates or new policies

3.1.8 All Staff

All staff (including seconded staff and those who have a roving role in the Trust) should be aware that despite the above responsibilities of senior staff, every staff member has an individual duty of responsibility to ensure that they:
- Know where to locate policies or procedures when necessary on the Internet.
- Adhere to all Trust Policies and Procedures.

All staff should be aware of how policies and procedures impact on their practice and be able to follow the specified requirements set out.

4. Definitions

For the purpose of clarity, the Trust will adopt the following definitions. These should be closely observed in the development of any new guidance document so that the correct term is used and the appropriate route to final ratification is followed:

4.1 **Corporate Governance Documents:** A set of documents which are in place to ensure that the Trust complies with statutory legislation.

4.2 **Strategy**: The current set of plans, decisions and objectives that have been adopted to achieve organisational goals. All strategies will be commissioned by the Board of Directors.

4.3 **Policy**: A set of statements that document the standards expected in order to achieve a stated aim or strategic direction.

4.4 **Procedure**: A procedure provides an explanation of the method to be adopted or the prescribed manner of performing work in chronological order as a series of related tasks. Usually refers to a single procedure, e.g. completion of an incident report form, complaints procedure. Procedures can often be represented as flowcharts.

4.5 **Clinical Guideline**: A clinical guideline describes, but is not prescriptive about, the action or actions that may be taken to achieve completion/delivery of an outcome. They prescribe minimum proper standards rather than giving 'counsel of perfection'. They are pertinent to most clinical practices as they allow for clinical judgement, where appropriate, e.g. Management of Aggression.

4.5.1 Clinical guidelines are systematically developed statements to assist decision-making about appropriate healthcare for specific clinical conditions.

4.5.2 The NHS Executive defines a clinical guideline as a set of "*systematically developed statements designed to assist clinicians and patients to make decisions about appropriate treatment for specific conditions*".

4.6 **Policy Author / Owner**: An individual appointed by a Director to lead on the writing of a policy and liaising with the Trust Secretary's Office to ensure its development, dissemination and monitoring.

4.7 **Equality Analysis**: The purpose of the Equality Analysis is to ensure the organisation mainstreams equality, diversity and human rights issues into all health and social care services to promote a culture whereby everyone considers the equality relevance, risks and impact of their actions and decisions on the local population, we serve.

The analysis needs to be understood broadly to embrace the full range of business plans, project initiation documents, service change, service delivery and provision and policies and other corporate documents[1] (here with known as documents): essentially everything we do, whether it is formally written down or whether it is informal custom and practice. This includes existing documents and any new documents under development *(please see Equality Analysis Guidance).*

5.   Development of Policies and Procedures

In reviewing this policy and associated procedure (**Appendix 1)** LPFT drew from the template document originally published by the NHS Litigation Authority, now known as NHS Resolution. Feedback on the previous version of this policy had been incorporated into this review.

The process of creating, developing and reviewing policies should be the same across the organisation. To this end all staff should follow the procedure detailed in **Appendix 1.**

This will ensure that the standards to be achieved (as detailed in section 2) are met by the Trust.

6.   Consultation and Approval Process

The policy will be consulted upon, approved and ratified in accordance with the procedure outlined in **Appendix 1**

7.   Review and Revision Arrangements including Version Control

This policy will be reviewed bi-annually by the Trust Secretary in accordance with the procedure outlined in **Appendix 1**. Revision may occur earlier if relevant new legislation or guidance is issued.

The Audit Committee monitors the effectiveness of the policy may call for an early review on the basis of the reports it receives.

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[1] Business plans, project initiation documents, service change, service delivery and provision and policies and other corporate documents, know as documents in the guidance.

The Trust Secretary's Office will maintain a version control sheet, as per the procedure outlined in **Appendix 1**.

8. **Implementation and Dissemination of a Policy**

This policy will be disseminated in accordance with the procedure outline in **Appendix 1**.

The policy will be implemented as detailed below:

Action	Date
Email sent by the Trust Secretary to all known policy authors and Executive Directors detailing new process and offering bespoke training/ further guidance and assistance.	Within a week of policy ratification.
Email sent by the Trust Secretary to those individuals responsible for editing the website to ensure no policies or procedures that have not been through the correct process are uploaded.	Within a week of policy ratification.
Email sent by the Trust Secretary to all Board Committee administrators detailing the new process and what they can expect.	Within a week of policy ratification.
Bespoke training available for policy authors	As required

The overall timeframe for implementation is therefore within a week of ratification.

9. **Policy Control including Archiving Arrangements**

The Trust Secretary's Office will retain a copy of each policy for the lifetime of the organisation plus 6 years in line with the requirements of the Records Management Code of Practise for Health and Social Care 2016 (NHS Digital)

Individuals wishing to obtain previous versions of this policy should contact The Trust Secretary's Office.

10. Monitoring Compliance with and Effectiveness of Policies and Procedures

Systems	Monitoring and/or Audit				
Criteria	Measurables	Lead Officer	Frequency	Reporting to	Action Plan/ Monitoring
Implementation complete within designated timescale	All actions detailed in section 8 are complete	Trust Secretary	At next Executive Committee following ratification	Relevant Board Committee	Action Plan: Trust Secretary Monitoring: Relevant Board Committee
For all policies to receive Executive Director sign-off for initial creation/ review	policy checklists for Executive Director sign-off to be included with approval paper	Trust Secretary	Bi-annual	Relevant Board Committee	Action Plan: Trust Secretary Monitoring: Relevant Board Committee
For all policies to be benchmarked against other organisations or national standards	Cover paper with draft policy to include details of benchmarking and standards	Policy Author / Owner	Bi-annual	Relevant Board Committee	Action Plan: Trust Secretary Monitoring: Relevant Board Committee
For all policies to be in a standard style and format (with the possible exception of multi-agency policies) which details: Definitions Duties Consultation Approval/Ratification Review & revision arrangements Document control & archiving Associated documents References	Each policy to be checked for appropriate section headings before approval by Committee	Policy Author / Owner	Bi-annual	Relevant Board Committee	Action Plan: Trust Secretary Monitoring: Relevant Board Committee
For all documentation to have an Equality Analysis carried out.	Equality Analysis to be presented with each policy to the approving committee	Policy Author / Owner	Bi-annual	Relevant Board Committee	Action Plan: Trust Secretary Monitoring: Relevant Board Committee
For all new/substantially revised policies to undergo consultation	Record of consultation periods to be included in the cover paper with the	Policy Author / Owner	Bi-annual	Relevant Board Committee	Action Plan: Trust Secretary Monitoring:

	draft policy				Relevant Board Committee
For all new/revised policies to be approved by the appropriate executive committee in a timely manner	Minute of committee decisions and Committee Forward Agendas, matching the policy archive	Trust Secretary	Bi-annual	Relevant Executive Committee	Action Plan: Trust Secretary Monitoring: Relevant Board Committee
For all policies to be easily accessible to staff	All policies available on the Trust website. –within 14 days of approval	Trust Secretary	Bi-annual	Relevant Executive Committee	Action Plan: Trust Secretary Monitoring: Relevant Board Committee
For all affected staff to be informed in a timely manner of any changes to policy	All revised policies to be reported in Weekly Word	Policy Author / Owner	As determined by monitoring table in each policy. It should be recorded where report not received	Relevant Executive Committee	Action Plan/Monitoring: As detailed in each policy
For all policies to be monitored for their effectiveness and improvements made where shortcomings are identified.	Reports to Committees made as per monitoring table in each policy	Policy Author / Owner	As determined by monitoring table in each policy. It should be recorded where report not received	Relevant Executive Committee	Action Plan/Monitoring: As detailed in each policy
For all policies to be regularly reviewed	Number of policies past review date	Policy Author / Owner	Quarterly	Each Executive Committee & Audit & Assurance Committee.	Action Plan: Trust Secretary Monitoring: Each Board Committee
For older versions of policies to be easily identifiable and accessible	Any policy not available when requested will be reported to the Audit Committee in the Quarterly governance report	Trust Secretary	By exception in Bi-annual report	Relevant Executive Committee	Action Plan: Trust Secretary Monitoring: Relevant Board Committee

11.   **References**

- NHS Litigation Authority Standards and Template documents last updated 2013
www.nhsla.com

12.   **Associated Documentation**

Equality Analysis procedures are set out in appendix 7
Template forms are available from the documents templates page on Sharon
The Trust's Equality Strategy and associated documents are available on this
link

13.   **Appendices**

Appendix 1: **Flowchart for the Development, Consultation, Approval, Dissemination,
          Implementation and Monitoring of Policies**
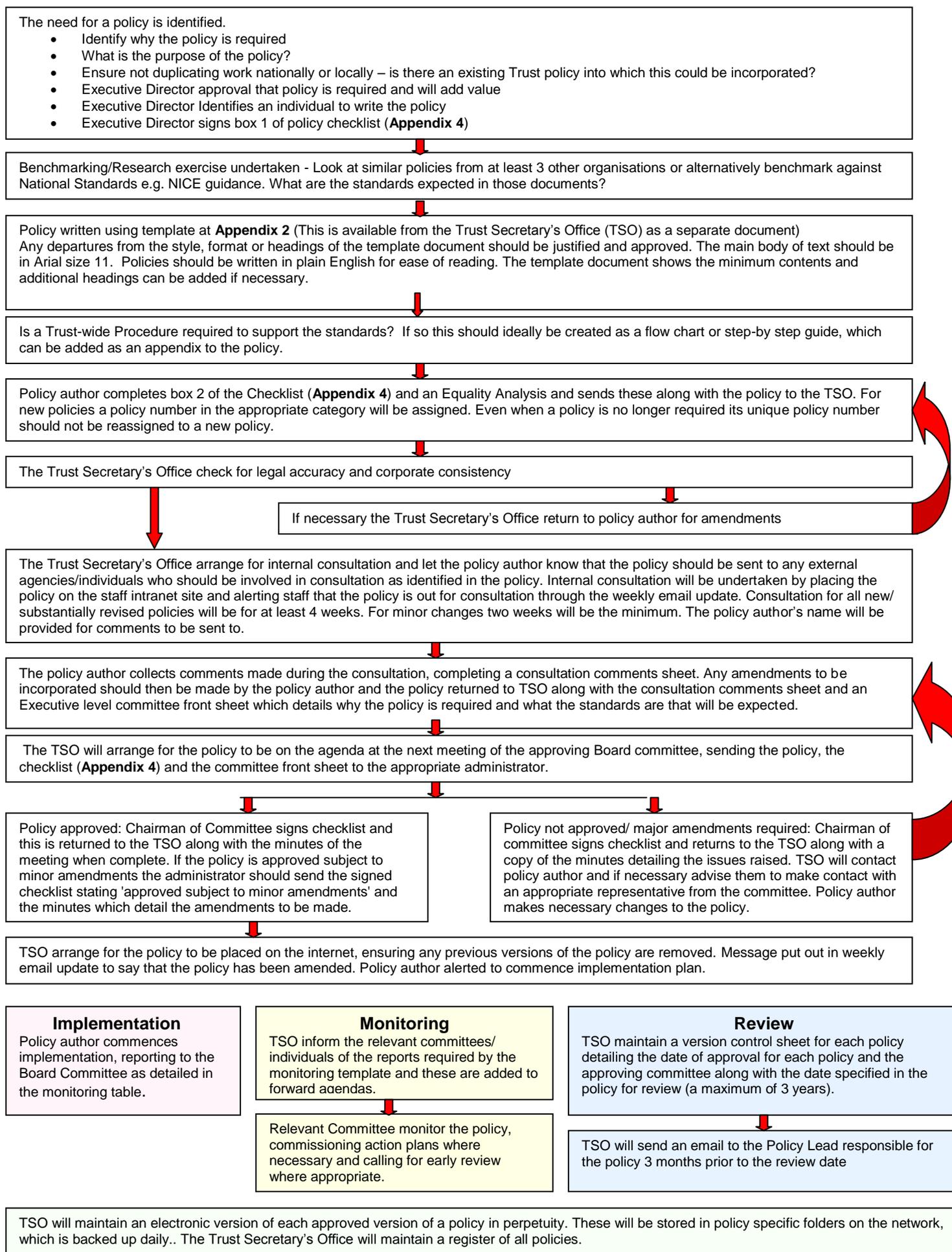
Appendix 2: **Template for Policy/Procedure**

Appendix 3: **Flowchart for the use of Multi-agency Policies**

Appendix 4: **Checklist for the Review and Approval of Policies and Procedures**

Appendix 5: **List of Policies to be approved by each Executive Committee.**

Appendix 6: **Consultation Comments Summary Sheet**

Appendix 7: **Equality Analysis Guidance**

Procedure for LPFT Policies and Procedures

The need for a policy is identified.
- Identify why the policy is required
- What is the purpose of the policy?
- Ensure not duplicating work nationally or locally – is there an existing Trust policy into which this could be incorporated?
- Executive Director approval that policy is required and will add value
- Executive Director Identifies an individual to write the policy
- Executive Director signs box 1 of policy checklist (**Appendix 4**)

Benchmarking/Research exercise undertaken - Look at similar policies from at least 3 other organisations or alternatively benchmark against National Standards e.g. NICE guidance. What are the standards expected in those documents?

Policy written using template at **Appendix 2** (This is available from the Trust Secretary's Office (TSO) as a separate document)
Any departures from the style, format or headings of the template document should be justified and approved. The main body of text should be in Arial size 11. Policies should be written in plain English for ease of reading. The template document shows the minimum contents and additional headings can be added if necessary.

Is a Trust-wide Procedure required to support the standards? If so this should ideally be created as a flow chart or step-by step guide, which can be added as an appendix to the policy.

Policy author completes box 2 of the Checklist (**Appendix 4**) and an Equality Analysis and sends these along with the policy to the TSO. For new policies a policy number in the appropriate category will be assigned. Even when a policy is no longer required its unique policy number should not be reassigned to a new policy.

The Trust Secretary's Office check for legal accuracy and corporate consistency

If necessary the Trust Secretary's Office return to policy author for amendments

The Trust Secretary's Office arrange for internal consultation and let the policy author know that the policy should be sent to any external agencies/individuals who should be involved in consultation as identified in the policy. Internal consultation will be undertaken by placing the policy on the staff intranet site and alerting staff that the policy is out for consultation through the weekly email update. Consultation for all new/ substantially revised policies will be for at least 4 weeks. For minor changes two weeks will be the minimum. The policy author's name will be provided for comments to be sent to.

The policy author collects comments made during the consultation, completing a consultation comments sheet. Any amendments to be incorporated should then be made by the policy author and the policy returned to TSO along with the consultation comments sheet and an Executive level committee front sheet which details why the policy is required and what the standards are that will be expected.

The TSO will arrange for the policy to be on the agenda at the next meeting of the approving Board committee, sending the policy, the checklist (**Appendix 4**) and the committee front sheet to the appropriate administrator.

| Policy approved: Chairman of Committee signs checklist and this is returned to the TSO along with the minutes of the meeting when complete. If the policy is approved subject to minor amendments the administrator should send the signed checklist stating 'approved subject to minor amendments' and the minutes which detail the amendments to be made. | Policy not approved/ major amendments required: Chairman of committee signs checklist and returns to the TSO along with a copy of the minutes detailing the issues raised. TSO will contact policy author and if necessary advise them to make contact with an appropriate representative from the committee. Policy author makes necessary changes to the policy. |

TSO arrange for the policy to be placed on the internet, ensuring any previous versions of the policy are removed. Message put out in weekly email update to say that the policy has been amended. Policy author alerted to commence implementation plan.

Implementation	**Monitoring**	**Review**
Policy author commences implementation, reporting to the Board Committee as detailed in the monitoring table.	TSO inform the relevant committees/ individuals of the reports required by the monitoring template and these are added to forward agendas.	TSO maintain a version control sheet for each policy detailing the date of approval for each policy and the approving committee along with the date specified in the policy for review (a maximum of 3 years).
	Relevant Committee monitor the policy, commissioning action plans where necessary and calling for early review where appropriate.	TSO will send an email to the Policy Lead responsible for the policy 3 months prior to the review date

TSO will maintain an electronic version of each approved version of a policy in perpetuity. These will be stored in policy specific folders on the network, which is backed up daily.. The Trust Secretary's Office will maintain a register of all policies.

NHS
Lincolnshire Partnership
NHS Foundation Trust

REF:

Lincolnshire Partnership NHS Foundation Trust (LPFT)

Title of Policy

DOCUMENT VERSION CONTROL	
Document Type and Title:	
Authorised Document Folder:	
New or Replacing:	
Document Reference:	
Version No:	
Date Policy First Written:	
Date Policy First Implemented:	
Date Policy Last Reviewed and Updated:	
Implementation Date:	
Author:	
Approving Body:	
Approval Date:	
Committee, Group or Individual Monitoring the Document	
Review Date:	

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Lincolnshire Partnership NHS Foundation Trust (LPFT) will develop and implement business plans, project initiation documents, service change, service delivery and provision and policies and other corporate documents that meet the needs of the local community. They will take account of the provisions outlined in the Equality Act 2010, to eliminate discrimination, harassment and victimisation, promote equality of opportunity and build on good relations between the diverse communities.

The aim is to ensure no individual receives less favourable treatment on the grounds of age, disability (learning disabilities), sex (gender), race, gender reassignment, sexual orientation, religion and belief, marriage and civil partnership and pregnancy and maternity.

LPFT will have due regard to the different needs of those listed as the 'protected characteristics' and those not listed to ensure dignity and respect, leading to a fair and equitable service for all.

1.   **Introduction**

This should give an overview of why this area is important. Why is it important to have a policy covering this area?

2.   **Purpose & Scope**

What is the purpose of the policy? What is the organisation trying to achieve by having it in place?

What are the standards the Trust is aiming for as a result of this policy?

TARGET/STANDARD TO BE ACHIEVED	REASON FOR TARGET/STANDARD

Who does this policy apply to? Does it cover all members of staff or only selected groups? Are there any exceptions to its use?

3.   **Duties**

What are the individual, departmental and committee duties including levels of responsibility for document development, monitoring and review. This should include the Chief Executive, the Director with Board level responsibility, the policy author, the approving committee, any other committees, any other agencies/stakeholders.

In this section simply refer to Executive Committee/Approving Committee rather than naming the actual committees.

4. Definitions

List and describe the meaning of the terms used in the context of the document if considered necessary.

5. Development of Policies and Procedures

How was the policy developed/reviewed? Identify those agencies, groups and individuals who have been involved.

Which standards have been referred to, have policies from other Trusts been examined?

Are there any specific groups/individuals who need to be consulted with over and above consulting with Trust staff? Are there any groups that should have this as an agenda item as part of the consultation process?

Are there any external stakeholders who need to be involved in the approval or implementation of this policy?

6. Consultation, Approval and Ratification Process

The policy will be consulted upon, approved and ratified in accordance with the Trust's Corporate Documents and Policies Procedure. The relevant Executive Committee is identified in the appendices to that procedure.

7. Review and Revision Arrangements including Version Control

This policy will be reviewed [state the timeframe eg. annually] by the policy author in accordance with the Corporate Documents and Policies Procedure. Revision may occur earlier if relevant new legislation or guidance is issued.

The Executive Committee monitoring the effectiveness of the policy may also call for an early review on the basis of the reports it receives.

The Trust Secretary's Office will maintain a version control sheet, as per the Corporate Documents and Policies Procedure.

8. Dissemination and Implementation of a Policy

This policy will be disseminated in accordance with the Corporate Documents and Policies Procedure.

The policy will be implemented....This requires a detailed plan of how those to whom the policy applies will find out that the policy has been approved and is in force and how they will be trained. It should include timeframes for implementation – what will be done by when. This could be in the form of a table. This may require a training needs analysis. Where

policies and procedures significantly impact on service users and carers how information will be communicated with them should be part of the implementation plan. Are associated documentation, such as forms or leaflets required? If so, how will these be printed and distributed and people trained in their use?

9. **Policy Control including Archiving Arrangements**

Corporate and Legal Services will retain a copy of each policy for a minimum of 10 years in line with the recommendations contained within 'Records Management NHS Code of Practice' (2006).

Individuals wishing to obtain previous versions of this policy should contact Corporate & Legal Services.

10. **Monitoring Compliance with and Effectiveness of Policies and Procedures**

For all policies this will identify how we will know if we have achieved the standards/targets set in section 2.

For all policies one standard will be that the policy is implemented within the timescales set out in the implementation plan at section 8.

Systems	Monitoring and/or Audit				
Standard/ NHSLA criteria	Measurable	Lead Officer	Frequency	Reporting to	Action Plan/ Monitoring
Implementation complete within designated timescale	As per section 8	Policy lead	After proposed implementation period		

11. **References**

List all references made

12. **Associated Documentation**

List those documents that staff will need access to in order to adhere to the policy/ follow the procedures documented as appendices and where these documents will

be available from. It is not necessary to have all of the documents as appendices as this would mean the policy would be out of date if a change is made to the document.

Procedure for Multi-agency policies

The need for a policy is identified.
- Identify why sign up to the policy is required
- What is the purpose of the policy?
- Ensure not duplicating work nationally or locally – is there an existing Trust policy into which this could be incorporated/would need to be removed?
- Executive Director approval that policy is required and will add value and assigns policy lead.
- Executive Director signs box 1 of policy checklist (**Appendix 4**)

Is a Trust-wide Procedure required to support the standards? If so this should ideally be created as a flow chart or step-by step guide. A monitoring template will also need to be created to assure the relevant Executive Committee that the policy is being complied with.

Policy Lead sends an Equality Analysis along with the policy, LPFT procedure, monitoring template and checklist to The Trust Secretary's Office (TSO).

The TSO arrange for internal consultation. Internal consultation will be undertaken by placing the policy on the staff intranet site and alerting staff that the policy is out for consultation through the weekly email update. The policy lead's name will be provided for comments to be sent to.

The policy author collects comments made during the consultation. These should be fed back to the multi-agency group and the outcome recorded on a consultation comments log. The completed consultation comments log should be sent to the TSO along with an amended version of the policy.

The TSO will arrange for the policy to be on the agenda at the next meeting of the approving committee, sending the policy, the checklist (**Appendix 4**) and the committee front sheet to the appropriate administrator.

Policy approved: Chairman of Committee signs checklist and this is returned to the TSO along with the minutes of the meeting when complete. If the policy is approved subject to minor amendments the administrator should send the signed checklist stating 'approved subject to minor amendments' and the minutes which detail the amendments to be made.

Policy not approved/ major amendments required: Chairman of committee signs checklist and returns to the TSO along with a copy of the minutes detailing the issues raised. The TSO will contact policy lead and if necessary advise them to make contact with an appropriate representative from the committee. Policy lead feeds back to the multi-agency group.

The TSO arrange for the policy to be placed on the internet, ensuring any previous versions of the policy are removed. Message put out in weekly word to say that the policy has been amended. Policy lead alerted to commence implementation plan.

Implementation
Policy lead commences implementation, reporting to the Board Committee.

Monitoring
The TSO inform the relevant committees/ individuals of the reports required by the monitoring template and these are added to forward agendas.

Relevant Committee monitor the policy, commissioning action plans where necessary and calling for early review where appropriate.

Review
TSO maintain a version control sheet for each policy detailing the dates of approval and ratification for each policy and the approving/ratifying committee along with the date specified in the policy for review (a maximum of 3 years).

TSO will send an email to the Executive Director responsible for the policy 3 months prior to the review date

The TSO will maintain an electronic version of each approved version in perpetuity. These will be stored in policy specific folders on the network, which is backed up daily. The TSO will maintain a register of all policies.

Checklist for Policies and Procedure Approval

To be completed by Executive Director

Policy Title...
Why is the policy required
....
....
....
I believe that this policy is required and does not duplicate a current LPFT policy or nationally available document.

Signed.. Date....................................

To be completed by Policy Author

This policy has been benchmarked against the policies of 3 other organisations or against national standards (please specify):
....
....
....
Specific groups/ individuals/agencies who need to be consulted with
....
....
....
Resource implications of implementation plan
....
....
....

Signed.. Date....................................
Please now send this form with the policy and EIA to The Trust Secretary's Office

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To be completed by the Trust Secretary's Office

All parts of the policy completed in full
No legal concerns identified
Equality Analysis present
Date put out for consultation........................... Date consultation expired ....
Consultation feedback received

Signed... Date...

To be completed by Approving Board Committee

Approved.   Yes/ Yes, subject to minor amendments/No

Please ensure minutes of the meeting detail any required amendments or revisions.

Signed.. Date...
Please now send this form and extract from the minutes to The Trust Secretary's Office

Policies for Approval at each Executive Committee

No	Document	Approving Committee	Policy Lead
Corporate Governance Documents			
	Constitution - including Standing Orders for the Board of Directors and Council of Governors	Council of Governors and Board of Directors	Trust Secretary
	Declaration of interests for the Board of Directors	Board of Directors	Trust Secretary
	Declaration of interests for the Council of Govenors	Council of Governors	Trust Secretary
	2017 Hospitality Register	Audit Committee	Trust Secretary
	2018 Hospitality Register	Audit Committee	Trust Secretary
	Directors' Responsibilities and Code of Conduct	Council of Governors and Board of Directors	Trust Secretary
	Governors' Responsibilities and Code of Conduct	Council of Governors and Board of Directors	Trust Secretary
	Safeguarding Declaration 2017-18	Quality Committee	Director of Nursing & Quality
	Same Sex Declaration 2017	Quality Committee	Director of Nursing & Quality
	Scheme of delegation	Board of Directors	Trust Secretary
	Standing financial instructions	Board of Directors	Director of Finance
	Legal Advice Procedure	Executive Team	Trust Secretary
	Corporate Documents and Policies Procedure	Audit Committee	Trust Secretary
Policies			
No	Document	Approving Committee	Policy Lead
1	Clinical Care Policy	Quality Committee	Head of Quality & Safety
2	Medicines Managment & Medical Devices Policy	Quality Committee	Chief Pharmacist
3	Human Resources and Workforce Development Policy Handbook	Quality Committee	Director of Human Resources
3a	Conduct & Capability Procedure for Medical Staff	Organisational Development Committee	Medical HR Manager
3b	Code of Conduct for Private Practice by Medical Staff	Local Negotiating Committee	Director of Human Resources
4	Safety-Health-Environment-and-Fire-Policy	Quality Committee	Health & Safety Advisor
5a	Board Assurance and Escalation Framework	Board of Directors	Head of Quality & Safety and Trust Secretary
5b	Reporting and Management of Risk Policy	Quality Committee	Head of Quality & Safety
5c	Duty of Candour Policy	Quality Committee	Head of Quality & Safety
5d	Whistleblowing Procedure	Audit Committee	Freedom to Speak up Guardian
5e	Counter-Fraud, Anti-Bribery and Hospitality Policy	Audit Committee	Trust Secretary

5f	Learning from Deaths Policy	Quality Committee	Head of Quality & Safety
6a	Mental Health Act Policy	Quality Committee	Legal Services Manager and Trust Secretary
6b	Mental Capacity Act including DOLS Policy	Quality Committee	Consultant Nurse Safeguarding
7	7a Infection Prevention and Control

7b Hand Hygiene

7c Outbreak of infection

7d Methicillin MRSA

7e Management of Clostridium difficile Infection

7f Isolation

7g Decontamination

7h Surveillance of Alert Organisms and Dissemination of Information

7i Safe Management and Disposal of Sharps and Avoidance of Occupational Exposure to Blood Borne Viruses

7k Aseptic Non Touch Technique

7l Scabies Management

7m Transfer of Patient with Known or Suspected Infection

7n Correct Use of Personal Protective Equipment in the Healthcare Environment

7o Animals in Healthcare Premises Guidance | Quality Committee | Matron (Infection Control) |
8	8a - Records Lifecycle Management and Information Governance Policy	Information Management and Technology Committee	Team Co-ordinator, Records management and Information Governance
	8b - Information Management and Security	Information Management and Technology Committee	Deputy Director of Informatics
	8c - ICT Systems Use Policy	Information Management and Technology Committee	Deputy Director of Informatics
	8d - Lincolnshire Health & Social Care Community - Overarching Information Sharing Protocol	County wide Information Governance Group	

9	Involving, Engaging and Consulting the Public, Patients, Carers, Staff, Volunteers and Stakeholders	Quality Committee	Director of Strategy and Performance
10	Trust Resilience Policy	Quality Committee	Director of Operations
11	Safeguarding Policy	Quality Committee	Consultant Nurse Safeguarding
12	Smoke Free Premises Policy	Quality Committee	Director of Operations

Consultation Comments Summary Sheet

Corporate Document / Policy:

Date consultation commenced:

Date consultation closed:

Date	Comment from	Comment	Action	Agreed by

Final sheet completed on: (date)

Final Sheet submitted to the Trust Secretary's Office by:

Final Sheet Uploaded to Policy Archived by:

Name:

Date:

Equality Analysis

Guidance

CONTENTS   Page

The website link below links to the resources:
http://sharon/lpft/HumanRights/Pages/EqualityAnalysis.aspx

1. Introduction

Lincolnshire Partnership NHS Foundation Trust (LPFT) recognises the importance of ensuring its services are fair and equitable to all.

At LPFT the diversity of our staff, service users, partners and any visitors to our services is celebrated. We expect everyone who visits any of our sites, comes into contact with any of our services or works for LPFT to be able to participate fully and achieve their full potential in a safe and supportive environment. We welcome all service users and members of staff inclusive of race, disability, sex, sexual orientation, gender reassignment, marriage and civil partnership, pregnancy and maternity, age, religion or belief.

The Equality Analysis (EA) process is a way of considering the equality effect on different groups protected from discrimination under the Equality Act. This is how the due regard is met from the Public Sector Equality Duty (Equality Act 2010).
There are two main reasons;
I.   To consider any unintended consequences for the protected groups, and
II.   To consider whether the change will be fully effective for all target groups.

It involves using equality information and the results of engagement with protected groups, to understand the actual impact or the potential impact of the change. It helps to identify practical steps to tackle any negative risks or discrimination, advance equality and foster good relations.

The analysis covers all aspects of the Trust business that involves service delivery or employment practices to service users and staff; it is essential to the Trust, involving everything we do, whether formally written or informal practices, including existing and new projects. It is not a one-off exercise and enables equality considerations to be taken into account before a decision is made.

2. Responsibility and Governance

Who is responsible?
The Chief Executive, the Board, Directors, Senior Managers and Managers are ultimately responsible for effective compliance. Management and members of their team will ensure compliance of all existing and new projects. All will be required to ensure the information is accessible should the Trust be subjected to external scrutiny from the Equality and Human Rights Commission (EHRC), Care Quality Commission (CQC),NHS Improvement, Health and Wellbeing Boards, Healthwatch, etc.

Internal Governance
The Quality Committee will have key responsibility for the implementation, on-going monitoring and scrutiny of the process. This is delegated down to the Organisational Development and Patient Safety and Experience sub committees, exception reports will be sent to the Quality Committee. The Equality and Diversity Lead will provide support, advice and guidance on the process.

Relevance
The process is an integral part of the day-to-day running of the Trust, making it a fundamental element to the Board Reporting process, as well as being part of a wider partnership activity with other organisations.
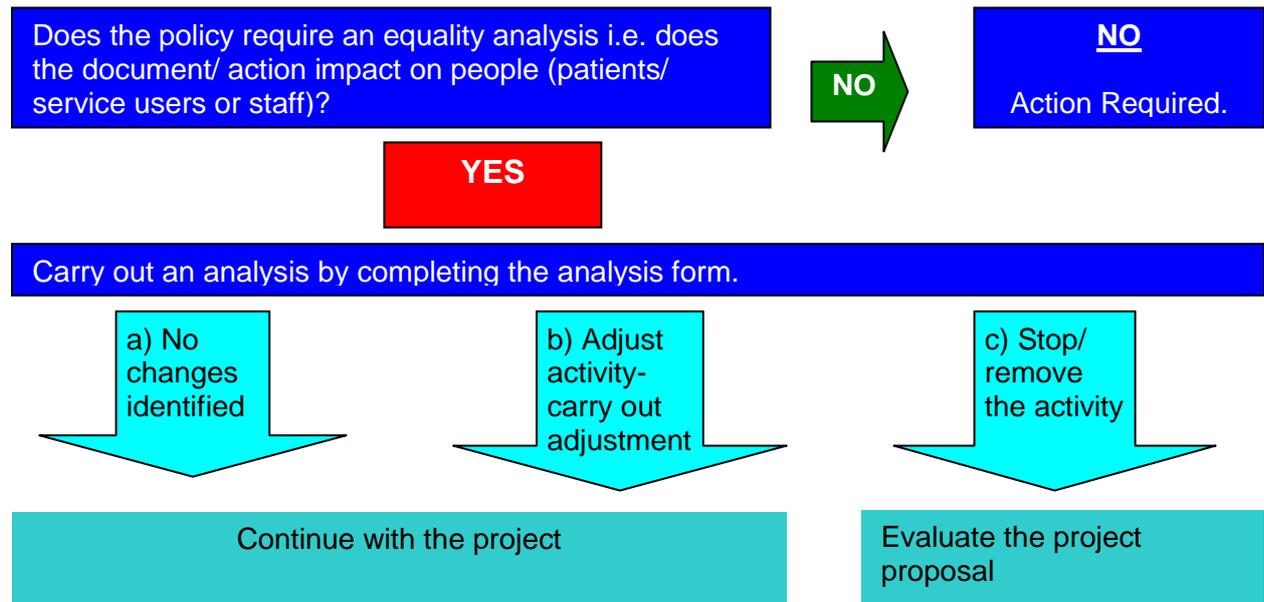
<u>Training</u>
Management are responsible for ensuring that staff are aware of their requirements in relation to these guidelines. The EHR Lead will provide continuous support, advice and guidance on the process.

3. When do you need to complete an Equality Analysis?

Example Areas for an Equality Analysis
1. Buildings
    a. New build
    b. Refurbished buildings
    c. Extensions

2. Service Changes
    a. Moving a service from one location to another
    b. Transfer of services from one provider to another
    c. Services changes which may restrict or disadvantage one group in comparison to another i.e. changes in light of the new Age Equality Consultation

3. Transfer of Staff
    a. Transfer from one department to another
    b. TUPE's
    c. At risk – i.e. do those individuals placed at risk potentially disadvantage one group of people identified under the 'protective characteristics' in comparison to another.

4. Financial Risks
    a. Cuts in budgets – do the cuts in financial expenditure disadvantage one group of people identified under the protected characteristics in comparison to another.

5. Policies
    a. HR Policies
    b. Strategies – i.e. changes to direction of service provision which may impact on one protected group in comparison to another.
    c. Clinical Policies that have a direct impact on the delivery of services to people.

6. Reception
    a. receiving and greeting people
    b. access to rooms, i.e. loop system, etc.
    c. catering facilities take account of different

4. Equality Analysis Process

| Does the policy require an equality analysis i.e. does the document/ action impact on people (patients/ service users or staff)? | **NO** → | **<u>NO</u>** Action Required. |

YES

Carry out an analysis by completing the analysis form.

a) No changes identified

b) Adjust activity- carry out adjustment

c) Stop/ remove the activity

Continue with the project

Evaluate the project proposal

5. Guidance on undertaking the Equality Analysis

Name of Policy/ project/ service:

Aims of policy/ project/ service:

Is this new or existing?   New   □   Existing   □

Person(s) responsible:

Key people involved:

Who does it affect?   Service users □   Staff □   Wider Community □

What data has been considered in identifying if there are any potential impacts? e.g. Patient demographic information/ workforce demographics/ population data/ JSNA data see Equality Analysis page on Sharon for guidance and links to data sources **http://sharon/lpft/HumanRights/Pages/EqualityAnalysis.aspx**

Think about the main sources of data, research and other sources of evidence (including full references) reviewed to determine the impact on each equality group. This can include national research, surveys, reports, research interviews, focus groups, pilot activity evaluations etc. If there are any gaps in evidence, state what you will do to close them.
Examples of data that is available:
- Comparisons with similar documents in other departments to help identify relevant equality issues.
- Analysis of enquiries or complaints from the public to help understand the needs or experiences of different groups.
- Recommendations from inspections or audits to help identify any concerns about equality matters from regulators.
- Information about the local community, including census findings to help establish the numbers of protected groups in your area.
- Recent research from a range of national, regional and local sources to help identify relevant equality issues.
- Results of engagement activities or surveys to help understand the needs or experiences of different groups.
- Information from protected groups and other agencies, such as equality organisations and voluntary or community organisations providing services to the public to help understand the needs or experiences of different groups (this list is not exhaustive).
- For patient/ service user equality data for the protected characteristic areas specific to LPFT you could refer to the Equality Annual report.
- For staff protected characteristic data the equality annual report could be used.
- Any anecdotal knowledge of patients/ service users, staff or the wider community as a whole.

Is the policy/ project/ service likely to have an effect on any of the protected characteristic groups? (please explain why there is likely to be an impact or not (refer to data where appropriate)		
	Positive	Negative	None
Age	Consider and detail any likely effect on different age ranges (including old and younger people). This can include safeguarding, consent and child welfare. *For example- a service that is being commissioned/ funded to work with a particular age range (e.g. 18-65) could be seen as having an negative impact on anybody not in that age range. However, the mitigating factors could be that there is a service available to the other age ranges, but is run slightly differently to take account of any additional needs or specific needs/ speciality that relate to that age range e.g. CAMHS.*		
Disability	Consider and detail any likely effect on attitudinal, physical and social barriers. *For example- a service that is moving location will need to consider the access into the new location for disabled people. Not just physical access but hearing loop availability etc. The move could have a positive impact for disabled people if it is a more accessible building in this regard.*		
Sex	Consider and details any likely effects on men and women (potential link to carers below). *For example- a policy that makes it compulsory to work full time can amount to indirect sex discrimination as it would put women at a particular disadvantage.*		
Gender Reassignment	Consider and detail any likely effects on transgender and transsexual people. This can include issues such as privacy of data and harassment. *For example- a single sex service would need to consider if there were any implications for a transgender person who identifies as that sex to accessing that service.*		
Sexual Orientation	Consider and detail the likely effects on heterosexual people as well as lesbian, gay and bi-sexual people. *For example- if a policy or service only offers benefits to the heterosexual partners of their employees or patients and service users and not to same-sex partners.*		
Race	Consider and detail any likely effects on different ethnic groups, nationalities, Roma gypsies, Irish travellers and any potential language barriers. *For example- does the service require people to have a fixed abode- if so, this could exclude gypsies and travellers or migrant workers. Is all of the information about the service written in English- does it need translating into different languages.*		
Religion and Belief	Consider and detail any likely effects on people with different religions, beliefs or no belief. *For example- a uniform policy that requires all employees to dress in a particular way if this means a member of staff can't wear an item of clothing they regard as part of their faith. However, if there are genuine reasons for the rule, policy or practice and that it has nothing to do with your religion or belief, this won't count as discrimination. For example, if staff need you to dress in a particular way for health and safety reasons, such as wearing protective headwear, even though it might be against their religion to remove your turban.*		
Marriage and Civil Partnership	Consider and detail any likely effects on single people, married people (including same sex couples) or those in a civil partnership. *For example- Because more married women than single women have childcare responsibilities, a policy of full-time working can amount to indirect marriage discrimination. Please note: you must be married or in a civil partnership at the relevant time; other marital status is not covered.*		
Pregnancy and Maternity	Consider and details any likely effects on working arrangements, part time working and infant caring responsibilities. *For example- If a service is restructuring consideration must be given to those members of staff pregnant or on maternity leave. Preferential treatment must be given to those people.*		

Carers	Consider and detail any likely effects on part time working, shift patterns and general caring responsibilities.
	For example- similar to the sex *a policy that makes it compulsory to work full time can amount to indirect sex discrimination as it would put women at a particular disadvantage.*

Is action possible to mitigate any negative impact?	Details of action planned (including dates or why action is not possible)

Any other information that is relevant to the equality impact of the policy/ project/ service?

Other identified groups- Consider and detail any likely effect on different socio-economic groups, area inequality, income, offenders, resident status, (migrants) and other groups experiencing disadvantage and barriers to access.

Result of Equality Analysis

Based on the information above- what is the outcome of the Equality analysis?

a) No change □	b) Adjust the activity □	c) Stop/remove the activity □
Detail any adjustments that are to be made and how these will be monitored		

Person who carried out this assessment	
Date assessment completed	
Name of responsible Director/General Manager	
Date assessment was signed	
Date of next review	

Checklist
- Is the purpose of the policy change/decision clearly set out? □

- Have those affected by the policy/decision been involved? □

- Have potential positive and negative impacts been identified? □

- Are there plans to alleviate any negative impact? □

- Are there plans to monitor the actual impact of the proposal? □

When complete please forward to Sophie.ford@lpft.nhs.uk