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NHS Sheffield Clinical Commissioning Group

Policy for the Development and Management of Policies and Procedural Documents

August 2021

Version:	3.3
Policy Number:	CO016/10/2022
Date ratified:	31 August 2021
Name of originator/author:	Corporate Services and Risk Manager Quality Manager Clinical Audit and Effectiveness
Name of Sponsor:	Associate Director of Corporate Services
Name of responsible committee	Governance Sub-committee
Date issued:	September 2021
Review date:	1 October 2022
Target audience:	All staff working within or on behalf of NHS Sheffield CCG

To ensure you have the most current version of this policy please access via the NHS Sheffield CCG Intranet Site by following the link below:

http://www.intranet.sheffieldccg.nhs.uk/policies-procedure-forms-templates.htm

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Policy Audit Tool

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

Please give status of Policy:	**Revised**

1.	**Details of Policy**	
1.1	Policy Number:	CO016/10/2022
1.2	Title of Policy:	Policy for the Development and Management of Policies and Procedural Documents
1.3	Sponsor	Director of Finance
1.4	Author:	Corporate Services Risk and Governance Manager / Quality Manager, Clinical Audit and Effectiveness
1.5	Lead Committee	Governance Sub-committee
1.5	Reason for policy:	Good Practice
1.6	Who does the policy affect?	All staff
1.7	Are the National Guidelines/Codes of Practices etc issued?	Yes
1.8	Has an Equality Impact Assessment been carried out?	Yes
2.	**Information Collation**	
2.1	Where was Policy information obtained from?	National best practice
3.	**Policy Management**	
3.1	Is there a requirement for a new or revised management structure for the implementation of the Policy?	No
3.2	If YES attach a copy to this form.	
3.3	If NO explain why.	Can be operated under existing structures
4.	**Consultation Process**	
4.1	Was there external/internal consultation?	Yes Quality Manager Clinical Audit and Effectiveness Equality and Diversity Manager
4.2	List groups/persons involved	Quality Manager Clinical Audit and Effectiveness Equality and Diversity Manager Governance Sub-committee
4.3	Have external/internal comments been included?	Yes
4.4	If external/internal comments have not been included, state why.	N/A

5.	**Implementation**	
5.1	How and to whom will the policy be distributed?	Staff will be made aware of all new policies via the Weekly Round-up and Staff Briefings. All Policies are available on the intranet.
5.2	If there are implementation requirements such as training please detail.	No
5.3	What is the cost of implementation and how will this be funded	N/A
6.	**Monitoring**	
6.2	How will this be monitored	Governance Sub-committee
6.3	Frequency of Monitoring	Quarterly

Version Control

Version	Date	Author	Status	Comment
1.0	2013	S Laing	New policy	Developed to ensure due process is followed and governance is in place
3.0	August 2017	S Laing B Ryton	Revised	General update to reflect CCG processes for approval and PRESS portal
3.1	August 2019	S Laing	Revised	Para 3.18 include reference to team briefings Para 6 – clarity around roles and responsibilities Para 7 – reference to Policy review sub-group Para 12 – Update to GP PRESS Portal Para 16 – Include reference to GDPR Para 17 – updated to include reference to Disability Confident Award – Level 2 Appendix 1 – minor changes to reflect process
3.2	September 2019	S Laing	Updated	Includes reference to Roles and Responsibilities following discussion at Governance Sub-committee August 2019
3.3	September 2021	C Henderson	Updated	Minor changes to job roles and typographical errors

Contents

1 Introduction and Purpose

NHS Sheffield CCG has a statutory duty to ensure that appropriate policies and supporting procedures, protocols or guidelines (referred to collectively as procedural documents) are in place to comply with legislation, enabling all staff to fulfil their roles safely and competently.

Policies and standard operating procedures, guidelines and protocols, communicate the standardised approaches and decisions of the CCG to the organisation's staff and stakeholders. These documents are an essential governance tool bringing consistency and transparency to day-to-day practice and contributing to achievement of strategic objectives. They are necessary to ensure that the CCG's intentions are clearly understood.

The rigorous development and management of these documents is a control mechanism for the CCG and provides assurance to the Governing Body on the consideration of relevant legal and statutory requirements and NHS policy and guidance.

The purpose of this policy is to provide a standardised approach to the development, approval, management and review of guidelines, protocols, policies and standard operating procedures (SOPs) whereby all policy documentation is consistent in format, compilation and dissemination. In addition, there will be an effective process for managing and reviewing procedural documents and any associated written control documents on a regular basis to ensure that documentation remains legally compliant.

This policy will ensure that the CCG meets its legal responsibilities and provides a clear organisational approach to documentation.

2 Scope and Definitions

2.1 Scope

This policy applies to all directly and indirectly employed staff and other persons working within or on behalf of the CCG.

The term 'procedural documents' is used throughout to collectively represent, Standard Operating Procedures (SOP), procedures, guidelines and protocols, written for implementation within the CCG and for whom the CCG has legal responsibility.

2.2 Definitions

CCG	Clinical Commissioning Group
Guidelines	Advisory or good practice principles put forward to set standards or determine a course of action.
JSCF	Joint Staff Consultative Forum

Policy	National or corporate framework that directs the organisation's practice in fulfilling statutory and organisational responsibilities. Policies are contractually and legally binding on all employees. It is a statement of the standard of service that is to be provided to enable management and staff to make correct decisions, deal effectively and comply with, relevant legislation, rules and good working practices.
Protocol	A set of rules defining or describing behaviour. A protocol defines and restricts what must happen in a particular situation. A signed protocol is legally binding on the individual.
Procedure	Detailed step-by-step instructions that describe how tasks or activities should be carried out to achieve the highest standards possible and to ensure efficiency, consistency and safety. A procedure defines a course of action to be followed.
Standard Operating Procedures (SOPs)	Written instructions intended to document how to perform a routine instruction
Strategy	An overarching document that reflects the objectives and goals of the organisation to achieve a longer term objective.

3 Policy Development - Process Requirements

3.1 A brief summary for the policy development and approval process is available at Appendix 1.

3.2 To have formal status, policies must be prepared and approved in accordance with the process described within this document.

3.3 All policies must be sponsored by a Director.

3.4 New policies should be developed with the involvement of key stakeholders and with adequate and appropriate consultation, including those affected by the proposed document. Documents affecting the public may be subject to consultation with members of the public. Where there may be implications for staff, the Joint Staff Consultative Forum (JSCF) should be included in the consultation and where there may be financial implications the Local Counter Fraud Specialist should also be consulted.

3.5 Policies must be prepared in a consistent style, using the policy template at Appendix 4.

3.6 The footer at each page must include:

a. Organisation

b. Version Number

b. Effective Date

c. Review Date

d. Author

e. Page Number

3.7 Headings and sub-headings should be numbered in the house style:

1. Introduction / Background
1.1. Xxxxxx

2. Other headings, etc
2.1. Xxxxxxx
2.2. Xxxxxx

3.8 All documents are to be prepared using Arial, point 12 and with due regard to guidance published by the Plain English Campaign[1]

3.9 The development or review process must include a comprehensive Equality Impact Assessment (EIA) using the guidance and template at **Appendix 3.**

3.10 Upon completion of the policy, including any revisions following consultation with stakeholders and completion of the EIA, the policy should be submitted to the Corporate Secretariat / Business Manager to Director of Finance to ensure approval by the appropriate committee.

3.11 Policies which require an update but do not include changes in legislation, or which have no financial or legal impact have continued approval to make the necessary amendments.

3.12 Policies previously approved by the Governing Body and which require an update to include changes in legislation, or have financial or legal consequences must be re-submitted to the relevant Committee/Sub-committee/Group for approval.

3.13 All policies require formal approval and will follow the process as described at Appendix 1.

3.15 The document owner/author will be responsible for ensuring all steps in the process are followed.

3.16 Approval will be documented within the minutes of the relevant meeting, a quarterly report of all non-clinical policies approved by the Governance Sub-committee will be submitted to the Audit and Integrated Governance Committee (AIGC).

3.17 Following formal approval policies will be posted onto the website by the Corporate Secretariat / Business Manager to Director of Finance within one

[1] http://www.plainenglish.co.uk/files/designguide.pdf

month of the date of approval. In order to comply with the Freedom of Information Act 2000, policies will be accessible to members of the public.

3.18 A brief summary of approved policies will be included in Team Briefings.

3.19 Approval of all clinical policies is via the Quality Assurance Committee (QAC).

4 Procedural documents

The majority of procedural documents will not require formal approval by a CCG committee. Where a procedure or guideline has significant impact on the organisation, the process for documents requiring approval should be followed (see Section 6 Policy Approval).

5 Consultation

5.1 It is the responsibility of the author to agree and undertake appropriate consultation on the document, prior to presenting for approval. Advice on groups/individuals who may be consulted should be sought from the Corporate Governance Manager (corporate policies) or Quality Manager Clinical Audit and Effectiveness (clinical policies). Individuals/groups consulted during the development or review of the document should be documented within the Policy Audit Tool.

5.2 All documents should be reviewed by and commented on by the appropriate internal and external stakeholders prior to formal approval by the relevant Committee or Sub-committee.

5.3 Staff Side consultation is a fundamental part of the approval process and should be included for most documents, but particularly those which have workforce / HR implications. HR and Corporate policies should be shared with the Joint Staff Consultative Forum (JSCF) as part of the consultation with key stakeholder process.

6 Roles and Responsibilities

6.1 Accountable Officer

The Accountable Officer has overall responsibility for the strategic and operational management of the CCG, including ensuring that the organisation's documents comply with all legal, statutory and good practice requirements.

6.2 Directors

All Directors are responsible for identifying and implementing policies and procedural documents and act as sponsor for those which are within their area of responsibility.

6.3 Chief Nurse

The Chief Nurse has responsibility for leading the development, review and approval of clinical policies and procedural documents as well as for the development, review and approval of safeguarding documents.

6.4 Director of Finance

The Director of Finance has responsibility for the development and review of Prime Financial Policies.

6.5 Document Author

Document owner(s)/author(s) are responsible for drafting documents and ensuring they are circulated for consultation to relevant staff groups. For policies requiring JSCF review, presentation to the group should be made by the relevant sponsor.

Document owner(s)/author(s) are also responsible for reviewing and amending as required within the review timeframe and following the corporate format.

6.6 Senior Managers

Senior managers are responsible for ensuring adequate dissemination and implementation of policies and procedural documents and for ensuring that all staff have access to and are made aware of any documents that apply to them. Senior managers are also responsible for auditing compliance within their service. (See section 11 Monitoring and Review).

6.7 Corporate Governance Manager

Corporate Governance Manager has responsibility for:

- Developing the Policy for the Development and Management of Policies and Procedural Documents and maintaining an overview of the corporate approval and governance process
- Leading the development, review and approval of governance and risk management documents
- Ensuring that documents are reviewed in a timely manner
- Ensuring continuity through the document management processes

6.8 Corporate Governance Manager

The Corporate Governance Manager has responsibility for:

- Policy management control and issuing a unique reference number for each policy

- Ensuring policies are made available on the intranet and communicated to staff within one month of approval
- Maintaining a central record of all procedural documents produced by the organisation
- Archive arrangements of previously approved documents
- Storage and accessibility of documents
- Notifying owners/authors of the need for review, three months prior to the review date.
- Ensuring all documents are referenced and will issue a unique reference number following approval by the relevant committee.

6.9 Employees

All staff are responsible for co-operating with the development and implementation of the organisation's policies / procedural documents as part of their normal duties. They are responsible for ensuring that they maintain up-to-date awareness of policies / procedural documents and compliance with these.

6.10 Member Practices

Member practices should have an understanding of CCG policies and procedures and adhere to these when undertaking CCG business. Practices will have their own policies and procedures relating to the management of their practice, but they may wish to adopt CCG policies as good practice.

7 Policy Review Sub-group

In order to streamline the process and in particular, where policies require discussion at the Joint Staff Consultative Forum (JSCF), a policy review sub-group has been established in order to facilitate timely discussion. The sub-group will review HR and corporate policies where this has been previously requested by JSCF. Staff should submit procedural documents to SHECCG.HumanResources@nhs.net prior to presentation to the Governance Sub-committee for formal review/approval, ensuring sufficient time is built into the review process before expiry of the procedural document.

8 Approval

The CCG's Scheme of Reservation and Delegation sets out those decisions delegated to the Governing Body, its Committees and sub-committees and key officers of the CCG. The table below outlines the approval process for each policy type:

Policy type	Approving Committee
Prime Financial Policies	Audit and Integrated Governance Committee
Operational Policies	Governance Sub-committee
HR Policies	Governance Sub-committee
Clinical Policies and clinical pathways	Quality Assurance Committee

Procedural documents will remain invalid until formally approved by the relevant committee. See Appendix 1.

9 Interaction with Other Policies / Documents

This document should be read in conjunction with the following policies:

- Records Management Policy
- Freedom of Information Policy

Further support in understanding and use of this policy can be gained from the Corporate Governance Manager / Quality Manager Clinical Audit and Effectiveness

10 Document Management

The Corporate Governance Manager will be responsible for the process relating to the production of documents and will maintain an up-to-date register which will include:

- Type of document
- Name of Document
- Date of Approval
- Review Date
- Document Owner/Author
- Any additional prior reviews required
- Archived information

11 Dissemination

New or updated policies will be published using Weekly Round-Up, Team Brief, the intranet and where relevant, emailed to Deputy Directors / Heads of Service.

All policies and procedural documents will be available to members of the public under the Freedom of Information Act via the organisation's Publication Scheme.

Advice and support on this process can be sought from the Corporate Governance Manager / Quality Manager Clinical Audit and Effectiveness. The Corporate Governance Manager will ensure superseded documents are archived appropriately.

12 GP PRESS Portal

The GP PRESS Portal is available via the CCG intranet. The Portal has been established in order to provide a single route for accessing a variety of information both clinical and non-clinical which supports joint working across the city. A separate governance process has been developed by the Elective Portfolio which will adhere to best practice principles as outlined in this policy and this should be followed if any documents are to be uploaded to the portal.

13 Monitoring and Review (this policy)

13.1 Monitoring compliance to this policy will be the responsibility of the Corporate Governance Manager in his/her role of ensuring continuity through the document management processes. Implementation and use of this policy will be monitored by the Governance Sub-committee.

13.2 Responsibility for monitoring, compliance and review of each procedural document remains with the document owner/author and the team responsible for drafting the document, it should be described within the document and include the following:

- Responsibilities for conducting the monitoring/audit
- A brief description of the method to be used for monitoring/audit
- Frequency of monitoring/audit, i.e. quarterly, on a rolling basis, etc.
- Process for analysing the results

Document owners / authors should define the frequency and detail of the measurement, monitoring and evaluation process.

13.3 This policy will be reviewed after two years or upon the publication of national guidance / legislation, whichever is the sooner.

14 Retention, Disposal and Archiving

The disposal of withdrawn or archived documents is the responsibility of the Corporate Governance Manager on the instruction of the document owner/author and will be in accordance with the Records Management Policy.

At least one copy of the old document will be archived and all other paper copies of the document should be destroyed.

Documents published on the intranet will be removed and replaced with the revised version following approval.

15 Equality and Diversity Statement

NHS Sheffield CCG aims to design and implement services, policies and measures that meet the diverse needs of our service population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the Human Rights Act 1998 and promotes equal opportunities for all. This document has been assessed to ensure that no-one receives less favourable treatment on grounds of their gender, sexual orientation, marital status, race, religion, age, ethnic origin, nationality, or disability. Members of staff, volunteers or members of the public may request assistance with this policy if they have particular needs. If the person requesting has language difficulties and difficulty in understanding this policy, the use of an interpreter will be considered.

NHS Sheffield CCG embraces the six staff pledges in the NHS Constitution. This policy is consistent with these pledges.

To ensure the above, all policies / procedural documents must have an Equality Impact Assessment.

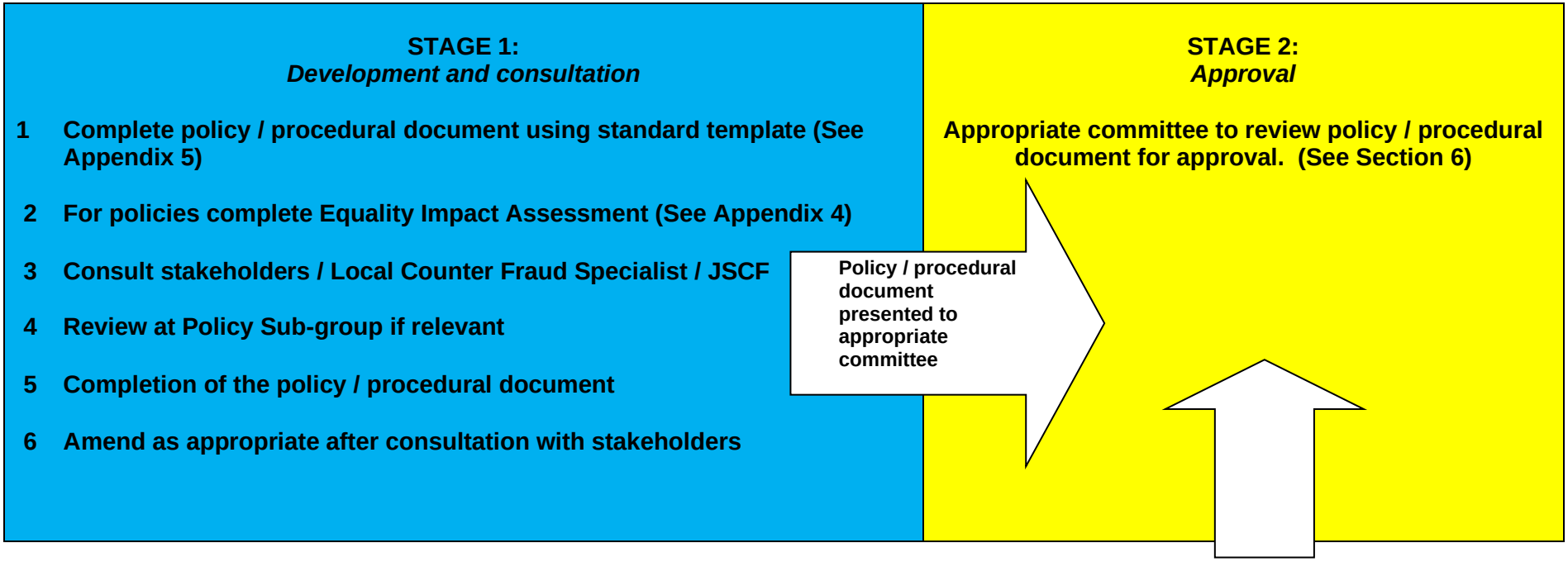
16 General Data Protection Regulations

The CCG is committed to ensuring that all personal information is managed in accordance with current data protection legislation, professional codes of practice, NHS records management and confidentiality guidance. More detailed information can be found in the CCG's Confidentiality Code of Conduct and Data Protection Policy and related CCG policies and procedures.

17 Disability Confident

The CCG has been accredited with the Disability Confident Award – level 2. This is in recognition of meeting the commitments regarding employment of disabled people and permits the organisation to use the Disability Confident logo on all of its stationery. The Disability Confident symbol should be added as a footer to all policies / procedural documents.

Summary of Policy / Procedural Document Development / Approval Process



STAGE 3
Review / Monitoring

Following review or after completing an audit, and where significant amendments are made consultation with stakeholders is required and the policy / procedural document will then need to go to the appropriate Committee/Sub-committee or group for approval as per STAGE 2 of this summary.

Appendix 2

Clinical Policies and Guidelines Appraisal Instrument

	Yes	No	N/A	Comments
Rationale				
1. Is the rationale for the clinical policy/guideline clearly defined?				
Policy/Guideline Development Group				
2. Is the group responsible for policy / guideline development clearly identified?				
3. Is there a clear description of the individuals involved in the policy / guideline development?				
4. Does the group represent all key disciplines?				
Context and Content				
5. Are the reasons for developing the policy / guidelines clearly stated?				
6. Are the objectives clearly identified?				
Is there a clear description or the patients/staff/groups to which this policy / guideline applies?				
8. Are there any circumstances in which exceptions might be made in using this policy / guideline? If so are the circumstances of this exception clearly documented?				
Clarity				
9. Does the policy / guideline describe the condition/process to be treated/detected/prevented?				
10. Are the possible management options clearly stated?				
11. Are the recommendations clearly stated?				
12. Are the health benefits/potential harms and risks/costs of utilising the policy / guideline clearly identified?				
13. Are there implications for services if implemented?				
Identification and interpretation of Evidence				
14. Are the sources of information used to devise the policy or guideline clearly described? eg. National Guidelines/Codes of Practice				
15. If so are they adequate?				
16. Is there a satisfactory description of the method used to interpret and assess the strength of				

	Yes	No	N/A	Comments
evidence and formulate appropriate recommendations?				
17. Is there an indication of how the views of interested parties were taken into account?				
Rigour of Development				
18. Was the policy / guideline independently reviewed prior to publication/issue?				
19. Was the policy / guideline piloted and if so has this been effectively evaluated?				
Application				
20. Are the staff that should receive this policy / guideline clearly identified?				
21. Are there any staff awareness raising/training sessions required as a result of the new/revised policy / guideline? If yes, have training and development leads been informed of this?				
22. Are methods of dissemination and implementation of the policy / guideline clearly identified?				
Updating				
23. Has a date for reviewing or updating the policy / guideline been agreed?				
24. Has an individual/group responsible for this process been clearly identified?				
Monitoring				
25. Does the policy/guideline define measurable outcomes that can be monitored?				
26. Has a process for monitoring and evaluating the effectiveness of the policy/guideline been agreed including, testing awareness and obtaining evidence of policy/procedures being put in place?				

NHS
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Equality Impact Assessment Guidance

Introduction

Equality impact assessment is a way of systematically analysing a new or changing policy, strategy, process and papers to CCG Committee etc. to identify what effect, or likely effect it could have on 'protected groups' to ensure appropriate decisions, which reduce health inequalities, address discriminatory consequences and maximise opportunities to promote equality, are made.

This toolkit has been developed to meet our obligations under the Equality Act 2010 general duty to

- Eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Act;
- Advance equality of opportunity between people who share a protected characteristic and people who do not share it
- Foster good relations between people who share a protected characteristic and people who do not share it**.**

Public bodies have to demonstrate due regard to the general duty. Due regard means active consideration of equality must influence the decision/s reached – as employers; in policy development, evaluation and review; in the design, delivery and evaluation of services, commissioning and procurement.

Having due regard to the need to advance equality of opportunity involves considering the need to

- Remove or minimise disadvantages suffered by people due to their protected characteristics;
- Meet the needs of people with protected characteristics; and
- Encourage people with protected characteristics to participate in public life or in other activities where their participation is low.
- Fostering good relations involves tackling prejudice and promoting understanding between people who share a protected characteristic and others.

Following a recent judicial review (costing Birmingham City Council a reported £600k) due regard was described as 'creating a decision making process that links the policy design, macro or micro, with the details of the impact of policy on individuals'. Before making policy decisions, even high level decisions about allocation of resources, an organisation must understand the potential impact of its decision on individuals (not necessarily named individuals, but a suitable range of typical service users) and ensure that this is explicitly factored into its decision-making.

This assessment process therefore aims to ensure we have:

- Evidence of consultation and other engagement activities that elicit sufficient information to enable it to identify the impact of a proposed decision on individuals;
- Informed the decision-makers of the potential impact and expressly considered how this can be reconciled with the organisation's equalities duties;
- Informed decision-makers how adverse impacts of a decision might be mitigated and whether there are alternatives to the proposed decision that could be taken that would avoid or reduce adverse impact.

Guidance

Equality impact assessment is an integral part of our commissioning processes. It involves looking at what steps could be taken to advance equality, eliminate discrimination and promote good relations.

Case law has demonstrated that we need to ensure that we give full consideration to the impact our decisions have on protected groups to avoid both risks in terms of litigation and reputation. We also need to ensure that those we commission deliver on equality improvements.

As a public authority we are subject to the General and Specific Public Sector Equality Duties. Using EQIA is one way of demonstrating that we are compliant with the Equality Act 2010.

Sheffield CCG uses an EIA screening process (Step1) to ensure policies, business cases, strategies and decisions embed equality and are inclusive to all. At the end of this screening an assessment is made whether to continue with a 'full' EIA (Step 2) where neutral or adverse impact is found. An EIA template and flowchart (Screening and Full EIA) can be found on http://www.intranet.sheffieldccg.nhs.uk/equality-impact-assessments.htm

Completing the EIA Form

a. Policy/ Paper outline:

The EIA will require information on the following areas:

- What is the purpose of the policy/paper
- In what context will it operate
- Who is it intended to benefit
- What results are intended
- Why is it needed
- Are there any implications for partners, or national or regional policy

b. Consideration of relevant information:

Consultation, engagement or experience

This could be any evidence of existing consultation or engagement from meetings, focus groups, satisfaction or patient experience surveys, staff surveys or others. It could be work done previously or undertaken for the purposes of the analysis. You may have to extrapolate from local, regional or national data.

Outline the main points form the consultations and then provide a link to the report/document for further information.

In the event of a service change the NHS may need to undertake a statutory consultation. This is called Section 242, this means that NHS organisations are required to make arrangements to involve and consult patients and the public in:

- Planning of the provision of services;
- The development and consideration of proposals for changes in the way those services are provided, and decisions made by the NHS organisation affecting the operation of services.

The duty applies if implementation of the proposal, or a decision (if made), would have impact on:

a) The manner in which the services are delivered to users of those services, or
b) The range of health services available to those users.

Evidence, data or research available

You will be required to detail relevant data such as monitoring, take up rates, census statistics, regional or national data or research. You can utilise evidence obtained from PALS, complaints or recommendations from inspections or audits, or any good practice in the area which could be drawn on.

Detail the data that is known about the area, what data we have from providers, what gaps there are in the data we ask to be recorded, what levels of use there are and if there are any gaps in the representation of our local communities.

It will also be useful to access data and information about our communities, public, staff and epidemiology to determine if there are any gaps in representation, or differentials in access and outcomes that may relate to equality.

National and regional data can be used to predict expected patterns/outcomes where data is not available locally. Comparisons should be made with expected use and against known community data, such as the census or local profiles.

Information collection and monitoring

Data can be routinely collected on age, gender, disability and ethnicity; however, there may be more difficultly with sensitive data monitoring of sexual orientation, religion and belief or gender reassignment. Different approaches may be used for

this monitoring such as anonymous survey work to gather views or snapshots of users. The integration of such monitoring is implicit in the Equality Act 2010.

Types of information you may wish to consider include;

- JSNA
- Demographic data
- Census findings
- Recent research finding
- Studies of deprivation
- Results of recent consultations and surveys
- Information from local groups and partner agencies
- Information analysis of audit reports and reviews
- Health Needs Assessment

c) Analysis of Information:

Now the data has been gathered together in one place it now needs to be considered for its likely impact, positive, neutral or negative, on people's experiences, outcomes or opportunities. The first column asks what are the identified issues, the second – 'what are you going to do about it? this forms the core of the analysis.

Some people can belong to more than one protected group, attention needs to be paid to issues which may affect across groups, such as learning disabled people who are gay or older Irish people etc. Detail what the likely issues could be, using the information already considered and other intelligence.

Some of the significant issues that may be relevant to our service users and staff are detailed below, this is not an exhaustive list but should be a good start;

- What equality data do you ask for from Providers to support that all people who are potential users of the service are able to, or do access them, i.e. is their service user data representative of the community as a whole, or of the proportion of the population eligible for it? Are there any representation/data gaps?
- How is the service advertised and promoted– is it in accessible formats, with representative images, in locations likely to be seen by people not being reached or who are under-represented have we ensured providers are required do this?
- What timing has the service been commissioned for; is this when the service is needed or can be accessed by people who may have different needs, parents of school age children, people of different religions and older and younger people?
- Have you required the provider to consider any different needs people may have, interpreters, accessible information, suitable catering and locations that are accessible by public transport and have accessible parking bays?
- When commissioning services have you incorporated the requirement to involve service users in service design, delivery and feedback mechanisms.
- To be able to measure progress in equality for our communities and staff we need to appreciate the outcomes, rather than the input, so the 'what difference will this make' column allows for consideration of the likely outcomes.

d. Action planning for improvement:

Give an outline of the key actions based on any gaps, challenges and opportunities you have identified. Include here any action to address specific equality issues and data gaps that need to be addressed through consultation or further research. If neutral, have you challenged yourself sufficiently? If negative, how will the gaps be address?
Ensure the actions are specific, measureable, achievable, realistic and have a timescale.

e. Monitoring, review and publication:

Detail how and who will monitor this action plan and review this equality analysis.

f. Sign off:

The completed equality analysis must be forwarded to your equality and diversity lead, for review once signed by the lead officer. If the assessment is to be used as part of a decision making process it must be recorded as such in the minutes or notes of the meeting held and those making the decision must be fully informed as to their legal responsibilities in regard to equality.

Appendix 4

NHS Sheffield Clinical Commissioning Group

NHS Sheffield CCG Equality Impact Assessment

Equality Impact Assessment

Title of policy or service:	Policy for the Development and Management of Policies and Procedural Documents	
Name and role of officer/s completing the assessment:	Carol Henderson, Corporate Governance Manager	
Date of assessment:	September 2021	
Type of EIA completed:	**Initial EIA 'Screening'** X ***or*** **'Full' EIA process** ☐	*(select one option - see page 4 for guidance)*

1. Outline	
Give a brief summary of your policy or service • Aims • Objectives • Links to other policies, including partners, national or regional	Set out at page 5 of the Policy

Identifying impact:

- **Positive Impact:** will actively promote or improve equality of opportunity;
- **Neutral Impact:** where there are no notable consequences for any group;

- **Negative Impact:** negative or adverse impact causes disadvantage or exclusion. If such an impact is identified, the EIA should ensure, that as far as possible, it is justified, eliminated, minimised or counter balanced by other measures. This may result in a 'full' EIA process.

2. Gathering of Information
This is the core of the analysis; what information do you have that might *impact on protected groups, with consideration of the General Equality Duty*.

	What key impact have you identified?			For impact identified (either positive an or negative) give details below:	
(Please complete each area)	**Positive Impact**	**Neutral impact**	**Negative impact**	**How does this impact and what action, if any, do you need to take to address these issues?**	**What difference will this make?**
Human rights	☐	☒	☐		
Age	☐	☒	☐		
Carers	☐	☒	☐		
Disability	☐	☒	☐		
Sex	☐	☒	☐		
Race	☐	☒	☐		
Religion or belief	☐	☒	☐		
Sexual orientation	☐	☒	☐		
Gender reassignment	☐	☒	☐		
Pregnancy and maternity	☐	☒	☐		
Marriage and civil partnership (only eliminating discrimination)	☐	☒	☐		
Other relevant groups	☐	☒	☐		
HR Policies only: Part or Fixed term staff	☐	☒	☐		

IMPORTANT NOTE: *If any of the above results in '**negative'** impact, a 'full' EIA which covers a more in depth analysis on areas/groups impacted must be considered and may need to be carried out.*

Having detailed the actions you need to take please transfer them to onto the action plan below.

3. Action plan				
Issues/impact identified	**Actions required**	**How will you measure impact/progress**	**Timescale**	**Officer responsible**
No issues identified				

4. Monitoring, Review and Publication				
When will the proposal be reviewed and by whom?	**Lead / Reviewing Officer:**	**Carol Henderson**	**Date of next Review:**	**1 April 2022**

Appendix 5

Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Name of Policy

Date of Issue

Version:	
Policy Number:	
Date ratified:	
Name of originator/author:	Title only not names
Name of Sponsor:	
Name of responsible committee	
Date issued:	
Review date:	
Target audience:	

To ensure you have the most current version of this policy please access via the NHS Sheffield CCG Intranet Site by following the link below:

http://www.intranet.sheffieldccg.nhs.uk/policies-procedure-forms-templates.htm

MINDFUL EMPLOYER

disability confident EMPLOYER

Policy Audit Tool

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

Please give status of Policy:	**New / Revised**

1.	**Details of Policy/Procedural Document**	
1.1	Title of Policy/document:	
1.2	Sponsor	
1.3	Author:	
1.4	Lead Committee	
1.5	Reason for policy/document:	
1.5	Who does the policy affect?	
1.6	Are the National Guidelines/Codes of Practice etc issued?	
1.7	Has an Equality Impact Assessment been carried out?	
2.	**Information Collation**	
2.1	Where was Policy information obtained from?	
3.	**Policy Management**	
3.1	Is there a requirement for a new or revised management structure for the implementation of the Policy?	
3.2	If YES attach a copy to this form.	
3.3	If NO explain why.	
4.	**Consultation Process**	
4.1	Was there external/internal consultation?	
4.2	List groups/persons involved	
4.3	Have external/internal comments been included?	
4.4	If external/internal comments have not been included, state why.	
5.	**Implementation**	
5.1	How and to whom will the policy be distributed?	
5.2	If there are implementation requirements such as training please detail.	
5.3	What is the cost of implementation and how will this be funded	
6.	**Monitoring**	
6.1	How will this be monitored	
6.2	Frequency of Monitoring	

Version Control

VERSION CONTROL				
Version	**Date**	**Author**	**Status**	**Comment**

Contents

1 Introduction & Purpose

This section should be used to highlight the rationale, standards etc to why the policy/procedural document has been developed

2 Scope

It is essential that the document explicitly states who it applies to eg:

- *All NHS Sheffield CCG staff*
- *Heads of service and senior manager*
- *All polices and procedural documents*

3 Definitions

Insert any definitions for terms used

4 Process/Requirements

There is no prescriptive way of detailing this section. The main body of the document will be unique depending on the subject matter. You may include subsections if required.

5 Roles and Responsibilities

6 Monitoring effectiveness of the policy/procedural document

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

Results of the evaluation should be documented and records kept of any discussions relating to monitoring for audit purposes.

7 Review

Include the standard statement:

This document may be reviewed at any time at the request of either staff side or management, but will automatically be reviewed after (twelve months/24 months/26 months) and thereafter on a bi-annual basis or when a change in legislation dictates.

8 References and links to other documents

Where applicable, the document must contain a section detailing the research / evidence / references that have been used to assist in the development of the policy/procedural document. Some of this information may be included at the

beginning of the document as way of an introduction but should be referenced in full at the back of the procedural document.

Signpost the reader to other relevant and supporting policies / Standard Operating Procedures. (Ensure these are cross-referenced within the main body of the procedural document where appropriate).

9 Interaction with other procedural documents

10 Equality & Diversity Statement

NHS Sheffield CCG aims to design and implement services, policies and measures that meet the diverse needs of our service population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the Human Rights Act 1998 and promotes equal opportunities for all. This document has been assessed to ensure that no-one receives less favourable treatment on grounds of their gender, sexual orientation, marital status, race, religion, age, ethnic origin, nationality, or disability. Members of staff, volunteers or members of the public may request assistance with this policy if they have particular needs. If the person requesting has language difficulties and difficulty in understanding this policy, the use of an interpreter will be considered.

NHS Sheffield CCG embraces the six staff pledges in the NHS Constitution. This policy is consistent with these pledges.

To ensure the above, all policies must have an equality impact assessment.

11 General Data Protection Regulations

The CCG is committed to ensuring that all personal information is managed in accordance with current data protection legislation, professional codes of practice, NHS records management and confidentiality guidance. More detailed information can be found in the CCG's Confidentiality Code of Conduct and Data Protection Policy and related CCG policies and procedures

12 Disability Confident

NHS Sheffield CCG has been accredited with the Disability Confident Award – level 2. This is in recognition of meeting the commitments regarding employment of disabled people and permits the organisation to use the Disability Confident logo on all of its stationery. The Disability Confident symbol should be added as a footer to the front sheet of all policies / procedural documents.

NHS Sheffield Clinical Commissioning Group

NHS Sheffield CCG Equality Impact Assessment

Equality Impact Assessment

Title of policy or service:		
Name and role of officer/s completing the assessment:		
Date of assessment:		
Type of EIA completed:	**Initial EIA 'Screening'** ☐ ***or*** **'Full' EIA process** ☐	

1. Outline	
Give a brief summary of your policy or service • Aims • Objectives • Links to other policies, including partners, national or regional	

Identifying impact:

- **Positive Impact:** will actively promote or improve equality of opportunity;
- **Neutral Impact:** where there are no notable consequences for any group;

- **Negative Impact:** negative or adverse impact causes disadvantage or exclusion. If such an impact is identified, the EIA should ensure, that as far as possible, it is justified, eliminated, minimised or counter balanced by other measures. This may result in a 'full' EIA process.

2. Gathering of Information
This is the core of the analysis; what information do you have that might *impact on protected groups, with consideration of the General Equality Duty*.

(Please complete each area)	What key impact have you identified?			For impact identified (either positive an or negative) give details below:	
	Positive Impact	**Neutral impact**	**Negative impact**	**How does this impact and what action, if any, do you need to take to address these issues?**	**What difference will this make?**
Human rights	☐	☐	☐		
Age	☐	☐	☐		
Carers	☐	☐	☐		
Disability	☐	☐	☐		
Sex	☐	☐	☐		
Race	☐	☐	☐		
Religion or belief	☐	☐	☐		
Sexual orientation	☐	☐	☐		
Gender reassignment	☐	☐	☐		
Pregnancy and maternity	☐	☐	☐		
Marriage and civil partnership (only eliminating discrimination)	☐	☐	☐		
Other relevant groups	☐	☐	☐		
HR Policies only: Part or Fixed term staff	☐	☐	☐		

IMPORTANT NOTE: *If any of the above results in '**negative'** impact, a 'full' EIA which covers a more in depth analysis on areas/groups impacted must be considered and may need to be carried out.*

Having detailed the actions you need to take please transfer them to onto the action plan below.

3. Action plan				
Issues/impact identified	**Actions required**	**How will you measure impact/progress**	**Timescale**	**Officer responsible**

4. Monitoring, Review and Publication				
When will the proposal be reviewed and by whom?	**Lead / Reviewing Officer:**		**Date of next Review:**	