NHS
Hampshire, Southampton and
Isle of Wight
Clinical Commissioning Group

POLICIES AND PROCEDURAL DOCUMENTS
Development and Management Policy

Policy number	CORP/002/V1.4
Version	V1.4
Approved by	Policy Sub Group
Document author	Governance Team
Executive lead	Chief of Staff
Date of approval	12 September 2021
Next due for review	April 2024

Version control sheet

Version	Date	Author	Comment
1.1	28.7.2021	Governance Manager	Amendments to streamline policy
1.2	10.8.2021	Governance Manager	To shorten elements relating to equality and diversity. Amendments to policy development flow chart to build in requirement for governance team to have early sight of policy prior to going out to any consultation.
1.3	12.8.2021	Governance Manager	Further amendments following discussion at Policy Sub Group of 12.8.2021 with regard to ensuring Equality Impact Assessment is considered throughout development of a policy and to acknowledge the transition from CCGs to becoming Integrated Care Systems and that that policies will need to be reviewed accordingly.
1.4	1.11.2021	Governance Manager	Reference to additional EIA template for HR policies.

Contents

1.   Introduction

1.1   Policies and procedural documents (for definition please see Section 4) are a key component of the Hampshire, Southampton & Isle of Wight CCG (the CCG) corporate governance framework and risk management system, which keep the organisation and its staff safe, protect the same from challenge, reputational damage and claim for redress.

1.2   The CCG is committed to designing and implementing services, policies and measures that meet the diverse needs of its population and workforce, ensuring that no individual or group is disadvantaged.

1.3   The CCG uses policies and procedures to enable staff working for, and with us, to do so in a way that is efficient, consistent, safe and in keeping with our values, objectives and purpose.

1.4   The development, approval and monitoring of the use of our policies, also ensures that we meet statutory, legal and insurance requirements as well as best practice in relation to corporate and clinical governance. In doing so it supports the NHS Constitution i.e.

"The NHS aspires to the highest standards of excellence and professionalism in the provision of high-quality care that is safe, effective and focused on patient experience; in the planning and delivery of the clinical and other services it provides; in the people it employs and the education, training and development they receive; in the leadership and management of its organisations; and through its commitment to innovation and to the promotion and conduct of research to improve the current and future health and care of the population".

1.5   It is recognised that Hampshire and the Isle of Wight is in the process of becoming an Integrated Care System (from April 2022). As such, existing CCG policies will need to be reviewed accordingly.

2.   Purpose

2.1   To provide a framework for the above in accordance with our values regarding transparency and openness.

2.2   The environment within which we operate is one of constant change, and we must be in a position to respond to the challenges posed by these changes. This document seeks to ensure that our policies and procedures remain relevant by setting out our process for their development and management.

3. Scope

3.1 This policy applies to all staff employed by, and staff working on behalf of the CCG and applies to all strategies, policies, procedures, protocols, guidelines and plans being issued under our CCG logo.

3.2 This policy sets out the expectations of quality and there are specific, limited circumstances where exceptions may apply:

- Where procedural documents are shared with other CCGs and/or the Commissioning Support Unit, the format and approval process may differ.

- Where procedural documents have been 'inherited' as part of collaborative or partnership working with other bodies. In this case, procedural documents will be reviewed in accordance with this guidance, as and when they come up for review.

- Strategies (and other operational/business planning documents) will conform to the corporate standards set out in this policy; however, the contents/headings may differ and will typically be nationally driven.

3.3 We may also utilise procedural documents developed for us by third parties. This policy together with the CCG policy template should be used for the purposes of approval and monitoring as well as assistance to those third parties in the development and format of such policies bearing our CCG logo (see Section 8 for further information). The CCG expects its commissioning partners and service providers to have in place an equivalent policy reflecting their own corporate standards of documentation.

4. Definitions

4.1 A **STRATEGY** is a plan designed to achieve a longer term aim or goal. These timeframes can range from 2-3 years through to 15-20 years.

4.2 A **POLICY** sets out an organisation's statement of intent and defines the course of action to be taken to meet this. It outlines processes specific to the particular organisation.

4.3 A **PROCEDURE** is a set of detailed step-by-step instructions that describe the appropriate method for carrying out tasks or activities to achieve the stated outcome.

4.4 A **PROTOCOL** is an explicit detailed plan of a procedure (usually locally defined).

4.5 A **GUIDELINE** is a broad statement of good practice. There is a degree of flexibility in the application of guidelines. Guidelines can themselves assist in determining strategies, policies, procedures etc.

4.6 A **PLAN** is a detailed document of what needs to be done and how this will happen.

4.7   The term **PROCEDURAL DOCUMENT** refers to all the above-mentioned documents.

5.   Roles and responsibilities

5.1   **Accountable Officer** – has ultimate accountability for the strategic and operational management of the organisation, including ensuring all policies are adhered to.

5.2   **CCG Governing Body** – is responsible for ratifying all policies in use by the organisation.

5.3   **Chief of Staff (or nominated lead**) – is responsible for advising staff/office holders on the contents of this policy and will ensure that the formal approval procedure set out in this policy is followed.

5.4   **CCG committees** – the terms of reference of Governing Body committees may require them to review and approve corporate policies prior to ratification by the Governing Body.

5.5   **Stakeholders** – are responsible for:

- reviewing this policy and providing feedback

- ensuring the policy has been implemented.

5.6   **Governance Team** - is responsible for ensuring the following:

- maintaining a central policy register

- ensuring the ratified documents are uploaded to the intranet and / or the CCG website in a timely manner as required by the policy

- contacting the Document Author when a policy is nearing its review date.

5.7   **Document Author** – is responsible for ensuring that:

- documents they are responsible for (as determined by their role) are regularly reviewed and maintained

- the Governance Team has been notified of any new policies or reviewed policies/procedural documents

- an Equality Impact Assessment is completed for all those policies which have been assessed as having a medium or high impact on people with protected characteristics (training and support is available from the CCG Equality and Diversity leads)

- appropriate consultation is undertaken with key members of staff, unions and relevant groups / sub committees (as appropriate)

- policies that they are responsible for are formally ratified following the correct procedures

- that documents are cascaded appropriately

- that all documents follow the corporate format

- that the effectiveness of the policy is monitored and evidenced

- that any issues identified through the standard monitoring are followed up and appropriate actions taken.

5.8 **Line managers** - are responsible for ensuring their staff are aware of, and adhere to, this policy.

5.9 **Staff and others engaged in the business of the CCG** - should ensure that they follow this policy when developing procedural documents.

6. Development of new and the revision of existing polices and procedural documents

6.1 Flow charts for the policy development, approval and ratification processes can be found at Appendix 1 and Appendix 2.

6.2 The grounds for creation of a new procedural document must be justified by the Document Author who must check to ensure that they avoid duplication.

6.3 Appropriate consultation must be undertaken with key members of staff, unions and relevant groups / sub committees (as appropriate) prior to the document being submitted to the Policy Sub Group for approval. Details of potential routes for consultation can be found at Appendix 5.

7. Statutory requirements

7.1 All policies etc. must comply with relevant statutory requirements, any subsidiary legislation and subsequent amendments, details of which should be referenced within the policy as appropriate.

7.2 Equality Act 2010 - Equality Analysis

7.2.1 CCGs, like all public authorities, have to demonstrate "due regard" to the Public Sector Equality Duty of the Equality Act 2010 to:

- Eliminate discrimination, harassment and victimisation.

- Advance equality of opportunity.

- Foster good relations between people who share a protected characteristic and those who do not.

7.2.2 Both new policies, and existing policies when reviewed, come within the Public Sector Equality Duty. This means that policy authors must consider whether the policy will be effective for all patients and / or staff. This process is called equality impact assessment (EIA).

7.2.3 The standard EIA template is attached at Appendix 6 and is also available on the CCG's intranet. This provides a clear and structured method to assess the potential

impact on protected groups and supports the identification of practical steps to address any negative effects or discrimination. There is separate EIA template for HR related policies as agreed by the CCG's Policy Sub Group, see Appendix 7.

7.2.4 Failure to assess the equality impact on a policy may increase the risk of making an unfair decision which could potentially be discriminatory. It also helps CCGs to identify opportunities to promote equality and reduces the potential for legal challenge.

7.2.5 Many policies, such as IT Security and Information Governance are procedural documents that will have low impact on people with characteristics protected by the Equality Act. As such, these do not need an EIA to be completed; in these cases policies should include the statement *'This policy has been assessed as having a low impact on people with characteristics protected by the Equality Act. As such a full equality impact assessment is not required'*. Advice may be sought from the Equality & Diversity Leads.

7.2.6 All policies which have been assessed as having a medium or high impact by an Equality & Diversity Lead should have an EIA completed, which should be appended to the policy when published. EIAs need to be reviewed as part of the review process when existing policies are reviewed.

7.2.7 The Policies and Procedural Documents: Development and Management Policy has been assessed as having a low impact on people with characteristics protected by the Equality Act. As such a full equality impact assessment is not required.

8. Style and format

8.1 All procedural documents must be presented in accordance with the standard template (see Policy Template on the intranet).

8.2 Non-compliance with the corporate standards detailed in this template must be exceptional, and justified on presentation for approval and adoption.

9. Non CCG policies/special circumstances

9.1 Policies which are adopted from our partner organisations (such as Commissioning Support Unit, Local Authority, NHS England / Improvement, Department of Health) do not need to be rewritten in the CCG format if the CCG is intending to adopt them. However, a separate front sheet (see Appendix 3) should be attached to the policy showing the title and CCG policy reference. Details of the consultation process and the standard document control requirements must also be given on this sheet with a nominated CCG owner, rather than the Document Author, who would be responsible for reviews and CCG adoption.

10. Approval process

10.1 If appropriate, the policy or procedural document should be presented to the relevant CCG sub-committee or group for review prior to approval by the CCG Policy Sub Group. Oversight of the policy development and review process is through the Audit & Risk Committee. The checklist attached as Appendix 4 should be used to guide practice when developing a new policy / procedural document for approval. To be completed and attached to any **new** document which guides practice when submitting the document to the Governance team for approval.

10.2 The Governing Body may wish to review this process and delegate this role to one of its sub-committees. This should also be reflected in the CCG Scheme of Delegation.

10.3 The CCG Governing Body is responsible for the final ratification of policies for use within the CCG. Final ratification will be made via a summary of those policies approved by the Policy Sub Group that shows the:

- Policy name in full
- Unique reference number
- Summary of key changes / points to note
- Committee(s) and / or group(s) which reviewed and approved the policy
- Date of approval
- Outstanding conditions to approval

10.4 Policies approved with outstanding conditions may be ratified by Chair's action dependent on the type of condition. This request should be made of the Chair at the time of ratification.

10.5 Ratification is the point at which the approved policy is presented to the CCG Governing Body as final and accepted as ready for publication. The CCG Governing Body minutes must reflect the ratification by policy name and unique policy reference number.

10.6 It is accepted that following approval of a procedural document by the appropriate committee or group there needs to be an allowance of time before the policy becomes fully operational in order to allow appropriate dissemination of the new/revised policy within the CCG. It is therefore expected that any procedural document approved will be fully operational within three months of the date of approval unless otherwise notified.

11. Dissemination//publication

11.1 The policy / procedural document must set out clearly how it will be disseminated to staff and relevant stakeholders.

11.2 The Document Author may also wish to consider other routes of dissemination e.g. notification via newsletters, direct mailings to stakeholder organisations etc.

11.3   The Governance Team will ensure that ratified procedural documents are uploaded on to the intranet (for staff) and the website (for the general public) and that previous copies are archived in accordance with information governance guidelines.

12.   Monitoring

12.1   The Document Author must be able to demonstrate the effectiveness of the policy at the point of review, for example by; carrying out audits, reviewing incidents that may have occurred related to the policy, feedback from staff. How procedural documents will be monitored for effectiveness must be set out in this section and include review of the EIA. If policy compliance is the subject of an Internal Audit review or other monitoring mechanism, this should be described in this section and will represent the audit of effectiveness and compliance. Results of evaluation / records of any discussion should be provided with the revised / updated policy when submitted for approval.

12.2   Where there are gaps or omissions, an action plan should be generated. The Policy Sub Group (or nominated group) will have oversight of this information.

12.3   Monitoring of each document will be undertaken on an individual basis and should be identified within the document.

13.   Review and revision

13.1   Unless otherwise specified, all procedural documents should be reviewed by the Document Author every three years, and resubmitted for approval to the Policy Sub Group, with a schedule of proposed changes. More frequent review may be required if there are significant changes in practice or law or as a result from staff feedback. The next scheduled date for review must be detailed on the cover of each procedural document, and it is the responsibility of the Document Author to carry this out.

13 2   Minor variations are permitted without the need to follow the full approval process (see flow chart in Appendix 1 below (existing policies). Additional advice can be sought from the Chief of Staff (or nominated lead).

14.   Version control

14.1   The version of the document should be clearly displayed on the cover sheet.

14.2   A version control table is provided in the policy template to keep track of each iteration of the document and the reason for the change, for example, amendments following a consultation or changes in legislation.

15. Extending the lifespan of policies (by exception)

15.1 The Chief of Staff may temporarily extend the lifespan of a policy in exceptional circumstances to enable robust and comprehensive review e.g. where new guidance is anticipated, but not yet issued. This extension is subject to confirmation from the Document Author of its continued validity and organisational relevance; the extension should normally not exceed a period of six months.

15.2 If the lifespan is extended, the Document Author must note this on the current policy's front cover and advise the Governance Team for updating of the central policy register and arranging for its upload to the CCG's intranet and / or website as appropriate.

16. Training requirements

16.1 The policy / procedural document must set out any training requirements for its implementation.

16.2 There is no training requirement identified within this Policies and Procedural Documents: Development and Management Policy. A policy template is available on the intranet and any specific queries should be addressed to the Governance Team. Advice in relation to the completion of EIAs can be sought from the Equality & Diversity leads.

16.3 All stakeholders involved in policy development should be aware of the contents of this Policies and Procedural Documents: Development and Management Policy ('Policy for Policies').

17. Dissemination of this policy

17.1 This policy will be published on the CCG website and / or intranet (as appropriate) and promoted to staff through internal staff communications such as the intranet / staff App / newsletters / staff briefings.

18. Monitoring of this policy

18.1 The Policy Sub Group will ensure that all policies meet the required format as detailed within this policy.

18.2 An audit of existing policies may be undertaken when this policy is due for review to confirm this.

19. Review of this policy

19.1 This Policy will be reviewed by the Governance Team every three years to ensure continued validity and relevance. More frequent review may be required if there are significant changes in practice or law or as a result from staff feedback.

20.   Stakeholder / consultation information

20.1   This Policy was already in place in the HIOW Partnership of CCGs. It has been through an internal process and reviewed by members of the Governance Team, and reviewed and approved by the Policy Sub Group.

21.   References and links relating to this policy

- The Advisory, Conciliation and Arbitration Service (ACAS).
- Good Governance Institute
- NHS Resolution
- Department of Health and Social Care

Appendix 1 – Development Process

Document Authors must be mindful that sufficient time is allowed to complete all the required steps in the process (from initiation to formal approval / final ratification). Indicative timescales are detailed below.
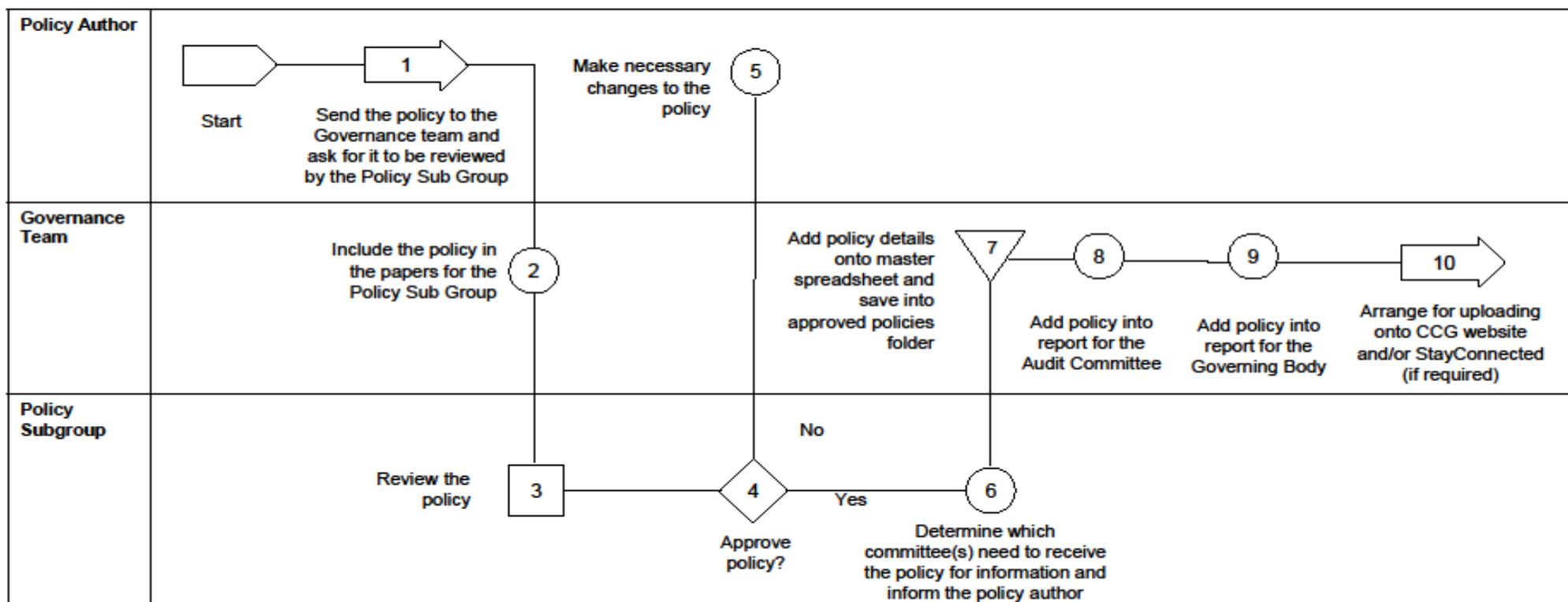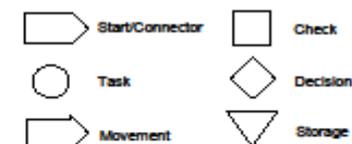
STEP	INDICATIVE TIMESCALE	POLICY DEVELOPMENT PROCESS – FLOW CHART PROCESS (NEW)
1.		Procedural document requirement identified
2.	Within first 28 days	Author and Executive Lead identified
3.		Author to Register New Policy with Governance Team
4.		Governance Team to register NEW policy on Policy Register and confirm receipt back to author
1.		Author to draft policy and obtain initial approval from Exec Lead
2.		Author to consider if the policy has a medium or high equality impact on people with protected characteristics and if so complete an Equality Impact Assessment (see Appendix 6). Advice can be sought from Equality and Diversity Leads.
3.	Within next 56 days	Author to share early draft with the governance team who can advise if it meets format requirements / if it is ready to go out for wider consultation (refer to Appendix 5 for potential routes for consultation) / if there are potential links with existing policies which need to be considered etc
4.		Author to co-ordinate consultation with key members of staff, unions and relevant groups / sub committees (where appropriate) and update as required.
5.		Final version to be approved by Executive Lead

STEP	INDICATIVE TIMESCALE	POLICY DEVELOPMENT PROCESS – FLOW CHART PROCESS (NEW)
6.		Author to submit Final version to the Governance Team to arrange review / approval (refer to approval process at Appendix 2)
7.		Once approved / ratified Governance Team to return final approved version to Document Author for their records / cascade.
8.		Governance Team to arrange for EIA to be signed by appropriate Executive Director (where required)
9.		Governance Team to register NEW policy and publish on the Website and / or Intranet as required and retain master copy in central records.
10.		Governance Team will send out reminder to document author at least three months prior to next formal review
		Policy review procedure to be followed as set out in this policy

STEP	INDICATIVE TIMESCALE	POLICY DEVELOPMENT PROCESS – FLOW CHART PROCESS (EXISTING) NB IF IT IS A MINOR VARIATION E.G. CHANGE OF JOB TITLE GO STRAIGHT TO STEP 5.
1.	3 months ahead of review date	Governance Team will send out reminder to document author at least three months prior to next formal review
2.	Within first 28 days	Author to update policy and obtain initial approval from Exec Lead
3.		Author to review the EIA i.e. if the policy has been assessed as having a medium or high equality impact on people with protected characteristics. Advice can be sought from Equality and Diversity Leads.
4.		Author to co-ordinate consultation with key members of staff, unions and relevant groups / sub-committees (as required) and update as required.
5.	Within next 56 days	Final version to be approved by Executive Lead
6.		Once approved final version returned to Governance Team to arrange review / approval (see Appendix 2). (Where significant / potentially contentious changes are required may also need to be submitted to CCG Governing Body for ratification).
7.		Once approved Governance Team to return final approved version to Document Author for their records / cascade.
8.		Governance Team to register updated policy and publish on the Website and / or Intranet as required and retain master copy in central records.
		Governance Team will send out reminder to document author at least three months prior to next formal review
		Policy review procedure to be followed as set out in the policy for policies.

Appendix 2 – Approval Process

Process Name: Policy approval process
Process Reference Number: TBC
Version Number: V2.0
Date of last review: 03/08/2021
Owner: TBC

Legend:
- Start/Connector
- Task
- Movement
- Check
- Decision
- Storage

Policy Author

Start → 1. Send the policy to the Governance team and ask for it to be reviewed by the Policy Sub Group → Make necessary changes to the policy → 5

Governance Team

2. Include the policy in the papers for the Policy Sub Group

Add policy details onto master spreadsheet and save into approved policies folder → 7 → 8. Add policy into report for the Audit Committee → 9. Add policy into report for the Governing Body → 10. Arrange for uploading onto CCG website and/or StayConnected (if required)

Policy Subgroup

Review the policy → 3 → 4. Approve policy? — No / Yes → 6. Determine which committee(s) need to receive the policy for information and inform the policy author

Appendix 3 – Cover sheet for joint policy

INSERT LOGOS OF BODIES/ORGANISATIONS

INSERT POLICY TITLE

CCG Policy number	
Version	
Approved by	
CCG owner	
CCG lead executive	
Date of approval	
Next due for review	
Consultation process	

Appendix 4 - Procedural Document - checklist for development

Procedural document checklist for approval
To be used as guidance to support development of new policies / procedural documents. To be completed and attached to any **new** document which guides practice when submitted to the appropriate committee for consideration and approval.

	Title of document being reviewed: Policy framework for the development and management of procedural documents	**Yes/No/ Unsure**	**Comments/Details**
A	**Is there a sponsoring director?**		
1	**Title**		
	Is the title clear and unambiguous?		
	Is it clear whether the document is a guideline, policy, protocol or standard?		
2	**Rationale**		
	Are reasons for development of the document stated?		
3	**Development Process**		
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?		
	Has the document been assessed as having a medium or high impact on people with protected characteristics, and if so, has an Equality Impact Assessment been completed?		
	Is there evidence of consultation with stakeholders, unions (where appropriate) and users?		
4	**Content**		
	Is the objective of the document clear?		
	Is the target group clear and unambiguous?		
	Are the intended outcomes described?		
5	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?		
	Are key references cited?		
6	**Approval**		
	Does the document identify which committee/group will approve it?		
7	**Dissemination and Implementation**		
	Is there an outline/plan to identify how the document will be disseminated and implemented amongst the target group? Please provide details.		

	Title of document being reviewed: Policy framework for the development and management of procedural documents	Yes/No/ Unsure	Comments/Details
8	**Process for Monitoring Compliance**		20
	Have details for how compliance will be monitored been included e.g. through internal audit, or audit standard developed i.e. have specific, measurable, achievable, realistic and time-specific standards been detailed to monitor compliance with the document?		
9	**Review Date**		
	Is the review date identified?		
10	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for implementing and reviewing the documentation i.e. role of author/originator?		

Appendix 5 – Stakeholders for Consultation

The following is a list of potential stakeholders / forums / routes for consultation that may be considered when developing new policies / procedures:

- Staff Forums/Networks
- Unions e.g. HR related policies
- All staff briefings
- StayConnected App
- Specific teams who may be particularly impacted by certain policies or be able to give advice e.g.
    - Continuing Healthcare teams would be impacted differently in relation to lone working, violence and aggression etc
    - Quality and safeguarding team who visit care homes / hospital settings etc
    - Local counter fraud specialist e.g. may have a view with regard to finance related policies / Standards of Business Conduct etc
    - Governance team for general advice on content / consultation requirements etc
- CCG sub-committees / groups e.g.
    - Patient involvement groups facilitated by the communications team
    - Hampshire Safeguarding Committee – includes reps from local authorities as well as wider NHS safeguarding teams
    - Hampshire Continuing Health Care Committee – includes reps from local authorities (joint NHS / LA policies)
    - Executive team e.g. where a proposed policy may be contentious or have financial implications which need to be considered before going out to wider consultation
    - Sub committees of the Governing Body for their awareness / for advice

Appendix 6 – Equality Impact Assessment Form

To be completed if a policy / procedural document has been assessed by an Equality & Diversity Lead as having a medium or high impact on people with characteristics protected by the Equality Act.

Equality analysis

Title of policy, project or proposal:

Name of lead manager:
Directorate:

Q1 What are the intended outcomes of this policy, project or proposal?
Q2 Who will be affected by this policy, project or proposal? *Identify whether patients, carers, communities, CCG employees, and/ or NHS staff are affected.*

Evidence
Q3 What evidence have you considered? *Consider, for example, national drivers, local drivers, Public Health data, ONS data, and any pilots undertaken nationally or locally.*
Age *Consider and detail (including the source of any evidence) across age ranges on old and younger people.*
Disability (physical and mental) *Consider and detail (including the source of any evidence) the impact on people with different kinds of disability (this might include attitudinal, physical and social barriers). Certain medical conditions are automatically classed as being a disability – for example, cancer, HIV infection, multiple sclerosis.*
Dementia *Given the CCGs commitment to commissioning "Dementia Friendly" services, consider and detail any impact on people with dementia.*
Gender reassignment (including transgender) *Consider and detail (including the source of any evidence) on transgender people. Issues to consider may include same sex/mixed sex accommodation, ensuring privacy of personal information, attitude of staff and other patients.*

Marriage and civil partnership *Note: This protected characteristic is only relevant to the need to eliminate discrimination within employment. Where relevant, consider and detail (including the source of any evidence) on working arrangements, part-time working, infant caring responsibilities.*

Pregnancy and maternity *Consider how the policy project or proposal impacts on staff and detailed (including the source of any evidence) impact on Health and Safety at work and working arrangements such as part-time working, infant caring responsibilities. As well as service provision, where applicable, for service users consider facilities, such as child and parent parking, baby changing, breast feeding.*

Race *Consider and detail (including the source of any evidence) the impact on groups of people defined by their colour, nationality (including citizenship), ethnic or national origins. This will include Roma gypsies, travellers, people from Eastern Europe, Nepalese and other South East Asian communities. It will also include language and different cultural practices and individual experience of health systems in other countries.*

Religion or belief *Consider and detail (including the source of any evidence) on people with different religions, beliefs or no belief. May be particularly relevant when service involves intimate physical examination, belief prohibited medical procedures, dietary requirements and fasting, and practices around birth and death.*

Sex (gender) *Consider and detail (including the source of any evidence) the impact on men and women (potential to link to carers below). This may include different patterns of disease for each gender, different access rates.*

Sexual orientation *Consider and detail (including the source of any evidence) the impact on heterosexual people as well as lesbian, gay and bisexual people.*

Carers *Consider and detail (including the source of any evidence) impact on people with caring responsibilities. This must include people who care for disabled relatives or friends (as specified in law to avoid discrimination by association) but should also consider patient/guardian(s) of children under the age of 18 years. Carers are more likely to have health problems related to stress and muscular-skeletal issues. They may have to work part-time, have shift-patterns, or face barriers to accessing services.*

Serving Armed Forces personnel, their families and veterans
The needs of these groups should be considered specifically. The CCG has a responsibility to commission all secondary and community services required by Armed Forces' families where registered with NHS GP Practices, and services for veterans and reservists when not mobilised (this includes bespoke services for veterans, such as mental health services).

Meeting psychological needs
The CCG is working to improve how services meet the psychological needs of patients. This recognises that an individual's experience of disease or illness, and/or their experience of treatment and time spent in care settings can cause stress and anxiety. This in turn, can impact on treatment and outcomes.
Do you have evidence of additional or unmet psychological need? Identify how the project, policy or decision could better meet the psychological needs of patients and carers. This might include staff training in Mental Health First Aid, signposting patients to sources of mental wellbeing support, provision of peer support or psychological therapy.

Other identified groups *Consider and detail and include the source of any evidence on different socio-economic groups, area inequality, income, resident status (migrants) and other groups experiencing disadvantage and barriers to access. This may therefore relate to: Poverty, living in rural areas, resident status (migrants and asylum seekers).*

Involvement and consultation
For each engagement activity, briefly outline who was involved, how and when they were engaged, and the key outputs.

Q4 How have you involved stakeholders with an interest in protected characteristics in gathering evidence or testing the evidence available?

Q5 How have you involved stakeholders in testing the policy or programme proposals?

Q6 For each involvement activity, please state who was involved, how and when they were engaged, and the key outputs:

Equality statement

Considering the evidence and engagement activity you listed above, please summarise the findings of the impact of your policy, project or proposal. Consider whether the evidence shows potential for differential impact, if so state whether adverse or positive and for which groups.

Positive impacts

Where there is evidence, provide a summary of the positive impact the policy, project or proposal will have for each protected characteristic, and any other relevant group or policy consideration. This should include outlining how equal opportunities will be advanced and good relations fostered between different groups.

Negative impacts

Where there is evidence, provide a summary of the negative impact the policy, project or proposal will have for each protected characteristic, and any other relevant group or policy consideration. This should include outlining how equal opportunities will be advanced and good relations fostered between different groups.

Health inequalities

Please outline any health inequalities highlighted by the evidence (for example, differential access to services or worse health outcomes for particular groups or localities).

Action planning for improvement, and to address health equalities and discrimination

Please give an outline of the key actions based on any gaps, challenges and opportunities you have identified. Include here any general action to address specific equality issues and data gaps that need to be addressed through consultation or further research.

Action	Person responsible	By date	Progress/ review (Add new actions if required)

For your records	
Role of person who carried out this assessment:	
Date assessment completed:	
Date to review actions:	
Role of responsible executive lead:	
Date assessment was approved:	

Appendix 7 – Equality Impact Assessment Form (HR Policies)

NHS
Hampshire, Southampton and Isle of Wight
Clinical Commissioning Group

Equality Impact Assessment of workforce policies

This Equality Impact Assessment (EIA) template should be used when developing new workforce policies and reviewing existing policies. The EIA provides evidence to demonstrate due regard to the need to **eliminate unlawful discrimination**, **advance equality of opportunity** and **foster good relations** with respect to the characteristics protected by the Equality Act 2010.

Policy being considered	
Please state whether new policy or policy review	
What are the intended aims/ outcomes of this policy?	
Which staff will be affected by this policy?	
How have you involved staff from protected characteristic groups and/or other stakeholders when developing or reviewing this policy?	
What relevant evidence about workforce trends or known inequity have you considered?	
What are the performance indicators or measures you are going to use to monitor implementation of this policy?	

Protected characteristic	Positive impact	Negative impact	Action to address negative impacts
Age			
Disability			
Gender reassignment			
Marriage and civil partnership			
Pregnancy and maternity			
Race			

Protected characteristic	Positive impact	Negative impact	Action to address negative impacts
Religion or belief			
Sex/ gender			29
Sexual orientation			
Other considerations			
Staff with caring responsibilities			
Staff from Armed Forces families, reservists and veterans			
Socio-economic factors			

Date assessment completed:	
Date to review actions:	
Name(s) of staff who completed the EIA:	
Name of responsible Director:	
Date assessment was approved:	