

Master ID

Version

Document Name

Type

Date adopted

Review Date

Responsibility for Review

Equality Impact Assessment Performed

Approved by

Policy for the Development and Management of Policies, Guidelines, Primary Care Referral Proformas and Procedural Documents

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1. Introduction

This policy applies to all Primary Care Trust (PCT) staff. Non PCT staff or organisations (e.g. the Oxford Radcliffe Hospitals (ORH) Trust) must comply with this policy if primary care guidelines and proformas are to be published on the PCT Intranet, or communicated or promoted under the auspices of the PCT.

This document details the PCT-wide processes and responsibilities for approving, publishing and disseminating policies, guidelines and primary care referral proformas and procedural documents.

The PCT considers it vital to follow this policy in order to help ensure that clinically effective and evidence-based guidance is available, and to reduce the risks associated with poorly developed and reviewed policies.

It is essential that all proformas and guidelines are effectively evaluated and their impact adequately considered. Additionally the process will ensure that all Primary Care guidelines and proformas are aligned with the PCT's commissioning policies, national guidance, and have been assessed by the PCT's clinical leads as appropriate and relevant.

This policy will apply to all PCT staff who develop and revise policies, guidelines and procedures, or referral guidelines and proformas for clinical use in primary care.

Non-PCT staff or organisations (eg the ORH) must comply with this policy if the guidelines/proformas are to be published on the PCT's clinical web pages, communicated or promoted under the auspices of the PCT. No referral guidelines or proformas provided by any other organisation (Community Health Oxfordshire (CHO), ORH etc) will be published by the PCT if it has not been through the PCT ratification process, even if these have been approved by the organisation's board or approval body/bodies.

2. Definitions

Strategy

- An approved plan or method outlining the direction and scope of an aspect of the organisation over a defined term created for the purpose of achieving a goal.

Policy

- A way of acting suggested by a major body; meant to be followed in its entirety. The policy has a significant effect on how the legal standard of care is defined.

Protocol

- Often used interchangeably with the term policy but very slightly lower than policy on the scale of importance.
- Protocols define acceptable practice and incorporate safeguards.
- It is easier to prove that a health professional has been negligent if a protocol has not been followed.

Guideline

- This is a recommendation, evidence based or current practice that has been shown to work well.
- A guideline is more flexible than a protocol as it allows for a degree of professional judgment.

Proforma

- A template or defined form containing a minimum data set which needs to be completed to ensure a high standard of communication between primary and secondary care, and for ease of clinical or other processing. In most cases clinical letters containing the same information specified in the proforma will also be accepted in lieu of the proforma.

3. Accountability and Responsibility

PCT Board

The Board has ultimate accountability for documents approved for use by the PCT staff but may delegate authority to board sub-groups as seen to be appropriate. This delegated authority will be recorded in the appropriate group's/committee's Terms of Reference, which will be agreed by the board.

Enhanced Clinical Executive

The Enhanced Clinical Executive has accountability for ensuring that any referral guidelines and proformas are approved for use within primary care. The Enhanced Clinical Executive may delegate authority to sub-groups as seen to be appropriate for the approval of such referral guidelines and proformas.

Medicines Management Team

The Medicines Management team is responsible for ensuring that any primary care referral guidelines and proformas take account of national and PCT prescribing policies.

Public Health Team

The Public Health team is responsible for ensuring that any draft primary care clinical referral guidelines and proformas which are sent to them for review are aligned with the recommendations in National Institute of Clinical Excellence (NICE) Technology Appraisal Guidance (TAG) and 'Lavender statements' (Oxfordshire PCT's local commissioning policies), and that NICE Interventional Procedure Guidance and Clinical Guidelines are taken into account.

Commissioners/ PCT Staff

All commissioners are responsible for ensuring that referral guidelines and proformas comply with the process and requirements contained in this policy.

CHO Board

This group has delegated authority to approve all policies, guidelines and procedural documents for Community Health Oxfordshire apart from Human Resources and Health and Safety documents.

Community Health Oxfordshire (CHO) Clinical Quality and Governance Group

The CHO Clinical Quality and Governance group has overall responsibility for monitoring all clinical policies, guidelines and procedural documents and for producing updates for approval at the CHO Board.

CHO Policies Group

The CHO Policies Group will approve some policies on behalf of CHO Clinical Quality and Governance Group. It will monitor and improve the development processes of all clinical policies, procedures and guidelines as well as the quality and usability of policies, and will ensure the development and ratification of all policies required by National Quality standards. The group will also review quarterly reports on overdue policies and policies that are soon due for review. The group will monitor audits of the policies section on the intranet in terms of duplication and whether policies are within date.

Health and Safety Committee

The PCT Health and Safety Committee has responsibility for monitoring all Health and Safety and Occupational Health policies, guidelines and procedural documents and for producing updates for approval at the Executive Board.

Executive Board

This group has delegated authority to approve all Non-clinical policies, guidelines and procedural documents for the PCT including those concerning Human Resources and Health and Safety.

Directors, Heads of Service and Service Operational Leads

Directors and senior managers are responsible for:

- ▶ Monitoring use of policy, guidelines and procedures within their teams.
- ▶ Identifying where reviews and updates are required ahead of planned review dates (for those documents where they are the named post-holder responsible for review).
- ▶ Instigating the review and update for any documents, where they are the named post-holder responsible for review, within the target timescale.
- ▶ Ensuring that this policy is followed for reviews.
- ▶ Ensuring that, when any new documents relevant to their service area are identified as being required, that these are produced in accordance with this policy.

Quality and Clinical Standards Team

The Quality and Clinical Standards Team is responsible for the following in relation to non-clinical policies and primary care referral guidelines:

- ▶ Ensuring that all documents submitted for publication comply with this policy

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- ▶ Ensuring that the Commissioners' policy, guidelines and procedural document database is kept up to date.
- ▶ Ensuring version control is applied to all approved documents.
- ▶ Ensuring that the PCT intranet website section on these documents is current.
- ▶ Uploading Policies, Guidelines and Primary Care Referral guidelines to the appropriate pages of the intranet.
- ▶ Ensuring documents, Equality Impact Assessments (EIAs) and front sheets are stored securely and appropriately and are archived once they are out of date.
- ▶ Producing regular reports to ensure that policies are being reviewed in a timely fashion and are being put through the correct approval process.
- ▶ Storing and monitoring amendment sheets.

CHO Clinical Quality & Governance (CHO CQG) Team

The CHO Clinical Quality & Governance team is responsible for the following in relation to clinical policies:

- ▶ Ensuring that the CHO policy, guidelines and procedural document database is kept up to date.
- ▶ Ensuring version control is applied to all approved documents.
- ▶ Ensuring that the CHO website section on these documents is current.
- ▶ Ensuring documents, EIA assessments and front sheets are stored securely and appropriately and are archived once they are out of date.
- ▶ Producing regular reports to ensure that CHO policies are being reviewed in a timely fashion and are being put through the correct approval process.
- ▶ Storing and monitoring amendment sheets.

Communications Web Team

- ▶ Will not upload any policy, procedural document or primary care referral guideline which has been submitted by anyone other than the policies administration team.
- ▶ Will not upload any referral proforma which has not been submitted by the PCT proforma admin lead.
- ▶ Work with the named PCT lead/owner for the referral guideline/proforma to ensure that primary care clinicians and practitioners are aware of new/revised information.

All Staff

All staff are responsible for following this policy and for ensuring that any policies, guidelines and procedural documents that they are involved in writing are produced and approved according to this policy.

4. Style and Format of Policies, Guidelines and Procedural Documents

All policies, guidelines and procedural documents should be written in a style which is concise and clear using unambiguous terms and language. Template policies (clinical and non-clinical), containing guidance about completion, have been

devised to assist policy authors and are available from the Oxfordshire PCT Intranet policies page.

Abbreviations should be used sparingly and only if an explanation of the abbreviation is given at its first use in the document, for instance “Primary Care Trust (PCT)”.

Style

All CHO and PCT policies (excluding primary care referral guidelines and proformas, which have their own recommended styles as outlined in Appendix J) must have the following:

- ▶ Arial font
- ▶ Organisation logo at the top right of the first page.
- ▶ Footer (line 1) “Printed versions of this document may be out of date”.
- ▶ “Draft” must be removed once the policy has been approved.
- ▶ Bottom left footer (line 2) should be the filename (under autotext in the headers and footers toolbar).
- ▶ Bottom right footer (line 2) should be “Page # of #”.
- ▶ Table of Contents numbers and pages should match actual sections.

	Font properties		Case	Other
Document title	Bold	Size 18	Title	In a box
Contents list	Bold	Size 12	Title	
Main section titles	Bold	Size 14	Title	Paragraph Formatting: Keep with next
Sub section titles	Bold	Size 12	Title	Paragraph Formatting: Keep with next
Section contents		Size 12	Sentence	Paragraph Formatting: Keep with next
Footer	Bold and italic	Size 10	Sentence	

	Paragraph properties
Alignment	Justified
Spacing	Single

Standard headings

In addition to the main body of the document, all documents must have the following sections:

- Contents
- Introduction and Purpose
- Definitions
- Accountability and Responsibility
- Process for monitoring compliance with and effectiveness of the policy/guidelines/procedure
- Process for review of the document
- References and Associated Documents

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Appendix A provides a checklist for review.

For Referral Guidelines and Proformas please see the process outlined in appendices G-J

5. Meeting National Criteria

Authors must ensure that the document satisfies legislative requirements and the relevant criteria from the National Health Service Litigation Authority (NHSLA) standards and the Care Quality Commission (CQC) Assessments of Quality. These standards are available from the Quality and Clinical Standards Team, the CHO Clinical Quality & Governance Team or the relevant websites.

6. Equality Impact Assessment

All public bodies have a statutory duty under the Race Relation (Amendment) Act 2000 to “set out arrangements to assess and consult on how their policies and functions impact on race equality”, in effect to undertake Equality Impact Assessments on all policies/guidelines and practices. In addition the Disability and Discrimination Act 2005 demands a similar process of Equality Impact Assessment in relation to disability. Oxfordshire PCT has extended its legal duty to undertake generic Equality Impact Assessments, taking account of other equality dimensions outlined in anti-discrimination legislation covering gender, age, religion and sexual orientation.

An EIA must be completed on all policies, guidelines and procedural documents, whether new or updated, using the checklist provided in Appendix B of this document.

7. Consultation, Approval and Ratification Process

Consultation Process

All documents should have consultation as required. As a minimum:

Type of Document	Consultation
Clinical	Representative(s) of clinical staff who will use document, patients/carers (e.g. Patient and Public Involvement Forum or others as applicable), stakeholders from other organisations if applicable.
Health and Safety	Health and Safety Committee
Human Resources	Staff side consultation via Staff Partnership Forum
General non-clinical	Stakeholders as applicable to subject of document
Occupational Health	Health and Safety Committee

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Further information on consultation for new referral guidelines and proformas is given in Appendices G and H.

Approval Process

The approval process for all policies, guidelines and procedural documents is given in the flow charts in **Appendix C**. The approval processes for Primary Care guidelines and proformas are given in Appendices G-J.

For support in ensuring your policy is up to date with the latest evidence, please contact the Primary Care Library Services in Oxfordshire through enquiries@hcl.ox.ac.uk or call on 01865 1221936 where a team is available to help with your search.

8. Submitting a Policy for Publication

Submit Non-Clinical and Clinical Commissioning Policies and referral guidelines to policies@oxfordshirepct.nhs.uk, and CHO Clinical Policies to the CHO CQG Team along with

- Front sheet with which it was submitted for Group and/or Board Approval
- EIA checklist (Appendix B)
- Submission Document (Appendix D)

If any of these three extra documents are missing or incomplete then the policy will not be accepted for uploading onto the intranet.

QCS or CHO CQG Team as appropriate will then

- Check the document for glaring grammatical and format errors
- Enter the document details on the Policies Database
- Prepare a front sheet, using details from the Submission Document
- Upload the policy to the Intranet, and, where relevant, to the public website.
- Produce reports reminding those with responsibility for review of the document when it is due for review within 6, and then 3, months, and when it has become overdue.

A full description of this process can be found on the policies page of the PCT Intranet www.oxfordshirepct.nhs.uk.

9. Review and Revision Arrangements Including Version Control

All policies, guidelines and procedural documents must include a review date. The standard review time will be no longer than three years.

All documents will be recorded on the CHO or Commissioning Policies database as appropriate, including:

- ▶ version number
- ▶ author
- ▶ review date
- ▶ all bodies which have approved the document
- ▶ post holder responsible for review
- ▶ EIA assessment
- ▶ Front sheet for main approving body

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Changes to a Policy

If a minor change to a policy is made, i.e. one that does not affect working practice, or simply reflects existing practice, then this will be referenced on an amendment sheet with the page and line numbers listed. Approval by committee is not required for this level of change, and the version number will change to the next point (.) number, e.g. from Version 2 to version 2.1. However approval of the alteration, by a manager at Head level or above, must be recorded on the amendment sheet. An example of an amendment sheet can be found in Appendix E.

A major change, which affects working practice or reflects a change of practice, requires approval by the relevant body and the new document will have a different version number (e.g. Version 2.3 will become Version 3.0)

10. Dissemination and Implementation

Approved policies, guidelines and procedural documents will be posted on the PCT internet site and the PCT intranet site. For PCT Wide policies this is the responsibility of the Quality and Clinical Standards Team. For CHO policies this will be the responsibility of the CHO Clinical Quality & Governance Team. Each document will be preceded by a front sheet, reflecting the information recorded on the database (listed in section 8), and also, where relevant, by an Amendment Sheet, on which minor amendments will be recorded (see section 9).

Notification of the approval of new and updated clinical, HR, Health and Safety and Occupational Health documents will be published in *Healthwise* and sent to service leads, which are responsible for passing this information on to their teams as required.

Document authors are responsible for ensuring that any resource implications for implementation are identified agreed/resolved prior to the document being submitted for approval.

For non-clinical documents the authors will be responsible for the dissemination of the documents to relevant personnel.

11. Archiving Arrangements

PCT-wide archived documents will be stored electronically by the Quality and Clinical Standards Team on the PCT network which is backed up daily.

CHO Archived documents will be stored electronically by the CHO Clinical Quality & Governance Team on the PCT network which is backed up daily.

Information on PCT-wide archived documents can be obtained from the Quality and Clinical Standards Team.

Information on CHO archived documents can be obtained from the CHO Clinical Quality and Governance Team.

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12. Monitoring

These processes will be monitored as follows:

A yearly review of the processes used to approve documents during that time period will be conducted, looking at:

- Consultation process
- Equality assessment
- Process used for approval
- Dissemination process
- Section contents of documents (i.e. all mandatory sections included)
- Storage and archive process, including version control.

This will be the responsibility of the Quality and Clinical Standards Team and will be reported via the Commissioning Quality Sub-Committee.

The database, maintained by the Quality and Clinical Standards Team, effectively monitors the duties of the responsibility, by recording authoring, approval and review responsibilities and completion.

The database, maintained by the CHO Clinical Quality and Standards Team, effectively monitors the duties of the responsibility, by recording authoring, approval and review responsibilities and completion.

Monitoring of the review of policies will be undertaken using the following quarterly process:

Report 1: Policies Overdue for Review.

To be sent to Head of Quality Systems, Quality and Clinical Standards, post holders responsible for review and their service leads.

Report 2: Policies Due for Review within 3 Months:

To be sent to post holders responsible for review and their service leads.

Report 3: Policies Due for Review within 6 Months:

To be sent to post holders responsible for review.

For non-clinical policies these reports will be produced by the Quality and Clinical Standards team. For clinical policies these reports will be produced by the CHO CQG Team.

13. Review

This document will be reviewed every three years or where necessary for example, following in response to exceptional circumstances, organisational change or relevant changes in legislation or guidance.

For Clinical Policies this review will be undertaken by the CHO CQG Team and for Non-Clinical Policies it will be undertaken by the QCS Team. A member of the Enhanced Clinical Executive will review primary care referral guidelines; for more information contact the Business Manager, Executive Office.

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14. References and Associated Document

All references must be cited in full, showing name of publication/regulations and date.

References for this document, and documents which are to be read in conjunction with this policy are as follows:

- ▶ NHSLA Risk Management Standards for Acute Trusts Primary Care Trusts and Independent Sector Providers of NHS Care, 2009/10
- ▶ Health and Social Care Act 2008 (Regulated Activities) Regulations 2009
- ▶ Care Quality Commission (Registration) Regulations 2009.
- ▶ In respect of section 6 and Appendix B -
 - Health and Social Care Act 2001
 - The Race Relations Act 1976 (as amended by the Race Relations (Amendment) Act 2000)
 - The Disability Discrimination Act 1995 amended 2005
 - The Gender Recognition Act 2004
 - The Civil Partnership Act 2004
 - Employment Equality (Religion or Belief) Regulations 2003
 - Employment Equality (Sexual Orientation) Regulations 2003
 - Sex Discrimination (Gender Reassignment) Regulations 1999
 - The Human Rights Act 1998
 - The Sex Discrimination Act (as amended) 1975
 - The Equal Pay Act (as amended) 1970
 - Promoting Equality and Human Rights in the NHS - A Guide for Non-Executive Directors of NHS
 - Boards (2005) Department of Health

Harvard style bibliographies and references

When providing a bibliography of documents referenced in the text, Harvard referencing is recommended. The format for this can be found in Appendix F:

Appendix A: Checklist for the Review of a Policy, Guideline or Procedural Document

Please note for referral guidelines or proformas the Checklist in Appendix I should be used instead

	Title of document being reviewed:	Yes/No/ Unsure	Comments
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		
	Is the method described in brief?		
	Are people involved in the development identified?		
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?		
	Is there evidence of consultation with stakeholders and users?		
	Does it comply with relevant NHSLA standards and Care Quality Commission Standards for Better Health?		
	Has an Equality Impact Assessment been carried out?		
4.	Content		
	Is the objective of the document clear?		
	Is the target population clear and unambiguous?		
	Are the intended outcomes described?		
	Are the statements clear and unambiguous?		
5.	Evidence Base		
	Is the type of evidence to support the document identified explicitly?		
	Are key references cited?		
	Are the references cited in full?		
	Are supporting documents referenced?		
6.	Approval		
	Does the document identify which committee/group will approve it?		
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?		
7.	Process to Monitor Compliance and Effectiveness		
	Are there measurable standards or Key Performance Indicators to support the monitoring of compliance with and effectiveness of the document?		
	Is there a plan to review or audit compliance with the document?		
8.	Review Date		
	Is the review date identified?		
	Is the frequency of review identified? If so is it acceptable?		
	Is it clear who will be responsible for coordinating the review of the document?		

Appendix B: Equality Impact Assessment

Equality Impact Assessment (EIA) Tool

The purpose of an equality impact assessment is to understand the impact of a new policy proposal or service on different people and diverse groups within our service population.

Key questions to consider when reviewing or developing policies, proposal and services:

- Are we acting fairly?
- Are we reaching all the communities we serve or employ, and are we meeting their needs?
- Are we applying the same professional standards in every situation?

An impact assessment is made up of two stages:

Stage 1: Standard screening

A standard screening assessment should produce estimates or signs of possible adverse or unequal impact. It will be based on information you already have.




(See green boxes overleaf)

Stage 2: Detailed screening

If the standard screening assessment points to real concerns about adverse impact, a more detailed assessment will be required. This includes consultation process leading to a final recommendation. Arrangements for monitoring and evaluating the impact of the policy or service will be made as part of the detailed assessment.

(See blue boxes overleaf)

Key for overleaf:

-  Standard screening
-  Detailed screening
-  Things to consider when screening

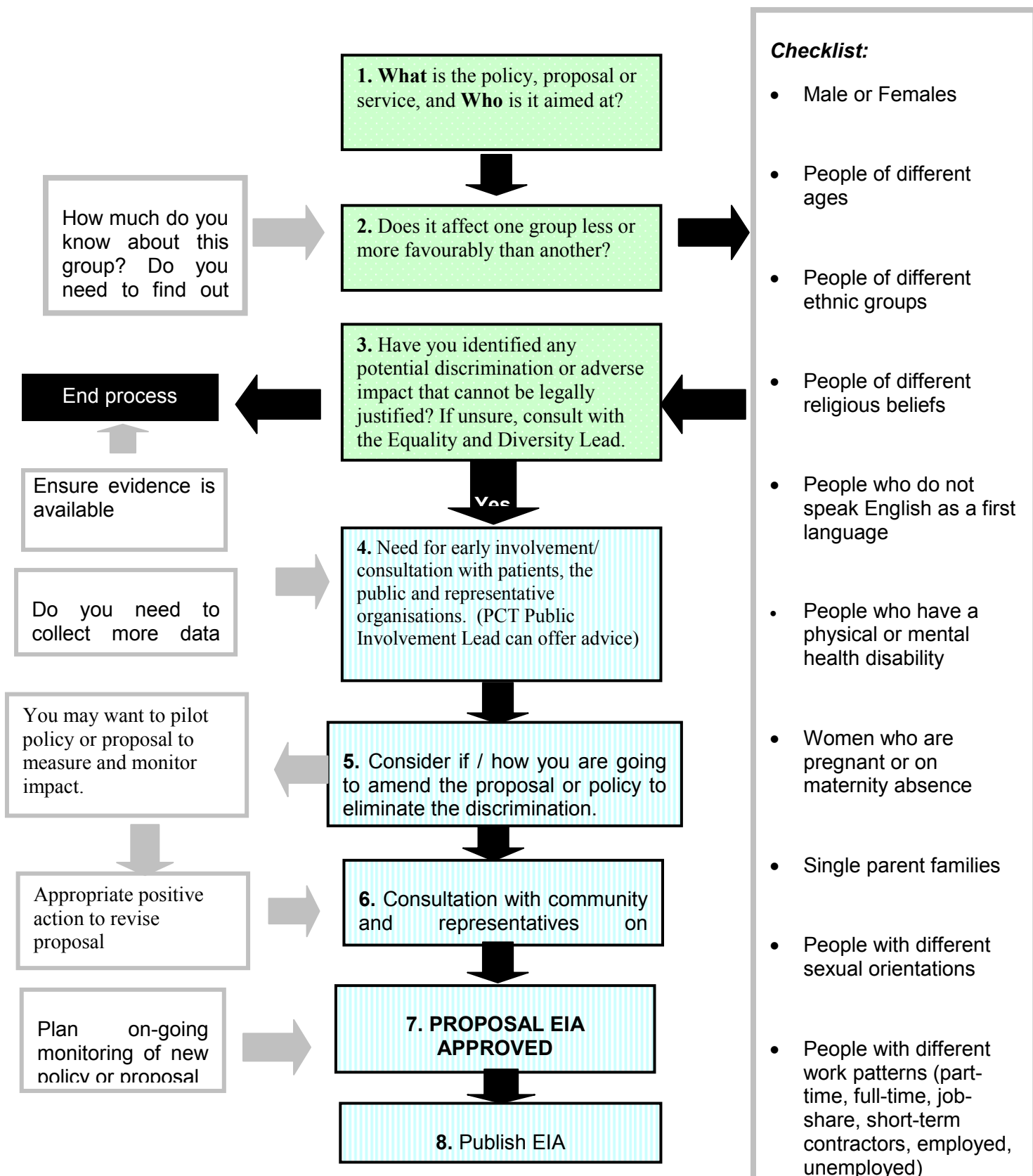
Discrimination:

Unfair treatment of a person or group on the basis of their....colour, race, culture, religion, disability, sexual orientation, age.....

Equality Impact Assessment (EIA) Tool

The PCT strives 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.

This tool is designed to help you to consider the needs and assess the adverse, positive or neutral impact of your policy, protocol, proposal or service on all groups within our local communities.



Equality Impact Assessment (EIA) - Evidence Form

The PCT strives 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. This form is designed to help you to consider the needs and assess the positive, adverse or neutral impact of your policy, protocol, proposal or service on all groups within our local communities, and to record the evidence that you have done so. Any proposal or policy submitted to the Board must have undergone EIA.

This form will be used as evidence of the assessment you have undertaken. It will need to be made available to the Board and PCT's Equality and Diversity Steering Group.

Policy/Proposal/Service Title _____

Name of EIA Lead _____

Others involved in assessment _____

Date EIA commenced _____

EIA Completed and Approved

Signature (Lead Director): _____

Name (print) _____

Job Title: _____

Date: _____

**ONCE COMPLETED, PLEASE SUBMIT TO EQUALITY AND DIVERSITY LEAD
FOR EVIDENCE AND PUBLICATION.**

STAGE 1: Standard Screening

EIA questions	EIA Narrative	Sources of Evidence
1. What is purpose and objectives of the policy, proposal or service?	<ul style="list-style-type: none"> Describe the aims and objectives of the policy, proposal or service. What are the intended outcomes? How does it fit into the PCT's strategic aims? Is it a new or redesigned policy or service? Are any other partners/stakeholders involved? 	
2. Who is the policy, proposal or service aimed at?	<ul style="list-style-type: none"> Who are the intended beneficiaries and why? 	
3. Does it affect one group less or more favourably than another (see groups below)?	<ul style="list-style-type: none"> Consider legal duty to eliminate discrimination, ensure equal opportunities and promotion good relations between different groups. Adverse impact: disadvantages one or some groups. Also may be differential between disadvantaged groups Positive impact: positive influence on group-proactively promotes equality. Neutral impact: similar impact on all groups. 	<ul style="list-style-type: none"> List and attach any initial data sources used to find out more about these groups: e.g. census data; Index of Multiple deprivation; QOF; secondary service data; local authority data; local health needs assessment; complaints; public consultations etc
Male or Females		
People of different ages		
People of different ethnic groups		

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EIA questions	EIA Narrative	Sources of Evidence
People of different religious beliefs		
People who do not speak English as a first language		
People who have a physical disability	<ul style="list-style-type: none"> • Disability: is a physical or mental impairment which has a substantial and long-term adverse effect on a person's ability to carry out normal day to day activities. • Focus on the 'social model' of disability, which recognises the negative impact on disabled people of a society designed for non-disabled people. 	
People who have a mental disability		
People with learning disabilities		
Women who are pregnant or on maternity absence		
Single parent families		

EIA questions	EIA Narrative	Sources of Evidence
People with different sexual orientations		
People with different work patterns (part-time, full-time, job-share, short-term contractors, employed, unemployed)		
People in deprived areas and people from different socio/economic groups		
Asylum seekers and refugees		
Prisoners and people confined to closed institutions, community offenders		
Carers		
Rural and/or isolated communities		

EIA questions	EIA Narrative	Sources of Evidence
<p>4. Have you identified any potential discrimination or adverse impact that cannot be legally justified?</p> <p>If unsure, consult with the PCT Equality and Diversity Lead.</p>	<ul style="list-style-type: none"> • Have you got evidence to support this assessment (statistics, previous consultations, Health needs assessments, surveys etc) • Is the evidence valid and how have you weighted it? 	<ul style="list-style-type: none"> • List and attach any extra evidence

STAGE 2: Detailed Screening (PCT's Equality and Diversity Lead to advise)

EIA questions	EIA Narrative	Sources of Evidence
<p>1. Need for early involvement/consultation with patients, the public and representative organisations. (named PPI Lead can offer advice)</p>	<ul style="list-style-type: none"> • Explain appropriateness of consultation method/s? • Is there any public concern that the policy, service or proposal is discriminatory? 	<ul style="list-style-type: none"> • Record and attach written evidence of consultation process and findings.
<p>2. Consider how you are going to amend the proposal or policy to eliminate the discrimination.</p>	<ul style="list-style-type: none"> • Who should be involved in decision making? • How have you weighted all the evidence? • Explain reasons for decision? 	
<p>3. Consultation with community and representatives on amended proposal.</p>		
<p>4. What processes are in place for on-going monitoring of policy or proposal implementation?</p>	<ul style="list-style-type: none"> • What monitoring criteria? • Who will be responsible for monitoring? • How often are you going to monitor? • When will you review? 	

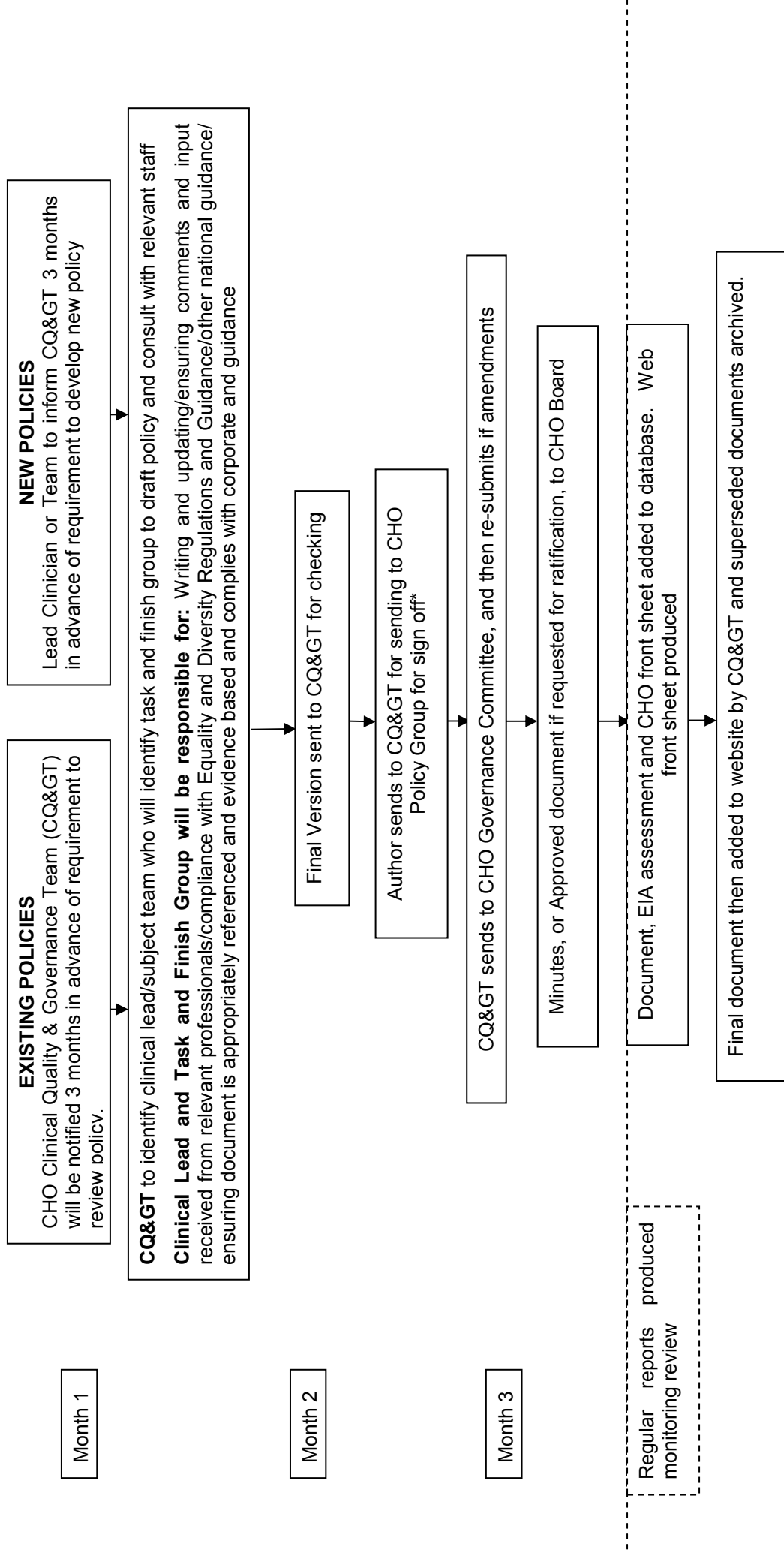
EIA Action Plan Follow-up

(For EIA of existing services, policies or projects)

EIA Recommendations	Key actions required	Officer Responsible	Progress Made

Appendix C: Review and Ratification Process

POLICIES, GUIDELINES AND PROTOCOLS Clinical Documents Approval Procedure



POLICIES, GUIDELINES AND PROTOCOLS
Non-Clinical Approval Procedure

Policy Approval – Non-Clinical

- ▶ Human Resources policies will go directly to Executive Board (after development in consultation with the Staff Partnership Forum)
- ▶ Health & Safety and Occupational Health Policies will go through the Health and Safety Committee and then to Executive Board
- ▶ Other non-clinical policies will go directly to Executive Board

Month 1

EXISTING POLICIES
QCS will inform the relevant policy manager at least 3 months in advance of requirement to review policy.

NEW POLICIES
Policy lead to inform Policy manager 3 months in advance of requirement to develop new policy

Month 2

Policy manager to identify lead/subject team who will identify task and finish group to draft policy and consult with relevant staff
Subject Lead and Task and Finish Group will be responsible for: Writing and updating/ensuring comments and input received from relevant professionals/compliance with Equality and Diversity Regulations and Guidance/other national guidance/ensuring document is appropriately referenced and evidence based and complies with corporate and national guidance.

Final Version sent to Policy manager for checking

Policy manager sends to Board for approval, and then re-submits if amendments required

Month 3

Document and EIA assessment sent to QCS to be stored and data from the submission form added to database. Web front sheet produced

Regular reports produced
monitoring review

Final document added to PCT Intranet by QCS Team and superseded documents archived.
Final document added to PCT website by the Web Development Team



Appendix D: Document Submission Form (complete online from Intranet Policies Page)

Document Submission Form

Submitter's Name

Email contact for policy

Submission Type

Document Type

Number (if known)

Formal Document Title

Location of Document
(Primary care only)

Type:

Author(s)

Responsibility for Review (job title)

Review Date:

Approved Date:

Committee Name

EIA Attached

Notes/Further info

Distribution to:

Appendix E: Amendment Sheet

Policies, Guidelines, Protocols and Procedures

Example of Amendment Sheet

Date:	
Author of Amendment:	
Approver (Head or above)	
Page Number:	
Line Number:	
Details of change:	
Inserted:	
Deleted:	

Date:	
Author of Amendment:	
Approver (Head or above)	
Page Number:	
Line Number:	
Details of change:	
Inserted:	
Deleted:	

Appendix F: Harvard Referencing

Book Family name, first initial(s). (year) *Title*. City of publication: Publisher. Page number of your quotation

Standard Author of standard. (year). Standard Number : Year. *Title of standard*. Place of publication : Name of publisher

Chapter in an edited book

Family name, first initial(s). (year) Chapter title. *In:* Initial(s) Family name of editor(s), (eds). *Title of book*. City of publication: Publisher. Page number of your quotation

Website with no author

Title of website (year as appearing on site) [Online]. [Date accessed]. Available from World Wide Web : <url of site>

Website with author

Family name, first initial(s) (year) *Title* [Online]. [Date accessed]. Available from World Wide Web : <url of site>

Thesis Family name, first initial(s). (year) *Title*. Type of qualification, academic institution

Illustration Originator, (year) *Title*. Material type, location

Online image Author (Year) *Title of image* [Online image]. [Date accessed]. Available from World Wide Web: <url of site>

Conference paper

Family name, first initial(s). (year) Title of paper. *In:* Editor(s) of conference proceedings if known. *Title of conference*, date of conference, location of conference. Place of publication: publisher. Page number(s)

Electronic journal article

Family name, first initial(s). (year) Title of article. *Journal title*. [Online]. **Volume** (issue number) [Date accessed], page number of your quotation. Available from World Wide Web: <url of site>

Journal article Family name, first initial(s). (Year) Title of article. *Journal title*. **Volume** (issue number), page number of your quotation

CD-ROM *Title* (year). [CD-ROM]. City of publication: Publisher

Appendix G: Description of the Development and Ratification Process for Primary Care Referral Guidelines

- 1 All new Primary Care referral guidelines (proposed or already developed) or those being revised must have a named PCT lead or owner
- 2 The PCT lead or named owner must ensure that the guidelines are drafted in a suitable PCT format
 - 2.1 A referral guidelines template has been provided and can be adapted to suit specific circumstances
 - 2.2 Referral guidelines should usually be made available in both Word 2003 (.doc) and PDF formats (note this is different for proformas – see section A2.4).
- 3 Once the referral guideline has been prepared the following review process must be followed as applicable:
 - 3.1 Check any prescribing protocols with the Medicines Management team
 - 3.2 Check with the Public Health team that that guidelines align with NICE guidance and PCT Lavender Statements or local commissioning priorities
 - 3.3 Ensure that any deviations from NICE guidelines are appropriately recorded at the NICE Implementation Group (this group reports to the Commissioning Quality sub-committee and thence to the Board)
 - 3.4 If referral guidelines are related to a cancer pathway then they should be validated by the PCT Cancer Lead. This may require further validation from Thames Valley Cancer Network (TVCN)
 - 3.5 Validate the referral guidelines with any Oxfordshire GPs named as lead for the speciality
 - 3.6 Elicit input from LMC (and any other relevant local reference bodies)
 - 3.7 All referral guidelines must have the approval of the Clinical Body or identified sub-group and must be accompanied with adequate information to enable the Enhanced Clinical Executive to make a decision, such as:
 - 3.7.1 Rationale and justification for the referral guideline
 - 3.7.2 Evidence that an appropriate ratification process has been followed and any necessary checks made
 - 3.7.3 Confirmation that an Equality Impact Assessment (EIA) has been undertaken where relevant
 - 3.8 Following these checks the referral guideline should be submitted, along with the Checklist (Appendix I), for ratification at the next available Enhanced Clinical Executive. Once agreed by the Enhanced Clinical Executive the guideline should be submitted as described in section 8.

NB:

- Previously published referral guidelines that have been updated may only need to go through the above steps if there has been a substantial change. Where minor changes have been made, referral guidelines will need to be presented to the Enhanced Clinical Executive

or appropriate clinical/sub committee for noting rather than approval. In these cases please follow the process outlined in Section 11 of this document.

- In some instances, referral guidelines may be accompanied by supporting proformas – in such circumstances both documents will be approved/ratified together but each will be sent to the appropriate publishing team.

Appendix H: Description of the Development and Ratification Process for Referral Proformas.

- 3.9 All new proformas or those being updated must have a named PCT owner/lead
- 3.10 The PCT lead or named owner must ensure that the proforma is drafted in the approved PCT format, including alignment with local clinical systems in use (EMIS LV, EMIS PCS, InPractice Vision and iSoft). The process for doing this is given in Appendix J.
- 3.11 Proformas must be checked against PCT prescribing protocols, NICE guidance and PCT Lavender Statements or local commissioning priorities with the appropriate teams, as described in 3 above.
- 3.12 If proformas are related to a cancer pathway or 2 week urgent referral pathways then these must be validated with relevant PCT leads
- 3.13 Proformas must be checked by at least one GP, get input from the LMC and be approved by the Enhanced Clinical Executive or appropriate clinical committee/subcommittee, for adoption by primary care clinicians. Appropriate information must be provided to the Enhanced Clinical Executive or named sub-group to enable them to make a decision
- 3.14 Once finalised, the PCT proforma admin lead will arrange for the proformas to be made available on the intranet. It is up to the PCT lead / named owner to raise awareness of the new proforma directly with primary care as appropriate.

NB : Please note that proformas being revised or updated only need to go through the above steps if they have been substantially changed; for minor changes they should be presented to the Enhanced Clinical Executive for noting.

Appendix I: Checklist for Updated or New Primary Care Referral Guidelines or Proformas

This checklist should accompany all requests for the approval of guidelines or proformas

Please insert a cross (X) where relevant

Approval History

Rationale/Justification for the guideline or proforma	<i>What is the reason/purpose for this guideline or proforma</i>			
Name of lead at PCT	<i>Include details even if PCT lead is promoting it on behalf of another organisation</i>			
Prescribing review	Completed (date)		Not applicable	
NICE Review	Completed (date)		Not applicable	
Lavender statement/priority review	Completed (date)		Not applicable	
Cancer/2 week review	Completed (date)		Not applicable	
LMC input	Completed (date)		Not applicable	
Primary Care impact assessed	Completed (date)		Not applicable	
Equality Impact Assessment	Completed (date)		Not applicable	
Other checks	<ul style="list-style-type: none"> ▪ <i>Describe any other checks that have been undertaken that may not be listed above</i> 			
Additional information	<ul style="list-style-type: none"> ▪ <i>List any other approval related information here (such as names of individuals approving the guidelines, or any other body such as Urgent Care Taskforce etc, which has approved)</i> ▪ <i>List any other supporting information here if required</i> 			

Notes:

1. If the referral guideline is accompanied by a proforma then this checklist only needs to be completed once. Both the referral guideline and proforma must meet the requirements set out in this policy
2. Not all checks will be required for all referral guidelines and proformas

Appendix J: Process for generating Referral Proformas in Standard Formats, and Proforma Specification

Background and Introduction

An agreement has been made with GPs in Oxfordshire and the support of LMC that new blank clinical proformas must be made available in formats ready to be integrated into clinical systems. The information below explains the new proposed process for developing proformas and generating versions for the different GP clinical systems. This guidance should be followed for all new proformas.

This process will be undertaken by Stephanie Wood the Informatics, Planning & Programmes Project Support Officer.

Proposed Process

- All new proposed proformas are to be sent to Stephanie Wood via a generic e-mail to, gpproformas@oxfordshirepct.nhs.uk to ensure the inbox is accessible and covered at all times.
- The drafted proforma will be sent to John Galuszka (or other designated clinician) for the initial clinical agreement.
- **Any clinically complex proformas must be agreed between the provider, PCT and LMC. e.g. Social Services.**
- The draft proforma will be checked against PCT guidance making any necessary amendments and checked with the sponsor.
- PCT in house conversions are made for EMIS-LV and INPS and sent for testing to the link GP.
- Basic blank proformas are created for EMIS-PCS and iSoft and sent for conversions and testing.
- Tested and converted proformas are sent back to the sponsor for confirmation.
- Final proforma sent to Policies@oxfordshirepct.nhs.uk with submission form (completed by template author)
- Completed proformas will be uploaded onto the intranet with the relevant naming convention/version control and arranged by clinical title e.g Cancer (Urological) 2 week urgent referral (excluding prostate cancer).
- 4 copies of the proforma will be uploaded, EMIS-LV, INPS, EMIS-PCS, iSoft and a blank doc.
- Communications will be sent out on a monthly basis advising practice managers of new uploaded available proformas.

Please note the PCT will be communicating to other organisations including the NOC and ORH confirming the new process for generating GP referral proformas.

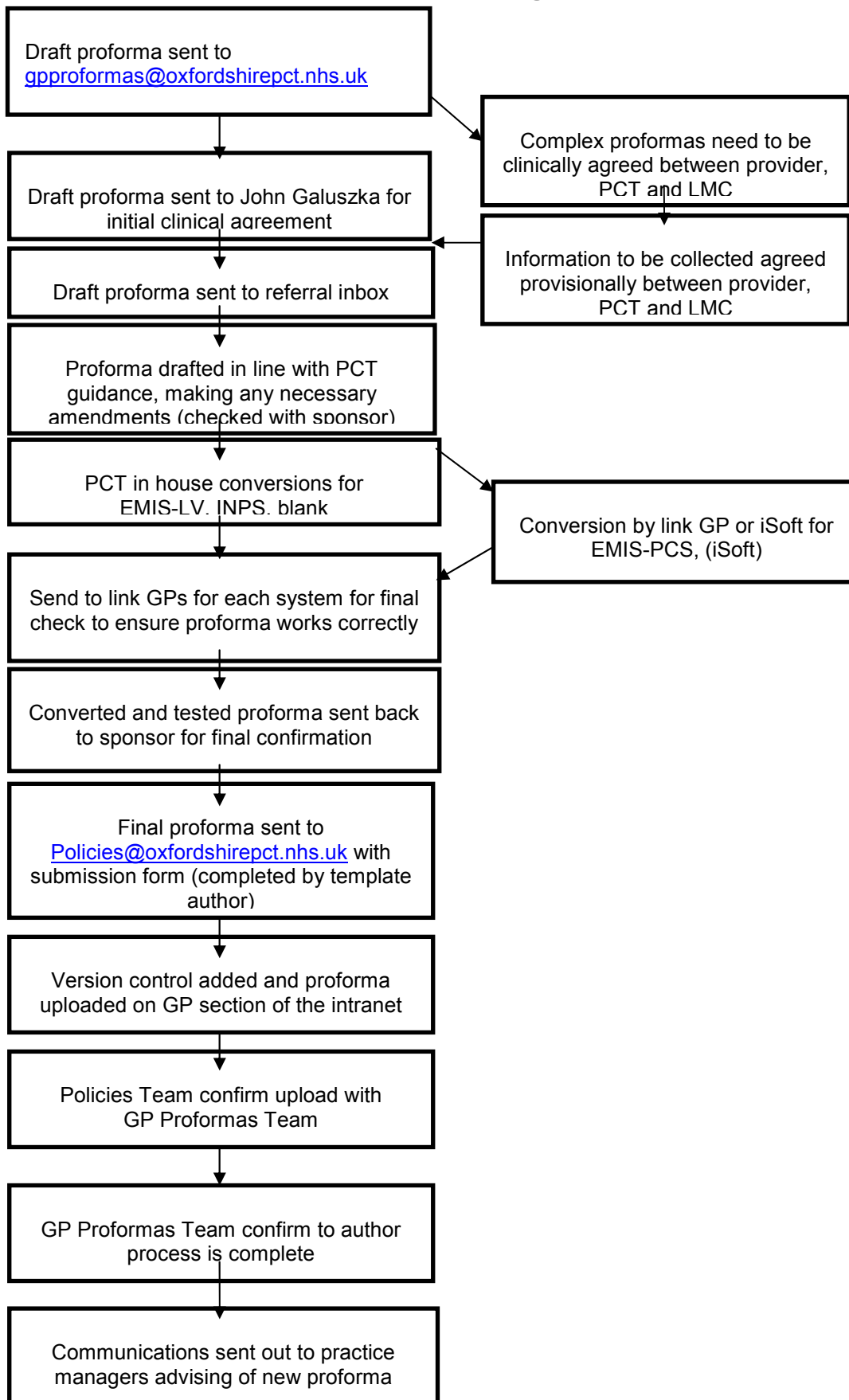
Link GPs

Several GPs have agreed to help with testing and/or converting proformas for specific clinical systems, referred to in the flow chart below

- EMIS-LV – John Galuszka (testing/initial clinical agreement)
- INPS – Tony Love (testing)
- EMIS-PCS – Tom Nichols (conversion/testing)
- iSoft – John Robinson (conversion/testing)

It has been agreed that link GPs will be recompensed for their time spent helping with this work. Invoices for their time should be sent to the Medical Directorate at the PCT.

Process Workflow for Generating Proformas



Printed versions of this document may be out of date