Torbay and South Devon NHS
NHS Foundation Trust

Clinical Audit and Effectiveness Policy

Ref No: 1910
Date: 10 March 2017

Partners in Care

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Document Information

Date of Issue:	10 March 2017	Next Review Date:	10 March 2020
Version:	3	Last Review Date:	
Author:	Clinical Effectiveness Information Analyst Clinical Audit Team Leader		
Owner:	Clinical Effectiveness Information Analyst Clinical Audit Team Leader		
Directorate:	Organisation Wide		
Applicability	All staff members involved in care		

Approval Route	
Approved By:	Date Approved:
Care and Clinical Policies Group	18 January 2017
Chief Nurse	1 February 2017
Medical Director	8 March 2017

Links or overlaps with other policies:

The Trust is committed to preventing discrimination, valuing diversity and achieving equality of opportunity. No person (staff, patient or public) will receive less favourable treatment on the grounds of the nine protected characteristics (as governed by the Equality Act 2010): Sexual Orientation; Gender; Age; Gender Reassignment; Pregnancy and Maternity; Disability; Religion or Belief; Race; Marriage and Civil Partnership. In addition to these nine, the Trust will not discriminate on the grounds of domestic circumstances, social-economic status, political affiliation or trade union membership.

The Trust is committed to ensuring all services, policies, projects and strategies undergo equality analysis. For more information about equality analysis and Equality Impact Assessments please refer to the Equality and Diversity Policy.

Amendment History

Issue	Status	Date	Reason for Change	Authorised
1	Ratified	7 November 2011	New	
2	Ratified	8 January 2015	Revised	
2	Ratified	20 January 2017	Withdrawn	
3	Ratified	10 March 2017	Revised	Care and Clinical Policies Group Chief Nurse Medical Director
3		19 February 2018	Review date extended from 2 years to 3 years	

Brief Summary of Contents

This policy has been developed to ensure that the Trust has in place a systematic and co-ordinated approach to clinical effectiveness processes, including nationally and locally agreed guidance, enquiries, clinical audit and surveys.

Target Staff

All staff members involved in care.

Contents

Appendices :

1 NATIONAL CONTEXT

1.1 Statutory and mandatory requirements for clinical effectiveness

When carried out in accordance with best practice standards, clinical audit:

- Provides assurance of compliance with clinical standards
- Identifies and minimises risk, waste and inefficiencies
- Improves the quality of care and patient outcomes.

The importance which the Department of Health and healthcare regulators attach to effective clinical audit is shown by the extent to which participation in national and local clinical audit is now a statutory and contractual requirement for healthcare providers.

The NHS standard contracts for acute hospital, mental health, community and ambulance services which came into effect in April 2011 cover agreements between commissioners and all providers delivering NHS funded services. The contract terms apply to new agreements from April 2011 for NHS Foundation Trusts. Providers must participate in the National Clinical Audit Patients Outcome Programme (NCAPOP) audits which are relevant to the services they provide and must implement all relevant recommendations of any appropriate clinical audit.

In addition to this contractual requirement, the regulatory framework operated by the Care Quality Commission (CQC) requires registered healthcare providers to regularly assess and monitor the quality of the services provided. They must use the findings from clinical and other audits, including those undertaken at a national level, and national service reviews to ensure that action is taken to protect people who use services from risks associated with unsafe care, treatment and support. They must also ensure healthcare professionals are enabled to participate in clinical audit in order to satisfy the demands of the relevant professional bodies (for example, for revalidation).

The Board is required by NHS Improvement and NHS England to certify that they have effective arrangements in place for the purpose of monitoring and continually improving the quality of healthcare provided to people, and must therefore ensure they have in place systems processes and procedures to monitor, audit and improve quality.

Under the Health Act 2009, the Trust is required to produce an annual Quality Account, which must include information on participation in national and local clinical audits, and the actions which have been taken as a consequence to improve the services we provide.

From April 2012, the NHS Litigation Authority (NHSLA) Clinical Negligence Scheme for Trusts (CNST) has included a standard which requires all participating trusts to have ‘an approved documented process for ensuring that all clinical audits are undertaken, completed and reported on in a systematic manner that is implemented and monitored’. As a minimum, the approved documentation must include a description of the:

a. duties
b. process for setting priorities for a clinical audit programme including participation in local and national clinical audit, and confidential enquiries
c. process for ensuring that audits reflect the standards set out in the organisation’s approved documents
d. process for disseminating audit results/ reports
e. format for all audit reports, i.e. methodology, conclusions, action plans, etc
f. process for making improvements
g. process for monitoring action plans and carrying out re-audits
h. process for monitoring compliance with all of the above

All organisations must have an approved documented process for taking into account agreed best practice as defined in National Institute for Health & Care Excellence (NICE) clinical guidelines.

a. duties
b. how the organisation identifies which NICE guidelines are relevant to its services
c. how a gap analysis is conducted to identify shortfalls
d. how action plans are created to address any shortfalls, including recording decisions not to implement NICE guidelines
e. how the organisation monitors compliance with all of the above

This policy is designed to fulfil these requirements however a separate NICE Guidance policy is available for full detail.

2 PURPOSE OF THIS POLICY

2.1 Statement of purpose

The purpose of this policy is to set out a framework for clinical effectiveness, including the conduct of clinical audit, confidential enquiries and surveys, processes relating to NICE guidance and local guidance within the Trust. Throughout the document "clinical projects" refer to clinical audit, surveys and service evaluation. It includes the Trust's procedures and expectations for:

- registering and approving clinical project proposal
- developing and designing clinical projects
- obtaining compliance with NICE guidance
- ensuring clinical protocols and guidelines are effectively reviewed, updated and ratified in a timely manner
- involving patients and service users and sets out the support that is available from the Clinical Effectiveness Team

2.2 Improvement and assurance

The Trust supports the view that whilst Clinical Effectiveness and Audit are fundamentally quality improvement processes, they also play an important role in providing assurance about the quality of services.

The Trust considers that the prime responsibility for auditing and surveying clinical care lies with the clinicians who provide that care. The Trust is committed to supporting clinicians who carry out projects by providing advice, assistance and training from appropriately trained and experienced audit and effectiveness staff. Appropriate advice and training will also be made available to non-clinical staff, patients and service users who may be involved in clinical audit projects.

In addition, the Trust is committed to ensuring that:

- The Trust participates in all national clinical audits, national confidential enquiries and service reviews which are relevant to the services which it provides
- All approved clinical effectiveness and audit activity within the Trust, or conducted in partnership with external bodies, is registered and conforms to nationally agreed best practice standards
- The programme of activity undertaken by the Clinical Effectiveness team meets the requirements of the Board Assurance Framework, and includes all of the clinical audits necessary to meet regulatory and commissioner requirements
- Records of all clinical effectiveness activity are maintained in order to demonstrate compliance with regulatory and other requirements

3 SCOPE

3.1 The target audience

This policy applies to anyone engaged in the clinical effectiveness process under the auspices of the Trust. This includes:

- all staff, both clinical and non-clinical, including staff on short-term or honorary contracts
- students and trainees in any discipline
- patients, carers, volunteers and members of the public

This policy also applies when effectiveness projects are undertaken jointly across organisational boundaries.

3.2 Multi-disciplinary and multi-professional projects and partnership working with other organisations

The Trust encourages effectiveness projects, i.e. clinical audit, surveys and service evaluations undertaken jointly across professions and across organisational boundaries. Partnership working with other local and regional organisations will be encouraged where improvements to the patient journey may be identified through shared effectiveness activity.

3.3 Involving patients, service users and the public

The Trust promotes a commitment to the principle of involving patients, carers and service users in the effectiveness process, either indirectly through the use of patient surveys/ questionnaires or directly through participation of identified individuals on project steering groups or patient forums.

4 DUTIES AND RESPONSIBILITIES

4.1 Key corporate roles

4.1.1 Overall Trust Responsibility

The Chief Executive is accountable and responsible for the Trust's statutory duty of quality and has overall responsibility for this policy.

4.1.2 Executive Leadership

- Executive Leadership is shared by the Chief Nurse and the Medical Director, ensuring that the Trust makes adequate provision to support clinicians and managers regarding all clinical effectiveness matters
- To ensure that clinical effectiveness is used appropriately to support the Board Assurance Framework
- To escalate any concerns raised by Clinical Effectiveness to the Board
- Responsible for an ethical oversight of clinical effectiveness and audit

4.1.3 Operational Leadership

The Clinical Effectiveness Information Analyst (CEIA) and Clinical Audit Team Leader (CATL) are the Operational Leads for Clinical Effectiveness activity. (See 4.2.4)

4.2 Roles and responsibilities

4.2.1 Service Delivery Units (SDU)

Each SDU should ensure that a named senior clinician within each directorate/ team/ service is nominated as the Clinical Audit Co-ordinator for each specialty.

The responsibilities of the Clinical Audit Co-ordinator are:

- To ensure that this policy is implemented throughout their specialty/ team
- To ensure that all clinical audit activity within their specialty/ team is registered and complies with nationally accepted best practice standards
- To ensure that their specialty/ team participates in all national audits, confidential enquiries and service reviews which are relevant to the services which it provides that have been approved by the Clinical Audit & Effectiveness Group (CA&EG)
- To work with clinicians, service managers, governance leads and Effectiveness staff to ensure that the effectiveness programme for their specialty meets all clinical, statutory, regulatory, commissioning and other Trust requirements
- HQIP have produced a 'Guide for Clinical Audit Leads' August 2016 that provides a full overview of expectations

4.2.2 Senior Managers

Managers are responsible for ensuring that service development and delivery is underpinned by clinical audit and forms part of Continuing Professional Development.

4.2.3 Deputy Director of Nursing - Professional Practice

The Deputy Director of Nursing - Professional Practice provides guidance and an oversight to Clinical Effectievenss Department (CED) and manages the department budget.

4.2.4 Clinical Effectiveness Department (CED)

The central clinical effectiveness and audit team comprises:

Clinical Effectiveness Information Analyst (CEIA)

- Deputise for Deputy Director of Nursing - Professional Practice in issues relating to Clinical Effectiveness activity
- Analysis and creation of surveys and service evaluations (including Friends & Family - (See separate Policy/ Process)
- Line-manage the Clinical Effectiveness Project Support Officer and Departmental Secretaries
- Design, create and maintain databases for the department using Microsoft Access
- Management of local Clinical Guidance and leaflets (See separate Policy/ Process)
- Management of NICE guidance until receipt of baseline compliance assessment (See separate Policy/ Process)

Clinical Audit Team Leader

- Deputise for Deputy Director of Nursing - Professional Practice in issues relating to audit activity
- Line-manage the Audit Facilitators (AFs) and Clinical Audit Support Officer (CASO)
- Develop the skills of the AFs in line with this policy and Principles of Best Practice in Clinical Audit
- Take responsibility for a range of audit/ improvement projects
- Management of NICE guidance action plan implementation and re-assessment process (See separate Policy/Process)

Clinical Audit Facilitators (AFs)

- To control/ take responsibility for a range of audit/ improvement projects
- Ensure all audit projects are registered with progress recorded on the database and presented at specialty/ team audit meetings

Clinical Audit Support Officer (CASO)

- To control/ take responsibility for the national audit and confidential enquiry programme, ensuring that published reports from national projects are distributed and robust local action plans are obtained
- Ensure all national audits are registered and progress recorded on the database

Clinical Effectiveness Project Support Officer

- To control/ take responsibility for a range of effectiveness projects, i.e. surveys, service evaluations etc
- Deputise for CEIA

Departmental Secretaries

- To provide secretarial/ clerical support to CED
- Format, using Microsoft Word, and distribute Clinical Guidance and leaflets
- Support Friends & Family project and other activity processed through Formic (data processing software)

4.2.5 Individuals

All staff employed by the Trust have a responsibility for the quality of the service that they provide, and all clinically qualified staff and registered professionals are individually accountable for ensuring they evaluate their own practice in accordance with their professional code of conduct.

4.3 Committees and Groups

Trust Board

- The role of the Trust Board is to ensure that CED resource is allied to broader interests and targets that the Board needs to address. HQIP have produced a 'Guide for NHS Boards and Partners' January 2015 that provides a full overview of expectations

Quality Assurance Committee (QAC)

- Overview of the performance of the Clinical Effectiveness function.

Quality Improvement Group (QIG)

- Review the CED monthly Report

Clinical Audit & Effectiveness Group (CA&EG)

- Assurance specifically in respect of audit and NICE guidance
- To ensure this policy is implemented across all clinical areas
- To ensure that any serious concerns regarding the Trust's policy and practice in CEIA or CATL opinion, or regarding project results and outcomes are brought to the attention of the Board
- The CA&EG is responsible for approval and reviewing all clinical effectiveness projects and monitoring NICE guidance

5 CONDUCT OF CLINICAL PROJECTS

5.1 Agreeing the programme of clinical effectiveness activity

The Trust should maintain a three year rolling programme consisting of:

5.1.1 National Audits/ Confidential Enquiries

- The Trust will seek to participate in any relevant national audits that form part of the Healthcare Quality Improvement Partnership's (HQIP) National Clinical Audit & Patient Outcome Programme (NCAPOP) through CED review of HQIP annual Quality Account listing. Teams/ Directorates will be advised of each relevant project with a request to ensure participation, this will be copied/ routed through relevant SDU with advice sought from CA&EG of non-participation is likely
- The Trust will take part in relevant national confidential enquiries
- The Trust will record participation in national audits and confidential enquiries on an Access database designed to ensure that actions are taken following publication of reports
- The Trust will also seek to participate in other relevant national audits as resources permit
- The Trust will make every effort via CED involvement to ensure data quality checks are undertaken before submission to lead audit body

5.1.2 Local Audits/ Surveys/ Service Evaluations

- The Trust is committed to supporting other locally determined effectiveness activity as a significant contributor to the continuous process of service improvement. It is acknowledged that individual clinicians may initiate a project on the basis of personal interest, personal development or as part of an educational or training programme. It is important that these are registered with CED after discussion at SDU level and reported through specialty/ team meetings and the CA&EG in order to maximise organisational learning
- The Clinical Effectiveness Programme should be regularly monitored by the CED Team Leader and published on the Clinical Effectiveness website. Completed projects will be removed from the programme on an annual basis when they have been completed for more than 12 months and in the Trust year before current year

5.2 Working with Commissioners

CA&EG papers will be shared with both South Devon & Torbay & NEW Devon CCGs.

5.3 Systems for registering, approving and recording results of projects

- For each project undertaken, the relevant proposal form must be completed by the project lead and approved by the CA&EG
- All surveys including patient participation where the survey has been locally designed should be approved by the Lead Clinical Psychologist following approval by CA&EG
- All projects must be registered with CED irrespective of the level of facilitation being requested of the Department
- Each stage of the project will be entered in a database held in CED and used to monitor progress and report to the CA&EG. The database will be updated/ amended to reflect current practice

5.4 The use of standards in clinical audit

- By definition, clinical audit involves measuring clinical practice against predetermined standards of best practice. The Trust expects clinical standards to be presented in a format which conforms to *New Principles for Best Practice in Clinical Audit* (NICE 2011) including measurable criteria. This is reflected in the structure of the Trust's clinical audit proposal form

- Wherever possible, clinical audit standards should be based on robust research evidence
- The control document on all protocols, guidelines, policies and procedures should state whether or not the document is evidence based and be referenced to best practice
- Process-based clinical audit project proposals which do not make reference to standards will not be registered as clinical audit but will be assessed and directed to relevant teams (for instance Research or Quality Improvement) for assistance and guidance

5.5 Dissemination and Reporting

- On completion of each audit cycle the analysed results should be presented at specialty/ team meetings where the findings should be discussed, action plans agreed and a commitment to re-audit made in a designated timeframe. A successful audit in one area may be transferable to other parts of the organisation, the Audit Facilitators should consider this when they are completing each project with learning points and transferrable projects discussed at CED Team meetings
- The CA&EG should review all summary reports on completion of Stage 1 of the project including action plan and again on completion of the re-audit. Any comments or required actions (including transferability – see above) from the CA&EG will be fedback to the relevant AF for transmission to the relevant audit lead(s)

5.6 Action plans

Where the initial results of a clinical audit indicate sub-optimal practice, an action plan will be produced. An effective action plan should contain the following:

- Action required - Details of the specific actions required to achieve compliance with the measureable standards of the project should be listed. They should be realistic and achievable
- Responsible Individuals - This should include the names and job titles of key individuals who are accountable for ensuring specific actions are put into place within the allotted timescale
- Timescales - In order to ensure that the change management process takes place as smoothly and quickly as is appropriate, realistic timescales should be agreed by the whole change team
- Monitoring - The action plan should state the Committee/ Group responsible for monitoring completion of this action plan

Not all projects will require an action plan e.g. where projects show that standards are being met or guidance followed. For such projects there should be an explicit statement saying ‘no further action required’ in the audit summary report.

A reason must be recorded if a Division/ Specialty/ Team decide not to re-audit.

The CA&EG will monitor the implementation of actions, ensuring that any identified changes are incorporated into relevant business plans as appropriate.

5.7 Re-audit

Re-audit is essential to confirm the implementation and impact of agreed actions. Targeted re-audit will be applied, i.e. re-audit will only be undertaken on criteria where Stage 1 of the audit has demonstrated poor performance. The Trust’s current target is to maintain the re-audit rate of 80%.

5.8 Monthly report

CED will produce a monthly report; this will be based on the notes of the monthly CA&EG meeting notes and received by the QIG.

6. GOVERNANCE AND ETHICS

6.1 Ethics and consent

By definition, clinical effectiveness projects should not require formal approval from a Research Ethics Committee. However one of the principles underpinning clinical effectiveness is that the process should do good and not do harm. Clinical effectiveness projects must always be conducted within an ethical framework.

6.2 Equality and diversity

The Trust aims to ensure that its healthcare and facilities are not discriminatory and, wherever possible, attend to the physical, psychological, spiritual, and social and communication needs of any patient, service user or visitor showing no discrimination on the grounds of ethnic origin or nationality, disability, gender, gender reassignment, marital status, age, sexual orientation, race, trade union activity or political or religious beliefs.

The process for determining choice of projects, and the manner in which project patient samples are drawn up, should not inadvertently discriminate against any groups in society based on their race, disability, gender, age, sexual orientation, religion and belief. Any person who has concerns regarding the ethics of clinical effectiveness activity within the Trust should refer them in the first instance to CA&EG, who may require equality impact assessments to be undertaken and/ or equality data to be collected as part of projects in order to determine whether any particular groups of patients are experiencing variations in practice.

6.3 Information Governance: collection, storage and retention of data and confidentiality

All clinical effectiveness activity must take account of the Data Protection Act (1998) and the Caldicott Principles (1997). This means, for example, that data should be:

- adequate, relevant and not excessive
- accurate
- processed for limited purposes
- held securely
- not kept for longer than is necessary

The Department of Health publication Records Management: NHS Code of Practice (2006) requires “project records” to be retained for a period of five years, although the document does not define the term “record” in this context. The Trust is currently committed to retaining clinical project reports indefinitely. “Raw” data should however be destroyed once a project has been completed, i.e. the project has been presented and the lead is content that there is no further purpose for holding the raw data.

The Trust adheres to the NHS Confidentiality Code of Practice (2003) regarding collection of patient identifiable data for the purposes of clinical audit and anonymises data.

Clinical project practice must confirm to the Trust policies regarding storage of data on removable devices, e.g. memory sticks.

6.3.1. Confidentiality agreements

There may be occasions when the Trust engages an individual in its clinical project activities who are not directly employed by the Trust, e.g. staff with honorary contracts, volunteers, patients and the public. Individuals who work with the Trust in these capacities will be required to sign a confidentiality agreement.

7 TRAINING AND DEVELOPMENT

7.1 Overall organisational approach

Training raises the profile of clinical projects and builds capacity and capability of all staff involved, acting as a driver for quality improvement. The Trust's Clinical Effectiveness Team is therefore committed to providing training in formats which reflect clinical needs. Clinical Effectiveness offer bespoke support to project leads during their involvement in projects, ensuring that the correct methodology is employed and that they are given appropriate time, knowledge and skills to successfully complete the project. Training is available to all healthcare professionals who are responsible for improving the quality of care delivered. Appropriate training will be available to any patients and/ or members of the public who participate in clinical effectiveness activities.

7.2 Provision of training

The CE Information Analyst and CA Team Leader will have overall responsibility for the provision of training. All staff within Clinical Effectiveness will provide support to project leads on Trust methodology as appropriate.

7.3 Employment and development of clinical effectiveness staff

The Trust is committed to employing a team of suitably skilled clinical effectiveness staff to support its programme of clinical effectiveness activity.

8 MONITORING

8.1 Monitoring the effectiveness of the policy

In accordance with the requirements of the NHS Litigation Authority, this policy together with associated documentation will be monitored on a regular basis by the CE Information Analyst and CA Team Leader and updated when required. Any changes will be reviewed and ratified by CA&EG.

Appendix 1

Locally accepted definitions

The trust adheres to the following definitions as set out in the Principles of Best Practice in Clinical Audit:

Clinical Effectiveness is the extent to which specific clinical interventions, when deployed in the field for a particular patient or population, do what they are supposed to do, i.e. maintain and improve health and secure the greatest possible health gain from available resources.

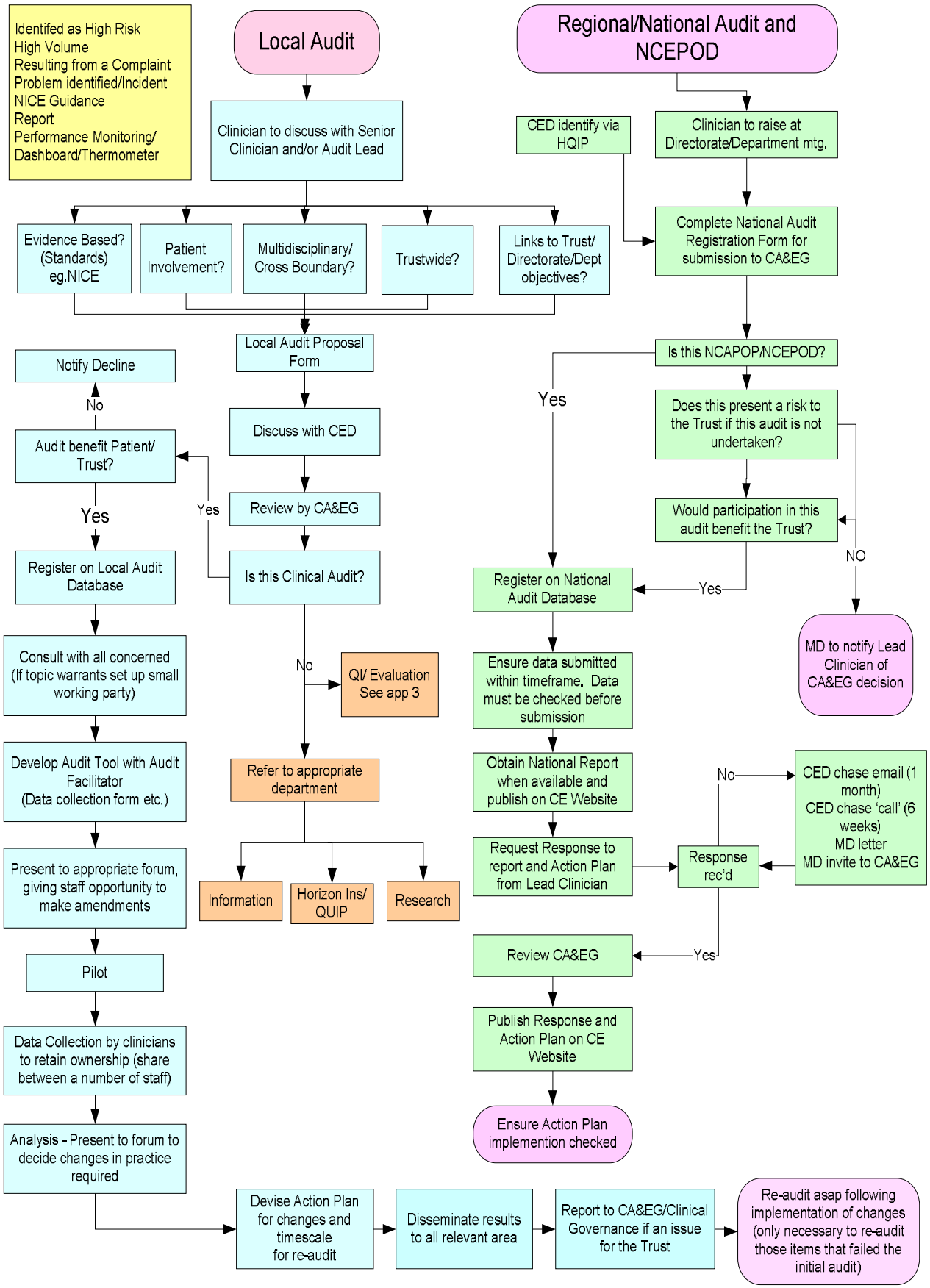
Clinical audit is a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes.

Clinical governance is a framework through which the NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

Clinical guidelines are systematically developed statements to assist practitioner and patient decisions about appropriate healthcare for specific circumstances. (These can be produced locally by clinical staff or nationally by the NICE)

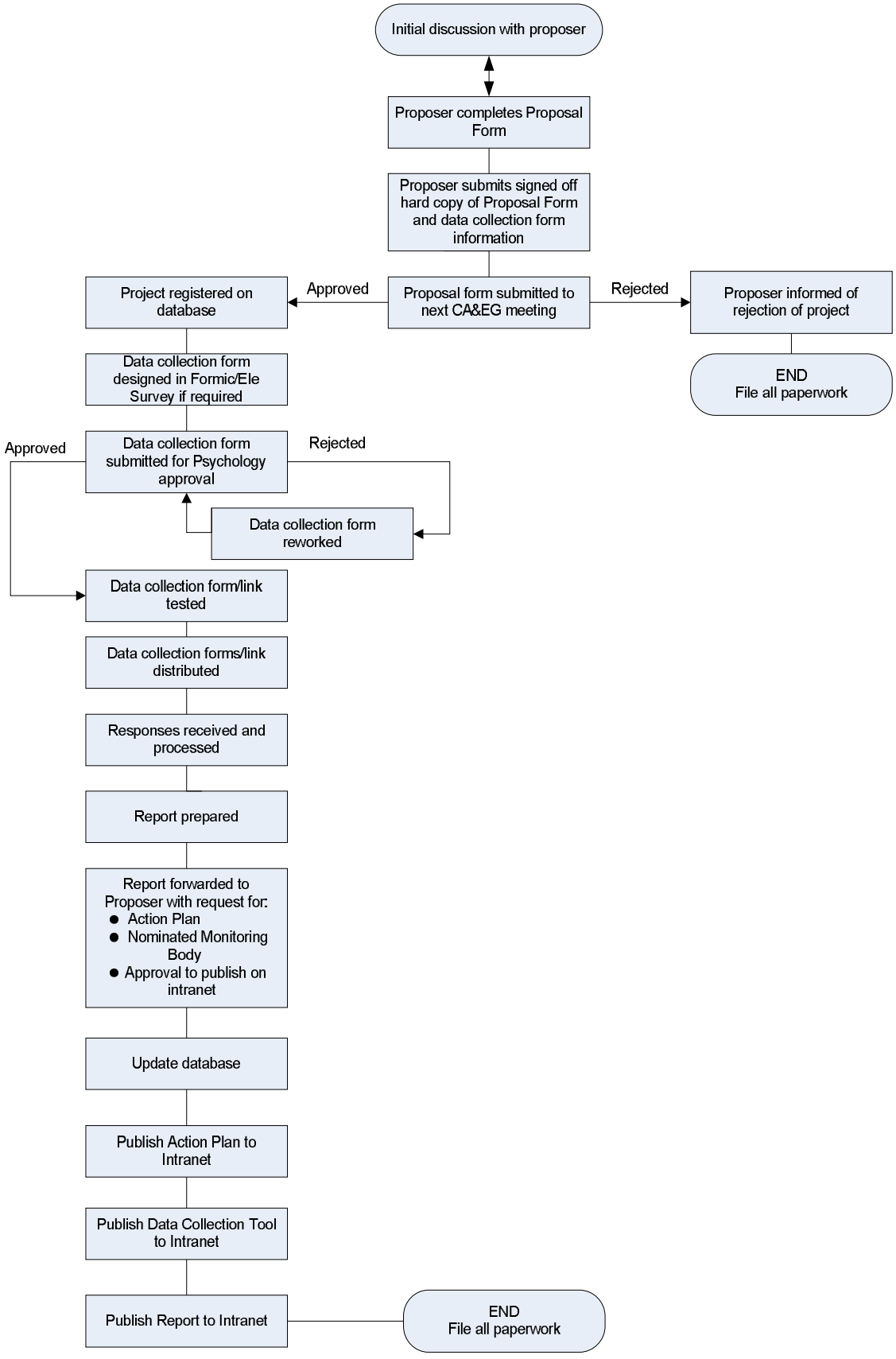
Appendix 2

CLINICAL AUDIT PROCESS



Appendix 3

Clinical Effectiveness Survey/ Questionnaire/Data Collection Projects Process



Appendix 4

Clinical Audit and Effectiveness Group

Terms of Reference

The Group will act as a sub group of the Quality Improvement Group (QIG) and an advisory and policy-making body for matters relating to the development and dissemination of clinical audit and clinical effectiveness documentation.

Membership
The membership will comprise of the following:

Medical Director or Deputy
Chief Nurse
Medical Director
Deputy Director of Nursing & Professional Practice
Associate Director of Therapies
Clinical Effectiveness Information Analyst
Clinical Audit Team Leader
'Others' to be invited to discuss relevant agenda items

Meetings

- The Group will meet every month, notes of the meetings will be taken and distributed to members with a copy provided to CCG
- The Medical Director or Director of Professional Practice, Nursing & Patient Experience will chair the meeting
- Members will attend meetings or send a deputy

Operation of the Clinical Audit & Effectiveness Group

- Ensure the Health Community is meeting the national agenda as outlined by NHS England and the CQC through discussion and dissemination
- Approve all local audit projects prior to commencement ensuring they link into Directorate/ Team objectives
- Approve all national audits prior to commencement ensuring that benefits to the Trust arise from participation
- Review results of all Clinical Audit projects, ensuring they are disseminated appropriately including approval for publication on the intranet
- Monitor and ensure that patients are involved in the clinical audit process and assist where appropriate
- Review clinician responses regarding national guidance in order to ensure that clinical practice is changed where necessary and approval is given for publication on the intranet
- Ensure that best clinical practice is maintained and changed where necessary
- Improve and strengthen links with Quality Improvement Teams across the Trust

Appendix 5

Confidentiality agreement

This declaration must be signed by any person who is not employed by Torbay and South Devon NHS Foundation Trust, or deemed an honorary employee through association with the appropriate department of the [academic body], who will be reviewing patient-related information for the purposes of clinical audit.

Declaration

I hereby declare that I fully understand that all patient-related information to which I have access, whether held on computer or in written form or given to me verbally, is confidential and I undertake never to divulge information to anyone without the authority of a senior member of administrative staff. I understand that this includes the divulging of information to the police.

I also understand that the names, addresses and details of patients contained in any documents or indexes are confidential and must not be accessed or divulged for personal interest or gain, or any other purpose other than healthcare business.

By signing this form I accept that I have been informed that under the provisions of the Data Protection Act 1998, unauthorised disclosure of data may result in personal prosecution.

Name	
Project title:	
Post:	*Department:*
Email address:	
Mobile/ telephone no:	
Signature and date:	
Witnessed by and date:	

Prepared by the Clinical Effectiveness Department, Torbay Hospital
Confidentiality Agreement, Version 2, June 2016

The Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions

Enshrined in the Mental Capacity Act is the principle that people must be assumed to have capacity unless it is established that they do not. This is an important aspect of law that all health and social care practitioners must implement when proposing to undertake any act in connection with care and treatment that requires consent. In circumstances where there is an element of doubt about a person's ability to make a decision due to 'an impairment of or disturbance in the functioning of the mind or brain' the practitioner must implement the Mental Capacity Act.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has statutory force which means that health and social care practitioners have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

"The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make decisions to protect themselves". (3)

All Trust workers can access the Code of Practice, Mental Capacity Act 2005 Policy, Mental Capacity Act 2005 Practice Guidance, information booklets and all assessment, checklists and Independent Mental Capacity Advocate referral forms on iCare

http://icare/Operations/mental_capacity_act/Pages/default.aspx

Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training programme.

NHS South Devon and Torbay Clinical Commissioning Group

Torbay and South Devon NHS
NHS Foundation Trust

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

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

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

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

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

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

Is it likely that the policy/procedure could affect particular 'Inclusion Health' groups less favorably than the general population? (substance misuse; teenage mums; carers[1]; travellers[2]; homeless[3]; convictions; social isolation[4]; refugees)	Yes ☐ No☐
Please provide details for each protected group where you have indicated 'Yes'.	

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

Is inclusive language[5] used throughout?	Yes ☐ No☐
Are the services outlined in the policy/procedure fully accessible[6]?	Yes ☐ No☐
Does the policy/procedure encourage individualised and person-centered care?	Yes ☐ No☐
Could there be an adverse impact on an individual's independence or autonomy[7]?	Yes ☐ No☐
If 'Yes', how will you mitigate this risk to ensure fair and equal access?	

EXTERNAL FACTORS

Is the policy/procedure a result of national legislation which cannot be modified in any way?	Yes ☐ No☐
What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?)	
Who was consulted when drafting this policy/procedure? What were the recommendations/suggestions?	

ACTION PLAN: Please list all actions identified to address any impacts

Action	**Person responsible**	**Completion date**

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

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

Please contact the Equalities team for guidance:
For South Devon & Torbay CCG, please call 01803 652476 or email marisa.cockfield@nhs.net
For Torbay and South Devon NHS Trusts, please call 01803 656676 or email pfd.sdhct@nhs.net

This form should be published with the policy and a signed copy sent to your relevant organisation.

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