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Title:	South Devon and Torbay System Education Plan and Priorities	
Document Author:	Consultant In Palliative Medicine	
Applicability:	All Healthcare Professionals As Defined In Document	

- [Appendix 1: Membership Of Cross Community End Of Life Education Group](#)
- [Appendix 2: Template For Organisations To Map Staff Requiring Training And Levels Of Training \(Adapt To Setting\)](#)
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South Devon and Torbay System Education Plan and Priorities

Every health and social care employee needs to be competent and up to date in their knowledge and practice to enable them to play their part in delivery of excellent end of life care (EOLC). It is vital that every professional has a framework for their education, training and continuing professional development to achieve and maintain their competence. We are in a unique position as a health and social care community to influence and significantly improve palliative and end of life care for our population.

This system plan has been produced by a cross community end of life education group (Appendix 1) with wider consultation. Oversight and progression of the work plan will continue to be the responsibility of this group, reporting to Torbay and South Devon End of Life Strategic Board.

The South Devon and Torbay System Education Plan and Priorities is integral to the successful delivery of end of life care across our health community. This document provides a framework and guidance on the delivery of education for staff employed by the following organisations who deliver elements of end of life care, along with patients, carers (both lay and professional) and the public:-

- Torbay and South Devon NHS Foundation Trust (acute and community)
- Rowcroft Hospice
- Torbay and South Devon GP practices
- Marie Curie
- South West Ambulance Trust
- Devon Doctors Ltd
- Independent care homes
- Independent care agencies

There is also a recognised need to forge links over time with wider teams and organisations to influence the end of life care received by:-

Prisoners
Homeless people
People with learning disabilities
Young adults in transition
Single elderly people
Patients with psychiatric illness
People with dementia

The level, or tier, of education required will be dependent on an individual's role. The mode of delivery will be a blended approach of traditional face to face teaching, new initiatives such as 'train the trainer' and the EOL Ambassadors training programme, and new technologies (HIVE, HIBLIO and national IT resources)

A key recommendation of the Devonwide EOLC Health Needs Assessment 2017 is wider training in end of life care across all sectors, an ambition echoed by the Devon STP Advance Care Planning working group.

A key priority in the Torbay and South Devon End of Life Care Strategy for Adults (2016-2020) produced by the EOLC Board is that:-

Provision of education and training to the workforce to deliver high quality end of life care to build a commonality of understanding of why end of life care is important in our system

National context

Each year around 500,000 people in England die. For each person, there are many around them who are affected by caring, grief and loss. The National End of Life Strategy 2008 set a determined path to improve the quality and experience of care for all. Following withdrawal of the Liverpool Care Pathway for the dying patient (2014) the 'One Chance to get it Right' document (2014) described five priorities of care that must be in place to care for patients in the last days of life.

1. The possibility that a person may die within the next few days or hours is recognised and communicated clearly, decisions made and actions taken in accordance with the patients' needs and wishes and these are regularly reviewed.

2. Sensitive communication takes place between staff and the dying person, and those identified as important to them.

3. The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.

4. The needs of families and others identified as important to the dying person are explored, respected and met as far as possible.

5. An individual plan of care, which includes symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.

More recently The Ambitions for Palliative and End of Life Care, a National Framework for local action 2015 – 2020 is a continuation of this work. It builds on the extensive national efforts made over the previous seven years and broadens its reach and challenge to the whole community. We are committed to ensuring we make these ambitions a reality. Such success will not just happen, but requires leadership and commitment from all organisations who provide an element of end of life care.

The Ambitions Framework recognises the important role of communities within end-of-life-care. The inclusion of concepts such as ‘each community is prepared to help’ is the desire to form new and improved partnerships between communities and professional services. This is why, as organisations, the introduction and provision of priorities included in the new ‘Ambitions Framework’ is so important in our everyday work. Building on the information previously available to us to achieve the best end of life care, we will include the 6’C’s. Our system plan will outline how, over the next three years, we will work towards the ‘Ambitions in end of life care’ (2014).

<p>Ambition 1 Each person as an individual</p>	<p>‘I, and the people important to me, have opportunities to have honest, informed and timely conversations and to know that I might die soon. I am asked what matters most to me. Those who care for me know that and work with me to do what’s possible.’</p>
<p>What we know</p>	<p>We will achieve this through</p>
<ul style="list-style-type: none"> ▪ Having our personal needs and wishes ignored or overridden is a deeply rooted fear for those who are dying, their families, and the many people who are carers, as well as those who have been bereaved ▪ We know that much about recognising dying and impending death is uncertain and challenging. However, timely identification and honesty where there is uncertainty is key to the quality of care – all else follows ▪ We know that despite the difficulty that can be associated with talking about death, people want repeated opportunities to consider whether to engage in such honest conversations about their future ▪ We know that people want to be involved in their care, and should be given all the information, advice and support they need to make decisions about it ▪ We know that with effort, collaboration and system leadership health and social care can be designed around the wishes of the person approaching death ▪ We know that asking, recording and working to support choices requires 	<ul style="list-style-type: none"> ▪ Developing skills in honest and well informed conversations regarding dying, death and bereavement by developing a training and competency framework. ▪ Delivery of training on the correct use of an individualised care plan for everyone receiving end of life care in our services. ▪ Working with our local partners to deliver education on the best clinical assessment and the aims of care delivery in an environment that meets your needs and preferences. ▪ Educating our staff to work with you and those important to you in preparation for bereavement and providing signposting to appropriate bereavement services.

<p>those who lead organisations and the care professionals who work in them to be innovative in how to enable choices to be met, particularly within resource constraints</p>	
<p>Ambition 2 Each person gets fair access to care</p>	<p>'I live in a society where I get good end of life care regardless of who I am, where I live or the circumstances of my life.'</p>
<p>What we know</p> <ul style="list-style-type: none"> ▪ People from black and minority ethnic (BAME) communities and deprived areas report a poorer quality of end of life care; similarly those who are living with non-malignant illnesses, people living in more deprived areas, the homeless or imprisoned, and those who are more vulnerable or less able to advocate for their own care ▪ The quality of end of life care is poorer and harder to access for people who live in very rural or other isolated areas. ▪ There remain unacceptable inequities and inequalities in access to palliative and end of life care particularly for those with learning disabilities, dementia and non-malignant long term conditions There is a collective responsibility on all of those involved in the commissioning and provision of end of life care to put this right ▪ There are unacceptable variations in aspects of palliative and end of life care such as access to pain control, related to different care settings 	<p>We will achieve this through</p> <ul style="list-style-type: none"> ▪ Delivery of education to our staff on provision of excellent end of life care. ▪ Raising awareness of vulnerable groups and individuals who may find it more challenging to access end of life services. ▪ Promoting a person centred approach within the education that we deliver along with involvement of those close to you, with your permission. ▪ Continuing to strengthen relationships between care providers to maintain clear and open communication to facilitate an ease of transition of your care between services, where this is required.

<p>Ambition 3 Maximising comfort and wellbeing</p>	<p>‘My care is regularly reviewed and every effort is made for me to have the support, care and treatment that might be needed to help me to be as comfortable and as free from distress as possible.’</p>	
<p>What we know</p>		<p>We will achieve this through</p>
<ul style="list-style-type: none"> • Many people approaching death are fearful of being in pain or distress. • Dying and death can be powerful sources of emotional turmoil, social isolation and spiritual or existential distress. • We know that distress from pain and symptoms can be relieved with expert palliative care and that inadequate and misguided clinical interventions are features of patients’ and their families’ poor experiences. • We know that access to good and early palliative care can improve outcomes for life expectancy as well as improve the quality of life. • A comfortable death can help those who are bereaved to adjust to their loss in ways that secure their future health and wellbeing 		<ul style="list-style-type: none"> ▪ Implementation of the End of Life education and competency framework for all clinical staff, to ensure skilled assessment and symptom management. ▪ Educating staff to work with you and support you to achieve your personal goals whilst maximising your independence. ▪ Delivery of education to embed the use of an Individualised Care Plan for the dying patient both in the inpatient and community setting. ▪ Equipping staff with the knowledge of how to access expert advice, medicines and equipment so they can respond rapidly to your changing needs.

<p>Ambition 4</p> <p>Care is coordinated</p>	<p>I get the right help at the right time from the right people. I have a team around me who know my needs and my plans and work together to help me achieve them. I can always reach someone who will listen and respond at any time day or night.</p>
<p>What we know</p>	<p>We will achieve this through</p>
<ul style="list-style-type: none"> • Fragmented and disjointed care is a source of frustration and anxiety for the dying person and for all those important to them. • Carers often testify to the difficulties of multiple professionals and organisations working with little awareness of each other. This lack of coordination causes significant distress. • Poor communication and a failure to share information about the dying person is a recurrent failing when care is not good enough. • We have to find a way to provide the social care that people need regardless of financial circumstances • We know that 24/7 expert palliative and end of life care services need to be available and that their availability around the clock is key to building a system of high quality care. • We know that access and trust in the services available in the community are crucial to sustaining care outside of hospitals – most people’s preferred environment. 	<ul style="list-style-type: none"> ▪ Educating staff to understand the place and importance of eliciting patients’ wishes. ▪ Educating staff on the use of documents such as Advance Care Plans and Advance Decisions to Refuse Treatment to record patients’ wishes. ▪ Encouraging staff to use the Electronic Palliative Care Co-ordination System (EPaCCS) to share important information (with consent) ▪ Raising awareness of available Specialist Palliative Care Support, including 24/7 access to advice on symptom management.

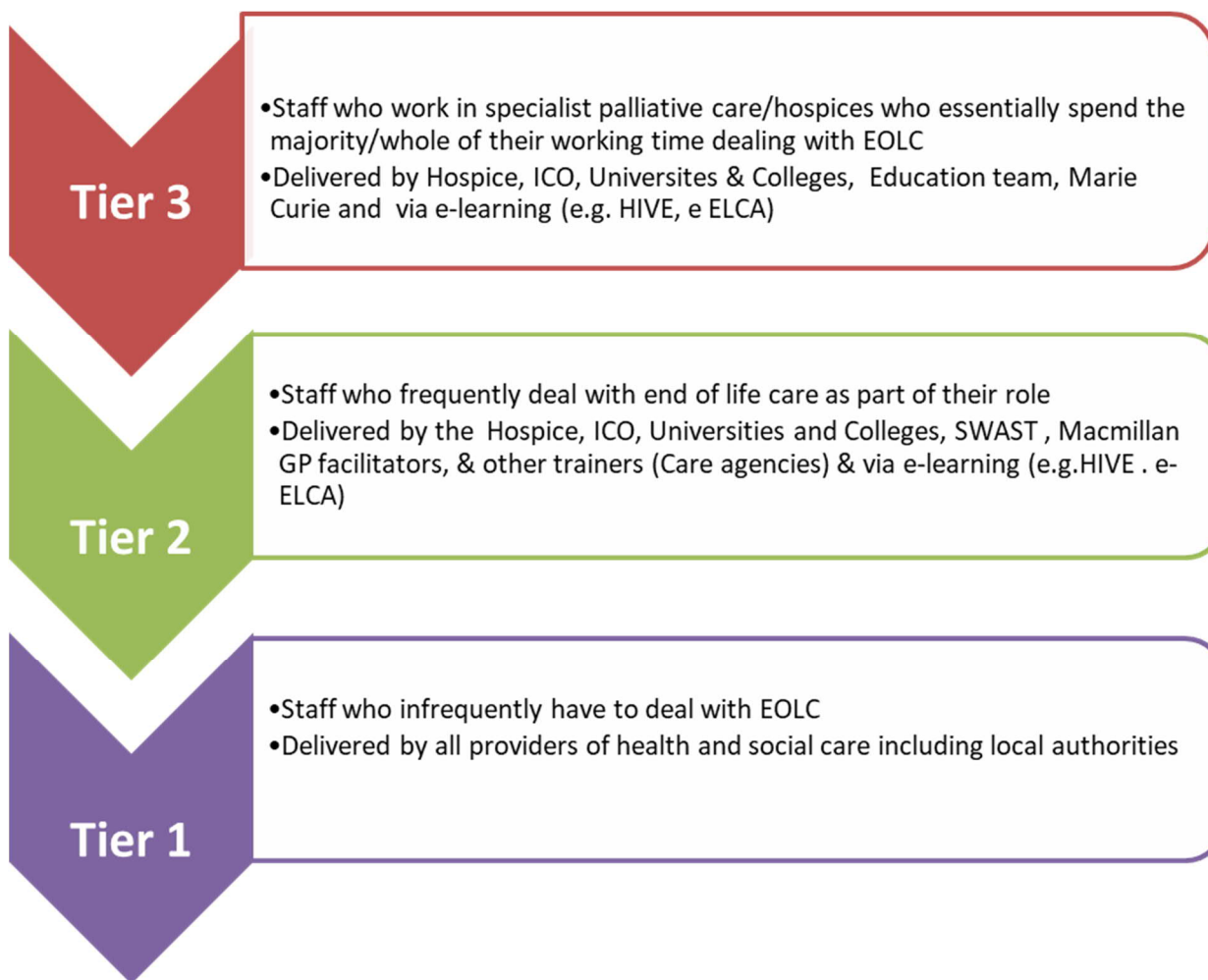
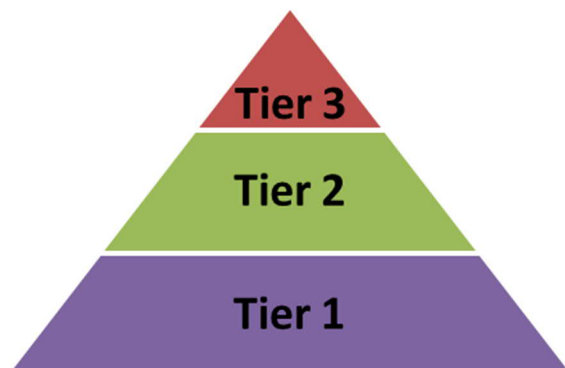
<p>Ambition 5 All staff are prepared to care</p>	<p>Wherever I am, health and care staff bring empathy, skills and expertise and give me competent, confident and compassionate care.'</p>	
<p>What we know</p>		<p>We will achieve this through</p>
<ul style="list-style-type: none"> • Caring for the dying, looking after the bodies of the dead and supporting people facing loss and grief, before and after death, is difficult and distressing. It challenges the resilience and fortitude of those working in end of life care • Most health and care staff look after people who are nearing death, so if care is to improve they must be trained in those aspects of end of life care that are appropriate to their role. Too often the employers of health and care professionals have not acted systematically to help their staff avoid the debilitating effects of burn out, avoidance or helplessness resulting from lack of education, training and support • Staff can only provide compassionate care when they are cared for themselves and must be supported to sustain their compassion so that they can remain resilient, and use their empathy and apply their professional values every time • We know that good pain and symptom management benefits both the dying and those who spend time with them • If we are to make deaths at home more achievable, we know that we have to do more 		<ul style="list-style-type: none"> ▪ Ensuring paid carers and clinicians at every level of expertise are trained, supported and encouraged to bring a professional ethos to the care they deliver. ▪ Creating organisational and professional environments that ensure psychological safety, support and resilience. ▪ Using technology to enhance professionals' learning and development ▪ Educating all those who provide palliative and end of life care to understand and comply with legislation that seeks to ensure an individualised approach. ▪ Aiming to facilitate, offer and encourage peer support in all clinical teams to allow for reflection and learning. ▪ Well trained, competent and confident staff who can bring professionalism, compassion and skill to their caring roles.

<p>to ensure sufficient support for those paid carers who may be vital to sustaining the viability of care at home</p>	
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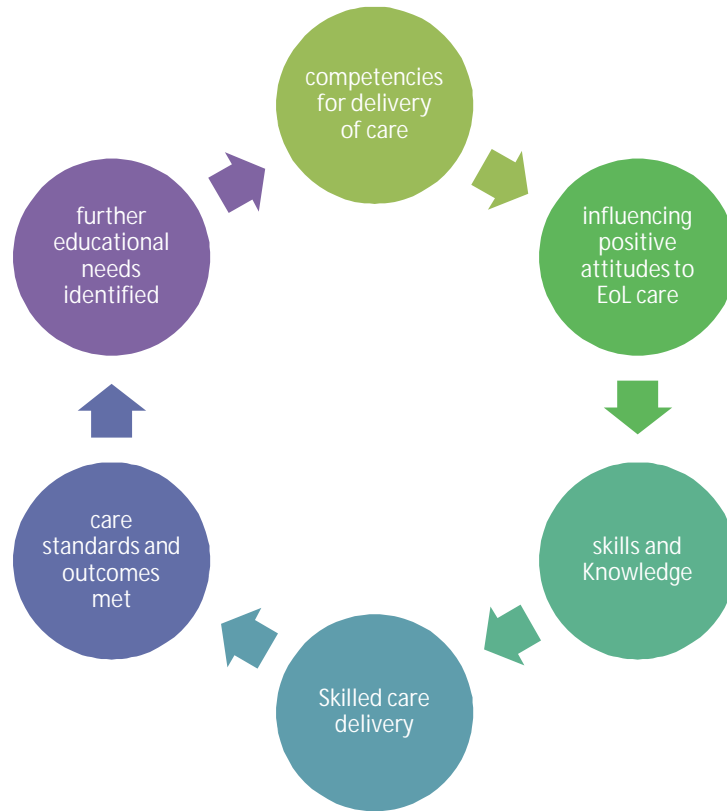
<p>Ambition 6 Each Community is prepared to help</p>	<p>I live in a community where everybody recognises that we all have a role to play in supporting each other in times of crisis and loss. People are ready, willing and confident to have conversations about living and dying well and to support each other in emotional and practical ways.</p>	
<p>What we know</p>	<p>We will achieve this through</p>	
<ul style="list-style-type: none"> • Dying, death and bereavement are not primarily health and social care events; they affect every aspect of people’s lives and experience • Dying and bereaved people often feel disconnected or isolated from their communities and networks of support • Despite some real progress and the growing reach and impact of the Dying Matters Coalition there remains a continued need to address and dissolve the taboo that many people feel when it comes to talking about dying, death and bereavement and facing up to their own mortality and that of the people important to them • There are ways to foster and support compassionate communities and to put end of life care at the heart of community health and wellbeing • Supporting and working with communities, to develop their capacity to play a significant role in supporting individuals and those important to them, at the end of life and through bereavement, can help achieve the best outcomes for those with pressing needs • Volunteers are a significant resource in creating good end 	<ul style="list-style-type: none"> ▪ Improved public awareness of the difficulties people face and creating a better understanding of what is available ▪ Developing new ways to give practical support, information and training that enables families, neighbours and community organisations to help e.g. websites, localised service directories, HIBLIO/HIVE resources, easy read leaflets ▪ Participating in and promoting the yearly “Dying Matters Campaign” ▪ Partnership working with national and local organisations who provide support ▪ Co-design - the people that know the most about what services should look like are those that are using them. Therefore all health and social care systems should involve people who have personal experience of death, dying and bereavement 	

<p>of life care and must be valued more highly and used more effectively</p>	
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Education and training model



Aims of end of life education and training across the healthcare community



Examples of Types of training

<p>Tier 1 Training</p>	<p><u>EOL care awareness training</u> Staff induction Dying matters awareness training How easy do people find it to talk about dying? YouTube film (Dying Matters) Dying matters awareness week focus across our health community</p>
<p>Tier 2 training</p>	<ul style="list-style-type: none"> ▪ Education to support communication, advance care planning, holistic assessment and care planning ▪ Understanding the principles of coordinated, patient centred discharge planning in end of life care (including CHC fast track applications) ▪ Understanding the needs of the dying patient and the principles of providing compassionate, patient centred care in the last days/hours of life (including symptom control) ▪ Understanding principles of compassionate care after death for the deceased patient and their family Examples include:- <ul style="list-style-type: none"> ❖ EOL Ambassadors Network training ❖ Syringe pump training ❖ Communication skills training ❖ Verification of expected death (VOED) ❖ Enhancing palliative care skills course (Rowcroft Hospice)
<p>Tier 3 training</p>	<p>Advanced communications skills Complex symptom control Non Medical Prescribing</p>

Modes of training delivery

- New starters training as part of induction
- EOL Ambassadors Network training
- Face to face sessions
- eLearning modules e.g. eELCA <https://www.e-lfh.org.uk/programmes/end-of-life-care/> and via the HIVE
- Information videos – local and national resources
- Podcasts

Outcome measures

- Each organisation to publish yearly training plan for each tier
- Individual organisations to report quarterly and yearly on education delivered by tier and to which staff groups
- Improved patient and family experience measured by public survey and review of complaints and other feedback about EOLC

Recording and reporting

How will training be recorded?	Each organisation to develop a plan
Who will be responsible for inputting these records?	Each organisation to develop a plan
Is there a requirement for compliance figures for this training to be reported? If so please state reason and relevant committee reported to.	<p>Yes quarterly</p> <ul style="list-style-type: none"> EOL Strategic Board reports
Specific % compliance target	Targets to be agreed

Delivery of training

Who will deliver the training?	<p>Agree for each organisation and each Tier</p> <p>Collaborative working via the cross community EOL education group</p>
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Appendix 1**Membership of Cross community End of Life Education Group**

End of Life Education Lead, Torbay & South Devon NHS Foundation Trust
End of Life Education Facilitator, Torbay & South Devon NHS Foundation Trust
GP Macmillan Cancer and Palliative Care Facilitator
Marie Curie Interim Practice Development Facilitator
Rowcroft End of Life Care Home Facilitator & Project Lead
Education Lead-Rowcroft Hospice
Consultant in Palliative Medicine, Rowcroft Hospice
CNS Hospital Palliative Care Team & Ambassadors project facilitator
Lead Cancer Nurse, Torbay & South Devon NHS Foundation Trust
Deputy Head of Education, Torbay & South Devon NHS Foundation Trust
Consultant in Palliative Medicine, Torbay & South Devon NHS Foundation Trust
Cancer Care Facilitator (Dorset, Devon & Somerset) SWAST
ADN, Torbay & South Devon NHS Foundation Trust
Service co-ordinator Palliative & End of Life Education & Training Team
Community CNS, Rowcroft Hospice
Clinical Nurse Manager, Marie Curie

Appendix 2

Template for organisations to map staff requiring training and levels of training (adapt to setting)

Target staff group	Number of staff in each group	Staff in each group requiring training	Level(s) required – please tick			
			1	2	3	other
Additional Prof Scientific and Technical E.g.pharmacist, optometrist, practitioner (theatre staff) and technician		Patient-facing				
		Non Patient-facing				
Additional Clinical Services E.g. HCA , health care support worker, helper/assistant and healthcare science assistant		Patient-facing				
		Non Patient-facing				
Administrative and Clerical E.g.clerical worker, manager, medical secretary , officer, GP practice receptionist and office staff		Patient-facing				
		Non Patient-facing				
Allied Health Professionals E.g.radiographer , physiotherapist, occupational therapist		Patient-facing				
		Non Patient-facing				
Estates and Ancillary E.g. housekeeper, porter , support worker		Patient-facing				
		Non Patient-facing				
Healthcare Scientists E.g.healthcare science practitioner, consultant healthcare scientist, healthcare scientist		Patient-facing				
		Non Patient-facing				
Medical and Dental		Non training grades				
		Training grades				
Nursing & Midwifery E.g. midwife matron, sister/charge nurse , staff nurse, practice nurse		Nursing				
		Midwifery				
Social care staff		Patient facing				
Total Substantive staff						

Appendix 3

What are the drivers that support the need for this learning

Legislation/guidance	Details (evidence)
<p>CQC</p>	<p>EOLC core service reviewed as part of CQC inspections. Requirements for staff education. Requirement to provide evidence of staff training in EOLC.</p>
<p>NICE Quality Standard</p>	<p>Staff supporting patients in the last days of life to have received training in EOLC. Health and social care workers have the knowledge, skills and attitudes necessary to be competent to provide high-quality care and support for people approaching the end of life and their families and carers.</p>
<p>National EOLC audit for hospitals</p>	<p>From 2017 the national EOLC audit for hospitals will be included in the national clinical audit programme and will be mandatory for all acute Trusts to complete.</p>
<p>Ambitions for palliative and end of life care (2015)</p>	<p>The national framework for EOLC identifies the requirement for frontline staff providing end of life care (support to patient in the last year of life) to have received training in EOLC.</p>
<p>Skills for Health – End of Life Core Skills Education and Training Framework http://www.skillsforhealth.org.uk/services/item/536-end-of-life-care-cstf-download</p>	<p>This national document sets out core competencies for staff providing support to patients with end of life care needs. These include:</p> <ul style="list-style-type: none"> ▪ Communication ▪ Assessment and care planning ▪ Symptom management, maintaining comfort and wellbeing ▪ Advance care planning

Devonwide EOLC Health Needs Assessment

Key recommendation is wider training in end of life care for staff across all sectors

3 Year Education Work Plan

Appendix 4

This work plan will form a working document and will be subject to regular review and updating via the cross community end of life education group.

Year	Tier	Priority area	Education delivered by	Mode of delivery (examples)	Staff groups/public
1 2019	1	Awareness of supporting people to plan ahead	All organisations	How easy do people find it to talk about dying? YouTube film End of life strategy film (ICO) Dying matters awareness events	All staff Public
	2	Staff being trained in supporting patients to plan ahead (Advance Care Planning) Identification of people approaching the end of their lives (last year and last few weeks) Legal issues related to people planning ahead (ACP)	All organisations	EOL Ambassadors training (includes care homes and care agencies) Enhancing Palliative Care Skills Course Brief intervention project	Trained staff

	3	<p>Resources for planning ahead (ACP)</p> <p>Enhancing communication skills for end of life care</p> <p>24/7 palliative care (including symptom management)</p> <p>Other essential EOL training:- VOED Syringe pump</p> <p>Non-cancer palliative care -Heart failure -Frailty</p> <p>Advanced communications skills training</p> <p>Advanced symptom control course</p> <p>Non-medical prescribing course</p>	External organisations	External course	Specialist palliative care staff
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2 2020	1	Continue Year 1 education	All organisations	As above	All staff Public
	2	Continue Year 1 education Provision of excellent end of life care -Recognition of dying -Individualised care planning -Symptom control -Anticipatory prescribing -Nutrition & hydration at EOL Non-cancer palliative care -COPD -Dementia EOL care for hard to reach groups			Trained staff
	3	As per Yr 1 depending on need			Specialist palliative care
3 2021	Review education plan in light of local				

	and national priorities May include carer education and bereavement education. Other hard to reach groups				
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Document Control Information

This is a controlled document and should not be altered in any way without the express permission of the author or their representative.

Please note this document is only valid from the date approved below, and checks should be made that it is the most up to date version available.

If printed, this document is only valid for the day of printing.

This guidance has been registered with the Trust. The interpretation and application of guidance will remain the responsibility of the individual clinician. If in doubt contact a senior colleague or expert. Caution is advised when using clinical guidance after the review date, or outside of the Trust.

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Date of issue:	20 November 2020	Next review date:	20 November 2023
Version:	2	Last review date:	
Author:	Consultant in Palliative Medicine		
Directorate:	Palliative Care		
Equality Impact:	The guidance contained in this document is intended to be inclusive for all patients within the clinical group specified, regardless of age, disability, gender, gender identity, sexual orientation, race and ethnicity & religion or belief		
Committee(s) approving the document:	End of Life Board		
Date approved:	18 November 2020		
Links or overlaps with other policies:			

Have you identified any issues on the Rapid (E)quality Impact Assessment. If so please detail on Rapid (E)QIA form.	Yes <input type="checkbox"/>	
	<i>Please select</i> Yes No	
Does this document have implications regarding the Care Act? <i>If yes please state:</i>	<input type="checkbox"/>	<input type="checkbox"/>
Does this document have training implications? <i>If yes please state:</i>	<input type="checkbox"/>	<input type="checkbox"/>
Does this document have financial implications? <i>If yes please state:</i>	<input type="checkbox"/>	<input type="checkbox"/>
Is this document a direct replacement for another? <i>If yes please state which documents are being replaced:</i>	<input type="checkbox"/>	<input type="checkbox"/>

Document Amendment History

Date	Version no.	Amendment summary	Ratified by:
15 June 2018	1	New	Workforce and OD Group
20 November 2020	2	Revised	End of Life Board

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 ICON.

<https://icon.torbayandsouthdevon.nhs.uk/areas/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.

Rapid (E)quality Impact Assessment (EqIA) (for use when writing policies)

Policy Title (and number)		Version and Date	
Policy Author			
An (e)quality impact assessment is a process designed to ensure that policies do not discriminate or disadvantage people whilst advancing equality. Consider the nature and extent of the impact, not the number of people affected.			
Who may be affected by this document?			
Patients/ Service Users <input type="checkbox"/>	Staff <input type="checkbox"/>	Other, please state...	<input type="checkbox"/>
Could the policy treat people from protected groups less favourably than the general population? PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below			
Age	Yes <input type="checkbox"/> No <input type="checkbox"/>	Gender Reassignment	Yes <input type="checkbox"/> No <input type="checkbox"/>
Race	Yes <input type="checkbox"/> No <input type="checkbox"/>	Disability	Yes <input type="checkbox"/> No <input type="checkbox"/>
Gender	Yes <input type="checkbox"/> No <input type="checkbox"/>	Pregnancy/Maternity	Yes <input type="checkbox"/> No <input type="checkbox"/>
Sexual Orientation			Yes <input type="checkbox"/> No <input type="checkbox"/>
Religion/Belief (non)			Yes <input type="checkbox"/> No <input type="checkbox"/>
Marriage/ Civil Partnership			Yes <input type="checkbox"/> No <input type="checkbox"/>
Is it likely that the policy could affect particular 'Inclusion Health' groups less favourably than the general population? (substance misuse; teenage mums; carers ¹ ; travellers ² ; homeless ³ ; convictions; social isolation ⁴ ; refugees)			Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>
Are the services outlined in the policy fully accessible ⁶ ?			Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>
Does the policy encourage individualised and person-centred care?			Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>
Could there be an adverse impact on an individual's independence or autonomy ⁷ ?			Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>
EXTERNAL FACTORS			
Is the policy a result of national legislation which cannot be modified in any way?			Yes <input type="checkbox"/> No <input type="checkbox"/>
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?			
Patients/ Service Users <input type="checkbox"/>	Trade Unions <input type="checkbox"/>	Protected Groups (including Trust Equality Groups)	<input type="checkbox"/>
Staff <input type="checkbox"/>	General Public <input type="checkbox"/>	Other, please state...	<input type="checkbox"/>
What were the recommendations/suggestions?			
Does this document require a service redesign or substantial amendments to an existing process? PLEASE NOTE: 'Yes' may trigger a full EIA, please refer to the equality leads below			Yes <input type="checkbox"/> No <input type="checkbox"/>
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 Devon CCG, please email d-ccg.equalityanddiversity@nhs.net & d-ccg.QEIA@nhs.net

For Torbay and South Devon NHS Trusts, please call 01803 656676 or email pdf.sdhct@nhs.net

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

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 is 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

Clinical and Non-Clinical Policies – Data Protection

Torbay and South Devon NHS Foundation Trust (TSDFT) has a commitment to ensure that all policies and procedures developed act in accordance with all relevant data protection regulations and guidance. This policy has been designed with the EU General Data Protection Regulation (GDPR) and Data Protection Act 2018 (DPA 18) in mind, and therefore provides the reader with assurance of effective information governance practice.

The UK data protection regime intends to strengthen and unify data protection for all persons; consequently, the rights of individuals have changed. It is assured that these rights have been considered throughout the development of this policy. Furthermore, data protection legislation requires that the Trust is open and transparent with its personal identifiable processing activities and this has a considerable effect on the way TSDFT holds, uses, and shares personal identifiable data.

Does this policy impact on how personal data is used, stored, shared or processed in your department? Yes No

If yes has been ticked above it is assured that you must complete a data mapping exercise and possibly a Data Protection Impact Assessment (DPIA). You can find more information on our [GDPR](#) page on ICON (intranet)

For more information:

- Contact the Data Access and Disclosure Office on dataprotection.tsdf@nhs.net,
- See TSDFT's [Data Protection & Access Policy](#),
- Visit our [Data Protection](#) site on the public internet.