The Newcastle Upon Tyne Hospitals NHS Foundation Trust

Clinical Practice Guidelines & Protocols Policy

<table>
<thead>
<tr>
<th>Version No.:</th>
<th>4.4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective From:</td>
<td>23 February 2017</td>
</tr>
<tr>
<td>Expiry Date:</td>
<td>23 February 2020</td>
</tr>
<tr>
<td>Date Ratified:</td>
<td>23 February 2017</td>
</tr>
<tr>
<td>Ratified By:</td>
<td>Clinical Effectiveness, Audit and Guidelines Committee</td>
</tr>
</tbody>
</table>

1 Introduction

This policy covers the standards and methods to be used in the development, ratification, review and dissemination of Clinical Practice Guidelines and Protocols within The Newcastle upon Tyne Hospitals NHS Foundation Trust. Clinical Practice Guidelines and Protocols should be in place in all Clinical Specialties for the most commonly used procedures.

2 Scope

This policy applies to all members of staff working within The Newcastle upon Tyne Hospitals NHS Foundation Trust who are involved in any aspect of developing or reviewing clinical guidelines and protocols. This document scope covers the development, approval and presentation of guidelines and protocols as defined in paragraph 5. This policy does not cover principles to be applied to the development of Trust policies and procedures, which are covered under the Policies and Procedural Documents: Development, Approval and Dissemination Policy.

3 Aim of the policy

The aim of this policy is to ensure an up to date, evidence-based set of Clinical Practice Guidelines and Protocols underpinning health care for patients of The Newcastle upon Tyne Hospitals NHS Foundation Trust. This aim will be achieved by means of:

- rigorous methods used in the development and ratification of evidence-based Clinical Practice Guidelines and Protocols
- process of endorsement of externally produced guidelines for use within the Trust
- processes to identify duplications and/or gaps in the set of Clinical Practice Guidelines and Protocols and to address those duplications/gaps
- a review process carried out on a regular basis using a common standard for appraisal
- version control and archiving arrangements
- Clinical Audit driven by Clinical Practice Guidelines and Protocols.
4 Duties – Roles and Responsibilities

4.1 Clinical Governance and Quality Committee

The Clinical Governance and Quality Committee has ultimate responsibility for ensuring effective, evidence-based practice is promoted within the Trust underpinned by robust clinical guidelines and protocols.

4.2 Clinical Effectiveness, Audit and Guidelines Committee

The Clinical Effectiveness, Audit and Guidelines Committee has delegated responsibility for ensuring effective, evidence-based practice is promoted within the Trust, by monitoring the processes for developing, reviewing and archiving clinical guidelines and protocols.

4.3 Clinical Governance and Risk Department (CGARD)

- CGARD has delegated responsibility for ensuring an effective, robust system is in place for the review and publication of all clinical guidelines and protocols within the Trust.
- CGARD also has responsibility for the archiving of guidelines and protocol documents within the organisation.
- The Clinical Effectiveness Manager within the Department has overall responsibility for the content of the clinical guidelines database on the Intranet. This includes the ongoing development, management and administration of the database.

4.4 Trust Committees

Trust Committees with responsibility for clinical practice are responsible for carrying out the approval of guidelines and protocols that fall within their remit, according to the processes outlined in this policy.

4.5 Clinical Directors

Clinical Directors are responsible for ensuring that there is a robust system in place within their Directorate for the approval of guidelines and protocols that fall entirely within their remit, according to the processes outlined in this policy, although the actual processes may be delegated to appropriate specialists / professions within the Directorate, or to the Directorate Clinical Governance Lead.

4.6 Guideline/Protocol Authors

- The author retains ownership through development, consultation, approval and ratification processes. Responsibility for monitoring and review of the guideline/protocol remains with the author after release of the final version to the Clinical Effectiveness Manager, CGARD.
• The author of the guideline/protocol must check that the proposed new guideline subject is not already covered by an existing policy document or guideline, or could not easily be incorporated into an existing policy document or guideline.

• The author of the guideline/protocol must ensure that the guideline/protocol is written in the agreed Trust format (see Appendix 1).

• The author must ensure that appropriate consultation with expert individuals or groups must take place, to ensure accuracy and adherence with existing Trust procedures and current evidence based practice.

• When notified that a guideline/protocol for which they are responsible is approaching or past its review deadline, it is the responsibility of the author to instigate a review process and update the guideline/protocol as necessary.

4.7 Wards and Departments

• It is the responsibility of all wards and departments to make staff aware that new or amended guidelines and protocols relevant to their area are available in response to the update notification from CGARD.

• Paper copies of Trust guidelines and protocols are discouraged, but if wards and departments do keep such copies there must be systems in place to keep these updated and it must be acknowledged that the definitive version is that displayed on the Intranet site.

• All new staff should be made aware of how to find and use Trust relevant guidelines during their induction programme as outlined in the Induction Policy.

4.8 All Staff

All staff within The Newcastle upon Tyne Hospitals NHS Foundation Trust are responsible for ensuring that the principles outlined within this policy are universally applied and that they familiarise themselves with all guidelines and protocols relevant to their area of work.

5 Definitions

5.1 Policy

• A policy enables management and staff to make correct decisions; deal effectively with and comply with relevant legislation, regulations, organisational rules and good practice.

• A policy document should be regarded as mandatory, with deviation only in exceptional circumstances, as it sets out a course of action which the Trust expects to be followed.

• Trust policies have been formulated and developed to guide staff in their
work ensuring their protection and that of service users, in order to
minimise risk and maximise safety for all concerned.

5.2 Procedure

A set of detailed step by step instructions that describe the appropriate
method for carrying out tasks or activities to achieve the highest standards
possible and to ensure efficiency, consistency and safety.

5.3 Protocols

Protocols are rigid statements allowing little or no flexibility or variation. A
protocol sets out a precise sequence of activities to be adhered to in the
management of a specific clinical condition.

5.4 Guidelines

- Clinical guidelines are systemically developed statements that assist
clinicians and patients in making decisions about appropriate treatments
for specific conditions.
- They allow deviation from a prescribed pathway according to the
individual circumstances and where reasons can be clearly demonstrated
and documented.
- “Endorsed” guidelines are, by definition, those which practitioners are
encouraged to follow.

6 The Development and Ratification of Clinical Guidelines and Protocols

6.1 Development of local guidelines and protocols

The development of guidelines and protocols by Trust staff for use across
the Trust and/or specified Directorates needs to be undertaken following a
process which ensures that the guidance is of a high standard and evidence
based.

The development and ratification of new internal guidelines and protocols
must follow the procedures set out in Appendix 2 and guidelines must be
written in the format and containing the minimum content as at Appendix 1.
This involves a process of review by the appropriate specialists within the
Trust and final ratification by the Clinical Director (or their nominated
delegate), Lead Clinician or Chairman of the appropriate committee.

6.2 Review of local guidelines and protocols

When an internally produced guideline/protocol is due to be reviewed, to
ensure that it still contains an accurate evidence base, the processes
outlined in Appendix 3 should be followed. When the guideline/protocol has
completed the review process, it will be displayed on the intranet with the
date reflecting any recent review of content and the current status of the
document.
As each existing internal guideline/protocol comes up for review it is appraised and revised accordingly, if necessary, starting with the formation of a multi-disciplinary team and a literature search and again requiring final ratification by the appropriate Clinical Director (or their nominated delegate), Lead Clinician or Chairman of the appropriate committee.

6.3 **Endorsement of new External Guidelines and Protocols**

Guidelines and protocols which are published by bodies including NICE and professional colleges also need to ratified by Trust clinicians to ensure that they are clinically effective and safe for use within our organisation. Externally produced guidelines undergo a process of endorsement which is outlined in Appendix 4.

6.4 **Publication of Clinical Practice Guidelines and Protocols**

Both internally and externally produced guidelines and protocols which have been ratified for use within the Trust are displayed on the Clinical Guidelines database on the intranet and available to staff. The intranet display includes the date of publication and whether it is an internally or externally produced document which is endorsed for use or for reference only.


Revisions to the Clinical Guidelines Database are published quarterly in a Newsletter to all Clinical Directorates; the Newsletter is also placed on the Intranet.


6.5 **Control of Clinical Guidelines and Archiving**

The Clinical Guidelines database follows the precedent set by the Trust Policies database in that the Intranet version, rather than the paper document, is the definitive version of an internal guideline/protocol document and this version should therefore be used in clinical practice.

Each guideline should contain the effective from date and review date to ensure that the latest version is published and this will be held on the database for each guideline.

The Clinical Guidelines database also holds an archive of all guidelines/protocols produced internally. As each guideline/protocol is superseded the previous version is archived within the guidelines database and can therefore be retrieved for reference as required.

In order to ensure that internal guidelines are up to date the standard review
period will be between one and three years, **any internal guideline more than 6 months past its review date may be archived off the database**; it can of course be reinstated if and when the review process is completed.

The Clinical Effectiveness Manager will make sure that copies of earlier versions of all guidelines and protocols are archived and subsequently deleted in line with the [Corporate Records Policy](#).

### 6.6 Annual Review

Directorates are responsible for the annual review of their guidelines/protocols to identify gaps, inconsistencies and duplications. Monitoring and review of this process is undertaken by the Clinical Effectiveness, Audit and Guidelines Committee (CEAGC) and each Audit Lead will report annually to this group on the effectiveness of the process within their Directorate. Guidelines which affect multiple Directorates need to be reviewed by the relevant committee(s).

### 6.7 Clinical Audit

Compliance with endorsed guidelines is determined by the Clinical Audit of guidelines and procedures. Each Directorate draws up an annual plan showing the audits to be carried out and their priority, incorporating any applicable national audits, in accordance with the [Trust's Clinical Audit Policy](#).

### 7 Training

Appropriate staff within CGARD will be trained on this policy and the management of the Clinical Guidelines database.

An on-line training package is available on the intranet in the use of the guidelines/protocols intranet site, and number of resources are also available on the development, appraisal and implementation of clinical guidance.

No other formal training is required in relation to the policy. Staff are advised to contact the Clinical Effectiveness Manager for advice in relation to guideline / protocol development.

### 8 Equality and diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. This policy has been appropriately assessed.

### 9 Monitoring the compliance/effectiveness of this policy

Monitoring compliance with this policy will be the responsibility of the Clinical Effectiveness Manager. This will be undertaken by:
<table>
<thead>
<tr>
<th>Standard / process issue</th>
<th>Monitoring and audit</th>
<th>Committee</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance with Trust guidelines format including: Compliance with;</td>
<td>Assessing all new and reviewed guidelines against the</td>
<td>The Clinical Effectiveness Manager</td>
<td>CEAGC</td>
</tr>
<tr>
<td>• Style and format</td>
<td>agreed format before updating the guidelines database</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Structure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compliance with review process</td>
<td>Monitoring of database with preparation of a status report</td>
<td>The Clinical Effectiveness Manager</td>
<td>CEAGC</td>
</tr>
<tr>
<td></td>
<td>on guideline reviews</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compliance with the requirement to have robust systems in place within</td>
<td>Included in Annual Audit Report</td>
<td>Directorate Clinical Audit Leads</td>
<td>CEAGC</td>
</tr>
<tr>
<td>Directorates for the development and review of clinical guidelines</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compliance with requirement to complete Review Forms for all new and revised guidelines</td>
<td>Audit of new and revised guidelines and protocols during</td>
<td>The Clinical Effectiveness Manager</td>
<td>CEAGC</td>
</tr>
<tr>
<td>and protocols</td>
<td>the year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compliance with the requirement to archive old versions of guidelines and protocols</td>
<td>Audit of archived files</td>
<td>The Clinical Effectiveness Manager</td>
<td>CEAGC</td>
</tr>
</tbody>
</table>

10 Consultation and review of this policy

This policy has been reviewed in consultation with the Clinical Effectiveness Manager, the Quality and Clinical Effectiveness Manager, and the Director of Quality and Clinical Effectiveness.

This policy will be reviewed every three years by the Clinical Effectiveness, Audit and Guidelines Committee (CEAGC). Any comments are to be addressed to the Information Systems Analyst.
11 Implementation of policy (including raising awareness)

This policy will be publicised by the Clinical Effectiveness Manager in the Trust Policy Newsletter and published on the Trust Intranet. **All guidelines will be reviewed in light of this policy and rewritten, where required, to conform to the layout and content requirements stipulated.**

12 References


13 Associated documentation

This policy relates to all clinical guidelines and protocols within the organisation. See also the:

- [Clinical Audit Policy](#)
- [Implementation of NICE Guidelines Policy](#)
- [Corporate Records Policy](#)
- [Policies and Procedural Documents: Development, Approval and Dissemination Policy](#)
Appendix 1 – Format of Guideline Documents

The guideline should be produced in a clear, accessible format (which accommodates the need for viewing electronically as well as from hard copy); **local Guidelines should follow the layout format as set out below.**

The Newcastle upon Tyne Hospitals NHS Foundation Trust

**Guideline Title**

<table>
<thead>
<tr>
<th>Version No.:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective From:</td>
<td>Full date (e.g. 1 July 2014)</td>
</tr>
<tr>
<td>Expiry Date:</td>
<td>Full date (e.g. 1 July 2014)</td>
</tr>
<tr>
<td>Date Ratified:</td>
<td>Full date (e.g. 1 July 2014)</td>
</tr>
<tr>
<td>Ratified By:</td>
<td>Owning Trust Committee/Clinical Director/Lead Clinician</td>
</tr>
</tbody>
</table>

1 **Introduction**

2 **Guideline scope**

For example, which patient cohort this does (or does not) apply to, the audience for whom it is intended.

3 **Main Body of the guideline**

4 **Training, Implementation, Resource Implications**

5 **Monitoring Section**

This should include what will be monitored, i.e. the content of the audit, who will gather this information, which group it will be presented to and the frequency at which this will occur, e.g.

“The organisation continually strives to achieve 100% compliance with this guideline and its intended outcomes. Where this is not met an action plan will be formulated and reviewed until completion. Please see the table below for standards and monitoring arrangements:”
<table>
<thead>
<tr>
<th>Standards</th>
<th>Monitoring and audit</th>
<th>By</th>
<th>Group / Committee</th>
<th>Frequency</th>
</tr>
</thead>
</table>
| This should be the steps that you have described in the process part of the guideline for example:  
*All inpatients will receive an initial* | This is how are you going to monitor this, for example:  
- *Snapshot random audit*  
- *Quality assurance audit* | Who will undertake the monitoring:  
Infant feeding lead | Who has overall accountability:  
*CGQ* | How often are these carried out:  
- *at least monthly*  
- *quarterly* |
| *NEWS score within an hour of admission* | | | | |
| Once you have pulled all the standards out of the guideline you then need to put in your outcome standards, for example:  
*Reduction in the rate of unexpected cardiac arrests* | Outcomes may be monitored differently for example:  
- *Review of all incidents of unexpected cardiac arrests*  
- *Review of rates and reasons of cardiac arrests* | As above | As above | If this is a review of incidents or complaints etc it should be continuous  
- *Continuously*  
- *Annually* |

The audit tool should be included as an appendix to the guideline.

6 Evidence Review and Evaluation

7 References

All guidelines must consider any new or revised external reports or guidance and reference must be made to NICE guidance in particular where this is applicable.
Appendix 1.2  Protocol Minimum Data Set

Local Protocols do not have a prescribed layout but should contain the minimum dataset of:

- title,
- **scope and purpose** (i.e. the overall aim of the guidance, the specific clinical questions and the target population),
- **evidence base, references and recommendations**, (it is acknowledged that in some circumstances there may be no evidence base for Protocols),
- **authorship / membership** of the development group,
- **date** of publication and **review date**,
- points for audit,

and in addition they may include,

- points for further research/discussion,
- development method employed (including literature search),
- resource requirements.
Appendix 1.3   General Principles for Writing Guidelines/Protocols

1. Guidelines are to be produced to a standard format as outlined in Appendix 1.1

2. The intended audience should be targeted and it should be ensured that anyone who reads the document will be able to understand it.

3. The information should be presented in a logical, sequential order.

4. The content of each guideline/protocol should comply with all relevant legal and statutory requirements, NHS guidance and policy in force at the time of writing or review and should reflect evidence based best practice.

5. Consider what relevant guideline/protocols documents already exist in the Trust and cross-reference where appropriate to avoid duplication.

6. A summary or introduction at the beginning of each guideline/protocol outlining the aims of the guideline/protocol and its application should be included.

7. The possibility of patient groups being involved in the production of policy/procedure should be considered.

8. Ensure that what is proposed does not make it impossible or unreasonably difficult for people to make use of any service that is being proposed or provided due to their age, gender, disability, language or race. The needs of people from diverse cultural or religious groups and general health and safety issues are to be considered.

9. Be aware that under the Freedom of Information Act there may be open access to your document by the general public.

10. Be aware that the guideline/protocol document will be viewed electronically and good practice to view in this format is:
    
    - Do not have a series of cover pages, contents lists and/or blank pages at the beginning of the document, which takes a while to load up and click past before the user gets the heart of the documents message.
    
    - Include appropriate references, acknowledgements and any appendices at the end of the document.

All Trust guidelines/protocols should:

- be written in Arial 12;
- be justified to the left;
- include page numbers in the footer of the document in the format Page x of y;
- use plain English with explanations of acronyms (go to http://www.plainenglish.co.uk/files/howto.pdf for a guide to plain English);
- use flow diagrams where possible; and
• Avoid the use of block capitals. Block capitals make the text difficult to read because the shapes of words disappear, causing the reader to slow down and study each letter. Ironically, readers tend to skip sentences written in all uppercase.
• To highlight information and maintain readability, use bold or italic text.
• Avoid underlining text for emphasis (in online documents underlining implies a hypertext link)
• Hypertext links should be underlined and in blue
• Capital letters should be used for referring to formal or specific committees, e.g. Patient, Quality, Risk and Safety Committee. This also applies to the title of individuals, e.g. Director of Finance and Information. Lower case letters should be used for generic reference, e.g. divisional managers, executive directors.
Appendix 2

Procedure for Developing Internal Guidelines and Protocols

The following methodology is to be used for the development of new internal guidelines:

- a check is carried out that appropriate organisations are not in the process of developing such a guideline;
- a multidisciplinary team (MDT) is set up with clearly delineated scope and responsibilities, incorporating representation from patients where necessary;
- a comprehensive literature search is carried out (involving a librarian if necessary);
- the guideline is evaluated by a peer review group, in a small minority of situations, an external peer review may be appropriate;
- the guideline is generally piloted before final approval and general dissemination;
- dissemination of the guideline should include a plan for implementation, including specific training requirements, resource requirements and timescales.
- following the process of peer review by the appropriate specialist(s) and interested bodies, the final approval sign off should be by the Clinical Director or his/her nominee.

New resources

Where guidelines require new resources the guideline will need to be referred to the appropriate body with sufficient authority to sanction the new resources.
Procedure for Developing Internal Guidelines and Protocols

1. New Clinical Practice Guideline to be developed
2. Scope & Terms of Reference defined
3. MDT set up, any experts/specialists co-opted
4. Literature search carried out
5. Analysis of evidence and current practice

Guideline revised by MDT

Content of Clinical Practice Guideline drawn up and sent for review*

Accepted?

Yes

Review date agreed

Clinical Practice Guideline published and sent with Review Form/Email to CGARD

Clinical Guidelines Database updated by CGARD

* Depending on the nature of the guideline patient representatives, specialists, or reviewers from neighbouring hospitals (for instance where procedures for shared care are concerned) may be invited to review the guideline.
Procedure for the Review of Internal Guidelines

The normal path for review and endorsement of Clinical Practice Guidelines is via a multi-disciplinary Review Team within each Directorate. This consists of a process of peer review by the appropriate specialist(s) and interested bodies, with final sign off by the Clinical Director or his/her nominee (see flow diagram below).

Where a guideline is to be used for shared care with another NHS Trust then the appropriate representative(s) from that Trust should be included in the review process. Likewise, where there are areas that involve patients (e.g. discussion of visitors’ facilities) then patient and visitor representatives should be consulted.

Two to three months before the review date falls due the Clinical Governance and Risk Department (CGARD) sends an Internal Clinical Guidelines Review Form to the relevant Directorate requesting review of the guideline. The Directorate decides whether any specialists or external personnel need to be involved in the review, depending on the nature of the guideline. One person is designated as the “lead” to oversee the review process. The guideline is amended where necessary in the light of recent research, to reflect changes in local practice, learning from experience and changes in fine detail, e.g. changes to contact details.

The guideline is then be circulated to the reviewers, if the guideline is accepted by the reviewers the review form is completed accordingly including the future review date and returned to CGARD, together with the revised guideline, to update the database. If the reviewers require further changes, the guideline is amended and re-submitted for review until accepted. On occasion a guideline may be considered too out of date or redundant and CGARD will be asked to archive the guideline off the database. (Archived guidelines can still be accessed by CGARD).

If the results of a review are not returned within two months a reminder is sent out by the CGARD and further reminders every month thereafter.

The normal path for review and endorsement of Clinical Practice Guidelines that fall outside the remit of an individual Directorate and apply to a service crossing many Directorates, e.g. Critical Care, is via a multi-disciplinary Review Team across multiple Directorates incorporating peer review by the appropriate specialists and interested bodies, with final sign off by the lead clinician for that speciality, e.g. Chair of Critical Care Executive or the Clinical Director. Where guidelines need to be reviewed by standing Committees, e.g. Medicines Management Committee, etc., the groups involved should be authorised by the Clinical Governance and Quality Committee to review and endorse Clinical Practice Guidelines.

Expiry of internal guidelines

In order to ensure that internal guidelines are up to date the standard review period will be between one and three years, any internal guideline more than 6 months past its review date may be archived off the database; it can of course be reinstated if and when the review process is completed.
Procedure for Review of Internal Guidelines

1. Internal Clinical Practice Guideline due for Review
2. CGARD sends Review request to Reviewer
3. Reviewer carries out analysis of evidence and current practice
4. Content of guideline revised (if necessary) & sent for comment*
   - *Depending on the nature of the guideline patient representatives, specialists, or reviewers from neighbouring hospitals (for instance where procedures for shared care are concerned) may be invited to review the guideline.
5. Clinical Practice Guideline reviewed
6. Accepted?
   - Yes: Next review date agreed
   - No, major concerns: Mark Review as "Archive"
7. Clinical Practice Guideline published and sent with Review Form to CGARD
8. Clinical Guidelines Database updated by CGARD

---

Page 17 of 19
Appendix 4

Procedure for the Endorsement of External Guidelines

Process

External guidelines are generally only reviewed as they are received in the Trust, to determine whether or not they are endorsed for use within the Trust. A guideline can either be endorsed, left as “for reference only”, or be archived off the database. The funding of Technology Appraisal Guidelines (TAGs) developed by the National Institute for Health and Care Excellence (NICE) is mandatory for all NHS Trusts within three months of publication; therefore, the review of TAGs should be completed within three months of publication (see NICE Guidelines Implementation Policy).

If a guideline is endorsed but some local variation in implementation needs to be documented this would necessitate the drawing up of an internal guideline to be linked to the external guideline on the database.

New resources

Where guidelines require new resources the guideline will need to be referred to the appropriate body with sufficient authority to sanction the new resources.
External Clinical Practice Guideline for Review

CGARD sends Review to appropriate clinical team

Lead clinician identified

Send to *reviewers for comments

Clinical Practice Guideline reviewed

*Depending on the nature of the guideline patient representatives, specialists, or reviewers from neighbouring Trusts (for instance where procedures for shared care are concerned) may be invited to review the guideline.

Accepted?  Yes  No, major concerns

Mark Review as "Archive"

No, minor issues

Mark Review as "Endorsed"

Mark Review as "Reference Only"

Send Review Form/Email to CGARD

Clinical Guidelines Database updated by CGARD
The Newcastle upon Tyne Hospitals NHS Foundation Trust

Equality Analysis  Form A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

PART 1

1. Assessment Date: 12/02/2017

2. Name of policy / strategy / service:
   Clinical Practice Guidelines & Protocols Policy

3. Name and designation of Author:
   Bernadette Risebury

4. Names & designations of those involved in the impact analysis screening process:
   Bernadette Risebury, Information Systems Analyst

5. Is this a: Policy [x] Strategy [ ] Service [ ]
   Is this: New [ ] Revised [x]
   Who is affected: Employees [x] Service Users [ ] Wider Community [ ]

6. What are the main aims, objectives of the policy, strategy, or service and the intended outcomes? (These can be cut and pasted from your policy)
   This policy covers the standards and methods to be used in the development, ratification, review and dissemination of Clinical Practice Guidelines and Protocols within The Newcastle upon Tyne Hospitals NHS Foundation Trust. Clinical Practice Guidelines and Protocols should be in place in all Clinical Specialties for the most commonly used procedures.

7. Does this policy, strategy, or service have any equality implications? Yes [ ] No [x]
   If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:
8. Summary of evidence related to protected characteristics

<table>
<thead>
<tr>
<th>Protected Characteristic</th>
<th>Evidence, i.e. What evidence do you have that the Trust is meeting the needs of people in various protected Groups</th>
<th>Does evidence/engagement highlight areas of direct or indirect discrimination? If yes describe steps to be taken to address (by whom, completion date and review date)</th>
<th>Does the evidence highlight any areas to advance opportunities or foster good relations. If yes what steps will be taken? (by whom, completion date and review date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race / Ethnic origin (including gypsies and travellers)</td>
<td>The policy asks for all guideline authors to involve relevant patient groups wherever applicable/appropriate when developing and reviewing guidelines</td>
<td>This policy relates to clinical procedures</td>
<td></td>
</tr>
<tr>
<td>Sex (male/ female)</td>
<td>As above</td>
<td>As above</td>
<td></td>
</tr>
<tr>
<td>Religion and Belief</td>
<td>As above</td>
<td>As above</td>
<td></td>
</tr>
<tr>
<td>Sexual orientation including lesbian, gay and bisexual people</td>
<td>As above</td>
<td>As above</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>As above</td>
<td>As above</td>
<td></td>
</tr>
<tr>
<td>Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section</td>
<td>As above</td>
<td>As above</td>
<td></td>
</tr>
<tr>
<td>Gender Re-assignment</td>
<td>As above</td>
<td>As above</td>
<td></td>
</tr>
<tr>
<td>Marriage and Civil Partnership</td>
<td>As above</td>
<td>As above</td>
<td></td>
</tr>
<tr>
<td>Maternity / Pregnancy</td>
<td>As above</td>
<td>As above</td>
<td></td>
</tr>
</tbody>
</table>

9. Are there any gaps in the evidence outlined above? If ‘yes’ how will these be rectified?

No

10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.

Do you require further engagement? Yes [ ] No [x]

11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?)

No
PART 2

Name: Bernadette Risebury

Date of completion: 12/02/2017

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)