Policy:

MD 019 - Implementation of NICE Guidance

Executive Director lead	Medical Director
Policy Owner	Head of Clinical Governance
Policy Author	Clinical Effectiveness Manager

Document type	Policy
Document version number	5
Date of approval	27/04/2020
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Summary of policy Provide a summary description of the policy

Target audience	Senior Management & Clinical Directors

Keywords	NICE, guidance, quality, standards

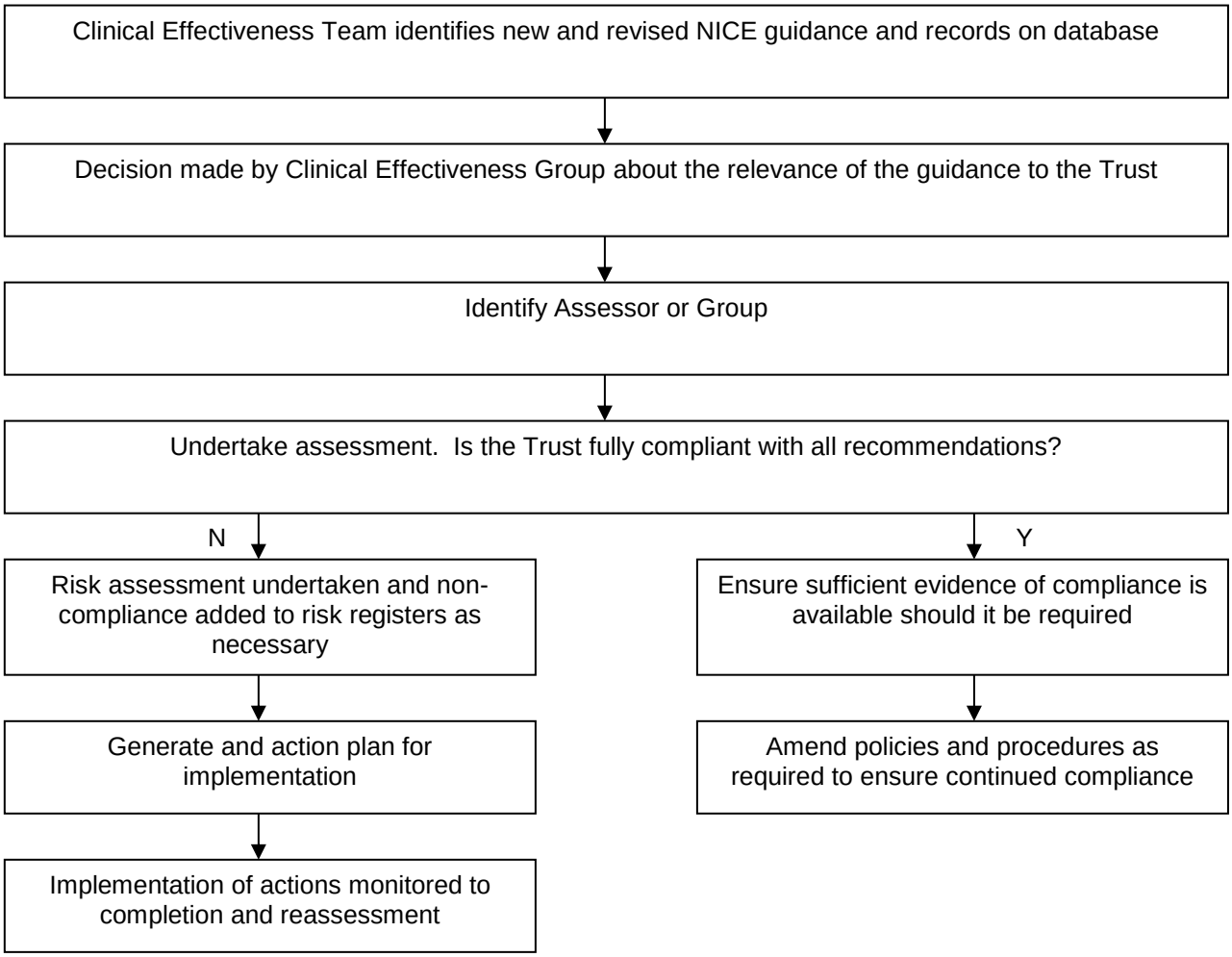
Storage Version 5 of this policy is stored and available through the SHSC intranet/internet. This version of the policy supersedes the previous version (V4 November 2016). Any copies of the previous policy held separately should be destroyed and replaced with this version.

Version Control and Amendment Log

Version No.	Type of Change	Date	Description of change(s)
4	Revision following Internal Audit review	Nov 2016	Further detail included on the specifics of the process, responsibilities and reporting/monitoring.
5	Review on expiry of policy	Feb 2020	Updates to some processes and job roles to bring policy up to date

Contents

Flowchart


Clinical Effectiveness Team identifies new and revised NICE guidance and records on database
Decision made by Clinical Effectiveness Group about the relevance of the guidance to the Trust
Identify Assessor or Group
Undertake assessment. Is the Trust fully compliant with all recommendations?
N
Y
Risk assessment undertaken and non-compliance added to risk registers as necessary
Generate and action plan for implementation
Implementation of actions monitored to completion and reassessment
Ensure sufficient evidence of compliance is available should it be required
Amend policies and procedures as required to ensure continued compliance

1 Introduction

National Institute of Health and Care Excellence (NICE) (https://www.nice.org.uk) recommendations are based on independent reviews of evidence for clinical and cost effectiveness of interventions. Once NICE guidance is published health professionals, commissioners and organisations are expected to take the guidance fully into account when deciding what services, treatments or advice to offer to service users and carers.

Implementing NICE guidance offers benefits to patients and carers, healthcare professionals and organisations. A clear process for the management of NICE guidance helps ensure that the care provided to patients is high quality and cost effective. It also helps organisations to meet standards set by the Care Quality Commission.

2 Scope

This policy is intended for all Trust staff involved with the implementation of NICE guidance. It should be read in conjunction with the Clinical Audit Policy. The policy covers all guidance issued by NICE.

This policy also applies to staff that work in Sheffield Health and Social Care NHS Foundation Trust services but are not employed by the Trust, including students, trainees, locum or temporary staff and staff on honorary contracts. Where staff employed by the Trust work in services provided by other organisations they have a duty to follow the policies of the organisation they are working in, and comply with their processes for NICE implementation.

3 Purpose

This policy describes how NICE guidance is identified, disseminated, assessed and implemented within Sheffield Health and Social Care NHS Foundation Trust (SHSC).

4 Definitions

Best practice - A best practice is a technique or methodology that, through experience and research, has proven to reliably lead to a desired result. A commitment to using the best practices in any field is a commitment to using all the knowledge and technology at one's disposal to ensure success.

NICE Guidance – NICE Guidance covers the following classifications (as per the NICE website):

Diagnostics guidance	Focus on the evaluation of innovative medical diagnostic technologies in order to ensure that the NHS is able to adopt clinically and cost effective technologies more rapidly and consistently.
Highly specialised technologies guidance	Contain recommendations on the use of highly specialised technologies.
Interventional procedures guidance	These recommend whether interventional procedures - such as laser treatments for eye problems or deep brain stimulation for

		chronic pain - are effective and safe enough for use in the NHS.
Medical technologies guidance		Focus specifically on the evaluation of innovative medical technologies (including devices and diagnostics).
NICE guidelines From January 2015 all guidance previously released under the headings to the right are being classified as NICE guidelines (NG)	cancer service guidelines,	The focus is to guide the commissioning of services and is therefore different from clinical practice guidelines. Based upon the implementation of the NHS Cancer Plan
	clinical guidelines	Provide guidance on the appropriate treatment and care of patients with specific disease and conditions.
	medicines practice guidelines	Provide recommendations for good practice for those individuals and organisations involved in governing, commissioning, prescribing and decision-making about medicines. They have a wide range of audiences across both health and social care.
	public health guidelines	Make recommendations for populations and individuals on activities, policies and strategies that can help prevent disease or improve health.
	safe staffing guidelines	Following the Report of the Francis Inquiry and the Berwick Review into Patient Safety, NICE produced 2 guidelines on safe staffing capacity and capability in the NHS. From June 2015 NHS England will take forward staffing work as part of a wider programme of service improvement.
	social care guidelines	Aim to improve outcomes for people who use social care support by ensuring that social care services and interventions are effective and cost-efficient.
Quality Standards		Quality Standards are a set of specific, concise statements that act as markers of high-quality, cost-effective patient care, covering the treatment and prevention of different diseases and conditions.
Technology Appraisal guidance		Technology Appraisals provide guidance on the use of new and existing medicines, treatments and procedures within the National Health Service (NHS) These follow a slightly different process for assessment and implementation within the Trust to the other NICE Guidance listed above and therefore at the end of each sub-section in section 6 a separate italicised statement has been made in relation to TAs.

5 Details of the policy

This policy describes how NICE guidance is identified, disseminated, assessed and implemented within Sheffield Health and Social Care NHS Foundation Trust (SHSC).

The procedure described in Section 7 is to be followed by all staff involved in the implementation of NICE guidance. Duties are set out in Section 6. The Clinical Effectiveness Group provides oversight of the implementation and monitoring of NICE guidance

6 Duties

Individual/Group	Duties
Chief Executive	The Chief Executive has ultimate responsibility for the quality of care and treatment and clinical effectiveness within the Trust, as well as the content of all policies and procedures and their implementation and review.
Medical Director	The Medical Director has lead executive responsibility for NICE Guidance implementation in the Trust and acts as a champion for NICE and evidence-based best practice. The Medical Director is responsible for providing assurance to the Board that an effective system exists to disseminate, implement and monitor compliance with NICE guidance. The Medical Director Chairs the Clinical Effectiveness Group (or may delegate this responsibility).
Associate Clinical Director	Providing support and assistance to the Medical Director in respect of the NICE Guidance implementation process. Chairs the Clinical Effectiveness Group (delegated authority from Medical Director).
Quality Assurance Committee (QAC)	Receives assurance reports related to NICE Implementation and Audit activity from EDG as necessary and offers assurance to the Trust Board of Directors.
Executive Directors Group (EDG)	The Executive Directors Group is responsible for ensuring good quality care is delivered and best practice is followed by the staff within the directorates, teams and services and professional groups they manage. The EDG receives quarterly reports from the Clinical Effectiveness Group. Provides assurance to Quality Assurance Committee as required.
Clinical Effectiveness Group (CEG)	Oversight and monitoring of NICE activity. Provides a quarterly report to the Executive Directors Group (EDG) on NICE assessments and related activity, and whether the process outlined in this policy is being followed. All Clinical Directors will be members of the CEG or included on the distribution list of the CEG.
NICE guidance assessors and chairs of Lead Groups	Work with the Clinical Effectiveness Team to co-ordinate completion of relevant assessments. Identify individuals to act as assessors. Work with the Clinical Effectiveness Team to ensure an action plan is produced and submitted to CEG. Undertake ongoing monitoring of implementation of action plans where appropriate.

Medicines Management Committee	Acts as Lead Group for all Technology Appraisal Guidance, unless otherwise notified to CEG (where the guidance does not concern medication).
Clinical and Professional Directors	Clinical and Professional Directors are responsible for ensuring NICE and other best practice guidance is disseminated to and implemented as much as possible by the health and social care staff they manage. Clinical and Professional Directors are expected to act as champions for NICE and evidence-based best practice within their directorates. Ensure all relevant staff are notified of any NICE guidance which they need to consider (this may be limited to individuals responsible for writing policies/procedures or guidelines for staff). All Clinical and Professional Directors will be members of the CEG or included on the distribution list of the CEG.
Head of Clinical Governance	The Head of Clinical Governance is responsible for overseeing the work of the Clinical Effectiveness Team and ensuring they provide the support needed for the implementation of NICE guidance.
Clinical Effectiveness Team	Day to day management of the NICE implementation and assurance process. Maintain the NICE database. Working with the Chairs of the Lead Groups to co-ordinate completion of assessments and action plans. Monitor and report the progress of all NICE implementation activity through monthly reports to CEG and quarterly reports to EDG and the Commissioners. Co-ordinating the inclusion of compliance with NICE guidance into clinical audits being undertaken or facilitating bespoke clinical audits where necessary.
Policy Authors	When reviewing existing policies and procedures, or writing new ones, authors are responsible for ensuring that relevant NICE Guidance recommendations are incorporated and that these documents describe a “NICE Compliant” service.
All staff providing care and treatment	All staff providing care and treatment have a fundamental responsibility to provide care and treatment that is safe and effective. They must therefore comply with Trust policies and procedures, which will incorporate NICE guidance where applicable.

7 Procedure

7.1 Identifying new guidance

NICE produce a forward planner, available via their website, which identifies upcoming guidance and its planned publication date. The Clinical Effectiveness Team will review this database on a monthly basis and include a list of guidance that is due to be published in the next three months within the monthly reports to CEG.

NICE guidance is published every month. Members of the Clinical Effectiveness Team receive this information via a monthly NICE e-newsletter and by reviewing the NICE website. Once a piece of NICE guidance is published on the NICE website, the

Clinical Effectiveness Team will record the newly issued guidance on the Trust's NICE database.

Technology Appraisal Guidance (TAs) will be identified by the Clinical Effectiveness Team, recorded on the NICE database, and immediately forwarded to the Chair of the Medicines Optimisation Committee. There is a requirement for TAs to be implemented by CCGs, NHS England and Local Authorities within 3 months and therefore the relevant medicines or equipment should be accessible within this time period.

7.2 Determining if the guidance is relevant

The Clinical Effectiveness Team and the chair of the Clinical Effectiveness Group will make a recommendation regarding the relevance to the Trust of each piece of newly published guidance for presentation to the CEG.

On a monthly basis the CEG meeting will receive a report which identifies:

- Newly published NICE Guidance (title & reference);
- Date of publication;
- Recommendation regarding relevance

On reviewing this report each month, the CEG will confirm and approve the relevance to the Trust. The outcome agreed by CEG will be recorded on the NICE database.

A quarterly report will be presented to EDG which includes all NICE guidance published within the quarter and the decision regarding relevance approved by CEG.

The Medicines Optimisation Committee will determine if the TA is relevant to the Trust and inform the Clinical Effectiveness Group of this decision. Where the TA does not relate to medication the Medicines Optimisation Committee will alert the Clinical Effectiveness Team and the TA will be processed in the same way as other NICE Guidance.

7.3 Identifying a Lead Group or Assessor

Using the monthly report produced by the Clinical Effectiveness Team (as per 6.2 above), the CEG will identify the most appropriate group or senior individual within the Trust governance structure to co-ordinate the initial assessment against the particular piece of NICE Guidance, dependent on the subject matter and relevance.

The Clinical Effectiveness Team will provide support and advice on the assessment process and ensure timeframes are clear.

Preference should always be given to identifying an existing group to act as the Lead Group. In exceptional circumstances, the CEG is authorised to establish a task and finish group to assess and implement a particular piece/ set of NICE guidance, where an appropriate group does not currently exist. The CEG will identify the Chair and membership of a task and finish group as appropriate.

The Medicines Optimisation Committee will automatically be the Lead Group for all TAGs. Where the TAG is not regarding Medication and is referred back to the CEG, the Lead Group will be identified in the same way as described above.

7.4 Completion of Relevant Assessment

The lead assessor or chair of the lead group will identify suitable individuals to complete the initial assessment (or baseline assessment) across all relevant directorates.

NICE produce some standardised 'Baseline Assessment Tools' which will be utilised where appropriate. In other cases, Trust documentation will be used.

The assessment is intended to identify whether there is currently sufficient evidence available that each recommendation within the guidance is being followed/standard is being met. The evidence may come in different forms and consideration should be given to:

- Relevant policies and procedures may identify whether the NICE recommendation is already incorporated into Trust expectations.
- Electronic systems may hold information which supports assessment of whether the recommendation is being followed. Alternatively, it may be identified that electronic systems do not capture the necessary information or do not capture it in a way which enables assessment of compliance.
- The Clinical Effectiveness Team will be able to provide previous audit data which may be of use. Directorates/Teams may also have their own audit data which demonstrates compliance or otherwise. The assessors are not expected to undertake new audits in order to determine if the recommendation is being followed.
- Where information is not available this should be flagged within the relevant assessment tool.

Any evidence used to support completion of the assessment should be identified within the relevant assessment tool. It should also be clearly identified where data is not currently captured that is needed to determine compliance and therefore what data is needed in the future (for inclusion in the action plan).

It is expected that assessments will be reported back to CEG within 3 months. The lead assessor or chair of the lead group will therefore need to ensure the assessment has been presented to relevant groups for approval prior to onward submission to CEG.

7.5 Evidence to Support Assessment

In completing the relevant assessment tool (either as an initial assessment or a re-assessment), assessors are expected to describe what evidence they have to substantiate a status of compliance with each recommendation in the NICE Guidance. This might include clinical audit results, patient surveys, policies, reports, data generated from an electronic system, service leaflets and other documentation.

Where evidence is not currently available, steps to obtain evidence should be included in the action plan.

7.6 Risk Assessment

The assessment tool provided to the assessor(s) will include space for identification of risks where there is currently insufficient evidence of current compliance with each recommendation.

The lead assessor or lead group, in scrutinising the completed assessment tool, will be expected to consider the overall risk to quality of care where full compliance is not being declared. .

Determination of risk should consider:

- How many recommendations do not have sufficient evidence of compliance;
- The significance of these recommendations;
- Whether it is believed that the Trust is compliant but there is a lack of evidence available at this time, or whether it is believed that the Trust is not compliant;
- The amount of work required to implement the recommendations.

This overall assessment of risk should accompany the completed assessment when it is submitted to CEG.

The Medicines Optimisation Committee will assess the risk posed by non-compliant TAs and report this back to the Clinical Effectiveness Team.

7.7 Approval of Assessment

All completed assessments will be reported to CEG. The CEG will review and approve each assessment, including the level of risk identified of the non-compliant elements, requesting any further information where necessary.

Where the assessment indicates that there are recommendations with which the Trust is not compliant, or there is insufficient evidence of compliance, the CEG will discuss the level of risk this poses consider inclusion of these risks within the relevant risk registers. The CEG will highlight these risk issues with relevant services, and notify the relevant risk register owner where not already done so, and will take responsibility for informing the EDG where risks are considered significant enough to require escalation.

Where the assessment indicates that there are recommendations with which the Trust is not compliant, or there is insufficient evidence of compliance, the CEG will request that the lead assessor takes responsibility for the generation of an action plan.

7.8 Action Plan

Following the approval of the assessment and risk by CEG, the assessor or relevant lead group will be expected to generate an action plan to bring the Trust to a position where it is compliant with the NICE guidance and/or is able to generate sufficient information to demonstrate this compliance.

Common elements on an action plan may be:

- Undertaking further detailed assessment;
- Amendments to relevant policies/procedures, including ongoing monitoring requirements (to provide ongoing evidence of compliance);
- Training for staff;
- Communication to staff of changes to policy;
- Changes to template documents/ data capture on electronic systems;
- Audit (local/isolated or inclusion on clinical audit plan);
- Re-assessment (this should be included on all action plans as re-assessment will need to occur once other actions are implemented).

In generating the action plan, the lead assessor or group should identify whether they believe additional resources will be required to complete the actions, which actions

this affects, and the extent to which the identified risk can be mitigated without additional resources being made available. These considerations should be submitted to the CEG at the same time as the action plan.

The action plan should be submitted to CEG within 3 months of the completed assessment being submitted. CEG will approve the action plan or request that it is amended and resubmitted for approval.

By approving each action plan, CEG will ensure that implementation of multiple NICE guidance recommendations is co-ordinated and prioritised across the Trust.

Common elements will be brought together and actioned 'en-masse' e.g. if 3 action plans contain amendments to Insight then these will be brought together and 1 request for amendments made to the relevant technical team.

Clinical Audit requirements will be taken from the action plans and co-ordinated by the Clinical Effectiveness Team to ensure they are incorporated in an efficient and effective manner.

Following approval of the action plan, the CEG will identify where the actions should be monitored through to implementation. The CEG may choose to delegate this responsibility to a more appropriate group, or receive assurance that another senior governance group is responsible for implementation of the action plan.

The Medicines Optimisation Committee will develop, implement and monitor action plans in relation to relevant TAs.

7.12 Ongoing Evidence of Compliance with NICE Guidance

Clinical and Professional Directors are responsible for ensuring NICE and other best practice guidance is implemented as much as possible across the organisation. All staff providing care and treatment have a responsibility to provide care that is safe and effective and therefore compliance with best practice guidance is expected. When reviewing existing policies and procedures, or writing new ones, policy authors are responsible for ensuring that relevant NICE Guidance recommendations are incorporated and that these documents describe a "NICE Compliant" service.

The Clinical Effectiveness Team will coordinate ongoing evidence of compliance. As well as reassessments of guidance, and implementation of Trust policies, ongoing evidence may also include 'additional evidence' which will include other activities/developments within the Trust that address recommendations and standards contained within the NICE guidance. The Clinical Effectiveness Team will ensure any 'additional evidence' identified is included in the NICE database.

Ongoing evidence of compliance will in part be linked to policy monitoring and will be the responsibility of whichever group is identified in the policy as having those responsibilities.

7.13 Decision not to implement recommendations

Where there are insufficient resources available to implement recommendations contained within NICE guidance, and a Business Case to secure funds has been unsuccessful, the CEG will request approval from EDG for a decision not to implement particular recommendations.

The date of this approval from EDG and the particular recommendations to which it relates will be recorded on the NICE database.

7.14 Annual review of recommendations not previously implemented

The CEG will receive a report prepared by the Clinical Effectiveness Team which identifies all guidance where a decision was approved by EDG between 7 & 18 months previously not to implement particular recommendations, as well as guidance from the previous annual report of this nature.

The CEG will decide, on the basis of reviewing the risk assessment and the costs of implementation, whether to approve a continued decision not to implement the particular recommendations.

Revised NICE guidance will be treated as a new piece of guidance and therefore this provides a safety check on guidance or recommendations previously deemed to be 'not relevant' to the Trust.

When a new service is commissioned it is the responsibility of the service implementation lead to check the NICE database to determine if any guidance previously deemed 'not relevant' to the Trust applies to the new service and inform the Clinical Effectiveness Team so that the guidance can re-enter the process.

7.15 Reporting (and monitoring of the process)

The Clinical Effectiveness Team will maintain a NICE database. This will include all the information necessary for monitoring the application of this policy.

Each (monthly) meeting of the Clinical Effectiveness Group will receive:

- List of guidance due to be published in the next 3 months (see section 6.1) for information and planning;
- List of newly published guidance, identifying relevance of guidance (see section 6.2) for approval of determined relevance;
- Current status of all NICE guidance assessment 'in process', for information and monitoring;
- Current status of all approved action plans.

Where these reports identify that individuals/groups have not complied with the processes and timeframes outlined in this policy, the Chair of CEG will contact the individual/chair of the group to request explanation and agree a method of getting the process back on track as soon as possible.

The Clinical Effectiveness Group should also receive the following in all instances, as soon as available:

- Completed relevant assessment and accompanying risk assessment;
- Action plans for approval;

On an annual basis CEG will receive:

- A report outlining guidance where it has been decided not to implement particular recommendations, for re-approval.

On a quarterly basis EDG will receive:

- A list of newly published guidance, identifying relevance of guidance (see section 6.2);

- Information on all NICE guidance assessments reviewed by CEG in the quarter and related action plans;
- In the relevant quarterly report (on an annual basis) a copy of the annual report submitted to CEG re-confirming decision not to implement.

EDG will provide assurance to QAC, as required by QAC.

8 Development, consultation and approval

The Implementation of NICE Guidance Policies from 10 other NHS Trusts were reviewed to ensure all aspects were covered.

Omissions and risks identified by the 360 Assurance Internal Audit Review were rectified through inclusion of further information and detail.

Consultation was undertaken within the Clinical Effectiveness Team. The draft policy was verified by the Chair of the Clinical Effectiveness Group.

Under the authority the policy was reviewed in February 2020 and minor updates undertaken to ensure it reflects current organisational structures and procedures.

9 Audit, monitoring and review

Monitoring Compliance Template						
Minimum Requirement	Process for Monitoring	Responsible Individual/ group/committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
A) The relevance of newly published guidance is determined by CEG in a timely manner	NICE database	CEG	Quarterly	EDG	CEG	EDG
B) NICE assessment is presented to CEG within 3 months of the Lead Group being notified	NICE database	Lead assessor or Chairs of Lead Groups	Monthly	Exception report to CEG	CEG	EDG
C) Action Plan submitted to CEG for approval within 3 months of initial assessment submission	NICE database	Lead assessor or Chairs of Lead Groups	Monthly	Exception report to CEG	CEG	EDG
D) Action plans progress according to approved timeframes	NICE database	Lead assessor or Chairs of Lead Groups	Monthly Quarterly	Exception report to CEG Exception report to EDG	CEG	EDG

10 Implementation plan

Action / Task	Responsible Person	Deadline	Progress update
Upload new policy onto intranet and remove and archive old version	Corporate Governance Team	May 2020	
A communication will be issued to all staff via the Communication Digest immediately following publication.	Corporate Governance Team	Within 5 working days of issue	
Specific Email to membership of CEG, Clinical Directors & Chairs of potential Lead Groups	Clinical Effectiveness Team	Within 5 working days of issue	
Review this policy	Clinical Effectiveness Team	3 years after issue	

11 Dissemination, storage and archiving (Control)

The Corporate Governance Team is responsible for the storage and dissemination of this policy.

This policy will be disseminated via the Sheffield Health and Social Care NHS Foundation Trust intranet and be made available to all staff.

The Director of Corporate Governance is responsible for making sure the new policy is inserted on the Trust intranet in the policies section.

An 'All SHSC staff' email alert should be sent to all staff telling them of the new policy and where to find it. Clinical and Service Directors are responsible for ensuring that all staff in their directorates are aware of new policies and know where to find them.

Additional promotion of the policy will take place through further publicity such as articles in Sheffield Health and Social Care Trust newsletters and other staff briefings.

Some teams have paper policy files or archives for easy reference. It is the responsibility of the locality team manager to ensure that paper policy files are kept up to date and comprehensive, and that staff are made aware of new or revised policies. Older versions should be

destroyed to avoid confusion. It is the responsibility of the team manager to make sure the latest version of a policy is available to all staff in the team.

It is the responsibility of the Director of Corporate Governance to maintain an archive of previous versions of policies, and to make sure that the latest version is the one which is posted on the Trust intranet. They will circulate a list of all Sheffield Health and Social Care Trust policies at least annually to team managers and directors throughout the Trust.

This section should describe how the new policy will be disseminated. It says where the policy will be made available and to whom. This will normally be that the policy is available on the Trust's intranet and available to all staff.

Version	**Date added to intranet**	**Date added to internet**	**Date of inclusion in Connect**	**Any other promotion/ dissemination (include dates)**
1.0				
2.0				
3.2				
4.0				
5.0	May 2020	May 2020	May 2020	

12 Training and other resource implications

There are no specific training implications with regards to this policy. The majority of tasks described within this policy fall within the skills, knowledge and job descriptions of senior managers and clinicians in the Trust.

The Clinical Effectiveness Team will provide informal training and development for staff implementing NICE guidance and guide them through the processes described in this policy.

13 Links to other policies, standards (associated documents)

The following Sheffield Health and Social Care NHS Foundation Trust policies are available on the Trust website on www.shsc.nhs.uk :

Risk Management Policy
Clinical Audit Policy

All NICE guidance is available on the NICE website. A full list of the guidance can be found on http://guidance.nice.org.uk/

Relevant assessment tools (for guidance published since April 2010) are available linked to specific guidance on the NICE website

14 Contact details

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Appendix A

Equality Impact Assessment Process and Record for Written Policies

Stage 1 – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? This should be considered as part of the Case of Need for new policies.

NO – No further action is required – please sign and date the following statement. **I confirm that this policy does not impact on staff, patients or the public.**	***I confirm that this policy does not impact on staff, patients or the public.*** Name/Date:	**YES,** Go to **Stage 2**

Stage 2 Policy Screening and Drafting Policy - Public authorities are legally required to have 'due regard' to eliminating discrimination, advancing equal opportunity and fostering good relations in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance and Flow Chart.

Stage 3 – **Policy Revision** - Make amendments to the policy or identify any remedial action required and record any action planned in the policy implementation plan section

SCREENING RECORD	Does any aspect of this policy or potentially discriminate against this group?	Can equality of opportunity for this group be improved through this policy or changes to this policy?	Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?
Age	**No**	**No additional opportunities were identified.**	**The need for further action was not identified.**
Disability	**No**	**No additional opportunities were identified.**	**The need for further action was not identified.**
Gender Reassignment	**No**	**No additional opportunities were identified.**	**The need for further action was not identified.**
Pregnancy and Maternity	**No**	**No additional opportunities were identified.**	**The need for further action was not identified.**
Race	**No**	**No additional opportunities were identified.**	**The need for further action was not identified.**

Religion or Belief	**No**	**No additional opportunities were identified.**	**The need for further action was not identified.**
Sex	**No**	**No additional opportunities were identified.**	**The need for further action was not identified.**
Sexual Orientation	**No**	**No additional opportunities were identified.**	**The need for further action was not identified.**
Marriage or Civil Partnership	**No**		

Please delete as appropriate: - ~~Policy Amended / Action Identified (see Implementation Plan)~~ / no changes made.

Impact Assessment Completed by: Jonathan Burleigh, Clinical Effectiveness Manager
Name /Date 27/02/20