East London
NHS Foundation Trust

Policy and Procedure for the Development, Review and Control of Trust Approved Procedural Documents

Version number :	2.4
Consultation Groups	Key governance leads / Service Directors
Approved by (Sponsor Group)	Quality Committee
Ratified by:	Quality Committee
Date ratified:	January 2018
Name and Job Title of author:	Risk and Datix Manager
Executive Director lead :	Chief Nurse
Implementation Date :	March 2021
Last Review Date	March 2021
Next Review date:	March 2024

Services	**Applicable to**
Trustwide	√
Mental Health and LD	
Community Health Services	

Version Control Summary

Version	Date	Author	Status	Comment
1.0	14 July 2008	Trust Secretary	Final	A new policy was required in line with the guidance and template published by the NHSLA. This policy replaces the Trust's *Policy on Management of Policy Development and Review*
2.0	19 July 2011	Associate Director of Governance	Revised Draft	Scheduled three year update, incorporating current Trust governance framework
2.1	17 March 2015	Trust Secretary		Section 6.5 updated to advise procedural leads to consider the recommendations in the Francis report when developing policies and procedures.
2.2	November 2017	Risk & Datix Manager	Revised	Policy reviewed to reflect current organisational needs, roles, responsibilities and structures.
2.3	February 2019	Risk and Datix Manager	Revised	Clarity added regarding approval and ratifying committees
2.4	September 2020	Risk and Datix Manager	Revised	Following recommendations from internal audit updated to reflect the need to include local and national reporting requirements and targets with procedural documents and to update to reflect any changes

Contents

Appendices

1.0 Introduction

In order to ensure a consistent, high quality level of service provision across the whole organisation, it is essential for the Trust to set standards that are evidence based and developed in conjunction with relevant stakeholders. These need to be compliant with mandatory requirements and consistent with the Trust's strategic objectives. To achieve this, it is important to have procedural documents that are developed and managed in a systematic way within the Trust.

The Trust has a responsibility to ensure that policies and procedural documents;

- Meet the Trust's needs and fit with its values and culture.
- Enable the Trust to deliver its strategic objectives.
- Provide a framework for safe, effective and acceptable practice and which comply with regulatory and mandatory requirements.
- Are standardised in the Trust format and style and gives clarity on the appropriate level of authority for the approval of different types of policy
- Are easy to understand and accessible.
- Promote diversity and are non-discriminatory.
- Are formally reviewed and revised at specified intervals.
- Are subject to consultation with the trades' unions with a view to reaching consensus with the Joint Staff Consultative Committee (JSCC) when appropriate.

For the purpose of this policy and related procedural guidelines the term approved procedural document applies to;

- Trust wide policies and procedural guidelines
- Trust strategies and implementation frameworks
- Operational and local policies,
- Standard Operating Procedures (SOPs)
- Clinical Guidelines, care pathways and protocols

2.0 Purpose

The purpose of this policy is to ensure that:

- All procedural documents are developed and reviewed within a clearly defined accountability framework;
- Staff involved in the process have access to appropriate guidance and support;
- All new procedural documents are generated due to a clearly identified need;
- There is consistency in the development, format, implementation and review of all Trust procedures;
- All Trust procedural documents are compliant/consistent with the Trust's strategic objectives, national guidance and relevant legislation;
- Appropriate consultation takes place when procedural documents are being developed;
- All procedural documents are properly disseminated throughout the Trust;
- Appropriate training is provided to staff;
- All procedural documents are subject to regular review of their effectiveness.

This policy and procedure seeks to reduce risk by having a robust document control process in place, so that the right procedures are available to the right staff at the right time, by ensuring that staff receive appropriate training, and ensuring that each procedure is regularly reviewed.

This policy and procedure provides a consistent approach on how Trust procedural documents are generated and provides a framework by which procedures are:

- Developed
- Approved
- Managed
- Implemented
- Monitored
- Reviewed

This policy and procedure does not apply to the development of service user information, which is governed by the Trust's Information for Service Users Policy.

3. Definitions

The different types of procedural documents used within the Trust are as follows;

Policy
A policy is a specific statement of principles/guiding actions that provide a basis for consistent decision-making and resource allocation. A policy should set out a framework for action and a minimum specification for Trust-wide practise in any setting.

Procedure
A procedure is a series of steps followed in regular order to be complete a given task (to implement a policy or otherwise). Procedures can also be mapped by use of a flow chart and diagrams.

It may also be necessary to develop local variations to procedures, given the range of services provided by the Trust. A register of locally approved procedural documents must be maintained by each individual directorate.

Guideline
A guideline is a set of systematically developed standards or rules, which assist in the decision of how to apply a procedure or appropriate management of specific conditions. Guidelines are often used to underpin a procedure.

Pathways
A systematic plan and follow up for a service user focused care programme.

Protocol
A protocol can be defined as a rigid statement of practice, which will be adhered to: they allow little flexibility or variation and as such are only suitable for certain, very specific aspects of practice, where the course of action is universal

4. Duties and Responsibilities

4.1. Duties and Responsibilities within the Organisation

Lead directors are accountable for all procedural documents within their area of responsibility, and will consult and involve the relevant committee in the Governance Framework as set out in Table 1 below.

Directors will have responsibility for identifying staff and other resources required for the development of individual procedures and will normally nominate a procedure lead (procedural documents author) to carry out the development work in accordance with this policy.

Directors will also ensure that new documents and changes are effectively implemented and monitored and cascaded to their staff through line managers.

Trust Approved Procedural Documents Authors / Leads are responsible for ensuring that documents are developed in line with best practice and legal requirements and updated in line with the agreed review date. Authors / leads will normally be subject matter experts.

Operational Managers are responsible for ensuring staff are aware and have read and understood relevant operational policies and procedures for their service.

All Trust Employees are responsible for ensuring that they:

- Cooperate with the development and implementation of procedural documents;
- Read, comply and maintain up-to-date awareness of procedural documents, as laid down in job descriptions and contracts of employment;
- Attend training as required, to familiarise themselves and enable compliance with, procedural documents relevant to their role and responsibilities; and
- Raise any queries about implementation of procedural documents with their line manager.

Table 1: Summary of responsibilities for Lead Director, approving and ratifying committees Governance Framework for ELFT

Type of procedure	Lead Director	Sponsor group	Ratifying Group
Clinical	Medical Director/Director of Nursing	Specialist Clinical Committee / Lead Nurses Group / Nursing Development Steering Group / Medical Managers	Quality Committee
Communications	Deputy CEO/Director of Performance & Business Development	Service Delivery Board / People Participation Committee	Service Delivery Board
Legal Affairs	Director of Corporate Planning	Quality Committee	Audit Committee / Quality Committee
Corporate Governance	Chief Executive	Quality Committee	Trust Board

Estates & Facilities	Director of Estates & Facilities	Service Delivery Board	Service Delivery Board
Finance	Director of Finance	Audit Committee and/or Finance, Business and Investment Committee	Trust Board / Audit Committee
Health and Safety	Chief Nurse	Health, Safety and Secuirty Committee	Quality Committee
Human Resource	Director of Human Resources	Joint Staff Sub Committee / Workforce Committee	JNC
Infection Control	Medical Director	Infection Control Committee	Quality Committee
IM&T	Deputy CEO/Director of Performance & Business Development	Information Governance Steering Group	Quality Committee
Information Governance	Senior Information Risk Owner	Information Governance Steering Group	Quality Committee
Mental Health Act	Director of Corporate Planning	Medical Managers	Quality Committee
Pharmacy	Medical Director	Medicines Committee	Medicines Committee
Risk Management	Director of Nursing	Quality Committee/Health & Safety Committee	Trust Board
Safeguarding Children / Adults	Director of Nursing	Safeguarding Committee	Quality Committee
User and Carer Involvement	Director of Nursing	Service Delivery Board and/or Public Participation Committee	Service Delivery Board and/or Public Participation Committee
Procedural documents / Local policies specific to directorates	Service Director	Directorate Management Team or appropriate sub-committee	Directorate Management Team

4.2 Consultation and Communication with Stakeholders

When developing a procedural document, it is essential to gain an understanding of different perspectives and experiences of the issue(s) being addressed, and to draw on the expertise of all relevant individuals. The procedural document lead must therefore identify relevant internal and external stakeholders to be consulted in the development of the procedure. This will always include those listed in the duties section and may include:

- Service users/carers and the local community (including specialist groups)
- Staff/Staff groups
- Specialist staff/staff groups
- Relevant external stakeholders

Communication arrangements relating to the development, consultation, approval and implementation of procedural documents will be the responsibility of the relevant director.

4.3 Approval of Procedural Documents

The Trust Board is responsible for approving the Policy and Procedure for the Development, Review and Control of Trust Approved Procedural Documents outlined in this document.

Those policies that require Trust Board approval are outlined in the scheme of delegation. These include policies which are likely to be of major strategic or political significance, such as those relating to the appointment, remuneration and dismissal of staff, policies relating to the management of financial or clinical risk and policies for management of complaints and claims. Policies requiring approval by the Trust Board may be approved by a committee of the Board subject to appropriate authority being granted through the terms of reference and scheme of delegation

This is summarised in table 1.

The sponsor groups identified will have responsibility for reviewing and approving procedural documents.

The ratifying committees will ratify the procedure on receipt of formal assurances from the sponsor group that the correct process for development, consultation and approval has been followed.

The Chief Nurse & Deputy Chief Executive will authorise exceptions in appropriate circumstances and chairs action will be sort as necessary.

Appendices to procedural documents (e.g. guidance and templates) may be changed from time to time with the approval of the policy lead, without the need for a full review of the procedure.

5 Style and Format of Procedural Documents

When drafting a procedural document, it is important to consider that the procedure needs to be read and understood by all members of Trust staff, as well as service users, volunteers, members of the public and others in the delivery of services and functions. Procedures should therefore be written with their target audience in mind, with the objective of increasing awareness. All procedural documents are public documents and may be made available on the Trust's website.

- All procedural documents must be written in a clear and consistent manner. Repetition and lengthy mission-style statements should be avoided and other Trust procedures should be cross-referenced where appropriate.

- Every effort should be made to check that correct grammar, spelling and punctuation have been used throughout the procedural document.

- Any terminology or acronyms used should be either included in the list of definitions or alternatively, written in full the first time it appears, and followed by the abbreviation; i.e. Care Programme Approach (CPA).

- Consideration should be given to making procedures available in different languages and formats as appropriate.

- All procedural documents should be typed in Arial Font (size 11).

- All headings should be in bold.

- All pages of text shall be numbered including appendices.

- A Header should include at the top of each page the Trusts name and the full title of the procedural document.

- Policies will contain a grid on the front sheet of the document and there should be completed with a version number, authors details, those involved in consultation and approval details.

Procedural documents should provide details of any references used in order to provide an evidence base.

All references should be cited in full, using the Harvard style, e.g.:
Books
FAMILY NAME, INITIAL(S). Year. Title. City of publication: Publisher

Journal article
FAMILY NAME, INITIAL(S). Year. Title of article. Journal title. Volume (issue number), page number of your quotation

Organisation report
ORGANISATION. (Unpublished, year). Title. Report dated date

Procedural documents should provide details of any supporting/linked documents, particularly in light of the need to avoid duplication of work and lengthy documents.

All procedural documents should be structured in the following manner:

- Standard front cover (including document control summary)
- Version control summary
- Contents page
- Executive summary
- Introduction
- Purpose
- Duties / Responsibilities
- Section headings
- References
- Associated Documentation
- Appendices

A template for procedural documents is attached as Appendix B.

Further guidance can be obtained from the NHS Toolkit for Producing Patient Information and the Accessible Information Standards Requirements.

6 The Development of Procedural Documents

A flowchart summarising the process is attached to this policy and procedure at appendix A.

6.1 Prioritisation of Work

When considering the justification and support for developing a procedural document, the responsible director should consider how the intended objectives are best met. This could include the review/development of an existing procedure, rather than developing a separate procedure, in order to prevent duplication of work. The director/procedure lead should check the Trust's library of current procedures on the intranet, and/or search for similar procedures in place in other organisations.

The director should consider the implications of implementing a new procedure, including operational and resource implications, and the risk of action or inaction.
The director should also consider how the proposed procedure links with the Trust's strategic objectives.

6.2 Identification of Stakeholders

Service users/carers and the local community (including specialist groups)

Service users/carers and the local community should be involved in the development and consultation of procedures that have a direct impact on clinical services.

Final procedures will be available to this group via the Trust's website. In some cases, it may be appropriate to produce summary leaflets.

Staff/Staff groups

The Joint Staff Committee will be involved in the development and consultation of Human Resource approved documents that has significant effect on working practices which have not been agreed at a national level.

For other classes of procedures, staff involvement will normally occur through the involvement of the appropriate group in the Healthcare Governance framework. In some cases, it may be appropriate to consult with a wider staff group.

Specialist staff/staff groups

Consideration should be given as to whether specialist staff/staff groups should be involved in the development of procedures. This may include:

- Legal Affairs
- Mental Health Law
- Safeguarding Children / Adults
- Social Inclusion/User Involvement
- Health and Safety
- Fire Safety
- Governance & Risk Management
- Trust Secretary
- Finance
- Nursing Advisory Committee/Medical Advisory Committee/Therapies Committee

Relevant external stakeholders

For procedural documents that that impact on beyond the organisation's boundaries (i.e. CPA policy, care pathways) consideration should be given to involving relevant external stakeholders in their development (i.e. Clinical Commissioning Groups and Local Authorities).

6.3 Equality Analysis

The Equality Act 2010 places a statutory duty on all public authorities to analyse the effect of their existing and new policies and practices on equality. It makes clear that the analysis has to be undertaken before making the relevant policy decision, and include consideration as to whether any detrimental impact can be mitigated. A written record to demonstrate that due regard has been taken is also expected. An Equality Analysis Tool (EAT) template has been developed for staff to help them assess equality issues and is available on the intranet. The tool also incorporates human rights and environmental issues.

Procedure leads are responsible for completion of the template and must do so prior to sending the procedure to the sponsor group for approval. It is recommended, however, that procedure leads consider potential equality issues at an early stage of the procedure development process, so that appropriate consultation can take place and major issues identified and addressed.

Help and advice regarding consulting on equality issues, and completion of the EAT can be sought from the Director of Human Resources.

The Trust is required to publish the findings of each Equality Analysis, actions that are proposed to mitigate any detrimental impact and procedures for monitoring the policy, the EAT is therefore a public document.

6.4 Compliance with Legislation, National Guidance, Local / National Reporting and Targets

Procedure leads should check that the proposed procedure complies with relevant legislation and national guidance (e.g. NICE guidance, Royal College guidance).
In relation to clinical procedural documents procedure leads should consult with the Associate Director of Mental Health Law regarding compliance with the Mental Capacity Act 2005.

Procedure leads should also consider the recommendations made in by relevant external reviews including the *Francis Report and Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015* in the development of all procedural documents.

Procedural documents should also reflect local and national reporting requirements and targets. Documents should be updated regularly regardless of the 3 yearly review to reflect changes in these requirements.

7 Consultation, Approval and Ratification Process

7.1 Consultation Process

Table 2 below identifies the consultation that should normally take place for each type of procedural document. The matrix is intended as a guide, and the most appropriate consultation arrangements should be considered by the responsible director for each procedure. Following consultation, the director should decide on any changes to the procedure, and inform the sponsor group of any major unresolved issues.
All procedural documents should be shared with the Mental Health Act team as part of the consultation process.

The matrix has been colour coded as follows:

Green = consultation should normally take place with this group
Amber = consultation may take place with this group
Red = consultation would normally not take place with this group
Specific staff/groups have been included where applicable.

Table 2 Consultation requirements

Type of procedure	**Service users/carers and the local community**	**Staff/staff groups**	**Specialist staff/staff groups**	**Relevant external stakeholders**
Clinical			Mental Health Law. Safeguarding Children and Adults. Medical/Nursing/Therapies Committees. Infection Control	
Communications				
Legal Affairs			Governance & Risk Management	
Corporate Governance				
Estates & Facilities			Health & Safety	
Finance				
Human Resource				
Infection Control			Medical/Nursing/Therapies Committees	
IM&T			Information Governance	
Mental Health Act			Legal Affairs	
Pharmacy			Medical/Nursing/Therapies Committees	
Risk Management			Governance & Risk Management	

Safeguarding Children			Governance & Risk Management	
Safeguarding Adults			Governance & Risk Management	
User/Carer Involvement				
Procedures specific to directorates				
Information Governance			IT	

7.2 Procedural Document Approval and Ratification

Procedural document ratification has been delegated by the Board of Directors to its standing and sub committees. Delegated standing and sub committees will ratify procedural documents following recommendation and approval by the relevant subcommittee (sponsor committee).

The procedure for approval and ratification is set out in Table 1.

Procedural leads must complete the committee report cover sheet as set out in appendix C providing assurance that due process and consultation has been followed.

8 Review and Revision Arrangements including Version Control

8.1 Process for Reviewing a Procedural Document

All procedures must be reviewed every three years. A director may decide to set a shorter review period, if appropriate/required. There may also be a need to review a procedure in advance of a planned review date, i.e. due to changes in national policy or legislation, changes in service provision, recommendation from internal or external review, change in local and national reporting requirement or targets.

The director identified in Table 1 will be responsible for the review process. All reviews and revision to any procedural document must be approved according to the process set out in section 7.

8.2 Version Control

A version control log e will be used for all procedures and maintained by the author / lead in order to aid tracking and retrieval, as follows:

Version	Date	Author	Status	Comment

9 Dissemination and Implementation

9.1 Dissemination

Procedural documents can be disseminated in a number of ways, including the following:

- Publishing on the Trust intranet/website
- Circulation via email
- Induction/training sessions
- Trust electronic communication medias

The implementation plan must record how each procedural document is to be disseminated.

The director should also consider whether confirmation that staff have read and understood the document is required, and if so, arrange for this to take place.

If the document replaces a previous version, the director must ensure that the previous version is recalled or otherwise removed from use.

The document must be submitted to the Risk and Datix Manager for updating of the Trust library of procedural documents. Authors must also provide any key words, intelligent and informed names to be utilised by the search function on the intranet.

9.2 Implementation of Procedural Documents

Each procedural document must be supported by an implementation plan, which records how the procedure will be disseminated, implemented and any training or audit requirements. The author / lead is responsible for undertaking this process.

An implementation plan template is attached as Appendix D.

10 Monitoring

The effectiveness in practice of all procedural documents should be routinely monitored to ensure the document objectives are being achieved. The process for how the monitoring will be performed should be included in the procedural document.

The details of the monitoring to be considered include:

- The aspects of the procedural document to be monitored through the use of standards or key performance indicators (KPIs).
- The methodology for monitoring e.g. spot checks, observation audit, data collection;
- Frequency of the monitoring e.g. quarterly, annually, to include the timeframe for performing and reporting;
- The designation (job title) of who will have responsibility for monitoring and reporting on compliance;
- The committee or group who will be responsible for receiving the results and taking action as required. In most circumstances this will be the committee which ratified the document.

11 Document Control including Archiving Arrangements

11.1 Library of Procedural Documents

The Risk and Datix Manager will be responsible for maintaining the Trust library of procedural documents.

Master copies of all procedural documents will be published on the Trust intranet.

Directors must submit all approved procedures and the supporting documentation to the Risk and Datix Manager for updating to the Trust library.

11.2 Archiving Arrangements

An archive of procedural documents will be kept in the Corporate Records file in the K (shared) drive. On receipt of a revised procedure, the Risk and Datix Manager will enter this into the Trust library and move the previous version to the archive file.

11.3 Process for Retrieving Archived Documents

Copies of archived documents are stored on the K drive and are available on requested from the Risk and Datix Manager.

11 Monitoring Compliance with Procedural Documents

Name	Element to be monitored	Lead	Tool	Frequency	Reporting Arrangements	Actions on recommendations and leads	Change in practice and lessons to be shared
Policy and Procedure for the Development of Procedural Documents	• Style and format • An explanation of any terms used • Consultation process • Ratification process • Review arrangements • Control, including archiving arrangements • Associated documents • Supporting references	Risk and Datix Manager	Peer review of minutes of ratification committees Audit of archive	Every three years	The Associate Director of Governance will receive the audit report	Policy Action plan will be updated with any actions to mitigates gaps identified.	The Quality Committee will receive, discuss and monitor the action plan within six weeks of the review having been completed

Appendix A - Flowchart for the development of procedural documents

Rationale and Priority

- Read "An organisation-wide policy for the development and management of procedural documents" before commencing
- Establish rationale / priority for the approved document / confirm if still required?
- Identify whether the subject can be part of an existing approved document or whether there is a national policy or template that can be utilised. Do not duplicate work.
- Agree the need for document with relevant committee and lead director.

Development Plan

- Identify: who will do the work, who should be involved including all relevant stakeholders including service users ensuring relevant expertise is used.
- Identify who will be responsible for dissemination, implementation and relevant timescales, training and review.

Content

- Identify clear, focused objectives Intended outcome - what you want it to achieve
- Target population e.g. service users, staff groups for whom the document is intended
- Keep statements simple and unambiguous. Include references cited in full in agreed organisational format
- How will the organisation measure compliance? Set measurable standards and design methods for monitoring compliance and effectiveness. Plan to develop any necessary support information, leaflets, etc

Evidence Base

- Identify what type and source e.g. research, expert opinion, clinical consensus, patient views Is it based on a national document? If yes, is local information needed?

Consultation and Approval

- Consult with all relevant stakeholders including service users. All procedural documents with HR implications must be taken to the staff side/human resources committee (or equivalent)
- Complete document review processes, including Impact Assessment Tool, Checklist and Implementation Plan
- Approve document as outlined in the 'Organisation-wide policy for the development and management of procedural documents' including completion of the Checklist for the Review and Approval of Procedural Documents
- Log document on the organisation's register/library of procedural documents

Dissemination, Implementation and Access

- Link with induction training, continuous professional development, and clinical supervision as appropriate
- Upload to the Trust website / intranet site and consider how and where will staff access the document (at operational level)?
- Plan to remove old copies from circulation

Review

- Review document in accordance with planned review date
- Content - is there new evidence of best practice to be incorporated into the document?
- Re-approve procedural document at the appropriate committee/group
- Archive old versions of the document according to organisation's procedure for archiving

Responsibility

- Identify who (clinical or service manager) will be responsible for co-ordinating the ongoing development, implementation and review of the document?

Appendix B

East London NHS Foundation Trust

Title of Policy / Procedural Document

Version number :	
Consultation Groups	
Approved by (Sponsor Group)	
Ratified by:	
Date ratified:	
Name and Job Title of author:	
Executive Director lead :	
Implementation Date :	
*Last Review Date	
*Next Review date:	

* All procedures must be reviewed every three years. A director may decide to set a shorter review period, if appropriate/required. There may also be a need to review a procedure in advance of a planned review date, i.e. due to changes in national policy or legislation, changes in service provision, recommendation from internal or external review, change in local and national reporting requirement or targets

Services	Applicable to
Trustwide	
Mental Health and LD	
Community Health Services	
Primarycare	

Version Control Summary

Version	Date	Author	Status	Comment

Contents

Appendix C

REPORT TO THE xxx COMMITTEE
Xx Month 20XX

Title	Approved document title
Author	
Accountable Executive Director	

Purpose of the Report:

A purpose of this report is to seek xxx committee approval for the newly developed / revisions to the xxxxxxx policy / procedure.

Summary of Key Issues:

This is a revision to an existing ELFT Policy / procedure undertaken as a result of …….

This is a newly developed ELFT Policy / Procedure as a result of ……

The following changes have been made to the policy and procedure:

-

-

-

Or

Very high summary of the policy / procedure……

The correct Trust has been undertaken as follows;

- Appropriate review date has been set
- Appropriate format has been used
- Clear reference to other trust policies has been made
- Appropriate consultation has taken place

Monitoring of compliance will be undertaken …….. (please write a set of words how you will be undertaking monitoring i.e who will be and how….. Outline any connection to the trust annual plan, commissioning contract, nhs constitution or key regulatory requirements. Suicide reduction policy and appropriate Quality Improvement projects (please include specific initiatives) have been considered – please confirm impacts / considerations have been taken into account or if this is not applicable please state.

Strategic priorities this paper supports (Please check box including brief statement)

Improving service user satisfaction	☐	
Improving staff satisfaction	☐	
Maintaining financial viability	☐	

Committees/Meetings where this item has been considered:

Date	Committee/Meeting
	Procedural document consulted with

Implications:

Equality Analysis	Equality impact has been considered….. (confirm that the equality impact has been reviewed / considered and if there is any impact on the procedural document with the new changes. If yes outline what impacts and how they are mitigated.)
Risk and Assurance	A summary statement on the level of assurance that can be provided from the report, and the key actions taken to address any implications for risks/controls identified in the Trust's Board Assurance Framework; Trust's Compliance with its Terms of Authorisation; or legal or health and safety implications
Service User/Carer/Staff	Implications for service users, carers and staff. Consider implications of the paper across all directorates and service groups in the Trust, and explain if any directorates/services are excluded from the scope of the paper.

Financial	This statement must identify whether or not there are any financial implications relating to the report, and if so, how these are proposed to be funded.
Quality	State any quality implications, particularly links to the Quality Improvement Programme

Supporting Documents and Research material

a.
b.

Glossary

Abbreviation	In full

1.0 Action being requested

a) RECEIVE and APPROVE the policy / procedure (sponsor committee)

or

b) RECEIVE and RATIFY the policy/procedure (ratifying committee)

NB Definitions are as follows:

To “approve” - accepting recommendations etc as satisfactory

To “ratify” - to approve an action/policy formally so that it can come into force

Appendix D

Implementation Plan Template

Procedure title: **Lead Director:**
Procedure lead: **Sponsor Group:**

Objective	Action	Lead	Timescale	Progress/Outcome
1. Final version provided to the Risk and Datix Manager				
2. The procedure is properly disseminated and communicated throughout the Trust.				
3. Appropriate training is provided to staff.				
4.Implement monitoring arrangements.				
5.Evaluate and plan for review.				

Appendix E – Procedure Checklist

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval together with the Report Cover Sheet at appendix C.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?		
2.	**Purpose**		
	Are reasons for development of the document stated?		
3.	**Development Process**		
	Are people involved in the development identified?		
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?		
	Is there evidence of consultation with stakeholders and users?		
4.	**Style/format**		
	Is the document in the correct structure/format		
	Is the document clear and concise?		
	Are key terms defined?		
5.	**Content**		
	Is the objective of the document clear?		
	Is the target population clear and unambiguous?		
	Are the intended outcomes described?		
	Are the statements clear and unambiguous?		
6.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?		
	Are key references cited?		
	Are the references cited in full?		
	Are supporting documents referenced?		
7.	**Approval**		
	Does the document identify which committee/group will approve it?		
	If appropriate have the joint Human Resources/staff side committee (or equivalent) reviewed the document?		
8.	**Implementation Plan**		
	Is there an Implementation Plan?		
	Does the plan clearly state how the procedure will be disseminated?		
	Does the plan include the necessary training/support to ensure compliance?		
9.	**Document Control**		
	Does the document identify where it will be		

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	held?		
	Have archiving arrangements for superseded documents been addressed?		
10.	**Impact Assessment**		
	Is the Impact Assessment completed?		
11.	**Review Date**		
	Is the review date identified?		
	Is the frequency of review identified? If so is it acceptable?		
12.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?		

Individual Approval			
If you are happy to approve this document, please sign and date it and forward to the chair of the committee/group where it will receive final approval.			
Name		Date	
Signature			
Committee Approval			
If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.			
Name		Date	
Signature			