East of England Ambulance Service NHS Trust

Policy for the Development of Procedural Documents

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Document Status	Approved
Version:	8.0

DOCUMENT CHANGE HISTORY		
Initiated by	**Date**	**Author (s)**
Integrated Governance Committee (IGC)	18th July 2008	Associate Director of Corporate Affairs
Version	**Date**	**Comments (i.e. viewed, or reviewed, amended approved by person or committee)**
V1.0	8th August 2008	Approved at Trust Board
V2.0	1st October 2008	Approved at Trust Board
V3.0	September 2011	Approved at Trust Board

Version	Date	Comments (i.e. viewed, or reviewed, amended approved by person or committee)
V4.0	30th July 2012	Approved at EMT
V5.0	17 November 2016	Approved by ELB
V5.0	September 2018	6 month extension approved at IGG
V5.0	11 October 2018	Approved by SLB
V5.1	February 2019	Review by Corporate Records Manager/FOI Officer
V5.1	12 March 2019	Approved by IGG
V6.0	20 March 2019	Approved by Management Assurance Group
V6.1	July 2019	Review by Corporate Records Manager/FOI Officer
V6.1	18 September 2019	Approved by Information Governance Group
V7.0	23 September 2019	Approved by Management Assurance Group
V7.1	February 2020	Reviewed by Head of Governance and Corporate Records Manager/FoI Officer
V8.0	April 2020	Approved by Compliance and Risk Group
V8.0	17 April 2023	Extension to October 2023 approved by Compliance and Risk Group

Document Reference	Directorate: Governance
Recommended at Date	Information Governance Group 18 September 2019
Approved at Date	Compliance and Risk Group 17 April 2023
Valid Until Date	October 2023
Equality Analysis	Completed
Linked procedural documents	Records Management Policy and Procedures Information Governance Strategy Information Governance Policy
Dissemination requirements	All personnel, via staff bulletins and intranet
Part of Trust's publication scheme	Yes

The East of England Ambulance Service NHS Trust has made every effort to ensure this policy does not have the effect of unlawful discrimination on the grounds of the protected characteristics of: age, disability, gender reassignment, race, religion/belief, gender, sexual orientation, marriage/civil partnership, pregnancy/maternity. The Trust will not tolerate unfair discrimination on the basis of spent criminal convictions, Trade Union membership or non-membership. In addition, the Trust will have due regard to advancing equality of opportunity between people from different groups and foster good relations between people from different groups. This policy applies to all individuals working at all levels and grades for the Trust, including senior managers, officers, directors, non-executive directors, employees (whether permanent, fixed-term or temporary), consultants, governors, contractors, trainees, seconded staff, homeworkers,

casual workers and agency staff, volunteers, interns, agents, sponsors, or any other person associated with the Trust.

All Trust policies can be provided in alternative formats.

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1.0 Introduction

NHS organisations must have in place procedural documents which are clear and comply with relevant legislation and national directives. Such documents should be appropriate, practical and assist staff in the application of consistent best practice across the East of England Ambulance Service (EEAST).

All procedural documents, including policies, procedures, guidelines etc, must be approved and sent to the Corporate Records Manager/FOI Officer for publication and to ensure they meet all aspects of this document.

2.0 Purpose

This Policy details the approved process for creating, renewing, approving, distributing, implementing and monitoring all EEAST procedural documents.

3.0 Responsibilities

3.1 Information Governance Group

The Information Governance Group (IGG) has overall responsibility for this Policy and the processes for the development and management of procedural documents.

3.2 Directors/Senior Managers

Directors/Senior Managers are responsible for the development, implementation and review of approved procedural documents within their delegated portfolios. They are also responsible for identifying and agreeing the need for such documents.

3.3 Head of Governance

The Head of Governance has overall responsibility for the processes in place for the development and management of

procedural documents across EEAST, both directly and through the Information Governance (IG) Group.

The Head of Governance also has responsibility for independently assessing compliance with this Policy and for reporting to the Audit Committee.

3.4 Compliance and Risk Group

In line with the Approvals Process outlined in Appendix A the Compliance and Risk Group (CRG) has final approval of Trust policies. The CRG is also responsible for ensuring that no policies are submitted for final approval without a completed checklist (see Appendix C)

3.5 Risk & Governance Manager

The Risk & Governance Manager responsible for ensuring that the Policy and Procedure Action Log (see Appendix D) is completed following each Compliance and Risk Group (CRG) meeting and sent to the Corporate Records Manager/FOI Officer. Where no documents have been presented, they must inform the Corporate Records Manager/FOI Officer by email.

3.6 Approving Committees/Groups

Once a document has received final approval it is the responsibility of the chair/minute taker of the approving group/committee to ensure that the completed Policy and Procedure Approval Action Log (see Appendix D) has been sent to the Corporate Records Manager/FOI Officer.

For the purposes of any Trust Board or Trust Board Sub-Committee approval the Head of Governance has overall responsibility for ensuring that the Policy Action Log is completed following each Compliance and Risk Group (CRG) meeting and other Trust Board Sub-Committees. However, this responsibility is delegated to the Risk & Governance Manager and the Deputy Head of Corporate Governance, who

will send the Action Logs to the Corporate Records Manager/FOI Officer.

Appendix B sets out which Committees/Groups can recommend and approve identified procedural documents.

3.6 Information Governance Manager

The Information Governance Manager is responsible for escalating to the CRG any procedural documents that have not been reviewed and updated 30 days after their Valid Until Date

3.7 Corporate Records Manager/FOI Officer

The Corporate Records Manager/FOI Officer is responsible for generating the reference numbers for each procedural document, as well as uploading approved documents to the Document Library and managing the Policy module within InPhase. They are also responsible for this Policy and ensuring that it is complied with.

Authors will receive an initial reminder 6 months before a procedural document's Valid Until Date, followed by a 3 month reminder to ensure that there is sufficient time to review or draft a replacement before the current document expires.

3.8 Authors and Document Leads

Authors and Document Leads are responsible for ensuring that the document has been recommended by the relevant committee/group and is sent to the Management Assurance Group for approval.

3.9 Communications Team

The Trust Communications Team will assist in the distribution of procedural documents where required.

3.10 All Members of Staff

All members of staff involved in the production of procedural documents must follow the processes and requirements in this Policy.

4.0 Definitions

4.1 Strategies

An organisation-wide, high-level plan designed to achieve a particular long-term aim. It is not static but evolves in response to changing circumstances.

4.2 Policies

A policy is a ratified corporate plan of action that outlines how the Trust will comply with legislation or directives, or is developed to ensure the implementation of a particular Trust strategy. It is mandatory for all staff members to comply with Trust policies.

4.3 Procedures/Manuals (includes Clinical Standard Operating Procedures)

A procedure is a standardised series of actions to accomplish an objective (sequence, timing, execution etc.) usually developed to describe the methods for implementing policy. This will apply to all relevant members of staff as a 'must do' document.

4.4 Guidelines/Guidance (includes Standard Operating Guidelines, Operational Instructions etc)

A guideline is a formal document that outlines Trust and accepted national best practice, and acts in an advisory way. Guidelines are not mandatory, however it is expected that staff members will follow guidelines except in exceptional circumstances.

For further information regarding Operational Instructions, Standard Operational Guidelines, Clinical Standard Operating Procedures and Manuals please see section 7.0.

5.0 Document Development

5.1 Development

Please see flow chart – Appendix A

The relevant lead Director/Senior Manager must approve the creation of any new procedural document. The Director/Senior Manager will then delegate responsibility for this procedural document to a member of staff as the author.

The author must then email the Corporate Records/FoI Officer requesting a document reference number. (see section 5.7)

5.2 Consultation

The author is responsible for ensuring that all relevant stakeholders are involved in the development of the draft document. Anyone with an interest in a procedural document can be considered a stakeholder, staff or third party. Documents for consultation should be circulated widely to ensure that all opinions are noted.

5.3 Format

Procedural documents must be written in plain English and in accordance with the following layout and font styles:

Title	**Frutiger, font size 16, Bold**
Headings	**Frutiger, font size 12, bold**
Sub-headings	**Frutiger, font size 11 bold**
Plain text	Frutiger font size 11, justified
Titles	Justified to the left
Headings	Justified to the left
Header	Include title of document (except on first sheet)

Footer	Include document name and version number in bottom left hand corner
Sub-headings or paragraphs	Outlined numbered e.g. 3.4
All text	Use plain, jargon-free English and avoid acronyms where possible
Glossary	Include when necessary

Authors are advised to use the Template in Appendix E or in the Document Library which already has the correct format, style and layout already set.

5.4 Monitoring Table

All procedural documents should have a Monitoring Table attached (see section 6.0)

5.5 Equality Impact Assessments

Equality Impact Assessments (EqIA) is the process by which we assess the impact of the way we provide our services. They are a legal requirement of the Equality Act 2010.

The purpose of an EqIA is to improve the way EEAST develops procedures and policies by ensuring that there is no discrimination in the way they are designed, developed or delivered.

Where required a completed Equality Analysis should be attached. This analysis should be undertaken as the procedural document is being developed (not afterwards) and must be approved by the relevant Director/Senior Manager. No procedural documents where an Equality Analysis is required should be accepted onto the agenda of a group/committee for recommendation/approval without an attached Equality Analysis.

The EqIA template, as well as guidance to assist with completing this, can be requested from records.management@eastamb.nhs.uk.

Please see Appendix I for the EqIA for this Policy for the Development of Procedural Documents.

5.6 Version Control

All procedural documents should include the document change history on the front page. This will specify the version of the document, and for revisions, list the main items revised within the document.

The following numbering system should be followed:

- All new draft documents should be labelled V0.1, V0.2 etc.
- The approved version will be labelled V1.0
- Draft reviews (significant or minor changes) will then become V1.1, V1.2 etc.
- The subsequent approved version will be V2.0 etc.

5.7 Document Reference Numbers

The Corporate Records Manager/FOI Officer will allocate an alphanumeric index number to each document according to the type of document:

Document type	Reference
Trust Policies	POL
Plans	PL
Strategies	ST
Guidelines	GU
Standard Operational Procedures (including Clinical and AOC)	SOP

Standard Operating Guidelines (including Clinical and AOC) SOG

Operational Instructions OI

5.8 Checklist

Prior to submitting a procedural document for final approval the Checklist (Appendix C) must be completed. This will ensure that all of the relevant steps have been completed and included with the documents before it is approved. Documents without a completed checklist will not be considered for approval and will be returned to the author.

5.9 Recommendation and Approval

All procedural documents must be recommended and approved by the appropriate groups/committee with designated or delegated Board authority. At each meeting where procedural documents receive final approval a completed Policy and Procedure Approval Action Log must be sent to the Corporate Records Manager/FoI Officer.

Appendix B sets out which Committees/Groups can recommend and approve identified Procedural Documents.

6.0 Implementation and Monitoring

All procedural documents should have an implementation schedule, where appropriate. This should include the intended audience, dissemination, training (if required) and monitoring of compliance.

Where training has been identified as a requirement, the author will work with the Education and Training department and/or the author to develop a training strategy.

6.1 Dissemination

The author will determine how the procedural document should be disseminated and communicated. This should

include clear information on where and how the document can be accessed and retrieved.

Staff will be made aware of any new procedural documents via the Trust's intranet page. If dissemination needs to be carried out more swiftly then local managers will be responsible for this.

Procedural documents must be made available on the Trust intranet, via the Document Library, and key documents must also be made available on the Trust's public website.

6.2 Monitoring Compliance

Monitoring provides assurance that prescribed systems are working and involves collecting information that will help answer questions about the Trust's systems, including:

- Are we managing risk?
- How well are we doing?
- Are we doing the things we said we should?
- Are we making a difference in doing those things?

All policies must include details of how the policy will be monitored, ideally in the form of a completed Monitoring Table. This will include the key standards/areas to be monitored and how this will be done.

It is important that the frequency and detail of the monitoring process is specified and that it can realistically be achieved.

6.3 Process for Monitoring Compliance and Effectiveness of This Policy

The Corporate Records Manager/FoI Officer will monitor compliance and effectiveness in the document review and renewal process on an on-going basis. They will look at:

- the timeliness of review
- the use of the Trust template
- the completion of the checklist
- the consultation and approval process

The outcomes and conclusions of this monitoring will be reported to the IG Group as required.

Appendix F shows the Template for Monitoring Table; Appendix G shows the completed Monitoring Table for this Policy.

7.0 Operational Documents

Operational Documents include Operational Instructions, Standard Operational Guidelines, Clinical Standard Operating Procedures, Standard Operating Procedures and Manuals. Due to the nature of these documents it is not practical or necessary for these to go through the whole process detailed above. However, the following steps must be taken:

- Document Numbering – if this is a new document then a number must be requested from the Corporate Records Manager/FoI Officer
- Version control – this must follow the guidance laid out in sections 5.6 and 5.7
- Equality Impact Assessment – an Equality Impact Assessment must be undertaken and documented where appropriate.
- Approval – the document must be approved as per the checklist/flowchart in section 5.8
- Monitoring – the document should include a process for monitoring compliance if necessary
- Review – the document should be reviewed as per section 8.0
- Document Control – as per section 9.0

8.0 Review and Revision Arrangements

All Trust documents must have a Valid Until Date. As a minimum, procedural documents should have a full review at

least every three years or more frequently if required, for example due to a change in legislation.

The review process must start 6 months before the Valid Until Date to ensure that the procedural document does not become out of date. The Corporate Records Manager/FOI Officer will send an initial review reminder to the author 6 months and a follow up 3 months before the procedural document's Valid Until Date.

The author(s) reviewing the document should either:

- Resubmit the Document to the appropriate Committee/Group explaining how it still meets the current requirements and standards.
- Revise and/or rewrite the existing document and repeat the consultation process, where necessary.
- Explain why the document can be safely withdrawn without replacing it with a revised version.

9.0 Document Control including Archiving Arrangements

The Policy Module within InPhase is the internal system in place to manage all procedural documents. It is the responsibility of the Corporate Records Manager/FOI officer to ensure that this is kept up to date with information received from authors and approving committees.

9.1 Register/Library of Procedural Documents

The Corporate Records Manager/FOI Officer is responsible for the maintenance of the Document Library (i.e. the register of the Trust's procedural documents held on the intranet).

Each member of staff is responsible for ensuring that any printed version in use is the current approved version of the document.

9.2 Archiving Arrangements

Procedural Documents will be archived when they are no longer ‘live’ documents but must be retained in case future reference is required or mandated by legislation.

10.0 Associated Documents

These are all the documents that are associated with the Procedural Document under development, and may include:

- Equality Analysis
- Data Protection Impact Assessment
- Other related Trust policies

11.0 References

Where applicable, all procedural documents must include references to legislation and national directives, e.g.:

- NHS Act 2006
- Health and Social Care Act 2012
- Bribery Act 2010
- Equalities Act 2010
- Human Rights Act 1998
- Data Protection Act 2018
- Records Management Code of Practice for Health and Social Care 2016 (Information Governance Alliance)
- NHS Constitution

Appendices

Appendix A Policy Approvals - Flowchart

Appendix B Policy Approvals – Committees/Groups

Appendix C Policy Approvals - Checklist

Appendix D Policy and Procedure Approval Action Log

Appendix E Procedural Document Template

Appendix F Monitoring Table Template

Appendix G Completed Monitoring Table

Appendix H Equality Impact Assessment Template

Appendix I Equality Impact Assessment

Appendix A: Policy Approvals - Flowchart

Read the "Policy for the Development of Procedural Documents"

Email Corporate Records Manager/FOI Officer for document reference number (if required)

Complete the Template

Complete Monitoring Table and Equality Analysis

All policies with HR implications must go to staff side/HR committee

Send to the relevant committee/group for discussion and recommendation

Ensure all relevant steps of the checklist have been completed to evidence approval

Send policy and checklist to CRG

Upon full approval

Insert approving committee/group names and approval dates into the policy

Amend Document Status to 'Approved' and ensure version number is the next whole number up

Send Word version and checklist to Corporate Records Manager/FoI Officer

Policy and checklist are checked to ensure the document is complete

PDF version uploaded to Document Library

InPhase updated and reminders set:

- ✓ **6 months before Valid Until Date** reminder email and PDPD pack sent to owner/author– PDPD pack contains Word copy of relevant policy, copy of Policy for the Development of Procedural Documents, policy template, Monitoring Table template, Checklist, and the Equality Impact Assessment template and guidance.

- ✓ Reminder email sent to owner/author **3 months before Valid Until Date**

- ✓ Owner/author contacted **1 day after Valid Until Date** and out of date policy removed from Document Library

- ✓ **1 month after the Valid Until Date** – escalation to the Information Governance Group, relevant Director and the Compliance and Risk Group

Appendix B: Policy Approvals – Committees/Groups

The tables below are to be used as guidance for the approval of procedural documents.

Strategy

Procedural Document Area	Lead	Recommending Group	Approving Committee/Group
Constitution: Standing Orders, Reservation of Powers to Trust Board and Scheme of Delegation	Head of Governance	Audit Committee	Trust Board
Finance: Standing Financial Instructions	Director of Finance and Commissioning	Audit Committee	Trust Board
Business Plans	Chief Executive	Executive Leadership Team	Trust Board

Procedural Document Area	Lead	Recommending Group	Approving Committee/Group
Clinical Strategy	Director of Clinical Quality & Safety	Quality Governance Committee	Trust Board
Fleet Strategy	Chief Executive	Transformation and Change Committee	Trust Board
Health & Safety Strategy	Director of Clinical Quality & Safety	Workforce Committee	Trust Board
Information Governance Strategy	Head of Governance	Audit Committee	Trust Board
Research Strategy	Medical Director	Quality Governance Committee	Trust Board
Risk Management Strategy	Head of Governance	Audit Committee	Trust Board

Policy

Procedural Document Area	**Lead**	**Recommending Group**	**Approving Committee/Group**
Policy for the Development of Procedural Documents	Head of Governance	Information Governance Group	Compliance and Risk Group
Safety Management Policies/ Procedures including, Duty of Candour, Management of Incidents including Serious Incidents, Investigations Guidance, Learning from Experience etc	Director of Clinical Quality & Safety	Avoidable Mortality and Patient Safety Group	Compliance and Risk Group
Safeguarding policies	Director of Clinical Quality & Safety	Safeguarding Group	Compliance and Risk Group
Clinical policies/procedures	Medical Director	Clinical Best Practice Group	Compliance and Risk Group

Procedural Document Area	Lead	Recommending Group	Approving Committee/Group
including best practice guidelines and clinical standard operating procedures			
Human Resources	Director of Workforce	Staff Partnership Forum	Compliance and Risk Group
Business Travel	Director of Workforce	Executive Leadership Team	Remuneration Committee
Finance and Procurement	Director of Finance and Commissioning	Compliance and Risk Group	Trust Board, via Executive Leadership Team
Equality and Diversity	Director of Workforce	Equality, Diversity and Inclusion Group	Compliance and Risk Group
Information Management & Information Technology	Chief Information Officer	Information Governance Group	Compliance and Risk Group

Procedural Document Area	**Lead**	**Recommending Group**	**Approving Committee/Group**
		Data Quality and Security Group	
Communications, Engagement and PPI	Director of Communications and Engagement	Patient Experience and Engagement Group and Organisational Development and staff engagement group	Trust Board via the relevant Sub-Committee (Workforce or Quality Governance Committee)
Patient Experience Policies/Procedures, including Complaints	Director of Clinical Quality & Safety	Patient Experience and Engagement Group	Compliance and Risk Group
Health and Safety	Director of Clinical Quality & Safety	Health, Safety and Wellbeing Group	Compliance and Risk Group
Patient Group Directives	Medical Director	Medicines Management Group	Compliance and Risk Group
Information Governance, including: Release of Information, Freedom of	Head of Governance	Information Governance Group	Compliance and Risk Group

Procedural Document Area	Lead	Recommending Group	Approving Committee/Group
Information, Information Governance, Records Management Policy and Data Protection			
Claims and Litigation	Director of Clinical Quality & Safety	Avoidable Mortality and Patient Safety Group	Compliance and Risk Group
Emergency Operations	Chief Operating Officer	Planning and Performance Group	Compliance and Risk Group
Civil Contingency Planning	Chief Operating Officer	Organisational Resilience Group	Trust Board, via Compliance and Risk Group
Project and Programme Management	Head of Transformation and Strategy	Transformation Programme Group	Executive Leadership Team

Procedural Document Area	Executive Lead	Recommending/approving Committee/Group	To receive notes of approval for information only
Clinical Standards Operating Procedures/Guidelines	Medical Director	Clinical Best Practice Group	Compliance and Risk Group
Standard Operating Guidelines (SOGs)	Chief Operating Officer	Performance and Planning Group	Compliance and Risk Group
Emergency Operations Centre	Chief Operating Officer	Performance and Planning Group (dependent on content)	Compliance and Risk Group
Procurement	Director of Finance and Commissioning	Products and Supplies Procurement Group	Compliance and Risk Group

Appendix C: Policy Approvals - Checklist

To be completed and attached to any policy when submitted to the appropriate committee/group for final approval, with evidence of committee/group recommendation.

Policies without a completed checklist will not be considered for approval by the Compliance and Risk Group

Title of document being reviewed:	Action
Template Policy entered into template for correct format with document reference number	Yes/No
Version Partial numbers when in draft , e.g. 1.1, 1.2, then whole numbers on final approval 2.0, 3.0	Yes/No
Director Approval Name Position Date	
Recommending Committee Name Date policy recommended Evidence of recommendation (e.g. minutes) attached	Yes/No
Equality Impact Assessment Has the Equality Impact Assessment been completed and attached by the author?	Yes/No
Monitoring Has the Monitoring Table been fully completed and attached?	Yes/No
Valid Until Date Has the Valid Until Date been identified?	Yes/No

Appendix D: Policy and Procedure Approval Action Log

Committee / Group name	
Date of meeting	

Document title:	Embed document	Author	Agenda item number	Outcome (e.g. Approved / Recommended / Approved subject to changes / Requires further clarification)

Please return completed logs to
Records.Management@eastamb.nhs.uk
after the respective meeting

NHS
East of England
Ambulance Service
NHS Trust

Title of Procedural Document

Document Reference	To be assigned by Corporate Records Manager
Document Status	Draft [change to Approved once approved]
Version:	When in draft change from V0.1 to V 0.2 and when approved V1.0, or 2.1 – 2.2 – 3.0, etc.

DOCUMENT CHANGE HISTORY		
Initiated by	**Date**	**Author (s)**
[Committee etc. originally requiring/ commissioning]	[Completion date of first Version]	[individual(s)' name], [job title]

Version	**Date**	**Comments (i.e. viewed, or reviewed, amended approved by person or committee)**
Draft V0.1	[date]	Circulated to xx [Group] for comments / Sent to xx Group for approval / reviewed following xxx [impact / event / input] / etc.
(etc.)	[date]	(etc.)
(etc.)	[date]	Approved by [Compliance and Risk Group / Trust Board / etc.]

Document Reference	[e.g. NHSLA – Relevant to standard x …] Directorate: [name of owning Directorate]
Recommended at Date	[name of Recommending Specialist Working Group] [Date of Recommendation for Approval]
Approved at Date	[name of Approving Committee / Group] [Date of Approval]
Valid Until Date	[Date by which this Version must be reviewed and updated / replaced by NEXT Version]
Equality Analysis	Completed [Date]
Linked procedural documents	Xxx Policy Yyy Strategy
Dissemination requirements	[To whom? By what method(s) ?]
Part of Trust's publication scheme	Yes / No?

The East of England Ambulance Service NHS Trust has made every effort to ensure this policy does not have the effect of unlawful discrimination on the grounds of the protected characteristics of: age, disability, gender reassignment, race, religion/belief, gender, sexual orientation, marriage/civil partnership, pregnancy/maternity. The Trust will not tolerate unfair discrimination on the basis of spent criminal convictions, Trade Union membership or non-membership. In addition, the Trust will have due regard to advancing equality of opportunity between people from different groups and foster good relations between people from different groups. This policy applies to all individuals

working at all levels and grades for the Trust, including senior managers, officers, directors, non-executive directors, employees (whether permanent, fixed-term or temporary), consultants, governors, contractors, trainees, seconded staff, homeworkers, casual workers and agency staff, volunteers, interns, agents, sponsors, or any other person associated with the Trust.

All Trust policies can be provided in alternative formats.

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3.1	[First duty-holder(s)]	x
3.2	[Second duty-holder(s)]	x
(etc.)	[Further duty-holder(s)]	x
3.n	Consultation and Communication with Stakeholders	x
4.	Definitions	x

Appendices

Appendix A	[Title of this Appendix]	x
Appendix B	[Title of this Appendix]	x
Appendix C	[Title of this Appendix]	x
(etc.)		

1. Introduction

[Introductory section to this document]

2. Purpose

[What is the aim of this document? Why is it being written?]

3. Duties

3.1 [First Duty-holder(s) e.g. Chief Executive]

[Clarify the duties of each of those responsible for all or aspects of this document]

3.2 (etc.) [Second etc. Duty-holder(s) e.g. specific Assistant Director]

4. Definitions

[Explanations of key words and phrases]

5. [Main body of document – first heading]

(etc.) [Main body of document – further headings]

Appendices

A Monitoring Table

B Equality Analysis

(etc.)

Appendix F – Template for Monitoring Table

Use this template to show the monitoring process of the document

What	**Who**	**How**	**Frequency**	**Evidence**	**Reporting arrangements**	**Acting on recommendations**	**Change in practice and lessons to be shared**
What key element that need monitoring	Role or group who will lead on this aspect of monitoring?	What tool will be used to monitor/ check/ observe/ asses/ inspect/ authenticate that everything is working according to this key element	How often is monitoring needed How often should a report be completed? How should a	What type of evidence will be presented	Who or what committee will the completed report go to and how will this be monitored. How will each report be interrogated to identify the required actions and how thoroughly should this be documented in	Which committee, department or lead will undertake subsequent recommendations and action planning for any or all deficiencies and recommendations within	How will system or practice changes be implemented lessons learned and how will these be shared.

			report be shared?		e.g. meeting minutes	reasonable timeframes?	
What	**Who**	**How**	**Frequency**	**Evidence**	**Reporting arrangements**	**Acting on recommendations**	**Change in practice and lessons to be shared**
				.	*The lead or committee is expected to read and interrogate any report to identify deficiencies in the system and act upon them*	*Required actions will be identified and completed in a specified timeframe.*	*Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.*

Appendix G – Completed monitoring table for this Policy

What	*Who*	*How*	*Frequency*	*Evidence*	*Reporting arrangements*	*Acting on recommend-ations*	*Change in practice and lessons to be shared*
Ensure the style and format of the document is in line with the Trust's requirements	Information Governance Team	The Corporate Records Manager/FOI Officer will review this aspect of the document prior to it being proposed for recommendation for approval, and if necessary it will be returned to the author for amendment	At each review of the document.	The document register / library will act as an audit trail	Reported to the Information Governance Team and where necessary discussed and minuted at the Information Governance Group	The document author will address any actions or changes required.	Required changes to practice will be identified and actioned. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

What	*Who*	*How*	*Frequency*	*Evidence*	*Reporting arrangements*	*Acting on recommend-ations*	*Change in practice and lessons to be shared*
All ambiguous language and non generic terms are explained and elaborated to ensure the understanding of the audience is fully gained	Information Governance Team	The Corporate Records Manager/FOI Officer will review this aspect of the document prior to it being proposed for recommendation for Approval, and if necessary it will be returned to the author for amendment	At each review of the document.	The document register / library will act as an audit trail	Reported to the Information Governance Team and where necessary discussed and minuted at the Information Governance Group	The document author will address any actions or changes required	Required changes to practice will be identified and actioned. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

What	***Who***	***How***	***Frequency***	***Evidence***	***Reporting arrangements***	***Acting on recommend-ations***	***Change in practice and lessons to be shared***
The document has been circulated to all relevant stakeholders for information and feedback	Information Governance Team	The Corporate Records Manager/FOI Officer will review this aspect of the document prior to it being proposed for recommendation for Approval, and if necessary it will be returned to the author for amendment	At each review of the document.	The document register / library will act as an audit trail	Reported to the Information Governance Team and where necessary discussed and minuted at the Information Governance Group	The document author will address any actions or changes required	Required changes to practice will be identified and actioned. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

What	***Who***	***How***	***Frequency***	***Evidence***	***Reporting arrangements***	***Acting on recommend-ations***	***Change in practice and lessons to be shared***
The document has passed through the correct route for approval to ensure that the relevant group / committee has given the final sign off.	Information Governance Team	The Corporate Records Manager/FOI Officer will review this aspect of the document prior to it being accepted and added to the register/library and made available and if necessary it will be returned to the author for correct approval	At each review of the document.	The document register / library will act as an audit trail	Reported to the Information Governance Team and where necessary discussed and minuted at the Information Governance Group	The document author will address any actions or changes required	Required changes to practice will be identified and actioned. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

What	***Who***	***How***	***Frequency***	***Evidence***	***Reporting arrangements***	***Acting on recommend-ations***	***Change in practice and lessons to be shared***
For the document to be reviewed in advance of its formal review date to ensure changes can be consulted on and approved in good time for it to be re-published before 'expiry'	Information Governance Team	The Corporate Records/FOI Officer will note and record this aspect of the document's development process at respective stages	At each review of the document.	Using minutes from Recom-mending and Approving Groups / commit-tees, the docu	Reported to the Information Governance Team and where necessary discussed and minuted at the Information Governance Group	The document author will address any actions or changes required	Required changes to practice will be identified and actioned. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

				ment register / library will act as an audit trail			

#WeAreEEAST

What	***Who***	***How***	***Frequency***	***Evidence***	***Reporting arrangements***	***Acting on recommend-ations***	***Change in practice and lessons to be shared***
Ensure that the document has clear version control and archiving arrangements are outlined	Information Governance Team	The Corporate Records/FOI Officer will review this aspect of the document prior to it being proposed for recommendation for Approval, and if necessary it will be returned to the author for amendment	At each review of the document.	The document register / library will act as an audit trail	Reported to the Information Governance Team and where necessary discussed and minuted at the Information Governance Group	The document author will address any actions or changes required	Required changes to practice will be identified and actioned. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

#WeAreEEAST

What	***Who***	***How***	***Frequency***	***Evidence***	***Reporting arrangements***	***Acting on recommend-ations***	***Change in practice and lessons to be shared***
All other procedural documents that either have an impact on or are to be read in conjunction with this document are clearly identified within its body	Information Governance Team	The Corporate Records/FOI Officer will review this aspect of the document prior to it being proposed for recommendation for Approval, and if necessary it will be returned to the author for amendment	At each review of the document.	The document register / library will act as an audit trail	Reported to the Information Governance Team and where necessary discussed and minuted at the Information Governance Group	The document author will address any actions or changes required	Required changes to practice will be identified and actioned. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

What	*Who*	*How*	*Frequency*	*Evidence*	*Reporting arrangements*	*Acting on recommend-ations*	*Change in practice and lessons to be shared*
All legislative references are recognised within a section of the document using their full titles and dates	Information Governance Team	The Corporate Records/FOI Officer will review this aspect of the document prior to it being proposed for recommendation for Approval, and if necessary it will be returned to the author for amendment	At each review of the document.	The document register / library will act as an audit trail	Reported to the Information Governance Team and where necessary discussed and minuted at the Information Governance Group	The document author will address any actions or changes required	Required changes to practice will be identified and actioned. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

Appendix H – Equality Impact Assessment Template

Guidance Note

Equality Impact Assessments (EIA) and Equality Analysis are processes by which we assess or test the impact of the way we provide our services be it services to our communities or staff. They are relevant to all of our services, policies and procedures and functions. They are a legal requirement and adhere to the EDS2 and Equality Act 2010.

EIA's are primarily used to help us demonstrate that we have considered equality and is designed to make us challenge our own assumptions about whether a policy or service is fair to all? We need to ensure and provide evidence that people are not being excluded or treated unfairly. We collect this evidence via equality analysis.

Providing information

We have a wealth of information that we can call on to help us assess the impact of our services, policies and procedures from an equality perspective. This could include data that is routinely collected. It can also include minutes from management or team meetings. It could simply be conversations we have with our staff and communities / service users who have used a particular service. Information could come from outside the service l, such as our partners or visitors. Anything that helps inform our understanding can be included.

Protected Characteristics

Through the EIA process, we are asking managers and staff to think seriously about equality based on the protected characteristics which we are bound by law to consider:

Race	**Religion/belief**	**Marriage/Civil Partnership**
Gender	**Disability**	**Sexual orientation**

Age **Gender re-assignment** **Pregnancy/maternity**

Action Plans

You may find that you need more information to help make a full assessment. Please put down what information you need and identify in the action plan, how you intend to collect it. When completing your action plan it is important that you clearly state where within existing management structures those actions will be performance monitored.

Guidelines	
Written policy involving staff and patients	
Strategy	
Changes in practice	
Department changes	
Project plan/Action plan	
Other (please state) Training Programme	

Please do not view EIAs as a simple tick box exercise designed to placate or meet the needs of some bureaucratic government department and something which can be ignored. Should we ever face a legal challenge on the grounds of discrimination, we will be asked to demonstrate to the courts that we have met the full requirements of the law. The completed EIA is ours/your written evidence of our commitment to equality, diversity, inclusion and human rights.

Equality Impact Assessment

EIA Cover Sheet	
Name of process/policy	
Is the process new or existing? If existing, state policy reference number	
Person responsible for process/policy	
Directorate and department/section	
Name of assessment lead or EIA assessment team members	
Has consultation taken place? Was consultation internal or external? (please state below):	
Internal	

<table>
<tr><td>The assessment is being made on:

Please tick whether the area being assessed is new or existing.</td><td>
<table>
<tr><td>Guidelines</td><td></td></tr>
<tr><td>Written policy involving staff and patients</td><td></td></tr>
<tr><td>Strategy</td><td></td></tr>
<tr><td>Changes in practice</td><td></td></tr>
<tr><td>Department changes</td><td></td></tr>
<tr><td>Project plan</td><td></td></tr>
<tr><td>Action plan</td><td></td></tr>
<tr><td colspan="2">Other (please state)

Training programme.</td></tr>
</table>
</td></tr>
</table>

Equality Analysis
What is the aim of the policy/procedure/practice/event?

<table>
<tr><td colspan="6">Who does the policy/procedure/practice/event impact on?</td></tr>
<tr><td>Race</td><td>☐</td><td>Religion/belief</td><td>☐</td><td>Marriage/Civil Partnership</td><td>☐</td></tr>
<tr><td>Gender</td><td>☐</td><td>Disability</td><td>☐</td><td>Sexual orientation</td><td>☐</td></tr>
<tr><td>Age</td><td>☐</td><td>Gender re-assignment</td><td>☐</td><td>Pregnancy/maternity</td><td>☐</td></tr>
<tr><td colspan="6">Who is responsible for monitoring the policy/procedure/practice/event?</td></tr>
<tr><td colspan="6">What information is currently available on the impact of this policy/procedure/practice/event?</td></tr>
<tr><td colspan="6">Do you need more guidance before you can make an assessment about this policy/procedure/ practice/event? Yes/No</td></tr>
<tr><td colspan="6">Do you have any examples that show that this policy/procedure/practice/event is having a positive impact on any of the following protected characteristics? Yes/No, If yes please provide evidence/examples:</td></tr>
<tr><td>Race</td><td>☐</td><td>Religion/belief</td><td>☐</td><td>Marriage/Civil Partnership</td><td>☐</td></tr>
<tr><td>Gender</td><td>☐</td><td>Disability</td><td>☐</td><td>Sexual orientation</td><td>☐</td></tr>
<tr><td>Age</td><td>☐</td><td>Gender re-assignment</td><td>☐</td><td>Pregnancy/maternity</td><td>☐</td></tr>
<tr><td colspan="6">Please provide evidence:</td></tr>
</table>

Are there any concerns that this policy/procedure/practice/event could have a negative impact on any of the following characteristics? Yes/No, if so please provide evidence/examples: **Race** ☐ **Religion/belief** ☐ **Marriage/Civil Partnership** ☐ **Gender** ☐ **Disability** ☐ **Sexual orientation** ☐ **Age** ☐ **Gender re-assignment** ☐ **Pregnancy/maternity** ☐ Please provide evidence:
Action Plan/Plans – SMART **S**pecific **M**easurable **A**chievable **R**elevant **T**ime Limited

Evaluation Monitoring Plan/how will this be monitored?
Who How By Reported to

Appendix I – Equality Impact Assessment - completed

EIA Cover Sheet	
Name of process/policy	Policy for the Development of Procedural Documents
Is the process new or existing? If existing, state policy reference number	POL001
Person responsible for process/policy	Corporate Records Manager/FoI Officer
Directorate and department/section	Head of Governance
Name of assessment lead or EIA assessment team members	Corporate Records Manager/FoI Officer
Has consultation taken place? Was consultation internal or external? (please state below):	
Internal	Information Governance / IGG
The assessment is being made on: Please tick whether the area being assessed is new or existing.	

Guidelines	
Written policy involving staff and patients	X
Strategy	
Changes in practice	
Department changes	
Project plan	
Action plan	
Other (please state) Training programme.	

Equality Analysis

What is the aim of the policy/procedure/practice/event?

To ensure staff are clear on how to develop Trust procedural documents, including the correct format, approvals process, and any relevant supporting documents.

Who does the policy/procedure/practice/event impact on? All staff who are responsible for procedural documents

Race	☐	**Religion/belief**	☐	**Marriage/Civil Partnership**	☐
Gender	☐	**Disability**	☐	**Sexual orientation**	☐
Age	☐	**Gender re-assignment**	☐	**Pregnancy/maternity**	☐

Who is responsible for monitoring the policy/procedure/practice/event?

Corporate Records Manager / FoI Officer

What information is currently available on the impact of this policy/procedure/practice/event?

There is no impact of this policy upon any specific protected charactistics

Do you need more guidance before you can make an assessment about this policy/procedure/ practice/event? ~~Yes~~/No

Do you have any examples that show that this policy/procedure/practice/event is having a positive impact on any of the following protected characteristics? ~~Yes/~~No, If yes please provide evidence/examples:

Race	☐	**Religion/belief**	☐	**Marriage/Civil Partnership**	☐
Gender	☐	**Disability**	☐	**Sexual orientation**	☐
Age	☐	**Gender re-assignment**	☐	**Pregnancy/maternity**	☐

Please provide evidence:

Are there any concerns that this policy/procedure/practice/event could have a negative impact on any of the following characteristics? ~~Yes/~~No, if so please provide evidence/examples:

Race	☐	**Religion/belief**	☐	**Marriage/Civil Partnership**	☐
Gender	☐	**Disability**	☐	**Sexual orientation**	☐
Age	☐	**Gender re-assignment**	☐	**Pregnancy/maternity**	☐

Please provide evidence: