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<b>Applicable to:</b>	<b>All Sites and Staff</b>

# Policy on the Development of Policies, Protocols and Guidelines

## (Draft Ver 2.06 – August 2009)

<b>Category:</b>	Organisational Document
<b>Summary:</b>	The purpose of this Policy is to provide a clear process for the development, review, amendment and withdrawal of Trust documents and establish a corporate style for all documents to be of a consistently high standard.
<b>Equality and Impact Assessment undertaken:</b>	
<b>Date of Review:</b>	August 2011
<b>Approval Date/ Via:</b>	<ul style="list-style-type: none"> <li>▪ Improved Awareness Safety Action Group –</li> <li>▪ Care Quality Board –</li> <li>▪ Board of Directors –</li> </ul>
<b>Distribution:</b>	<p>Via Safety, Quality and Risk Department to:</p> <ul style="list-style-type: none"> <li>▪ Divisional Directors and Directorate Managers</li> <li>▪ Safety, Quality and Risk Intranet Site</li> </ul> <p>Via PFI Client Contract Office to:</p> <ul style="list-style-type: none"> <li>▪ Carillion Health</li> <li>▪ G4S</li> </ul>
<b>Related Documents:</b>	NHS Litigation Authority Risk management Standards April 2009
<b>Author(s):</b>	'Policy on Policies' Working Group
<b>Further Information:</b>	Board Secretary
<b>This Document replaces:</b>	"Guidelines on Policies and Procedures" (Version 1.0 – 2004)

**Lead Director:** Chief Operating Officer  
Director of Nursing and Clinical Leadership

**Issue Date:**

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# Policy on the Development of Policies, Procedures and Guidelines (Draft Ver 2.06 – August 2009)

## Introduction

1. Oxford Radcliffe Hospitals NHS Trust ('the Trust') needs policies, protocols and guidelines ('the documents')
  - 1.1 for effective operational management
  - 1.2 for identifying and mitigating risks
  - 1.3 as evidence of the Trust's current practice and future intentions.
2. Documents must be clear and consistent in both content and format, in order to provide patients, staff and other stakeholders with understandable statements of the Trust's values, beliefs, strategies, policies and practices.

## Policy Statement

3. The Trust's policy is to:
  - 3.1 keep the number of policies to a minimum.
  - 3.2 develop documents that reflect the Trust's core vision and values, in response to statutory, Government, or Trust requirements, or to lessons learnt from adverse events.
  - 3.3 to write each document in plain English that takes account of design and layout as well as language, so that the intended audience can understand and act upon the document the first time that they read it.
  - 3.4 develop, implement or review documents in line with this policy, and the standard templates attached.
  - 3.5 publish documents on the Trust's inter/intranet websites.
  - 3.6 approve **policies** for implementation only after full consultation and impact assessment.

## Scope

4. This policy applies to all areas of the Trust, and all employees of the Trust, including individuals employed by a third party or external contractors, or as voluntary workers, students, locums or agency staff. In exceptional circumstances, the **Documents Co-ordinator** may authorise suspension of this policy in the preparation of any document.
5. All documents are disclosable under the Freedom of Information (FOI) Act 2000, subject to exemptions. Policies should be included in the FOI Publication Scheme on the FOI web pages under **policies** and **procedures**.

## Aim

6. The purpose of this Policy is to ensure:

- 6.1 a clear process for the development, implementation, maintenance, review, amendment or withdrawal of Trust documents.
- 6.2 a corporate approach and style that ensures that all documents achieve a consistently high standard.
- 6.3 the development of documents with representative stakeholders, including staff, to incorporate statutory and professional standards.
- 6.4 clear approval processes that can be readily followed.

### Definitions

7. See **Document Categories** and **Responsibilities** below.

### Document Categories

8. A **strategy** states the direction in which the Trust intends to go. It is a long-term plan of action to achieve a particular goal in relation to the Trust's strategic aims and objectives. It is dynamic, responding to changing circumstances and requiring regular and systematic revision.
9. A **policy** states what staff must know or do. It is a formal, corporate statement of intent of the Trust's position, and overall aims and objectives, on an issue, based on principles adopted by the **Board of Directors**. It may be used to support the Trust during legal action, and must be reviewed at least every two years. All staff - whether permanent, temporary or third party contractors – must comply with Trust policies. All policy statements that refer to a designated Board Director, and policies that impact on all areas of the Trust, must be approved only by the **Board of Directors**, or by one of its designated **Board Committees**. For the same reason, they are prepared at a corporate level and not by an individual directorate, division, ward or department unless the **Documents Co-ordinator** asks it to do so.
10. Accordingly, a policy:
  - 10.1 is as short as a possible.
  - 10.2 can be easily understood, so that a large number of people can be made aware that it exists, and what it is for.
  - 10.3 briefly specifies what the policy is, and who has responsibility for it.
  - 10.4 is compatible with equality and diversity requirements.
  - 10.5 refers to other documents as appropriate.
11. A **procedure** describes how to do something should be done. Usually, but not always, a procedure supports a policy. Its length may vary, but it must be operational, and written for the staff that are to implement it. It will be approved by the committee or group most relevant to it, and listed by the Care quality Board.
12. There are two types of procedure:
  - 12.1 A **protocol** is the mandatory way of doing something, and must be followed.
  - 12.2 A **guideline** is an indication of the course that is usually followed, unless there are good reasons for not doing so.
13. Both protocols and guidelines are based on recognised best practice, with an acknowledged evidence base. The distinction between protocols and guidelines is not absolute, and some overlap is inevitable.

## Responsibilities

14. The **Chief Executive** has overall responsibility and final accountability for ensuring that the Trust has appropriate documents in place; and that the Trust works to best practice, and complies with all relevant legislation. S/he ensures that responsibility for developing specific document categories is delegated to appropriate **Lead Directors** (see **Appendix B**).
15. The **Board Secretary** is the **Documents Co-ordinator**. S/he is responsible for
  - 15.1 co-ordinating the development, review and approval of documents
  - 15.2 maintaining a central database and archive of all documents
  - 15.3 advising on the availability and scope of existing documents
  - 15.4 authorising suspension of this policy in the preparation of any document in exceptional circumstances that usually (but not always) derive from external mandatory requirements.
  - 15.5 notifying the appropriate **Lead Director** that review is due, six months before the date that the Approval Committee has specified for review.
  - 15.6 ensuring that account is taken of changing external advice (see **Appendix A**), and for monitoring and evaluating the Implementation Plan (see **Appendix A**).
16. The **Lead Directors** (see **Appendix B**) are designated Directors to whom the **Chief Executive** has delegated responsibility for individual document categories. They are responsible for identifying a **Policy Author** for each document required within the category; for ensuring that each document is reviewed within two years of approval, or in accordance with any shorter timescale specified when the document is approved; and for ensuring that the requirements of this policy are generally followed.
17. **Lead Authors** are responsible for ensuring that documents:
  - 17.1 comply with the corporate standards of production.
  - 17.2 follow the consultation and ratification pathways.
  - 17.3 are reviewed and updated in line with review timescales set at the time of approval, or as a result of changes to best practice or organisational changes.
  - 17.4 undergo the necessary equality impact assessments before they go through the approval process.
  - 17.5 do not in any way, directly or indirectly, discriminate unlawfully against any group or individual.
18. **Divisional Directors of Operations, Directorate Managers** and **Heads of Specialist Services** are responsible for:
  - 18.1 identifying additional documents for preparation.
  - 18.2 ensuring that approved documents, where applicable, are implemented within their Divisional/Directorate/Service.
  - 18.3 ensuring that systems are in place to audit compliance with documents.
  - 18.4 nominating, within their areas of responsibility, **Policy Champions** (see 21 below).
19. **Ward Managers** and **Departmental Managers** are responsible for:
  - 19.1 identifying additional documents for preparation.
  - 19.2 bringing the attention of their staff to the publication of a new/revised document.

- 19.3 providing evidence that documents have been circulated throughout their team or department.
  - 19.4 ensuring that new or revised documents are effectively implemented.
  - 19.5 ensuring that their staff attend all training required to implement each document.
20. **Policy Champions** are responsible for:
- 20.1 maintaining manuals of current paper copies of approved documents for defined areas.
  - 20.2 ensuring that these are available to staff 24 hours a day/7 days a week.
  - 20.3 ensuring that document implementation plans are activated.
21. **Individual Staff** are responsible for:
- 21.1 identifying additional documents for preparation.
  - 21.2 reading and complying with documents relevant to their job, as required by their conditions of employment.
  - 21.3 attending training to familiarise themselves with, and comply with, all documents relevant to their jobs and responsibilities.
  - 21.4 raising with their line manager any queries about the implementation of documents.
22. **Document Committees**
- 22.1 The **Board of Directors** determines those policies that it reserves for its direct approval, and the **Board Committees** that are to approve remaining policies on the Board's behalf. A schedule of these policies will be included in the Trust's standing orders, and will be placed on the Trust's inter/intranet sites, and circulated in the Trust by global email.
  - 22.2 The relevant **Board Committee** will clearly record its approval of any authorised policy in the minutes presented to the subsequent meeting of the **Board of Directors**; and will make available to each Director in advance of that meeting a full electronic copy of the policy. The policy will not be circulated until the Committee's approval has been reported to the **Board of Directors**.
  - 22.3 The Executive **Care Quality Board (CQB)** may act as a discussion and review body in the development and endorsement of Trust-wide policies before their presentation by the sponsoring **Lead Director** to a meeting of the **Board of Directors** or a **Board Committee**.
  - 22.3 **Document Development Groups** (see **Appendix B**) are responsible for recommending the first draft of each document to **Approval Bodies, which** are responsible for approving documents (other than policies) that meet the standards set out in this policy. Only the **Board of Directors**, or a designated **Board Committee**, approves policies.

## Style and Format of Documents

23. All documents must be written in a clear, concise style that uses unambiguous terms and language. Consideration should be given to producing appropriate documents in languages other than English, depending on the population groups served by the Trust.
24. Abbreviations must be used sparingly, and only if their meanings are explained at their first use in the document.

25. Until a document is approved, each page should be marked *Draft*.

**Style**

26. Documents should be produced using Microsoft Word and follow the formatting below:

<b>Document title</b>	Arial 16 pt (bold)
<b>Main section headings</b>	Arial 14 pt (bold)
<b>Sub-section headings</b>	Arial 12 pt (bold)
<b>Main text</b>	Arial 11 pt
<b>Paragraph/numbering</b>	Each paragraph should be numbered and indented as follows, and not be in bold type: 1. Example 1 1.2 Example 2 a. Example 3
<b>Justification</b>	Full justified
<b>Line spacing</b>	<ul style="list-style-type: none"> <li>▪ Spacing after each heading and paragraphs should be 6 pt.</li> <li>▪ Spacing after each section should be 12 pt.</li> <li>▪ Spacing after each sub-section should be 9pt.</li> </ul>
<b>Bullet points</b>	Only be used in tables or charts.
<b>Underlines</b>	None
<b>Logo</b>	The Trust's NHS logo should always appear in the header on the right hand side of the 'Document' cover sheet, front page of any attached toolkit or on all pages of any forms.
<b>Margins</b>	<ul style="list-style-type: none"> <li>▪ Portrait - 2 cm top, bottom and right. 2.5 cm left.</li> <li>▪ Landscape – 2 cm top and bottom. 1.5 cm left and right.</li> </ul>
<b>Appendices</b>	Should always commence on an uneven page number
<b>Headers, footers and page numbering</b>	<ul style="list-style-type: none"> <li>▪ Headers (except those with the Trust's NHS logo), should state on left side – Oxford Radcliffe Hospitals (<i>Arial 12 pt – Bold</i>). It should be in a single row and column with paragraph space of 6 pt after and a bottom border of 1½ pt. Portrait length 16.8 cm, landscape length 27 cm (see this document for an example).</li> <li>▪ Footers should be in a single row with 2 columns with paragraph space of 6 pt before and a top border of 1½ pt. The left column should state, document title, status, version and date. The right column should state page numbering (see this document for an example).</li> </ul>
<b>Blank pages</b>	The following should be stated and centered in the middle of the page, using Arial 18 pt (bold): <p style="text-align: center;"><b>This page is deliberately blank</b></p>
<b>Printing/copying</b>	Double-sided

**Format**

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27. All documents must follow the standard Trust format, for easy use by relevant staff. A word copy of the 'Document' master layout will be made available by hyperlink to the intranet.

### Document Development Process

28. Before development of a document is started, careful consideration should be given to the type required *i.e.* policy, procedure, guideline or protocol.
29. The need to develop a document will generally be identified at a corporate level, but may derive from other sources, including:
- 25.1 the Board of Directors.
  - 25.2 a Board, Executive or other committee.
  - 25.3 senior management
  - 25.4 legislation.
  - 26.5 changing practice in the Trust.
  - 27.6 individuals.
30. An individual, group or committee that identifies the need to develop a document in response to particular circumstances must bring the matter to the attention of the relevant Lead Director through the appropriate line manager(s).
31. Development of a document cannot begin until it has been registered with the **Documents Co-ordinator**. S/he confirms that there is no potential duplication with an existing or developing document, and initiates the **document administration process**.
32. In developing the document, the following questions must be answered:
- 32.1 what the document is for, and at whom it is targeted?
  - 32.2 who are the **Lead Author** and **Lead Director**?
  - 32.3 is anyone else in the Trust likely to be dealing with the same or similar issue(s), with whom liaison will be necessary? Will the new document replace an existing document?
  - 32.4 who should be involved in or consulted about, developing the document *e.g.* patients, staff, staff side, experts (such as health and safety advisors) and external input as necessary or desirable?
  - 32.5 what is the timescale?
  - 32.6 what is the implementation plan?
  - 32.7 what is the communication plan?
33. **Stages**

Stage	Status
1.	<b>Document Development Group</b> accepts proposal for a new or revised document; allocates its priority ranking; and identifies its <b>Lead Author</b> , <b>Lead Director</b> sponsor, and (where appropriate) a Sub-group to work on it.
2.	<b>Lead Author</b> confirms with <b>Documents Co-ordinator</b> that the document does not overlap an existing document.
3.	<b>Lead Author</b> and <b>Sub-group</b> develop or revise the document; prepare implementation plans; and complete the equality and/or other appropriate

	impact assessment for attachment to draft document.
4.	<b>Sub-group</b> submits first draft document to <b>Document Development Group</b> for endorsement, and agreement to consultation route.
5.	<b>Lead Author</b> places draft document on the intranet, and seeks comments on it by a specified date.
6.	<b>Lead Author</b> submits draft document, implementation training plans, and review date to <b>Document Development Group</b> for endorsement.
7.	<b>Lead Author</b> submits endorsed draft to the appropriate <b>Approval Committee, Board Committee</b> or <b>Board of Directors</b> for sponsorship by the <b>Lead Director</b> and final approval.
8.	Following approval, <b>Lead Author</b> places document and 'At a Glance Poster' version on the intranet, and communicates its availability by global email.
9.	<b>Lead Author</b> and Learning and Development communicate the availability of the appropriate training identified in the document, and implement it.
10.	Three months before the date that the <b>Approval Committee</b> specifies for review, the <b>Documents Co-ordinator</b> notifies the appropriate <b>Lead Director</b> that the review is due.

### References

34. It is important to allow readers to understand the sources of information that have been referred to or used in developing a document (see the section for this Policy as an example.)

### Equality Impact Assessment

35. It is important that all authors ensure that documents do not in any way, directly or indirectly, discriminate unlawfully against any group or individual. To demonstrate this, documents must be assessed in accordance with the Trust's Equality Impact Assessment Tool. The Single Equality Scheme, outlining the Trust's legal duty, is available on the Trust intranet and website. The Equality Impact Assessment must be attached to the document before it can be approved.

## Document Consultation, Approval and Ratification Process

### Consultation Process

36. The Trust is committed to involving staff and key stakeholders in the development, review and monitoring of documents, through robust and inclusive communication arrangements (see 31 above).
37. The Staff Side must be consulted about all employment and health and safety-related documents (see 31 above).
38. Patients, carers and patient/carers representatives must be involved in the development or review of documents that relate to services that directly affect them (see 31 above).

### Document Approval Process

39. The stages towards approval of a document are set out above (see 31 above).

40. The **Board of Directors** will determine those policies that it reserves for its direct approval, and the **Board Committees** that are to approve remaining policies on the Board's behalf (see 17 above).

### Ratification Process

41. The stages towards ratification of a document are set out above (see 33 above).

## Review and Revision Arrangements

### Review Process

42. The process for reviewing and revising existing documents is the same as that for developing new documents. All documents must be reviewed at least every two years, and revised to take account of current best practice; changes in policy and/or legislation; and/or changes in staffing and/ or organisation.
43. The **Lead Author** of the original document is responsible for ensuring that this task is carried out by the agreed date. If that person is no longer in post, the new post holder or her/his immediate manager undertakes the task.

### Version Control

44. Version control is used to make clear which is the most up-to-date version of each document e.g. the version number of the first draft of a document being written for the first time is 0.1. If the document is later amended, the version number of the second draft is 0.2. Each version must be archived so that an audit trail can be produced of the changes made in each draft.
45. The version number of the document should be included on the front cover sheet and in the footer of every page of the document, including all attachments to it.
46. As soon as the document has been approved and is ready for dissemination, its version number will change to 1.0. This is a simple way of showing that the document has been validated.
47. When a document is being reviewed, and a revised draft is being prepared, the version will change to 2.1 and so on. As soon as the new changes have been approved and the updated policy is ready to be disseminated, it will replace the existing version 1.0 of the document to become version 2.0. This also applies to documents that do not require approval but have been changed.
48. If a policy is reviewed, and there are no changes made to it, its version number does not change.
49. In summary, only documents with a whole number as a version (e.g. 1.0, 2.0, 3.0) are approved and disseminated. In this way, it is clear that the document has been approved and is the version that must be used.

## Dissemination and Implementation

### Dissemination

50. To ensure that Trust standards are met and maintained, only the **Lead Author** has publishing rights for approved documents.
51. The **Lead Author** is responsible for publishing an approved document in pdf format on the Trust's inter/intranet. S/he communicates its availability (and a request to destroy all

previous paper versions of the document) by global email, with an accompanying 'At a Glance' poster; by Trust Briefing; and by ORH News.

### Implementation

52. In developing a document, the **Lead Author** or **Document Development Group** must identify actions required for its implementation, including e.g. awareness-raising, training, equipment requirements, as identified within the training needs analysis (see **Appendix A**).

## Document Control, Retention and Archiving

### Register/Library of Documents

53. The **Documents Co-ordinator** maintains an electronic database of all master documents, and ensures that all approved documents are published. As a minimum, the database records dates of approval and issue, version numbers and dates for review.
54. The management of complaints, claims and other legal processes often require a demonstration that a particular document was in place at the time of a particular incident. The **Documents Co-ordinator** is responsible for ensuring that arrangements exist for the archiving of successive versions of documents in accordance with HSC 1999/053 *For the Record* and the Trust's *Retention and Destruction of Health Records Policy*.

### Process for Retrieving Archived Documents

55. A member of staff who needs to obtain an archived document should contact the **Documents Co-ordinator**, who will retrieve the relevant document.

## Training

56. Induction training ensures that new employees are aware of all documents relevant to their job. More detailed training is given in those documents that exist to meet statutory requirements.
57. The **Document Development Group** is responsible for identifying any training need associated with a new or revised document', and for informing the annual training needs analysis accordingly.

## Monitoring Compliance

### Process for Monitoring Compliance

58. Documents must be realistic and achievable, so that delivery of 'what the document says' can be monitored. Each document should state:
  - 55.1 who is responsible for auditing compliance with it.
  - 55.2 how and when it is audited.
  - 55.3 where the results of the audit are reported, and who is responsible for formulation and implementation of remedial action.
  - 55.5 who is responsible for the two-yearly review of its effectiveness and appropriateness.

### Key Performance Indicators (KPI)

59. The **Lead Author** and Document Development Group must identify between three and five key performance indicators to monitor the effect of implementing the document. These must be listed in the Implementation Plan under **Quality and Assurance**.
60. Indicators must be SMART *ie*

**Specific**  
**Measurable and meaningful**  
**Achievable and action-oriented**  
**Realistic, relevant and reasonable**  
**Time-based and traceable.**

51. Other examples include:
- 59.1 the percentage of staff trained in application of the document.
- 59.2 the percentage of incidents/complaints that contravened the document.
- 59.3 the number of risk assessments undertaken as defined by the document.

### **Review of this Policy**

62. Three months before the date that the Approval Committee specified for review, the **Documents Co-ordinator** notifies the appropriate Lead Director that the review is due.

### **References for this Policy**

63. NHS Litigation Authority, *Risk Management Standards*, April 2009.
64. Mid Cheshire Hospitals NHS Foundation Trust, *The Development and Control of Trust Documents*, July 2006.
65. Surrey and Borders Partnership NHS Trust, *Policy, Procedure and Guideline Development Policy*, August 2006.
66. Eastbourne Down NHS Primary Care Trust, *Procedure on the Management of Policies and Procedures*, April 2004.

### **Document History for this Policy**

<b>Version</b>	<b>Date</b>	<b>Author</b>	<b>Status</b>	<b>Comment</b>
2.03	May 2009	Jim Roy	Draft	Review and replacement of "Guidelines on Policies and Procedures" document dated 2004, due to the requirements of the NHSLA Risk Management Standards and Best Practice.
2.04	July 2009	Jim Roy	Draft	Re-drafting following comments and further examples.
2.05	August 2009	Jim Roy	Draft	Re-drafting following comments from Working Group.
2.06	August 2009	Jerry Park, Jim Roy	Draft	Re-draft following further comments

## Appendix A: Implementation Plan

### Part A - Corporate Responsibilities

#### Communication/Training Plan

Policy on Policies	
1. Goal and Purpose of the Communication and Training Plan?	<input type="checkbox"/> Ensure that appropriate staff understand broad strategy and processes, and personal responsibilities.
2. Target group(s) for Communication or Training?	<input type="checkbox"/> Directors <input type="checkbox"/> Senior and Middle Managers.
3. Target Numbers?	<input type="checkbox"/> Training: 50 <input type="checkbox"/> Communications: 250
4. Methodology – how will the communication be carried out?	<input type="checkbox"/> Generally by Intranet, Team Brief and ORH <input type="checkbox"/> Locally, by team meetings.
5. Methodology – how will the training be carried out?	<input type="checkbox"/> Corporate training programme
6. Communication/Training delivery?	<input type="checkbox"/> Internal experts <input type="checkbox"/> Managers
7. Funding?	<input type="checkbox"/> The only cost will be the release of staff to attend, and this should be met within local budgets.
8. Measurement of success, learning outcomes and/or objectives?	<input type="checkbox"/> Compliance with document <input type="checkbox"/> Competence to undertake task <input type="checkbox"/> Completion of paperwork.
9. Review effectiveness – learning outputs?	<input type="checkbox"/> Measure against goal/purpose <input type="checkbox"/> Review of further communication <input type="checkbox"/> Training needs.
10. Issue date of document?	Date on document
11. Start and completion date of communication/training plan?	Planned start and finish.
12. Support from Learning and Development and Communication Services?	<input type="checkbox"/> Planning the communication and training <input type="checkbox"/> Advertising and collecting nominations <input type="checkbox"/> Preparing resources/packs <input type="checkbox"/> Training delivery and review.

#### External Communication

When communications are received from external sources (eg HSE, NHSLA) relating to policies on policies, the **Documents Co-ordinator**:

- a. identifies the effects of the existing policy.
- b. consults relevant parties.
- c. reviews and amends the policy if applicable.

## **Quality and Assurance**

The **Documents Co-ordinator** is responsible for adequately monitoring and evaluating this Implementation Plan to ensure its continued effectiveness. S/he does so by developing the following key performance indicators six months after approval of the policy:

- a. Documents are disseminated within ten days of being approved.
- b. Staff are trained to know where to access approved documents.
- c. Documents are reviewed by the date specified at their approval.
- d. The percentage of new and revised documents compliant within this policy.

**Appendix B: Document Committees and Designated Responsible Directors for Identified Groups of Documents**

Section	Document Category	Numbering Prefix	Development Groups	Approval Bodies	Lead Director
1a	Clinical (Nursing and PAMS)	C			Director of Nursing and Clinical Leadership
1b	Clinical (Medical)	C			Medical Director
2	Human Resources	HR			Director of Human Resources
3	Corporate Risk Management	RM		Care Quality Board	Director of Nursing and Clinical Leadership
4	Health and Safety	HS	Risk Policies and Procedures Group	Health and Safety Committee Care Quality Board	Director of Nursing and Clinical Leadership
5	Infection Control	IC	Hospital Infection Control Committee		Medical Director / DIPC
6	Estates and Facilities <i>(Inc. Fire, Security and Environmental)</i>	EandF			Director of Estates and Facilities
5	Finance	F			Director of Finance
6	General <i>(Organisational)</i>	G	Care Quality Board	Board of Directors	Chief Operating Officer / Director of Nursing and Clinical Leadership
7	Information, Management and Technology	IT	Information Governance Group	Governance Committee	Director of Finance / Director of Nursing and Clinical Leadership
8	Procurement	P			Director of Finance
9	Research Governance	RG			Medical Director

## Appendix C: Checklist for the Review and Approval of Documents

**Currently being developed**

## Appendix D: Document Approval Flowchart

**Currently being developed**

## Appendix E: Document Communication Plan

**Currently being developed**

## Appendix F: Document Dissemination Plan

**Currently being developed**

## Appendix G: Equality Impact Assessment Tool

**Currently being developed**