NHS
Cambridgeshire and Peterborough
NHS Foundation Trust

Trust-Wide Document Control Policy

Document Type:	Policy		
Secretariat Index Number:	CP05	Version No:	1.1
Document Owner:	Associate Director of Corporate Governance and Trust Secretary		
Clinical/Non-Clinical:	Non-Clinical		
Directorate:	Corporate Directorate		
Team/Service:	Corporate Governance Department		
Target Audience:	Staff across all sites.		
Standards, legislation and key related documents:	- Public Records Act 1958 - Records Management Code of Practice 2021 - Freedom of Information Act 2000 Section 46: Code of Practice for Records Management - Data Security and Protection Toolkit - Race Relation (Amendment) Act 2000 - Equality and Human Rights Act 2010 - NHS Counter Fraud Authority - Anti-Fraud Bribery and Corruption Policy - CPFT Standing Financial Instructions		

APPROVAL				
Level 1 Approval Group:	Policy Ratification Group			
	Date Approved:	May 2023	Review Date:	May 2026
Level 2 Ratification Group:	Patient Safety Executive Group			
	Date Approved:	May 2023	Review Date:	May 2026
Level 3 Formal Sign-Off:	People Safety and Quality Committee			
	Date Approved:	26/05/23	Review Date:	May 2026
Financial Implications:	Where a document has any financial implication on the Trust, the Local Counter Fraud Specialist (LCFS) has the authority to investigate and challenge this document with regards to current fraud and bribery legislation and to ensure appropriate counter fraud measures are in place.			
Counter Fraud Approval:	Yes or No:	N/A	Date:	
Equality and Diversity Impact Assessment: (Policies only)	The author has carried out an E&DIA and there are no negative impacts. The E&DIA Form is attached to this document.			
Staff Side Approval:	Yes or No:	N/A	Date:	

VERSION CONTROL SUMMARY

FORMAL RATIFICATION RECORD							
Version	Date	Author	Details of Previous Version:	Oversight Group	Approval Group	Ratifying Committee	Date:
V1.0	April 2023	AD of Corporate Governance and Trust Secretary	New Policy to replace previous 'Policy for Developing Policies'.	Policy Working Group	Patient Safety Executive	PSQ Committee	01/05/23

CAUTION: Please refer to the Documents that Guide Practice Intranet Page for the most recent version of this document

UNCONTROLLED COPY WHEN PRINTED

MINOR CHANGE RECORD					
Version	Date	Author	Description of Change/s Made:	Authorising Executive	Date:
1.0	29/12/25		Equality Impact Assessment updated within templates.	N/A	29/12/25
1.1	27/01/25		Fraud Prevention and Compliance questions added under the Quality Assurance Checklist.	N/A	27/01/25

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1.0 INTRODUCTION

1.1 This document sets out the Trust's process for the creation, approval and review of all procedural documents as well as the roles and responsibilities around the management of procedure documents.

1.2 As a prerequisite for robust corporate governance assurance, the Trust must have an agreed framework in place for the standardisation in the creation, approval and review of its clinical and non-clinical documents. This includes (but is not limited to) Policies, Procedures, Clinical Guidelines, Standard Guidelines and Standard Operating Procedures (SOPs).

1.3 In order to provide robust controls in the management of its procedural documents, the Trust has an electronic document management library, where all procedural documents are held and published centrally with an appropriate review date. The document library is managed by the Trust Secretariat.

1.4 It is a requirement that all procedural documents must be in the Trust's approved template, which conforms to the Race Relations (Amendment) Act 2000, and the Counter Fraud (NHS Counter Fraud Authority) legislation and standards.

1.5 Exceptions to the above may include Strategies, Emergency Planning Resilience and Response (EPRR) Management and Recovery Planning Documents.

1.6 In specific circumstances, some regional or national documents may be published in the Trust's document library without being in the Trust's approved template.

1.7 All current procedural documents must be held centrally by the Trust Secretariat and made available on the Trusts Intranet to ensure they are accessible to all relevant staff at all times. To ensure the Trust meets standards described in the policy and the Trust's legislative obligations, staff must not, under any circumstances, hold procedural documents on local drives.

2.0 OBJECTIVES AND AIMS

2.1 To ensure that all Trust clinical and non-clinical procedural documents are fit for purpose, confirm to the standard corporate governance appearance, follow standardised templates, and meet any legislative requirements and guidance.

2.2 To ensure all Trust procedural documents are accessible to all relevant staff at all times.

3.0 ROLES AND RESPONSIBILITIES

3.1 **Chief Executive Officer (CEO)**

Overall responsibility for the Trust's procedural documents is held by the Chief Executive Officer.

3.2 Executive Directors

Responsibility for the identification, review, approval, implementation and monitoring of their relevant procedural documents (i.e. those procedural documents relevant to their portfolio).

3.3 Trust Secretary

Overall responsibility for the Corporate Governance Team, who hold responsibility for quality assuring procedural documents, maintaining a document register, maintaining a document library, publication, and for maintaining and providing clinical and non-clinical document tracker and forecast reports.

3.4 Document Owners / Subject Matter Experts

This policy applies to all document owners at CPFT who are involved in the drafting, approval and publication of procedural documents. Document owners have responsibility to ensure that:

- procedural documents are kept up to date and in line with changes to the law, best practice, national guidance and changes to any other associates Trust documents;
- all procedural documents have followed the right governance process for approval;
- procedural documents are kept in date and reviewed in a timely way in line with the agreed review date;
- a risk assessment form is completed for any document past their review date; and
- communication of any change to procedural documents is overseen by the relevant oversight group and subsequently shared with staff.

3.5 Board Sub-Committees (Level 3)

Responsible for receiving procedural document activity reports and ratifying procedural documents related to their respective terms of reference, to ensure they have been through the requisite assurance process. Responsible for clearly recording the ratification in minutes of meetings.

3.6 Executive Led Approval Groups (Level 2)

Responsible for receiving, reviewing and approving the content of all policies which fall under their respective terms of reference; for reviewing the necessary assessment forms and agreeing any action; and for monitoring compliance with any procedural document out of date or due for review within the next six month period. Approval Groups are also responsible for authoring requests for document review date extensions, ensuring there are justified reasons for the request and that the number of extensions agreed and minimised; and ensuring risk assessments are completed where necessary. Chairs of each Executive Led Approval Group must ensure decisions are clearly recorded in the minutes of the meetings, Responsible for clearly recording the ratification in minutes of meetings.

3.7 Specialty Oversight Working Groups (Level 1)

Responsible for ensuring procedural documents have been reviewed by the appropriate lead and/or team/service responsible; for completing an initial quality assurance check of the document; for ensuring the necessary E&DIA, Counter Fraud and Staff Side

assessment forms are completed, as appropriate. Oversight Working Groups must keep a log of all documents reviewed in the Meeting Action Log.

3.8 Pharmacy Team

For any clinical procedural document containing reference to the administration/ prescription of drugs, involvement from the Pharmacy Team and completion of the Pharmacy Quality Assurance Chaecklist is essential at initial stage of development.

3.7 All Staff

All staff have a duty to read procedural documents relevant to their practive and comply with them. Failure to do so may result in performance or disciplinary action being taken.

4.0 DOCUMENT TYPE

4.1 The Trust has a number of document types, these are listed below with a brief explanation:

- **Strategy**
  A strategy sets out the services plan for the future and how end goals will be achieved. They can be high level formal documents, sometimes required by NHS England or the Department of Health, external assessment bodies or simply to reflect organisational good practice.

- **Policy**
  A policy is a formal, strategic level document and provides a 'statement of intent' about how the Trust will comply with the legislation and directives of its subject matter. It is a mandatory document and does not allow for variation of practice. It is relevant to all staff in all service areas (including volunteers and third-party contractors).

- **Standard Operating Procedure**
  A standard operating procedure (SOP) is a set of directions on how to perform a task on a day-to-day basis which must be followed in a regular order.

- **Clinical Guidelines**
  A clinical guideline is the most appropriate course of action under normal circumstances defined by national or regional published guidance and, where they refer to clinical practice, these should guide decisions and criteria regarding diagnosis, management and treatment of patients based on best practice.

- **Code of Practice**
  Set of written rules which explain how staff should behave, particularly in relation to Health and Safety, and IT.

- **Protocol**
  A written plan specifying the procedures to be followed in giving a particular examination, conducting research, or providing care for a particular condition.

- **Plan**
  A plan can be for operational delivery or for dealing with specific circumstances and is a mechanism through which the Trust can monitor or guide the delivery of services and new developments; the use of a plan reduces vulnerability to risks.

5.0 DOCUMENT CONTROL AND TEMPLATES

5.1 Document Control Procedure and Templates

Document control procedures for both clinical and non-clinical policies ensure a standardised approach which must be followed.

The Policy Document Templates is available on the Documents that Guide Practice Intranet Page, or on request from the Corporate Governance Team (corporateoffice@cpft.nhs.uk).

5.2 Content

Authors must ensure their procedural document references any relevant legislation and guidance issued by any other relevant body. They should be mindful of content as some procedural documents held are automatically published on the Trust's website and are therefore in the public domain.

Authors should ensure they engage with key stakeholders who provide the same or similar services, especially those that will be required to implement the document.

5.3 Clinical Abbreviations

Clinical abbreviations are not encouraged but if used they must conform to the Acronyms Glossary which is published on the Trust website.

5.4 Equality and Diversity Impact Assessment

The Equality and Diversity Impact (EDI) Assessment process is a key function to identify and mitigate inequality in policies and processes adopted by the Trust.

All policies must have a completed EDI Assessment attached to the document, which is completed by the document author. If no significant in inequalities are identified, this is the end of the process. If moderate or greater inequalities are identified, then escalation to the relevant Executive Led Approval Group is necessary, and a work programme to support the inequality to its minimal level must be produced.

In many cases, a discussion with the Equality and Diversity Lead will provide an immediate solution. Please contact the Equality and Diversity Team for further support or more detailed information. EDI Team details are available on the Trust's Intranet.

A copy of the Equality and Diversity Impact Assessment Form is available at Appendix 1.

5.5 Financial Implications

In order for the Trust to meet its obligation with the NHS Counter Fraud Authority in relation to bribery and corruption, a statement around financial implications must appear in all policy documents. This statement forms part of the model template (frontpage) and must not be deleted.

5.6 Transferring Document Ownership

As a document evolves, it may be decided that due to the updated content, the document should sit under a different Executive portfolio and subsequent Directorate. It is the current Executive/Directorates responsibility to liaise with the proposed Executive/Directorate to gain approval of the ownership transfer.

Once approved, the current owner must contact the Corporate Governance Team (via email: corporateoffice@cpft.nhs.uk) to inform them of the transfer including evidence of the acceptance of transfer. The Corporate Governance Team will amend central records to reflect this change.

6.0 DOCUMENT APPROVAL

6.1 First Level - Sign Off – Specialty Oversight Working Group

Procedural documents must be developed by the most appropriate Subject Matter Expert (SME) with the appropriate expert Specialty Oversight Working Group reviewing the content for accuracy, evidence base and best practice.

It is vital to the success of implementation that the expertise and experience of all relevant parties has been considered, particularly those who will be expected to implement the requirements. For *clinical* procedural documents, a Pharmacy specific Quality Assurance Checklist should be completed (See Appendix 2a). For both clinical and non-clinical procedural documents, completion of the Quality Assurance Checklist (outlined at Appendix 2b) will be undertaken by the Corporate Governance Team.

In providing robust control it is the responsibility of Subject Matter Experts (SME), through their respective team, to present and seek formal sign off of their procedural documents from the relevant expert Oversight Working Group. It is recognised that not all Oversight Working Groups produce formal meeting minutes. In these cases, approval must be logged in the Meeting Action Log.

6.2 Second Level - Approval – Executive Led Approval Group

Following sign off by the Oversight Working Group, procedural documents should be presented to the relevant Executive Led Approval Group for formal approval.

In providing robust control it is the responsibility of the Subject Matter Experts (SME) to provide a copy of the signed off procedural document (along with relevant assessment forms) to the Executive Led Group, for formal approval.

All approvals must be minuted clearly. In cases where meetings are not minuted, an approval email from the relevant Executive Director is acceptable.

6.3 Third Level – Ratification – Board Sub-Committee

Following formal approval by the relevant Executive Led Approval Group, procedural documents should be presented to the relevant Board Sub-Committee for ratification.

In providing robust control it is the responsibility of the Corporate Governance Team to report all approved procedural documents to the relevant Board Sub-Committee, detailing the requisite approval process undertaken.

7.0 DOCUMENT PUBLICATION

7.1 Dissemination and Publication

It is the responsibility of all document owners to ensure dialogue exchange with the Corporate Governance Team for approval, publication and communication purposes. The Corporate Governance Team email address is: corporateoffice@cpft.nhs.uk.

All approved documents will be allocated a Secretariat Index Number and held centrally by the Corporate Governance Team. Documents must not be stored on local drives.

It is the document owners responsibility to ensure that details of any new or revised document are communicated to the target audience by the most appropriate means and any requirements for training are considered and discussed with relevant personnel.

It is the responsibility of the Corporate Governance Team to ensure the document register is kept up-to-date, and links to procedural documents are made available on the Documents that Guide Practice Intranet page.

The Corporate Governance Team will also take an active role in ensuring any approved new and/or updated procedural document (clinical and non-clinical) are communicated to all Trust staff through Staff News (via the Communications Team).

8.0 DOCUMENT REVIEW

8.1 Authors Checklist

It is the responsibility of document owners to ensure that the content of their document remains relevant and up-to-date.

When reviewing an existing procedural document, an 'Authors Checklist' should be completed, acting as a prompt for reviewing the content. This form is outlined at Appendix 3.

8.2 Expired Documents

When reviewing a procedural document which has passed its review date, the Specialty Oversight Group should consider the reasons as to why the document is overdue review; consider wider risks and impacts on the Trust; and request an extension to the review period from the relevant Executive Led Approval Group.

Any decision and agreement made to extend review dates should be clearly minuted in the Executive Led Approval Group meeting minutes, and the Corporate Governance Team informed of that decision.

8.3 Amendments

Minor

In most circumstances, if changes to procedural documents are minor and the document is still in date, then it does not need to go back through the formal approval process.

Minor changes should be detailed in the 'Minor Change Record' section (page 2), and the version number adjusted to second level (i.e. version 2 would be amended to version 2.1).

Major

If changes alter the major processes of the document, then the document must be re-approved. It is essential that the version number and date on the front page, and in the footer, are also updated.

Type	Definitions
Minor Change	Changes which do not impact on the practice / staff responsibilities. They normally relate to changes to staff titles, committee names or review dates (where a review has highlighted no major changes are required).
Major Change	Changes which impact on the practice being used or staff responsibilities (e.g. new responsibilities, changes to forms used etc.).

8.4 Review Dates

All documents have an automatic review date of three years from the date of first level sign off, unless a shorted review date is set by the author to meet statutory or legal requirements.

8.5 Document Extensions

Requests for extension to documents past their review date are only to be considered in extenuating circumstances and should not be seen as part of the document lifecycle.

Extension requests must be made to the Executive Led Approval Group and the decision clearly documented in the meeting minutes.

Extension requests must be authorised by the responsible Executive Director only for a maximum of *two* occasions only.

It is the responsibility of the Document Author to inform the Corporate Governance Team of any extension granted.

9.0 DOCUMENT ARCHIVING

9.1 Where a document is no longer viable it can be archived at any time under instruction from the Document Owner, along with email agreement from the relevant Executive Director.

9.2 All archived documents will be retained by the Corporate Governance Team and can be retrieved on request.

10.0 MONITORING COMPLIANCE

10.1 Compliance on all clinical and non-clinical policies is reported regularly to the Trust Board through the Board Sub-Committee Assurance Reports.

Monitoring compliance of the content of procedural documents must be undertaken, recorded on the 'Monitoring Compliance Form' and attached for the document.

11.0 ASSOCIATED DOCUMENTS

- Policy Template
- Equality and Diversity Impact Assessment Form
- Pharmacy Quality Assurance Checklist
- Quality Assurance Checklist
- Authors Checklist
- Monitoring Compliance Form

APPENDIX 1 – Equality and Diversity Impact Assessment

Equality Impact Assessment Form

Introduction

The general equality duty that is set out in the Equality Act 2010 requires public authorities, in the exercise of their functions, to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

The general equality duty does not specify how public authorities should analyse the effect of their existing and new policies and practices on equality, but doing so is an important part of complying with the general equality duty. It is up to each organisation to choose the most effective approach for them. This standard template is designed to help CPFT staff members to comply with the general duty.

Training on undertaking Equality Impact Assessment can be made available for individuals or teams on request. If there is something that is not clear regarding the EIA process or you need help to complete the EIA form please contact:
EDI@cpft.nhs.uk
Sue Rampal - Equality and Diversity Lead
Sharon Gilfoyle – Associate Director of Inclusion

Equality Analysis Form

Name of Proposal - policy, strategy, function, service being assessed:	Trust-Wide Document Control Policy
Is this a new or existing policy, practice or change to a service?	Replaces the POLICY FOR THE DEVELOPMENT AND MANAGEMENT OF PROCEDURAL DOCUMENTS
Directorate, Department / Service:	Trust Wide
Details of the person completing this impact assessment form. Name, Job Title, Telephone / Extension:	Natalie Larham Corporate Governance Officer
Those involved in the assessment:	Caroline Macpherson Trust Secretary Policy Approval Group
Date:	May 2023

What are the intended outcomes of this work)? (Include outline of objectives and function aims)	To move policy into new template and include new policy / guidance templates for use going forward.
Who will be affected? (e.g. staff, patients, service users etc.)	Staff will need to use this policy template / guidance going forward.
What are the desired outcomes?	For bring all policies and guidance into alignment.
What does this policy, function, process link to in terms of wider Business plans and objectives?	

Evidence considered

When looking at the impact on the equality groups, you must consider the following points in accordance with General Duty of the Equality Act 2010:

In summary, those subject to the Equality Duty must have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation;
- advance equality of opportunity between different groups; and
- foster good relations between different groups

Consider how your assessment has been able to demonstrate Positive Impact, Negative / Adverse Impact or Neutral Impact?

What evidence have you considered? *List the main sources of data, research and other sources of evidence This can include national research, surveys, reports, research interviews, focus groups, pilot activity evaluations etc.*
Disability Consider *and detail on attitudinal, physical and social barriers.* Neutral Impact
Sex *Consider and detail on men and women (potential to link to carers below).* Neutral Impact
Race *Consider and detail on difference ethnic groups, nationalities, Roma gypsies, Irish travellers, language barriers.* Neutral Impact
Age *Consider and detail across age ranges on old and younger people. This can include safeguarding, consent and child welfare.* Neutral Impact
Gender reassignment (including transgender) *Consider and detail on transgender and transsexual people. This can include issues such as privacy of data and harassment.* Neutral Impact
Sexual orientation *Consider and detail on heterosexual people as well as lesbian, gay and bi-sexual people.* Neutral Impact
Religion or belief *Consider and detail on people with different religions, beliefs or no belief.* Neutral Impact
Pregnancy and maternity *Consider and detail on working arrangements, part-time working, infant caring responsibilities.* Neutral Impact
Carers *Consider and detail on part-time working, shift-patterns, general caring responsibilities,protected characteristics of the carer themselves and if this makes seeking help from services more challenging.* Neutral Impact
The Patient and Carer Race Equality Framework (PCREF) *is an important part of the NHS's efforts to address racial disparities in mental health. It's a national plan that aims to help NHS organisations, like Cambridgeshire and Peterborough NHS Foundation Trust (CPFT), improve how they serve people from communities facing racial inequalities. We know, for instance, that Black people experience higher rates of mental health conditions – but are less likely to get the help they need. This framework, recommended by the Mental Health Act review, will be mandatory for all NHS Trusts that provide mental health services and will form part of assessments by the Care Quality Commission (CQC).*

A key method through which the PCREF will be implemented is through the completion of equality impact assessments to identify and mitigate inequalities in access, experience and outcomes of care faced by different ethnic minority groups. More information on CPFTs work on PCREF can be found here:
Patient and Carer Race Equality Framework | CPFT NHS Trust

Neutral Impact

Other identified groups *Consider and detail and include the source of any evidence on different socio-economic groups, area inequality, income, resident status (migrants) and other groups experiencing disadvantage and barriers to access.*
Neutral Impact

Engagement and involvement

Have you consulted on the proposal? N/A

If so with whom?

If not why not?

How have you engaged stakeholders in gathering evidence or testing the evidence available?
N/A

For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:
N/A

Action planning for improvement:

Outline key actions based on any gaps, challenges, and opportunities you have identified and will be addressed through consultation or further research.

Category	Actions required to address gaps and issue/s	Target date	Person responsible and their division
Gaps and Challenges	N/A		
Monitoring, evaluating & reviewing	Review May 2026	26/05/2026	Trust Secretary

Signed off by EDI Team	Name: Sue Rampal Equality and Diversity Lead	Date: 30/01/25

Completed form should be sent to:

EDI@cpft.nhs.uk
Sue Rampal - Equality and Diversity Lead
Sharon Gilfoyle - Associate Director of Inclusion

APPENDIX 2 – Quality Assurance Checklist

		Y/N or N/A if not applicable	Comments
1.	Title of document		
	Is the title clear and unambiguous	Y	
2.	Type of document (e.g. policy, guideline etc)		
	Is it clear whether the document is a policy, guideline or procedure?	Y	
3.	Introduction		
	Is the introduction clear?	Y	
	Are reasons for the development of the document clearly stated?	Y	
4.	Content		
	Is the correct corporate template used?	Y	
	Is the document in the correct format?	Y	
	- Paragraphs numbered consecutively?	Y	
	- Headers: logo on front page only?	Y	
	- Footers: on every page except front page?	Y	
	Are the version control numbers correct on the front page and in footer?	Y	
	Are objectives/aims clearly stated?	Y	
	Are duties, roles and responsibilities clearly explained? (Policies only)	Y	
	Are definitions of terms clearly explained?	Y	
	Does this document concern the handling, moving or storage of personal identifiable or commercially sensitive information? If yes, has there been engagement with the Information Governance Team?	N/A	
5.	Evidence Base		
	Is the type of evidence to support the document explicitly identified?	Y	
	Are associated documents referenced?	Y	
6.	Approval		
	Does the document identify which Oversight Working Group is responsible for reviewing the content?	Y	
	Does the document identify which Exec Led Approval Group is responsible for approval?	Y	
	Does the document identify which NED led Ratification Group is responsible for formal sign off?	Y	
7.	Review Date		
	Is the review date identified and 3 years (max) following initial development (sign off by Oversight Working Group)?	Y	
8.	Equality and Diversity		
	Is a completed Equality Impact Assessment attached?	Y	
9.	Monitoring Compliance		

	Has section 'Monitoring Compliance' been completed?	Y	
10.	Fraud Prevention and Compliance		
	Does the document include fraud prevention measures appropriate to its scope (such as financial controls, segregation of duties, or reporting mechanisms)?	Y	Where a document has any financial implication on the Trust, the Local Counter Fraud Specialist (LCFS) has the authority to investigate and challenge this document.
	Does the document reference the Trust's Anti-Fraud and Anti-Bribery Policy and, where relevant, NHS Counter Fraud Authority standards?	N/A	
	Are the responsibilities for fraud risk management clearly defined within the document?	N/A	
	Does the document outline the monitoring and audit processes used to ensure fraud-related compliance?	N/A	
	Have any financial implications been reviewed by the Local Counter Fraud Specialist?	N/A	

APPENDIX 3 – Authors Checklist

Document Title:	Trust-Wide Document Control Policy
Secretariat Index Number:	CP05

Before beginning the process of reviewing and updating an existing procedural document, please take the below into consideration.

Consideration for all documents		Y/N	Action to be taken	
			'Yes'	'No'
1.	Is the document still required?	Y	Go to question 2.	Arrange document removal with the Executive Lead/Approval Group and inform the Corporate Governance Team (corporateoffice@cpft.nhs.uk)
2.	Has there been any change in guidance or national policy since the previous version?	N	Go to question 4.	Go to question 3.
3.	Can Executive authorisation (only) be granted if ***minor*** changes have been made to the document?	Y	Executive lead to approve new review date by email. Update dates on the document and send the updated document and Exec email to the Corporate Governance Team (corporateoffice@cpft.nhs.uk)	Go to question 3.
4.	Can formal ratification be granted if ***major*** changes have been made to the document?	Y	Agree content at Level 1 Oversight Group. Seek Approval at Level 2 Exec Led Approval Group. Seek Ratification at NED led Board Sub-Committee (via: corporateoffice@cpft.nhs.uk)	Go to question 3.

APPENDIX 4 – Monitoring Compliance

Document Section		Control	Check to be carried out	How often will the check be carried out	Responsible for carrying out the check	Results of check reported to	Frequency of reporting
Page	Section	WHAT?	HOW?	WHEN?	WHO?	WHERE?	WHEN?

Appendix 5: Policy Template

NHS
Cambridgeshire and Peterborough
NHS Foundation Trust

POLICY TEMPLATE - Insert Title of Policy			
Document Type:	Policy		
Secretariat Index Number:	Leave blank is unknown	Version No:	VX.X
Document Owner:	Insert Job Title of Document Lead/Owner		
Clinical/Non-Clinical:	Clinical or Non-Clinical		
Directorate:	Insert Directorate		
Team/Service:	Insert Team or Service Name		
Target Audience:	E.g. All staff across all sites.		
Standards, legislation and key related documents:	State any standards, legislation or key related documents that are relevant and current.		
APPROVAL			
Level 1 Approval Group:	Enter name of Approval / Specialty Oversight Group		
	Date Approved: XX/XX/XX	Date Approved:	XX/XX/XX
Level 2 Ratification Group:	Enter name of Ratification Group (Exec Led)		
	Date Approved: XX/XX/XX	Date Approved:	XX/XX/XX
Level 3 Formal Sign-Off:	Enter name of Formal Sign-Off Committee (QS&PE, PCC, B&P or AAC)		
	Date Approved: XX/XX/XX	Date Approved:	XX/XX/XX
Financial Implications:	Where a document has any financial implication on the Trust, the Local Counter Fraud Specialist (LCFS) has the authority to investigate and challenge this document with regards to current fraud and bribery legislation and to ensure appropriate counter fraud measures are in place.		
Counter Fraud Approval:	Yes or No: Yes or No	Date:	XX/XX/XX
Equality and Diversity Impact Assessment: (Policies only)	The author has carried out an E&DIA and there are no negative or unknown impacts. The E&DIA Form is attached to this document.		
Staff Side Approval:	Yes or No: Yes or No	Date:	XX/XX/XX

AUTHOR’S CHECKLIST

Document Title:	
Secretariat Index Number:	

To be completed when reviewing existing published documents

Consideration for all documents		Y/N	Action to be taken	
			‘Yes’	‘No’
1.	Is the document still required?	Select	Go to question 2.	Arrange document removal with the Executive Lead/Approval Group and inform the Corporate Governance Team (corporateoffice@cpft.nhs.uk)
2.	Has there been any change in guidance or national policy since the previous version?	Select	Go to question 4.	Go to question 3.
3.	Can Executive authorisation (only) be granted if ***minor*** changes have been made to the document?	Select	Executive lead to approve new review date by email. Update dates on the document and send the updated document and Exec email to the Corporate Governance Team (corporateoffice@cpft.nhs.uk)	Go to question 3.
4.	Can formal ratification be granted if ***major*** changes have been made to the document?	Select	Agree content at Level 1 Specialty Oversight Group. Seek Approval at Level 2 Exec Led Approval Group. Seek Ratification at NED led Board Sub-Committee (via: corporateoffice@cpft.nhs.uk)	Go to question 3.

VERSION CONTROL SUMMARY

FORMAL RATIFICATION RECORD							
Version	Date	Author	Details of Previous Version:	Oversight Group	Approval Group	Ratifying Committee	Date:
VX.X	April 2023	Insert Job Title of Document Owner/Lead	Add detail as necessary.			XXX Committee	01/05/23

MINOR CHANGE RECORD					
Version	Date	Author	Description of Change/s Made:	Authorising Executive	Date:
VX.X	April 2023	Insert Job Title of Document Owner/Lead	Describe document changes (including page number/section)	XXX	01/05/23

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Appendix 1: Definitions of Terms

Appendix 2: (Title of Appendix)

Appendix 3: Equality Impact Assessment

Appendix 4: Quality Assurance Checklist

The latest version of this document is on the Document Library.

Any printed copies must be checked against the Document Library version to ensure that the latest version is being used.

1.0 INTRODUCTION

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12.0 OBJECTIVES and AIMS

2.1

2.2

13.0 DUTIES, ROLES and RESPONSIBILITIES

3.1

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14.0 TRAINING and COMPETENCY

4.1

4.2

15.0 PROCESS and CONTENT

5.1

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16.0 ASSOCIATED DOCUMENTS

6.1

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17.0 MONITORING COMPLIANCE

Document Section		Control	Check to be carried out	How often will the check be carried out	Responsible for carrying out the check	Results of check reported to	Frequency of reporting
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APPENDIX 1: DEFINITION OF TERMS

APPENDIX 2: (TITLE OF APPENDIX)

Please add any appendices relevant to this policy as required. Once added, please update the contents page.

APPENDIX 3: EQUALITY IMPACT ASSESSMENT

Equality Impact Assessment Form

Introduction

The general equality duty that is set out in the **Equality Act 2010** requires public authorities, in the exercise of their functions, to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between people who share a protected characteristic and those who do not

Training on undertaking Equity Impact Assessment can be made available for individuals or teams on request. If there is something that is not clear regarding the EIA process, or you need help to complete the EIA form, please contact:

EDI@cpft.nhs.uk

Equality Assessment Form

Name of Proposal - policy, strategy, function, service being assessed:	
Is this a new or existing policy, practice or change to a service?	
Directorate, Department / Service:	
Details of the person completing this impact assessment form. Name, Job Title, Telephone / Extension:	
List any associated policies / procedures	
Those involved in the assessment:	
Date:	

What are the intended outcomes of this work)? (Include outline of objectives and function aims)	
Who will be affected? (e.g. staff, patients, service users etc.)	
What are the desired outcomes?	
What does this policy, function, process link to in terms of wider Business plans and objectives?	
What equality information is available? (Quantitative and qualitative)	
Are there any information gaps you are aware of? If so, what are they?	

Who are the stakeholders for this practice or service change?	
How were these stakeholders identified?	

Engagement and involvement

Have you consulted on the proposal?	
If so with whom?	
If not, why not?	
How have you engaged stakeholders in gathering evidence or testing the evidence available?	
For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:	

Evidence considered

When looking at the impact on the equality groups, you must consider the following points in accordance with General Duty of the Equality Act 2010:

In summary, those subject to the Equality Duty must have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation.
- advance equality of opportunity between different groups; and
- foster good relations between different groups

Consider how your assessment has been able to demonstrate <u>Positive Impact</u>, <u>Negative / Adverse Impact</u> or <u>Neutral Impact</u>?

What evidence have you considered? *List the main sources of data, research and other sources of evidence This can include national research, surveys, reports, research interviews, focus groups, pilot activity evaluations etc.*
Disability Consider *and detail on attitudinal, physical and social barriers.*
Sex *Consider and detail on men and women (potential to link to carers below).*

Race *Consider and detail on difference ethnic groups, nationalities, Roma gypsies, Irish travellers, language barriers. See Trust website for the Patient and Carer Race Equality Framework for more information on how to identify potential impacts for racialised communities.* [Patient and Carer Race Equality Framework | CPFT NHS Trust]
Age *Consider and detail across age ranges on old and younger people. This can include safeguarding, consent and child welfare.*
Gender reassignment (including transgender) *Consider and detail on transgender and transsexual people. This can include issues such as privacy of data and harassment.*
Marriage and Civil Partnership *Consider if the policy unjustifiably treats people differently based on marital status. Are there hidden assumptions favoring married couples over single people.*
Sexual orientation *Consider and detail on heterosexual people as well as lesbian, gay and bi-sexual people.*
Religion or belief *Consider and detail on people with different religions, beliefs or no belief.*
Pregnancy and maternity *Consider and detail on working arrangements, part-time working, infant caring responsibilities.*
Other identified groups *Consider and detail and include the source of any evidence on different socio-economic groups, area inequality, income, resident status (migrants) and other groups experiencing disadvantage and barriers to access.*
Carers *Consider and detail on part-time working, shift-patterns, general caring responsibilities, protected characteristics of the carer themselves and if this makes seeking help from services more challenging.*
Patient and Carer Race Equality Framework (PCREF) *Consider additional barriers for racialised communities accessing mental health services. How might the policy impact different ethnic minority groups' experiences and outcomes. See Trust website for the Patient and Carer Race Equality Framework for more information on how to identify potential impacts for racialised communities.* Patient and Carer Race Equality Framework | CPFT NHS Trust

Action planning for improvement:

Outline key actions based on any gaps, challenges, and opportunities you have identified and will be addressed through consultation or further research.

Category	Actions required to address gaps and issue/s	Target date	Person responsible and their division
Gaps and Challenges			
Monitoring, evaluating & reviewing			

Signed off by EDI Team	Name:	Date:

Completed form should be sent to:
EDI@cpft.nhs.uk

APPENDIX 4: QUALITY ASSURANCE CHECKLIST

TO BE COMPLETED BY THE CORPORATE GOVERNANCE TEAM

		Y/N or N/A if not applicable	Comments
1.	Title of document		
	Is the title clear and unambiguous		
2.	Type of document (e.g. policy, guideline etc)		
	Is it clear whether the document is a policy, guideline or procedure?		
3.	Introduction		
	Is the introduction clear?		
	Are reasons for the development of the document clearly stated?		
4.	Content		
	Is the correct corporate template used?		
	Is the document in the correct format?		
	- Paragraphs numbered consecutively?		
	- Headers: logo on front page only?		
	- Footers: on every page except front page?		
	Are the version control numbers correct on the front page and in footer?		
	Are objectives/aims clearly stated?		
	Are duties, roles and responsibilities clearly explained? (Policies only)		
	Are definitions of terms clearly explained?		
	Does this document concern the handling, moving or storage of personal identifiable or commercially sensitive information? If yes, has there been engagement with the Information Governance Team?		
5.	Evidence Base		
	Is the type of evidence to support the document explicitly identified?		
	Are associated documents referenced?		
6.	Approval		
	Does the document identify which Oversight Working Group is responsible for reviewing the content?		
	Does the document identify which Exec Led Approval Group is responsible for approval?		
	Does the document identify which NED led Ratification Group is responsible for ratifying?		
7.	Review Date		
	Is the review date identified and 3 years (max) following initial development (sign off by Oversight Working Group)?		
8.	Equality and Diversity		
	Is a completed Equality Impact Assessment attached?		
9.	Monitoring Compliance		

	Has section 'Monitoring Compliance' been completed?		
10.	Fraud Prevention and Compliance		
	Does the document include fraud prevention measures appropriate to its scope (such as financial controls, segregation of duties, or reporting mechanisms)?		
	Does the document reference the Trust's Anti-Fraud and Anti-Bribery Policy and, where relevant, NHS Counter Fraud Authority standards?		
	Are the responsibilities for fraud risk management clearly defined within the document?		
	Does the document outline the monitoring and audit processes used to ensure fraud-related compliance?		
	Have any financial implications been reviewed by the Local Counter Fraud Specialist?		

If answers to any of the above questions is 'no', then this document is not ready for approval and needs further review.

Appendix 6: Guidance Template

NHS
Cambridgeshire and Peterborough
NHS Foundation Trust

GUIDANCE / SOP TEMPLATE - Insert Title Here			
Document Type:	Guidance		
Secretariat Index Number:	Leave blank is unknown	Version No:	VX.X
Document Owner:	Insert Job Title of Document Lead/Owner		
Clinical/Non-Clinical:	Clinical or Non-Clinical		
Directorate:	Insert Directorate		
Team/Service:	Insert Team or Service Name		
Target Audience:	E.g. All staff across all sites.		
Standards, legislation and key related documents:	State any standards, legislation or key related documents that are relevant and current.		
APPROVAL			
Level 1 Approval Group:	Enter name of Approval / Specialty Oversight Group		
	Date Approved: XX/XX/XX	Review Date:	XX/XX/XX
Level 2 Ratification Group:	Enter name of Ratification Group (Exec Led)		
	Date Approved: XX/XX/XX	Review Date:	XX/XX/XX
Level 3 Formal Sign-Off:	Enter name of Formal Sign-Off Committee (QS&PE, PCC, B&P or AAC)		
	Date Approved: XX/XX/XX	Review Date:	XX/XX/XX
Financial Implications:	Where a document has any financial implication on the Trust, the Local Counter Fraud Specialist (LCFS) has the authority to investigate and challenge this document with regards to current fraud and bribery legislation and to ensure appropriate counter fraud measures are in place.		
Counter Fraud Approval:	Yes or No: Yes or No	Date:	XX/XX/XX
Equality and Diversity Impact Assessment: (Policies only)	The author has carried out an E&DIA and there are no negative or unknown impacts. The E&DIA Form is attached to this document.		
Staff Side Approval:	Yes or No: Yes or No	Date:	XX/XX/XX

AUTHOR'S CHECKLIST

Document Title:	
Secretariat Index Number:	

To be completed when reviewing existing published documents

Consideration for all documents		Y/N	Action to be taken	
			'Yes'	'No'
1.	Is the document still required?	Select	Go to question 2.	Arrange document removal with the Executive Lead/Approval Group and inform the Corporate Governance Team (corporateoffice@cpft.nhs.uk)
2.	Has there been any change in guidance or national policy since the previous version?	Select	Go to question 4.	Go to question 3.
3.	Can Executive authorisation (only) be granted if ***minor*** changes have been made to the document?	Select	Executive lead to approve new review date by email. Update dates on the document and send the updated document and Exec email to the Corporate Governance Team (corporateoffice@cpft.nhs.uk)	Go to question 3.
4.	Can formal ratification be granted if ***major*** changes have been made to the document?	Select	Agree content at Level 1 Specialty Oversight Group. Seek Approval at Level 2 Exec Led Approval Group. Seek Ratification at NED led Board Sub-Committee (via: corporateoffice@cpft.nhs.uk)	Go to question 3.

VERSION CONTROL SUMMARY

FORMAL RATIFICATION RECORD							
Version	Date	Author	Details of Previous Version:	Oversight Group	Approval Group	Ratifying Committee	Date:
VX.X	April 2023	Insert Job Title of Document Owner/Lead	Add detail as necessary.			XXX Committee	01/05/23

MINOR CHANGE RECORD					
Version	Date	Author	Description of Change/s Made:	Authorising Executive	Date:
VX.X	April 2023	Insert Job Title of Document Owner/Lead	Describe document changes (including page number/section)	XXX	01/05/23

CONTENT

Author's Checklist 2

Version Control Summary 2

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2.0 Who is it for? 5

3.0 Guidelines / SOP details 6

4.0 Training requirements associated with these guidelines/SOP.. 7

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6.0 Key Duties and Responsibilities.. 9

7.0 How will this guidance / SOP be monitored for effectiveness?.. 10

8.0 Links to related documents..11

9.0 References and Acknowledgements..12

10.0 Monitoring Compliance..13

Appendix 1: Definitions of Terms

Appendix 2: (Title of Appendix)

Appendix 3: Equality Impact Assessment

Appendix 4: Quality Assurance Checklist

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1.0 WHY DO WE NEED THESE GUIDELINES/SOP

This section should state what the guidelines are for and what it aims to do, i.e.

- *Overarching purpose – A clear statement on what it is for*
- *Rationale - Is it mandated by law/national standards or to ensure proper and consistent application of evidence of best practice?*
- *What does it aim to do?*

1.10

1.11

18.0 WHO IS IT FOR?

This section should clearly state the staff groups, services and/or activities covered by the document.

2.1

2.2

19.0 GUIDELINES / SOP DETAILS

This is the 'meat' of the document and should set out what staff should/should not do, when and how. Be clear, succinct, and direct to the point, avoiding long paragraphs or unnecessary information. Use bullet points where possible and flowcharts where this will be helpful to summarise a set of steps with explanatory notes. Include diagrams or pictures if it will help to clarify a process or procedure.

This should also state who they can approach for advice or support, if needed.

3.1

3.2

20.0 TRAINING REQUIREMENTS ASSOCIATED WITH THIS GUIDANCE / SOP

This should state any training needed, formal or informal (i.e. supervision or on-the-job training), to undertake the interventions, processes and procedures for the application of this guidance/SOP.

4.1

4.2

21.0 DEFINITIONS

This section should list and describe the meaning of the terms used in the context of the document, if considered necessary.

5.1

5.2

22.0 KEY DUTIES AND RESPONSIBILITIES

This should give statement of committees/groups, departments, and individual, with direct responsibility for the implementation of this guideline/SOP.

6.1

6.2

23.0 HOW WILL THIS GUIDANCE / SOP BE MONITORED FOR EFFECTIVENESS?

This should describe the process for review/monitoring the effective implementation of the guidelines/SOP, which includes:

- *monitoring arrangements for implementation, i.e. audit, review, etc.;*
- *responsibilities for conducting the monitoring/audit;*
- *frequency of monitoring/audit, i.e. quarterly, on a rolling basis, etc.;*
- *process for reviewing results and ensuring improvements.*

7.1

7.2

24.0 LINKS TO RELATED DOCUMENTS

Other related Trust procedural documents should be identified here.

8.1

8.2

25.0 REFERENCES AND ACKNOWLEDGMENTS

This should list and include all the processes and procedures required for the implementation of the guideline/SOP

9.1

9.2

26.0	MONITORING COMPLIANCE

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Gaps and Challenges			
Monitoring, evaluating & reviewing			

Signed off by EDI Team	**Name:**	**Date:**

Completed form should be sent to:
EDI@cpft.nhs.uk

APPENDIX 4: QUALITY ASSURANCE CHECKLIST

TO BE COMPLETED BY THE CORPORATE GOVERNANCE TEAM

		Y/N or N/A if not applicable	Comments
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9.	Monitoring Compliance		

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	Are the responsibilities for fraud risk management clearly defined within the document?		
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