# FRIMLEY
# INTEGRATED CARE BOARD

## Serious Incident Management Policy

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| Document Author | Director of Quality & Safety |
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Version control sheet

| Version | Date | Author | Status | Comment |
|---|---|---|---|---|
| V1 | 07.04.2021 | Melanie Bessant | Awaiting approval | |
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## Equality Statement

Frimley Integrated Care Board aims to design and implement services, policies and measures that meet the diverse needs of our service, population, and workforce, ensuring that none are placed at a disadvantage over others.

Throughout the development of the policies and processes cited in this document, we have:

Given due regard to the need to eliminate discrimination, harassment, and victimisation, to advance equality of opportunity, and to foster good relations between people who have shared a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it.

Given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and in securing that services are provided in an integrated way where this might reduce health inequalities.

Members of staff, volunteers or members of the public may request assistance with this policy if they have particular needs. If the member of staff has language difficulties and difficulty in understanding this policy, the use of an interpreter will be considered.

We embrace the four staff pledges in the NHS Constitution. This policy is consistent with these pledges.

# Contents

## Contents

## 1. Introduction

1.1. This policy outlines the systems and processes to report and manage serious incidents (SIs). It applies to serious incidents reported by the Frimley Integrated Care Board (ICB) and organisations for which the Frimley ICB is lead commissioner.

1.2. Serious incidents requiring investigation in healthcare are rare, but when they do occur, everyone must ensure there are systematic measures in place to respond to them. These measures must protect patients, their families and carers and staff, and ensure that robust investigations are conducted, which result in organisations learning from serious incidents to minimise the risk of the incident happening again. When an incident occurs, it must also be reported to all relevant bodies.

1.3. Frimley ICB has a duty to obtain information on serious incidents from NHS providers where they have commissioned services and within its boundaries, to both identify learning opportunities for improving safety and to ensure that these NHS organisations have robust arrangements in place.

1.4. Frimley ICB will ensure that appropriate management systems are in place across their commissioned providers to:

- Comply with the requirements of the NHS England Serious Incident Framework 2015 (including the revised 2021 Never Events Policy)
- That all Sis are dealt with in a timely fashion and without prejudice
- Embed systematic measures to manage SIs robustly and effectively
- Ensure actions are taken to improve quality and safety and to minimise the risk of future reoccurrences
- Share the learning

1.5. Intelligence gained from SIs will be used to influence contract monitoring, quality and safety standards for care pathway development and service specifications.

1.6. Reporting SIs is a legal requirement under CQC regulations. All SIs, including Never Events must be reported to the CQC. This requirement continues regardless of the organisational changes within the NHS.

## 2. Purpose

2.1. The aim of the policy is to ensure that lessons are learned, and actions are taken by the provider in which the SI occurred in order to prevent them happening again and so reducing the impact on patient safety.

2.2. Frimley ICB also believe that it has a fundamental role in cascading the lessons learnt to the wider health economy.

## 3. Scope

3.1. This policy applies to all substantive and temporary staff employed by Frimley ICB. It should also be complied with by all organisations whose services are commissioned by Frimley ICB and to all third parties and others authorised to undertake work on behalf of the ICB. It applies to all Serious Incidents involving members of staff, patients, relatives, visitors, contractors, provider organisations and the general public.

## 4. Definitions

### 4.1. Serious Incident (SI)

4.1.1. In broad terms, serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver on going healthcare.

4.1.2. The occurrence of a serious incident demonstrates weaknesses in a system or process that need to be addressed to prevent future incidents leading to avoidable death or serious harm to patients or staff, future incidents of abuse to patients or staff, or future significant reputational damage to the organisations involved. Serious incidents therefore require investigation to identify the factors that contributed towards the incident occurring and the fundamental issues (or root causes) that underpinned these. Serious incidents can be isolated, single events or Serious Incident Policy Page 10 of 52 multiple linked or unlinked events signalling systemic failures within a commissioning or health system.

4.1.3. The Serious Incident Framework does not give a definitive list of events/incidents that constitute a serious incident and lists should not be created locally as this can lead to inconsistent or inappropriate management of incidents. Where lists are created there is a tendency to not appropriately investigate things that are not on the list even when they should be investigated, and equally a tendency to undertake full investigations of incidents where that may not be warranted simply because they seem to fit a description of an incident on a list.

4.1.4. The definition below sets out circumstances in which a serious incident must be declared. Every incident must be considered on a case-by-case basis using

the description below. Inevitably, there will be borderline cases that rely on the judgement of the people involved.

4.1.5. Serious Incidents in the NHS include:

- Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:
  - Unexpected or avoidable death of one or more people. This includes:
    - suicide/self-inflicted death; and
    - homicide by a person in receipt of mental health care within the recent past.
  - Unexpected or avoidable injury to one or more people that has resulted in serious harm
  - Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent:
    - the death of the service user; or
    - serious harm
  - Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking, and modern-day slavery where:
    - healthcare did not take appropriate action/intervention to safeguard against such abuse occurring; or
    - where abuse occurred during the provision of NHS-funded care.

This includes abuse that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally led investigation, where delivery of NHS funded care caused/contributed towards the incident.

4.1.6. A Never Event - all Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death. See Never Events Policy and Framework for the national definition and further information. (Link in appendix 1).

4.1.7. An incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following:

- Failures in the security, integrity, accuracy, or availability of information often described as data loss and/or information governance related issues

- Property damage

- Security breach/concern

- Incidents in population-wide healthcare activities like screening and immunisation programmes where the potential for harm may extend to a large population

- Inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act. Deprivation of Liberty Safeguards (MCA DOLS)

- Systematic failure to provide an acceptable standard of safe care (this may include incidents, or series of incidents, which necessitate ward/ unit closure or suspension of services or activation of the Major Incident Plan by provider, commissioner, or relevant agency

4.1.8. Major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation.

## 4.2. Never Events

4.2.1. Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

4.2.2. Each Never Event type has the potential to cause serious patient harm or death. However, serious harm3 or death does not need to have happened as a result of a specific incident for that incident to be categorised as a Never Event.

4.2.3. Each Never Event type must be able to be clearly defined and its occurrence easily recognised – this requirement helps minimise disputes around classification and ensures focus on learning and improving patient safety.

4.2.4. Never Events are incidents that require full investigation under the Serious Incident framework. The requirements for reporting, principles for investigation, and the roles and responsibilities associated with the management and oversight of other Serious Incidents apply, including the need to fully and meaningfully engage patients, families and carers at the beginning of and throughout any investigation.

4.2.5. The most updated list can be found at Appendix 1.

### 4.3. Assessing whether an incident is serious or not

4.3.1. In many cases it will be immediately clear that a serious incident has occurred, and further investigation will be required to discover what exactly went wrong, how it went wrong (from a human factors and systems-based approach) and what may be done to address the weakness to prevent the incident from happening again.

4.3.2. Whilst a serious outcome (such as the death of a patient who was not expected to die or where someone requires on going/long term treatment due to unforeseen and unexpected consequences of health intervention) can provide a trigger for identifying serious incidents, outcome alone is not always enough to delineate what counts as a serious incident. The NHS strives to achieve the very best outcomes, but this may not always be achievable. Upsetting outcomes are not always the result of error/acts, and/or omissions in care. Equally some incidents, such as those which require activation of a major incident plan for example, may not reveal omissions in care or service delivery and may not have been preventable in the given circumstances. However, this should be established through thorough investigation and action to mitigate future risks should be determined**.**

4.3.3. Where it is not clear whether or not an incident fulfils the definition of a serious incident, providers and commissioners must engage in open and honest discussions to agree the appropriate and proportionate response. It may be unclear initially whether any weaknesses in a system or process (including acts or omissions in care) caused or contributed towards a serious outcome, but the simplest and most defensible position is to discuss openly, to investigate proportionately and to let the investigation decide. If a serious incident is declared but further investigation reveals that the definition of a serious incident is not fulfilled- for example there were no acts or omissions in care which caused or contributed towards the outcome- the incident can be downgraded. This can be agreed at any stage of the investigation and the purpose of any downgrading is to ensure efforts are focused on the incidents where problems are identified and learning, and action are required.

## 5. Roles and responsibilities

**5.1 Accountable Officer –** has ultimate accountability for the strategic and operational management of the organisation, including ensuring all policies are adhered to.

5.1.1. Has the overall responsibility for ensuring all incidents are appropriately managed as stipulated in this policy and ensure that the Frimley ICB have the processes in place to support the successful implementation of the management of serious incidents.

**5.2 ICB Governing Body** – is responsible for ensuring that all policies in use in the organisation are ratified by the ICB Governing Body.

**5.3. Executive Director of Quality & Nursing** - has responsibility to ensure compliance with this policy.

5.3.1. Has the responsibility for monitoring the effective management of serious incidents across Frimley ICB and to ensure that all investigations are dealt with effectively and appropriately.

### 5.4. Directors of Quality

5.4.1. Have responsibility for the effective management of serious incidents by ensuring:

- Commissioned organisations have robust systems and processes for prompt reporting and management systems for SIs,
- Performance monitoring of commissioned organisations' reported SIs is robust
- Governing Body and the Quality, Performance and Finance Committee are assured on the performance management of SIs within commissioned organisations and the ICB overall serious incident management process
- NHS England and Improvement (NHSE/I), other stakeholder ICB and/or relevant professional bodies are informed of the relevant SIs,
- Informing the NHSE/I (South East) Regional Team when an SI originates in or involves the actions of the Frimley ICB and ensuring a robust investigation is undertaken.
- SI's are shared at Place if impact of the local population, or a number of providers are involved
- Identifying SI's which would benefit from a multiagency/provider investigation

### 5.5. ICB Quality Team

5.5.1. Has delegated responsibility for:

- Monitoring and maintaining an overview of all serious incidents logged onto STEIS by providers of the Frimley ICB commissioned services, ensuring they are recorded appropriately and identifying any trends and patterns
- Ensuring relevant respective ICBs are notified of SIs promptly, highlighting those that may be of higher risk and/or media interest
- Reporting incidents on STEIS for all commissioned providers who do not have access to the system
- Providing a consistent approach for the sign-off and closure of commissioned provider SIs by the Frimley ICB

- Monitoring provider timeframes for reporting and submission of SI reports to ensure compliance with all relevant national guidance

- Developing close working relationship with commissioned providers' identified Quality and Safety Leads

- Supporting & offering guidance to all commissioned providers to ensure they can comply with policy requirements

- Providing regular reports on commissioned provider SIs to the Frimley ICB

- Preparation and administration of the Serious Incident Review Panel meetings.

### 5.6. Clinical Leads

5.6.1. Engagement with specialist clinical leads including representation at Serious Incident Review Panel Meeting will be undertaken as required in line with the Serious Incident Review Panel Terms of Reference.

### 5.7. Serious Incident Review Panels

5.7.1. Have delegated responsibility from Quality, Performance and Finance Committee for the review and closure of commissioned services serious incidents. This group is also responsible for reviewing investigation reports prior to their submission to NHS England (South East) for review before closure.

### 5.8. Quality, Performance and Finance Committee

5.8.1. Provide assurance to the Governing Body that robust serious incident performance management processes are in place.

### 5.9. Commissioned Providers

5.9.1. Providers must be compliant with the requirements identified within the NHS England SI Framework document, published in March 2015, and have a responsibility to ensure that their first priority when an SI occurs is to ensure the needs of individuals affected by the SI are attended to, including any urgent clinical care and management action that may reduce harmful impact. The commissioned provider should give early consideration to the provision of information and support to patients, relatives and carers and staff involved in the SI, including information regarding support systems which are available. The commissioned provider must comply with the duty of candour requirements and the principles of being open and have an approved 'Being Open Policy'.

5.9.2. Commissioned providers also have the following responsibilities:

- Ensuring there are structured risk management systems and processes for collecting, collating and analysis of data on all SIs and lessons identified, including reporting SIs via STEIS. Those commissioned providers without access to STEIS should contact the Frimley ICB Quality Team/Lead directly and report SIs using the reporting form in Appendix 2.

- Reporting and ensuring all SIs defined by the National SI Framework, are investigated as per national guidance, using root cause analysis (RCA) methodologies. Re-establishing a safe environment where all equipment or medication involved in the SI are retained and isolated, relevant documentation copied and secured to preserve evidence and facilitate investigation and learning.

- Contacting the police if there is a suggestion that a criminal offence has been committed.

- Manage the reporting to Health and Safety Executive (HSE), as appropriate of Health and Safety Incidents, CQC and to NHS Improvement through the National Reporting and Learning System (NRLS) for Patient Safety Incidents

- Informing Frimley ICB if they are considering commissioning services (or parts of) through other commissioned providers and assuring Frimley ICB that any commissioned services are compliant with this policy.

- Ensuring appropriate representatives attend the Frimley SI Review Panels as outlined in the relevant panel's terms of reference.

### 5.10. Involvement of more than one Commissioned Provider

5.10.1. Often more than one organisation is involved in the care and service delivery in which a serious incident has occurred. The organisation that identifies the serious incident is responsible for recognising the need to alert other providers, commissioners and partner organisations as required in order to initiate discussions about subsequent action.

5.10.2. All organisations and agencies involved should work together to undertake one single investigation wherever this is possible and appropriate.

5.10.3. Frimley ICB Quality Team may be contacted to help facilitate discussions relating to who is the most appropriate organisation to take responsibility for coordinating the investigation process if this is unclear or is disputed. The team can provide support in complex circumstances and where no one provider organisation is best placed to assume responsibility for co-ordinating an investigation, Frimley ICB may lead this process.

### 5.11. Quality Surveillance Groups

5.11.1. NHS England and Improvement (NHSE/I) developed Quality Surveillance Groups where data, incident reports and the quality of responses to SIs that give cause for concern will be shared. This will assist in the triangulation of other quality related information and the formulation of appropriate responses, such as triggering a Risk Summit or keeping the provider under regular review. The ICB, and NHSE/I should fully exploit the opportunities for sharing information about SIs in relevant providers with partner organisations who make up the relevant local and regional Quality Surveillance Groups.

### 5.12. NHS England and Improvement (NHSE/I)

5.12.1. Has responsibility for:

- Commissioning independent investigations/inquiries into serious incident cases which meet nationally agreed criteria. Working with NHS and Regional Teams to identify relevant intelligence and learning to be shared at national level and to facilitate such learning and sharing at a national level.

- High level oversight of SI reporting and responses, including reviewing trends, quality analysis and early warnings via Quality Surveillance Groups will be proportionate to requirements.

- Providing support to contract management for primary and specialised care providers' responses to SIs and, where appropriate, commissioning and coordinating primary and specialised care SI investigations.

- Having oversight of SI investigations undertaken in acute, community, mental health and ambulance care including reviewing trends, quality analysis and early warnings via Quality Surveillance Groups.

- Management of SIs in services directly commissioned by NHS England will be the responsibility of NHS England to comply with National Standards & SI investigation.

## 6. Process for reporting and managing Sis

6.1. All providers commissioned by Frimley ICB are required to report SIs using the STEIS system. Providers are required to put in place an internal governance process which ensures all serious incidents are reported on STEIS within 2 working days of the SI being identified.

6.2. Incidents falling into any of the serious incident categories below should be reported immediately to Frimley ICB via telephone and electronically. This should be via the on-call procedure if out of hours:

- Incidents which activate the NHS Trust or Commissioner Major Incident Plan

- Incidents which will be of significant public concern

- Incidents which will give rise to significant media interest or will be of significance to other agencies such as the police or other external agencies.

6.3. Serious Incidents declared by providers that do not have access to STEIS must be reported to Frimley ICB using the dedicated email address Frimleyccg.quality@nhs.net within two working days of identification of the incident.

6.4. Providers should undertake an initial review within 72 hours and upload this onto STEIS.

6.5. Frimley ICB will review all SIs reported and initial questions/comments to support the investigation will be sent to the provider.

6.6. Providers have 60 working days from declaration of the incident to complete a Root Cause Analysis investigation.

6.7. On rare occasions, extensions to the above timescales can be agreed with the provider. The circumstances for an extension must be those that are outside the normal working arrangement such as witnesses being unable to be interviewed due to absence or Police investigations. Requests for extensions must be made in writing using the Extension Request Form (Appendix 3) and must be formally agreed with the ICB Quality team/Lead manager. The reason for the extension must be included on the Strategic Executive Information System (STEIS) incident form.

6.8. On receipt of the investigation, Frimley ICB will undertake a review of the final report and action plan and ensures it meets requirements for a robust investigation using the checklist found at Appendix 4.

6.9. The SI will be reviewed at the relevant Serious Incident Review Panel and a decision taken as a system on closure of the SI based on the evidence submitted by the provider. This will include ensuring that the action-plan contains action points to address all root causes identified and that they include a named lead for each action and a timescale for completion.

## 7. Dissemination of Learning

7.1. One of the key aims of the serious incident reporting and learning process is to reduce the risk of recurrence, both where the original incident occurred and elsewhere in the NHS. The timely and appropriate dissemination of learning following a serious incident is core to achieving this and to ensure that the lessons identified are embedded in practice.

7.2. Evidence of learning can be demonstrated at organisational level by sustainable changes and improvements in process, policy, systems, and procedures relating to patient safety within healthcare organisations. Key

learning points that may be shared more widely may fall into the following areas:

- understanding and identification of the influence of Human Factors
- solutions to address incident root causes that may be relevant to other teams, services, and provider organisations
- Identification of the components of good practice that reduced the potential impact of the incident and how they were developed and supported
- Systems and processes that allow early detection or intervention that will reduce the potential impact of the incident
- Lessons identified from conducting the investigation that may improve the management of investigations in future
- Documentation of identification of the risks, the extent to which they have been reduced and how this is measured and monitored

7.3. Reporting organisations and Frimley ICB will work together to share the learning from serious incidents both within the Frimley Integrated Care System and through Serious Incident Learning Events including Berkshire, Hampshire, Surrey, Regional and National levels.

## 8. Training and Competencies

8.1. Key people within Frimley ICB who are involved in the performance management of SIs will undertake specialist training on root cause analysis.

## 9. Statutory requirements

### 9.1. Equality analysis

9.1.1. An Equality Impact Assessment is attached in Appendix 5.

### 9.2. Other requirements

9.2.1. “Bribery Act 2010 – the ICB has a responsibility to ensure that all staff are made aware of their duties and responsibilities arising from The Bribery Act 2010. The Bribery Act 2010 makes it a criminal offence to bribe or be bribed by another person by offering or requesting a financial or other advantage as a reward or incentive to perform a relevant function or activity improperly performed. The penalties for any breaches of the Act are potentially severe. There is no upper limit on the level of fines that can be imposed, and an individual convicted of an offence can face a prison sentence of up to 10 years. For further information see http://www.justice.gov.uk/guidance/docs/bribery-act2010-quick-start-guide.pdf.

9.2.2. Due consideration has been given to the Bribery Act 2010 in the review of this policy and no specific risks were identified.

9.3. **Data protection legislation – (as defined in the Data Protection Act 2018)**

9.3.1. This policy will comply with the Data Protection Act 2018.

## 10. NHS Constitution

10.1. **The ICB is committed to:**

Designing and implementing services, policies and measures that meet the diverse needs of its population and workforce, ensuring that no individual or group is disadvantaged.

10.2. This Policy supports the NHS Constitution as follows:
*"The NHS aspires to the highest standards of excellence and professionalism in the provision of high-quality care that is safe, effective and focused on patient experience; in the planning and delivery of the clinical and other services it provides; in the people it employs and the education, training and development they receive; in the leadership and management of its organisations; and through its commitment to innovation and to the promotion and conduct of research to improve the current and future health and care of the population".*

## 11. Dissemination//Publication

11.1. This policy will be available on the ICB Website and the staff intranet.

## 12. Monitoring

12.1. In order to comply with the requirements of the National Framework for the reporting and learning from serious incidents, Frimley ICB will monitor trends in serious incidents. Frimley ICB will use both quantitative and qualitative data analysis of incidents where root causes and lessons have been identified**.**

12.2. On-going compliance with the requirements of the National Reporting and Learning Framework for Reporting and Learning from serious incidents will be carried out by using the following measures:

| Standard | Detail | Data Source |
|---|---|---|
| Incidents will be reported within two working days of identification of the incident | Time from date of knowledge to incident reported on STEIS | STEIS |

| Standard | Detail | Data Source |
|---|---|---|
| A 72-hour update report will be uploaded onto STEIS | Time from date of incident coming to light and completion of 72-hour update must be no more than 72 hours | STEIS |
| Incident investigations will follow the structure and process of Root Cause Analysis methodology.<br><br>Understanding and analysis within the investigation should include a thorough analysis of key contributory factors to include description against these and identification and understanding of any Human Factors that may lead to wider learning. | Investigation structure to follow the National Patient Safety Agency Root Cause Analysis Guidance and Template or similar robust framework determined at local level | Investigation reports |
| STEIS must be kept up to date and incidents closed according to national timescales. | STEIS will reflect the current status of the investigation. | STEIS |
| Serious Incident Review Panels to receive assurance on the implementation of action plans | Serious Incident Review Panel to receive assurance on SIs so that robustness of actions resulting from SIs can be assured | Serious Incident Review Panels' papers, action plans and investigation reports |

12.3. Key performance indicators to be used to review the effectiveness of the incident reporting process are:

- Monitoring of the level of incident reporting via provider organisation's quarterly incident and serious incident reports
- Monitoring the numbers of incidents reported within 2 working days of the incident occurring
- Monitor completion of 72-hour updates provided on STEIS

- Monitoring the number of incident investigation and SI investigations completed within 60 days

- Monitoring the incidents formally closed within 6 months of date of reporting.

12.4. Ongoing review of the policy will take place in line with the Frimley Policy review requirements or when there are national changes to Serious Incident Management guidance.

## 13. Review and revision

13.1. This policy will be reviewed every three years by the Document Author to ensure continued validity and relevance, with a schedule of proposed amendments presented to the Governing Body for approval.

# Appendices

## Appendix 1.

NHS Improvement Revised Serious Incident Framework 2015

https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

Never Events Policy and Framework (revised) 2018

Revised-Never-Events-policy-and-framework-FINAL.pdf (england.nhs.uk)

Never Events List 2018 (updated 23rd February 2021)

2018-Never-Events-List-updated-February-2021.pdf (england.nhs.uk)

## Appendix 2.

New Blank STEIS Report.docx

## Appendix 3.

Blank Extension Request Form.docx

## Appendix 4.

SI Closure Checklist.docx

## Appendix 5.

SI Management
Policy Equality Impa

# Procedural Document - checklist for approval

| Procedural document checklist for approval | | | |
|---|---|---|---|
| To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval. | | | |
| | **Title of document being reviewed:**<br>Policy framework for the development and management of procedural documents | **Yes/No/ Unsure** | **Comments/Details** |
| **A** | **Is there a sponsoring director?** | Yes | |
| **1.** | **Title** | | |
| | Is the title clear and unambiguous? | Yes | |
| | Is it clear whether the document is a guideline, policy, protocol or standard? | Yes | |
| **2.** | **Rationale** | | |
| | Are reasons for development of the document stated? | Yes | |
| **3.** | **Development Process** | | |
| | Do you feel a reasonable attempt has been made to ensure relevant expertise has been used? | Yes | |
| | Is there evidence of consultation with stakeholders, unions (where appropriate) and users? | No | This is based on national guidance |
| **4.** | **Content** | | |
| | Is the objective of the document clear? | Yes | |
| | Is the target group clear and unambiguous? | Yes | |
| | Are the intended outcomes described? | Yes | |
| **5.** | **Evidence Base** | | |
| | Is the type of evidence to support the document identified explicitly? | Yes | |
| | Are key references cited? | Yes | |
| **6.** | **Approval** | | |
| | Does the document identify which committee/group will approve it? | Yes | |

| **Procedural document checklist for approval** | | | |
|---|---|---|---|
| To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval. | | | |
| | **Title of document being reviewed:**<br>Policy framework for the development and management of procedural documents | **Yes/No/ Unsure** | **Comments/Details** |
| **7.** | **Dissemination and Implementation** | | |
| | Is there an outline/plan to identify how the document will be disseminated and implemented amongst the target group? Please provide details. | Yes | |
| **8.** | **Process for Monitoring Compliance** | | |
| | Have specific, measurable, achievable, realistic, and time-specific standards been detailed to monitor compliance with the document? | Yes | |
| **9.** | **Review Date** | | |
| | Is the review date identified? | Yes | |
| **10.** | **Overall Responsibility for the Document** | | |
| | Is it clear who will be responsible for implementing and reviewing the documentation i.e., role of author/originator? | Yes | |
| **Director Approval** | | | |
| On approval, please sign and date it and forward to the chair of the committee/group where it will receive final approval. | | | |
| Name | | Date | |
| Signature | | | |
| **Committee Approval** | | | |
| On approval, Chair to sign and date. | | | |
| Name | | Date | |
| Signature | | | |