Somerset Partnership NHS
NHS Foundation Trust

POLICY ON MANAGING POLICIES, PROCEDURES AND GUIDANCE DOCUMENTS

Version:	6
Date Ratified:	**February 2017**
Review Date:	**February 2020**
Applies to:	Senior Managers and staff who produce procedural documents.

This document is available in other formats, including easy read summary versions and other languages upon request. Should you require this please contact the Equality and Diversity Lead on 01278 432000

DOCUMENT CONTROL

Reference	**Version**	**Status**	**Author**
AS/Feb17/PoP	6	Final	Head of Corporate Business
Amendments: Updated in line with new 2017 Governance Structure; clearer definition of types of procedural documents; identifying Groups/Committee responsibility for procedural document approval; identifying quarter reports of each type of procedural document approval and new monitoring of percentage of documents in date and under review. New appendices containing the procedures for producing Policies e.g. Flowchart of Process, user-friendly checklist for document authors to be used as a quick guide. Updated template to replace standard headings.			
Approving Body	Quality and Performance Committee	Date: February 2017	
Formal Impact Assessment	Part 1	Date: February 2017	
Ratification Body	Trust Board	Date: February 2017	
Date of Issue	**March 2017**		
Review Date	**February 2020**		
Contact for Review	Head of Corporate Business		
Lead Director	Director of Strategy and Corporate Affairs		

CONTRIBUTION LIST Key individuals involved in developing the document

Contributors - Designation or Group
Director of Strategy and Corporate Affairs
Head of Corporate Business
Claims and Litigation Manager
Non-Executive Director - Patient Safety Lead
Executive Management Team
Clinical Policy Review Group
Quality and Performance Committee

CONTENTS

1. INTRODUCTION

1.1 The Trust needs formal written documents which communicate standard organisational ways of working. These help clarify strategic and operational requirements and bring consistency to day to day practice. They can improve the quality of work and increase the successful achievement of its objectives.

1.2 A common format and approval structure for such documents helps to reinforce corporate identity and, more importantly, helps to ensure the formal documents in use are current and reflect an agreed organisational approach. It also helps avoid confusion and assists staff in identifying key issues within such a document.

1.3 This document sets out the Trust requirements when developing, modifying or updating its written procedural documents to ensure consistency in quality and compliance with Trust and national requirements.

2. PURPOSE AND RATIONALE

2.1 **Purpose** - to provide the framework within which procedural documents in the Trust are managed, and to explain the roles, responsibilities and process for the development, review, approval, dissemination, version control and monitoring of all Trust procedural documents (as defined in section 5 below).

2.2 **Rationale** – in order to be considered as a well-led organisation with robust governance systems the Trust needs to be able to demonstrate that it has a clearly described process for the development of new and the review of existing policies, procedures, standard operating procedures and guidelines (collectively known as 'procedural documents') which ensures that staff undertake their duties in a safe and effective way that takes account of statute and guidance.

2.3 This document is relevant for Trust-wide procedural documents. It is sometimes the case that individual areas will have their own localized policies and procedures. These are outside the scope of this document, though it is to be expected that the principles described below will still be followed in their production and management.

3. POLICY STATEMENT

3.1 It is the policy of the Trust that:

- all policies, procedures, strategies, protocols and guidelines must adhere to the requirements set out in this policy and its supporting documents;

- all relevant procedural documents are developed or reviewed in accordance with this policy and are formatted in accordance with the Template for Policies (Appendix B), with effect from 1 April 2017;

- 90% of documents requiring review are reviewed, approved and disseminated by their review date and that the remaining 10% of documents are reviewed, approved and disseminated within 3 months of their review date;

- where appropriate, that divisional and ward / service documents do not contradict trust-wide documents;

- staff continue to have access to the most up-to-date and relevant documents either through the trust's website or intranet;

- trust-wide procedural documents are referenced on the Trust Policy Schedule and that copies are held in the Trust's procedural documents library maintained by the Corporate Governance Team.

3.2 Through this policy, the Trust will aim to ensure:

- that all procedural documents are structured and formatted in such a way as to make them as intelligible and understandable as possible to the intended audience;

- all procedural documents follow a standardised approach that reflects the needs and objectives of the Trust and conforms to any external requirements or standards;

- all procedural documents are realistic in their content and requirements so that they are practical to follow and implement.

4. DEFINITIONS

4.1 The Trust has five types of documents that are generically referred to as procedural documents:

Document type	
Strategy	A statement of vision and detailed plan for achieving organisational-level success over a defined period of time
Policy	A statement of the overall aims, objectives and principles that underpin a practice
Procedure	A set of mandatory or necessary actions, steps or requirements that must be followed by staff to achieve a particular end. Procedures always have a beginning and an end. Clinical procedures in particular are sometimes known as Standard Operating Procedures. In the context of this document, they are treated identically.
Guidance	A description of recommended action(s) or 'best practice' to inform a way of working. They are sometimes called "Guidelines" – the two terms are interchangeable. Guidance is not necessary mandatory.
Protocol	These documents are a formal understanding of how one body communicates with another, in particular with outside organisations.

4.2 In brief, a strategy sets out a vision and plan for achieving organisational aims; a policy sets out what you must know or do; a procedure tells you how it must be done; and guidance tells you how it may be done in line with best practice or other recognised guidelines.

5. DUTIES AND RESPONSIBILITIES

5.1 The **Trust Board** has responsibility for ensuring there is robust documentation describing the governance arrangements for approving strategy and other relevant procedural documents, which are described in the Trust's Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation. The Trust Board has delegated responsibility for the ratification or approval of certain policy documents to Trust committees and groups.

5.2 The **Director of Strategy and Corporate Affairs** has devolved responsibility from the Board to oversee the monitoring and implementation of the development of procedural documents in order to ensure that this policy is applied throughout the Trust.

5.3 Every policy must have a Lead **Executive Director** who will be identified within the document control process. The Lead **Executive Director** is responsible for:

a) the identification, review, endorsement, implementation and monitoring of the relevant procedural documents (i.e., those procedural documents relevant to their executive portfolios - a list of the executive leads can be found in the relevant Policy Schedule);

b) overseeing the work of the Lead Author(s);

c) approving the progression of the policy document through the various stages of approval and ratification (outlined in section 8 below);

d) where a new policy document needs Trust Board / Board Committee approval, to produce a report seeking approval.

5.4 **Document Lead Authors** (the specialist leads e.g. medicines, safeguarding, infection control, mental health Act etc.) are the member(s) of staff responsible for writing, reviewing and auditing the procedural document in accordance with this policy and its supporting documents. Acting in support of the Lead Executive Director, the Lead Author(s) are responsible for:

a) on behalf of the Lead Executive Director, overseeing the process for approving and ratifying procedural documents as described in section 8 below;

b) developing / updating draft (working) procedural documents, taking account of trust strategy, other trust procedural documents, commissioning requirements, statutory requirements and relevant evidence-based practice and guidance;

c) consulting as appropriate with service users / carers, staff and other stakeholders in the development / review of the document;

d) in respect of trust-wide procedural documents, attending the relevant Governance or Policy Review Group to discuss their procedural document;

e) ensure documents ratified subject to further amendments have been updated and provided to the Claims and Litigation Manager within ten working days unless agreed otherwise. Documents ratified without further amendments will be retrieved directly from the SMT/Trust Board papers;

f) undertaking a training needs analysis, in conjunction with the relevant executive director (where appropriate) and the Learning and Development team;

g) undertaking the equality impact assessment for the policy document, using the Equality Impact Assessment forms in the Equality Impact Assessment document (see section 7 below). Authors must consider updating the document with consideration of possible recommendations advised by the Equality and Diversity Lead during the EIA process;

h) Ensure forms appended to the document are accessible in 'word' format on the Trust intranet and existing forms are replaced following review.

5.5 The **Head of Corporate Business** has responsibility for ensuring efficient and robust processes are in place for the administration and dissemination of procedural documents, this includes the archiving of old versions of documentation.

5.6 The **Claims and Litigation Manager** is responsible for the central administration and dissemination of procedural documents following their approval and ratification. This includes ongoing update and maintenance of the register/library of procedural documents, and the secure archiving of old versions. In addition the Manager will provide quarterly updates to the Chair of each Responsible Group/Committee (Appendix D) in respect of policies which are due for review and holds responsibility for the dissemination of the final document via a range of processes including (but not limited to) the Trust's intranet, email system and the Trustwide Newsletter.

5.7 The **Equality and Diversity Lead** is responsible for reviewing the initial screening completed by Document Authors and will advise the document author of amendments required or where a full impact assessment of the procedural document will need to be carried out.

5.8 **Quality and Performance Committee** – the role of the Quality and Performance Committee in respect of policy development is to:

a) approve the Policy for Managing Policies, Procedures and Guidance Documents;

b) approve the Trust Policy Schedule, taking account of the Trust's Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation;

c) receive a regular report from the Head of Corporate Business in respect of trust-wide clinical and non-clinical policy documents showing the trust-wide policy documents due for review;

d) receive assurance that in respect of divisional procedural documents the appropriate Divisional Governance Group has approved the procedural document within the review dates;

e) approve the terms of reference for the Groups/Committees responsible for policy approval.

5.9 **Responsible Group/Committee (see Appendix D)** – the relevant committee / group within the trust's governance arrangements has responsibility:

a) to undertake the detailed scrutiny of new and reviewed policy documents;

b) for making comments and suggestions to the Lead Author(s) as necessary, which must be minuted;

c) as specified in the Policy Schedule, to ensure that the committee / group either recommends or approves the procedural document;

d) as specified in the procedural document, developing the dissemination and implementation plan / managing the implementation of the procedural document (particularly relevant for Divisional Governance Groups).

e) the Chairs of each Responsible Group/Committee are responsible for identifying policy authors relevant to their individual areas of responsibility and establishing a rolling programme of policy review (supported by the quarter Policy Report), update and approval ensuring updates are compliant with the local and national requirements.

5.10 **Divisional Governance Groups** – in respect of operational procedural documents (including standard operating procedures) the relevant Divisional Governance Group has the following responsibility in addition to those described in paragraph 5.9 above:

a) approving the relevant operational procedural documents;

b) identifying an officer(s) – a Divisional Lead for the development of procedural documents - who oversees the document development work within their division.

5.11 **Operational and Professional Managers** (including Heads of Service, Senior Managers, Matrons and Service Managers and Ward/Team Managers) are responsible for implementing procedural documents.

5.12 **All Trust Staff** including Locum, Bank/Agency and Contractors are individually responsible for their actions and must comply with policies and procedures.

6. WRITING A NEW OR REVISED POLICY

6.1 When writing a new or revised policy, document authors should follow the guidance and documentation set out in Appendices A, B and C.

7. MONITORING COMPLIANCE WITH THIS POLICY

7.1 It is the responsibility of the approving Committee/Group to ensure, at the point of approval, all procedural documents are compliant with the requirements outlined within this policy.

7.2 It is the responsibility of the approving Committee/Group to satisfy itself, prior to approval, that each document meets the criteria set out within this policy including formatting prior to progressing the document.

7.3 Monitoring of the level of compliance with the requirements of this policy will be undertaken at the point of ratification by the Senior Management Group.

7.4 The Head of Corporate Business will submit an annual report to the Quality and Performance Committee outlining the activities undertaken in respect of procedural document development and approval. The report will identify all procedural documentation which has passed its review date and will outline actions being taken to address issues identified.

8. TRAINING AND COMPETENCY REQUIREMENTS

8.1 Any member of staff who requires training in order to fulfil the criteria for the development and review of procedural documents as laid down within this policy should contact their line manager in the first instance.

9. REFERENCES, ACKNOWLEDGMENTS AND ASSOCIATED DOCUMENTS

9.1 Other related documents to this Policy/Guidance are:

- Counter Fraud (including Bribery and Corruption) Policy;
- Equality Impact Assessment Policy;
- Equality and Diversity Policy;
- Freedom of Information Policy;
- Record Keeping and Records Management Policy;
- Risk Management Policy and Procedure;
- Risk Management Strategy.

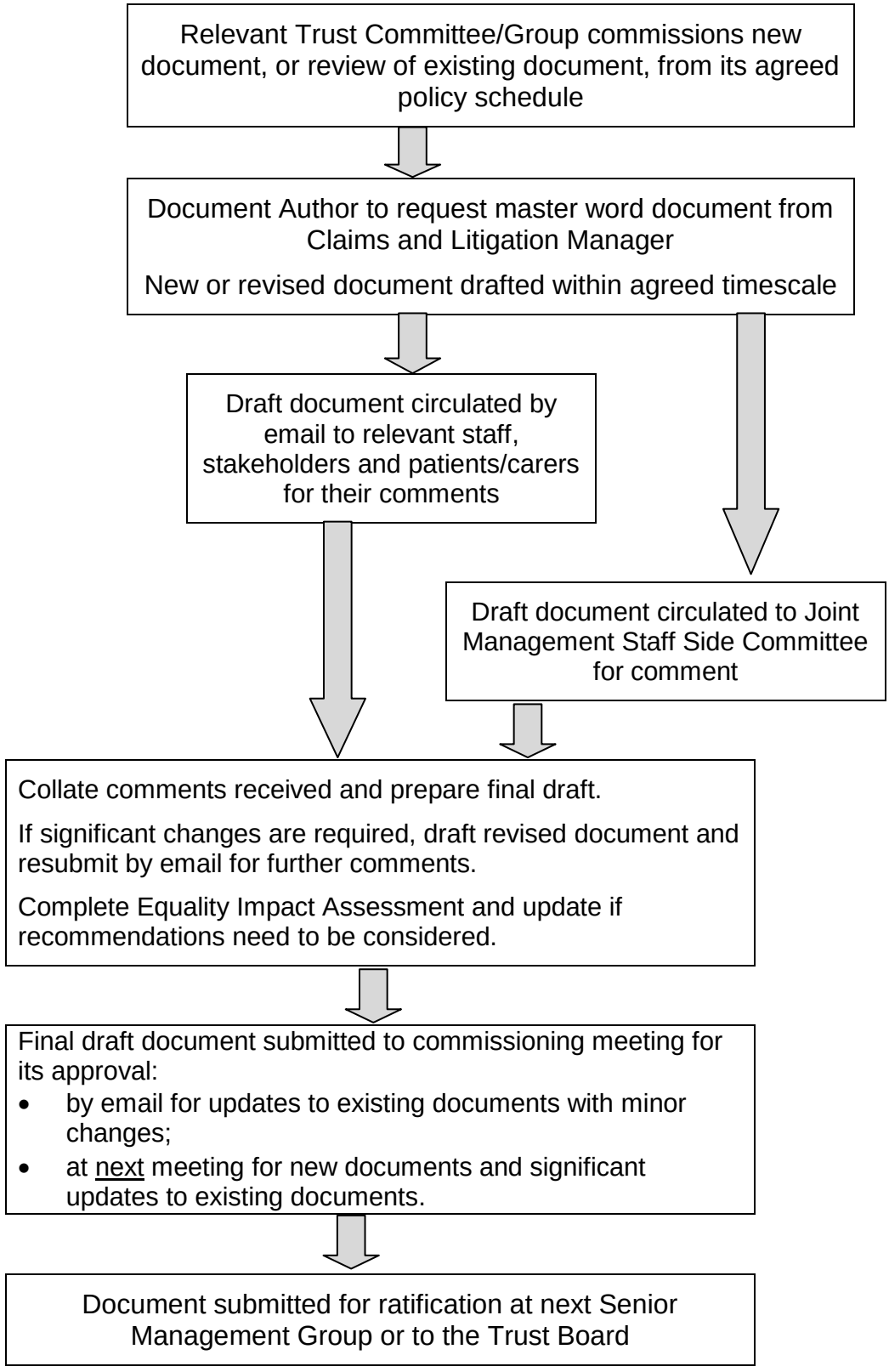
9.2 All current policies and procedures are accessible in the policy section of the public website (on the home page, click on ‘Policies and Procedures’). Trust Guidance is accessible to staff on the Trust Intranet.

10. APPENDICES

10.1 For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such.

APPENDIX A

FLOWCHART AND GUIDANCE FOR THE DEVELOPMENT AND APPROVAL OF POLICIES



WRITING A NEW OR REVISED POLICY

Policy Development Checklist

1.1 A Checklist is provided below as a quick guide for document authors to assist the development of all new and revised policies and trust-level procedural documents which should be written using the Template for Procedural Documents at Appendix B.

1.2 Prior to starting a full review of an existing policy the Lead Author(s) request the master word document from the Claims and Litigation Manager/ Corporate Business Team and should identify the process to be used, dependent upon the type of change intended:

Type	Definitions	Process
Minor Change	These are 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)	Lead Executive Director signs off amendment. Approving / ratifying committee and staff notified of change using the form in Appendix F
Major Change	Changes which impact on the practice being used or staff responsibilities (e.g., new responsibilities, changes to forms used etc)	Required to use the full review process shown in Appendix A
Not required	Policy no longer required due to changes in internal / external processes or statute	Lead Executive Director signs off withdrawal amendment. Approving / ratifying committee and staff notified of withdrawal

1.3 No specific format is stipulated for procedures, guidance or local/team procedures but the format chosen should be appropriate and accessible to the subject matter and the intended audience.

1.4 When considering the development of new policies, authors should ensure they are not duplicating other work, either nationally or locally (including checking against the local register/library of procedural documents) held by the Claims and Litigation Manager and confirm implementation is achievable within Trust resources.

Equality Impact Assessment

1.5 All Trust procedural documents must be Equality Impact Assessed to help the Trust meet its obligations under the Equality Act 2010. The Equality Impact Assessment (EIA) process has two stages. The first stage is an initial screening assessment which is undertaken by the Author during the procedural development stage. The outcome of all EIAs must be sent to the

Trust's Equality and Diversity Lead. When indicated, a full impact assessment of the procedural document will be carried out.

2. CONSULTATION, APPROVAL AND RATIFICATION PROCESS

Consultation Process

2.1 It is the responsibility of the Lead Author to ensure key stakeholders are consulted with throughout the development of the document. Stakeholders may include staff, trade union organisations, partner agencies and, whenever appropriate, patients and carers.

Consultation and Communication with Stakeholders

2.2 As consultation is a core requirement, each Lead Author must demonstrate they have applied the process through:

- following the Flowchart and Checklist for the Development and Approval of Procedural Documents - Appendix A;
- completing the Template (including Document Control page) – Appendix B;
- ensuring style and format is correct – Appendix C;
- ensuring Committee/Group approval and ratification – Appendix D;
- ensuring Board ratification if required – Appendix E
- notifying the ratifying Committee/Group of minor changes – Appendix F

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2.3 Contributors should pass on their comments to the lead author(s) within a time frame specified by the author but no later than one month from receiving the draft version. The Author will consider all comments, update the document, update the version number and forward to the appropriate Group for approval.

Approval and Ratification Process

2.4 The process is set out in the flowchart in Appendix A and a record of compliance will be recorded within the Document Control page in Appendix B.

Approval of Procedural Documents

2.5 All procedural documents must be approved by the designated Committee/Group. If the document is not approved by the Committee/Group, its Chair will ensure the document is returned to the Author with appropriate advice and the review process will continue. A schedule of the relevant Committees/Groups for each policy type is set out in Appendix D.

2.6 In circumstance where the document is approved at the designated Committee/Group subject to minor amendments, the document will be

returned to the Lead Author with appropriate advice (consistent with the minutes of the meeting), in a timely manner. In exceptional circumstances, approval can take place at an Executive Management Team meeting.

The Lead Author will then update the document and send it to the Chair who will forward directly to Senior Management Team for ratification (or Board if required, as listed in Appendix E).

Ratification of Procedural Documents

2.7 The Senior Management Team (or Board if required, Appendix E) will ratify each document**.**

2.8 Following ratification the Author will again update the document control page then forward the document to the Claims and Litigation Manager.

3. REVIEW AND REVISION ARRANGEMENTS

Review process

3.1 Each procedural document will be reviewed at least every three years except where the ratification process identifies otherwise.

3.2 In exceptional circumstances, for example where there is expected to be a change in National Guidance, the life of the procedural document may be extended, but not by more than six months, all such documents will remain current until they are superseded by the next version.

3.3 Where there is a major change to law, legislation or circumstances arise which have significant impact on the procedural document in question, a review will take place as soon as reasonably practicable.

Version Control

3.4 Each procedural document must have version control and authors should follow the guidance in Appendix C (Style and Format) and recorded in the document control page as shown in the Template for Procedural Documents at Appendix B.

3.5 Until finally approved, all versions of a policy under review should have the word DRAFT as a watermark.

4. DISSEMINATION AND IMPLEMENTATION

Dissemination

4.1 Each new and reviewed procedural document, once ratified, will be uploaded to the appropriate strategy or policy section with policies and procedures on the Trust's Public Website by the Claims and Litigation Manager who will ensure the correct PDF version is available and old versions are archived securely.

4.2 The Claims and Litigation Manager will provide a monthly Policy Update for the Trustwide newsletter 'What'sOn' to raise staff awareness.

4.3 Heads of Service, Senior Managers, Matrons and Service and Ward Team Managers are advised to remind staff within local Team briefings and to print a copy of the newsletter and display within staff areas for those staff who do not regularly use a computer.

Implementation

4.4 Responsibility for implementing procedural documents is devolved to Operational and Professional Managers (including Heads of Service, Senior Managers, Matrons and Service and Ward Team Managers).

4.5 Where the procedural document includes a training and competency assessment requirement, staff should discuss this with their line manager in the first instance.

5. DOCUMENT CONTROL INCLUDING ARCHIVING ARRANGEMENTS

Register/Library of Procedural Documents

5.1 The process for collating the register/library of procedural documents is a master spreadsheet of all procedural documents in place and is stored within the secure drive in Corporate Governance, labelled 'Master Procedural Documents Register'. The Claims and Litigation Manager is responsible for recording new, reviewed and redundant procedural documents within this spreadsheet.

Archiving arrangements

5.2 All procedural documents must be kept for the life time of the document, then electronically archived for a minimum of ten years or permanently, depending on the document type. The Claims and Litigation Manager will archive historic procedural documents within the Procedural Document Section of the secure drive in Corporate Governance when revised documents have final ratification status. Access to archived documents will be via the Claims and Litigation Manager.

CHECKLIST FOR DOCUMENT AUTHORS FOR NEW/REVIEW POLICIES PROCESS

It will remain the responsibility of the Document Author to ensure the procedural document is systematically progressed in a timely manner throughout each stage of the development/review process. To assist Document Authors the following checklist has been provided

1.	Produce DRAFT Document	**NEW POLICY** - Document Author produces first DRAFT (using Policy Template) and marked DRAFT as a watermark **POLICY REVIEW** – Document Author requests 'master word' document from Claims and Litigation Manager and makes appropriate revisions to the first DRAFT/REVIEW	
2	Consultation with Key Stakeholders	**Document Author** to ensure key stakeholders/appropriate policy review group have been consulted and contributed to the document eg: Best Practice Groups / Infection Control / Clinical Policy Review Group (CPRG), Joint HR Policy Review Group / JMSCC etc	
3	Update following comments	**Document Author** to make appropriate updates following comments/contributions from Key Stakeholders and update the document contributors list.	
4	Equality Impact Assessment	**Document Author** completes the initial EIA screening during the development of the document by completing Appendix One of the Equality Impact Assessment Policy. Authors will forward the EIA Screening form to Andrew Sinclair, for EIA screening, who will sign off or recommend appropriate amendments (author to update if req.).	
5	Group / Committee Approval	**Document Author** to forward updated version of the policy/procedural document to the appropriate Responsible Group/Committee (identified in Appendix D at least seven days prior to the meeting.	
6	SMT / TB for ratification	**Document Author** to make appropriate amendments if suggested by the Responsible Group/Committee, update document control page eg version, group/committee approval date and date of EIA, then forward to the SMT for ratification (or Trust Board if required) at least ten days prior to the meeting	
7	Corporate Governance Upload to Public Website	Documents ratified at SMT will be forwarded to the **Claims and Litigation Manager** who will save the final word version within the Master Document file in the secure Corporate Drive, then PDF and upload to the Public Website. However, if documents were ratified subject to further amendments **the author** must action and forward the updated document to the Claims and Litigation Manager for upload.	
8	Raising Staff Awareness	The **Claims and Litigation Manager** will provide a monthly Policy Update to the Trust Newsletter – WhatsOn to raise staff awareness.	

This checklist does not replace the Policy/Guidance, but is intended as a quick guide for staff.

APPENDIX B

TEMPLATE FOR POLICIES

Somerset Partnership NHS
NHS Foundation Trust

TITLE OF POLICY

***Note**:*

Please remove

- *Unused optional headings and information in italics once section(s) are completed.*
- *These guidance notes*

Please change

- *Contents page (as appropriate)*
- *Footer*

Please keep

- *Order and layout of template*
- *All DRAFTS in Word with a watermark of 'DRAFT'. Final version will be converted to PDF by Corporate Services Administrator for website.*

  All policies should be written in a style which is concise and clear, avoiding abbreviations and using unambiguous terms and language.

Version:	
Date of Approval:	
Review Date:	*(usually three years unless otherwise agreed)*
Applies to:	*(identify staff groups to whom this policy is specifically relevant)*

This document is available in other formats, including easy read summary versions and other languages upon request. Should you require this please contact Document Author.

DOCUMENT CONTROL *(Author to complete this page and update following ratification)*

Reference Number	**Version** *e.g. v0.1*	**Status** *DRAFT*	**Author** *Insert Job Title not name*
Amendments	*Set out key changes that have been made to the previous document*		
Approving body	*Insert Responsible Group or Committee or Executive Management Team*		Date:
Equality Impact Assessment	Impact Part 1		Date:
Ratification Body	*Senior Management Group or Trust Board (delete as appropriate.)*		Date:
Date of issue			
Review date	*(usually three years unless otherwise agreed)*		
Contact for Review	*Insert Job Title (not name)*		
Lead Director	*Insert Job Title (not name)*		

CONTRIBUTION LIST Key individuals involved in developing the document

Contributor – Designation or Group

CONTENTS

1. INTRODUCTION

1.1 *A short paragraph introducing the procedural document. Include a brief rationale for development.*

2. PURPOSE AND RATIONALE

2.1 *State the purpose of the procedural document and the rationale for needing a policy or procedure.*

2.2 *Describe who the procedural document applies to (including Temporary, Locum, Bank, Agency, Contracted staff as appropriate).*

3. POLICY STATEMENT

3.1 *Include a clear statement of the Trust's policy on the issue(s) which the policy covers.*

4. DEFINITIONS

4.1 *List and describe the meaning of the terms used in the context of the document if considered necessary.*

5. DUTIES AND RESPONSIBLITIES

5.1 *State duties and accountabilities towards the policy of directors, committees, specialist staff, and identify the author of the document.*

6. *(Author to add main body of the document with relevant sub headings. In a policy, this section should not be used to describe procedures – these should be put into appendices to make updating them easier and more practicable or into separate documents).*

7. MONITORING COMPLIANCE AND EFFECTIVENESS

7.1 *Outline the Trust's process to monitor compliance of all procedural documents. This should relate back to the Aims and Objectives (section 4) and make clear how the effectiveness of the policy will be monitored and measured (e.g. through audit)*

The following list is a guide to issues which could be considered within this section and should be added to where appropriate:

- *Who will perform the monitoring?*
- *When will the monitoring be performed?*
- *How are you going to monitor?*
- *What will happen if any shortfalls are identified?*
- *Where will the results of the monitoring be reported?*
- *How will the resulting action plan be progressed and monitored?*

- *How will learning take place?*

8. TRAINING AND COMPETENCY REQUIREMENTS

8.1 *Describe and mandatory or specific training that will be required to support implementation of this policy. This should relate back to section 5 (Duties and Responsibilities)*

9. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

References
These should be up to date and evidence based and should be written in the following format – *author, title, date*

Acknowledgements *(give relevant information or delete if appropriate).*

Cross reference to other procedural documents

Add to List related procedural documents, e.g.:
- *Risk Management Policy and Procedure*

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet.

10. APPENDICES

10.1 For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such.

APPENDIX C

Style and Format of Trustwide Procedural Documents – Checklist

The following is the official format which must be used for all Trust procedural documents:

Action	Description	Complete
Font	Arial 12pt: except for documents copied from external sources.	
Watermark	All draft documents watermarked with 'DRAFT' auto size	
Margins	Left: 2.7cm, Right : 2.5cm, Top : 2.5cm, Bottom: 2.5cm.	
Alignment	Left justified	
Bullets	Text following a bullet point should be in lower case.	
Section Headings	Should be numbered, in bold text and capitals.	
Paragraphs	Paragraphs or key points within a section should be sub-numbered for ease of reference, eg. 2.1.	
Dates	Dates within text should be written as: number, month and year (12 June 2006, 1 July 2006)	
Times	Times should be written as 9.30am, 2.00pm, etc.	
Numbers	Numbers between one and ten should be written in full.	
Headers	The document should not contain any headers	
Footers	All footers should be aligned left and contain the title of the document, the version, page and date.	
Page Numbering	All pages, with the exception of the cover page, should have 'Page Number' included in the centre of the footer.	
Version Control	Record which version the document is eg new draft documents will start v0.1, when amended and throughout the consultation period this will subsequently become v0.2, v0.3 etc until the document has final approval to v1.0. During the next review stage this will progress as v1.1, v1.2, v1.3 etc until the final approval to v2.0.	
Names	No staff names should be included in the document, it should contain job titles only	
Appendices	Should be listed as A, B, C instead of 1, 2, 3 etc	

APPENDIX D

POLICY APPROVAL/RATIFICATION GROUP / COMMITTEE

Policy Type	No.	Description of Scheduled documents	Report sent to	Responsible Group for Approval	Q1.17	%	Q2.17	%	Q3.17	%	Q4.17	%
Corporate	1	Health, Safety & Security	Head of Corporate Business	Health, Safety, Security, Estates and Facilities								
	2	Estates & Facilities	Head of Estates and Facilities	Health, Safety, Security, Estates and Facilities								
	3	Mental Health Legislation	Mental Health Act Coordination Lead	Mental Health Legislation Committee								
	4	Patient and Carer Involvement	Director of Strategy and Corporate Affairs	Patient and Carer Involvement Group								
	5	Corporate (other)	Director of Strategy and Corporate Affairs	Executive Management Team								
Clinical	6	Infection Prevention Control	Head of Infection Prevention and Control/Decontamination Lead	Clinical Governance Group								
	7	Medicines	Head of Medicines Management	Clinical Governance Group								
	8	Safeguarding	Head of Safeguarding	Clinical Governance Group								
	9	Clinical Governance (other)	Senior Nurse Clinical Practice	Clinical Governance Group								
Finance	10	Finance	Assistant Director of Finance	Finance and Investment Committee								
Information	11	Information Management and Technology	Information Governance & Records Manager / Director of Strategy and Corporate Affairs	Caldicott and Information Governance Group								
HR Non-Med	12	HR Non Medical	HR Business Partner	JMSSC / Our Partnership Group								
HR Med Dir.	13	Medical Directorate	Head of Medical Services	LNC / Executive Management Group								

Ratification - The Senior Management Team (or Board if required, see Appendix E) will ratify each document**.**

APPENDIX E

DOCUMENTS REQUIRING TRUST BOARD RATIFICATION

All Strategies must be approved by the Trust Board.

The following Trust procedural documents must also be ratified by the Trust Board:

- Business Code of Conduct Policy
- Counter Fraud (including Bribery and Corruption) Policy
- Equality and Diversity Policy
- Health and Safety Policy
- Incident Response Plan
- Infection Control Policy
- Risk Management Policy
- Standing Orders and Standing Financial Instructions
- Safeguarding Adults at Risk Policy
- Safeguarding Children Policy
- Raising Concerns (Whistleblowing) Policy

APPENDIX F

Somerset Partnership NHS
NHS Foundation Trust

DOCUMENT CHANGE SUMMARY

Policy Name and Version: *e.g. Risk Management Policy v7.1*

Reason for Amendment *indicate why only a minor amendment is required*

Author: *include job title*

Summary of Policy (Brief explanation, intended audience, main points etc.)

Amendments from last version (if applicable)
