Somerset Partnership NHS Foundation Trust
Taunton and Somerset NHS Foundation Trust

Development and approval of policies and other procedural documents

Policy

This document can only be considered current when viewed via the Trust intranet/internet. If this document is printed or saved to another location, you are advised to check that the version you use remains current and valid, with reference to the review due date

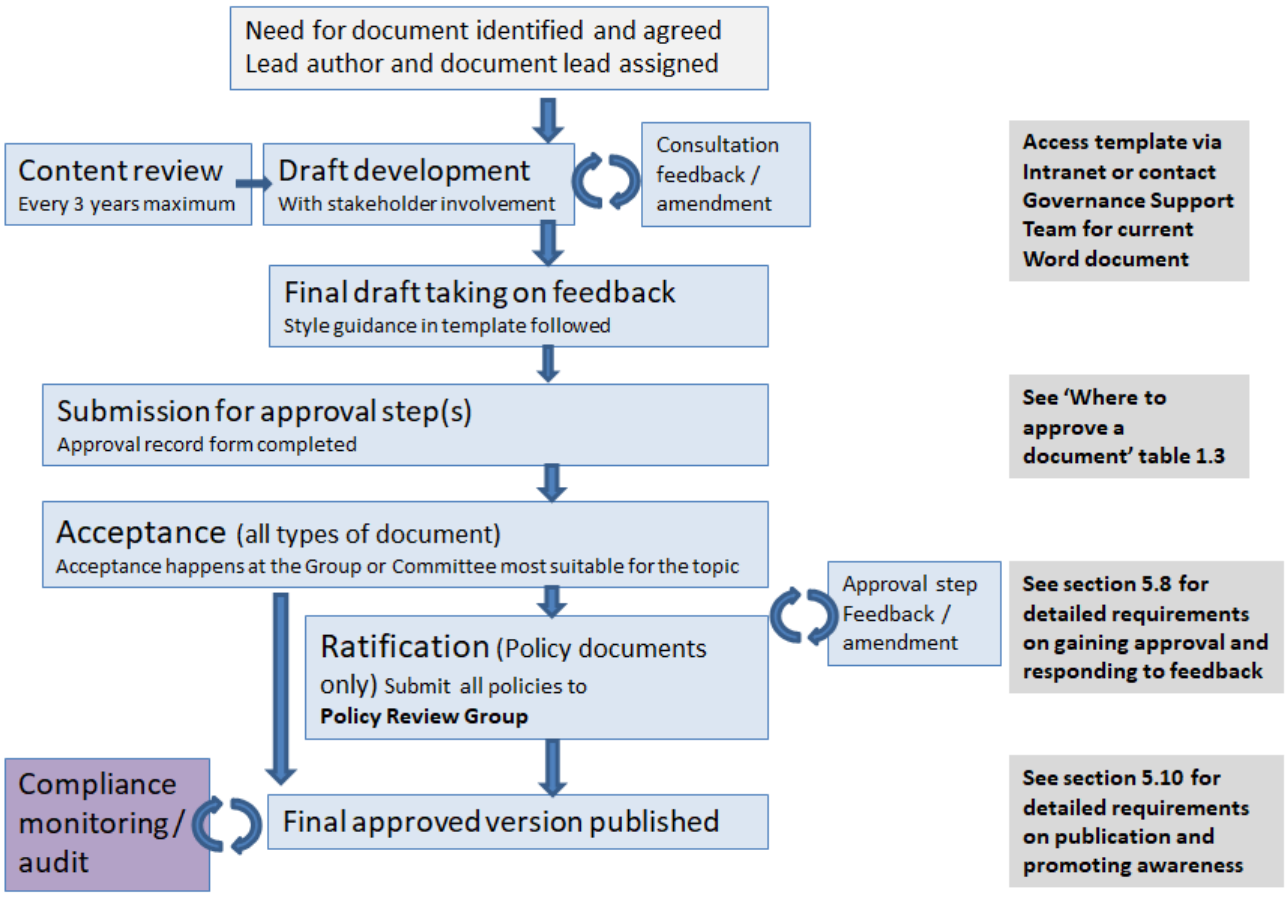
CONTENTS

1.0 FLOW DIAGRAM AND QUICK REFERENCE

1.1 Quick reference **Procedural document cycle**

This policy sets out the cyclical process of document development and review, which is ongoing. The flowchart below provides a simple summary of the stages involved.

Colleagues involved in document production or review can refer to the **5-step Quick Reference process guide**, on page 4 below. For fuller process guidance, please refer to section **5.0** of the policy.



For all **supporting template documents and forms** including the Trust template for procedural documents and the Approval Record Form used for the submission for approval step, go to either:

- TST Intranet – A-Z - Governance Support and go to Polices via the menu
- Somerset Partnership Intranet – A-Z – Policies and procedures – guidance and templates

1.2 Quick Reference Policy and procedure development and approval process

The following standard process is for use when either producing or reviewing any policy or procedural document.

STEP		Guidance
1	**Produce or review the document according to standard format**	The same **format and template** is used for either a policy or procedure and for a document that applies to any of the Trusts' services – including for Trust-wide documents. Ensuring the format is followed is a responsibility of the Lead Author. An inclusive and consultative approach to production or update should be used. The scope of consultation must be fitting for the document scope. If updating an existing document, the 'master' version of the current document must be accessed – contact the Governance Support team.
2	**Circulation to gain feedback on draft**	Once drafted, a stakeholder group is identified and are given the opportunity to review and comment. This will include individuals and groups providing input at the development stage, but also others, including colleagues who will be expected to implement the processes / arrangements the document sets out. Consultation feedback is to be taken on-board and appropriate amendments made.
3	**Submission for group or committee acceptance**	This is the content approval step and applies to ***all types of document***. It is the only formal approval step required for non-policy procedural documents. For all documents, an **Approval Record Form** is completed. This is the record of scope and consultation and other key checks. This includes **Equality Impact Assessment Screening**, for which completion is required for all policies. The completed forms are submitted with the document. The right level of Group must review, fitting for the level of document – see **Approval Matrix** (below) for further guidance. Accepting Group or Committee Chairs are responsible for ensuring the rigour of review and for agreeing the document as appropriate for use. When accepted, sign-off is recorded using the approval record form.
4	***Policies only*** **Submission for ratification review**	***For any policy***, submission is required for a final review via a jointly run Policy Review Group. This is *in place of, not as well as*, a second committee or Board review. This is a quality control step to check that the document development and approval process has met minimum requirements. ***How to submit a policy for review is included at the end of the approval record form.***
5	**Submission for publication**	Established document publication arrangements remain in place in the interim, with jointly developed documents (both Trusts) uploaded to both intranet resources. For policies, publication will follow a positive ratification review outcome. ***How to submit a non-policy document for publication is included at the end of the approval record form.***

1.3 Quick Reference – Approval Matrix (Where to approve a document)

Where to take a document for approval depends on two things: the type of document and the breadth of its relevance across services (its scope). Use this matrix as a guide:

The document is a…	**Policy** ***Most*** policies apply to the whole organisation	**Guidance document, procedure or protocol** ***Most*** will apply at service level
Document is accepted via..	**Trust-wide:** **The appropriate Trust-level specialist group or committee** (eg Falls Policy to the Trust Falls Group) **If not Trust-wide:** **Directorate level governance meeting (typically)**	**Service level:** **The service-level group with governance remit** **If applies across services:** **Directorate level governance meeting** (a 'lead' Directorate can accept on behalf of all providing all have been included within the development and consultation process).
Document is ratified via..	**Policy Review Group** **(This is an integrated group)**	**Does not apply to non-policies**

2.0 INTRODUCTION

2.1 Organisational and patient care benefits arise from having in place policies and other procedural / guidance documents that are clear, current and easily accessible. Robust and consistent arrangements are needed for their development, approval and ongoing control.

2.2 The purpose and aim of this policy is to set out the standard ways of working for all colleagues in developing and gaining approval for new or updated documents. The arrangements set out in the policy are expected to be followed whenever documents are initially produced or are reviewed.

2.3 Policies, guidelines procedures, protocols and applicable to all levels of the organisation (Trust-wide applicable and more local) fall under the scope of this policy.

2.4 Authors of polices and other procedural documents play a critical role in ensuring the quality and appropriateness of content for the intended purpose. All authors should familiarise themselves with the requirements of this policy prior to commencing document development or revision.

2.5 The Trust's aim is to support the maintenance of an accessible library of policies and procedural guidance documents designed to enable colleagues to:

- Deliver care according to evidence-based best practice
- Work according to nationally defined mandatory requirements
- Be clear on the procedures / processes relevant to them to follow, to permit compliance with standards
- Work in an environment focussed on high quality care, the protection of rights and the promotion of equality.

3. DEFINITIONS

3.1 **Procedural document –** Generic term referring to all types of internally developed structured documents, forming a framework for our ways of working, including:

- **Policy** - an approved document that sets out the organisational approach for an aspect of practice or process. Policy sets out employees' roles and responsibilities and is usually informed by national requirements; either legislation or a regulatory framework or both. Other evidence-based recommendations will also often underpin policy requirements. A policy determines the standard for the way things are done within the organisation and it is expected that these are followed at all times. Because of this, compliance and outcomes will be at least periodically monitored.

- **Protocol and Procedure** - These provide a detailed description of the steps taken to deliver care or treatment in line with best practice or, if not addressing a clinical process, to achieve a defined outcome. They set out the specifics of what should be done, where, when how and have the aim to standardise care and other processes. Colleagues are expected to follow all protocols or procedures applicable to them.

- **Guidelines** - Are sets of principles or recommendations which are set down to help manage a specific condition or situation. They help colleagues to make decisions in

line with best available evidence but do not replace professional judgement and discretion. Colleagues are expected to follow guidelines where applicable unless there are justifiable reasons not to. Where a clinical guideline is not applied the reasons must be documented within the record of care. The same principles apply to integrated care pathways and care bundles, for which variances can be expected, where justified.

Note on level of detail:

- A policy will not always state 'the steps to take' to deliver a process in detail – reference to separate guidance is considered usual and permissible
- A procedure and protocol – will state the steps to take – in sufficient detail that an informed / qualified reader can use it alone to guide practice
- Guidance – will usually state the steps to take alongside where practitioner judgements are needed.

3.2 **Approval** – A formal process for agreeing that a document has been developed rigorously, is appropriate for use, and meets the needs of the people expected to implement it. Approval is the process of checking that all relevant organisational requirements have been met and that once in use, the document will be likely to achieve its stated aims.

3.3 **Acceptance** – An approval step at which a group or committee appropriate for the document type and subject-matter agrees a document can be approved.

3.4 **Ratification** – A secondary approval step, specific to policies, at which key organisational requirements (according to this policy) are checked. Ratification therefore is a central step to ensure consistency and good governance of policy production.

3.5 **Approval Record Form –** The record demonstrating to an accepting group that all key checks have been made. Serves as the record of acceptance once agreed by a group or committee. Completion is a requirement of the Trust process for all documents.

3.6 **Equality Impact Assessment (EIA) (screening) –** A written evaluation of a policy or other document supports the Trust to enact its general equality duty under the Equality Act. Any identified issues that constitute a failure to promote equality and/or counter discrimination must lead to a re-appraisal of the relevant document content. EIA is a requirement of Trust approval process for all polices, to ensure that polices support the organisational aim to promote equality and protect rights.

4.0 ROLES and RESPONSIBILITIES

4.1 Document author

A colleague assigned to produce a document acts as the **author** and holds responsibility for ensuring that the content is underpinned by all applicable standards of practice. The author therefore will be the person with knowledge and expertise in the topic of the document. The author has the duty to ensure that all steps as outlined in this policy are followed, including inclusive development of content and seeking of approval. If more than one colleague contributes to content development, a 'Lead Author' is nominated. The author ensures the content is clear and promotes understanding.

4.2 Document owner

The document owner has overall accountability for the document, including ensuring that a current and suitable author is in place and appropriate for the topic. The owner supports the author to ensure they are able to release the time needed to produce a timely document.

The document lead also ensures that the document is approved according to this policy, providing a point of contact should there be significant non-compliance concerns with approval requirements.

For Directorate-owned documents, the lead should be a senior clinical or managerial member of the directorate, for Trust wide documents; this should be a member of or be appointed by the Executive Team. For all Trust wide policies, the document owner is an Executive Director, unless an exception is agreed by the Executive.

4.3 Director of Governance and Corporate Development

Fulfils the role of document owner (as 4.2 above) for this policy.

4.4 Directorate Management Teams and Heads of Corporate functions

Directorate teams and heads of corporate functions have responsibility to maintain oversight of document production and, especially, timeliness of review via their governance structures and processes. All must have in place arrangements for monitoring performance on document review and to take action where performance is below accepted levels.

4.5 Accepting Group and Committees (Chairs and members)

Any group or committee receiving a document for acceptance has the responsibility to conduct a thorough appraisal of both document quality and the process of development, making reference to the Approval Record Form. Acceptance should only be agreed in the presence of a full opportunity to review the document, address improvement points and ensure completion of the Approval Record Form to the satisfaction for the membership. The Chair has overall responsibility for the rigour of this process.

Accepting groups can be either team/service, directorate or Trust level. Either operational groups or topic-based specialist groups can accept documents fitting for the scope / Terms of Reference of that group. The level of the group must be fitting for the document level.

4.6 Topic Lead(s) for Policy and Procedure Management

The role of the Topic Lead is defined according to a separate overall role outline. This encompasses process and policy design, design and operation of effective monitoring arrangements, ensuring suitable reporting arrangements and summary assurance reporting at Trust level according to established arrangements. Topic leadership is provided from within the Governance Support team.

4.7 Governance Support Team

The Governance Support team will provide:

- The resource for maintaining an accessible directory of approved documents that all colleagues can use.
- Ensuring that an accessible archive of inactive documents is maintained, for future investigation purposes for example Serious Incidents Requiring Investigations,

Disciplinary process, NMC investigations, Inquests and claims and litigation purposes when the document current at the time of material events will be required.

- Operating the checking process at the ratification step, for all policy documents.
- Advice and guidance to staff developing documents, supporting authors so that organisational requirements are consistently met and high quality documents are available for use.

4.8 **Policy Review Group**

Oversees the operation of approval process for Policies specifically, ensuring effective application of this policy and maintaining an effective ratification-check process.

5.0 PROCESS DESCRIPTION

The process requirements summarised below follow the stages of the document cycle as presented in the quick reference section (1.0, above):

5.1 Identifying a need for a document and assigning Leads

The purpose and benefits of producing a new document should be clearly established at the outset with the involvement of all relevant decision-makers appropriate for the topic and level of document. The primary consideration is whether the production of a document will either support the delivery of high quality, safe care, or will support colleagues' safety/ wellbeing. The secondary, frequently applicable consideration is whether having the document in place will help underpin processes and practice with a robust framework of standards, often sourced from the following (or a combination):

- Legislation – The law says that certain arrangements must be defined
- Regulation – The standards sets out within regulatory frameworks or other sets of externally defined standards, e.g. accreditation.
- National evidence-based guidance – by informing local documents with national recommendations, best practice can be implemented in line with the best available evidence.

The typical starting point for agreeing the need will be the team with expertise in the field – this might be a multidisciplinary team (in the context of a clinical protocol or guideline) or a Directorate team or Specialist Committee membership for documents applicable at a more Trust-wide level.

The assigned Lead author must be well-placed to develop a document reflecting the sources as above, and to take on contributions from relevant stakeholders. The author must also be supported in terms of time, with appropriate recognition of the time commitment required for good quality documents to be produced.

A document owner must be identified who can reasonably hold the author to account for the timely production of a suitable document. Frequently this will be the Clinical Service Lead in the context of a clinical team, the Head of Department, or for Trust-level policies, usually the Executive Director holding the relevant portfolio.

Queries regarding the need for a document, type of document (see definitions), or assignment of Leads can be raised with the Governance Support team who will advise.

Duplication of content with existing documents must be avoided and document development only to proceed if agreement of need is confirmed. This will normally be via

the group or committee (or the Chair) that would ultimately accept the document once produced.

5.2 Document development (including style and format)

All policies and guidance documents intended for reference beyond a single specialist area (commonly a single clinical specialty) are required to be consistent with the standard format set out in the **style guide and template**, available via the Governance Support Unit pages of the Trust intranet (for TST) and (for Somerset Partnership) intranet A-Z - Policies and Procedures – guidance and templates. All documents must be written clearly, in plain English.

Limited departure from the style guide can be made for more locally-relevant documents by agreement of the accepting group, where this can be justified. The style and format must be clear to the intended user-group and also be written with consideration to an external audience, including external agencies and the public.

Policy content should always be written to make the requirements clear, including how requirements can be met.

Definition / explanation of terms / abbreviations

All documents including those intended for a single team are required to include definitions of key terms used. Trainees and new-comers to the team will be a main user-group for these documents and all terminology must be unambiguous.

It is good practice to include explanation of abbreviations used (given in full on first use) where likely these would be unfamiliar to the intended audience. Overuse of abbreviations / acronyms is to be avoided. Clinical authors especially must take care not to use acronyms that may have more than one meaning. Policy authors basing content on Acts of law must avoid extensive replication of legal detail and / or use of legal jargon. Any terms with specific meaning in law to be used must be clear and defined.

References and evidence-base

Any source material used as a basis for a policy or guidance document is to be included in a list of references – including national guidance documents, legislation etc. Clinical authors must give special attention to referencing research and other reliable source literature, to enable demonstration of a clear evidence base, including any national clinical guidance sources (such as produced by the National Institute for Health and Care Excellence (NICE)).

Style and format permitted exceptions

The Trust's Drug Policy and related Pharmacy guidance is web-based, with appropriate hyperlinks to other documents. For this reason, the format may not comply with all of the above requirements; all other principles in this Policy apply. The following areas have their own documentation systems and format / style conventions to meet their quality requirements: Pathology, Cancer Services. Relevant managers and document leads must ensure that local quality processes and the core principles of this policy are followed.

Document length

There is no maximum or minimum length for approved documents. The guidance for authors is 'as long as it needs to be - and no longer'. Clarity and usability should be the focus for authors.

Supporting documents, appendices

Supporting documents, especially forms, should *not* generally be appended. These add to length and can be made more easily accessible if placed on the Intranet. It is sometimes a good idea to separate 'guidance' from 'policy' content, to minimise length and help keep documents useful. Documents such as Group/Committee Terms of Reference generally should not be appended (unless required for a specific reason). Whilst a brief outline of auditing and monitoring method can and should be stated as part of the monitoring arrangements (see below), full detail of audit standards should not usually be part of a procedural document.

Note – Direct document links are vulnerable to breaking. Links to online resources or other controlled documents should be kept to a minimum.

5.3 Revision of an existing document

It is a requirement that authors keep their document live and relevant. This means regular consideration of the need for review throughout the document cycle so that new or updated national guidance, legislation or other underpinning reference material can be incorporated in a timely way.

The maximum timeframe for review is 3 years. This is a maximum, beyond which there is an increasing risk that the practice within a procedural document will not reflect the needs of the organisation or current best practice in the case of clinical guidance.

When reviewing an existing document, all the above arrangements and principles apply, including involvement of stakeholder and consultation on changes. The processes supported by making the changes to the document evident within revised drafts.

It is **essential that authors update the current working version** of the document and ensure they access the editable master version prior to commencing the review. The master Word version is accessible from the Governance Support team or via a request to policies@sompar.nhs.uk.

5.4 Archiving and access to archived documents

At the point that existing document content is reviewed, the decision may be taken that it is appropriate to remove the document from the active library and to move it to the archive, thereby making it accessible only for appropriate investigations for example, Serious Incidents Requiring Investigations, Disciplinary process, NMC investigations, Inquests and claims and litigation purposes. Both author and document lead must agree that archiving is appropriate. This will usually be based on either: 1) the content is addressed by a different, more recent active document. Or 2) the topic of the document no longer applies to Trust services. When this applies, a request can be submitted to the Governance Support team (for TST) and policies@sompar.nhs.uk (for Somerset Partnership) with no further requirement for approval process, as long as there is a record

of the decision (email is sufficient). Access to any archived document is via the Governance Support team.

5.5 Stakeholder input and consultation

It is the responsibility of the Lead Author to ensure key stakeholders are fully involved in document production or review and consulted with throughout the development stages. Stakeholders may include colleagues, trade union organisations, partner agencies and, whenever appropriate, patients and carers (as 5.6, below). Further guidance on stakeholder involvement is available via the Governance Support team's intranet pages (see 'Policies' section). Authors must provide sufficient time for stakeholders to meaningfully provide their input. A usual consultation period would be no less than two weeks and up to a month.

5.6 Patient and carer involvement in document production

For certain topics and pathways of care, the involvement of people using the relevant service(s) will play a key part in defining appropriate and effective processes to achieve good outcomes and experience. The Lead Author should determine the appropriateness of involving representative people or groups, provide opportunity to feedback and influence the content and make the necessary contacts.

Involvement in this way is good practice and must be conducted such that people involved can genuinely contribute. This can be achieved by including membership of a key group or committee.

People involved in this way may need support and arrangements must be in place to appropriately recognise their contribution in terms of time and expense, for example travel costs to attend meetings.

When patients and/or carers are involved, the core requirements according to this policy remain applicable in terms of content conventions and approval process.

When making arrangements to invite input into document development, the appropriate method of communication and provision for access must be considered so that these are inclusive of all groups of people, including all members of protected characteristics according to the Equality Act 2010 (notably, those whose first language is not English and people with sensory disabilities affecting communication).

Specific skills and experience may be needed to engage people effectively and colleagues must recognise this at the outset.

5.7 Integration of procedural documents across the organisation

Policies and procedural documents can and should be used as a means to support and promote integration and achieve a harmonisation of practice across the whole organisation. Documents applicable to care pathways can also be used to define and clarify arrangements according to the clinical model formed as part of the integration work being undertaken.

At the point when any existing document is reviewed, the potential to integrate across

services and/or to harmonise similar documents must be considered.

5.8 Gaining approval and responding to feedback at approval stages

Processes for approval are devolved: Document approval must be via the most suitable route within the Trusts governance structure and must be auditable: A record must be available that approval has been gained.

No document will be considered suitable for publication via trust systems without these two key requirements being met, unless the changes can be considered minor (see below).

Quick reference section 1.3 indicates which groups/committee types should accept / ratify, determined by both document type and level of relevance within the organisation.

For all documents an Approval Record Form (available via the Policy page of the Governance Support intranet (for TST) and (for Somerset Partnership) intranet A-Z - Policies and Procedures – guidance and templates is to be completed. This applies for new documents, substantially revised documents and to no change (date extension) approvals.

When approval is agreed, the sign-off section of the Approval record is completed and the form is submitted with the final document according to the guidance at the end of the form.

Group / Committee Review

It is the responsibility of the Chair of the group to which a document is submitted to ensure that decisions are clearly recorded and fed back to the submitting author. The target maximum time from submission to feedback of an initial decision (which may result in the need for further review cycles) is one month. This applies to both accepting and ratifying groups.

Review via circulation to group members must be used to prevent delay where meeting schedules do not permit timely review. Under some circumstances, document amendments may be considered ‘urgent’ and the timeframes / process condensed accordingly.

Ratification of policy documents

The ratification stage is in place to verify that all policies –

- meet the criteria for a policy (see definitions)
- has content presented in a clear and accessible way
- has clear and effective monitoring /governance arrangements described (see below)
- was subject to production / review process as required, including consultation
- is accompanied by adequate plans to implement successfully

The Policy Review Group is established to provide a consistent central ratification process. Policy Review members aim to support policy authors in meeting the requirements for ratification.

Making and approving minor alterations to a document

It is common for minor updating to be necessary within the 'life' of a document version. Changes that do not alter significantly the practice of implementing the content may be made without formal approval process, so long as the Governance Support team accepts that it is 'minor' as a screening check prior to upload.

Note that judging a change as 'minor' is based on the significance of changes to *meaning and process,* and not the quantity of words changed. Changes such as addition of explanation for clarity, revision of designations or alterations to individual roles, or updating of monitoring arrangements can usually be considered 'minor' for this purpose.

Updating content on this basis is only permitted for presently in-date documents. All documents submitted for upload to the system as minor alterations must be accompanied by an outline of the nature of the changes and confirmation of document owner awareness. Minor alterations will not result in the review date being extended.

When no content change is needed, or full review is deferred

When it is considered that a document requires no change to content (or only very minor changes) at the 3-year review limit, this is still to be approved via acceptance by a formal group, but can be done via chairs approval in most cases. Only with this acceptance recorded via the approval record form can the review period be extended.

Sometimes a document reaches its 3 year limit but either national or local changes known to be coming make it difficult to fully review immediately. In this instance, the accepting group should review the current document (unchanged) to assess its appropriateness, taking a pragmatic view on its suitability. The timeframe for the fuller review should be agreed and a limited extended review date agreed for the current version. Extension of this sort should not be for longer than 12 months.

5.9 Equality Impact Assessment (EIA)

The general equality duty (under the Equality Act 2010) refers to the need to eliminate discrimination; advance equality of opportunity; and foster good relations – when making decisions and *setting policies*. To do this, it is necessary for the Trust to understand the potential effects of its activities on different people. Where these are not immediately apparent, it may be necessary to carry out an impact assessment, in order to understand them.

Consideration of a document's impact on the protected groups defined under Equality legislation is integral to these arrangements for review and approval. Reviewing groups (both accepting and ratifying) must consider potential impact and seek wider review if necessary. These considerations are prompted by completion of the **Approval Record**

Form. Completion of the supporting **equality impact screening form** is required for any Trust Policy and is checked at the acceptance and ratification stages. Completion for any other procedural document is determined by the topic and patient group it applies to. If there is doubt about relevance of the screening, it should be completed.

5.10 Publication, accessibility and promoting awareness

Note – The arrangements for document publication for the merged Trust remain under review and this section will be updated in line with decisions taken:

It is the intention to make all documents easily accessible to all colleagues. Public access will always be granted on request on an individual document basis and there is provision for making requests via the Trust's website. Publication of documents directly on the Trust's website remains under consideration and the decision will result in an update to this policy.

Accessibility and version control will be ensured by the maintenance of a central document management system that indexes all approved documents and permits these to be readily searched. Upload of documents to the system is managed via the Governance Support Team.

Publishing a document on the established trust system is a separate consideration to actively promoting awareness amongst relevant colleagues. The method for promoting awareness should be agreed at the document approval stage. Consideration of the suitable method for promoting implementation / awareness is prompted via the Approval Record Form, approved by the appropriate Group/Committee.

Policies must not be directly uploaded to intranet locations other than the central system. Once published via the system, links can be created from an intranet page to support ease of access.

For other procedural documents, the arrangements remain under consideration. Currently, any non-policy procedural document applicable only to acute services is uploaded to the central system, and any intranet link must be to the system record. For documents applicable to community and mental health services only, non-policy documents are published directly to service-owned intranet pages, once approved.

5.11 Implementation and monitoring compliance

The monitoring of compliance with policies and their effectiveness is a key part of the Trusts arrangements for quality assurance. It is a requirement of all policies that they include a clear statement of arrangements for monitoring and a requirement that the stated arrangements are undertaken by the Lead or Leads responsible. There is provision for this by use of a table format within the template for a policy document, as used for this policy (see 7.0 below).

It is for the accepting group or committee to ensure that the stated monitoring arrangements are clear, specific and deliverable within available resource. It is important that the stated arrangements take into account the resource burden of delivering the monitoring, to ensure arrangements are achievable.

The ratification step for policies includes a further supportive check that monitoring is fit for purpose and will support good governance of policy compliance. The Governance Support

team will support authors address monitoring considerations as part of document development, on request.

The group defined as responsible for monitoring within a policy must receive regular reports on the monitoring of the policy and any actions to be taken to improve compliance with the policy.

5.12 Management and escalation of significantly out of date documents

Should the review cycle processes for a document break down to the extent that it remains without a review for an extended period (and not covered by an agreed no-change extension period), an escalation process will apply. The primary consideration in this scenario is whether a risk is associated with the document content remaining live for use. Assurance is required of a clear plan for review as a priority.

The Governance Support team will co-ordinate a quarterly review of all documents significantly overdue, remaining live on the Trust's system. Documents in excess of 1 year beyond their stated review date will be included in the review.

Escalation and management process:

1) Document Lead and Directorate team asked to provide support to the author assigned and/or consider if re-assignment is required.
2) Risk level assigned and verified with author, Document Lead and Directorate team. Commitment to a set timeframe for review will be requested, usually not greater than 3 months from point of escalation.
3) Management according to level of risk:
   Low risk: Existing document remains live, unchanged, pending the update. So long as the update is delivered to the expected timeframe, usual acceptance and upload process applies. Any delay will elevate the risk level.
   Medium risk: Removal of the existing document is considered, prior to the update being produced and approved. Any delay will elevate risk level.
   High risk: Removal of the existing document to be actioned immediately, pending the update. Author, Document Lead, Directorate team and authors line manager (if different) notified. Update to be prioritised and delivered within 1 month.

For all levels of risk, delivery of the update is to be monitored at Directorate Manager / Corporate function Lead level.

6.0 TRAINING/COMPETENCE REQUIREMENTS

There are no mandatory training or competency requirements associated with applying this policy. Any colleague who requires training in order to fulfil duties under the policy, especially if required to produce or review procedural documents, should contact their line manager in the first instance. The Governance Support team provide a source of expertise and guidance.

7.0 MONITORING

Element of policy for monitoring	Section	Monitoring method - Information source (e.g. audit)/ Measure / performance standard	Item Lead	Monitoring frequency / reporting frequency and route	Arrangements for responding to shortcomings and tracking delivery of planned actions
Document review – maintaining documents within their review period.	**5.3**	A performance indicator for the proportion of documents in date will be reported using the document management system as the source.	Head of Compliance and Effectiveness	The indicator is reported at least quarterly. Review is via Directorate Governance meetings and corporate function meetings according to established reporting schedules.	Directorate teams are held to account for taking actions to correct document review issues via Performance Assurance Framework Review meetings and via Directorate Assurance reporting to the Integrated Quality Assurance Board (IQAB).
Approval is documented using the Approval Record Form for all documents submitted for publication	**5.7**	Monitored prospectively as part of the pre-publication screening undertaken by the Governance Support team. A log will be kept, including instances of failure to submit an Approval Record, or where there are shortcomings in completion requiring return to the submitter.	Head of Compliance and Effectiveness	An annual compliance rate will be reported as a % rate of all document submissions. Reported annually as part of the IQAB assurance report.	
Equality Impact Assessment completed fully for all policies	**5.8**	Monitored prospectively as part of the policy ratification checks undertaken by the Governance Support team. Annually, a sample of policies will be selected for specific examination of EIA requirements. Policies will be selected intentionally to include topics more likely associated with equality / human rights issues. The review will include a judgement of how thoroughly and meaningfully the EIA process was undertaken.	Head of Compliance and Effectiveness and Equality & Inclusion Topic Lead jointly	Reported annually to the Equality & Inclusion Working Group. Reported annually as part of the IQAB assurance report.	

8.0 REFERENCES

- Equality Act 2010

9.0 DOCUMENT CONTROL

Document Author	Lincoln Andrews Head of Compliance and Effectiveness		
Lead Owner	Phil Brice Executive Director of Governance and Corporate Development		
This Version	V1.0	**Status**	Final
Replaces	All previous Taunton and Somerset NHS FT and Somerset Partnership NHS FT individual policies relating to the development and management of policies and other procedural documents		
Approval Date	25 February 2020	**Where**	IQAB
Ratification Date	25 February 2020	**Where**	IQAB
Date of issue	9 March 2020	**Review date**	25 February 2023
Applies to	All staff involved in the development, review or governance of procedural documents.	**Exclusions**	None