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Management of Procedural Documents Policy

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5.0	Sept 2016	Risk team	A	Approved by TMG
6.0	October 2019	Kate Taylor	A	Full review of document and approved by TMG.
6.1	Nov 2022	Risk Team	A	TMG approved extension until Jan 2023
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6.5	Sep 2024	Levi MacInnes	D	Full policy review to align with new procedural documents approval process.
7.0	October 2024	Risk Team	A	Policy approved within October Risk and Assurance Group.
A = Approved D = Draft				
Document Author = Risk and Assurance Manager				
Associated Documentation: Template for Policies/Procedures Policy – Key Changes Document Equality Impact Assessment user guide and template				

Staff Summary

The effective management of policies and other procedural documents is an essential component of good governance. This includes the development, review, approval and dissemination of policies and other procedural documents.
The Risk and Assurance Team has a primary role in co-ordinating the management of policies and other procedural documents published on the procedural documents library and the Trust's public website in line with Publication Scheme requirements.
Consistent format and structure should be used in the development of procedural documents. The Risk and Assurance team will undertake quality checks to ensure that policies submitted for approval comply with Trust standards.
The document author and / or subject matter expert is responsible for ensuring that content is in line with national guidance, accepted standards or best practice and is updated in a timely fashion where these standards change.
For all new procedural documents, the initial review period is a maximum of one year from first approval. Following the initial one-year review period, the standard review period for policies and other procedural documents will be three years.
The outlined governance groups are responsible for ensuring the approval of relevant procedural documents and compliance with internal and external standards.
Managers must ensure that their staff comply with all relevant procedural documents. All staff should ensure that they are aware of and are using the most recent versions of all policies and procedural documents relevant to their role. All newly approved policies will be outlined in the YAS Staff Update.
No specific training is required regarding the authoring and preparation of a procedural document. The Risk and Assurance Team will support and advise authors regarding the content of policy documents and the management of the development, review and approvals processes.
Unless exemptions apply, all procedural documents require an Equality Impact Assessment (EIA) to be completed prior to approval.
On a periodic basis the Risk and Assurance team will carry out compliance testing against a sample of policies. Trust-wide compliance with this policy will be subject to periodic testing and reporting via the Trust's internal auditors.

1.0 Introduction

1.1 Effective management of policies and other procedural documents is an essential component of good governance. This includes the development, review, approval and dissemination of policies and other procedural documents.

1.2 The effective control, management and monitoring of procedural documents contributes to the assurance of:

- Safe operations
- Risk reduction
- Staff awareness of current practice
- Delivery of high-quality patient care
- Effective quality control
- Transparency for stakeholders
- Good governance

2.0 Purpose/Scope

2.1 This policy presents the Trust's requirements regarding the management of policies and other procedural documents. This policy applies to the categories of procedural documents defined in Appendix A

2.2 The scope of this policy includes the development, review, approval, publication, implementation and compliance monitoring of policies and procedural documents.

2.3 This policy:

- Describes the Trust's standard approach to the effective development, implementation, monitoring, and review of procedural documents.
- Requires that procedural documents be produced and managed in accordance with a consistent corporate style and format.
- Defines roles and responsibilities relevant to the effective management of policies and procedural documents.
- Defines the Trust's standard approvals processes for all policies and other procedural documents.
- Supports appropriate ownership and management accountability for the implementation of approved policies and procedures, including arrangements for document dissemination, staff awareness, and compliance monitoring.

2.4 The content of this document supersedes the content of any previous versions of this document that have previously operated.

3.0 Principles

3.1 This policy is based on a set of general design principles as follows:

- The Risk and Assurance team will co-ordinate and support the management of policies, including the quality check of policies prior to the approval process and maintenance of publication.

- All policies and procedural documents must have a designated owner, usually the document author and subject matter expert. It is the responsibility of document owners to ensure the content remains up to date and relevant to the Trust.
- All policies and procedural documents must have Executive-level oversight from a designated Responsible Director.
- All policies must be approved by the agreed approval groups as outlined in section 9.2. Exemptions include documents requiring the approval of an Executive Group or Trust Board.
- All other procedural documents other than policies must be approved by the most appropriate governance body based on content and membership. If such documents have a significant Trust wide impact, then further approval may be required by the agreed approval groups as outlined in section 9.2.
- For policies with staff implications, (for instance, terms and conditions pf employment, working patterns etc.), Union representation should be considered as part of key stakeholder engagement.
- All procedural documents require an Equality Impact Assessment (EIA) to be completed prior to approval. This process is governed by the Diversity and Inclusion Team.
- All key stakeholders should be consulted, and their engagement recorded within the document control information.
- A consistent format should be used in the development of policies and procedural documents, in line with approved Trust templates.
- Relevant supporting documents should be included as Appendices.
- Standard review and refresh periods will apply to all policies and procedural documents as outlined in section 6.0.
- All policies will be published on the Trust's intranet and public website unless specified for internal publication only.
- The Risk and Assurance team may carry out quality control, compliance, and other assurance activities regarding adherence to this policy.

4.0 Development of a New Procedural Document

4.1 When considering the development of a new policy or procedural document, authors should first establish that:

- There is a clear need and justification for the document. This need might arise from statutory, regulatory, policy or other formal requirements, or from other dimensions such as assurance activity or emerging good practice.
- There is no duplication of content with existing Trust procedural documents. Authors should establish that the purpose of their new document cannot be met by adapting existing documents.
- The most appropriate type of procedural document is developed, in line with the categories defined at Appendix A.

4.2 Procedural documents must be prepared using the appropriate Trust template. The current template is available on the Trust intranet. It can also be obtained directly from the policy management function within the Risk and Assurance team via yas.policies@nhs.net. Authors are responsible for ensuring that their document complies with the current version of the appropriate template.

4.3 Supporting documents associated with a policy or procedural document should be presented as appendices to the document rather than being incorporated into the body of the document. Such supporting documents include, but are not limited to, Guidance, Standard Operating Procedures or similar, flow charts, decision trees, business process diagrams, algorithms etc. Such documents should be presented in the style and format which best communicates the key points to the target audience.

4.4 An Equality Impact Assessment (EIA) must be completed alongside the development of a new procedural document and be approved by the Diversity and Inclusion team.

4.5 Documents submitted for approval will be quality checked by the Risk and Assurance team to ensure compliance with the appropriate Trust template. Non-compliant documents will be returned to the author along with advice about how to achieve compliance.

4.6 The approval process for all procedural documents is outlined in Appendix B.

5.0 Review and Refresh of an Existing Procedural Document

5.1 The author of any policy or procedural document is responsible for ensuring that its content remains up to date, relevant to the Trust's strategic context and operating environment, and is consistent with legislation, regulatory frameworks, national policy and guidance, professional standards and best practice. Authors are responsible for ensuring that their policies and procedural documents are reviewed and updated in an appropriate and timely manner should these or other relevant factors change.

5.2 The Risk and Assurance team will contact policy authors six months before the review date in order to initiate the review process. The Risk and Assurance team will issue a follow-up reminder two months before the review date.

5.3 An Equality Impact Assessment (EIA) must be completed alongside the review of a new procedural document and be approved by the Diversity and Inclusion team.

5.4 For all policies undergoing a review, a Policy – Key Changes form must be completed.

5.5 Upon completion of the review documents are to be submitted for approval via the Risk and Assurance team email yas.policies@nhs.net to ensure compliance with Trust process. The document will be presented for approval in line with the process in section 9.0.

5.6 The review and refresh of an existing policy or other procedural document can be initiated at any time. This is at the discretion of the policy author or the Responsible Director.

5.7 Where a policy review takes place earlier than the required review date, and any proposed amendments are minor and of no substantive significance, the updated document is not required to be re-presented for approval prior to being published. The existing review date will remain the same until such time a full review is undertaken.

5.8 Minor changes are such amendments that do not materially alter the substantive content of a policy document, or the processes outlined within it. Examples include, but are not limited to, changes in job titles, team names, system names etc. In such instances, the Risk and Assurance Team will advise whether the full approval process is required, with final decisions escalated to the Director of Corporate Services and Company Secretary as required.

5.9 The process for review and approval of an existing policy or other procedural document is presented in Appendix B.

6.0 Review Periods

6.1 For all new procedural documents, the initial review period is a maximum of one year from first approval. This provides an early opportunity to review the operation and impact of a newly introduced policy or procedural document. It also provides an early opportunity to apply learning and enhancements, and to identify and resolve any unforeseen or unintended adverse consequences that might have occurred as a result of the newly introduced policy or procedural document.

6.2 Following the initial one-year review period, the standard review period for policies and other procedural documents will be applied.

6.3 The maximum review period for existing policies and other procedural documents is three years. A compulsory review must be conducted at this stage. When the three-year review period expires the document will automatically be classified as out of date.

6.4 Notwithstanding this standard three-year timescale, the review of any previously approved policy or procedural document may be initiated at any time. The decision to initiate an early review will be at the discretion of the policy author or the Responsible Director.

6.5 In exceptional circumstances, an extension can be requested for approval via the Risk and Assurance team. Requests for extension must include a reasonable justification and a risk assessment and must be approved at the designated approval group for that policy, as outlined in section 9.2.

6.6 A maximum of a 6 months extension can be requested at one time. Only two, 6-month extensions (totaling 12 months) can be requested and approved by the approval group. Further extension requests past the 12-month mark will be escalated to the Trust Executive Group for approval.

7.0 Procedural Documents Controls

7.1 The standard template for all policies and procedural documents includes a control sheet which presents information about the version history, ownership, approvals and other document controls. The current version of the document control sheet is set out in Appendix C.

7.2 <u>Document Naming and Version Control</u>

7.2.1 All documents must have a title / name in a format that complies with a standard naming convention (for example, PO = Policy, PR = Procedure, GU = Guidelines, SOP = Standard Operating Procedure). The standard naming convention currently applied by the Trust is set out in Appendix D.

7.2.2 Version control numbering must be applied to all policies and procedural documents, and this should be updated following both major and minor revisions. The version control convention currently applied by the Trust is set out in Appendix D

7.3 <u>Document Ownership</u>

7.3.1 All policies and procedural documents must have a designated owner, usually the document author and subject matter expert. It is the responsibility of document owners

to ensure the content remains up to date and relevant to the Trust.

7.3.2 All policies and procedural documents must have a designated Responsible Director. This is the Executive Director / Trust Executive Group member responsible for the Directorate which owns the document. The Responsible Director should be referred to by title only (and not as a named individual). The Responsible Director must sign-off a policy as ready for approval prior to it being submitted for final approval.

7.4 Document Approval History

7.4.1 The document control sheet for all procedural documents must identify the relevant approval group that has granted final approval of the document prior to publication.

7.4.2 The document control sheet for all procedural documents must state the document's most recent approval date. This is the date on which the document was last approved. This will be recorded by month and year.

7.4.3 The document control sheet for all procedural documents must state the document's next review date. This is the date by which the procedural document must be reviewed and approved, in accordance with the timescales set out in section 6.0.

7.5 Additional Document Controls

7.5.1 The document control sheet must record whether an Equality Impact Assessment (EIA) is required. If an EIA is not required, this must be specified as Not Applicable (N/A). The EIA process is outlined below in Section 8.0.

7.5.2 The document control sheet must indicate the document's publication status of 'Public Website' or 'Internal ONLY' as outlined in section 11.0.

8.0 Equality Impact Assessment (EIA)

8.1 The Trust is committed to ensuring that its ways of working are fair and ensure equality in all aspects of its operations. All documents must adhere to the EIA process determined by the Diversity and Inclusion team.

8.2 The EIA process must be completed and signed off by the Diversity and Inclusion team as part of the policy development or review process. Support for the completion of the EIA can be sought from the Diversity and Inclusion Team.

8.3 Procedural documents will not be finally approved and published without the Diversity and Inclusion team confirming that an EIA is either approved OR not required.

9.0 Policy Approval Process

9.1 The process for development, review, approval and publication of a procedural document is outlined in the diagram at Appendix B.

9.2 Procedural Documents Approval Groups

9.2.1 The following approval groups are responsible for final approval of all Trust policies, other than where clause 9.2.3 applies:

- People and Culture Group
- Clinical Governance Group
- Executive Health and Safety Group

- Risk and Assurance Group
- Information Governance Working Group
- Resilience Governance Group
- Finance and Performance Committee

9.2.2 All policies have a designated approval group responsible for finally approving the policy. The Risk and Assurance team will maintain a record and provide guidance to support policy approval.

9.2.3 For a small number of specified policies, the Trust Board may be responsible for final approval. The Corporate Governance team will maintain a record of those policies for which approval is a matter reserved for the Trust Board. Where the Trust Board is responsible for final approval, the policy must be formally recommended by the Trust Executive Group for approval by the Trust Board.

9.3 Key Stakeholder Engagement

9.3.1 The policy author should engage with relevant stakeholders including management groups or governance bodies as part of the policy development and review process.

9.3.2 For policies with staff implications, Union representation should be considered as part of key stakeholder engagement.

9.4 Formal Approval

9.4.1 Upon completion of a new or reviewed document a final draft version of the policy, Equality Impact Assessment and the Policy Key Changes Document (where applicable) must be sent to yas.policies@nhs.net.

9.4.2 The Risk and Assurance team will check that the policy document complies with this policy and submit it to the next available meeting of the designated approval group for final approval. Authors are required to attend the group and present their policy.

9.4.3 Upon receipt of a policy for approval the Risk and Assurance team will require evidence that the approval group has reviewed and endorsed a policy. Such evidence could include, but is not limited to, draft meetings minutes, action logs, or email confirmation from the chair of the committee.

9.4.4 Upon confirmation of final approval the Risk and Assurance Team will update the document control sheet to reflect the approval. The Risk and Assurance team will then publish the policy online, and the previous version will be archived.

9.4.5 Other procedural documents (those which are not policies) must be approved by the relevant management group, Trust executive sub-group, specialist committee or other formally constituted governance body.

9.4.6 Where a procedural document that is not a policy, but nevertheless has material cross-organisational impact, or requires adherence from a number of service areas, it must follow the same approval process for policies as outlined above and be submitted to the Risk and Assurance Team to co-ordinate final approval and publication.

10.0 Procedural Document Archiving Arrangements

10.1 The Risk and Assurance team maintains an archive of previous versions of all procedural documents on the Trust wide library.

10.2 All previously published versions of procedural documents will be archived upon a new version being uploaded online.

11.0 Publication of Procedural Documents

11.1 A summary of recently approved policies will be published in the Staff Update.

11.2 All Trust wide procedural documents will be published on the Trust intranet. The default position is for all documents to be available in full for internal access via the Trust Intranet. Policies will be published within the 'Policy, Procedures and Strategy Documents Library' section of the intranet.

11.3 Procedural documents (other than policies) that have a team specific audience (for example a Standard Operating Procedure) will be published within the specific team pages of the Trust intranet. It is the responsibility of the relevant team and document author to ensure that documents published on these pages remain up to date.

11.4 All employees must ensure that they are working to the most recent approved versions of policies and other procedural documents. To support this, employees are advised not to print off copies and instead to work from the most recent versions published on the Trust intranet. Where services do opt to work from printed documents it is the responsibility of the person printing the document to ensure that this remains the most current document if referenced in future.

11.5 The Freedom of Information Act 2000 requires every public authority to have a Publication Scheme, approved by the Information Commissioner's Office (ICO), and to proactively publish information covered by the scheme. The Publication Scheme sets out the Trust's commitment to make certain classes of information routinely available; this includes policies and procedural documents. The default position is for all policies to be available in full for external access via the Trust's website unless specified internal only by the author. Guidance Documents, Procedures and Standard Operating Procedures will remain internal only.

11.6 The Publication Scheme status is recorded in the document control section. It is the responsibility of the Author and/or Responsible Director to determine if the policy requires restricted access and therefore should be shared internally only. This will be determined within the document control section as 'Public website' or 'Internal ONLY'.

11.6.1 'Public Website' – The policy will be published internally on the Trust intranet and externally for the public to access.

11.6.2 'Internal ONLY' – The policy will be published internally ONLY on the Trust intranet. This will include any policies covered by exclusions under the Freedom of Information Act 2000.

11.7 Procedural documents publication will be managed by the Risk and Assurance Team.

12.0 Training Expectations of Staff

12.1 No specific training is required regarding the authoring and preparation of a procedural document.

12.2 The Risk and Assurance Team will support and advise authors regarding the content of policy documents and the management of the development, review and approvals processes.

13.0 Implementation Plan

13.1 This policy will be published on the Trust's intranet for all members of staff to access and reference. New members of staff will be signposted to procedural documents as part of their induction.

13.2 A central policy register will be maintained by the Risk and Assurance Team in order to provide oversight of the current status of all Trust policies.

13.3 To support timely review and approval of existing procedural documents, a prompt email will be sent to authors six months prior to the review date. A subsequent reminder will be sent two months prior to the review date.

13.4 The agreed approval groups as outlined in section 9.0 will receive a report outlining procedural documents requiring approval and extension request approvals. Overdue documents and a six-month forward view of documents due for review will also be reported.

13.5 A summary of all recently approved procedural documents will be published in the Staff Update within one month of approval.

14.0 Monitoring Compliance with this Policy

14.1 The Risk and Assurance Team will ensure that policy documents are compliant with this policy prior to being submitted for approval and their subsequent publication.

14.2 Each policy document must set out suitable arrangements for monitoring compliance with the requirements of that policy.

14.3 Procedural documents that are not policies or not Trust wide documents should be maintained and managed by the relevant team or author. It is their responsibility to ensure that the document remains in date and is updated accordingly. As far as is reasonably practicable, the Risk and Assurance team will conduct periodic checks of the 'Policy, Procedures and Strategy Documents Library' and issue reminders to authors of out of date procedural documents.

14.4 As part of its second-line assurance activities, the Risk and Assurance team may undertake periodic audits of procedural documents other than policies in order to test compliance with this policy. All procedural documents operative within the Trust will potentially be in the scope of compliance and assurance testing and reporting by the Trust's internal auditors.

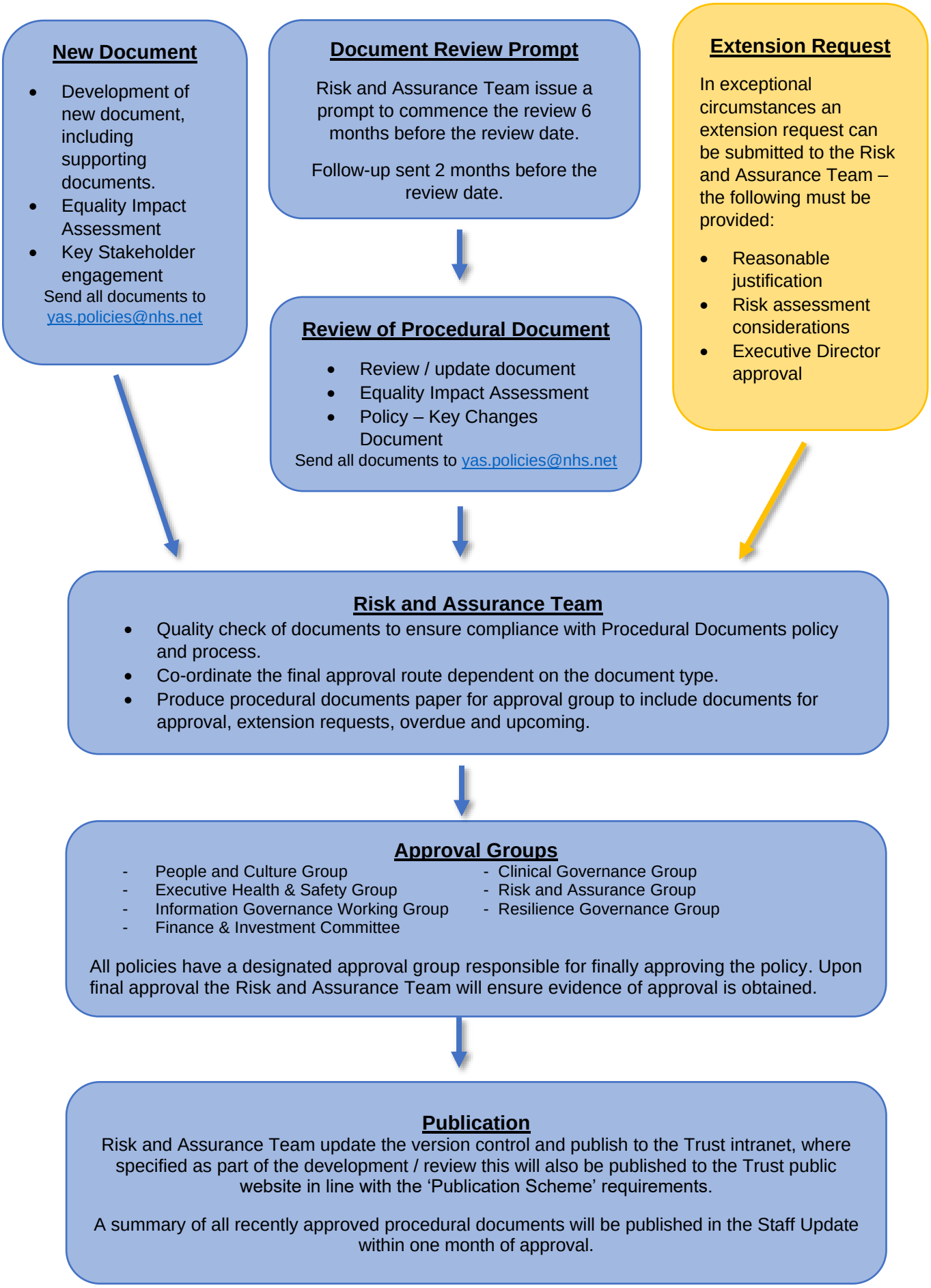
15.0 Appendices

15.1 This Policy includes the following appendices:
Appendix A – Procedural Document Definitions
Appendix B – Flow Diagram: Procedural Documents Process
Appendix C – Document Control Sheet Definitions
Appendix D – Document Naming and Version Control
Appendix E – Roles and Responsibilities

Appendix A: Procedural Document Definitions

Procedural Documents	'Procedural documents' is a collective term used to describe official operational documents, such as policies, standard operating procedures, and guidance. Such documents must be formally approved by a designated governance body or designated role before being adopted for implementation by the Trust.
Policy	A policy is a statement of the Trust's officially agreed position, governing principles and operational requirements relating to particular issues or situations that must be adhered to throughout the Trust by all members of staff. Policies will often be linked with or accompanied by supplementary documents such as procedures or guidance documents.
Policy Procedure	A policy procedure is a structured set of actions or steps to be followed in implementing a policy and/or it's processes. It is the official, accepted and expected way of performing a task or carrying out a duty. A policy is likely to be underpinned by one or more procedures and these should therefore be outlined as Appendices within a Policy.
Standard Operating Procedure (SOP)	A SOP is an official document outlining formally agreed step-by-step instructions for carrying out routine activities. A SOP will typically be used within a team to support everyday operations. A SOP is a mandated way of doing things and should be followed at all times. Senior management authority must be obtained for any proposed deviation from a SOP. Permanent changes to a SOP require formal approval from the appropriate governance body.
Guidance Document	A guidance document will usually define standards and expectations about a process or task, including a preferred process of operation for staff to follow. Generally speaking, however, guidance is regarded as good practice or a recommended approach but not as a mandated or prescribed way of doing things.
Equality Impact Assessment (EIA)	An EIA is a process and associated document to be completed by the document author when creating and/or reviewing a procedural document. The process is to ensure that any adverse or negative impact is identified and addressed when making strategic or operational decisions or when developing and reviewing policies and procedures. The Trust has a standard approach to EIAs, including support and advice from the Diversity and Inclusion function.

Appendix B: Flow Diagram: Procedural Documents Process



Appendix C: Document Control Sheet Definitions

Document Reference	Document reference should follow the standard naming convention (section 7.3) PO – Insert document name – review date e.g. PO – Management of Procedural Documents Policy – January 2019
Version	Document version control to follow the standard convention (section 7.4) First draft will be V:0.1, approved version would be V:1.0
Responsible Director (title)	The Executive Director / TEG member responsible for the directorate which owns the document. The responsible director should be referred to by title only (not as a named individual).
Document Author (title)	The author / subject matter expert of the document. The document author should be referred to by title only (not as a named individual)
Approved by	Designated approval group that has approved the final version of the document in accordance with the Management of Procedural Documents Policy (section 9.2)
Date Approved	Date of which final approval of the document was last granted. e.g. January 2015 (Do not include a specific date only the month)
Review Date	Date by which the document must have been reviewed and re-approved, in line with the required review timescales (section 6.0) . e.g. new Procedural Documents – one year only, three years maximum thereafter.
Equality Impact Assessed (EIA)	Ensure this has been done prior to approval and indicate Yes or Not Applicable (this option must be agreed with Diversity & Inclusion Unit).
Document Publication	Internal only – Trust intranet Public Website – Trust intranet and Public website

Appendix D: Document Naming and Version Control

1. Document Title: Naming Conventions

All documents must be identified by a unique name or title using a standard naming convention as follows:

- The initials in capitals of the type of document (PO = Policy, PR = Procedure, GU = Guidelines, SOP = Standard Operating Procedure.
- The above initials should then be followed by a hyphen.
- The hyphen should be followed by the full document title.
- The document title should then be followed by a further hyphen.
- The further hyphen should then be followed by the review date i.e., the date it is next due to be reviewed, (month and year).

Example:	PO - Management of Procedural Documents Policy – October 2024

2. Document Version Control

Version control conventions should be used to manage all procedural documents and will follow both major and minor versions:

- The first draft (unapproved) version of a new procedural document should be identified as draft v0.1. Subsequent drafts should be identified in increasing numerical order, v0.2, v0.3, v0.4, etc.
- The first approved version of a document should be identified as a whole number; v1.0.
- Any subsequent minor changes at the next review stage should be identified as draft v1.1, v1.2 etc.
- The next approved version of the document should be identified as approved v2.0, and so forth.

Appendix E: Roles and Responsibilities

Trust Board

The Trust Board sets the organisation's mission, strategy, priorities, values and culture. These are embodied and operationalised through the organisation's framework of policies and supporting processes and procedures.

The Trust Board may receive assurance that individual policies and procedural documents are fit for purpose, and that the Trust's policy management framework is designed appropriately and operates effectively. The approval of a small number of specific policies is a matter reserved for the Trust Board.

The Trust Board has a structure of sub-committees which oversee policy development and implementation within their respective remits. These sub-committees may report to the Trust Board regarding policy compliance, controls and assurance in their areas and to escalate any risks. The approval of a small number of specific policies or other procedural documents may be reserved for Board sub-committees.

Trust Executive Group (TEG)

The Trust Executive Group is the most senior of the Trust's management groups and, amongst other things, is accountable for the operational management of the Trust. TEG will often be a key stakeholder in the review and development of policies and procedural documents. In that role TEG will ensure that emerging policies and procedures are appropriately aligned with Trust priorities and values. In exceptional circumstances TEG may be required to approve policies or other procedural documents.

Individual TEG members will be the designated Responsible Director for policies and other procedural documents which are owned by their directorate or otherwise directly owned by that TEG member. TEG members are required to sign-off any policies owned by their directorate, or for which they are the designated Responsible Director, prior to these receiving final approval.

Responsible Director

The Responsible Director is the Executive Director (or other TEG member) with overall responsibility for the policy or procedural document.

The Responsible Director may nominate a Deputy Director / Associate Director or other senior manager as the delegated document owner. In such circumstances, the delegated owner will have overall day-to-day responsibility for the development, content, implementation and review of the policy or other procedural document. However, ultimate accountability for the policy or procedural document cannot be delegated and will always rest with the Responsible Director.

Document Author

The document author is the author of the document, and is responsible for developing, monitoring and maintaining allocated procedural documents. The document author may also be the individual responsible for implementation of and compliance with the policy. If the document author is not responsible for implementation and compliance, this must be clearly stated within the procedural document.

Document authors should liaise regularly with the Risk and Assurance team regarding all matters relating to the development, review and approval of policies and other procedural documents. Document authors should give particular attention to the requirements of this

policy and of the standard procedural document template. Policy documents that do not meet these requirements will not be accepted for final approval.

Approval Group

The approval group is the formally constituted governance body within the Trust that has ownership and oversight of a policy or other Trust wide procedural documents approval.

The approval group is the body responsible for reviewing and agreeing the content of all policies and other procedural documents relevant to its remit. All policies must be reviewed and endorsed / finally approved by the approval group prior to publication.

Joint Steering Group (JSG)

Policies and other procedural documents with significant implications for the workforce may be subject to a consultation process involving staff and staff-side representatives, including discussion at the Joint Steering Group (JSG). In instances where the policy might change staff terms and conditions or fundamentally change core working practice the policy must go through JSG. Additionally, if a policy heavily impacts on another policy in ways that align with the above criteria it should be considered for possible JSG comment.

The requirement for policies and procedural documents to be treated in this manner will be decided on a case-by-case basis following discussion with the Executive Director of People and Organisational Development or appropriate delegates.

Director of Corporate Services and Company Secretary

The Director of Corporate Services and Company Secretary has operational responsibility for the design, review and operation of the Trust's policy framework and the Management of Procedural Documents policy.

The Director of Corporate Services and Company Secretary will:

- Act as Policy Author for the Management of Procedural Documents Policy, ensuring this remains up-to-date and fit-for-purpose.
- Lead the Risk and Assurance team functions and processes relating to the management of policy and procedural documents (see section 8 below).
- Report to TEG regarding the development, review, and approval of policies, including risk-based extensions to policy review periods.
- Report to TEG regarding compliance with the Management of Procedural Documents Policy.
- Provide subject matter expertise to Trust regarding policy management.
- Liaise with third-line sources of assurance (e.g., internal audit) regarding the review and testing of the design of and compliance with policies and procedural documents.

Risk and Assurance Team

The Risk and Assurance Team will ensure policies are compliant with the standard template and the requirements of this policy prior to submission for final approval. In addition, the Risk and Assurance team will:

- Maintain an accurate and up-to-date central register of Trust policies
- Maintain a forward view of policies due for review and re-approval

- Co-ordinate the approval process and reporting to the approval groups
- Prepare a quarterly policy and procedural documents report for TEG
- Issue a review prompt to policy authors 6 months before the policy expiry date (with a further reminder at 2 months)
- Provide advice and guidance regarding the policy development, review, and approvals process
- Liaise with the Corporate Communications team regarding Trust-wide notification about newly approved policies
- Conduct periodic policy compliance testing of a sample of approved policies

Communications and Engagement Team

The Corporate Communications team will prepare a summary of recently approved policies for publication in the Staff Update or other Trust publication as appropriate. This will usually be within one month of final approval; however, this timescale is contingent on the policy author providing appropriate content for the Staff Update in a timely manner.

Managers

Managers must ensure they are up to date with the latest policies and other procedural documents relevant to their role. This should include reading Trust communications bulletins, regular contact with other management colleagues and proactively checking the Policy, Procedures and Strategy Documents Library. Managers should provide updates to their staff in a timely manner regarding new policies and procedural documents or revisions to existing ones.

All managers are expected to contribute to the process of developing and reviewing policies and other procedural documents by taking part in relevant consultations.

Managers must ensure that their staff comply with all relevant policies and procedural documents and take corrective action when necessary and in line with the Trust's capability and disciplinary policies.

Staff

All staff must ensure they are up to date with the latest policies and procedural documents relevant to their role. This should include reading Trust communications bulletins, proactively accessing the Trust Intranet site and regular contact with their managers.

All staff are expected to contribute to the process of developing and reviewing procedural documents by taking part in relevant consultations. This is considered to be part of normal duties.

All staff are expected to comply with all relevant policies and procedural documents. In cases of non-compliance, managers may take corrective action when necessary and in line with the Trust's capability and disciplinary policies.