POLICIES MANAGEMENT FRAMEWORK

POLICY

Reference	GV/002		
Approving Body	Trust Management Team		
Date Approved	2 July 2025		
For publication to external SFH website	**Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:**		
	YES	**NO**	
	X		Removal of N/A
Issue Date	February 2024		
Version	5.2		
Summary of Changes from Previous Version	Full review to address internal audit report recommendations.		
Supersedes	Development, Approval, Implementation and Review of Policies / Procedure / Guidelines / Standard Operating Procedures / Pathways Version 5.1		
Document Category	Governance		
Consultation Undertaken	Executive Team		
Date of Completion of Equality Impact Assessment	30 June 2025		
Date of Environmental Impact Assessment (if applicable)	N/A		
Legal and/or Accreditation Implications	Compliance with Governance Good Practice		
Target Audience	All authors of trust wide policies, procedures, guidelines, standard operating procedures and pathways.		
Review Date	2 July 2027		
Sponsor (Position)	Director of Corporate Affairs		
Author (Position & Name)	Corporate Secretariat Team Leader		
Lead Division/ Directorate	Corporate		
Lead Specialty/ Service/ Department	Corporate Secretariat		
Position of Person able to provide Further Guidance/Information	Director of Corporate Affairs		

Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
• Development of Policies – TEMPLATE & GUIDANCE	February 2024
• Development of Procedures – TEMPLATE & GUIDANCE	February 2024
• Development of Guidelines – TEMPLATE & GUIDANCE	June 2022
• Development Standard Operating Procedure – TEMPLATE & GUIDANCE	June 2022
• Development of Pathways – TEMPLATE & GUIDANCE	June 2022

• Amendment / Extension of an existing policy / procedure – **REQUEST FORM** Associated '– **PROCEDURE FOR APPROVAL, IMPLEMENTATION AND REVIEW OF CLINICAL DOCUMENTS (POLICIES, PROCEDURES, GUIDELINES, SOPs, PATHWAYS** Developed to support **CLINICAL** documents	February 2024 February 2024
Template Control	June 2020

CONTENTS

APPENDICIES

1.0 INTRODUCTION

This policy gives authors of Trust policies, procedures, guidelines, standard operating procedures, and pathways a comprehensive description of the requirements for such documents at Sherwood Forest Hospitals NHS Foundation Trust (SFHFT) and describes the process for the development, approval, implementation, and review of these documents. This policy also describes the process for the extension to, the amendment of and the removal of obsolete policies.

This document ensures that authors are aware of the types of documents, the overall requirements for content, style and formatting, the lead responsibilities of authors and corporate bodies, and the requirements for consultation, impact assessments, implementation, review, and archiving.

DO

- Use the latest Trust templates (available from Corporate Secretariat / Clinical Documents inbox for all new or reviewed documents, found below: http://sfhnet.nnotts.nhs.uk/departments/clinicalguidelines/deptbrowse.aspx?recid=1007&homeid=5586
- Ensure that all associated documents have been reviewed and accompany the policy, procedure, guideline, standard operating procedure or pathway.
- Adhere closely to requirements for content and formatting.
- Fully update the document control sheet (front page) before submission.
- Ensure fully appropriate consultation and impact assessments on each version.
- Contact the Corporate Secretariat Team Leader / Clinical Documents inbox if you need further guidance.

DO NOT

- Allow your existing document to exceed its planned review date without providing an updated version.
- Submit a revised version by updating the extant version on an outdated template, rather than transferring to the current template.
- Assume that there have been no relevant legal or policy changes (national or local) on your subject matter since the previous version was implemented.

2.0 POLICY STATEMENT

SFHFT recognises that its policies, procedures, guidelines, standard operating procedures, and pathways are key risk management tools, which ensure all members of staff are able to read, understand and implement the requirements relating to a given subject, in the interests of both optimum patient care and effective use of resources. The Trust is therefore committed to ensuring all such documents are fit for purpose, easily accessible and reviewed and updated in a timely manner. It also follows that the requirements described in these documents are mandatory and a failure to comply with them could render the employee liable for disciplinary action, up to and including, dismissal.

3.0 DEFINITIONS/ ABBREVIATIONS

3.1 Policy

A policy is a statement of intent which members of staff are expected to follow. It is mandatory for all staff. By definition, it is always Trust wide in ambit.

A policy should:

- Be short (unless there is a specific reason for it to be any longer – for example it follows a national model policy).
- Be easily understood and commensurate with its purpose.
- Briefly specify the policy and who has responsibilities under it.
- Be compatible with equality and diversity legislation and policy.
- Be developed with the full involvement of relevant staff, patients, and patient involvement group(s).
- Refer and cross reference to other relevant trust documents.
- Be indexed (by use of paragraph numbering).
- Include page numbering.
- Include all the document control elements outlined in this policy.

3.2 Procedure

A procedure is an official way of doing something which must be followed i.e. a mode of proceeding or a method of conducting business. It is mandatory for all staff.

Thus a policy (see above) will usually be supported by a procedure (unless the policy statements are self-evidently sufficient for purpose).

A procedure may be short or substantial but must be operational in focus and aimed at those staff who will be involved in implementing it.

3.3 Guidelines

A guideline is an indication of a course of action that will usually be followed, unless there are good reasons for not doing so. Other courses of action are not prohibited but the reason for deviation must be fully justifiable. They are usually clinical in nature, since non-clinical matters will tend to be mandatory (and thus to be found in policy or procedure).

3.4 Pathways

A pathway is one of the main tools used to manage the quality in healthcare concerning the standardisation of care processes. Clinical pathways promote organised and efficient patient care based on evidence-based practice.

Generally, pathways refer to medical guidelines. However, a single pathway may refer to guidelines on several topics in a well detailed framework, especially within a multidisciplinary context. It is a management tool based on evidence-based practice for a specific group of patients with a predictable clinical course, in which the different tasks (interventions) by the professionals involved in the patient care are defined, optimised, and sequenced.

Clinical pathways are patient care algorithms based on best evidence. They are intended to minimise variance in treatment and often work well in the form of flowcharts.

3.5 Standard Operating Procedures

A standard operating procedure (SOP) is specifically designed to describe a set of step-by-step instructions compiled by the Trust to help staff carry out routine activity. It clearly states how to do something. Unlike a standard procedure (outlined above), it concentrates on capturing more than just the process; it additionally captures the element of the doing and details the functional responsibilities.

3.6 Best Practice

All Trust policies, procedures, guidelines, standard operating procedures and pathways should be based on recognised best practice with an acknowledged evidence-base and should provide a written description of what is required.

4.0 ROLES AND RESPONSIBILITIES

4.1 The Audit & Assurance Committee

The Audit & Assurance Committee will, on behalf of the Board, monitor the production and review of non-clinical Trust policies and procedures at each meeting.

4.2 Trust Management Team (TMT)

A list of all new and reviewed (and any overdue for review) non-clinical and clinical policies will be presented to the Trust Management Team (TMT) for noting on a quarterly basis.

TMT will also review, on an annual basis, the appropriateness of the designated approving body or officer for every Trust policy.

4.3 The Quality Committee

The Quality Committee will, on behalf of the Board, annually monitor the production and review of clinical Trust policies and procedures.

4.4 Patient Safety Committee

The Patient Safety Committee will oversee the Trust's production of clinical trust policies and procedures with respect to clinical data and patient identifiable information to ensure that this is in accordance with all relevant legislation and guidance, including the Caldicott Principles and Data Protection Act 2018, on a quarterly basis.

4.5 Document Authors

Identify and substantiate the need for a policy/procedure and decide upon the content noting there must be a very clear reason. Please contact the Director of Corporate Affairs / Clinical Documents inbox if you are unsure.

Obtain Executive Level sponsorship (for Trust wide policies) and discuss and agree:

- Who the document is targeted at and why. The author must ensure the target audience is defined specifically – thus the term "all staff" should not be used unless that is genuinely the case.
- The author.
- Whether anyone else in the Trust is likely to be addressing the same or similar issue(s) with whom liaison will be necessary or whether a similar document already exists which will be superseded by the new document.
- Who should be involved in the documents development (for example, patients, staff, Staff Side, internal technical leads, experts).
- Timescale for production of the document.
- To undertake the various impact assessments.
- Which stakeholders, including trust groups/committee(s) should be consulted during the development of the document.
- An appropriate implementation and review mechanism.
- The plan for implementation (including communication).

Ensure that all required elements/aspects are included in the policy, for example:

- Patient care/safety
- Risk management

4.6 The Director of Corporate Affairs

The Director of Corporate Affairs is responsible to the Board of Directors for corporate governance, and related matters of policies, procedures and guidelines. The Director of Corporate Affairs also acts as the Board of Director's lead for monitoring policies, procedures and guidelines.

To this end the Director of Corporate Affairs will:

- Produce reports for the Audit & Assurance Committee and TMTto provide assurance that non–clinical policies and procedures are kept updated – See Monitoring Matrix at Appendix 1.
- Ensure that all such documents meet the required formatting requirements before publication to staff.
- Act as a point of contact and advice for document authors.
- Act as the single link with ICT and Communications for the posting of approved non-clinical policies and procedures onto the Trust's Intranet and the Trust's website in accordance with the Freedom of Information Act, together with any additional methods of access which may be developed by the Trust.

4.7 Director of Nursing Quality and Governance

The Director of Nursing Quality and Governance is responsible for clinical governance and related matters of policies and procedures, ensuring that appropriate archive arrangements are in place to retain all previous versions of any such documents relating to clinical governance.

To this end the Director of Nursing Quality and Governance will:

- Produce reports for the Quality Committee / Patient Safety Committee to provide assurance that clinical policies and procedures are kept updated – See Monitoring Matrix at Appendix 1
- Ensure that all such documents meet the required formatting requirements before publication to staff.
- Act as a point of contact and advice for document authors.
- Act as the single link with ICT and Communications for the posting of approved clinical policies, procedures and guidelines onto the Trust's Intranet and the Trust's website in accordance with the Freedom of Information Act, together with any additional methods of access which may be developed by the Trust.

4.8 Sponsors are responsible for

- Having full oversight of the suite of documents within their remit and ensuring staff have access to relevant resources for undertaking their duties, particularly in relation to authorship.
- Ensuring the most appropriate person is identified as the author for developing or reviewing and updating these documents and has the necessary skills.
- Nominating and identifying a new author, where a previous author has either changed job role or is no longer responsible for a document.
- Of note, for trust wide policies, the document sponsor will be the Executive associated with the policy category or senior manager for the subject matter.

4.9 Managers and Other Employees

Managers and other employees are responsible for contributing to the development of the Trust's suite of policies, procedures, guidelines, standard operating procedures and pathways via the consultation process, as well as ensuring their implementation, as required.

In this regard, managers are specifically responsible for ensuring that their members of staff have the opportunity to be aware of the existence of all such documents which are relevant to such staff and have the means to access, read and understand them.

Some documents are not Trust wide, for example those which are specialty / Division-specific only. Such documents, (together with their implementation and monitoring plans if required) should follow the principles contained in this document. They may be agreed at the appropriate level within the respective division or directorate. Such documents must not conflict with relevant Trust policies or Trust wide procedures.

5.0 APPROVAL

Apart from the exceptions at 5.1 and 5.2, all Trust policies, procedures, guidelines, standard operating procedures and pathways should be scrutinised and approved by the **most appropriate local expert** committee, group or sub-committee of the Board. The approval body is also responsible for positively confirming that the content does not risk the safety of patients or the public and thus are suitable for publication to the trust's external website. The Policy Author is responsible for initiating the approval process for each policy they submit. This includes confirming the approval and providing evidence through minutes of the approving body's meeting.

5.1 The Board

The Board may reserve to itself the authority for giving final approval to any trust policy, procedure, guideline, standard operating procedure or pathway. That said, for the purposes of the Executive Team/TMT's annual review of applicability of SFHFT approving entities, it has determined that the following characteristics shall apply to documents reserved for Board level approval:

- where there is a link to primary legislation or a CQC requirement, where the impact of failing to implement could result in prosecution or present significant risk, or
- where there is a specific legal requirement (for example, policies and procedures which involve medical and dental staff), or
- where the subject matter is of particular interest to the Board

5.2 Trust Management Team

The following characteristics shall apply to documents delegated to the Trust Management Team for approval:

- where the document primarily relates to an operational process, or
- where there is a lower risk of legal challenge or regulatory enforcement action, or

- where the latest amendments (to documents approved by the Board) are neither material nor consequential

6.0 DOCUMENT REQUIREMENTS

6.1 Legislation and Guidance

Authors are responsible for ensuring that all relevant legislation and national guidance is taken into account and referenced when developing Trust policies, procedures, guidelines, standard operating procedures and pathways.

6.2 Impact Assessments

When authors have completed their first draft of the new document, they must then undertake the mandatory impact assessment/s in accordance with the instructions in the template. When a policy is revised, the author must redate the current Equality Impact Assessment (EqIA) form if it remains unchanged or submit an updated version.

In the event that these assessments identify further consideration about, or changes to, the extant draft, such actions must then be undertaken. The template provides for authors to state, in the case of each assessment, whether or not the need for any such changes was identified as a course of the assessment.

6.3 Consultation

Authors must undertake all necessary consultation. Such consultation must be meaningful and should thus take place with all relevant groups and individuals during the document's development.

- The Staff Side must be consulted about all employment related policies.
- The union accredited health and safety representatives must be consulted on all health and safety policies and procedures.
- Any other internal and/or external stakeholders as appropriate

Authors should also, as appropriate, take advice from the Finance and Procurement Directorate, regarding any additional resource consequences of any proposed new policy or procedure or any revision to existing versions.

Staff with the relevant expertise and knowledge regarding the subject matter must be sought as well as consulting with identified individuals with specialist knowledge for sections of the document e.g. training representative (for training and education section), pharmacy representative (for medicines related information).

Ultimately, the author must ensure that the full consultation has been undertaken, based on a case by case approach applicable to the content of the document. Further advice can be obtained from the Director of Corporate Affairs / Director of Nursing Quality and Governance.

6.4 Communication

The Director of Corporate Affairs and Director of Nursing Quality and Governance are responsible for posting a copy of all approved non–clinical and clinical policies, procedures, guidelines, standard operating procedures and pathways on the Trust intranet.

The majority of documents will also be proactively posted on the Trust's public website. In a very few cases, documents will be retained and issued on a 'need to know' basis only.

Executive sponsors and authors are responsible for ensuring they have identified (by reference to the document control sheet at the front of the document) those staff groups within their area of responsibility to whom the document applies.

Authors are responsible for liaising with local managers who are responsible for the identified staff groups to ensure appropriate communication plans are in place.

Local managers must make arrangements to ensure such members of staff have had the opportunity to be aware of the existence of the document and have the means to access, read and understand it.

In the event that those members of staff do not regularly use electronic methods to access Trust information, the manager is responsible for identifying alternative appropriate methods.

6.5 Review and Archiving

All Trust policies, procedures, guidelines, standard operating procedures, and pathways should be:

- Reviewed and equality impact assessed within a maximum of three years of their approval.
- In the event of a full review, a document must be revised, updated, subjected to consultation, and resubmitted for approval in accordance with this document.
    - If after a full review, no significant changes are required, the sponsor can authorise the review and the policy does not need to be re-submitted to consultation or resubmitted for approval.
- The default date for policy reviews is three years.
- In the event of a minor amendment, see section 13.

Some documents may have to be reviewed annually for accreditation purposes and the same process should be followed. A document can be reviewed before its planned review date, if circumstances so dictate. If a document is scheduled for its planned review but is awaiting external guidance, it is recommended that the approving forum considers renewing the document for one year to prevent multiple extensions of the review date.

The Director of Corporate Affairs / **Director of Nursing Quality and Governance** is responsible for ensuring that there are processes in place for overseeing the review, maintenance and communication of all policies, procedures, guidelines, standard operating procedures and pathways.

It is the responsibility of the document author to ensure appropriate archive arrangements are in place to retain all previous versions of the document.

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

For policies, the author must complete the Monitoring Matrix section. The Monitoring Matrix for this policy can be found at Appendix 1. The Executive Assistant to the Director of Corporate Affairs / **Director of Nursing Quality and Governance** will act as 'gatekeeper' to ensure all documents comply with the requirements of this policy. Policy authors must ensure the Monitoring Matrix captures all actions to cover the policy's roles and responsibilities.

An example of what should be included within the Monitoring Matrix in relation to this policy has been provided below:-

Minimum Requirement to be Monitored	Responsible Individual	Process for Monitoring e.g. Audit	Frequency of Monitoring	Responsible Individual or Committee/ Group for Review of Results
Compliance with the Trust requirements for policy formatting and processes	Director of Corporate Affairs	Review of documents on receipt from authors, prior to publication on the staff intranet/internet	As and when documents are received	Compliance with the Trust requirements for policy formatting and processes Will be resolved directly with the Clinical / Non – Clinical Policy officer
Review of the status of Existing Non – Clinical Policies	Director of Corporate Affairs	Review New, Approved, Updated and Overdue Non – Clinical Policies	2 x yearly	Audit Committee

Minimum requirement to be monitored should identify the role/responsibilities to be covered, for example, in relation to this policy the ***review of the status of existing non-clinical policies*** would be entered within this column. The ***responsible individual*** is the person who ensures this action is carried out, in this example we would identify the ***Director of Corporate Affairs*** as the responsible officer.

The ***process for monitoring*** is the task the be carried out to cover the role/responsibility, in this example the task would be to ***review new, approved, updated and overdue non-clinical policies***. The ***frequency of monitoring*** in this example is ***2x yearly***. The ***responsible individual or committee/group for review of results*** should reflect the forum or responsible individual for receiving assurance from the completed action, in this example the ***Audit Committee*** was identified as the most suitable forum to receive this assurance.

8.0 TRAINING AND IMPLEMENTATION

If any issues are identified with the training or implementation of a policy or other document type, prior to submission, a separate implementation plan, agreed by the Sponsor, should be devised. (The plan should be retained by the author for implementation and future reference, and need not be inserted within the document, nor sent to the Director of Corporate Affairs / Director of Nursing Quality and Governance).

9.0 FORMATTING REQUIREMENTS

9.1 Formatting principles

The same formatting principles should be applied to trust policies, procedures, guidelines, standard operating procedures, and pathways.

All new (or revised) documents should be completed in the respective mandatory templates available from Corporate Services/ Governance Support Unit and found on the Intranet using the below link;-

http://sfhnet.nnotts.nhs.uk/departments/clinicalguidelines/deptbrowse.aspx?recid=1007&homeid=5586

The templates contain sufficient guidance to ensure that the author complies with the trust's requirements. However, the following points of emphasis should be noted:

9.2 Document Title

- The document title should always end in the document type (policy, procedure, guideline, standard operating procedure or pathway). It should never start with these words
- Consistency – please make sure you use a single, identical, title in all of the following:

    - Title header on front page
    - Footnotes (throughout)
    - Body of text (throughout)
    - The electronic file name which you give to the Word document itself.

9.3 Document Control Front Page

- Please ensure that you use the latest version of the document control page/ template (as per the current templates)
- Top line alpha/ numerical reference on new documents will be entered by the Director of Corporate Affairs / **Director of Nursing Quality and Governance** if one is not provided. Revised versions of existing documents retain the same reference number.
- Approval and issue dates will be entered by the Author.
- The review date should be a maximum of three years ahead following month of approval.
- The job title of the Sponsor should always be stated (for Trust wide policies this must be an executive director of the Board, no-one else).
- The author position should also be separately stated (do not use the 'Executive Director Sponsor' unless that person is also the actual author).

9.4 Font

- Documents must be in Microsoft Word Arial 12 font throughout (unless in PDF format or sourced from external documents for reference) the main body of the policy. This does not include flowcharts etc.

9.5 Version Control

- If a document is new for SFHFT, it will always be version 1 (no matter how many interim drafting versions you have created).
- Subsequent versions will follow on from the existing SFHFT version (whole numbers are used when a planned / full review is undertaken (even if the procedural content remains the same) and decimal points are used to denote amendments have been made prior to the review date (i.e. during the lifecycle of the document) but when this occurs, the current review date stays the same).
- In subsequent versions, authors should enter (on the document control front page) the version number of the document being superseded and the approval date of that superseded version. Additionally, the author should provide the version number, issue date, review date, and title (if changed) of the superseded document for reference and convenience.

9.6 Footers

- Please use the following template (at bottom left of the document, noting this is Arial 8 point) - example:

  Title: Dress Code and Uniform Policy
  Version: 1.0; Issued: November 2017 Page XofY

- There should be one, identical, updated footer running through every single consecutive page of the document from first to last, **including documents which have been collated from a number of individual source files – the footer must be consistent throughout**.

9.7 Contents Page

This must be fully accurate in relation to the version being submitted to the Corporate Secretariat Team Leader / Clinical Documents inbox including entering all page numbers on the contents page and referencing the page numbers of all the appendices through to the final page of the document.

9.8 Colour

Use of colour should be avoided. If essential, it should be used with discretion and for genuine added value only, not simply to 'enhance' presentation which is already fit for purpose.

9.9 General Formatting

Please check your final draft thoroughly before sending to the Corporate Secretariat Team Leader /Clinical Documents inbox including looking for the following, which will be returned to authors if still non-compliant:

- Unresolved grammar or spell check queries by Word (green and red underlining)
- Portrait / landscape orientation problems – this can be a particular problem when alternating between these two modes in the same document.
- Indenting or related problems, for example table borders which 'jump outside' the visible page.
- Documents must be in Microsoft Word Arial 12 font throughout (unless in PDF format or sourced from external documents for reference) the main body of the policy. This does not include flowcharts etc.

The formatting and completeness of policies and procedures will be scrutinised prior to publication to ensure compliance with the requirements detailed in this policy.

10.0 IMPACT ASSESSMENTS

Equality Impact Assessments (EqIA) and Environmental Impact Assessments (EIA) must be completed as appropriate:

- Equality –
  It is not necessary to complete an EqIA on a guideline or procedure where an EqIA has been completed in an overarching policy.
  It is not necessary to complete an EqIA on a procedure where an EqIA has been completed in an overarching guideline.
  It is not necessary to complete an Equality Impact Assessment on a Pathway or Standard Operating Procedure

- Environmental –
  Environmental Impact Assessments are required for matters likely to have a significant effect on the environment, they also provide an opportunity to identify measures to avoid or reduce that effect.

This could include but is not limited to matters relating to the Trust's estate and infrastructure and flood-risk management. If you are unsure please contact H & S Manager or Director of Estates and Facilities for clarification.

11.0 KEYWORDS

Policy authors must include keywords that will be used to assist with intranet searches. In relation to this policy they are: Policies Management Framework, policies template, policy guidance, clinical policies, non-clinical policies.

12.0 EVIDENCE BASE (e.g. RELEVANT LEGISLATION / NATIONAL GUIDANCE) AND RELATED SFHFT DOCUMENTS

Evidence Base (e.g. relevant legislation/ national guidance)-

- Health & Social Care Act 2012
- NHS Litigation Authority Risk Management Standards 2013/14 (used for best practice)
- NHS Identify Guidelines
- Care Quality Commission Fundamental Standards
- Caldicott Principles
- Data Protection Act 2018

Related SFHFT Documents:

- Risk Management Policy
- Retention and Destruction of Records Policy

13.0 AMENDMENT TO / EXTENSION OF AN EXISTING TRUST WIDE POLICY

Updates can be undertaken at any time during the lifecycle of documents without changing the review date. Updates must be approved by the relevant trust committee/ group utilising the amendment request form found on the Intranet. For clinical documents, where there is no impact on practice, it may be possible to agree minor updates directly with the Lead for Clinical Documents **Director of Nursing Quality and Governance**, please liaise accordingly.

A pragmatic approach must be undertaken if requesting an extension of a document review date. This will only be approved in exceptional circumstances and on a case by case basis which should be agreed with the policy sponsor, and Director of Corporate Affairs / Director of Nursing Quality and Governance that the current document will not cause any safety issues. If you are unsure about the requirements, authors are advised to liaise with the non-clinical policy officer/Lead for Clinical Documents.

14.0 POLICY REVIEW COMPLIANCE

The Corporate Secretariat Team will ensure authors of policies, procedures and associated documentation are reminded of upcoming reviews via email reminders which will be sent to policy authors 60 days and 30 days prior to the review date. A third and final reminder will be emailed if the policy becomes overdue.

If a policy surpasses the review date, it will be reported as non-compliant to the Audit Committee for non-clinical documents and the Quality Committee for clinical documents.

All documents must be reviewed in accordance with the allocated deadline according to the process detailed in this policy, even if it is decided that no substantial changes will be made to content.

15.0 REMOVAL OF OBSOLETE POLICIES

In the event a policy or procedure becomes obsolete, a request must be submitted to the relevant approving forum to consider the ask. Upon approval, the document will immediately be removed from the Trust Intranet, and where applicable Internet. The policy author will need to provide evidence (minutes via an email) of this approval to the Clinical Documents inbox or Corporate Secretariat Team, and the document information will be recorded on the 'removed policies' section of the relevant Policy Management spreadsheet.

No copies of obsolete documents will be retained as it is the responsibility of the respective speciality (HR / Medicine Division) of the policy document to keep these saved in their local files

16.0 APPENDICES

- Appendix 1 Monitoring Matrix
- Appendix 2 Equality Impact Assessment

APPENDIX 1 – MONITORING MATRIX

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
Compliance with the Trust requirements for policy formatting and processes	Director of Corporate Affairs	Review of documents on receipt from authors, prior to publication on the staff intranet/internet	As and when documents are received	Compliance with the Trust requirements for policy formatting and processes Will be resolved directly with the Clinical / Non–Clinical Policy officer
Review of the status of Existing Non – Clinical Policies	Director of Corporate Affairs	Review New, Approved, Updated and Overdue Non – Clinical Policies	At each scheduled meeting	Audit & Assurance Committee
Review of Existing Clinical Policies	Director of Nursing Quality and Governance	Review status of all existing Clinical Documents	Annually	Quality Committee
Review of Approving Committees	Director of Corporate Affairs	List of Non - Clinical Policies and associated Approving Committees to be reviewed	Annually	Executive Team Meeting
Review of Approving Committees	Director of Nursing Quality and Governance	List of Clinical Policies and associated Approving Committees to be reviewed	Quarterly	Patient Safety Committee

APPENDIX 2 - EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service document being reviewed: Policies Management Framework – Policy			
New or existing: Existing			
Date of Assessment: 16/02/2024			
Please answer the questions a – c below against each characteristic (if relevant consider breaking the document or implementation down into areas)			
Protected Characteristic	**a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?**	**b) What is already in place in the document or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?**	**c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality**
The area of the document or its implementation being assessed:			
Race and Ethnicity	Availability of this policy in languages other than English	Alternative versions can be created on request.	None
Gender	None	Not applicable	None
Age	None	Not applicable	None
Religion / Belief	None	Not applicable	None
Disability	Visual accessibility of this document	Already in Arial font size 12. Use of technology by end user. Alternative versions can be created on request.	None
Sexuality	None	Not applicable	None
Pregnancy and Maternity	None	Not applicable	None
Gender Reassignment	None	Not applicable	None
Marriage and Civil Partnership	None	Not applicable	None

Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)	None	Not applicable	None

What consultation with protected characteristic groups including patient groups have you carried out?

- None for this version, in that all previous principles remain in accordance with previous version (which was subject to consultation) and this version continues agreed practices.

What data or information did you use in support of this EqIA?

- Trust policy approach to availability of alternative versions.

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

- No

Level of impact

From the information provided above and following EqIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact:

Low Level of Impact

Name of Responsible Person undertaking this assessment: Sally Brook Shanahan, Director of Corporate Affairs

Signature: 

Date: 30/06/2025