Policy Document

Reference: G01

University Hospitals of North Midlands NHS Trust

Development and Control of Policies and Procedures

Version:	**10**
Date Ratified:	**October 2018 by the Trust Executive Committee (TEC)**
Date of Next Review:	**October 2021**
Expiry Date:	**October 2022**
Policy Author:	**Associate Director of Corporate Governance**
Executive Lead:	**Director of Strategy and Performance**

Version Control Schedule G01

Final Version	Issue Date	Comments
1	December 2003	Developed to ensure procedural documents are developed/reviewed to standardised criteria and processes to reduce and manage risk and support effective and safe practice, in line with NHSLA requirements.
2	August 2005	Ratified
3	October 2006	Ratified
4	October 2007	Ratified
5	August 2011	Updated to separate policy and procedural information. Monitoring table to reflect the requirements of NHSLA Assessment included.
6.1	August 2012	Streamlining of the checklist process to aide compliance with NHSLA and Internal Audit. To improve the process of assurance for Internal Audit purposes and provide clarification of roles and responsibilities New role for the Compliance Steering Group in policy compliance defined and the role of the Trust Secretary in pursuance of policies requiring/due for review. Addition of version control schedule for corporate documents as best practice and reflecting the requirements of the Information Governance Toolkit. Clarification of the ratification process.
7	November 2013	Reviewed following audit. Ratification process reviewed now occurring at forum level with noting at Executive Committee.
8	June 2014	Reviewed in preparation for MSFT working groups policy review schedule
9	November 2015	Reviewed for alignment for RSUH and MSFT sites
10	October 2018	Full review undertaken with streamlining of information and changes made to responsibilities

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1. INTRODUCTION

This policy sets out the standards for the development and control of policies and procedures, including consultation, approval, implementation and monitoring. The purpose of these standards is to ensure that policies and procedures are:

- standardised
- understandable, clear and concise
- clear regarding lines of accountability and responsibility
- reviewed and up to date
- accessible to all wards and departments
- co-ordinated from a central point, including document control and approval
- consulted upon with relevant stakeholders and where appropriate, external agencies
- relevant and evidence based (where appropriate/applicable)

Compliance with this policy will ensure:

- that the Trust has robust, high quality, evidence based policies and procedures which set out what is expected and required of staff in order to safeguard the safety of our patients, staff, and visitors;
- appropriate control of such documents to enable timely and reliable provision of current and archived copies. This could include for investigation of, and response to, investigations, inquests, tribunals, court hearings, and Freedom of Information requests.

All agreed policies and procedures will be available on the Trust's Intranet.

2. STATEMENT

An overarching statement which is applicable to policy can be found on the Trust Policies Intranet page.

3. SCOPE

This policy applies to all areas of the Trust and all individuals employed by the Trust including contractors, voluntary workers, students, locum and agency staff, bank staff and those holding honorary contracts.

All Trust policies should comply with G01 unless there is compelling national guidance to the contrary which will allow them to be ratified as an exception.

4. DEFINITIONS

Key Term	Definition
Policy	States what the Trust requires employees to do across the organisation, i.e. the rules. These set out defined boundaries and are informed by legislation, professional regulation, national policy directives and codes of practice. They are a 'must do' document which should be adhered to. Failure to follow a policy may result in disciplinary action.
Procedure or Standard Operating Procedure (SOP)	A procedure is a fixed step-by-step sequence of activities or course of action (with definite start and end points) that must be followed in the same order to correctly perform a task. Procedures should be utilised where there are no defined boundaries as noted within legislation, professional regulation, national policy directives and codes of practice. Procedures may be developed as a supporting document to a policy and referenced within the policy rather than being fully integrated into the policy framework.

Key Term	Definition
Guideline	Guidelines provide advice and recommendations on how best to deal with particular issues or situations, however there is room for professional judgement.

5. ROLES AND RESPONSIBILITIES

The **Corporate Governance Department** are responsible for:

- ensuring that policies have been approved and are compliant with this policy before they are published on the Intranet
- ensuring that procedures (SOPs) with specific links to policies, have been approved and are compliant with this policy before they are published on the Intranet
- ensuring that only the latest versions of policies are available via the Intranet
- maintaining an electronic policy register and archive of all policies
- updating this policy, its associated templates, and publicity and training material
- reminding authors of upcoming policy expiry dates in addition to informing the relevant Executive Lead
- providing a source of expertise and advice for staff developing procedural documents

Authors of Policies and Procedures are responsible for ensuring that documents which they have written comply with this policy, remain up to date and are in line with relevant legislation and current best practice.

In addition they should:

- ensure that policies are reviewed in a timely manner informing the Corporate Governance Department of expected date of ratification
- ensure an Equality Impact Assessment is completed for newly developed and reviewed policies (Appendix 4)
- ensure that the policy document is formatted in line with the policy template (Appendix 3)

Accountable Executive Directors are responsible for:

- scrutinising new and revised documents submitted to them
- ensuring there is no duplication or conflict with existing policies
- endorsing policies for ratification by the Trust Executive Committee
- ensuring that their policies are reviewed within agreed timescales and granting extensions to reviews to allow more time to complete a policy review, so long as the existing version is checked to ensure the content does not pose a risk of harm to patients, visitors, and/or staff .

A maximum of 3 extensions will be given. Policies will expire 12 months after the review date and these will be removed from the Intranet at the expiry date unless exceptional circumstances require these to remain until they have been urgently reviewed.

Specialist Groups are responsible for reviewing and consulting upon specific policies, relevant to their subject area, prior to ratification.

The members of the **Policy Review Group** are responsible for reviewing each policy to ensure they are in line with current legislation and have received consultation ahead of approval. This includes Divisional representatives who must ensure that their Division have had the opportunity to review and comment.

Divisional Chairs, Associate Directors and Associate Chief Nurses (or equivalent for non-clinical Divisions) are responsible for:

- ensuring new staff, contractors and others are aware of how to access Trust Policies on the Intranet
- ensuring Trust Policies are disseminated throughout the Division/Departments appropriately for implementation following ratification at the Trust Executive Committee
- ensuring local systems and processes comply with Trust Policies

- ensuring staff are aware of their roles and responsibilities within relevant policies
- ensuring appropriate consultation of policies within their Division
- raising any queries about implementation of Trust Policies with the Corporate Governance Department, regardless of the review date of the policy.

The **Trust Executive Committee** is responsible for:
- ratifying policies once consultation has taken place and the Executive Lead has endorsed the document being submitted for ratification
- reviewing and receiving audit reports in relation to the implementation of this policy and monitoring progress against related action plans.
- approving the minor alterations of current, previously ratified policies

The **Audit Committee** will receive quarterly updates on the number of out of date policies and will be also be provided with a summary of changes to financial policies in addition to considering key financial policies.

All staff are responsible for ensuring that:
- if they are required to develop or review a Trust Policy, they familiarise themselves and adhere to the contents of this policy
- they raise any queries about implementation of Trust Policies with their line manager, regardless of the review date of the policy.

6. EDUCATION/TRAINING AND PLAN OF IMPLEMENTATION

All staff who have responsibility for development of procedural documents will be assisted and supported by the Corporate Governance Department.

7. MONITORING AND REVIEW ARRANGEMENTS

Monitoring Arrangements
The following key standards will be monitored via audits undertaken by the Corporate Governance Department on an annual basis:
- 100% of policies will be published with a completed Equality Impact Assessment
- 100% of policies will be archived when replaced by a revised version
- A random sample of 50% policies approved during the previous financial year will be audited against 100% compliance with the following standards:
  a) Style and format
  b) An explanation of any terms used
  c) Consultation process
  d) Approval process
  e) Review arrangements

Reports on the audit outcomes will be reported to the Trust Executive Committee and this group will be responsible for monitoring and ensuring the implementation of any actions arising from the audit report.

A review of the Policy Register will be undertaken on a monthly basis by the Corporate Governance Department to identify any policies due for review or past their review date. These will be reported to the Executive Committee.

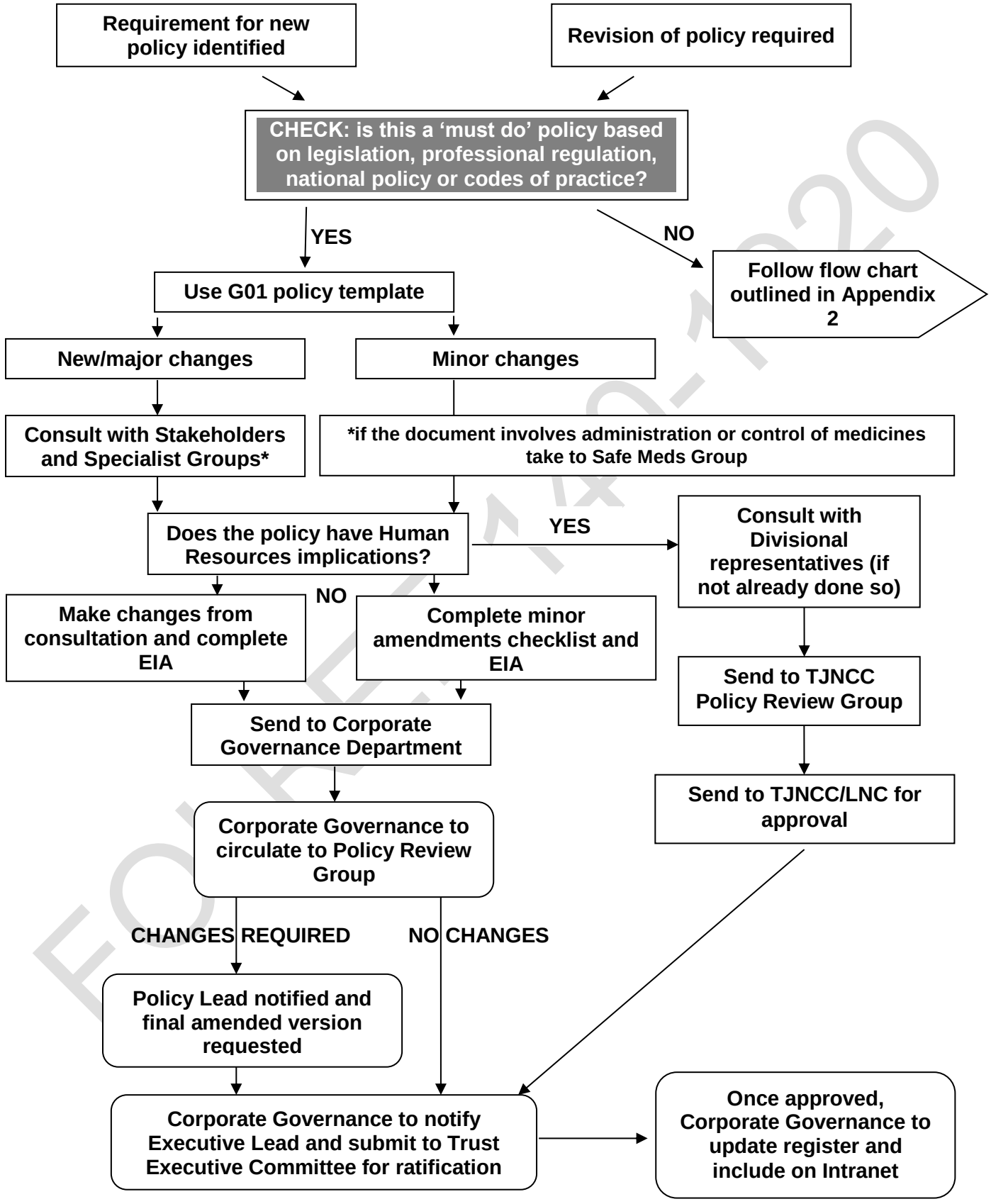
Review
This policy will be reviewed by the Corporate Governance Department at least every three years post ratification, unless it is deemed necessary to do so sooner.

8. REFERENCES

An Organisation-Wide Policy for the Development and Management of Procedural Documents, NHS Litigation Authority March 2012

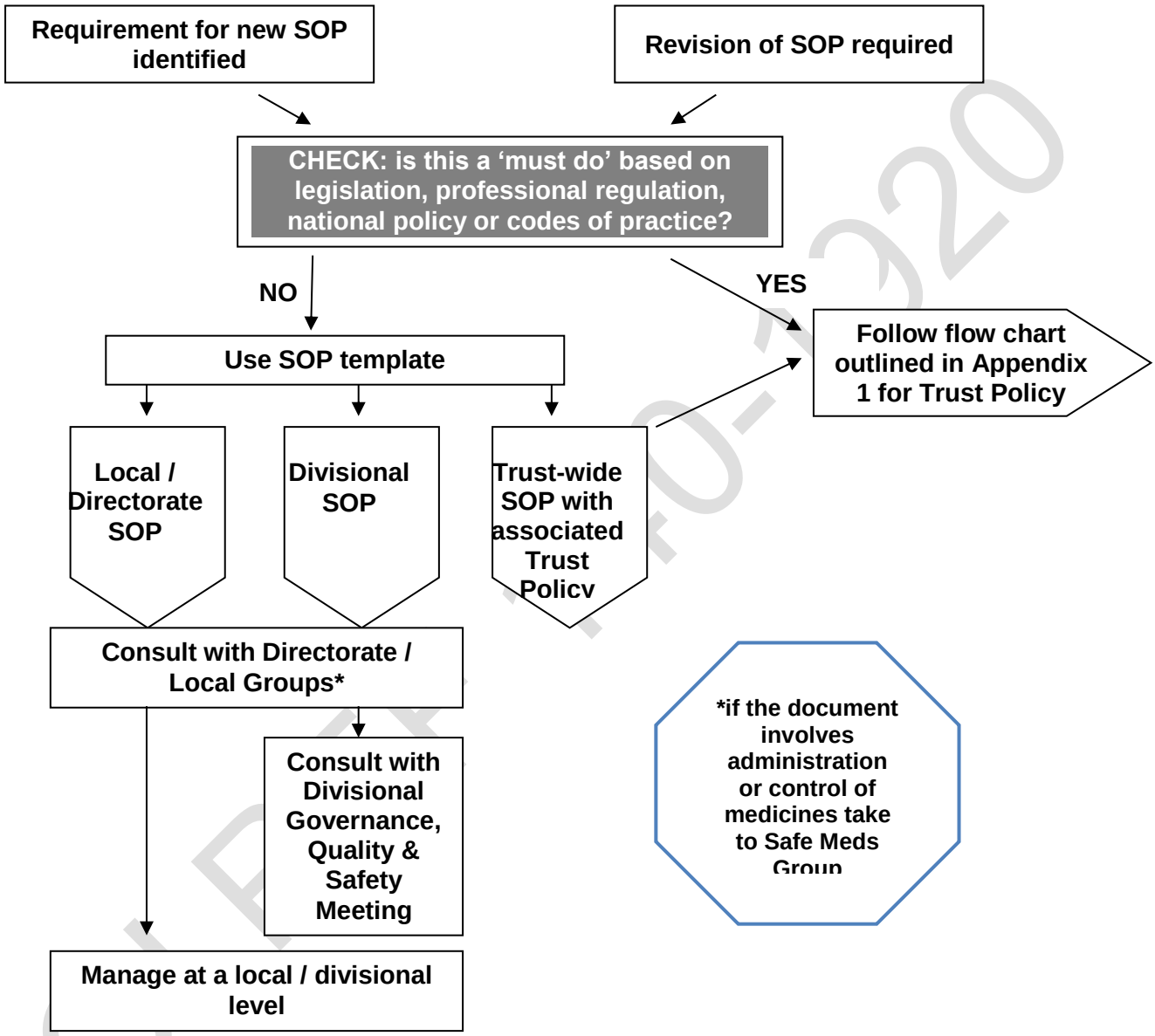
Appendix 1- Flowchart for Trust-wide Policy Development

A Policy should state what the Trust requires employees to do across the organisation, i.e. the rules. These set out defined boundaries and are informed by legislation, professional regulation, national policy directives and codes of practice. They are a 'must do' document which should be adhered to. Failure to follow a policy may result in disciplinary action.



Appendix 2- Flowchart for the Development of Standard Operating Procedure (SOP)

A procedure is a fixed step-by-step sequence of activities or course of action (with definite start and end points) that must be followed in the same order to correctly perform a task. Procedures should be utilised where there are no defined boundaries as noted within legislation, professional regulation, national policy directives and codes of practice.
Procedures may be developed as a supporting document to a policy and referenced within the policy rather than being fully integrated into the policy framework.



Appendix 3 - Policy Development & Review SOP

Standard Operating Procedure (SOP)

Policy Development and Review (G01 - SOP1)

October 2018 - Version 1

University Hospitals of North Midlands NHS Trust

The purpose of this SOP is to outline the steps to be taken by the policy author when developing a new policy or reviewing an existing policy.

This SOP links to Trust Policy G01 Trust Policy for the Development and Control of Procedural Documents

Part A: Development of a New Trust-Wide Policy or Review of Existing Trust-Wide Policy (Major Changes Required)

(to be used where there is legislation, professional regulation, national policy or codes of practice which need to be set out for staff)

No.	Description of Procedural Steps		
1	Use the G01 Policy Template (Appendix 4) for your policy, utilising the headings provided		
2	Consult on the policy with staff within your local area before disseminating the policy to key staff such as:		
	Subject Matter Experts • Clinicians • Nursing and Clinical Leads • Pharmacy • Infection Control • Trauma • Transfusion • Thrombosis • Paediatrics • Safeguarding • Health & Safety • Health Records	**Support Services** • Pathology/laboratory services • Radiology • Estates, Facilities & PFI • Information Management and Technology • Human Resources • Telecommunications • Supplies and Procurement • Clinical Technology	**Other** • Operational leads • Relevant Executive Directors • Divisional Management Teams • Divisional Governance Teams • Quality, Safety and Compliance • Equality • Clinical Audit • Learning & Development • Information Governance • Staff Side Representatives • Patient groups
3	Amend the policy to take on board the comments made following first consultation		
4	Undertake an Equality Impact Assessment (EIA) (Appendix 5). All public bodies have a statutory duty to "set out arrangements to assess and consult on how their policies and functions impact on equality".		
5	**For HR related policies** Submit to TJNCC Policy Review Group	**For other policies** Submit to Corporate Governance Department	
6	To be considered by TJNCC and / or LNC	Corporate Governance Department to undertake steps outlined in Part D	
7	To be considered at Trust Executive Committee once approved		

Part B: Review of Existing Trust-Wide Policy (Minor Changes Required)

(to be used where there is legislation, professional regulation, national policy or codes of practice which need to be set out for staff)

No.	Description of Procedural Steps
1	Use the G01 Policy Template (Appendix 4) for your policy, utilising the headings provided and make the minor changes proposed.
2	Complete the Minor Alterations Checklist (Appendix 6) to outline the changes which have been made

No.	Description of Procedural Steps	
3	Undertake an Equality Impact Assessment (EIA) (Appendix 5). All public bodies have a statutory duty to "set out arrangements to assess and consult on how their policies and functions impact on equality".	
4	**For HR related policies** Submit to TJNCC Policy Review Group	**For other policies** Submit to Corporate Governance Department
5	To be considered by TJNCC and / or LNC	Corporate Governance Department to undertake steps outlined in Part D
6	To be considered at Trust Executive Committee once approved	

Part C: New Standard Operating Procedure

(to be used to outline a fixed step-by-step sequence of activities or course of action when there are no defined boundaries noted within legislation, professional regulation, national policy directives and codes of practice)

No.	Description of Procedural Steps
1	Use the G01 SOP Template (Appendix 7) for your procedure to provide a clear step by step guide for staff
2	Consult on the SOP with staff within your local area (with divisional consultation as appropriate)
3	Amend the SOP to take on board the comments made following first consultation
4	Local / Directorate / Divisional SOPs to be managed at a local level

NB. SOPs associated with a Trust Policy should be reviewed in line with the Policy and follow the associated ratification process - these will be uploaded onto the Trust-wide Policy and Procedures page on the Intranet.

Part D: Receipt of New or Revised Trust-Wide Policy in the Corporate Governance Department

No.	Description of Procedural Steps
NEW OR REVISED POLICY (MAJOR CHANGES)	
1	Policy received into the Corporate Governance Department: • pre-ratification checklist completed • policy number issued, as appropriate • assurance obtained with regards to the consultation which has taken place • record of completed Equality Impact Assessment • confirmation of Executive Lead sign off
2	Policy included on the next Trust Executive Committee (TEC) meeting and disseminated to Policy Review Group for comments via email requesting a response two weeks before the next TEC meeting. Members of the Policy Review Group are as follows: • Associate Director & Deputy Associate Director of Corporate Governance • Deputy Head of Quality, Safety and Compliance • Deputy Director of Nursing (Quality & Safety) • Senior Nurse Education and Workforce • Compliance Manager • People and Organisational Development Officer, Human Resources • Clinical Audit and Effectiveness Manager • Assistant Director of Human Resources • Assistant Director of Estates, Facilities and PFI • Lead for Allied Health Professionals • Quality Improvement Facilitator (Nursing) • Divisional Governance & Quality Managers - for dissemination to divisional governance meetings • Leads of Quality Groups
3	Comments regarding the content of the policy to be provided to the policy lead as appropriate, requesting an updated policy

No.	Description of Procedural Steps
4	Policy considered at the next available Trust Executive Committee for approval
5	Post ratification, the Corporate Governance Department will: • ensure that policies are archived when a reviewed policy has been ratified • make newly ratified policies available to all staff in a PDF version, via publication on the Trust's Intranet • amend the status of policies on the Trust Register as appropriate • disseminate the information regarding policy approval to all staff via the Policy Online Update
MINOR CHANGES TO EXISTING POLICY	
1	Policy received into the Corporate Governance Department: • pre-ratification checklist completed • policy number issued, as appropriate • assurance obtained with regards to the consultation which has taken place • record of completed Equality Impact Assessment • record of completed Minor Alterations Checklist
2	Policy taken to the next available TEC for ratification
3	Post ratification, the Corporate Governance Department will: • ensure that policies are archived when a reviewed policy has been ratified • make newly ratified policies available to all staff in a PDF version, via publication on the Trust's Intranet • amend the status of policies on the Trust Register as appropriate • disseminate the information regarding policy approval to all staff via the Policy Online Update • provide a copy of the policy to the Information Governance Team for uploading to the Trust's website

Trust Policies are accessible to all staff and are located via the Trust Intranet, under 'Policies'. The register and online updates can also be found via the Trust Intranet. This is with the exception of MM07 Policy and Procedures for the Safe Handling, Use and Administration of Intrathecal Chemotherapy, Including the Training & Registration of All Involved Staff, which is only available in hard copy within the relevant clinical areas (wards 201, 202, 217 and 217B, Pharmacy).

Appendix 4 - Template for a Trust-wide Policy

Policy Document

Reference:

University Hospitals of North Midlands NHS Trust

Title of Policy Document

Version:	
Date Ratified:	**by Trust Executive Committee (TEC)**
Date of Next Review:	**New policies - the review date should be one year post ratification, unless changes in national legislation override this.** **Other policies - the review date should be at least every three years, unless changes in national legislation override this or there has been a specific request to review sooner.**
Expiry Date:	**i.e. 1 year after review date**
Policy Author:	**i.e. policy developer or specialist in the subject area (Job Title, not name)**
Executive Lead:	**i.e. the Executive Director responsible for the subject area (Job Title, not name)**

Version Control Schedule

Version	Issue Date	Comments
1		Reasons for development of policy
2		Summary of changes
3		For revised documents you should bullet list all important changes. If this is an update of a previous version but there are no important changes to the content, please state this.

[A summary schedule can be obtained from the Corporate Governance for existing policies]

[A header should also be inserted, with the Trust name followed by the number and title of the policy. In addition, a footer should be used for referencing purposes including the following:

- Policy reference number followed by Policy Title
- Version reference, e.g. v1 for version 1
- Status of the document which can be
  - Draft
  - Final
- Month and year
- Page x of y

When the policy is ratified, this should be changed to V1 – Final. When the policy is reviewed again, this should be changed to V2 with the status of the document included]

CONTENTS **Page**

1. Introduction

2. Scope

3. Definitions

4. Roles and Responsibilities

5. Education/Training and Plan for Implementation

6. Monitoring and Review Arrangements

7. References

8. Appendices:

[All procedural documents should be written in plain English and a style which is concise and clear using unambiguous terms and language. The main body of text within all policies should be in Arial and Font Size 11, using bold text and/or capitals for numbering and titles. Circular bullet points can be used for lists etc. All text should be justified.

All policies should be developed using this template, including title page, version control, contents page, order of headings and appendices]

1. INTRODUCTION

The introduction should include:

- The background and justification for developing the policy
- A reference to any related documents, e.g. NHS guidance/recommendations, legislation, and any associated Trust Policies or other related guidance from professional bodies.
- Reference to any safety or legal considerations
- Assurance that an "Equality Impact Assessment" has occurred and no actual or potential discriminatory impact has been identified relating to this document.

2. SCOPE

This should refer to whom the policy applies and where applicable, the circumstances which apply.

3. DEFINITIONS

The policy may contain terminology that is not clear and easy to understand. Where this is the case, you should include a list of the terms used and a definition of their meaning under this heading.

4. ROLES AND RESPONSIBILITIES

Where teams, groups or individuals have specific roles and/or responsibilities relating to the policy, they should be described in this section. We recommend that you list roles, starting with staff that needs to implement the document and progressing to staff with more senior management responsibilities.

It is important to note that implementation of the policy should be measured against delivery of the roles and responsibilities you identify. Therefore these must be accurate, measurable and realistic.

5. EDUCATION/TRAINING AND PLAN OF IMPLEMENTATION

Identify clearly the arrangements for training and support etc. establishing how to ensure the policy is implemented. If training is required ensure the method of documenting the training is also included which should be recorded within the individual staff member's personal record, ideally within ESR.

6. MONITORING AND REVIEW ARRANGEMENTS

6.1 Monitoring Arrangements

Outline the process to monitor compliance with the effectiveness of the policy. As a minimum, this should include:

- Monitoring arrangements for compliance and effectiveness

- Key standards i.e. benchmarks, targets or key performance indicators that will be used
- Methodology to be used i.e. audit, spot checks, observation, competency assessments, review of training attendance.
- Who is responsible for conducting the monitoring
- Frequency (i.e. quarterly/annual)
- Process for reviewing results and ensuring improvements in performance occur - this should state how will you report back and ensure action is taken if required, e.g. 'monthly compliance dashboards will be shared with the teams involved and reported to xxx'.

*****If clinical audit is an appropriate method of monitoring inclusion of an audit tool in the appendix is encouraged. Clinical audits should be registered with the Clinical Audit team. Where evidence of non-compliance with the policy is to be monitored through submission of adverse incident reports (DATIX) a description of how this data will be collected, collated and reported should be provided in this section.

6.2 Review

For new policies, it is recommended that it should be reviewed one year post ratification, unless changes in national legislation override this.

For reviewed policies, it is recommended that they should be re-reviewed at least every three years post ratification, unless changes in national legislation override this or there has been a specific request to review sooner.

7. REFERENCES

Provide up to date references.

8. APPENDICES

Appendices should include any associated SOPS, flowcharts, forms etc. to support the document. All appendices should be listed in the contents page and cross-referenced throughout the document.

Appendix 5 - Equality Impact Assessment Template

Equality Impact Assessment (EIA)

Title of Policy (No.)
Date

University Hospitals of North Midlands NHS Trust

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. The Equality Impact Analysis Form is designed to help consider the needs and assess the impact of each policy. To this end, EIAs will be undertaken for all policies.

Policy reference & version number			
Please list which service users, staff or other groups have been consulted with, in relation to this			
Were any amendments made as a result? If yes, please specify			
Does this policy have the potential to affect any of the groups listed below differently - please tick *the appropriate box.* Prompts for consideration are provided, but are not an exhaustive list			
	Yes	**No**	**Unsure**
Age (e.g. are specific age groups excluded? Would the same process affect age groups in different ways?)			
Gender (e.g. is gender neutral language used in the way the policy or information leaflet is written?)			
Race (e.g. any specific needs identified for certain groups such as dress, diet, individual care needs? Are interpretation and translation services required and do staff know how to book these?)			
Religion & Belief (e.g. Jehovah Witness stance on blood transfusions; dietary needs that may conflict with medication offered)			
Sexual orientation (e.g. is inclusive language used? Are there different access/prevalence rates?)			
Pregnancy & Maternity (e.g. are procedures suitable for pregnant and/or breastfeeding women?)			
Marital status/civil partnership (e.g. would there be any difference because the individual is/is not married/in a civil partnership?)			
Gender Reassignment (e.g. are there particular tests related to gender? Is confidentiality of the patient or staff member maintained?)			
Human Rights (e.g. does it uphold the principles of Fairness, Respect, Equality, Dignity and Autonomy?)			
Carers (e.g. is sufficient notice built in so can take time off work to attend appointment?)			
Socio/economic (e.g. would there be any requirement or expectation that may not be able to be met by those on low or limited income, such as costs incurred?)			
Disability (e.g. are information/questionnaires/consent forms available in different formats upon request? Are waiting areas suitable?) Includes hearing and/or visual impairments, physical disability, neurodevelopmental impairments e.g. autism, mental health conditions, and long term conditions e.g. cancer.			

Are there any adjustments that need to be made to ensure that people with disabilities have the same access to and outcomes from the service or employment activities as those without disabilities? (e.g. allow extra time for appointments, allow advocates to be present in the room, having access to visual aids, removing requirement to wait in unsuitable environments, etc.)			
Where you have identified that there are potential differences, what steps have you taken to mitigate these? (what action has been taken or will be taken, who is responsible for taking a future action, and when it will be completed by – may include adjustment to wording of policy or leaflet to mitigate)			
Where you have identified adjustments would need to be made for those with disabilities, what action has been taken? (what action has been taken or will be taken, who is responsible for taking a future action, and when it will be completed by – may include adjustment to wording of policy or leaflet)			
Will this policy require a full impact assessment and action plan? Yes / No (a full impact assessment will be required if you are unsure of the potential to affect a group differently, or if you believe there is a potential for it to affect a group differently and do not know how to mitigate against this - please contact the Corporate Governance Department for further information)			
Name of Author			
Date Completed			

Please return the completed EIA along with a word version of the policy to the Corporate Governance Department

Appendix 6 - Minor Alterations Checklist

Minor Alterations Checklist

Title of Policy (No.)
Date

University Hospitals of North Midlands NHS Trust

1) What has been reviewed in the policy and why?

2) Has been anyone been consulted in the revision of the policy?

3) Which Executive Director(s) has reviewed and approved the revised policy?

Policy Reviewer			
Name:		**Designation:**	
Signature:	**(electronic acceptable)**	**Date:**	

Please return this form with the revised word version of the policy and completed EIA to the Corporate Governance Department.

Appendix 7 - Standard Operating Procedure Template

Standard Operating Procedure (SOP)

Title (No.)

Date of Issue & Version Number

University Hospitals of North Midlands NHS Trust

The purpose of this SOP is to xxx

This SOP links to Trust Policy xxx (delete if not applicable).

Part A: xxx

No.	Description of Procedural Steps
1	Please provide a brief outline the steps to be taken (including any screenshots/diagrams, reference to any appendices and person(s) responsible (please use job title not names), as required)
2	
3	
4	
5	
6	
7	
8	

Part B: xx

No.	Description of Procedural Steps
1	
2	

Appendix 1 - Flowchart