Policy for the Development and Implementation of Procedural Documents

(Previously 'Policy on Policies')

Solent NHS Trust policies can only be considered to be valid and up-to-date if viewed on the intranet. Please visit the intranet for the latest version.

Purpose of Agreement	To outline the standard format of Policies and Standard Operating Procedures and approval routes.
Document Type	[X] Policy [ ] SOP [ ] Guideline
Reference Number	Solent NHST/Policy/GO 01
Version	18
Name of Approving Committees/Groups	Policy Steering Group, Management Meeting
Operational Date	July 2020
Document Review Date	March 2023
Document Sponsor (Name & Job Title)	Chief Executive Officer
Document Manager (Name & Job Title)	Associate Director of Corporate Affairs / Company Secretary
Document developed in consultation with	Policy Steering Group, Diversity and Inclusion Lead
Intranet Location	Solent Policies; Operational Policies
Keywords (for website/intranet uploading)	Policy, policies, Standard Operating Procedure, SOP, procedures, GO01

Review Log

Include details of when the document was last reviewed and summary of amendments:

Version Number	Review Date	Name of reviewer	Ratification Process	Reason for amendments
	24/04/2007	RG	N/A – document review	
	16/08/2007	RG	N/A – document review	
	30/11/2007	RG	N/A – document review in light of CFT application withdrawal	
	26/05/2009	RC	Document Steering Group Provider Management Board Trust Board	Reviewed to take into consideration recent organisational changes and inclusion of Standard Operating Procedures
	10/05.2010	KB SL	Policy & NHSLA Group Assurance Committee Trust Board	Reviewed to take into consideration recent organisational changes
	20/01/2012	SL RT	Policy & NHSLA Steering Group	Biennial review
	31/03/14	SL RT	Policy & NHSLA Steering Group	Biennial review
	01/03/2016	Rachel Cheal	Policy Steering Group	Complete policy review following expiry.
	08/12/2016	Rachel Cheal		Amendment to Policy Template to ref: Equality, Diversity and Human Rights Policy
	30/08/2017	Rachel Cheal	Policy Steering Group	Amendment to include requirement to notify if a service cannot comply with policies (and associated Appendix 5). Minor other updates re: job titles
16	25/11/2019	Rachel Cheal		Amended re: ratification routes from Assurance Committee to TMT and reference to EIA completion. Amended EIA template.
17	19/03/2020	Rachel Cheal	Policy Steering Group	Updated Appendix 5 – EIA template included, following agreement at Feb 2020 PSG meeting to amend
18	15/07/2020	Rachel Cheal	Policy Steering Group	Updated title: Associate Nurse Director. Added policy checklist to Appendix 1 – Policy Template. Amended ratification route from TMT to Management Meeting

Amendments Summary:

Amend No	Issued	Page	Subject	Action Date
1	Feb 2018	17	Amended standard Scope wording as agreed at the PSG Jan 2018	Feb 2018
2	Feb 2018	19	Amended EIA template as agreed at the PSG Jan 2018	Feb 2018
3	Nov 2018		Deletion of term 'Governor' from Scope wording	Nov 2018 (Version 14)
4	April 2019	5	Amended location of term 'bank staff' within scope wording	April 2019

SUMMARY OF POLICY

Policies must follow a **standard format** and in some sections contain standard wording - a template is available (see **Appendix 1**).

All policies must be **developed in consultation** with others/key subject matter experts before being reviewed by the **Policy Steering Group**. The Policy Steering Group, a multidisciplinary group including corporate (which includes Human Resources and staff-side representation) as well as clinical representation, will ensure that the standard policy template has been followed. The Group will approve policies and recommend ratification by the Assurance Committee.

For **Standard Operating Procedures /Guidelines**, whilst there is no set format for the content, a template guide is available (see **Appendix 2)**.

All procedural documents, regardless of type, must consider equality, diversity and inclusion issues. An **Equality Analysis and Equality Impact Assessment** must be completed for all policies **(Appendix 5).**

For queries relating to policies, please liaise with:

Corporate Support Administrator (Policy Steering Group administrator and maintains the Policy Register)
Associate Director of Corporate Affairs and Company Secretary (Policy Steering Group Chair)
Associate Nurse Director (Policy Steering Group Deputy Chair)

For queries relating to SOPs please liaise with:

Associate Nurse Director

POLICY FOR THE DEVELOPMENT AND IMPLEMENTATION OF PROCEDURAL DOCUMENTS

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POLICY FOR THE IMPLEMENTATION AND DEVELOPMENT OF PROCEDURAL DOCUMENTS

1. INTRODUCTION AND PURPOSE

1.1 Organisations need formal written documents which communicate standard organisational ways of working. These help clarify strategic, regulatory and operational requirements and bring consistency to day to day practice.

1.2 A common format and approval structure for such documents helps to reinforce corporate identity and, more importantly, helps to ensure consultation (and not isolation) and reflect national, organisational and best practice approaches.

2. SCOPE AND DEFINITIONS

2.1 This policy applies to locum, permanent, and fixed term contract employees (including apprentices) who hold a contract of employment or engagement with the Trust, and secondees (including students), volunteers (including Associate Hospital Managers), bank staff, Non-Executive Directors and those undertaking research working within Solent NHS Trust, in line with Solent NHS Trust's Equality, Diversity and Human Rights Policy. It also applies to external contractors, agency workers, and other workers who are assigned to Solent NHS Trust.

2.2 All policies must follow the template provided in Appendix 1 which includes the standard required wording.

2.3 As the content of Standard Operating Procedures and Guidelines can be varied, there is no strict format however the template in Appendix 2 can be used to ensure a standard approach.

2.4 For the purposes of this Policy, the term "procedural document" refers to (and therefore this Policy applies to) the following document types:

Type	Definition
Policy	• A policy is a specific statement of principles • It formally documents a Trust approved standard or procedure, often based on statutory legislation and/or NHS mandatory objectives that must be followed, • Non-compliance could expose the Trust and its staff to unacceptable risk. • An effective policy should therefore describe **what** is to be achieved by **whom**. Trust wide policies can only be authorised by the Trust board or a subcommittee of the Board with specific delegated authority.
Procedure/ Standard Operating Procedure (SOP)	• A procedure often supports a policy in that it sets out a series of steps that must be followed to deliver specific aspects of the policy. • Procedures can usually be mapped using a flowchart. • An effective procedure should describe **how** to achieve the required standards. • It provides individuals with information to perform a task properly and facilitates consistency in the quality and integrity of an end result. • A procedure/SOP specifies **what** should be done, **when**, **where** and by **whom**.

Guidance/ Guidelines	• Guidance/Guidelines are a general rule, principle or piece of advice • A 'clinical guideline' is an evidence-based statement used to assist clinicians in the decision making process for the diagnosis, interventions, timescales and expected outcomes for appropriate management of a specific condition • Where possible, Trust staff are asked to follow guidelines, but there may be instances where professional judgement may differ from guidance. In these cases, Trust staff must record (either within clinical notes if a clinical issue or in minutes of meetings if a corporate/operational issue) where they have not followed the Trust approved guidance, outlining the rationale for doing so.

2.5 The following terms are also defined.

Document Manager	• The person who is the author / subject matter expert • The person who is responsible for reviewing/revising the document • The person who responsible for ensuring the document is • implemented
Document Sponsor	• The Executive Lead who has overarching accountability for the document

3. DEVELOPING A NEW DOCUMENT

3.1 All documents must follow the below checklist:

☑ Check there isn't a **similar/same document** already in existence beforehand

☑ Use the **templates** (Appendix 1 for Policies, Appendix 2 for SOPs/Guidelines)

☑ Use a minimum font **size 11 calibri** and be concise and clear, using unambiguous terms and language.

☑ **Number all sections** sequentially including paragraphs and Appendices.

☑ Include a **footer** (title of the document, the page numbers and number of pages and version number)

☑ **Abbreviations** – only to be used after the first full reference and include a **glossary** at the end of the document.

☑ Pay special consideration to **Adult & Child safeguarding issues, mental capacity** and **information governance**

☑ **Consultation** – key groups/individuals consulted with must be referenced, including the name and date of where a group agreed the document.

☑ **Training** – any training needs to implement the policy/procedure and any on-going training commitments must be considered in consultation with the Learning & Development Team.

☑ **Resource implications** – consider any resource implications for your policy to be implemented successfully. Ensure that the relevant parties have been consulted with, for example, the finance team, and agreement reached if funding is required.

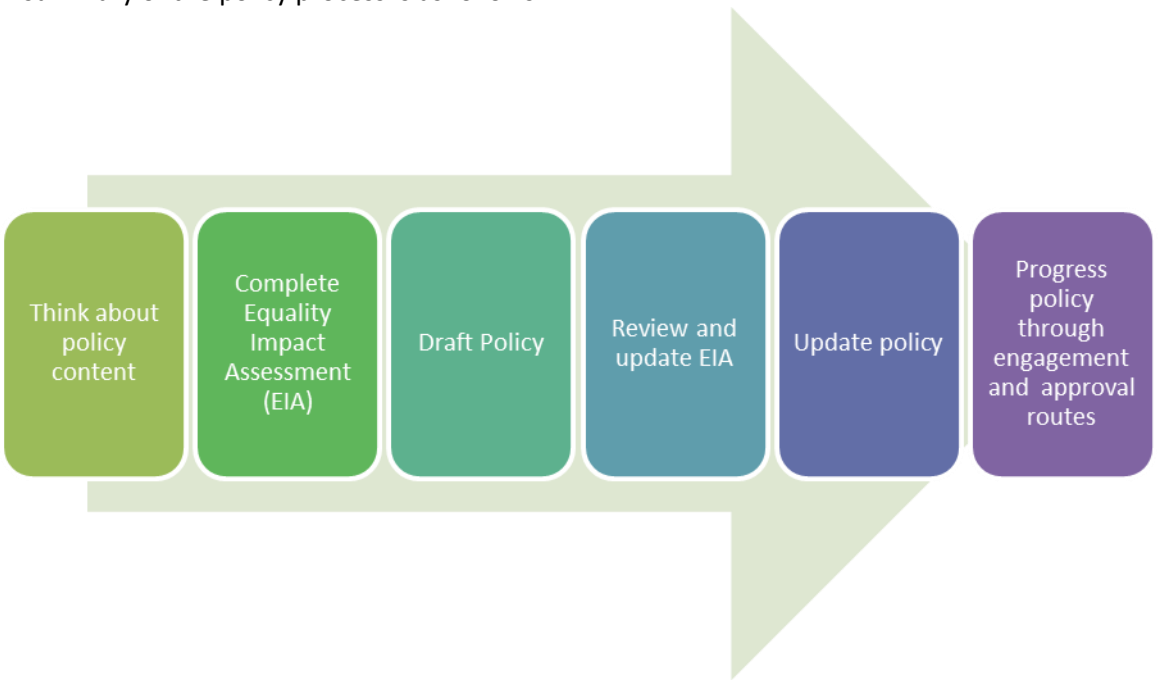
☑ Consider **version control** even during drafting - Once approved for the first time the policy will be known as version 1. As the policy is subsequently reviewed and re-approved the version number will be advanced (e.g. version 2). Policies under development or review will have a draft number against 'version' (e.g. version 2, draft 1).

☑ **Equality Analysis and Equality Impact Assessment (EIA)**–
The EIA is an assessment of a proposed organisational policy or service change, in conjunction with the Equality Act 2010 and to narrow the health inequalities that exist between people across the protected characteristics. As well as being a legal requirement, the EIA is also an opportunity to ensure that we make better decisions based on robust evidence.
An EIA must be completed for all policies. Policy authors will be required to submit a copy of their EIA together with the policy for presentation to the Policy Steering Group and for onward ratification. The EIA should be completed at the beginning of the policy process and revisited regularly throughout the policy development to ensure considerations are incorporated. A summary of the process is illustrated below.

☑ For **joint documents** - it will be necessary to include the logo for the partner organisation on the left hand side of the front cover. It should be noted that joint documents will require approval/ratification by all partner organisations concerned prior to implementation.

☑ For **external policies** – (such as Department of Health or other national body policies) these do not need to be rewritten if the organisation is intending to adopt them without change. However, a front cover sheet, as per the first page of Appendix 1, should be attached to the beginning of the document to support appropriate ownership within the organisation for regular review.

A summary of the policy process is as follows:



4. UPDATING EXISTING DOCUMENTS

4.1 All documents must follow the below checklist:

- ☑ All documents must be **reviewed within the stipulated timescales** to take into account changing circumstances, including regulation changes. Policies must be reviewed within a three year period.

- ☑ The updated document will be allocated the **next sequential version number** and the previous version must be removed from the intranet and archived.

- ☑ Document Managers should ensure that any **references or hyperlinks** used within the document are still relevant and current

- ☑ For policies;
  - All policies must be **represented** to the Policy Steering Group **for re-approval.**
  - If there are **non-material changes only** (e.g. minor changes that do not impact on the content of the policy) it may not be necessary for the policy to go through the full approval route again –in which case **liaise with the Chair of the Policy Group.**

- ☑ **Highlight any changes** made in the policy so that people reviewing / approving the changes can clearly see the difference(s) from the original version. (Once approved ensure any highlights / tracked changes are removed and a 'clean' copy is published).

5. APPROVAL ROUTES

5.1 The following summarises approval routes.

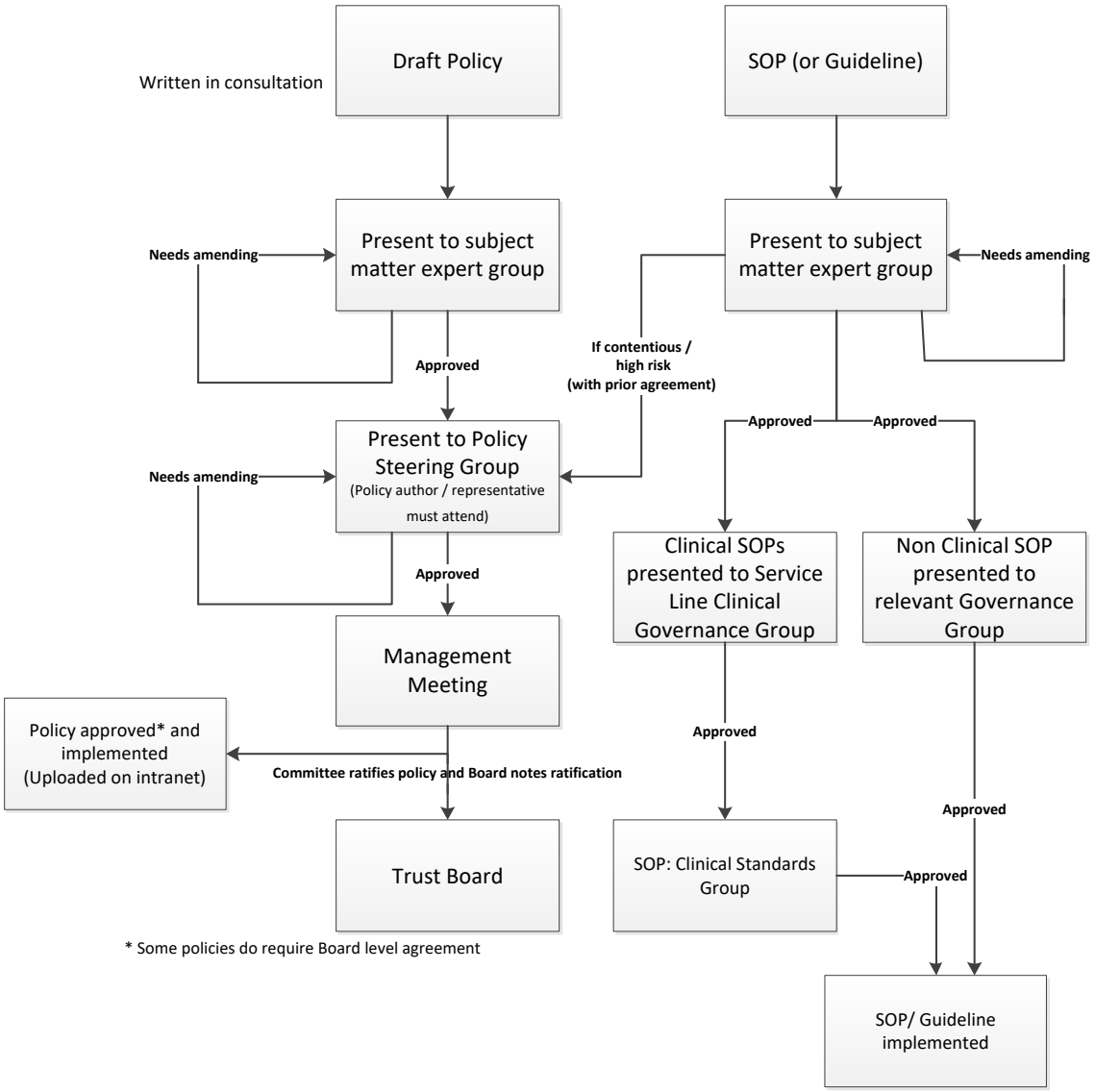
5.2 Whislt it is not necessary for SOPs/ Guidelines to be reviewed and approved via the Policy Steering Group, it may be appropriate for contentious or high risk documents to be considered by the Group, with prior agreement or referral from another Committee. In such cases, document managers are asked to seek clarification/liaise with the Policy Steering Group Chair/Deputy Chair.

5.3 For SOPs:

- Clinical SOPs must be presented to the Clinical Standards Group

- Non Clinical SOPs must be presented via the appropraite local governancce route (the AD Corporate Affairs and Company Secretary can advise where appropriate).

Policy approval routes



5.4 The policy author or their representative must attend the Policy Steering Group meeting to present the policy.

5.5 It is acknowledged that due to timing there may be occasions when it is necessary to take 'Chairs action' on policies by the Chair/Deputy Chair of the PSG and the Management Meeting. Where this occurs this will be reported into the next Management Meeting.

6. PROCESS AFTER APPROVAL

6.1 Once a policy is ratified, the Policy Steering Group Administrator will:

☑ Notify the document manager and request that they provide a summary (no more than 3-4 bullet points) to assist in the communication of the policy and to identify any key changes to staff where the policy has been revised/amended.

☑ Notify the communications team –who will include an item in the next issue of Staff News

☑ Arrange for the policy to be uploaded onto SolNET (the Trust's internal intranet)

☑ Contact the policy author to check the policy is appropriate for uploading on the Trust's public website. The default position will be that policies are assumed to be available to the public (and requested under FOI) unless there is a justifiable reason why this should not be the case under FOI exceptions

☑ Archive any previous approved versions of the policy and make appropriate arrangements to withdraw from circulation

☑ Update the Policy Register/Log

7. DOCUMENT CONTROL AND ARCHIVING

7.1 Under the HSC 1999/053 and the Document Retention Schedule, all policies must be retained for permanent preservation. It is, therefore, the responsibility of the Document Manager to ensure previous versions are appropriately archived electronically in a central/accessible location (which is accessible to the wider service team and not just in a restricted folder owned by the individual).

7.2 It is paramount that Document Managers or another responsible person ensures appropriate communication of any amended documents or revisions to the relevant service areas within the organisation.

7.3 Any subsequent versions should be documented on the front cover and a new version number must be given to the document for tracking and audit purposes.

7.4 All policy documents are listed on the Policy Register, maintained and kept up to date by the Policy Steering Group administrator.

7.5 The Policy Steering Group administrator will allocate a unique identifier to each new document created. All versions of documents on the same subject will keep the same unique identifier, with a different version number being used for each update.

8 DEFUNCT/OBSELETE POLICIES

8.1 On some occasions, policies become defunct/obsolete and are no longer required (e.g. replaced by a different document altogether). In such circumstances there must be clear justification made as to why the policy is to be withdrawn.

8.2 Policy authors must provide a reason to the Chair of the Policy Group. The Policy Administrator will then log this and keep a record of the last version of the published policy. Policy authors must also archive the policy within their agreed local filing area.

9. ROLES AND RESPONSIBILITIES

9.1 Chief Executive

9.1.1 The Chief Executive has ultimate accountability for the strategic and operational management of the organisation, including ensuring all policies are adhered to. Operational accountability for policy management is delegated to the Associate Director of Corporate Affairs and Company Secretary.

9.2 Document Sponsor (Executive Lead)

9.2.1 The Document Sponsor is responsible for ensuring that:

- A Document Manager (Author) has been identified to carry out regular review and revision of the document
- Documents originating from their areas of responsibility are reviewed within the stipulated timescales

9.3 Document Managers

9.3.1 Document Managers are responsible for ensuring the following:

- That documents they are responsible for (as determined by their role) are appropriately developed in consultation, reviewed and maintained
- That an EIA has been completed for each policy
- That the policy is appropriately communicated with the relevant staffing groups
- That documents are uploaded to and accessible on the intranet and that the Policy Administrator is informed as to whether the policy is appropriate to be uploaded onto the public website
- Policies that they are personally responsible for are formally approved following the correct procedures
- That all documents follow the corporate format
- That the implementation and effectiveness of the document is monitored and evidenced
- That justification is given to any obsolete or defunct policies

9.4 The Policy Steering Group Administrator

9.4.1 The Policy Steering Group Administrator is responsible for the following tasks including:

- Maintaining the Policy Register
- Liaising with the meeting secretaries of the Management Meeting and the Board as appropriate.
- Checking with the Document Author that amendments at approval have been actioned
- Issuing a review reminder to a Document Manager three months prior to review date and escalating policies that have expired to the Policy Steering Group Chair as appropriate
- Uploading the policy, after approval onto the intranet and public website as appropriate
- Providing a summary of policies ratified by the Trust Management Team to the Communications Team for inclusion in the next staff wide communication
- Archiving previous approved versions of documents and taking necessary steps to remove these from circulation
- Maintaining a log of service policy non-compliance (in accordance with section 10.3)

10. TRAINING

10.1 There are no specific training requirements in respect of this policy. However, managers may request advice from the Chair of the Policy Steering Group and / or the Policy Steering Group administrator on request.

11. SUCCESS CRITERIA / MONITORING COMPLIANCE – INCLUDING NON-COMPLIANCE

11.1 Compliance with Solent NHS Trust Policy is a requirement of staff contracts. Non-compliance, other than that in the following section and reported as such, may result in disciplinary action.

11.2 Individual's non-compliance with policy

Non-compliance introduces risk for the individual, organisation and service user. In rare circumstances, if staff members are **unable** to follow Trust policies, as the policy requirements cannot be applied in a specific set of circumstances, this must immediately be reported to the Line Manager who must consider what remedial steps will be taken to manage risk. The Non-Compliance Form (Appendix 3) must be completed. This may prompt an early review of the policy.

11.3 Service non-compliance with policy

On occasions, it may not be possible (for example due to differing commissioning models and requirements) for services to comply with a Trust Policy. In such cases the Policy Steering Group Chair must be informed and the details must be logged centrally (the log is held by the Policy Steering Group administrator). Where a service cannot comply, a clear justification must be provided and alternative practice (for example, the development of a SOP) must be implemented – such practice must be developed in conjunction with and with approval of the Policy Document Manager and / or Subject Matter expert. The Non-Compliance Form (Appendix 4) must be completed.

11.4 With regard to this policy, the Policy Steering Group are responsible for ensuring compliance with this policy and the template in Appendix 1. Policies not conforming will be rejected and asked to be represented prior to approval.

12. REVIEW

12.1 This document may be reviewed at any time at the request of either staff side or management, but will automatically be reviewed 3 years from initial approval and thereafter on a triennial basis unless organisational changes, legislation, guidance or non-compliance prompt an earlier review. This policy will remain in force until such time as a new one is formally agreed. (An EIA has been completed for this policy and is held separately by the AD of Corporate Affairs)

13. LINKS TO OTHER DOCUMENTS

- Disciplinary Policy
- Equality, Diversity, Inclusion & Human Rights Policy
- Deprivation of Liberty Safeguards and Mental Capacity Act Policy