Mersey Care NHS
NHS Trust

TRUST-WIDE NON-CLINICAL POLICY DOCUMENT

POLICY ON POLICIES

Policy Number:	**SA01**
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Recommending Committee:	**Policy Group**
Appproving Committee:	**Executive Committee**
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Lead Author(s):	**Trust Secretary**

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2015 – Version 1

Quality, recovery and wellbeing at the heart of everything we do

Mersey Care NHS Trust

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POLICY ON POLICIES

Further information about this document:

Document name	**Policy on Policies (SA01)**
Document summary	**This document details the process to be used when developing / reviewing and approving Mersey Care policy documents (policies, procedures, standard operating procedures and guidelines)**
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Published by Copies of this document are available from the Author(s) and via the trust's website	**Mersey Care NHS Trust** **8 Princes Parade** **Princes Dock** **St Nicholas Place** **Liverpool** **L3 1DL** **Your Space Extranet: http://nww.portal.merseycare.nhs.uk** **Trust's Website www.merseycare.nhs.uk**
To be read in conjunction with	**Standing Orders (F01)** **Standing Financial Instructions (F02)** **Scheme of Reservation and Delegation (F03)** **Induction and Mandatory Training Policy (H228)** **Policy Template (SA01A)** **Policy Checklist (SA01B)** **Trust Policy Schedule (SA01C)** **Divisiional Policy Schedules** **Document Control Procedure (SA01D)** **Equality & Human Rights Analysis (SA01E)**
This document can be made available in a range of alternative formats including various languages, large print and braille etc	

Version Control:

		Version History:
Consultation Draft	Circulated to Stakeholders for Comment	22 January 2015
Approval Draft	Presented to the Executive Committee for Approval	19 February 2015
2015 – Version 1	Version Place on the Trust's Website	2 March 2015

SUPPORTING STATEMENTS – this document should be read in conjunction with the following statements:

SAFEGUARDING IS EVERYBODY'S BUSINESS

All Mersey Care NHS Trust employees have a statutory duty to safeguard and promote the welfare of children and vulnerable adults, including:

- being alert to the possibility of child/vulnerable adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child/vulnerable adult;
- knowing how to deal with a disclosure or allegation of child/adult abuse;
- undertaking training as appropriate for their role and keeping themselves updated;
- being aware of and following the local policies and procedures they need to follow if they have a child/vulnerable adult concern;
- ensuring appropriate advice and support is accessed either from managers, *Safeguarding Ambassadors* or the trust's safeguarding team;
- participating in multi-agency working to safeguard the child or vulnerable adult (if appropriate to your role);
- ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to Mersey Care NHS Trust policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation;
- ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session

EQUALITY AND HUMAN RIGHTS

Mersey Care NHS Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the *protected characteristics* of age, disability, gender, race, religion or belief, sexual orientation and transgender. The Equality Act also requires regard to socio-economic factors including pregnancy /maternity and marriage/civil partnership.

The trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer. The trust believes that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discriminatory practices.

Mersey Care NHS Trust also is aware of its legal duties under the Human Rights Act 1998. Section 6 of the Human Rights Act requires all public authorities to uphold and promote Human Rights in everything they do. It is unlawful for a public authority to perform any act which contravenes the Human Rights Act.

Mersey Care NHS Trust is committed to carrying out its functions and service delivery in line the with a Human Rights based approach and the FREDA principles of **F**airness, **R**espect, **E**quality **D**ignity, and **A**utonomy

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1 PURPOSE AND RATIONALE

1.1 **Purpose** – to explain the roles, responsibilities and process for the development, review, approval, dissemination, version control and monitoring of all Mersey Care NHS Trust policy documents (as defined in section 4 below)

1.2 **Rationale** – in order to be considered as a well-led organisation with robust governance systems the trust needs to be able to demonstrate that it has a clearly described process for the development of new / review of existing policies, procedures, standard operating procedures and guidelines which ensures that staff undertake their duties in a safe and effective way that takes account of statute and guidance.

1.3 All trust policy documents must include a 'purpose' and 'rationale'.

2 OUTCOME FOCUSED AIMS AND OBJECTIVES

2.1 All trust policy documents must clearly describe the aims and objectives to be achieved as a result of the development and approval of the document, which in turn will assist with the monitoring and review of the document to ensure it is effective.

2.2 For this *Policy on Policies* the aims and objectives are as follows

(a) to ensure all new documents are developed in accordance with this guidance and are formatted in accordance with the *Policy Template*, with effect from 2 March 2015;

(b) to ensure all documents subject to review are updated in accordance with this guidance and are formatted in accordance with the *Policy Template*, with effect from 2 March 2015;

(c) to ensure that all policy documents are subject to an audit against their *Policy Monitoring Checklist* during their *Life Cycle* (see section 9 below);

(d) to ensure 95% of documents requiring review are reviewed, approved and disseminated by their review date and that the remaining 5% of documents are reviewed, approved and disseminated within 3 months of their review date;

(e) to ensure, where appropriate, that divisional and ward / service documents do not contradict trust-wide documents;

(f) to ensure that staff continue to have access to the most up-to-date and relevant documents either through the trust's website / intranet / sharepoint (where appropriate) and through local systems (i.e., divisional sharepoint);

(g) to ensure that trust-wide policy documents are referenced on the *Trust Policy Schedule* and that copies are held in the trust's policy document file maintained by the Corporate Governance Team with effect from 2 April 2015;

(h) to ensure that divisional and ward / service based policy documents are referenced on *Divisional Policy Schedules* and that copies are held in the division's policy document file maintained by each of the 3 divisions with effect from 2 April 2015.

2.3 All policies, procedures, standard operating procedures and guidelines must adhere to the requirements set out in this document and its supporting documents (see section 13 below).

3 SCOPE

3.1 As a **trust-wide non-clinical** document, this *Policy on Policies* applies to all staff employed by Mersey Care NHS Trust (whether on a permanent or temporary contract) who are involved in writing or reviewing policy documents.

3.2 The *Policy on Policies* and its supporting documents should be used by all **Lead Authors** who are responsible for developing new / reviewing existing policies, procedures, standard operating procedures and guidelines for any document – whether clinical or non-clinical, affecting the whole or part of the trust.

4 DEFINITIONS

4.1 The trust has three types of documents which operate across four different levels (generically these are referred to as **policy documents**):

Table 1: Types and Levels of Policy Documents

Type of Policy Document		
Policy	A statement of the overall aims, objectives and principles that underpin a practice	A set of mandatory or necessary actions / requirements that must be followed by staff
Procedure (Standard Operating Procedure)	A description of a process in support of the actions which underpin a practice	
Guidance	A description of recommended action(s) or 'best practice' to inform a way of working	
Level of Policy Document		
Trust-wide Clinical document	Policies, procedures, guidance that refer to the application of clinical practice by staff, which are applicable across the whole of Mersey Care	
Trust-wide Non-clinical document	Policies, procedures, guidance that refer to the application of non-clinical practice by staff, which are applicable across the whole of Mersey Care	
Divisional document	Policy documents, procedures, guidance that refer to the application of clinical or non-clinical practice by staff specifically working in one of Mersey Care's three divisions *(Note – has to align with practice outlined in trust-wide documents)*	
	Continued on the next page	

Level of Policy Document	
Ward / Service based document	Policy documents, procedures, guidance that refer to the application of clinical or non-clinical practice by staff specifically working on a ward (location) or a specific service in one of the two Clinical Divisions *(Note – has to align with practice outlined in trust-wide / divisional documents)*

4.2 A policy sets out what you must know or do, a procedure tells you how it must be done and guidance tells you how it may be done. The *level of document* tells you where the document has to be applied in the trust.

5 DUTIES

5.1 **Trust Board** - the Trust Board has responsibility for ensuring robust documentation describing the governance arrangements for approving strategy and policy documents, which are described in the trust's *Standing Orders*, *Standing Financial Instructions* and *Scheme of Reservation and Delegation*. The Trust Board has delegated responsibility for the recommending or approving certain policy documents to trust committees. A detailed list of responsibility for approving trust-wide policy documents can be found in the *Trust Policy Schedule*, whilst details about divisional and ward / service based policy documents can be found in the relevant *Divisional Policy Schedule*.

5.2 **Lead Executive Director** – each and every policy document must have a *Lead Executive Director* who is accountable for:

(a) the identification, review, endorsement, implementation and monitoring of the relevant policy documents (i.e., those policy documents relevant to their executive portfolios - a list of the executive leads can be found in the relevant *Policy Schedule*);

(b) overseeing the work of the *Lead Author(s)*;

(c) approving the progression of the policy document through the various stages of approval (outlined in section 6 below);

(d) where a policy document needs Trust Board / Board Committee approval[1], to produce a report seeking approval.

For the purpose of this *Policy on Policies* the executive lead is the Executive Director of Communications and Corporate Governance.

5.3 **Lead Author(s)** – the member(s) of staff responsible for writing, reviewing and auditing the policy document in accordance with this *Policy on Policies* and its supporting documents. Acting in support of the Lead Executive Director, the lead author(s) are responsible for:

[1] With the exception, normally, of policy documents sent to the Executive Committee.

(a) on behalf of the Lead Executive Director, overseeing the process for approving and ratifying policy documents as described in section 6 below;

(b) developing / updating draft (working) policy documents, taking account of trust strategy, other trust policy documents, commissioning requirements, statutory requirements and relevant evidence-based practice and guidance;

(c) consulting as appropriate with service users / carers, staff and other stakeholders in the development / review of the document;

(d) in respect of trust-wide policy documents, attending the Policy Group to discuss their policy document;

(e) providing copies of all policy documents to the Trust Secretary / Corporate Governance Team (once they have been finally approved and issued);

(f) developing an action plan for the implementation of the policy document and overseeing the monitoring of that implementation action plan (although responsibility may be delegated to other parts of the trust's governance and management structures);

(g) undertaking a training needs analysis, in conjunction with the appropriate executive director and the Education Governance Committee (where appropriate);

(h) undertaking the impact assessment for the policy document, using the *Equality and Human Rights Analysis* tool in the supporting documents (see section 10 below)

(i) at the appropriate stage in the *Life Cycle* of the policy document, undertaking an audit against the *Policy Monitoring Checklist* (see section 9 below).

For the purpose of this *Policy on Policies* the Lead Author is the Trust Secretary.

5.4 **Executive Committee** – the role of the Executive Committee in respect of policy development is as follows:

(a) approves the *Policy on Policies*;

(b) approves the *Trust Policy Schedule*, taking account of the trust's *Standing Orders*, *Standing Financial Instructions* and *Scheme of Reservation and Delegation*;

(c) as defined in the *Trust Policy Schedule*, recommends / approves trust-wide clinical and non-clinical policy documents;

(d) receives a regular report from the Policy Group in respect of trust-wide clinical and non-clinical audit policy documents showing:

(i) the trust-wide policy documents it needs to recommend / approve,

(ii) the trust-wide policy documents that have yet to be approved by their review date,

(iii) whether or not audits against the *Policy Monitoring Checklist* have been undertaken for trust-wide policy documents;

(e) receives assurance (through their minutes) that in respect of divisional and ward / service based policy documents the appropriate Divisional Governance Board has:

(i) approved the policy document within the review dates,

(ii) ensured that the audit against the Policy *Monitoring Checklist* has been undertaken;

(f) approves the terms of reference for the Policy Group.

5.5 **Committees, Sub Committees and Other Groups (Governance Arrangements)** – the relevant committee / group within the trust's governance arrangements has responsibility:

(a) to undertake the detailed scrutiny of new and reviewed policy documents;

(b) for making comments and suggestions to the Lead Author(s) as necessary, which must be minuted;

(c) as specified in the *Policy Schedule*, to ensure that the committee / group either recommends or approves the policy document;

(d) as specified in the policy document, developing the implementation plan / managing the implementation of the policy document (particularly relevant for Divisional Governance Boards).

For the purpose of this *Policy on Policies* the Policy Group is responsible for recommending approval of this policy document to the Executive Committee.

5.6 **Divisional Governance Boards** – to clarify, in respect of divisional and ward / service based policy documents the relevant Divisional Governance Board has the following responsibility in addition those described in paragraph 5.5 above:

(a) approving the *Divisional Policy Schedule* (which shows the same information as the *Trust Policy Schedule* for the policy documents it has responsibility for);

(b) approving the relevant divisional and ward / service based policy documents;

(c) receive assurance (including action plans where required) on the completion of audits by Lead Author(s) against the *Policy Monitoring Checklist*;

(d) identifying an officer(s) – a *Divisional Lead for Policy Development* - who oversees the *Divisional Policy Schedule* and policy development work within their division;

5.7 **Policy Group** – the Policy Group (a sub-committee of the Executive Committee) has its membership drawn from across the trust and is chaired by the Trust Secretary, oversees part of the trust-wide policy document approval process and is responsible for:

(a) on behalf of the Executive Committee, undertaking detailed scrutiny of trust-wide policy documents to ensure they meet the requirements set out in the *Policy on Policies* and supporting documents;

(b) considering all *Policy Schedules* to ensure no duplication of policy documents and advise whether a policy document contradicts any existing trust-wide policy documents;

(c) monitoring compliance against the Policy Schedules, including the audits against the *Policy Monitoring Checklist*.

5.8 **Trust Secretary** – is responsible for the development and review of the Policy on Policies (and supporting documentation) and for chairing the Policy Group. Supported by the **Corporate Governance Team** the Trust Secretary also has responsibility for:

(a) as chair of the Policy Group, to report to the Executive Committee in respect of those trust-wide policy documents:

(i) which require Executive Committee approval,

(ii) that have yet to be approved by their review date,

(iii) whether or not audits against the *Policy Monitoring Checklist* have been undertaken;

(b) maintaining the *Trust Policy Schedule*;

(c) dissemination of all trust-wide policy documents through the trust's website / intranet / sharepoint (where applicable) and ensure reference of any changes is made in the weekly staff bulletin once final approval has been given;

(d) ensuring all trust-wide policy documents are retained and held on the trust's policy file;

(e) ensuring only up-to-date trust-wide policy documents are made available to staff, archiving / removing out-of-date documents from the trust's website / intranet;

(f) notifying Lead Author(s) when their trust-wide policy document needs to be reviewed (i.e., at least three months before the review date);

(g) notifying Lead Author(s) when their trust-wide policy document needs to have its audit against the Policy Monitoring Checklist (i.e., at least three months before the required date);

(h) providing advice and support on the implementation of this policy and the development / review of policy documents.

5.9 **Divisional Lead for Policy Development** – each division needs to identify an officer(s) which has responsibility for:

(a) maintaining the *Divisional Policy Schedule*;

(b) dissemination of all relevant divisional and ward / service based policy documents through the division's website / intranet / sharepoint / other systems (where applicable) and ensure reference of any changes is made in the weekly staff bulletin once final approval has been provided;

(c) ensuring all relevant divisional and ward / service based policy documents are retained and held on the trust's policy file;

(d) ensuring only up-to-date divisional and ward / service based policy documents are made available to staff, archiving / removing out-of-date documents from the division's website / intranet / sharepoint / other systems;

(e) notifying Lead Author(s) when their divisional and ward / service based policy document needs to be reviewed (i.e., at least three months before the review date);

(f) notifying Lead Author(s) when their relevant divisional and ward / service based policy document needs to have its audit against the Policy Monitoring Checklist (i.e., at least three months before the required date);

5.10 **Divisional / Ward / Service Managers** – are responsible for:

(a) ensuring that they and their staff comply with policy documents;

(b) where delegated, for the development, implementation and monitoring of action plans;

(c) ensuring that relevant staff are notified about the introduction of new / updated policy documents through team briefs.

5.11 **Equality and Human Rights Team** – the team will support authors in conducting an equality analysis and ensuring the equality analysis tool is appropriate and up-to-date.

5.12 **Line Managers** - are responsible for ensuring up-to-date policy documents are accessible to all their staff, ensure staff have read and understood these documents (that are relevant to their role) and ensure their staff training needs are identified on implementation of new and updated policy documents.

5.13 **All Staff** - staff (temporary, permanent, bank and agency) must ensure that their practice is in line with current policies, procedures and guidelines relevant to their area of work.

6 PROCESS OF RECOMMENDING / APPROVING POLICY DOCUMENTS

6.1 The Trust Board requires robust documentation describing the governance arrangements for approving policy documents. In support of the trust's *Standing Orders*, *Standing Financial Instructions* and *Scheme of Reservation and Delegation* the relevant *Policy Schedules* provides a detailed list of those elements of the trust's governance and management arrangements are responsible for the recommendation / approval of policy documents.

6.2 The following diagrams outline:

(a) the process for new / reviewed policy documents (see **Figure 1**);

(b) in detail, further information on Step 3 of this process – specifically which committee either recommends the approval / approves a policy document (see **Figure 2**).

6.3 Prior to embarking of a full review of an existing policy the Lead Author(s) has to identify the process to be used, dependent upon the **type of change** intended (see Table 2 below):

Table 2: Types of Changes to Policy Documents

Type	Definitions	Process
Minor Change	These are changes which don't impact on the practice / staff responsibilities. They normally relate to changes to staff titles, committee names or review dates (where a review has highlighted no major changes are required)	Lead Executive Director sign off amendment. Approving / ratifying committee and staff notified of change
Major Change	Changes which impact on the practice being used or staff responsibilities (e.g., new responsibilities, changes to forms used etc)	Required to use the full review process shown in Figure 1
Not Required	Policy no longer required due to changes in internal / external processes or statute	Lead Executive Director sign off withdrawal amendment. Approving / ratifying committee and staff notified of withdrawal

6.4 Subject to the approval of the Executive Committee, other types of *minor change* may be implemented where a particular type of change is being made to all or a range of trust-wide, divisional or wards / service based policy documents (e.g., where executive portfolio changes are made).

Figure 1 – Process for new / reviewed policy documents

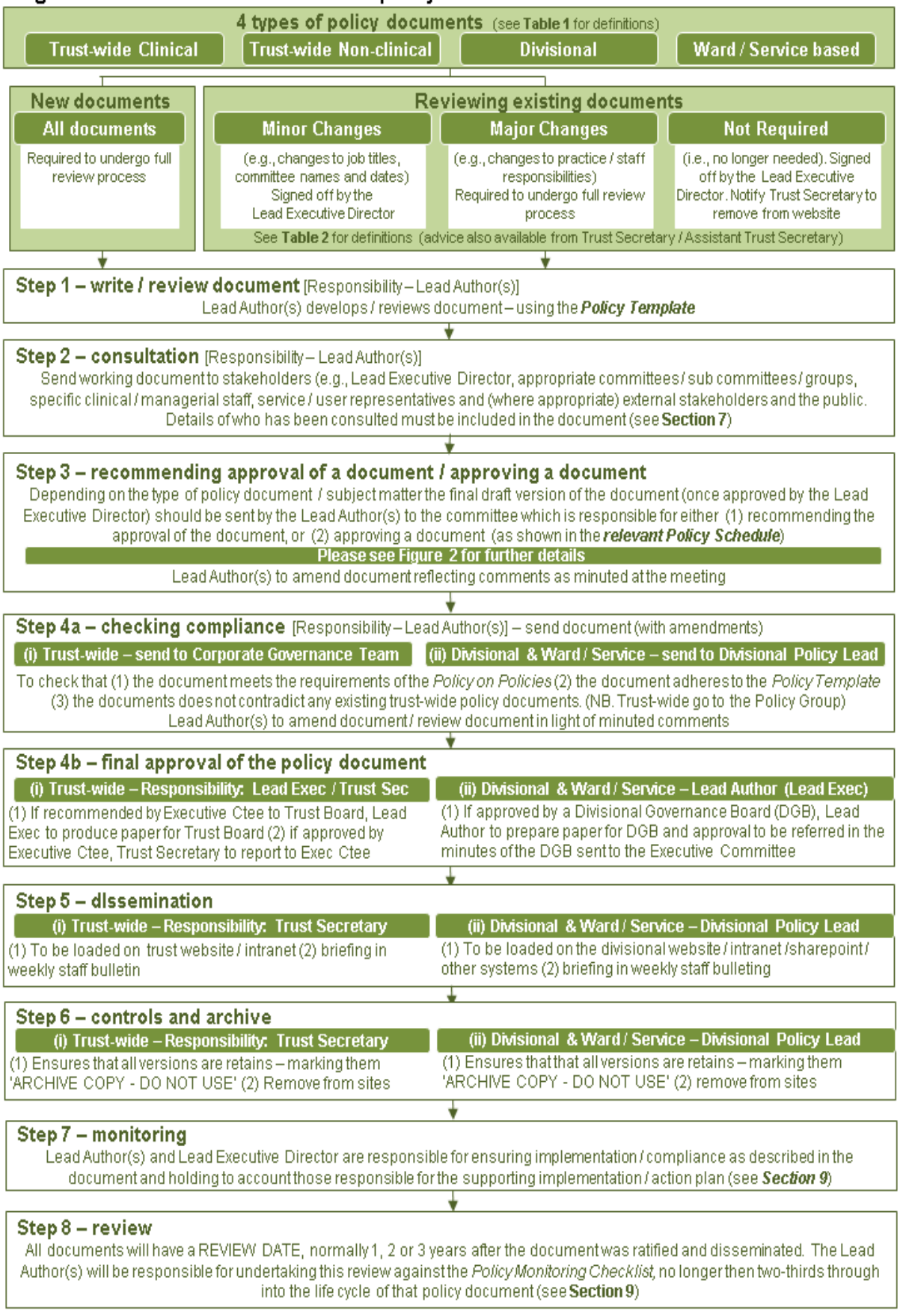

Figure 2 – Further details on Step 3 – recommending approval of a document / approving a document (see Figure 1)

Step 3 – recommending approval of a document / approving a document

Depending on the type of policy document / subject matter the final version of the document (once approved by the Lead Executive Director) should be sent by the Lead Author(s) to the committee which is responsible for either (1) recommending the approval of the document, or (2) approving a document (as shown in the Policy Schedule)

Please see Figure 2 for further details

Lead Author(s) to amend document reflecting comments as minuted at the meeting

The table below outlines which committees are responsible for either approving or recommending the approval of the different types of policy at a high level – together with the committee responsible for final approval of the policy documents. Detailed information on policy documents be found either in the 'Trust Policy Schedule' or the relevant 'Divisional Policy Schedule'

Type of document	Approving a document (A) / Recommending a document (R)	Final Approval of the Policy Document (Step 4b)
Trust-wide Clinical Documents		
Clinical Practice	Patient Safety Committee (A)	Executive Committee
Infection Prevention & Control	Infection Control Sub Committee (A)	Executive Committee
MHA - Governance	MHA Managers Committee (R)	Trust Board
MHA – Other documents	MHA Managers Committee (A)	Executive Committee
Medicines Management	Drugs & Therapeutics Committee A)	Executive Committee
Safeguarding	Safeguarding Strategy Group (A)	Executive Committee
Trust-wide Non-clinical Documents		
Strategies / Plans	Executive Committee (R)	Trust Board
Governance and Risk	Executive Committee (R)	Trust Board
Health & Safety - Overarching	Health & Safety Committee (R)	Trust Board
Health & Safety - Other	Health & Safety Committee (A)	Executive Committee
HR / Workforce	Human Resources Policy Group (A)	Executive Committee
Equality & Diversity	Human Rights & Equality Committee (A)	Executive Committee
Informatics	Joint SIRO / Caldicott Committee (A)	Executive Committee
Finance	Executive Committee (A)	Executive Committee
Divisional Documents		
All Documents	Relevant Divisional Governance Board (A)	Relevant Divisional Governance Board
Ward / Service Based Documents		
All Documents	Relevant Divisional Governance Board (A)	Relevant Divisional Governance Board

7 CONSULTATION

7.1 Formal consultation on proposed changes to policy documents will be led by the Lead Author(s) and may include such parties as:

(a) committees, sub-committees and groups;

(b) staff side;

(c) those clinical and managers staff likely to be affected by any change;

(d) service users and carers;

(e) specialist advisors;

(f) external bodies, such as local authorities, commissioners, partners.

7.2 The Lead Author(s) in consultation with the Lead Executive Director shall determine the period of consultation, but normally the consultation periods would be:

(a) for policy documents requiring minor change – 1 / 2 weeks;

(b) for policy documents requiring major changes – 3 / 4 weeks.

7.3 For the purpose of this *Policy on Policies* the Trust Secretary consulted members of the Executive Committee and the Policy Group for a period of 3 weeks

8 CONTROLS AND ARCHIVING

8.1 All policy documents will be managed in accordance with the *Document Control Procedure*, one of the supporting documents to this Policy on Policies. The Trust Secretary / Assistant Trust Secretary will be the Lead Author(s) and the procedure will be approved by the Policy Group.

9 IMPLEMENTATION, MONITORING, TRAINING AND SUPPPORT

9.1 **Implementation Plan** - all policy documents will need an implementation plan which:

(a) identifies

(i) the tasks to be completed,

(ii) the date these tasks will be completed by,

(iii) the person(s) responsible for completing the task(s);

(b) and takes account of:

(i) which part of the trust's governance arrangements will receive assurance that the policy document is being implemented;

(ii) which staff need to be briefed;

(iii) whether additional training and / or ongoing training is required as part of a member of staff's Personal Development Plan (see paragraph 9.4 below);

(iv) how the policy document will be monitored using the *Policy Monitoring Checklist* (see paragraph 9.2 below).

The *Implementation Plan* template is part of the *Policy Template*.

9.2 **Policy Monitoring Checklist** – in order to provide greater clarity and guidance to Lead Author(s) on the sort of issues they need to monitor and provide assurance about, a standardised approach to the monitoring of all policy documents has been introduced, involving a three-step process:

(a) Step 1 – each policy document identifies which part of the trust's governance arrangements will receive assurance monitoring;

(b) Step 2 – using a trust-wide standardised *Policy Monitoring Checklist*, each policy document will identify how evidence will be gathered to provide assurance monitoring;

(c) Step 3 – an audit against the *Policy Monitoring Checklist* (identified in Step 2), will be completed no longer that two-thirds into the 'life cycle' of the policy document (see paragraph 9.3 below) by Lead Author(s) - with the results (and any necessary action plan) reported to the governance arrangements identified in Step 1.

The *Policy Monitoring Checklist*, which can be found as part of the *Policy Template*, takes account of a range of existing processes (e.g., quality review visits, complaints) which provide evidence that can then be used to monitor / provide assurance on the effectiveness of the use of policy documents.

9.3 **Life Cycle** – usually a policy document is approved with a review date of one, two or three years. For audits to be completed no longer that two-thirds into the 'life cycle' of a policy document, this would mean the following:

(a) 1 year – no later that 8 months since the date the document was approved;

(b) 2 years – no later than 16 months since approval;

(c) 3 years – no later than 24 months since approval.

9.4 **Training** - Lead Author(s) will be required to identify training requirements as part of the development of the policy documents. This assessment should also consider whether such training needs should be included in existing statutory and mandatory training identified by the trust or be a requirement for affected staff as part of their Personal Development Plans. Lead Author(s) will need to liaise with the Education Governance Committee through their HR Business Partners.

10 EQUALITY AND HUMAN RIGHTS

10.1 As is reflected in the supporting statement at the beginning of this document, the trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and as a major employer. Using the *Equality and Human Rights Analysis* tool, which is a supporting document to this *Policy on Policies*, it is essential that Lead Author(s) work with the Equality & Human Rights Team to ensure that all policy documents are impact assessed.

11 APPROVAL OUTSIDE OF THIS PROCESS

11.1 In exceptional circumstances, the Executive Committee (and not a Divisional Governance Board) may approve a policy document as a **working document** prior to completion of the approval process detailed in this policy, i.e., where a specific risk has been identified which the *working document* will address or where approval is part of a multi-agency / partnership arrangement which does not meet the trust approval process. The exceptional circumstances must be recorded in the minutes of the Executive Committee and the chair of the committee which normally approves the policy document shall be informed. A *working document* must be reviewed within 3 months

11.2 Note – this exceptional process cannot be used where the policy document is reserved for the approval / ratification of the Trust Board. Flexibility to approve Trust Board policy documents in exceptional circumstances / outside of this process is provided in the trust's *Standing Orders* (please consult with the Trust Secretary).

12 CONTENTS, STYLE AND FORMAT

12.1 Details of the contents, style and format for policy documents are detailed in the Policy Template. Table 3 below summarises the contents of policy documents.

Table 3: Contents of Policy Documents

Type	Description
Front Cover	• Level of document • Name of policy document • Policy number • Scope of the document • Name of the recommending committee • Name of the approving committee • Date ratified • Next review date • Version number • Lead Executive Director • Lead Author(s)
Inside Front Cover	• Further information about the document (including document summary, contact details, what policy documents it is to be read in conjunction with, availability statement, copyright notice) • Version Control
Page 1	• Supporting statement for safeguarding and equality / human rights
	Continued on the next page

Type	Description
Main Body	• Contents page • Purpose and rationale • Outcome focused aims and objectives • Scope • Definitions • Duties • Process (where applicable) • Consultation • Implementation and Monitoring • Training and Support • Reference • Glossary of terms
Supporting Documents	• Equality & Human Right Analysis • Implementation Plan • Policy Monitoring Checklist

13 SUPPORTING DOCUMENTS

13.1 The *Policy on Policies* should be read in conjunction with the list of policy documents shown on the inside of the front cover. However the following documents, approved and ratified by the Policy Group, support the policy development process.

Table 4: List of Supporting Documents

Ref No	Name	Purpose
SA01A	Policy Template	Provides a template and guidance for completion of a policy document, including the implementation plan and Policy Monitoring Checklist
SA01B	Policy Checklist	To be used by Lead Author(s) and the Policy Group to ensure the policy document complies with the *Policy on Policies*
SA01C	Trust Policy Schedule	Details the accountabilities, review dates and monitoring audit dates for all trust-wide policy documents
TBC	Divisional Policy Schedule	For each Division, details the accountabilities, review dates and monitoring audit dates for all the divisional and ward / service based policy document relevant to that division
SA01D	Document Control Procedure	Outlines how policy documents are to be disseminated and archived
SA01E	Equality & Human Rights Analysis	Provides guidance to Lead Author(s) on the requirement to impact assess policy documents

14 GLOSSARY OF TERMS

Table 5: Glossary of Terms

Term	Description	Reference
Approve	Where a Committee / the Board, which has the appropriate delegated authority, formally agrees a policy document for issue and implementation.	Sections 6 and 11
Divisional Policy Document	A policy document that refers to the application of practice by staff specifically working in one of Mersey Care's three division	Paragraph 4.1 (Table 1)
Divisional Policy Lead	The staff member identified within each Division with responsibility for maintain the Divisional Policy Schedule and ensuring divisional adherence to the Policy on Policies	Paragraph 5.9
Divisional Policy Schedule	A document outlining all divisional policy documents and key information relating to each one – see also *Trust Policy Schedule*	Paragraphs 5.6(a) & 5.9(a)
Impact Assessment	A tool to be completed to determine any direct or indirect discrimination arising from the policy document.	Section 10
Implementation Plan	A document template to be complete which identified the tasks to be completion, by when and by who, to ensure the policy is embedded across the ward/ service/ division/ trust as appropriate.	Section 9
Lead Author	The staff member (nominated by the relevant Executive Director) responsible for writing, reviewing and auditing a policy document in line with the *Policy on Policies*	Paragraph 5.3
Lead Executive Director	The Executive Director identified as accountable for the development, review, endorsement, implementation and monitoring of a policy document	Paragraph 5.2
Level of Document	Where the document has to be applied to in the trust (trust-wide, divisional or ward / service specific.	Paragraph 4.1 (Table 1)
Life Cycle	The maximum length of time prior to the need for review of a policy document (1, 2 or 3 years - defined by the review date)	Paragraph 9.3
Major Change	Changes which impact on practice being used or staff responsibilities	Paragraph 6.3 (Table 2)
Minor Change	A change to a policy document that does not impact on practice / staff responsibilities.	Paragraph 6.3 (Table 2)
Policy	A type of policy document defined that provides a statement of overall aim, objectives and principals that underpin a practice	Paragraph 4.1 (Table 1)
Policy Document	Generic term used throughout the Policy on Policies to refer to policies, procedures, guidelines and standard operating procedures	-
Policy Template	A document including a template and guidance for completion of a policy document, including the implementation plan and Policy Monitoring Checklist	Section 13
Procedure (Standard Operating Procedure)	A type of policy document that provides a description of a process in support of the actions which underpin a practice	Paragraph 4.1 (Table 1)
Trust Policy Schedule	A document outlining all trust-wide policy documents and key information relating to each one – see also *Divisional Policy Schedule*	Section 13
Trust-wide Clinical Document	A policy document that refers to the application of clinical practice across the whole of Mersey Care	Paragraph 4.1 (Table 1)

Continued on the next page

Term	Description	Reference
Trust-wide Non-clinical Document	A policy document that refers to the application of non-clinical practice across the whole of Mersey Care	Paragraph 4.1 (Table 1)
Ward / Service Based Policy Document	A policy document that refers to the application of practice by staff specifically working on a ward (location) or a specific service in one of the two Clinical Divisions	Paragraph 4.1 (Table 1)
Recommend	Where a Committee/ Sub-Committee/ Group does not have authority to approve (under its terms of reference) but undertakes detailed scrutiny and proposes this approval to the relevant Committee/ Sub-Committee / Group.	Sections 6 and 11
Policy Monitoring Checklist	A standardised section included (and completed) in all policy documents which sets out how embedding of the document will be monitored.	Section 9
Working Document	A draft document which remains subject to further changes.	Section 11