NHS
Mersey Care
NHS Foundation Trust

Community and Mental Health Services

Policy Document Change Process due to COVID-19 Pressures

For all policy documents within the scope of the Policy Management Framework (SA01)

- **All Staff**

Any queries about this document to be addressed to:

- Andy Meadows, Trust Secretary (andy.meadows@merseycare.nhs.uk)
- Sarah Jennings, Deputy Trust Secretary (sarah.jennings@merseycare.nhs.uk)
- Paula Murphy, Corporate Governance Compliance Officer (paula.murphy@merseycare.nhs.uk)

Purpose

- To provide a process to allow all those policy documents ***within the scope*** of the trust's ***Policy Management Framework (SA01)*** to be amended and approved (if required) where pressures on the trust and / or changes to models of care mean that changes are required as a result of the COVID-19 outbreak.
- Amendments required need to be listed on a ***COVID-19 Document Change Form*** – you ***don't need*** to amend the policy document itself – and this form should be submitted to:
  - the relevant Divisional Tactical Coordination Group
  - the Strategic Coordination Group

  as shown on page 4 for approval (or in the case of Board-approved policy documents, to recommend to the Board that they should be changed).
- Consultation on proposed changes will take place at the relevant Tactical Coordination Group / the Strategic Coordination Group considering the *COVID-19 Document Change Form.* ***If a clinical policy requires major change, it will need to be referred to the Clinical Cell*** (see page 3).)
- Once approved, the *COVID-19 Document Change Form,* should be PDF'd and then ***added to the front of the existing policy document*** that is held on the relevant division's intranet site or the trust's website. ***All versions*** of the policy documents ***must be retained*** in accordance with the records management processes.
- Adding the *COVID-19 Document Change Form* to the front of the existing policy document will allow the staff (and the public) to clearly understand the changes to the usual policy document.
- A message will be added to the trust's policy website pages stating that existing timelines described in trust-wide documents may not be met due COVID-19 pressures on the organisation. This should negate having to make changes to trust-wide policy documents about response timeframes
- Changes to policy documents approved under this process shall initially remain in place until **30 June 2020**, although this may be reviewed and amended by the Strategic Coordination Group.

Type of Change – Clinical Policies

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- For clinical policies, if they relate to a single clinical division or are trust-wide, then consideration needs to be given as to whether they need to be referred to the Clinical Cell.
- The decision to refer to the Clinical Cell is based on whether a ***minor*** or ***major*** change is being made to the clinical policy, and this has to be determined by the relevant Tactical Coordination Cell
- For the purposes of this *Policy Document Change Process*, examples of what a major or minor change could consist of includes:
  - **Major Change** –
    - major changes to care pathways or ways of working for clinical staff – or
    - which involve a significant departure from national clinical guidelines or contractual requirements - or
    - any departure from statutory requirements
    - any change to the role or responsibilities of an Executive Director (Trust Secretary also to be notified)
  - **Minor Change** –
    - minor changes to clinical practice
    - changes to the role and responsibilities of clinicians providing care (i.e., so as to allow other appropriately trained clinical colleagues to provide a service)
    - changes to management oversight (i.e., so as to allow a greater number of clinical managers to ‘approve’ matters
- However it is for Tactical Groups to determine this, ***consulting*** with the Clinical Cell as required
- Minor changes to clinical policies may be approved by the relevant Tactical Group, but all minor changes are to be notified to the COVID-19 Strategic Coordination Cell
- Major changes are to be referred to the Clinical Cell for its consideration. They will then be referred to the COVID-19 Strategic Coordination Cell for approval.

Policy Document Change Process due to COVID-19 Pressures

For policy documents within the scope of the Policy Management Framework (SA01)*

Mersey Care
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A policy, procedure, protocol or guidance* needs amendment due to pressures upon the trust and / or a changing model of care in response to the COVID-19 outbreak

Complete a *COVID-19 DOCUMENT CHANGE FORM* outlining the change(s) required to the existing policy* document (referencing the changes to be made on the form)
NOTE – you don't have amend to the document itself, as this form will be put at the front of the document

Send the *COVID-19 DOCUMENT CHANGE FORM* to the relevant group for approval as shown below

***Note** – In respect of clinical policies, if the change(s) is considered a **minor change** by the relevant Tactical Group then the Tactical Group may approve it. If the Tactical Group consider the change is a **major change** then the clinical policy must be referred to the Clinical Cell – once considered it will be referred to the SCG for approval (see page 3)*

The *COVID-19 DOCUMENT CHANGE FORM* is considered by the relevant group

***Note** – the SCG will recommend changes to Board approved policies, the Board will then be asked to approve these changes (in accordance with the Virtual Meeting by Email process managed by the Trust Secretary)*

Rejected

Existing document stays in place

Approved

The *COVID-19 DOCUMENT CHANGE FORM* is added as a PDF to the front of the policy document on the relevant Division's intranet or the Trust's website
Initially until 30 June 2020 (subject to review)
NOTE – all versions need to be retained permanently

Version 1 (1 April 2020)

Policy Number	[INSERT POLICY REF]

Mersey Care NHS Foundation Trust
Community and Mental Health Services

COVID-19 DOCUMENT CHANGE FORM

In light of the COVID-19 outbreak it has been necessary to make temporary changes to this Policy Document. Therefore when reading the policy document please take account of the changes highlighted in Part B and C of this form.

PART A – INFORMATION ABOUT THIS POLICY DOCUMENT

<table>
<tr><td>Policy Name</td><td colspan="4"></td><td>Reference No</td><td></td></tr>
<tr><td colspan="2">Executive Lead
(Trust-wide policies)</td><td colspan="5"></td></tr>
<tr><td colspan="2">Chief Operational Officer
(Clinical Division policies)</td><td colspan="5"></td></tr>
<tr><td rowspan="2">Policy Document
(Tick only one)</td><td>Trust-wide
(Board approved)</td><td>☒</td><td>Trust-wide
(Executive Director approved)</td><td>☐</td><td rowspan="2">Secure & Specialist Learning Disabilities Division</td><td rowspan="2">☐</td></tr>
<tr><td>Community Division</td><td>☐</td><td>Local Division</td><td>☐</td></tr>
<tr><td>Type of Policy
(Tick only one)</td><td colspan="2">Clinical Policy ☐</td><td colspan="3">Non-clinical Policy</td><td>☐</td></tr>
<tr><td>Clinical Policy Only
(Tick only one)</td><td colspan="2">Minor Change
(Not referred to the Clinical Cell) ☐</td><td colspan="3">Major Change
(Referred to Clinical Cell, then to SCG for approval)</td><td>☐</td></tr>
<tr><td rowspan="2">Approving Body
(Tick only one)</td><td>Board of Directors</td><td>☐</td><td>COVID-19 Strategic Coordination Group</td><td>☐</td><td rowspan="2">Secure & Specialist Learning Disabilities Division Tactical Coordination Group</td><td rowspan="2">☐</td></tr>
<tr><td>Community Division Tactical Coordination Group</td><td>☐</td><td>Local Division Tactical Coordination Group</td><td>☐</td></tr>
</table>

PART B – CHANGES TO THE POLICY DOCUMENT

Section / Paragraph No	Outline of the information that has been amended in this policy document

PART C – RATIONALE FOR CHANGES

Please explain why this document needs to be amended during the COVID-19 outbreak

PART D – APPROVAL (for completion by officer loading policy document onto intranet / website)

Date Referred to the Clinical Cell *(Clinical Policies only)*	
Date Referred by the Clinical Cell to the SCG *(Clinical Policies only)*	
Date Approved by the Approving Body	
Date Circulated to Relevant Staff	
Date Published on the Divisional Intranet / Trust Website	

Note – the Approving Body to send this form to the appropriate divisional officer (for divisional policies) or the Corporate Governance Team (for trust-wide policies) who will be responsible for adding this form to the front of the existing policy and then uploading these onto the intranet / trust website.

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TRUST-WIDE POLICY DOCUMENT

POLICY MANAGEMENT FRAMEWORK

Policy Number:	SA01
Scope of this Document:	All Staff
Recommending Committee:	Policy Group
Approving Committee:	Executive Committee
Date Ratified:	February 2020
Next Review Date (by):	January 2023
Version Number:	Version 3
Lead Executive Director:	Executive Director of Communications and Corporate Governance
Lead Author(s):	Deputy Trust Secretary

TRUST-WIDE POLICY DOCUMENT

Version 3

Striving for perfect care and a just culture

TRUST-WIDE POLICY DOCUMENT

POLICY FRAMEWORK

Further information about this document:

Document name	**Policy Management Framework (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)**
Author(s) Contact(s) for further information about this document	**Sarah Jennings Deputy Trust Secretary Telephone: 0151 473 2778 Email: sarah.jennings@merseycare.nhs.uk**
Published by Copies of this document are available from the Author(s) and via the trust's website	**Mersey Care NHS Foundation Trust V7 Building Kings Business Park Prescot Liverpool L34 1PJ 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)**
This document can be made available in a range of alternative formats including various languages, large print and braille etc	
Copyright © Mersey Care NHS Foundation Trust, 2019. All Rights Reserved	

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 Placed on the Trust's Website	2 March 2015
2015 – Version 1	Revised document uploaded to the website	8 March 2017
Version 2	Presented to the Executive Committee for Approval	22 Nov 2018
Version 3	Fundamentally reviewed and re-named	February 2020

SUPPORTING STATEMENTS

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

SAFEGUARDING IS EVERYBODY'S BUSINESS

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

- being alert to the possibility of child / adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child / 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 / 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 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 Foundation 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 Foundation Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the *protected characteristics* of age, disability, sex, race, religion and belief (or lack thereof), sexual orientation, gender reassignment, pregnancy and maternity and marital and civil partnership status. The Equality Act also requires regard to socio-economic factors.

The trust is committed to promoting and advancing equality and removing and reducing discrimination and harassment and fostering good relations between people that hold a protected characteristic and those that do not 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 Foundation 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 Foundation 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** – This document sets out the roles, responsibilities and process for the development, review and management of all Mersey Care NHS Foundation Trust policy documents including policies, procedures, standard operating procedures and guidelines.

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.

2 OUTCOME FOCUSED AIMS AND OBJECTIVES

2.1 The aims and objectives of the Policy Management Framework are as follows

(a) to ensure all new Policy Documents are developed in accordance with this Framework and are formatted in accordance with the *Policy Document Template*;

(b) to ensure all documents subject to review are updated in accordance with this guidance in line with the review date and are formatted in accordance with the *Policy Template*;

(c) to ensure that staff continue to have access to the most up-to-date and relevant documents;

(d) to ensure that Trust-wide and Divisional Policy Documents are referenced on the *Policy Schedules* and that copies are held centrally;

(e) to ensure that all Trust-wide and Divisional Policy Documents are approved in line with the governance arrangements set out in the Policy Management Framework.

2.2 All policies, procedures, protocols, standard operating procedures and guidelines must adhere to the requirements set out in this document and its supporting documents.

3 SCOPE

3.1 This *Policy Management Framework* applies to all staff employed by Mersey Care NHS Foundation Trust (whether on a permanent or temporary contract) who are involved in writing, reviewing or the management of Policy documents.

4 DEFINITIONS

4.1 **Approval** - agreement of the Policy Document by the appropriate body as fit for use. Refer to appendix E.

4.2 **Consultation** - a process by which stakeholders are requested to provide comments on a draft document. Refer to appendix D.

4.3 **Divisional Document** - refers to the application of the document across one particular Division in the organisation.

4.4 **Equality Analysis** - a risk assessment designed to assess whether different groups of people are, or could be disadvantaged through implementation of the Policy Document.

4.5 **Guidance** - a description of recommended action(s) or 'best practice' to inform a way of working.

4.6 **Major Change** - Changes which impact on the practice being used or staff responsibilities (e.g., new responsibilities, changes to forms used etc). Policy Documents requiring major change will be subject to the review process outlined in figures 2 or 3 dependent on whether the document is Trust-wide or Divisional.

4.7 **Minor Change** - changes which don't impact on the practice / staff responsibilities. These normally relate to changes to staff titles, committee names or review dates (where a review has highlighted no major changes are required). Policy Documents requiring minor changes will be subject to the review process outlined in figures 2 or 3 dependent on whether the document is Trust-wide or Divisional.

4.8 **Policy** - a statement setting out the overall aims, objectives and principals that underpin practice.

4.9 **Policy Document** - overarching term for the purpose of this Policy Framework which encompasses policies, procedures, protocols, standard operating procedures and guidelines.

4.10 **Policy Schedule (Trust-wide / Divisional)** – a document which references all live Policy Documents and associated details including Lead Executive Director, author, review date and approving Committee/ Board.

4.11 **Procedure / Standard Operating Procedure** - a method or approach by which a policy will be implemented which includes set of mandatory or necessary actions / requirements that must be followed by staff.

4.12 **Protocol** - similar to a procedure, but often used more frequently in in clinical areas.

4.13 **Publication** – uploading of the Policy Documents to ensure there are accessible by staff.

4.14 **Trust-wide Policy Document** - refers to the application of the document across all Divisions in the organisation.

4.15 **Version Control** - the process used for tracking development of a document.

5 DUTIES

5.1 **Board of Directors** - the Board of Directors has responsibility for ensuring robust documentation describing the governance arrangements for approving strategy and policy documents, which are described in the Trust's *Constitution*, *Standing Financial Instructions* and *Scheme of Reservation and Delegation of Powers*. The Board of Directors has delegated responsibility for the approval of certain policy documents to Board Committees or officers. A detailed list of responsibility for approving trust-wide policy documents can be found in the *Policy Schedules* available via the Corporate Governance Team. The Board of Directors will receive a bi-monthly assurance report on the status of the Trust-Wide and Divisional Policy sets as part of the Board Governance Report.

5.2 **Lead Executive Director** – Each Policy Document will have a Lead Executive Director as set out within the Policy Schedule. The Executive Lead for this Policy Framework is the Executive Director of Communications and Corporate Governance and is accountable for ensuring the Trust has a robust policy management system in place. The Executive Director of Communications and Corporate Governance is responsible for the approval of this Policy Management Framework.

5.3 **Lead Author(s)** – Each Policy Document shall have a lead author identified by the Policy Lead. The Lead Author responsible for writing, reviewing and overseeing implementation of the Policy Framework is the Deputy Trust Secretary.

5.4 **Policy Leads** – the Lead(s) identified by each Executive Director will be responsible for identifying an appropriate author for policy documents in their Executive Director's portfolio and requesting review of such policy documents in line with their review date.

5.5 **Policy Leads Group** – the Policy Leads Group will oversee the Trust Wide Policy Schedule and make recommendations to the appropriate Lead Executive Director(s) in respect of creation or removal of documents Team in respect of policy management is as to receive a monthly assurance report on the status of the Trust-Wide and Divisional Policy sets.

5.6 **Deputy Trust Secretary** – is responsible for the development and review of the Policy Framework (and supporting documentation). Supported by the Corporate Governance Team the Deputy Trust Secretary also has responsibility for:

(a) reporting to the Executive Committee in respect of those Trust-Wide Policy Documents which require Executive Committee approval along with an update on both Divisional and Trust Wide Policy Schedules.

(b) maintaining the *Trust Policy Schedule* and overseeing *Divisional Policy Schedules* (for the purpose of providing update reports to the Executive Committee);

(c) publication and dissemination of all Trust-Wide Policy Documents through the Trust's website and ensures 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; with only up-to-date trust-wide Policy Documents made available to staff, archiving / removing out-of-date documents from the Trust's website;

(e) notifying Lead Author(s) when their Trust-Wide Policy Document needs to be reviewed (i.e., at least three months before the review date); NB – the responsibility to ensure a Policy Document remains up to date ultimately lies with the Lead Author and Lead Executive Director.

5.7 **Divisional Lead for Policy Development** – each divisions Policy Lead has responsibility for:

(a) maintaining the *Divisional Policy Schedule*;

(b) dissemination of all relevant Divisional Policy documents through the division's website / intranet and ensure staff are advised of new and updated documents in a timely manner;

(c) ensuring all relevant divisional Policy Documents are retained and held on the Trust's policy file;

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

5.8 **Equality and Human Rights Team** – the team will support authors in conducting an Equality Impact Assessment and ensuring the associated tool is appropriate and up-to-date.

5.9 **All Staff** - staff (temporary, permanent, bank and agency) that are involved in the development, review or consultation on a Policy Document must ensure that this is in line with this *Policy Framework*.

6 PROCESS

Requirements of All Policy Documents

6.1 All new Policy Documents must be written in line with the *Policy Document Template* (Appendix A). All existing Policy Documents, if not currently, should be placed into this template when next reviewed. Details of the contents, style and format for Policy Documents are detailed in this *Policy Template*. Table 1 on the following page summarises the contents of Policy Documents.

Table 1: Contents of Policy Documents

Type	Description
Front Cover	• Level of document (Trust Wide or Divisional) • Name of policy document • Policy number • Scope of the document • Name of the recommending committee / relevant Lead Executive • Name of the approving committee / relevant Lead Executive • Date ratified • Next review date • Version number (**Refer to Appendix B for further guidance)** • Lead Executive Director (job title only) • Lead Author (job title only)
Inside Front Cover	• Further information about the document (including document summary, contact details, which 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
Main Body	• Process Flow Chart for timely access by staff • Contents page • Purpose and rationale • Outcome focused aims and objectives • Scope • Definitions • Duties • Process (Flowcharts to be used where possible) • Consultation – **Refer to Appendix C for further guidance** • Implementation and Monitoring – **Refer to Appendix D for further guidance** • Training and Support – **Refer to Appendix D for further guidance** • Reference • Glossary of terms
Supporting Documents	• Appendices as appropriate • Equality & Human Right Analysis (Template contained with Policy Document Template) • Implementation Plan for new policy documents (Template contained with Policy Document Template)

6.2 Policy documents should be as concise as possible and should incorporate process flow charts where relevant to quickly assist staff.

6.3 A *Policy Document Checklist* is available at **Appendix E** which should be completed by the document author prior to the submission of any new or reviewed Policy Document for approval to ensure the document has been written/ reviewed in line with the requirements of the Policy Management Framework and has followed the appropriate process.

Process for the Development of New Policy Documents

6.4 The process set out in figure 1 should be followed for the development of all new Policy Documents (both Trust-Wide and Divisional).

Process for Review of Existing Policy Documents

6.5 ***Trust-wide Policy Documents*** - The process set out in figure 2 should be followed for the review of existing Trust-wide Policy Documents.

6.6 ***Divisional Policy Documents*** - The process set out in figure 3 should be followed for the review of Divisional Policy Documents.

6.7 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** required; minor or major change.

a) Minor Changes - these are changes which do not impact on the practice / staff responsibilities. These normally relate to changes to staff titles, committee names or review dates (where a review has highlighted no major changes are required);

b) Major change - these are changes which impact on the practice being used or staff responsibilities (e.g., new responsibilities, changes to forms used etc).

Figure 1 – DEVELOPMENT OF NEW POLICY DOCUMENT

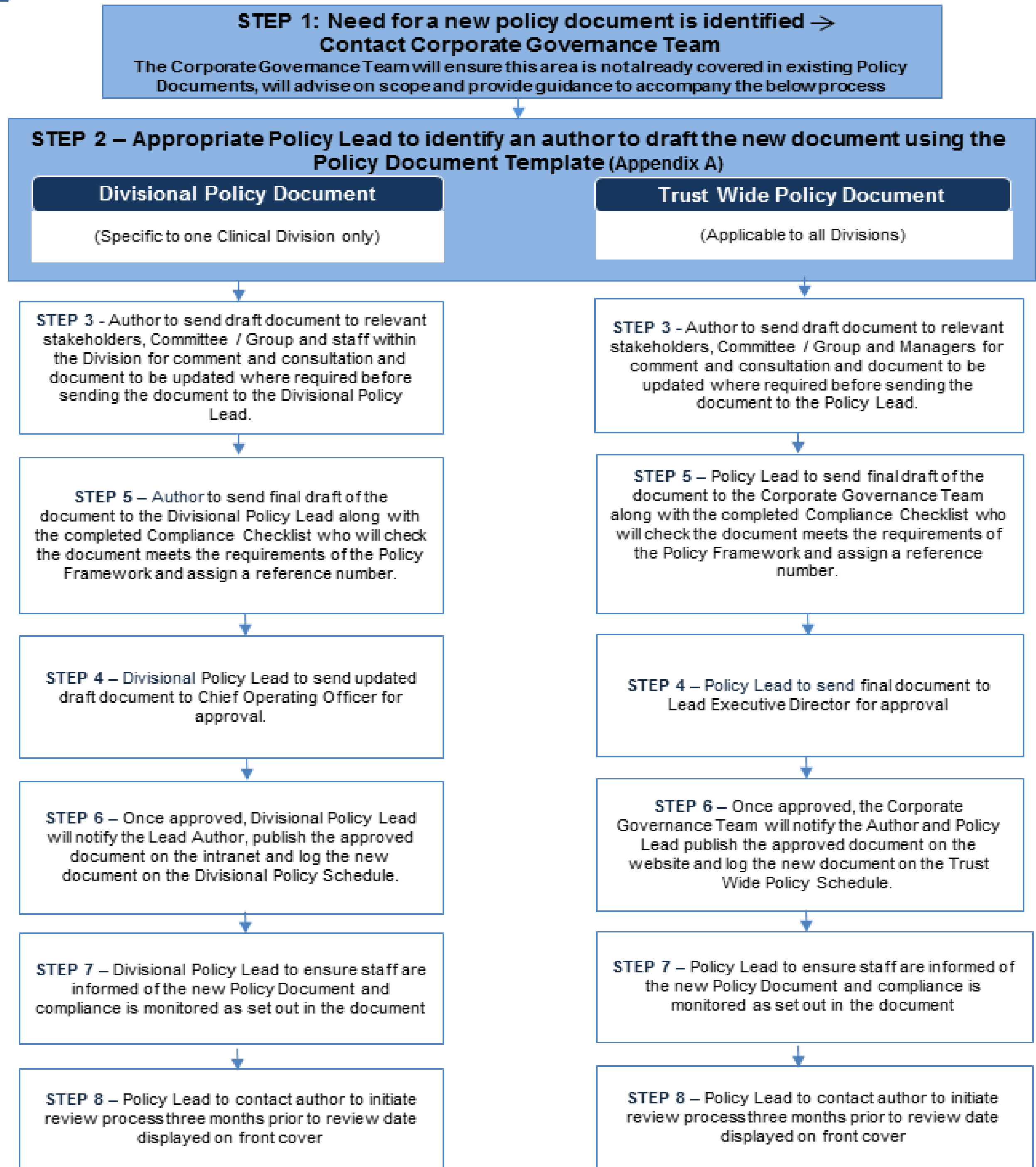


Figure 2 – PROCESS FOR REVIEW OF EXISITING TRUST WIDE POLICY DOCUMENT

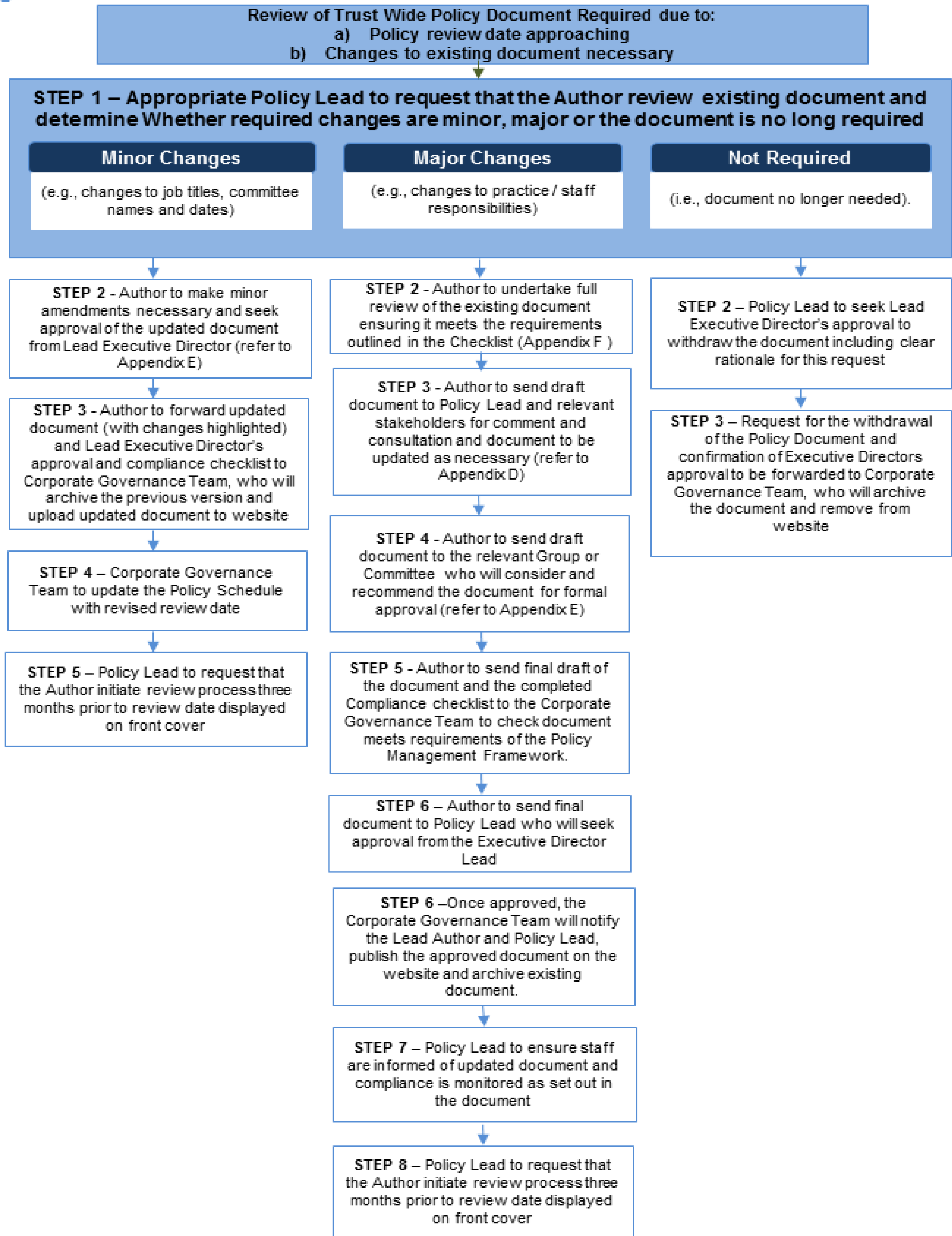
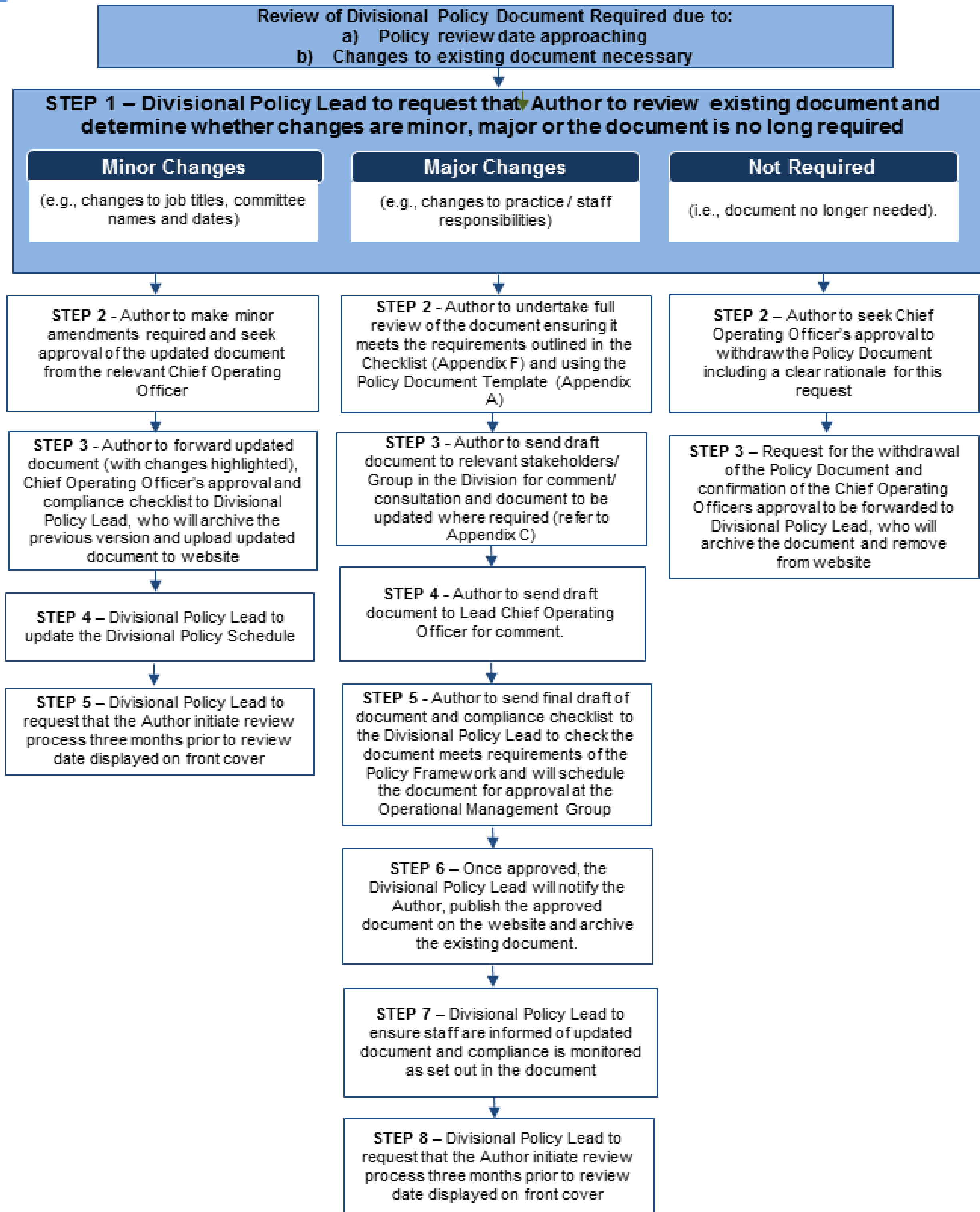


Figure 3 – PROCESS FOR REVIEW OF EXISTING DIVISIONAL POLICY DOCUMENT



Approval Outside of This Process

6.8 In exceptional circumstances, the relevant Lead Executive Director may approve a policy document as a **working document** prior to completion of the approval process detailed in this *Policy Management Framework*, 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 a paper to the Executive Committee. A *working document* must be reviewed within 3 months and approved by the Executive Committee within this time.

6.9 Note – this exceptional process cannot be used where the policy document is reserved for the approval / ratification of the Board of Directors.

6.10 Subject to the approval of the Executive Team, 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 / locality based policy documents (e.g., where executive portfolio changes are made).

7 CONSULTATION

7.1 Formal consultation on the revised Policy Framework was led by the Lead Author and included:

(a) Executive Directors;

(b) Corporate Governance Team;

(c) Divisional Policy Leads;

(d) Chief Operating Officers;

(e) Quality and Nursing Leads;

8 TRAINING AND SUPPPORT

8.1 There are no specific training requirements associated with the implementation of this document but any author who requires assistance with the processes set out in the Policy Management Framework should contact the Corporate Governance Team or appropriate Divisional Policy Lead for support.

9 MONITORING

Table 2: Policy Management Framework Monitoring Arrangements

Element to be monitored	Lead	Tool	Frequency	Reporting Arrangements
100% of Trust-wide and Divisional Policy Documents are in date	Corporate Governance Team	Trust-wide and Divisional Policy Schedules	Monthly	Reported monthly to the Executive Team
100% of Divisional Policy Documents are in place	Divisional Policy Leads	Divisional Policy Schedules	Bi-monthly	Operational Management Groups
100% of Trust-wide Policy Documents are in date	Corporate Governance Team	Trust-wide Policy Schedule	Bi-monthly	Reported to the Board of Directors via the Corporate Governance Report

10 SUPPORTING DOCUMENTS

10.1 The *Policy Management Framework* should be read in conjunction with the list of policy documents shown on the inside of the front cover. However the following documents outlined in table 3 support the policy development / review process.

Table 3: List of Supporting Documents

Appendix Number	Name	Purpose
A	***Policy Template***	Provides a template and guidance for completion of a Policy Document, including the implementation plan and Equality Analysis templates
B	***Policy Document Compliance Checklist***	Form for completion prior to submitting a policy document for approval.
C	***Document Control Procedure***	To advise on version control requirements, storage and publication of Policy Documents and the arrangements for policy set management.
D	***Consultation Process Guidance***	To provide guidance on the importance of consultation, who should be included in the consultation of a Policy Document and how long consultation should take place for.
E	***Guidance on Recommending Approval / Approval of a Policy Document***	Outlines which committees/ Executive Directors are responsible for either approval or recommending the approval of the different type of Policy Document at a high level together with the committee responsible for final approved of the document
	Guidance on	Provides guidance on preparing an implementation

Appendix Number	Name	Purpose
F	***Implementation, Monitoring and Training***	plan, how to develop policy monitoring arrangements and training consideration requirements.
G	***Policy Document Checklist***	To be used by Lead Author(s) and the Policy Group to ensure the policy document complies with the *Policy on Policies*

APPENDIX A

POLICY DOCUMENT TEMPLATE

See separate document sat adjacent to the Policy Management Framework on the Trusts website.

APPENDIX B

POLICY DOCUMENT COMPLIANCE CHECKLIST

*Please note that this form **must** be completed for all Policy Documents submitted for approval. Please complete this form and submit with the final Policy Document to Policy Lead (for Trust Wide document) or Divisional Policy Lead (for Divisional Policy Documents.*

Trust Wide Policy Document ☐ **Divisional Policy Document** ☐

Name of Policy Document:

....

Policy Lead / Divisional Policy Lead: ....

Lead Executive Director / Chief Operating Officer: ....
....

Policy Author: ....

1. Has the document been developed using the Policy Document Template and Checklist? Yes ☐ No ☐

2. Have you taken into consideration the relevant legislation that may be applicable to this Policy Document? Yes ☐ No ☐

3. Has the document been subject to consultation with key staff groups and all relevant Divisions? Yes ☐ No ☐

   Has the document been considered by the relevant Sub-Committee Group and recommended for approval? Yes ☐ No ☐

   Insert name of Group/ Sub Committee ....

4. If this is a new document, has an Implementation Plan been prepared? Yes ☐ No ☐ N/A ☐

5. Has the document been subject to an equality impact analysis? Yes ☐ No ☐

Signature of author:

Date:

APPENDIX C

DOCUMENT CONTROL PROCEDURE

A Policy Document must not be utilised unless it has been ratified through the appropriate channels, and all Policy Documents, once approved, must be made available to all staff via the most appropriate page of the Trust intranet / external webpages as appropriate.

The following principles must be adopted when introducing a new Policy Document, or reviewing an existing Policy Document already in place in the organisation:

- The author/reviewer of a Policy Document must be the 'most appropriate' or competent person based on the role and experience. Where an author is not already in place, a suitable author will be identified by the Policy Lead (for Trust wide document) or Divisional Policy Lead (for divisional policy documenta);
- The author/reviewer will usually be an employee of the Trust; however, there may be occasions when external or specialist support will be required to ensure a Policy Document is robust or involves a very specialist topic;
- **Life Cycle** – usually a policy document is approved with a review date of one, two or three years however, reviews must be brought forward under the following circumstances
  - The issue of pertinent NICE guidelines
  - Changes in legislation and guidance
  - Changes in best practice
  - To address identified risks, or trends
  - To address changes in service provision, or governance arrangements
  - To incorporate advancements in technology or clinical practice as identified through relevant governing bodies
  - In response to regulator recommendations and directives.

Version Control

All Policy Documents will indicate on the front sheet the version number. This is to ensure that we can monitor the varying iterations of the document through its life span and ensure staff do not use outdated copies.

The Policy Document version numbering convention will follow the following format:

- Whole numbers should be used for approved versions or a new document or following full/ major review, e.g. 1.0, 2.0, 3.0 etc.
- Decimals should used to represent the ratified documents subject to minor amendment, e.g. 1.1, 1.2, 1.3, 1.4 etc.

Storage of Policy Documents

Master copies of Policy Documents are stored on the Trusts T: Drive and accessible by the Corporate Governance Team and Divisional Policy Leads within clinical divisions. All

previously approved versions of Trust-wide and Divisional Policy Documents must be stored to ensure they can be located should they be required.

Policy Set Maintenance

Policy Schedules are in place for Trust-wide policy documents and Divisional Policy Documents. These schedules include the following details:

- Policy ref number;
- Policy Title;
- Status (RAG rated in terms of whether the document is in date, under review or overdue review);
- Next review date;
- Date ratified;
- Lead Executive Director;
- Approving Committee;
- Recommending Committee;
- Author;
- Version number;

The Policy Schedule will be maintained by the Corporate Governance Team for Trust wide documents and Divisional Policy Leads for divisional documents and should be reviewed monthly as a minimum to ensure the RAG rating is up to date.

The Trust Secretary/ Deputy Trust Secretary will utilise the information within the Policy Schedules to provide a Policy Document Update Report to the Executive Team on a monthly basis and Board of Directors on a bi-monthly basis.

Publication

Once approved, all Policy Documents must be accessible to staff.

For Trust-Wide Documents, these will be published on the Trusts website by the Corporate Governance Team.

For Divisional Policy Documents, these will be published on the Division’s intranet page by the Divisional Policy Lead.

In the event that the intranet is not available, all policies are available from the Corporate Governance department.

APPENDIX D

CONSULTATION PROCESS

Consultation must be undertaken for all new Policy documents or those subject to Major Review.

Consultation is described as a process by which stakeholders are requested to provide comments on a draft document.

Consultation on proposed changes to policy documents will be led by the Lead Author(s) and may include such:

(a) committees, sub-committees and groups;

(b) staff side;

(c) HR Policy Group (for HR policy documents);

(d) Clinical Standards Group (for clinical policy documents)

(e) Chief Operating Officers and Associate Medical Directors;

(f) those staff likely to be affected by any change;

(g) service users and carers;

(h) specialist advisors;

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

The author(s) in consultation with the Policy Lead or Divisional Policy Lead shall determine the period of consultation, but normally the consultation periods would be a minimum of 2 weeks.

Consultation **must** be undertaken and the Policy Document updated accordingly prior to submission to the relevant body for approval.

The Key group/ individuals consulted with must be referenced within the Policy Document in line with the *Policy Document Template* (Appendix A).

APPENDIX E

Recommending Approval / Approving a Policy Document

Depending on the type of Policy Document / subject matter, the final version of the document (once agreed by the relevant Executive Director) should be sent by the Author to the Committee or Group responsible for either (1) recommending the approval of the Document, or (2) approving the document.

The table below outlines which committees/ Executive Directors are responsible for either approval or recommending the approval of the different type of Policy Document at a high level together with the committee responsible for final approved of the document. Further detail can be obtained by the Corporate Governance Team.

Trust-wide Policy Documents			
Type of Document	**Lead Executive Director**	**Recommending body/ bodies**	**Approving Officer/ Body**
Clinical practice	Executive Director of Nursing and Operations	Patient Safety Committee / Clinical Standards Group	Executive Director of Nursing and Operations
Infection Prevention and Control Matters	Executive Director of Nursing and Operations	Infection Control Committee	Executive Director of Nursing and Operations
Mental Health Act - Governance	Medical Director	Mental Health Act Managers Committee	Board of Directors
MHA / MCA / DoLs – practice	Medical Director	Mental Health Act Managers Committee	Medical Director
Medicines Management documents	Medical Director	Drugs and Therapeutics Committee	Medical Director
Safeguarding	Executive Director of Nursing and Operations	Safeguarding Strategy Group	Executive Director of Nursing and Operations
Risk	Medical Director	Audit Committee	Board of Directors
Governance	Executive Director of Communications and Corporate Governance	Audit Committee	Board of Directors
Health and Safety – Overarching Policy Document	Executive Director of Communications and Corporate Governance	Health and Safety Committee	Board of Directors

Health and Safety – other documents	Executive Director of Communications and Corporate Governance	Health and Safety Committee	Executive Director of Communications and Corporate Governance
HR / Workforce	Executive Director of Workforce	HR Policy Group	Executive Director of Workforce
Equality and Diversity	Executive Director of Workforce	Equality and Human Rights Committee	Executive Director of Workforce
IT / Informatics	Executive Director of Finance / Medical Director	Joint IG and Caldicott Committee	Executive Director of Finance / Medical Director
Divisional Policy Documents			
Type of Document	**Lead Executive Director**	**Recommending body**	**Approving Body**
All Policy Documents	Relevant Chief Operating Officer	Relevant Divisional Group	Operational Management Group

APPENDIX F

IMPLEMENTATION, MONITORING AND TRAINING

Implementation Plan

All new Policy Documents or those subject to major change will require an implementation plan which:

(j) 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);

(k) 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 development;
- (iv) how the policy document will be monitored;

The *Implementation Plan* template is part of the *Policy Template (*Appendix A*)*. This can be removed from the template if a Policy is already in place and is subject to only minor change.

Policy Monitoring Arrangements

Every Policy Document should include the process to be undertaken to monitor adherence to the policy document including how this will be monitored, how often, who will lead this process and where the outcomes will be reported. Authors should take account of the range of existing processes (e.g., quality review visits, complaints, performance indicators) which provide evidence that can then be used to monitor / provide assurance on the effectiveness of the use of policy documents to avoid introducing additional monitoring arrangements/ audit requirements.

Training

Lead Author(s) will be required to identify training requirements as part of the development or review of a Policy Document. Authors will need to 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 on-going personal development. Lead Author(s) will need to liaise with the Strategic Workforce Committee through their HR Business Partners should it be deemed necessary for training to mandatory.

APPENDIX G

POLICY DOCUMENT CHECKLIST

CONTENT		
		Yes/No
Page 1	Policy No	
	Scope of document	
	Recommending Committee	
	Approving Committee	
	Date Ratified	
	Next Review Date	
	Version Number	
	Lead Executive Director (job titles only)	
	Lead Author(s) (job titles only)	
	Version/date	
	Footer – Policy Ref and Title	
Page 2	Document Name (Policy title)	
	Document Summary (brief description of document)	
	Author(s) and contact details	
	Published by: MCT details and website details	
	To be read in conjunction with (names and ref numbers of any other relevant policies	
	Version Control: list each version produced and date	
Page 3	Supporting statements 1. Safeguarding 2. Equality and Human Rights	
Page 4	Process Flow Chart (for quick access by staff)	
Page 5 onwards	Clear purpose and rationale	
	Aims of the Policy Document	
	Scope	
	Definitions	
	Duties	
	Process	
	Consultation	
	Training and Support	
	Monitoring Arrangements	
Supporting Documents	Equality Analysis	
	Implementation Plan (for new documents)	
	Additional Appendices	