Nottinghamshire Hospice
adding life to days

POLICY/PROCEDURE INFORMATION (Policy no OP003)	
Subject	**Policy for Policy Development** *(This policy is subject to periodic review and will be amended according to service development needs)*
Applicable to	All staff involved in policy, procedure and guideline development
Target Audience	This policy must be read and understood by all staff involved in policy, procedure and guideline development
Date issued	Sept 2018
Next review date	Sept 2021
Lead responsible for Policy	Chief Executive Office
Policy reviewed by	CEO and EA
Notified to (when)	Corporate Management Team Aug 18
Authorised by (when)	Strategy and Corporate Governance Aug 18
CQC Standard if applicable	
Links to other Policies	All Nottinghamshire Hospice Policies
Summary	This policy should be followed by anyone who is responsible for creating or reviewing a policy, procedure or guideline document for use in Nottinghamshire Hospice
This policy replaces	NH00002

VERSION CONTROL		
Status	**Date**	**Review/authorised date**
Original policy written by Donna Payne, Director of Operations	Jun 2015	Jun 2017
Policy reviewed by Rowena Naylor-Morrell, CEO and Katie Budd Executive Assistant	July 2018	
Updated front cover and formatted document	Aug 2018	
Updated Policy Log and published on Policy Doc App	Sept 2018	
Updated logo and published on website	December 2020	

1. INTRODUCTION

1.1. This policy sets out how all procedural documents policy, process, standard operating procedure (SOP) or guideline will be developed by the Hospice.

1.2. Procedural and policy documents should not be developed in isolation and their development should be balanced against the priorities of the Hospice and the content of other existing policies and procedures.

1.3. All policies that do not go through the process outlined in this policy will not be ratified or implemented.

2. POLICY AIMS AND OBJECTIVES

2.1. The aims of this policy are to ensure that a systematic and evidence based approach is applied to the development of any policy, process, standard operating procedure (SOP), or guideline that is to be used by the Hospice.

3. DEFINITIONS

3.1. **Strategy** is a detailed plan for achieving organisational success that generally includes an action plan.

3.2. **Policy** is a statement of the Trustee Boards agreed position and governing principles relating to a specific issue or situation. They promote the ethos and values of the organisation as well as clarifying roles and responsibilities. Policies have a purpose to guide staff and volunteers on what to do in any given situation. Organisations are expected to have policies on a number of subjects including staffing, clinical, health and safety, equal opportunities, finance etc. A policy says what you must know or do.

3.3. **Procedure** is a set of actions that are official or accepted way of doing something. Reasons for deviation from a procedure are usually recorded. A standing operational procedure (SOP) is a laid down procedure for doing routine activities and are used to minimise risks. A procedure is an unambiguous document that describes the responsibilities and the procedures, including audit, which are necessary to safely and accountably manage a set of processes. Procedures inform staff of what steps to take to implement a policy. A procedure is a set of actions which are the accepted way of doing things. A procedure tells you how it must be done.

3.4. **Guideline** is a document setting out a preferred method of operation, which may be clinical or non-clinical. Other methods are not prohibited but a reason for deviation from the guideline should be fully justified and documented. A guideline tells how it may be done.

3.5. **Clinical guideline** is a document that is systematically developed method of operation to assist practitioner and patient decisions about appropriate healthcare for specific clinical situations. A clinical guideline is often informed by national guidance e.g. National Institute of Clinical Excellence (NICE) and codes of practice. The

Hospice recognises and uses the Royal Marsden clinical guidelines, which are used nationally.

3.6. **Protocol** is a document that enables staff to put evidence into practice by addressing the key questions on what should be done, when and by whom at a local level. It tells you how it should be done.

3.7. **Stakeholder** is a person or a party with an interest in the Hospice e.g. employees, patients, volunteers and may have a valid interest in the content of any document.

4. ROLES AND RESPONSIBILITIES

4.1. **Chief Executive** has accountability for ensuring the provision of high quality, safe and effective services by the Hospice. The CEO must approve all policies before they are forwarded for ratification.

4.2. **Trustees** are responsible for ratifying policies and procedures through sub groups to ensure that the policies are deliverable.

4.3. **Trustee Subgroups** are responsible for quality checking all documents to ensure statutory and Hospice requirements are met and that new documents have been adequately published and implemented.

4.4. **Corporate Management Team** is responsible for ensuring the content of policies and procedural documents reflect the legal and regulatory requirements of their core operations and that they support the main function and principles of the Hospice Strategy. CMT are also responsible for ensuring that policies and procedural documents are implemented into practice when published.

4.5. **Managers** are responsible for communicating the publication of a policy or procedure that is relevant to their area of business to their staff and volunteers, and providing evidence that the document has been cascaded, and implemented. They also need to ensure that staff do have the knowledge and skills to implement the policy.

4.6. All **staff and volunteers** are responsible for adhering to published policies and procedures, ensuring they attend training and keep their competencies up to date. They are also required to cooperate with the development and implementation of policies as part of their normal duties and responsibilities.

4.7. **Authors** are responsible for researching the legal, regulatory and recommended practice that is needed to inform policy content and circulate it with stakeholders for comments and make amendments (as appropriate) prior to the final sign off.

5. STYLE AND FORMAT

5.1. Below is the agreed format for policies that are developed for use by Nottinghamshire Hospice.

5.2. Style – all documents

- In Arial, font size 11
- Each item must be numbered and have a header
- All page footers must contain the name of the document and number of the page with the total number of pages
- Once ratified each document will be allocated a policy number and added to the policy list

5.3. Format – all documents must contain as a minimum the following completed section

- Cover sheet
- Version control sheet
- Contents page / index
- Introduction
- Aims and objectives
- Main body of the policy
- Implementation process
- Monitoring process

6. DEVELOPING OR REVIEWING A POLICY OR PROCEDURE

6.1. Before a policy or procedure can be developed, CMT must assess whether the policy or procedure is required

6.2. Policies will need to be reviewed within 12 months if a staff member leaves the Hospice who has either contributed to a policy or is named in the policy

6.3. The Executive Assistant who holds and manages the policy list on behalf of the CEO will advise CMT if a policy needs reviewing three months before the policy is due to expire.

6.4. When developing or reviewing a policy the author must consider the following questions:

- What is the purpose of the policy
- Who is the policy for
- Is there an existing policy, procedure, process or system
- Are there any existing practice that needs to be considered when writing the policy
- Do you have the latest information that will inform this policy?
- Have information security, confidentiality / data protection, and information quality requirements been taken into account

6.5. The author will need to define the area or situation the policy is required to cover, whether there is any legislation or recommended practice that needs to be included in the policy. Advice and clarity can be sought from the CMT as appropriate.

6.6. The author will draft a policy or procedure using the style and format described in section 5.

6.7. The draft policy must be circulated for consultation with relevant stakeholders. The author is not obliged to incorporate stakeholder comments but should be able to provide a rationale for any decision not to include them. Once the author has incorporated any comments they feel appropriate they must forward the document to the Executive Assistant, who will take to CMT for content approval.

7. APPROVAL, REVIEW AND RATIFICATION OF POLICIES AND PROCEDURES

7.1. The content of all policies and procedures must be reviewed and approved by the CMT to ensure the content is relevant and reflects the needs of the Hospice.

7.2. Once the content has been approved the policy should be forwarded to a trustee led sub group for ratification e.g. Strategy and Corporate Governance or Quality and Safety Group.

7.3. Any policies ratified by a sub group should be included in the next Board meeting agenda for information as a consent item.

8. CONTROL OF DOCUMENTS

8.1. Authors will be responsible for version control of draft documents until the document has been sent to the Executive Assistant. Once a policy has been ratified, all draft versions held by the author may be deleted.

8.2. The Executive Assistant will hold and maintain a register of all ratified policies and procedural documents centrally on the N:drive > Policies and Procedures.

8.3. The database as a minimum should consist of the following

- Document title
- Policy number
- Date of ratification / authorisation
- Date of renewal
- Manager responsible
- Name of author / last reviewed by
- Where the policy is located

8.4. All policies should have a control sheet attached to them to record all changes and updates. See appendix 2.

8.5. The Executive Assistant should keep a master copy of the final word version of the document electronically on the N:drive – Policies and Procedures.

8.6. The policy / procedure should be published as a PDF document to prevent it being altered outside of the policy process.

8.7. Once a policy/ procedure has been reviewed and ratified any earlier version of the document will be archived in a restricted folder for 6 years on the N:Drive > Policies and Procedures > ARCHIVE > Department

8.8. All documents must have a review date to recommend when it is advisable for the policy or procedure to be updated

8.9. In the situation where the policy or procedures has gone past its review date it will remain valid until it has been reviewed up to a maximum of 6 months, this variance in process must be agreed with the CEO.

8.10. The Corporate Management Team is responsible for ensuring that policies and procedure are reviewed within 3 months of their expiry date and agreeing contingency plans as appropriate where this cannot be achieved.

8.11. All reviewed documents will go through the same approval and ratification process as a new policy / procedure unless it is considered a minor change. This will be decided by CMT and if so will not require further consultation.

9. IMPLEMENTATION

9.1. The Executive Assistant will inform CMT the document has been ratified and uploaded to the N:Drive.

9.2. The Executive Assistant will send out an 'All Users' email alerting staff that a new policy has been added to the policy and procedure folder.

9.3. The Executive Assistant will upload the new policy to the 'Policy Doc App' to ensure remote staff who do not have access to the N:Drive are aware of new policies / procedures.

9.4. Managers need to ensure relevant new policies and procedures are placed on team meeting agenda's for discussion.

9.5. Line Managers are expected to develop local systems to ensure that staff actually read and understand the policies and procedures that are relevant to their area, this could be via team meetings, training etc. This should be no later than 30 days from the date of issue and need be confirmed on email to the Executive Assistant when complete, so it can be added to the Policy Log.

10. TRAINING NEEDS

10.1. Training that is needed for the policy to be implemented should be identified, sourced or written and included in the policy content at the time of writing. This should identify which groups / grades of staff or volunteers need to receive the training, frequency, content and whether this will be an internal or externally provided course. Training

requirements should then be passed to HR as it is usually their responsibility to arrange.

10.2. The Hospice acknowledges that it is not always possible for training to be provided prior to a policy being published but will endeavour to provide the training within 90 days of the policy being published.

APPENDIX 1: TEMPLATE FOR POLICY FRONT COVER, VERSION CONTROL AND CONTENT

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POLICY / PROCEDURE INFORMATION (Policy no XXXX)	
Subject	NAME OF POLICY *(This policy is subject to periodic review and will be amended according to service development needs)*
Applicable to	XXXX
Target Audience	XXXX
Date issued	XXXX
Next review date	XXXX (Usually 2 years from issue date)
Lead responsible for Policy	XXXX
Policy reviewed by	XXXX
Notified to (when)	Corporate Management Team
Authorised by (when)	XXXX
CQC Standard if applicable	XXXX
Links to other Policies	XXXX (Please include their policy no)
Summary	XXXX
This policy replaces	(If applicable)

VERSION CONTROL		
Status	**Date**	**Reviewed date**
Original policy written by XXXX		
Policy reviewed by XXXX		
Updated front cover and formatted document		
Updated Policy Log and published on Policy Doc App		

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APPENDIX 2: POLICY PROCESS FLOWCHART