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East Hampshire

Primary Care Trust

Guidelines for producing Policies and Procedures

Version 2.0

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Guidelines for developing Policies & Procedures

1. INTRODUCTION

1.1 This document sets out arrangements for the development and management of policies and procedures in East Hampshire Primary Care Trust.

1.2 Policies are often linked to the strategic aims and vision of the organisation that in turn, may be based on statutory requirements, codes of conduct, codes of practice and national guidance. The need for a Policy or Procedure can also arise from the identification of a situation or set of circumstances that poses a threat to the organisation, an individual or groups of individuals, property or reputation.

1.3 The PCT Board is accountable for the delivery of services and work within both a legal framework and contracts agreed with Purchasers. Within this, the PCT has developed its own direction, values, service strategies and business plans. Policies and procedures reflect and underpin these initiatives and facilitate development and change, whilst ensuring that the interests of the public and staff are safeguarded.

1.4 Policies are designed to cover key issues relating to the spectrum of the PCTs business. They may be **Corporate,** applying to all parts of the PCT, **Care Group or Service related**, i.e. specific to a particular service or client group, or **Local,** i.e. specific to a particular location.

1.5 This document is primarily concerned with **Corporate Policies**, however **Section 6** does include brief guidance relating to development of Care Group/Service and local Policies.

2. DEFINITIONS AND SCOPE

2.1 ***Policies*** can state one or more of the following:

- what must be done to reduce, manage or eliminate a risk (e.g. violence and aggression, health & safety, lone working)
- the PCTs approach to an operational management (e.g. internet usage), personnel management (e.g. appraisal) or clinical management issue (e.g. nurse prescribing)

2.2 ***Guidelines***, ***protocols,*** and ***procedures*** set out a process for enabling staff to comply with a Policy.

2.3 As the various terms used are open to different interpretation, the definitions adopted for the purpose of this document are set out in **Appendix A**.

2.4 Certain Policies and Procedures will relate to issues managed or lead by a Shared Support Service. For example, IM&T support is provided to the PCT by Portsmouth Hospitals Trust as is the Occupational Health service; the PCTs Estates function is provided by Portsmouth City PCT, and so on.

2.5 This development procedure applies to all policies that relate to East Hampshire PCT including those developed by a Shared Support Service. Therefore, policies proposed by a Shared Support Service which relate to the PCT, must have comply with the trial, consultation and implementation process described in the next Section before they will be formally endorsed and adopted by East Hampshire PCT.

3. NEW POLICY DEVELOPMENT PROCESS

Proposing a new Corporate Policy

3.1 Any member of staff can suggest that a new Policy or Procedure is needed. The person wishing to develop the Policy should firstly check with the Business Manager to ensure there is not an existing policy or one under development. If there is not, the policy proposer should complete **Appendix B** (Policy Proposal Form) of this Policy and arrange for it to be submitted to the relevant Committee for consideration:

Type of Policy:	Development to be approved by:
Operational Risk (clinical and non-clinical) Policies	Risk Management Committee
Clinical Practice Policies................................	Clinical Governance Committee
Personnel & Occupational Health Policies..........	Human Resources Committee
Financial Policies...	Audit Committee
Medicines Management Policies......................	Prescribing Sub (PRES) Group

3.2 The person proposing the Policy may be asked to attend the relevant Committee to give more details.

3.3 The Committee will take the following factors into consideration in deciding whether to agree or disagree with the Policy development:
- whether it is an issue which indicates significant and ongoing risk to people or the organisation and there is no clear guidance to staff
- whether it is a management issue and there is no clear guidance to staff
- whether there is an existing policy which covers the suggested topic or if such guidance does exist, it is out of date
- whether national, legal or other directives indicate a need for local action
- whether there is a change in existing national policy which needs to be reflected in local guidance
- what level of final approval is needed – Executive Committee or Board level.

3.4 The proposer will be informed of the Committee's decision and if approval is given, policy development will begin. The Committee will also provide direction regarding the most appropriate person to develop the Policy and who (individuals or groups of staff) should be consulted during the development process. The person allocated with responsibility for development of the policy will forward the proposal form to the Business Manager who will maintain a register of Policies under development.

Format & Content

3.5 Each corporate policy should be as succinct as possible and follow a standard format to ensure that all relevant issues are covered. **Appendix C** sets out the Standard Policy format.

Development, Trial & Consultation

3.6 Policy documents should make use of existing advice/guidance and *not* replicate it. This is particularly true where there are clear national directives, which must be followed by the Trust. In these cases it may be sufficient to adopt that document with some local interpretation where that is needed, together with appropriate procedures.

3.7 When developing a Policy or Procedure, it is important to recognise that to achieve compliance the Policy must be realistic and achievable at local level, and there must a sense of ownership from local staff. One way to achieve this is to offer Policies and Procedures for comment to the staff that it will ultimately effect. The co-operation of all staff is essential to ensure that the PCT's policies are realistic and consistent.

3.8 Various groups/teams/services or individuals should be involved in and consulted about the policy, prior to approval by Operational Management Group and the PCT Executive Committee. These are set out in the diagram in **Appendix E** and include:

Policies relating to Directly Managed Services - Operational Management Group members, Prescribing Sub Group (if medicines implications), Audit Committee and Professional Advisory Groups where relevant. Other organisations such as purchasers and other providers, GPs, etc. will also need to be consulted on shared policies or those which potentially affect them.

Clinical & Non-Clinical Risk Management Policies (e.g. those relating to clinical care) should be referred to the appropriate professional advisory groups such as the Health & Safety Committees, Risk Management Group, Medical Advisory Committee, Clinical Governance Committee, Prescribing Sub Group, the Professional Advisors' Group or the Nursing Network for comment.

Commissioning Policies should be shared with the Whole Systems Planning & Commissioning Group.

Policies relating to or impacting upon **Independent Contractors** should be shared during development with the Primary Health Care Team Development Group.

Corporate Policies which affect the whole organisation such as **Finance, Personnel & Occupational Health Policies Policies**, it may be appropriate to consult staff groups and staff organisation representatives, via the Joint Negotiating Committee for example. For all proposed Personnel Policies, the Senior Personnel Manager will advise about the most appropriate method of consultation. For Finance Policies, the Audit Committee should be consulted during the development process.

This list is provided as an example and is not exhaustive. The Policy author needs to assess which individuals, groups and organisations should be consulted during the development process and seek their comments. Failure to fully consult could hinder progress through the approval stage.

3.9 Policies that require a change in practice or the introduction of a new system or process may benefit from being trialled or tested in a selection of services.

3.10 As part of the development process, Policy authors must also consult with other Trusts to ensure that, wherever possible, those policies developed by the PCT are consistent with other local policies, philosophies and approaches. This will assist East Hants PCT staff that work across the District in complying with policies, wherever they may be working.

Approval

3.11 Once a Policy/Procedure has been tested, trialled and consulted on, it should be presented to the relevant Group for first level approval. Again see **Appendix E**:

	Approval Body:
▪ Commissioning Policies	Whole Systems Planning & Commissioning Group
▪ Independent Contractors	Primary Health Care Development Group
▪ Managed Services	Operational Management Group
▪ Corporate Policies	Combination of any of the above as appropriate

3.12 The person who has developed the Policy may be asked to attend the meeting to give more details and bring the Policy to life.

3.12 The relevant Group can approve a Policy at its first presentation or, if anything is unclear, further consultation is needed, etc, refer it back to the author for amendment. Depending on that nature/scale of the amendments, the author may be asked to re-present the Policy at a later date, or make the amendments suggested and then submit for approval at the next level, without returning to the approval Group.

3.13 The next level is approval by the Executive Committee. As long as the Policy has been through the former processes, it is unlikely the author will be asked attend the Executive Committee meeting. For some policies, this level of approval will be sufficient and after the Executive Committee meeting the policy author should arrange for the Business Manager to receive a copy so that distribution can be arranged.

3.14 Certain policies will also require Board approval (e.g. Risk Management, Health & Safety, etc) Once the Board has approved the Policy, the Business Manager will arrange for it to be distributed to Policyholders.

Implementation

3.15 This is the most important phase of the policy and procedure development process. In order to ensure compliance, policies and procedures must to be communicated effectively to staff and introduced and implemented appropriately.

3.16 When Policies are presented to the relevant Group for approval, an appropriate method of implementation and a timetable will be agreed. The nature and content of the Policy will dictate how it should be implemented which could range from Managers discussing the Policy at team briefings, raising at the PCT Communications Group, organising one-off events to launch the policy and developing an ongoing training programme. If training is required, the various stages will include:
Identifying those people in the organisation who need to be fully conversant with the policy

- Mapping out the training and education requirements.
- Devising a training package and programme
- Implementation within a given time scale

3.17 When formal training is arranged by the Training & Development Department (hosted by Fareham & Gosport PCT), staff will be required to sign a Register to say that they have attended training session(s) and/or read relevant materials. This is particularly important in the case of activities such as manual handling where there is a

high risk of litigation. Following attendance on formal training, staff will be issued with a Training Certificate that they retain. Evidence of attendance on other training courses will be kept in the individual's personal file that is held by their Line Manager.

3.18 As well as specific implementation plans, staff will be made aware of new Policies as they are approved via Information Exchange, team briefings and staff meetings, the Quarterly Quality Report and SEQUAL (Quality Newsletter).

3.19 At Induction with their Line Manager, new staff will be informed of the existence of, content and local interpretation of specific policies that relate to their role, and how they can be accessed on a day to day basis. This will be recorded on the Induction Checklist, which is signed by both Manager and new member of staff.

Distribution

3.21 The Business Manager at PCT Headquarters will arrange for distribution of Policies and Procedures to individuals who have been identified as Corporate Policy holders.

3.22 Policyholders will acknowledge receipt by returning a reply slip and confirming that they have discussed details and implications of new and revised policies with relevant staff.

3.23 Each Policyholder is responsible for storing policies in clearly labelled and recognised folders.

3.24 It is every Policyholder responsibility to ensure that the whereabouts of the Policy folders is made known to staff, and that the policies are accessible and available to staff to refer to, at any time.

3.25 Policies will also be available on a read-only basis to all staff with access to the PCTs intranet. Policies can be accessed via *(web site address to be entered).*

4. POLICIES MANAGEMENT

Central Co-ordination

4.1 The **Finance Director** is the Executive Lead for policy management and for providing an assurance to the PCT Board that there is an effective process for developing, consulting, approving, distributing and reviewing policies is in place.

4.2 Responsibility for managing the Central Register of policies and co-ordinating distribution to policy holders is the responsibility of the **Business Manager**.

4.3 The Central Register includes details of:

- Each policy, author, approval date, and review date
- Address of each Policy Holder
- The status of each Policy – under development, approved, awaiting distribution, under review, etc.

4.4 The Policies Register and a file copy of the Policy itself (including all appendices) will be held on PCT intranet for ease of updating, access and reference.

4.5 Effective policy management is an essential part of Corporate Governance and Risk Management. The **Risk & Governance Manager** will liaise with and where appropriate offer support and advise the Finance Director and Business Manager in managing this process.

Revision

4.3 Policies require regular review to take account of changing circumstances. All policies are subject to annual or bi-annual review unless circumstances change significantly in the meantime. The first review date and review frequency will be agreed at OMG at the time the Policy is first approved.

4.4 Manager's personal objectives will include responsibility for review of policies for which they are accountable.

4.5 The Business Manager is responsible for liaising with Policy leads to ensure they are reviewed on time and re-distributed.

4.6 The central Policy Register will allow identification of policies due for review. The person who developed or last revised a policy will be responsible for arranging the latest review, on request from the Business Manager.

4.7 The stages of policy revision should include:

- seeking comments on the policy from the relevant personnel
- literature review to check the information is up to date
- ensuring that no other policy overlaps
- consultation with relevant groups on any revision

4.8 Authors will be asked to complete a pro forma to identify the changes made to the Policy, which will accompany the Policy through the re-approval process and when it is re-distributed.

4.9 If there are significant changes to a Policy, other than just to minor wording, the author should again attend relevant Committees to explain the changes and their implications, present the Policy to the relevant approval body and liaise with relevant Managers during implementation, etc.

4.10 The policy will then be returned to the Executive Committee for re-approval, following which, the Business Manager will arrange re-distribution.

5. MONITORING COMPLIANCE WITH POLICIES

5.1 It is intended that the process defined in this document will ensure that any PCT Policy and Procedure is timely, realistic and necessary. The consultation and trial phase of the development procedure should allow implementation and compliance difficulties to be raised and the Policy adapted accordingly.

5.2 It is therefore important that any member of staff who finds it difficult or impossible to comply with a particular Policy or Procedure informs their Manager as soon as possible.

5.3 In most circumstances, ensuring there is Policy compliance among individual members of staff is the responsibility of each Manager or Service. However, if implementation and compliance has proved difficult across a number of Services or the

PCT as a whole, the author may be required to review and revise it, following a period of further consultation with the Services involved.

Annual Risk Assessment

5.4 Appended to each new Policy should be a risk assessment checklist. A checklist template is shown in **Appendix D**. The checklist will be included in the PCT document "**A Guide to the Risk Assessment Process**" and will ensure that compliance is audited in each area across the PCT, on a yearly basis. The Risk Assessment process requires that PCT Headquarters are informed of any risk (e.g. non-compliance) issues arising from assessment and action being taken. All issues of Policy non-compliance will be entered in the Primary Care Trust's Risk Register.

6. SERVICE, CARE GROUP or LOCAL POLICY DEVELOPMENT

6.1 Some Corporate Policies require adaptation and interpretation for local use (by a site, service or care group); where this is the case, members of the Risk & Governance Leads Group will ensure that the locally adapted Policy is cross-referenced to and meets the requirements of, the Corporate Policy.

6.2 There are other occasion's when a Corporate Policy or Procedure does not exist but local policies, procedures and guidelines are developed to aid staff in day to day working practices.

> **Example :** the PCT Code of Financial Procedures contains a reference to petty cash management arrangements across the Trust. Many areas that maintain a petty cash float, have developed their own, more detailed and locality specific, petty cash procedures to act as an aide memoir and guide for the person(s) with petty cash responsibilities.

6.3 In such instances, Managers of areas where local policies may exist are responsible for ensuring they are developed in line with PCT protocols (where applicable), recognised good practice, etc.

6.4 It remains a requirement that local policies and procedures are validated/approved via a source independent to the author. For example, in relation to the example above, local petty cash procedures should be checked by the Finance Department.

6.5 Where local policies exist, Managers are responsible for making sure they are reviewed regularly and kept up to date.

6.6 For information and to avoid duplication of effort, a list of Service, Care Group and local policies will also be held on the Central Policies Register at PCT Headquarters. An updated index for Care Group and Service policies should be sent to the Business Manager at Trust Central Office whenever a change is made.

7. DISTRIBUTION

East Hampshire PCT Corporate Policy Holders
All Service Managers

PCT Management Team
Shared Support Services Managers (IM&T, Estates, Occupational Health, Training & Development, etc)

Author/s	Julie Jones, Risk & Governance Manager
Approved by	Operational Management Group – November 2001
Date 1st Approved by Executive Committee	**December 2001**
Date 1st Reviewed & approved by the Executive Committee	**January 2003** Reviewed by Julie Jones, Risk & Governance Manager in consultation with the PCT Policy Review Group. Presented for approval/agreement to: ▪ Operational Management Group ▪ Prescribing Sub-Group ▪ Audit Committee ▪ Primary Care Development Group ▪ Planning & Commissioning Group

APPENDIX A

CORPORATE POLICIES

DESCRIPTION OF RELATED TERMS

Policy Document

Sets out the organisations approach to management of a particular issue; it includes accountability arrangements, standards and requirements.

Procedure

Detailed guidance about how a particular task should be carried out; a step by step guide which someone not familiar with the work can follow. A procedure often sets out the process which is required in order to meet the requirements of a Policy.

Code of Practice

Laid down specifications of standards, which have to be met within a legal framework.

Code of Conduct

Standards laid down by a professional body which have to be adhered to by members of that profession

Guidelines

Advisory standards, the application of which lead to good practice.

Standards

Statements specifying a required level of performance for the purpose of monitoring or auditing.

Accountable Person

The person(s) who has a duty required by the Trust to develop a policy, consult with the relevant bodies, obtain approval, and update the policy at the specified time.

Responsible Person

The person(s) who has a duty to oversee the implementation of policy and ensure that their staff are fully conversant and comply with the requirements of the policy.

APPENDIX B

Policy/Procedure Proposal Form

The person/group/team wishing to develop a Policy or Procedure for the PCT should complete this form.

Subject	
Content Outline	
Why is it needed?	
List the NHS or statutory guidance the proposed Policy links to	
Who is target audience/will be required to change practice?	
What are the anticipated cost implications? (a) for implementation (b) ongoing	
What are the anticipated training implications (a) for implementation (b) ongoing	
Who will be consulted as part of the development process?	
Will the Policy/Procedure be trialled, if so, where?	
Who will develop the Policy?	
What is the proposed launch date?	
Who proposes the Policy?	
Proposal date	

APPENDIX C

STANDARD POLICY FORMAT

Each Policy should contain the following information, in the following order:

Purpose
A statement of the overall intended purpose and, if appropriate, why it has been produced, e.g. as a result of national directive.

Scope/Definition
This briefly describes the scope of the subject, to whom it applies and any definitions required to ensure that it will be clear to anyone reading the document.

Responsible Persons
The person(s) with a duty to carry out the implementation of policy and ensure that their staff are fully conversant comply with the requirements of the policy, and the staff who are expected to adhere to the policy.

Requirements

This is the heart of the policy setting out the standards and action required.

Audit Standards and Criteria

This section describes how compliance with the policy will be monitored, problems identified and appropriate action taken.

Reference Documentation

The purpose of this section is to specify any reference documentation on which the policy is based such as legislation, statutory requirements, national directives, codes of practice, library search material etc.

Procedures/Guidelines

The relevant procedures should follow the policy document. It should be explicit in this section whether the procedures need to be applied verbatim across the PCT or whether they are guidelines on which local/service/care group procedures should be based.

Appendices

Includes any forms or templates which support the Policy or Procedures

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Author/s (Accountable Persons)
Approved by

Date Approved by Executive Committee

Date of 1st Review

APPENDIX D

Lone Working

This risk assessment checklist summarises the requirements of the **Lone Working Policy**.

EXAMPLE

1.	Are there any staff who work in isolation (i.e. alone in a building or part of a building), in people's homes or who travel as part of their job?	**YES**	**NO**	If **NO** proceed no further
2.	Is there a written Statement, which sets out Lone Working Systems/Procedures for these staff?	**YES**	**NO**	
3.	Has the Lone Working Statement been communicated to all staff working in the area?	**YES**	**NO**	
4.	Are Lone Working procedures covered as part of new staffs Induction?	**YES**	**NO**	
5.	Does the Lone Working Statement include arrangements for (where applicable):			
	a) risk assessing new clients for safety risks to staff?	**YES**	**NO**	
	b) staff checking in & out with base during the day?	**YES**	**NO**	
	c) ensuring staff whereabouts are known/traceable?	**YES**	**NO**	
	d) access to and appropriate use of mobile phones and/or other communications devices?	**YES**	**NO**	
	e) making staff aware of incident reporting requirements?	**YES**	**NO**	
	f) access to out-of-hours management support for staff?	**YES**	**NO**	
	g) emergency procedures for staff thought to be missing?	**YES**	**NO**	
	h) requirements for recording car registration numbers?	**YES**	**NO**	
	i) sharing information about known risks with other staff/services/agencies?	**YES**	**NO**	
	j) guidelines on not leaving property (Trust or personal) in vehicles wherever possible (such as patient notes, equipment, drugs, medicine bags, etc.)?	**YES**	**NO**	
6.	Is the Lone Working Statement reviewed and updated each year as applicable?	**YES**	**NO**	

APPENDIX E