POLICY/PROCEDURE INFORMATION (Policy no OP003)	
Subject	**Policy Management Policy OP003** *(This policy is non-contractual and is subject to periodic review and will be amended according to service development needs).*
Applicable to	All staff and volunteers of Nottinghamshire Hospice
Target Audience	This policy must be read and understood by all staff involved in policy, procedure and guideline development
Date issued	3 Oct 2024
Next review date	3 Oct 2024
Lead responsible for Policy	Chief Executive
Policy reviewed by	Governance Lead
Notified to (when)	Senior Leadership Team 3 Oct 2024
Authorised by (when)	Senior Leadership Team 3 Oct 2024
CQC Standard if applicable	Well-led
Links to other Hospice Policies	All Nottinghamshire Hospice Policies
Links to external 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	Policy for Policy Development Policy OP003 (2023-7)

IMPORTANT NOTICE

Staff should refer to the Hospice website for the most up to date Policy. If the review date of this document has passed it is still valid for 3 months. After that staff should seek advice from their clinical lead or manager.

VERSION CONTROL		
Status	**Date**	**Review 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	
Policy reviewed by Governance Lead	Jan 2023	August 2026
Notified to Strategy and Corporate Governance Sub-Group	29 Oct 2024	
Authorised by Strategy and Corporate Governance	18 Jul 2023	18 Jul 2026
Authorised by Senior Leadership Team	3 Oct 2024	3 Oct 2027
Updated Policy Log and published on Policy Doc App	Sept 2018	
Updated logo and published on website	Dec 2020	Jul 2023
Updated on website	Jul 2023	Oct 2024

1.	**Introduction** This policy sets out how all procedural documents policy, standard operating procedure (SOP) or guideline will be developed by the Hospice. 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. All policies that do not go through the process outlined in this policy will not be ratified or implemented.
2.	**Policy Aim** The aims of this policy are to ensure that a systematic and evidence-based approach is applied to the development of any policy, SOP, or guideline that is to be used by the Hospice. It is supported by a Policy and Procedures SOP.
3.	**Definitions** **Policy** A policy is an internal document written for a specific audience linking to specific service aims (improving service quality, keeping patients and service users safe). Policy is mandatory, we must do as they say and they are often linked to legislation or regulation. Policy should be: ***Specific*-** if it is uncertain, then the implementation will become difficult ***Clear*-** it should be written in plain English and avoid use of jargon and connotations ***Reliable/uniform*-** so it can be followed by staff ***Appropriate*-** to the present Hospice goals ***Simple*-** and easily understood by all the policy applies to

Inclusive/Comprehensive- In order to have a wide scope

Stable- otherwise it will lead to indecisiveness

Procedures (SOPs)

Procedures provide details of how to comply with the policy by providing step by step instructions or checklists.

They are founded on evidenced based practice/best practice

Procedures are also mandatory.

Guidance

A guideline is defined as a principle or criterion that guides or directs action.

Guidance/guidelines provide general advice and support for policies. They are usually produced by national bodies expert in the specific topic.

Guidelines are voluntary/optional although, as an organisation if we have recommended, they are followed, staff would need to evidence why they did not.

Clinical guidelines

Clinical Guidelines are a 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 nationally recognised Royal Marsden clinical guidelines.

Stakeholder

A Stakeholder is a person or a party with an interest in the Hospice e.g., staff, patients, volunteers and partner agencies and may have a valid interest in the content of any document.

4.	**Roles and Responsibilities** **Chief Executive** Has accountability for ensuring the provision of high quality, safe and effective services by the Hospice. **Senior Leadership Team (SLT)** SLT members are responsible for deciding which policies and SOPs are required within their areas and prioritising their development. **Trustees** Are responsible for authoring policies through the Board and Committees. They are responsible for quality checking all policy documents to ensure statutory and Hospice requirements are met. **Leadership Team (LT)** LT 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. LT are also responsible for ensuring that policies and procedural documents are implemented into practice when published. They are responsible for communicating the publication of a policy or procedure that is relevant to their area of business to their staff and volunteers, They also need to ensure that staff have the knowledge and skills to implement the policy. **Staff and volunteers** 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.

	Authors 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** Below is the agreed format for policies that are developed for use by Nottinghamshire Hospice. • Arial, font size 12 • Tables within documents, arial font size 11 • Each item must be numbered and have a header • All page footers must contain the name of the document the month/year it was authorised and number of the page with the total number of pages • Once authorised each document will be allocated a policy number and added to the policy list All documents must contain as a minimum the following completed sections (See Appendix 1) • Cover sheet • Version control sheet • Contents page / index • Introduction • Aims • Main body of the policy • Equality Impact Assessment (or statement explaining why it is not required) • References (as appropriate)
6.	**Policy Development** A new policy, procedure or guideline will usually be developed when:

- There is a change in legislation or regulation
- A gap has been identified from the service/practice
- Following an Accident/ Serious Incident/Case Review

Policy Structure

All policies must use the relevant standard Policy Template (Appendix 1) and be written in a style which is concise and clear using unambiguous terms and language. These include the style and format which must be followed for all policy documents.

Naming a Policy

Policies must be titled to make it easier for users to find e.g., using key words/starting with key words.

Policy Number

All policy documents will be uniquely numbered by the Governance Lead, issuing the policy number for each new document. Each Department in the Hospice will have an identifying prefix:

- CS – Care Services
- FR – Finance and Resources
- PS – People Services (previously Human Resources - HR) * including Volunteer Policies
- NH – Hospice Wide (previously Operations - Op) *
- IG – Income Generation

Policy Author

For each policy developed or reviewed there will be a designated Policy Author. The Policy Author will be responsible for reviewing, developing and consulting upon the policy, considering statutory and national requirements,

current legislation, standards or best practice e.g., Care Quality Commission standards, NICE Guidance, HSE).

The Governance Lead will support in terms of process, guidance, research.

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?
- Is 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 considered?

The author will need to define the area or situation the policy is required to cover. Advice and clarity can be sought from the LT as appropriate.

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

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 Governance Lead, who will forward it to the appropriate member of SLT.

What next?

Consultation

All changes to existing policies and new policies must be developed with the involvement of key stakeholders and undergo appropriate consultation on their content prior to seeking approval. Examples of appropriate consultation may

	include individual(s) with expertise in their fields (and other appropriate stakeholders such as working groups, staff groups, patients). Consultation should be proportionate to the changes made to existing policies, and the impact upon the organisation. As part of the consultation process the Author will also consider the target audience of the policy i.e., which groups of staff need to know and comply with the content of the policy. The target audience will be clearly identified on the Target Audience (Front Page), for example nursing staff. LT will be responsible for implementing the Policies once reviewed or developed.
7.	**Equality Impact Assessment (EIA)** EIAs are tools that will help us to place equality, diversity and inclusion at the centre of what we do. All policies and procedures will have an EIA carried out at development or review in line with the Equality Impact Assessment Policy PS037.
8.	**Reviewing a Policy or Procedure** Newly developed policies will be reviewed within 12 months, thereafter existing policies and procedures will be reviewed at a maximum of 3 years. A policy may be called forward for review at an earlier date if: • There is a change to legislation/national or local guidance • Learning from a Serious Incident • Feedback from practice that the policy/procedure needs to be updated. The Governance Lead who holds and manages the policy list will prompt the Policy Lead and Author 3 months before a policy review date is due. The Governance Lead will support the Author through the review if necessary. In the situation where the policy or procedure has gone past its review date it will remain valid until it has been reviewed up to a maximum of 3 months.

	If a policy review needs to be delayed by more than 3 months (agreed by SLT), the Governance Lead will update the Policy/SOP front page review date in red detailing the delay and a revised date of no longer than 12 months.
9.	**Approval, Review and Authorisation of Policies and Procedures** **Policies** Once the content has been approved by the appropriate SLT Lead, the policy should be forwarded to the Board or Trustee led committee for authorisation e.g., Strategy and Corporate Governance or Quality and Safety Committee. Policies that are at the one year review will be authorised by SLT unless there are substantial changes that will require them to go back to committee. Any policies authorised by a committee should be included in the next Board meeting agenda for information as a consent item. **Board Ratification** The following policies must be ratified by the Board of Trustees • Complaints • Health and Safety • Liquidity, Investment and the Treatment of Reserves • Safeguarding Children at Risk (annual review) • Safeguarding Adults at Risk (annual review). **Procedures (SOPs)** Procedures (SOPs) will be ratified by the Policy Working Group which has core representatives from all Directorates and coopted members as required. They will then be authorised by SLT. **Urgent Policy change/development** If there is a need to urgently amend a Policy/SOP or develop one quickly, approval can be sought from the relevant committee via email correspondence and later authorised at the next meeting.

10.	**Implementation** The Governance Lead upload the Policy document to the Hospice website. The Governance Lead will forward a PDF copy of the authorised policy to People Services for uploading to the Bluestream Academy (where appropriate). The Governance Lead will produce a Policy on a Page briefing, specifically targeted to those staff and volunteers the Policies and SOPs are relevant to. This will be circulated by the Executive Assistant. LT will ensure relevant new policies and procedures are placed on team meeting agendas for discussion. LT are expected to have in place systems to ensure that staff read and understand the policies and procedures that are relevant to their area, this could be via team meetings, training etc.
11.	**Control of Documents** Authors will be responsible for version control of draft documents until the document has been sent to the Governance Lead. Once a policy has been ratified, all draft versions held by the author may be deleted. The Governance Lead will hold and maintain a register of all ratified policies in a PDF format. Copies of the original Word documents and work in progress will be held by the Governance Lead. The Governance Lead will also hold a database on excel outlining the current status of all policies. The Policies and Procedures database as a minimum will consist of the following • Document title • Policy number • Date of authorisation • Date of renewal

	• Manager responsible • Name of author / reviewer All policies should have a control sheet attached to them to record all changes and updates. See Appendix 1. All documents must have a review date to recommend when it is advisable for the policy or procedure to be updated. All reviewed documents will go through the same approval process as a new policy / procedure unless it is considered a minor change. This will be agreed by the appropriate SLT Lead.
12.	**Archiving**. 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.
13.	**Training Needs** 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 their responsibility to arrange (in most circumstances). 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 Document, Version Control and Content

Nottinghamshire Hospice adding life to days **POLICY/PROCEDURE INFORMATION (Policy no)**	
Subject	*(This policy is non-contractual and is subject to periodic review and will be amended according to service development needs).*
Applicable to	All staff of Nottinghamshire Hospice
Target Audience	Others such as agents, consultants and other representatives of Nottinghamshire Hospice may be required to comply with the policy as a condition of appointment.
Date issued	
Next review date	
Lead responsible for Policy	
Policy written/reviewed by	
Notified to (when)	
Authorised by (when)	
CQC Standard if applicable	
Links to other Hospice Policies	
Links to external policies	
Summary	
This policy replaces	

IMPORTANT NOTICE

Staff should refer to the Hospice Intranet for the most up to date Policy. If the review date of this document has passed it is still valid for 3 months. After that staff should seek advice from their clinical lead or manager.

VERSION CONTROL		
Status	**Date**	**Reviewed date**
Original policy written by		
Policy reviewed by		
Policy notified to		
Policy ratified by		
Updated control sheet and published on Intranet		

Appendix 1 continued

INDEX

Policy Process Flowchart