# Policy:

## CG 006 - Policy Framework

| | |
|---|---|
| **Executive Director Lead** | Director of Corporate Governance (Board Secretary) |
| **Policy Owner** | Head of Corporate Assurance |
| **Policy Author** | Head of Corporate Assurance and Director of Corporate Governance |

| | |
|---|---|
| **Document Type** | Policy |
| **Document Version Number** | V9 |
| **Date of Approval By PGG** | May 2024 – Policy Governance Group |
| **Date of Ratification** | July 2024 |
| **Ratified By** | Audit and Risk Committee |
| **Date of Issue** | June 2024 |
| **Date for Review** | 30/04/2027 |


**Summary of policy**

This policy outlines requirements around development and approval of policies. Standing Operating Procedures (SOPs) are managed locally however the Policy Governance Group oversees management of the Master schedule of SOPs in place.


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|---|---|
| **Target audience** | All SHSC staff (including staff seconded into or working in SHSC services) |

| | |
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| **Keywords** | Policies, procedures, Standard Operating Procedures, SOP, guidelines, guidance, protocols, document, author, write. |

**Storage & Version Control**

This is Version 9 of the policy and is stored and available through the SHSC Intranet. V8 involved a full revision to incorporate the adoption of changes that were agreed in-year.

This version of the policy supersedes the previous version. Any copies of the previous policy held separately should be destroyed and replaced with this version.

**Version Control and Amendment Log**

| Version No. | Type of Change | Date | Description of change(s) |
|---|---|---|---|
| Version 7 | New draft policy created | 07/2019 | New policy commissioned by EDG on approval of a Case for Need. |
| Version 7.2 | Amendment | 04/2020 | Amended to include Policy Verification and Ratification Groups on the Checklist as agreed at Policy Governance Group. |
| Version 7.3 | Amendment | 06/2020 | The addition of the EIA Form on the Contents Page |
| Version 8 | Full revision | 08/2020 | Date of issue inserted and 2 appendices amended. |
| V9 | Review / approval / issue | 04/2024 | Policy moved to current policy template<br>Addition of 'Actions' – key points for action from this policy.<br>Addition of a flowchart - page 4<br>Addition to text throughout the document to support clarity of process and procedure<br>Update to titles, and reporting committees throughout the document<br>Addition of Policy blank template as an appendix – appendix 1 |

**Contents**



# Action

These are the key points for action from this policy:

- The Policy Framework is designed to provide guidance to Policy Owners and Authors to support the development, consultation and approval of all policies within the Trust.
- This framework and its associated templates should be followed for ALL policies within the Trust.
- Staff within the Trust as asked to familiarise themselves with the requirements outlined and to follow the processes outlined

**Flowchart – summary process to follow.**

New/ Review of Policy:
Contact policygovernance@shsc.nhs.uk. The policy register will be updated, a reference number will be assigned (for new policies) and advise will be provided. Documentation can be found on Jarvis

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Development:
Develop/ review the policy using current best practice/evidence practice. See section 5.3. Each Policy that is submitted to PGG must meet the 5-way test – see section 6 – and evidence for each of the 5 items must be given.

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Action Plan, Flowchart and QEIA:
Key points for action from the policy to be highlighted to strengthen the cascade to staff approach.
A flowchart, summarising the policy and processes to be followed, including references to sections of the policy to assist with finding the right place in the full document.
QEIA -potential impact on staff, patients or the public

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Consultation:
Consult on the new policy or changes to a reviewed policy via Jarvis by contacting communications@shsc.nhs.uk

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Review/New Policy Checklist:
Complete this checklist to be used as part of the development or review of a policy and presented to the Policy Governance Group (PGG) with the revised policy. (See appendix 3)

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Following approval of the policy at Policy Governance group, the policy will the submitted to the relevant Board subcommittee for ratification.

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Approval:
Ensure the Executive lead is sighted on the policy. Following sign off by the Executive lead, submit the policy and the summary report (see appendix 3) for Policy Governance group (PGG) to policygovernance@shsc.nhs.uk

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Extensions to review dates: These will be presented in line with policy approvals as shown in paragraph 6.1 and require the approval of the Policy Owner (the Director lead) before a request is made. See appendix 5.

## 1. Introduction

1.1 In order to ensure a consistent, high-quality level of service provision across the whole organisation, it is essential for the Trust to set standards that are evidence based and developed in conjunction with relevant stakeholders. These need to be compliant with mandatory requirements and consistent with the Trust's strategic objectives. To achieve this, it is important to have procedural documents that are developed and managed in a systematic way within the Trust.

1.2 A policy is defined as a statement of strategic intent or principle setting out SHSC's position and/or practice and reflecting the organisation's values and core purpose. This guidance applies to all policies and other procedural documents that are developed by SHSC for implementation.

1.3 The purpose of this document is to implement a co-ordinated and uniform approach to policy development and management; and to provide clarity and consistency to the process of policy production, approval, implementation and review.

1.4 SHSC will develop policies as required to fulfil statutory and organisational requirements. These will be comprehensive, formally approved and ratified, disseminated through approved channels, and implemented.

1.5 This policy and procedure seeks to reduce risk by having a robust document control process in place, so that the right procedures are available to the right staff at the right time, by ensuring that staff receive appropriate training, and ensuring that each procedure is regularly reviewed.

## 2. Scope

2.1 This policy applies to all policies, procedures and SOP developed and reviewed within SHSC. It applies to all staff working for, or seconded to, Sheffield Health and Social Care Trust. The guidance applies to all staff who develop, implement and review Trust-wide and service-specific clinical and corporate policies, procedures and protocols.
This guidance applies to documents which have been created by a team or department; and which describe how that team/department or individuals in it perform their daily tasks, such as Operational policies, System specific policies, Clinical operational policies, Business Operational policies, Standard Operating Procedures

## 3. Purpose

3.1 Sheffield Health and Social Care NHS Foundation Trust (SHSC) will develop policies to fulfil all statutory and organisational requirements. These will be comprehensive, formally approved and ratified, disseminated through approved channels and implemented.

3.2 The purpose of this guidance is to implement a co-ordinated and uniform approach to strategic, operational and clinical management by ensuring the development and management of procedural documents which are clear and consistent

## 4. Definitions

The different types of procedural documents used within the Trust are as follows:
Policies

4.1 A policy is a document that describes the principles, rules, and guidelines formulated or adopted by an organisation to reach its long-term goals and support the delivery of strategy. They are published widely in the organisation and would generally be expected to not contain information that would prevent their publication more widely.

4.2 Policies and procedures are designed to influence and determine all major decisions and actions, and all activities take place within the boundaries set by them. Policies should consist of a policy statement and may also include detail on procedures where it is appropriate for this to be contained within the policy document.

Procedures

4.3 A procedure is the specific method employed in day-to-day operations. A procedure is a series of steps followed in regular order to be complete a given task (to implement a policy or otherwise).
Whether a procedure is detailed within the policy or a separate Standard Operating Procedure (see below) will depend on the circumstances and judgment of the Policy Owner and Policy Author (see paragraphs 4.1 and 4.2).

Standard Operating Procedures

4.4 A Standard Operating Procedure (SOP) is a set of written instructions that document a repetitive or routine activity and is an integral part of an effective quality system. These are developed locally and relate to a policy. A SOP would ordinarily be an internal document that is available to the service or services to which it applies.

4.5 It may be necessary to develop local variations to procedures, given the range of services provided by the Trust. A register of locally approved procedural documents must be maintained by each individual directorates. Standing Operating Procedures (SOPs) are managed locally however the Policy Governance Group oversees management of the Master schedule of SOPs in place and teams are required to forward their SOPs registers to the policy governance administrator for registering on the master register.

4.6 The SOP should be forwarded to the Communications team for uploading to Jarvis.

Other documents

4.7 Other documents may be in circulation from time to time such as guidelines, which would normally reflect nationally prescribed practice, or protocols. These are acceptable but services should consider whether the document would best fit under one of the categories described above for consistency and to ensure appropriate governance channels are followed for development, review and approval.

## 5. Duties - Roles in reviewing, developing, approving and ratifying a policy

5.1 The **Director of Corporate Governance** is responsible for managing and maintaining an effective policy governance system. The Corporate Assurance team overseen by the Head of Corporate Assurance will hold a central register of all policies and Standard Operating Procedures and shall update the registers regularly.

5.2 The **Policy Owner** (the **Executive Director lead)** will be notified on a regular basis by the administrator to the Policy Governance Group of existing policies within their remit which are due for review or beyond their review date. The Policy Owner will also be responsible for identifying where new policies are required or where existing policies can be archived and whether the policy should be made available on the

website, intranet (Jarvis) or both.

5.3 Policies should be developed and reviewed by an appropriate **Policy Author**, as nominated by the policy owner. The Policy Author is responsible for ensuring the policy is drafted appropriately, that a Case for Need is completed for a proposed new policy and that any revision to existing policies are completed in line with requirements. The Policy Author is responsible for ensuring that the draft policy has used the appropriate template, been consulted on and has been tracked through the normal governance routes. They are responsible for ensuring the Policy Owner has signed off the policy prior to its submission through governance approval routes.

5.4 **Policy Champions** are nominated individuals across services who take a dual role in representing their services. In relation to policies that fall within their services, Policy Champions may represent their services in the consideration of proposals such as extensions to review dates, and play a key role in ensuring policies within their directorate are reviewed on time. In relation to policies from other services, Policy Champions will contribute relevant views that need to be taken into account on behalf of their services. These discussions will normally take place at or in advance of Policy Governance Group.

5.5 **Policy Governance Group** is a meeting of Policy Champions, chaired by the Director of Corporate Governance, where the approval of policies and extension to review dates is considered and recommendations made to Executive Management Team and/or the ratifying board sub committees.

5.6 **Board committees** are those committees which report directly into the Trust Board, where the ratification of decisions made by Policy Governance Group is considered.

## 6. Procedure - Policy approval

6.1 Policy Governance Group will meet monthly, or as agreed by the group, to consider any new or amended policies requiring approval and to consider any extension requests. The policy shall be presented by the Policy Owner or Policy Author. The policy may be presented by the relevant Policy Champion where they have consented to represent the Policy Owner or Policy Author. It should go through the team's relevant professional and/or assurance and /or governance groups for agreement prior to being presented to the Policy Governance Group for approval, on their recommendation.

6.2 In determining whether the policy is fit for approval, Policy Governance Group will consider each Policy that is submitted to PGG and whether it meets the 5-way test – see below – and therefore evidence for each of the 5 items must be given.

6.3 Test 1. That the policy has been developed using current best practice/evidence practice
Test 2. Evidence that it has been through appropriate consultation including staff side
Test 3. That there is an agreed plan for dissemination and training
Test 4. That audit arrangements have been clearly identified and agreed
Test 5. That staff wellbeing has not been negatively impacted, or that the policy update has positively impacted staff wellbeing, and how

6.4 Where Policy Governance Group is satisfied that it can approve the policy, it can be considered a live document with immediate effect although final ratification has not yet been achieved by the ratifying board subcommittee. As a live document actions such as making immediate and urgent changes to procedure can be implemented, and the policy can be uploaded to the intranet and shared. Where changes are

required between formal policy review and approval points which are minor chairs action can be sought from the Chair of the Policy Governance Group and this will then be recorded in the minutes of the next meeting.

6.5 The policy checklist to be completed in advance of policies being considered by Policy Governance Group is shown at Appendix 2.

6.6 The cover report to be used for consideration of new/amended policies by Policy Governance Group is shown at Appendix 3.

6.7 The policy template is available from the Corporate Governance team. This template should be used for all policies. Where flexibility in approach is needed the Policy authors should indicate this on the cover sheet to explain why a change is needed in order for the Policy Governance Group to agree if such a change is appropriate. (See Appendix 4

Any change from the prescribed template should ensure it provides the required information for staff and/or service users and others as appropriate to understand what is required, include information enabling the Policy Governance Group to consider it and include an Equality Impact Assessment appendix, completed appropriately.

## 7. Procedure - Policy Extension

7.1 Where a policy has not been reviewed within the previously agreed timescale, or where it is anticipated that it will not be approved, Policy Governance Group can approve extensions to review dates. These will be presented in line with policy approvals as shown in paragraph 5.1 and require the approval of the Policy Owner (the Director lead) before a request is made.

7.2 In determining whether the policy review date should be extended, Policy Governance Group will consider:

- Whether the current policy is fit for purpose and should be advised of this by the Policy Owner and Policy Author;
- Any risks arising from extending the review date;
- Whether the grounds for extension are reasonable;
- Whether the policy author is able to confirm that the five tests detailed at paragraph 5.2 will all be satisfied in consideration of an amended or new policy by the time of the proposed extension.

7.3 The cover report for consideration of extensions to review dates by Policy Governance Group is shown at Appendix 5.

## 8. Procedure - Ratification

8.1 The relevant Board Committee, at the next opportunity following the Policy Governance Group meeting, will consider any approved policies or review date extensions within their area of responsibility and in doing so will be provided with a report which outlines key changes to the policy/and or the rationale for any extension request.

8.2 In determining whether the decision should be ratified, the committee will receive a report from the Director of Corporate Governance detailing how it applied the five tests shown in paragraphs 5.2 and 6.2 in reaching its decisions.

8.3 Where an approved policy is not ratified, the Policy Owner and Policy Author will be informed immediately and will be required to prioritise taking immediate steps to alleviate any areas of concern highlighted by the Board Committee in order to report back to the Policy Governance Group and Board Committee at the next opportunity. If a policy is approved subject to changes requested by Policy Governance Group these should be made immediately following the meeting in order to ensure the policy is published at the earliest opportunity and prior to the policy being advised for ratification at the board committee.

8.4 Where a review date extension is not ratified, the policy's status will be changed to 'beyond its review date' and overdue with immediate effect and the Executive Management Team advised at their next meeting.

## 9. Openness and transparency in the policy approval process

9.1 As policies have the potential to impact on a wide range of people including staff, service users and the public, the availability of material relating to the approval and ratification of policies shall normally by available to view upon request. Reasons for refusal could include the inclusion of confidential or sensitive information, but the presumption will be in favour of openness at all times.

9.2 Where a person is unable to utilise a written report or minute extract due to a disability or other reasons, the Director of Corporate Governance will make arrangements for this information to be communicated in a means which is deemed reasonable, acceptable and appropriate.

## 10. Development of this Policy Framework

10.1 As indicated throughout this policy, any policy should include both formal and informal consultation throughout its development. This should enable all interested parties to be involved in, and have the opportunity to influence, policy development so as to ensure the process is logical and efficient and the outcome meets the corporate needs of SHSC.

10.2 This policy will be developed by consultation across the Trust using the Trust communications systems. Feedback from policy authors and the policy governance administrator on areas to strengthen has been incorporated into the policy review. The Policy Governance Group and the Executive Management Team will contribute to its review

10.3 This Policy Framework details the management of policies, as defined at paragraphs 3.1 and 3.2, within the organisation. Procedures and SOPs, as defined in paragraphs 3.3 and 3.4, are managed within services; the Policy Governance Group will oversee management of the SOP master schedule.

## 11 Audit, Monitoring and Review

A three-year review date is proposed for a formal review of this policy.

The Policy Governance Group shall take regular feedback from its membership around the functionality of this policy and propose changes as required. If these can be adopted without the need for a policy refresh, then any changes will be consulted upon with Board Committees or Board Committee Chairs as appropriate.

The Director of Corporate Governance shall take feedback from Board Committees and Chairs on the improvement of the process as monthly reports are considered.

| **Monitoring Compliance Template** | | | | | | |
|---|---|---|---|---|---|---|
| Minimum Requirement | Process for Monitoring | Responsible Individual/ group/committee | Frequency of Monitoring | Review of Results process (e.g. who does this?) | Responsible Individual/group/ committee for action plan development | Responsible Individual/group/ committee for action plan monitoring and implementation |
| Policy Governance | Review | Policy Governance Group | 3-yearly | Executive management Team<br>Audit and Risk Committee | Corporate Assurance team | Corporate Assurance team |

**Policy review date: April 2027**

## 12 Implementation Plan

The processes detailed within this policy have been adopted following review of policies from across NHS Trusts. Consultation with the Policy Governance Group, Executive Management team in advance of it being proposed for approval, to achieve best practice outcomes. The policy will therefore be formally implemented with immediate effect upon its approval.

No additional training needs have been identified, although these may arise periodically as Policy Champions change within services**.**

| Action / Task | Responsible Person | Deadline | Progress update |
|---|---|---|---|
| Publish new policy on the Trust Intranet and website, and remove old version | Policy Governance Administrator via the Communications team | May/June 2024 | Following approval by Policy Governance Group and ratification from the appropriate Board subcommittee. |
| Trust electronic communications media | Policy Governance Administrator via the Communications team | May/June 2024 | |
| Overall accountability | Director of Corporate Governance and Head of Corporate Assurance | N/A | Review as part of Policy Governance Group |

## 13 Dissemination, Storage and Archiving (Control)

The issue of this policy will be communicated to all staff via the SHSC Extranet -Jarvis. Local managers are responsible for implementing this policy within their own teams.

This policy will be available to all staff via the Sheffield Health & Social Care NHS Foundation Trust Intranet and on the Trust's website. The previous version will be removed from the Intranet and Trust website and archived.

Any printed copies of the previous version should be destroyed and if a hard copy is required, it should be replaced with this version. Managers are responsible for ensuring that hard copies of any policy/procedure manuals or files stored locally are kept up to date. It is the readers' responsibility to ensure that they are reading the most up to date version of this policy, which will always be the on-line version available on the policy section of the Intranet. Word and pdf copies of the current and the previous version of this policy are available via policygoverance@shsc.nhs.uk.

| Version | Date added to intranet | Date added to internet | Date of inclusion in Connect | Any other promotion/ dissemination (include dates) |
|---|---|---|---|---|
| Version 9 (current version) | tbc | tbc | tbc | tbc |
| Version 8 | September 2020 | September 2020 | September 2020 | N/A |
| Version 7 | August 2019 | August 2019 | August 2019 | N/A |
| Version 6 | December 2017 | December 2017 | December 2017 | N/A |
| Version 5 | August 2016 | August 2016 | August 2016 | N/A |
| Version 4 | June 2016 | June 2016 | June 2016 | N/A |
| Version 3 | Sept 2011 | Sept 2011 | Sept 2011 | N/A |
| Version 2 | January 2009 | January 2009 | January 2009 | N/A |
| Version 1 | July 2007 | July 2007 | July 2007 | N/A |

## 14 Training and other Resource Implications

Support for policy authors to support delivery of effective and high quality policies.
Resources withing the corporate assurance team to ensure accurate recording and monitoring of completed policies.

## 15 Links to Other Policies, Standards, References, Legislation and National Guidance

- Records Management Policy
- Freedom of Information Act 2000 Policy
- The Trusts Good Communication Guide
- Care Quality Commission
- Equality Act 2010

## 16 Contact Details

| Job Title | Name | Contact |
|---|---|---|
| Director of Corporate Governance | Deborah Lawrenson | deborah.lawrenson@shsc.nhs.uk |
| Head of Corporate Assurance | Amber Wild | amber.wild@shsc.nhs.uk |
| Policy Governance Group Administrator | Danielle Cooper | policy.governance@shsc.nhs.uk |

## Appendix 1

## Equality Impact Assessment Process and Record for Written Policies

**Stage 1** – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? This should be considered as part of the Case of Need for new policies.

| | | |
|---|---|---|
| **NO** – No further action is required – please sign and date the following statement.<br>**I confirm that this policy does not impact on staff, patients or the public.** | ***I confirm that this policy does not impact on staff, patients or the public.***<br>Name/Date: Amber Wild, Head of Corporate Assurance – 18 March 2024 | **YES,** Go to **Stage 2** |

**Stage 2 Policy Screening and Drafting Policy** - Public authorities are legally required to have 'due regard' to eliminating discrimination, advancing equal opportunity and fostering good relations in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance and Flow Chart.

**Stage 3** – **Policy Revision** - Make amendments to the policy or identify any remedial action required and record any action planned in the policy implementation plan section

| SCREENING RECORD | Does any aspect of this policy or potentially discriminate against this group? | Can equality of opportunity for this group be improved through this policy or changes to this policy? | Can this policy be amended so that it works to enhance relations between people in this group and people not in this group? |
|---|---|---|---|
| **Age** | **No** | **No** | **No** |
| **Disability** | **Yes** | **Yes** | **Inclusion of Section 8 and specifically paragraph 8.2 to ensure access to information to all.** |
| **Gender Reassignment** | **No** | **No** | **No** |
| **Pregnancy and Maternity** | **No** | **No** | **No** |

| | | | |
|---|---|---|---|
| **Race** | **No** | **No** | **No** |
| **Religion or Belief** | **No** | **No** | **No** |
| **Sex** | **No** | **No** | **No** |
| **Sexual Orientation** | **No** | **No** | **No** |
| **Marriage or Civil Partnership** | **No** | | |

Please delete as appropriate: - Policy Amended / Action Identified (see Implementation Plan) / no changes made.

Impact Assessment Completed by: Amber Wild
Date: 18 March 2024

**Appendix 2**

# Review/New Policy Checklist

This checklist to be used as part of the development or review of a policy and presented to the Policy Governance Group (PGG) with the revised policy.

| | | Tick to confirm |
|---|---|---|
| | **Engagement** | |
| 1. | Is the Executive Lead sighted on the development/review of the policy? | ✓ |
| 2. | Is the local Policy Champion member sighted on the development/review of the policy? | ✓ |
| | **Development and Consultation** | |
| 3. | If the policy is a new policy, has the development of the policy been approved through the Case for Need approval process? | N/A |
| 4. | Is there evidence of consultation with all relevant services, partners and other relevant bodies? | ✓ |
| 5. | Has the policy been discussed and agreed by the local governance groups? | EMT May 2024<br>Staff Side May 2024 |
| 6. | Have any relevant recommendations from Internal Audit or other relevant bodies been taken into account in preparing the policy? | N/A |
| | **Template Compliance** | |
| 7. | Has the version control/storage section been updated? | ✓ |
| 8. | Is the policy title clear and unambiguous? | ✓ |
| 9. | Is the policy in Arial font 12? | ✓ |
| 10. | Have page numbers been inserted? | ✓ |
| 11. | Has the policy been quality checked for spelling errors, links, accuracy? | ✓ |
| | **Policy Content** | |
| 12. | Is the purpose of the policy clear? | ✓ |
| 13. | Does the policy comply with requirements of the CQC or other relevant bodies? (where appropriate) | ✓ |
| 14. | Does the policy reflect changes as a result of lessons identified from incidents, complaints, near misses, etc.? | ✓ |
| 15. | Where appropriate, does the policy contain a list of definitions of terms used? | ✓ |
| 16. | Does the policy include any references to other associated policies and key documents? | ✓ |
| 17. | Has the EIA Form been completed (Appendix 1)? | ✓ |
| | **Dissemination, Implementation, Review and Audit Compliance** | |
| 18. | Does the dissemination plan identify how the policy will be implemented? | ✓ |
| 19. | Does the dissemination plan include the necessary training/support to ensure compliance? | ✓ |
| 20. | Is there a plan to<br>i. review<br>ii. audit compliance with the document? | <br>✓<br>✓ |
| 21. | Is the review date identified, and is it appropriate and justifiable? | ✓ |