# POLICY DEVELOPMENT FRAMEWORK

| | |
|---|---|
| Lead Manager: | Head of Policy |
| Responsible Director: | Director of Corporate Planning and Policy |
| Approved by: | Policy Planning and Performance Group |
| Date approved: | 17 January 2008 |
| Date for Review: | January 2011 |
| Replaces previous version: [if applicable] | n/a |

# Policy Development Framework

## Contents



## Appendices

## 1. Introduction

NHS GGC requires a robust framework for the development, approval and management of policies and other associated documents. This framework aims to ensure that:

- There is a consistent and clear approach to policy development, consultation, approval, dissemination / communication, access to documents and review
- NHSGGC complies with relevant legislation, governance, audit and controls assurance requirements
- Policy processes are appropriate for new organisational arrangements and single system working
- The impact of policies is fully assessed and understood
- Policies in use are current, relevant and up to date
- NHSGGC meets its commitment to embed an equalities approach into all our functions.

## 2. Scope

This policy applies to all NHSGGC staff in all locations.

It sets out the route to be followed when developing or updating policies, strategies and procedures and introducing them within the organisation. The following broad definitions are applied:

*Policy* - statement of intent, describing the approach or course of action the organisation is taking in respect of a particular issue.

*Strategy* – long term plan setting out the organisation's major objectives and broad actions to achieve them

*Procedure* - detailed steps taken to fulfil a policy

## 3. Roles and Responsibilities

**Director of Corporate Policy and Planning**

- Overall responsibility for policy framework.
- Provide advice on policy processes including approvals process and equality impact assessment, through the Head of Policy and the Corporate Inequalities Team

**Head of Policy**

- Author and lead manager for the policy development framework
- Provide advice on policy processes

- Ensure implementation of the framework, including the development of policy management systems.
- Ongoing review of the framework and processes to ensure it remains fit for purpose

**Heads of Administration**
- Ensure a database of policies and procedures is maintained and that the documents are readily accessible to all relevant staff.
- Provide advice on the policy framework
- Ensure appropriate distribution and review of policies, strategies and procedures
- Ensure a system is for policies to be placed on the intranet

**Lead Manager**
- Meet the requirements for consultation, review of evidence, impact assessment and document format as set out in the *Policy Development Framework*
- Develop a communication and implementation plan for the policy, strategy or procedure, working through the general management structure for implementation.
- Disseminate the document as appropriate with support from the Heads of Administration if required.
- Ensure that the policy, strategy or procedure is reviewed at the stated date.

**Responsible Directors**
- Ensure that the requirements of the Policy Development Framework are followed
- Provide advice to the lead manager on the approvals process, taking account of the impact assessment

**Approving Groups**
- Ensure that the development process has included appropriate consultation and review of evidence prior to approval
- Ensure an appropriate implementation and communication process is in place
- Review the impact assessment
- Ensure that policies, strategies or procedures are not approved outwith the authority of the group

**Directors and General Managers**
- Ensure systems are in place to implement relevant policies in their areas

**Line Managers**
- Ensure policies, strategies and procedures are accessible for all their staff
- Ensure staff have read and understood the relevant policies, strategies and procedures
- Ensure systems exist to identify staff training needs on the implementation of new and updated policies, strategies and procedures

**Employees**

- All staff must ensure that their practice is in line with current policies, strategies and procedures relevant to their area of work

## 4. Policy Development

Policies, strategies and procedures may be developed for one of the following:

- NHSGGC wide.
- An individual operational entity, or groups of operational entities.
- An individual department or directorate.

Policies, strategies and procedures should only be developed for individual entities or departments in isolation where they are exclusively relevant to that area. There should be no duplication of policies.

All policies, strategies and procedures should have an identified lead manager and responsible Director. The responsible Director may be a Corporate Director, Partnership Director or Acute Services Director.

Policies, strategies and procedures should meet the following standards:

- Be evidence based
- Have a clear rationale for change
- Be based on robust information about the affected group of staff or patients and the likely impact.
- Be clear about the scope
- Include wide consultation and engagement with affected parties or organisations. This should include representatives from all operational entities affected by the policy, strategy or procedure, and those responsible for implementation, as well as wider stakeholders where appropriate, e.g. patients, voluntary organisations, staff partnership groups. Consideration should be given to the need for formal public consultation, where a significant change to services is proposed in line with guidance on *Informing, engaging and consulting the public in developing health and community care services.*
- Be based on any available assessment of existing policy and systems and the likely impact of the proposed new policy, strategy or procedure.
- Meet the requirements set out in this Policy Development Framework in relation to impact assessment, format and style, approvals, communication and dissemination, audit and review
- Able to be monitored and evaluated

## 5. Impact Assessment

Impact assessment is an integral part of the process of developing policy, strategy and procedure. As a minimum, all policies should consider the following:

- Cost implications
- Workforce and staff requirements
- Service delivery implications
- Risk (clinical or financial)
- Impact on environment
- Equalities impact (EQIA). An initial screening tool is attached at Appendix 1 to help lead managers identify where an EQIA is required, using the NHSGGC EQIA tool and guidance.

Advice should be sought from appropriate specialist departments where required, such as finance or HR.

The impact assessment will be supported by wide consultation and engagement in the development process, which may identify additional impacts.

A checklist to guide impact assessment is attached at appendix 2. The completed checklist should be made available to the group or committee approving the policy.

Equalities Impact Assessments should be published alongside the policy when approved.

## 6 Format

Policies should be in a standard format which meets disability access standards, in accordance with the template at Appendix 3. Drafts should clearly state version number.

All policies should be in Arial font with a preferred font size 12 (14 where practical). Type should be justified on the left. All sentences should be in lower case. Policies should be printed in a black font on a plain background.

Policies should clearly state the following:

- Lead manager
- Responsible director
- Date of approval
- Approving body
- Date for review

Consideration should be given to the expected audience for the policy and the level of understanding of technical terms. Policies should be written in plain English avoiding the use of jargon where possible and with acronyms set out in full.

Alternative formats should be made available if requested, such as large print, audio CD, alternative languages, Braille and an easy-to-read version. All documents should state how alternative formats can be requested. Further

guidance on this will be available in the Communications Support and Language Plan.

Electronic versions of policies, including those placed on the intranet, should be in pdf files where possible or read only files to prevent alteration.

## 7 Approvals process

Policies should receive final approval from the relevant management group or committee as set out below. Documents submitted for approval should have completed all necessary consultation and revision. A higher level of approval such as PPPG should not be a substitute for a comprehensive consultation process

Each policy should have an identified lead manager and responsible Director who will take a final view on the appropriate level for approval. Further advice can be sought from the Heads of Administration and the Head of Policy.

It is the responsibility of the lead manager to identify where policies have a significant impact in any of the areas identified in section 5, which is outwith the authority of the approving group. This should be done with specialist advice, e.g. finance or HR. Where there is significant impact, policies should be approved by the relevant operational entity management group or PPPG in line with the structure set out in the table below on operational and clinical practice policies.

Policies and procedures which relate exclusively to an individual department or Directorate level can be approved by the relevant Departmental or Directorate meetings (following assessment to ensure that they don't have wider implications).

Policies, strategies and procedures presented for approval should include information on the impact assessment and implications of the policy to enable informed decisions to be made – using the template at Appendix 2. They should also be clear about who has been consulted and support for the policy, strategy or procedure from other relevant groups.

Policies, strategies and procedures should be taken to the board for approval if required in the guidance on *Decisions Reserved for the Board* (Appendix 5) or to the relevant Board committee as set out in each committee's remit (some examples identified below).

A flowchart summarising this process is included at Appendix 4.

| **Approvals structure** | |
|---|---|
| Human Resources | HR Executive |
| Child Protection | Child Protection Forum |
| Risk Management | Risk Management Steering Group |
| Clinical Governance | Clinical Governance Implementation Group |
| Health & Safety | Health and Safety Forum |
| Infection Control | Control of Infection Committee |
| Finance | Audit Committee / Board / PRG |
| Emergency and Continuity Planning | Civil contingencies strategy group |
| Prescribing and pharmacy | Prescribing Management Group<br>Area Drug and Therapeutics Committee |
| HI&T including records, information governance | HI&T programme board |
| Corporate Governance | Board / Audit Committee |
| PFPI | Involving people committee |
| Communications | Communications Group |
| Radiation | Radiation Protection Committee |
| Research and Development | R&D committee |
| Operational policies<br>Clinical Practice<br>• Acute only<br>• Mental Health only<br>• CH(C)P only<br>• All<br>• Single CH(C)P | By operational entity<br><br>Senior management group<br>Senior management team<br>CH(C)P co-ordinating group<br>PPPG (following approval by 3 above)<br>CH(C)P committee or senior management team |
| Major Service Strategies and Plans | PPPG / Board |

## 8. Communication and Dissemination

The intranet site will be the primary location for all policies, strategies and procedures. Relevant policies, strategies and procedures will also be published on the Internet site and included in the Freedom of Information publication scheme.

Following approval, policies, strategies and procedures should be forwarded to the relevant Head of Administration for inclusion on the intranet and on the document management system. The lead manager should take responsibility for distributing the policy, strategy or procedure to the relevant groups with support from the Heads of Administration.

All policies, strategies and procedures should include a clear communication and implementation plan which sets out:

- Recipients for information
- Recipients for action
- Process for ensuring availability of hard copies where this is required in specific areas
- Training required
- Any formal process such as signing for receipt to meet legislative requirements
- Timescales for implementation
- Evaluation and audit planned

## 9. Review

All policies, strategies or procedures should be reviewed every 3 years as a minimum, or sooner if there is a specific legislative or service requirement or change in guidance, law or practice.

Reviews should take account of:

- the evaluation or audit of the current policy, strategy or procedure
- changes to organisational and national policy and context
- the ongoing requirement for the policy, strategy or procedure

The lead manager for the policy is responsible for ensuring that review takes place at the appropriate time. The Heads of Administration through the policy management system will ensure that lead managers receive a prompt at the appropriate date.

## 10. Implementation of the Policy Development Framework

This document will be made available on the intranet and widely circulated to Directors, Senior Managers and the approving groups set out in section 7.

The Heads of Administration and Heads of Policy will keep an ongoing review of policy processes to ensure they are in line with the framework. The Clinical Governance Implementation Group will receive a regular report on clinical policies to ensure that clinical governance standards are met.

This framework will be reviewed 3 years from the date of approval.

ENDS

**APPENDIX 1**

**Equalities Impact Assessment – Initial Screening Tool**

This quick tool is designed to help identify whether policies require to have an Equalities Impact Assessment carried out on them. In time, all policies should have an EQIA. However, it is recognised the principles of proportionality and relevance must be applied until this becomes routine for NHSGGC. This tool aims to help identify where EQIA is essential.

Lead managers should consider in all cases that the primary purpose of EQIA is to ensure that policies do not unintentionally discriminate against people on the basis of sex, disability, race, faith, sexual orientation or age, or against particular marginalised groups. If you have any concern that your policy may result in discrimination or have a different impact on different groups of people then an EQIA should be carried out.

Priority for EQIA should be given to policies where the *primary purpose* will be a change *directly* affecting staff or patients.

**Initial Screening Tool**

| **STEP 1** |
| --- |
| **Do <u>any</u> of the following apply?**<br><br>• It is already known or expected that the policy now, or in future, impacts differently on different groups of people<br><br>• The policy has been identified as a corporate priority for EQIA (in which case the lead manager will have been informed)<br><br>• The policy aims to address inequalities or specific requirements of equalities legislation.<br><br>• The policy has a major impact on the organisation in terms of scale or significance, for example is likely to be high profile in the media or politically sensitive. |
| **YES to one or more – EQIA REQUIRED, Proceed to STEP 3**<br>**NO – proceed to STEP 2** |

| **STEP 2 – further checks** | | | |
|---|---|---|---|
| **Who will be affected by the Policy** | **In what way?** | **Impact** | **EQIA required?** |
| Patients, carers, public | Change to services – access, type, availability, outcomes | Major service change – likely to impact on large numbers of people, or make a major change to the services in place e.g. change criteria for access, significant change to location or timing | Yes |
| | | Minor change – small numbers of people, small change to access | No, provided it is not expected that a particular group will be exclusively affected |
| Staff | Change to terms, conditions or procedures | All staff | Yes |
| | | Small number of staff | No, provided it is not expected that a particular category of staff will be exclusively affected |
| Staff | Requirement to change practice to implement policy | | No |
| **EQIA required?**<br>**YES – Go to step 3**<br>**NO – END** | | | |
| **STEP 3**<br>**Carry out EQIA using the NHSGGC tool**<br>**http://staffnet/NR/rdonlyres/23BAF895-CDBA-43D1-BC7A-55D0B6D21BFE/36134/EQIAguidanceandtooldec21st076.doc** | | | |

Further advice can be sought from the Corporate Inequalities Team, Equality and Diversity Team, Heads of Administration or Head of Policy

**APPENDIX 2 – APPROVALS COVER SHEET**

**Name of Policy, Strategy or Procedure……..**

**Approving body……**

**Lead manager / Director…… …….**

| | **Requirement** | **Comment** |
|---|---|---|
| **Scope** | The scope is clearly defined. Where the scope is limited to one area, department or operational entity, there is clear evidence that it does not apply more widely. | *<<Include information on scope and justification if not NHSGGC wide>>* |
| **Consultation** | There has been wide consultation with those affected by the policy, including those with responsibility for implementation. | *<<include information on who was consulted with and response to any significant issues raised>>* |
| **Communications Plan** | There is a comprehensive communication and implementation plan in place | |
| **Finance** | Cost implications are fully understood and agreed by budget holders, or additional resource secured | *<<include details of likely cost and source of any funding>>* |
| **Equalities** | The policy has been screened to see if EQIA is required and EQIA carried out if necessary. | *<<confirm whether EQIA required and attach completed EQIA where relevant>>* |
| **Human Resources** | Implications for staff are fully understood and agreed | *<<confirm that this has been considered>>* |
| **Sustainability** | Impact on the environment (e.g. carbon emissions; travel) is understood and agreed. | *<<confirm that impact and any action to minimize impact have been considered>>* |
| **Risk** | Any risks to the organisation are fully understood and agreed | *<<confirm that appropriate risk assessment and controls are in place>>* |
| **Service Delivery** | Implications for service delivery including achievement of HEAT targets are fully understood and agreed. | *<<include details where relevant>>* |

**APPENDIX 3 - TEMPLATE**

NHS
Greater Glasgow and Clyde

# <<TITLE>>

| | |
|---|---|
| Lead Manager: | <<post title>> |
| Responsible Director: | <<post title>> |
| Approved by: | << committee or group>> |
| Date approved: | <<date>> |
| Date for Review: | <<date>> |
| Replaces previous version: [if applicable] | <<date of original>> |

## 1. Contents page

optional: dependent on the length and complexity of the document.

## 2. Introduction

Introduces the topic and includes reference and applicability of relevant legislation, definitions and context. This section should also include detail of the purpose and objectives.

## 3. Scope

The target audience for the policy or procedure. For example “this policy applies to all employees of NHSGGC in all locations”

## 4. Roles and responsibilities

expectations of staff as a whole and any specific roles and responsibilities associated with particular posts

## 5. BODY OF POLICY OR PROCEDURE

## 6. Review

Arrangements for review, including review date or any triggers for review (e.g. expected legislation)

## 7. References

**Supporting Information (may be included in main policy document, or in separate supporting documentation)**

## A Communication and Implementation Plan

To include any training required and clear plan for communications with anyone expected to be aware of or implement the policy

## B Monitoring

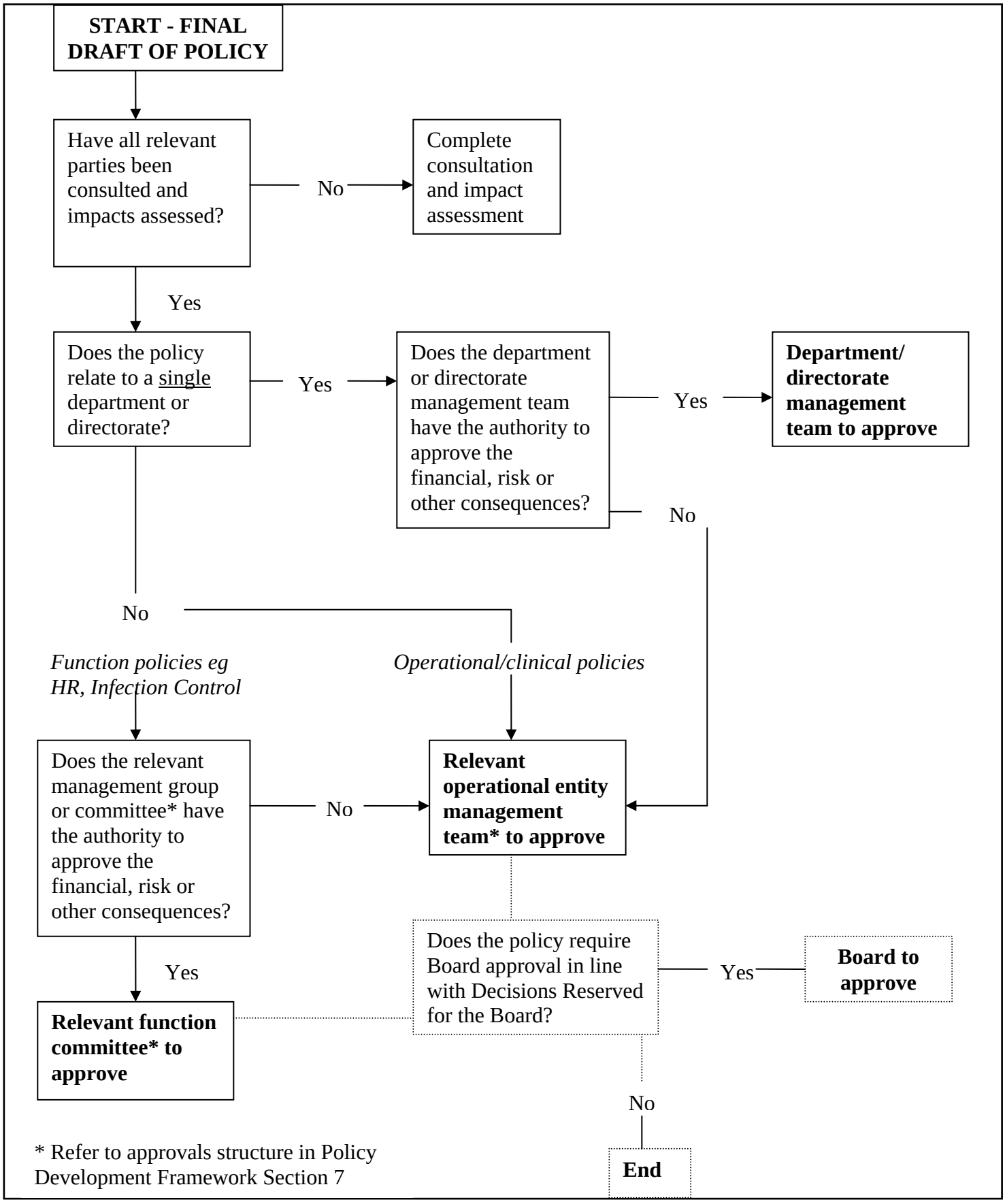
Arrangements for monitoring the implementation of the policy and whether the aims have been achieved

## C Impact Assessment

Details of the implication of the policy including risk assessment, EQIA and other impacts as set out in the policy development framework

# POLICY APPROVALS PROCESS – FLOWCHART

Appendix 4



# NHS GREATER GLASGOW AND CLYDE

## Decisions Reserved for the Board

This has been set out in a way that shows the NHS Board's responsibilities for setting the strategic direction for health improvement/care against a governance framework which is designed to ensure probity and transparency for the decision making process. It also recognises the delegation of functions to Standing Committees although does not take away the NHS Board's responsibility to take executive action across the range of its responsibilities

Strategy for Health Improvement

i) Improving the Health of the Population

ii) Strategic development and direction

iii) Development and Implementation of Local Health Plan/Local Delivery Plan

iv) Performance Management of NHS Greater Glasgow and Clyde (including the monitoring of waiting times and handling of complaints).

Governance

i) Resource Allocation (for both capital and revenue resource allocation)

ii) Approval of Annual Accounts

iii) Scrutiny of Public Private Partnerships

iv) Appointment of Directors

v) NHS Statutory Approvals

vi) Corporate Governance Framework including

- Standing Orders
- Establishment, Remit and Reporting Arrangements of all Board Committees
- Standing Financial Instructions and Scheme of Delegation

Dec 2005
Revised April 2007