South Central Ambulance Service
NHS Foundation Trust

POLICY FOR THE DEVELOPMENT OF TRUST POLICIES

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DOCUMENT INFORMATION

Author: Company Secretary

Ratifying Committee/Group: Executive Management Committee and Audit Committee

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SUMMARY

This document outlines the procedures for the preparation, approval, publication and review for official policy documents within the Trust

A definition of a policy is: a statement of the Trust's principles and intent.
The policies in themselves do not specify "how to" and as such any policy should be supported by other working documentation such as procedures. Policies are high-level statements and provide Trust rules for consistent practice and to ensure compliance.

Key principles:

- All new and revised policy documents need to be reviewed and approved by the appropriate Committees in the Trust at Executive and at Board level. Policy approval paperwork, including a certificate to be used when approving new and revised policies is available on the intranet.

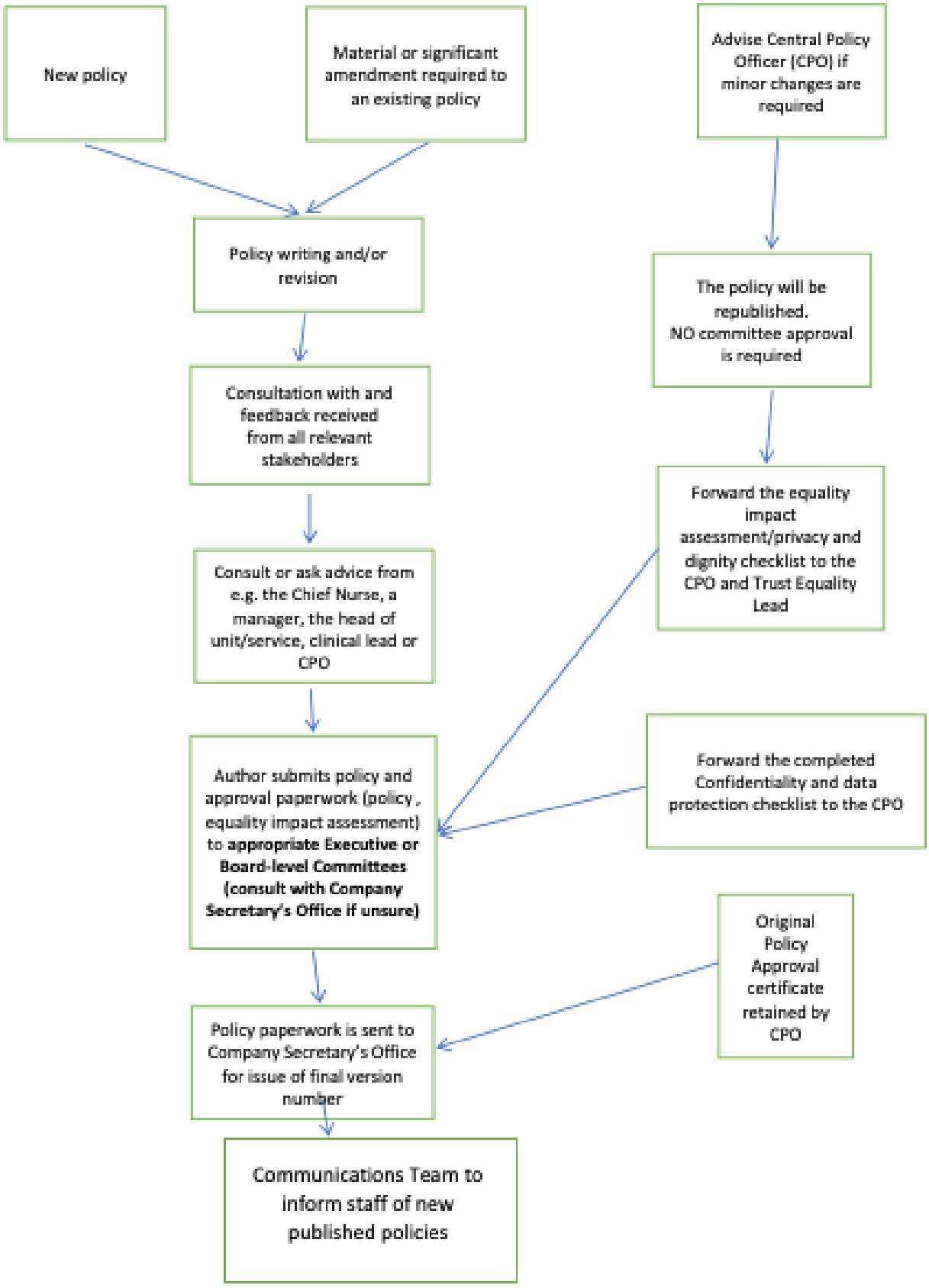
- All policy documents must show evidence of consultation and have a dissemination plan to demonstrate who has been consulted as part of development or review and how, once (re)published they will be brought to the attention of personnel in the Trust.

- An **equality impact assessment** must be undertaken for all policies.

The procedure for approval of Trust policies is outlined as a flowchart in Figure 1.

A template to assist with writing a policy is available on the intranet.

FIGURE 1 – SUMMARY OF THE PROCESS FOR PUBLISHING POLICIES



1. BACKGROUND TO DOCUMENT CONTROL

1.1 The purpose of this policy is to provide direction and guidance to ensure that working documents are produced to the highest standard as part of the Trust's requirements to meet its legal responsibilities and conform to risk management standards, thereby ensuring a high level of safety and effectiveness for patients and staff.

1.2 Document control is the process used to ensure that documents are ratified, reviewed, consulted and maintained. Up-to-date, unambiguous and comprehensive procedural documents are essential to the provision of safe patient care and the effective working of the Trust.

1.3 Document control covers:

- Production of new documents
- Systems and procedures for dissemination and publication of documents
- Systematic updating and review of existing documents
- Removal and archiving of old documents

1.4 Definitions

The following terms are used and apply to this policy:

Strategy

A plan of action designed to achieve a long-term or overall aim or goal in relation to the Trust's corporate aims, they are not working documents.

Policy

A policy is a statement of corporate intent, which will be adopted and followed by Trust staff. Policies enable management and staff to take decisions and actions consistently and efficiently, and direct Trust practice, in fulfilling statutory and organisation responsibilities. Policies are contractually and legally binding on all employees.

Procedure

A procedure is an operational mechanism or step by step description which details and regulates the manner in which a specified issue is to be handled. It is based on expert opinion, best practice and research. It may stand alone or be attached as an appendix to policies or strategies.

Protocol

A protocol defines and restricts what must happen in a particular way. Protocols are a set of measurable, objective standards to determine a course of action. They are rigid statements allowing little or no flexibility or variation.

Guideline

A guideline is a **broad statement of good practice** that is based on evidence-based best practice about appropriate healthcare for specific clinical conditions.

Locally-produced guidance must be followed where possible; where this is not possible the rationale for deviation must be documented.
Where guidelines are associated with a policy they should be kept together. However, guidelines may be generated separately from any policy.

Clinical guidelines (produced both locally and nationally) are intended to provide practitioners with guidance regarding specific areas of healthcare practice (National Institute for Clinical Excellence: Clinical Guidelines factsheet) and must be followed where possible; where not possible the rationale for deviation must be documented.

Pathway

A pathway is a multi-disciplinary plan for delivering health and social care to patients with a specific condition or set of symptoms. Pathways are often used for the management of common health conditions and are intended to improve patient care by reducing unnecessary variance from best practice.

Stakeholder Group or Review/Development Body

This is the body that policies are presented to for comments and improvements prior to being ratified. The review/development body is usually a body that has some knowledge on the policy subject.

Ratification Body

This is the body, for example, the Trust Board, Board sub-committees, Executive Team, where policies are presented for final approval. They will usually have some knowledge on the document they are approving or designated authority as set down in their terms of reference.

Working Document

The term 'working document' may refer to policies, procedures and guidance material that is in draft or under review.

2. WRITING AN OFFICIAL POLICY DOCUMENT

In event of the need for a working document or review of an existing document, the following four steps should be used as a guide:

2.1 Step 1

Consider the rationale to justify the need to produce a working document. Confirm if there is an existing or national document to avoid duplication. This could be done by conducting a search on the intranet or contacting the Central Policy Officer. Where possible the revision of an existing document would be preferred to the creation of a new document.

2.2 Step 2

Review evidence in order to ensure that the document includes up-to-date information. Further, document authors should ensure the working document is evidence based by undertaking a thorough evidence review to ensure that it meets national and professional standards. Examples of useful sources may include: Department of Health; Care Quality Commission; NHSE/I; National Institute for Health and Clinical Excellence; etc.

2.3 Step 3

Identify stakeholders who can contribute, comment and agree to the content of the working document. Examples of stakeholders may include: subject matter experts, individual colleagues; budget holders; relevant departments; Partner organisations; patients , volunteers, etc.

2.4 Step 4

After production of the initial draft document, consult with relevant stakeholders (review/development Body) to improve the accuracy, validity and quality of the document and to facilitate effective implementation when ratified or approved. Consultation may take the form of: face-to-face discussions; formal meetings; via email or hard copy distributions etc. The Review/Development Body must be referenced on the front sheet of the working document.

2.5 Step 5

Upon completion the final version must be made into a pdf by the author and forwarded to the Company Secretary's department where it will allocated a number and logged in a database along with all the other policies so that a renewal cycle can be managed, notifying the author when the policy is up for review.

2.6 Step 6

Company Secretary's department will then take the final version of the policy and upload it to the corporate website and Intranet, removing any old versions in the process. A template for the drafting of a policy is given in Appendix 2 along with a style guide.

3. CONSULTATION PROCESS

3.1 The author should ensure that staff groups affected by the policy have the opportunity to shape its production. Views should be sought from relevant staff representatives at the start of the drafting/review process. As drafts are produced, they should be circulated for further comment. These comments should be considered by the author(s). Members of relevant multidisciplinary committees/groups could also be consulted.

3.2 Patient/Volunteers views should be sought in developing documents that relate to the principles of their care.

4. APPROVAL PROCESS

4.1 Following review and consultation, a draft or revised policy must be seen and approved by the relevant Executive or Board-level committee or group in the Trust that has overall ownership for the policy area. In certain circumstances, documents may be reviewed and ratified by committee members or chair's action taken outside the meeting. This process must be noted at the next available meeting with the minutes stating the document was agreed.

4.2 It is recommended that authors are invited to attend ratification meetings where their documents are discussed to allow them to respond to questions and to ensure that feedback from the committee is direct and appropriate. A written summary or appropriate section of the minutes of the meeting should be provided to document authors.

5. SCHEDULED REVIEW OF POLICIES

5.1 Policies must be reviewed at least every three years except those which the Central Policy Officer advises are to be reviewed annually. Any material changes to policies must be approved in accordance with section 4 of this Policy.

5.2 The review frequency is monitored by the Central Policy Officer. Document authors are responsible for ensuring that their policies are reviewed on time and for responding to prompts/reminders from the Central Policy Officer.

5.3 Review does not occur in isolation and authors should seek advice or information from others in relation to the policy they are asked to review.

6. EQUALITY IMPACT ASSESSMENT CHECKLIST

6.1 The Trust aims to design and implement services, policies and measures that meet the diverse needs of its service, population and workforce; ensuring that where issues for concern are highlighted actions are taken to address them.

6.2 Where a policy is new or it is an existing policy that requires an amendment, an Equality Impact Assessment must be completed. The Equality Act states that we must show 'due regard' to the impact (of any policy/procedure/guidance) on the Protected characteristics.

6.3 The Equality Impact Assessment enables an evaluation of a policy, service or process to be undertaken and are needed for all policies to comply with the requirements of the Trust's Equality, Diversity & Inclusion Strategy and legislation.

6.4 Authors must ensure that all policies comply with the principles of the data protection legislation to reflect the General Data Protection Regulation and Data Protection Act (2018) and Caldicott Guardian principles of using confidential information. This checklist ensures the Trust complies with the NHS Information Governance Toolkit.

6.5 The approved document and the Equality Impact Assessment/ Checklist must be sent to the Central Policy Officer together with a copy of the approval minutes.

7. MINOR POLICY AMENDMENTS

7.1 Minor changes to policies (such as correction of grammar or spelling, changes to telephone numbers or post holder titles) may be changed without requiring committee approval. More substantial changes will require formal approval.

7.2 If unsure, the proposed changes should be discussed with the Central Policy Officer who will consult the Company Secretary.

8. PUBLICATION AND DISSEMINATION

8.1 Documents are published to make them available to their audience.

8.2 The main method of dissemination is via the Trust Intranet.

8.3 All new policies or policies with significant amendment must detail as part of the approval certificate who has been consulted as part of the development or review process, the policy's intended audience and how the policy will be brought to its attention. Relying solely on the policy being placed under the relevant section of the intranet is not enough. It is the author's responsibility to ensure that consultation and dissemination takes place.

8.4 Once the policy is approved it should be forwarded in pdf and word format to the Central Policy Officer who will check the document for accessibility formatting before uploading the policy onto the Intranet once they have received the completed policy approval documents. Only the Central Policy Officer and teammates should publish documents in the intranet Trust policy folder and external website. The superseded policy will be archived in the policies folder on a shared drive in accordance with the retention policy.

8.5 Following approval and submission to the Central Policy Officer, it is the author's responsibility to confirm that their policy appears on the intranet and internet in an appropriate format. The Central Policy Officer will notify the author when their policy has been (re)published on the Trust intranet and internet.

8.6 The Central Policy Officer will compile a weekly list of all approved policies for the Trust bulletin.

9. KEY ROLES IN POLICY DOCUMENT CONTROL

9.1 Authors:

9.1.1 Write or amend policies in consultation with appropriate staff representatives and patients, with particular attention to accuracy.

9.1.2 Ensure that existing published policies are reviewed and if necessary, updated within the review period.

9.1.3 Identify and eliminate areas of contradiction or overlap with existing documents.

9.1.4 Identify documents that will be replaced by the new or amended policy.

9.1.5 Respond to any changes identified by the committees.

9.1.6 Forward policy for publication with the fully completed policy approval certificate to the Central Policy Officer when approved.

9.1.7 Confirm that the policy has been correctly published.

9.1.8 Disseminate as required.

9.1.9 Complete and submit an Equality Impact Assessment checklist.

9.1.10 Ensure that the final MS Word and Adobe pdf document comply with the law on accessibility by using the 'Check accessibility' feature in Word.

9.2 Ratifying committees/groups:

9.2.1 Review draft documents and provide feedback to the document's author(s) including amendments where required.

9.2.2 Ensure that documents are prepared in the proper format (e.g. committees need to distinguish between forms, policies and procedures, clinical guidelines, standard operating procedures, protocols and ensure that the author is aware of the different mechanisms of publication).

9.2.3 Ensure that outdated documents are reviewed and removed as appropriate.

9.3 Central Policy Officer:

9.3.1 Publish policies to the appropriate intranet and internet section's when evidence of approval is given and advise the author when this has happened.

9.3.2 Assist authors with formatting of their policies including formatting accessibility issues and provide advice about the revision, approval and publication processes.

9.3.3 Collate and present bi-monthly policy library status reports to the Executive Management Committee:

- New policies and policies republished in the last six months
- Policies made obsolete in the last six months
- Policies outstanding for review
- and other issues of compliance with this policy.

9.3.4 Support the author's responsibility to review their policy on time by providing prompts three months before the review date is reached. A further reminder is also sent to authors, if needed, the month that policy review is due and further prompts sent to authors for policies passing their review date.

9.3.5 Maintain policy approval records and paper record files and archive as well as log and update information and communication relating to each policy on a numbered database.

9.3.6 To support the audit of document control processes.

9.4 All Staff

It is the duty of all employees to familiarise themselves with those policies and procedures relevant to their particular job function, and to apply them fully.

10. CONSIDERATIONS WHEN WRITING A POLICY

10.1 Consideration for users should be given when naming and writing documents. Avoid jargon, unfamiliar abbreviations and unnecessarily technical language. All policies should use compassionate language. Name documents for maximum user understanding. For example, it is very difficult to find the policy you need if a majority are titled '*Policy and procedure for*…'. Documents should contain the key terms in their title where possible and be no longer than 100 characters.

10.2 Long documents that combine procedures with the policy may not be that easy for the intended audience to read. Authors should consider writing separate documents and include references that may be linked.

10.3 Authors should also check existing policies to make sure that out-of-date policies have been removed from the intranet and internet that there is no confusion with the naming of new policies. The titles of obsolete policies remain on the intranet policy index list, marked as obsolete.

10.4 Old or similar policies that are being replaced should be identified to the approving committees and the Central Policy Officer who will remove them from general access when the new policy is published.

10.5 The policy approval must detail consultation undertaken and planned dissemination to show who has been consulted and how the target audience will be informed of the changes to the policy or procedure.

10.6 Policies should contain a brief summary of the key points at the beginning. This may also be used to promote the policy on bulletin boards and in e-mails. Algorithms or flowcharts that summarise the policy will be presented at the beginning of the policy to help readers readily understand what is required by the policy.

10.7 Related documents and forms published elsewhere on the intranet should not be included in the policy either in the body of the text or as an appendix. Instead, a hyperlink to the related document or sections should be used. This is to ensure that the policy is always connected to the current version of the related document.

10.8 All policies must comply with the latest laws laid out in the Trusts Accessibility statement. This will enable our polices to be read out using screen reader software for deaf and partially sighted users. More details on how to do this can be found on the Accessibility Hub. If authors are unable to make the policy accessible themselves, they will be required to pay a third party design agency to ensure that the Trust does not get fined for breaking UK accessibility laws.

11. ARRANGEMENTS FOR CERTAIN NON-POLICY DOCUMENTS AND DEFINITIONS

11.1 Standard Operating Procedure (SOP)

Definition: A set of actions which describe an agreed way of carrying out activities.

- A series of detailed steps to accomplish an end
- Step by step instructions for implementation

Review frequency and process: 12 months on first publication, every two years thereafter.

11.2 Protocol

Definition: A formal or official record of scientific experimental observations.
A procedure for carrying out a scientific experiment, research, evaluation or a course of medical treatment.

Review frequency and process: 12 months on first publication, every two years thereafter.

11.4 Equality Analysis

Equality analysis is a way of considering the effect on different groups protected from discrimination by the Equality Act, such as people of different ages. There are two reasons for this:

- to consider if there are any unintended consequences for some groups
- to consider if the policy will be fully effective for all target groups

The form in **Appendix 1** below is used for the equality analysis.

APPENDIX 1: STAGE 1 EQUALITY IMPACT ANALYSIS (EIA) SCREENING TOOL

This form is used for an equality analysis. This is a way of considering the effect on different groups protected from discrimination by the Equality Act, such as people of different ages.

This is an internal form used by staff only. It can be found on the Trust Intranet.

APPENDIX 2: POLICY TEMPLATE

This Microsoft Word Template should be used as a starting point for all polices. It contains all the elements mentioned in this policy. It is also fully accessible.

This is an internal template is used by staff only. It can be found on the Trust Intranet.

1. Title of Policy:
This should be style type 'Heading 1'. Text must be centred, Dark blue, Arial 22

2. Table of contents
Add a list of the section headings from the policy here with page numbers. For accessibility in MS Word use the automatic table generation feature found in 'References > Table of Contents'.

3. Document information
should include the policy number given by the Company Secretary's department, the author, the department, the approval date, the expiry/review date, the version number, Consultation & Approval (y/n), Equality Impact Assessment (y/n)

4. Summary
Write a summary with key points to help users here. The summary should give an idea of what the policy covers so users can quickly judge if this is the policy they need.

Remember that you are writing this policy primarily to help employees in the Trust understand the expectation of the Trust. Your intended audience is the staff the policy is aimed at, not the committees that will approve it.

5. Background
If needed, the background to the policy may be added (if it is relevant to users).

Definitions and scope
What this policy covers should be added here.

- It will also be helpful to define any terms that may be ambiguous or may not be familiar to readers.
- It may be necessary to include colloquial terms here so that staff understand the terms used in the policy. But, it should be explained that ambiguous or colloquial terms should not used in the body of a Trust document to avoid misunderstanding.

- Using 'common' or colloquial terms may also assist users to find the policy as it will allow the user to find policies using colloquial terms in the search engine.

6. Diagrams/flow charts

It might be helpful to add diagrams or flow charts. Algorithms or flowcharts that summarise the policy will be presented at the beginning of the policy to help readers readily understand what is required by the policy. Please note that each picture must have a very exact alternative text description, or it will fail the accessibility checker. The use of clip art and multiple images must be avoided for the same reason.

7. The content of the policy

Add the actual content of the policy here. Remember to use adequate headings and sub headings so users can navigate through the policy easily. You may also use bulleted or numbered lists. Show the evidence base for policies with up to date references. All references are to be cited in full.

8. Key roles

A detailed overview of the duties and responsibilities must be described for key staff, departments and Committees for the implementation of the working document.

9. Equality statement

It is not necessary for the full EIA to be included at the bottom of the policy, but a brief description on the assessment should be included under the section called 'Equality Statement'.

10. Forms

Forms that are only used by staff internally should not be included in the policy as once displayed on the Internet they will become confusing to the public. Instead, all form should be placed on the intranet and linked to with the words 'An internal form for the use of staff can be found on the corporate intranet'.

11. References

If necessary, provide the evidence base for procedural documents with up-to-date references.

12. Linked documents

Add a list of documents that are related here.
Related documents published elsewhere on the intranet should not be included in the policy either in the body of the text or as an appendix. Instead, a hyperlink to the related document should be used. This is to ensure that the policy is always connected to the current version of the related document.

13. Style

- Trust policies must be written in **Arial font at type size 12**. This font can be clearly read on a screen compared to other fonts that have features including serifs that make them harder to read in an electronic document.

- All policies should be written in UK English.

- Ensure that the policy has a summary at the beginning and a table of contents.

- Ensure that the hierarchy of headings and sub-headings is consistently applied throughout using the 'Styles' feature in Microsoft Word.

- When formatting do not present the policy in a table.

- Top and bottom margins must be set at a minimum of 2cm to allow enough space for the document control header and footer to be set during the intranet publication process.

- Do not include effective dates in the text as dates are automatically added in the policy footer when published.

- Incorrectly formatted policies or those requiring changes to style and accessibility will be returned to the author for correction before publication can take place.

14. Font

The fonts are all set using the 'Styles' feature in MS Word within the policy template, so as long as these are used then no adjustments will be required by the author when writing a policy. However, the following set out what is used for each section.

- **Title and crest logo**– The SCAS logo must contain descriptive text and be justified to the right. The policy title on the front page must be centered, Arial, size 28, font colour dark blue. The address of the main office should be at the very bottom of the front page, centered and Arial 12 point
- **Contents** – The font is Arial size 12
- **Main headings** – These must be numbered. The font is Arial, bold size 12 font, colour dark blue, Capital letters. There is 24 points before the heading and six points following the heading
- **Subheading** – These must be numbered as per the heading it is under and what number subheading it is. The font is Arial, bold size 12. There are 0 points before the subheading and six points after
- **Subheading 2** – These must be numbered as per the subheading and then with the number of this subheading as well. The font is Arial, bold size 12. There are 0 points before the subheading and six points after.
- **Normal** – This forms most of the text within the policy. It should be Arial size 12 There should 0 points before and 12 points after. Line spacing is single.
- **Bullet points –** These should be based on the same format as 'normal' above. The bullet points should be at level one and should be solid black circles. If a second level bullet point is used this should be at level two and be a circle outline. Do not use any other bullet points within the document.
- All font colours and sizes must be set using the 'Styles' feature in MS Word or the document won't pass the final 'check accessibility test.

15. Version control

To ensure that there is a clear trail in regard to changes made and reviews of policies version control must be used.

The first draft of a working document will be given the version number v0-1, any subsequent draft will follow as v0-2, v0-3, etc. The author must include 'DRAFT' into the top right hand side of the header. When the document has been approved and ratified, the version number will be v1-0 and 'DRAFT' removed from the header.

The version number will be referenced on the 'Version Control Sheet'

When the document is reviewed/amended, the first draft becomes v1-1 and 'DRAFT' should be re-inserted into the top right-hand side of the header. Subsequent drafts will be v1-2, v1-3, etc. The approved and ratified version will be v2-0 and 'DRAFT'

removed from the header and the version number updated in the version control sheet

APPENDIX 3: POLICY CERTIFICATE

This form is used as a checklist to make sure that all policies have been created correctly.

This is an internal form used by staff only. It can be found on the Trust Intranet.