A teaching trust of Brighton and Sussex Medical School

NHS Sussex Partnership NHS Foundation Trust

PROCEDURAL DOCUMENTS POLICY

(Replaces Policy No. TP/CO/078 V.1)

POLICY NUMBER	TP/CO/078
VERSION	V.2
RATIFYING COMMITTEE	Professional Policy Forum
DATE RATIFIED	16 July 2018
DATE OF EQUALITY & HUMAN RIGHTS IMPACT ASSESSMENT (EHRIA)	TBC
NEXT REVIEW DATE	16 July 2021
EXECUTIVE SPONSOR	Director of Corporate Affairs
POLICY AUTHOR	Head of Corporate Governance & Assurance

KEY POLICY ISSUES:

- How to develop new procedural documents inc. policies, procedures, protocols, guidelines and terms of reference
- How to draft wording/format for new procedural documents
- How to get procedural documents ratified
- How to distribute procedural documents
- How to review procedural documents
- **Appendix 6 provides a template policy document to be followed in the writing of all policies**

If you require this document in another format such as large print, audio or other community language please contact the Corporate Governance Office on: 0300 304 1195 or email: policies@sussexpartnership.nhs.uk

CONTENTS

1.0 Introduction

1.1 Purpose

- why the policy is necessary (purpose/rationale)
- to whom it applies and where and when it should be applied (scope)
- the underlying beliefs upon which the policy is based (principles)
- the standards to be achieved (policy)
- how the policy standards will be met through working practices (procedure).

1.2 Definitions

1.2.1 A procedural document is defined as the following for the purpose of this policy:

- a Policy
- a Procedure
- Guidelines
- a Protocol
- Terms of Reference

1.2.2 Other policy definitions

Local procedural document:
A procedural document which is intended to be used internally within a care delivery service or support service only and / or only has local implications, not trustwide, and therefore only requires local ratification.

Trust-wide procedural document:
A procedural document which is intended to be used trustwide and / or a local document that has trustwide implications therefore requires trustwide ratification.

Stakeholders:
Individuals, groups or organisations that are affected by and/or have an interest in a particular issue

Minor Amendments:
Changes that do not change the essence of the document or practice implications

Procedural Document Sponsor:
The procedural document sponsor will be a member of the Executive Management Team.

1.3 Rationale of this Policy

1.3.1 The purpose of this policy is to ensure a structured and systematic approach to the development, review, ratification, recording, distribution, archive, destruction and audit of trust procedural documents. It will establish a framework that ensures all procedural documents are:

- of a consistently high standard
- will follow a standard format including a Equality and Human Rights Impact Analysis (EHRIA)
- up-to-date

- published & notified to staff
- implemented
- accessible
- stored to meet audit requirements
- version controlled

1.3.2 NHS organisations need procedural documents:

- to shape the behaviour of care and support staff so that it is consistent with the purpose of the organisation and its values
- to reduce uncertainty about what behaviour and practices are permitted among employees, including bank and agency staff
- to reduce stress and conflict among staff because there is an agreed way of doing things
- to ensure that staff do not take risks by using ad hoc procedures based on arbitrary decisions
- to improve the quality of decision making within the organisation
- to safeguard individuals' rights
- to protect staff and the organisation from legal action
- to prevent loss of reputation
- to meet standards set down by external inspecting bodies and regulators.

1.3.3 **To ensure the purpose of the policy is consistently achieved (Appendix 6) offers a template policy document to be followed for all policy documents.**

1.4 Scope

1.4.1 This policy will apply to all trustwide procedural documents as defined in this policy – clinical, corporate (e.g. governance / finance / procurement), workforce, risk & safety and pharmacy - produced by trust staff for use within the trust and wherever the trust carries responsibility for the staff it employs.

This policy must be implemented through the specified process **(Appendix 2).**

The process of consultation and ratification in this policy does not include local procedural documents; however, the style, format, content & document numbering/logging should be adhered to. Local procedural documents are developed and approved through the Care Delivery Service Board. The CDS are responsible for any local procedural documents (excluding Terms of References) in gathering information and uploading to the intranet where appropriate/required.

Multi-agency policies and procedures may be developed independently of the requirements of this policy; however, trust ratification will be required by the Chief Executive or delegated committee / forum

1.5 Principles (Our Beliefs)

This policy is to ensure that all trustwide procedural documents are developed in accordance with legislative requirements and best practice.

2.0 Duties

2.1 Executive Management Team (Procedural document sponsors)

The procedural document sponsor is responsible for initiating the development / review of procedural documents (excluding Terms of Reference). The development & review can be delegated to an appropriate document author, with final drafts returned to the sponsor prior to ratification for checking and approval.

The sponsor is responsible for identifying, taking forward and presenting the procedural document to the appropriate forum for consultation and ratification **(Appendix 1)**.

The sponsor is responsible for informing the Corporate Governance Team of new / amended procedural documents once ratified (excluding Terms of Reference), so that they can be allocated an official document number, logged on the trust central database and uploaded to the trust website.

The sponsor is responsible for ensuring that the procedural document implementation plan is valid, achievable and actioned.

The sponsor can, when necessary, seek approval from the ratifying forum's Chairperson to make minor amendments to procedural documents, without requiring full committee / group ratification (See section 5.3 for further clarification)

The sponsor is responsible for ensuring the monitoring arrangements for procedural documents are undertaken and any recommendations / outcomes actioned.

The sponsor and author are jointly responsible for ensuring procedural document content complies with legislation, regulatory standards and national guidance.

2.2 Procedural document author

The author ensures (with the policy document sponsor) that identified relevant stakeholders are consulted where necessary about the procedural document **(Appendix 1)**.

The author is responsible for ensuring that the document is formatted in the correct style / layout **(Appendix 5 & 6)**.

The author will ensure that the procedural document complies with the Human Rights Act 1998; Equalities based legislation, including The Equality Act 2010, the Mental Health Act 1983 Code of Practice (2008 edition), the Data Protection Act 2018, GDPR and Freedom of Information Act and any legislation associated with the document.

2.3 Committees / Forums / Groups

Identified committees / forums (see appendix 1) providing ratification or being consulted or providing technical / professional approval of procedural documents are responsible for considering:

- Ensuring the document meets legal and statutory requirements applicable.
- Accuracy of content
- Layout
- References to other procedural documents, regulatory standards and national guidance to ensure compliance.
- Possible implications – corporate / care / professional and legal to ensure compliance.

The ratifying committee's chairperson can occasionally agree minor amendments to procedural documents in conjunction with the sponsor without requiring full group approval (see section 5.3 for details)

It is the responsibility of the committee / group chairperson to create and review terms of references to ensure they accurately reflect the aims and purpose of the committee / group. The chairperson will also ensure that the terms of reference fit within the trust's governance framework. The committee / group will collectively agree the terms of reference and frequency of review.

2.4 Corporate Governance Team

The Corporate Governance Team are responsible for ensuring the trust procedural documents database is maintained, issuing official document numbers when required.

The Corporate Governance Team is responsible for ensuring procedural documents are uploaded to the trust website

The Corporate Governance Team is responsible for notifying the sponsor when procedural documents are due for review.

The Corporate Governance Team will liaise with the Communications Department to issue regular staff notifications of new procedural documents

2.5 The Communications Department

The Communications Department will issue notification of new procedural documents via the trust electronic news bulletin, upon request from the Corporate Governance Team

2.6 Care Delivery Service Boards

Care Delivery Services are responsible for ensuring local governance arrangements include a process for the ratification and review of local procedural documents.

2.7 All staff

Any member of staff can bring to the attention of the appropriate procedural document sponsor (or committee / group chairperson in relation to terms of reference) the need for a new procedural document to be developed or an existing procedural document to be reviewed.

2.8 Trust Chief Executive – multi-agency ratification

The trust Chief Executive or delegated appropriate committee are responsible for approving multi-agency procedural documents between the trust, other NHS organisations, local authorities and the emergency Services. (Excluding Pharmacy shared guidelines and protocols)

3.0 Style and Format of Procedural Documents

3.1 All trust procedural documents should be written in a style which is concise and clear, using unambiguous terms and language.

3.2 In situations where documents are applicable to service users and carers, there should be a facility for them to be made available in a range of appropriate community languages and formats upon request. The Corporate Governance Team will facilitate this.

3.3 All trust procedural documents will be presented in a standard structure; including local procedural documents **(Appendix 5)**. This will include references to supporting documents and a list of documents that must be cross referenced and read in conjunction with the document. Each document must also contain a list of definitions of terms used within the document.

3.4 Multi-agency procedural documents the trust has signed up to can be accepted in the format agreed between agencies.

4.0 Development of trust procedural documents

4.0.1 A flow chart illustrating the process for development and implementation of procedural documents can be found in **(Appendix 2)** and should be referred to on each occasion (with the exception of Terms of Reference)

4.0.2 Terms of reference will be developed and ratified by the group / committee that has been formed. The terms of reference should be forwarded for information and comment to any governing group or committee **(Appendix 7)**.

4.1 Prioritisation of work

4.1.1 All trust procedural documents must be developed in line with this policy.

4.1.2 The potential need for a new procedural document to be developed or an existing procedural document to be reviewed may be identified by any member of staff and should be brought to the attention of the procedural document sponsor (see appendix 1 for details) Terms of reference should be brought to the attention of the relevant committee / group chairperson.

4.1.3 Local procedural documents should be developed in line with local governance arrangements and the need for a new document or review of a document should be raised with CDS Leadership Teams in the first instance.

4.1.4 Before new procedural documents (excluding terms of reference) are developed a check should be made with the Corporate Governance Team to ensure there is not already a relevant procedural document in existence. A preliminary check can be made by any individual by referring to the policy section on the trust website.

4.1.5 The procedural document sponsor will discuss the need for a new procedural document with the appropriate author (this could include a committee / group or specialist staff)

4.2 Identification of Stakeholders & Consultation

4.2.1 It is an expectation that service users and carers will be consulted with regards to all procedural documents that have a direct impact on the patient experience. It is the responsibility of the procedural document sponsor in collaboration with the document author to identify stakeholders who are required to be part of the development and consultation process and the appropriate ratifying forum. Stakeholders may include service users, carers, staff networks, trade union representatives and relevant trust staff and committees / groups.

Evidence of stakeholders engagement should be recorded on the policy briefing **(Appendix 4, section 3).**

4.2.2 The aim should be to develop an integrated health & social care procedural document and social care should be invited to be involved and contribute to procedural document development

4.3 Responsibility for Document Development

4.3.1 The procedural document sponsor in collaboration with the author is responsible for overseeing the development and review of procedural documents. In relation to terms of reference this responsibility will fall with the committee / group chairperson.

4.3.2 Identified committees / groups and other stakeholders involved in consultation and ratification are responsible for considering accuracy of content, layout and references to other procedural documents and national guidance to ensure compliance.

4.3.3 Procedural documents should be developed by the document author, ensuring compliance with the:

- Human Rights Act 1998
- Mental Health Act 1983 Code of Practice (2008 edition)
- Data Protection Act 2018 and GDPR
- Freedom of Information Act 2000
- Health & Safety at work Act 1974
- Corporate Manslaughter and Corporate Homicide Act (2007)
- The Equality Act 2010

- Plus employment regulations and other legislative requirements & trust Procedural documents

The above list is by no means exhaustive.

4.3.4 The procedural document sponsor is responsible for ensuring that any procedural documents that require clinical audit are identified and brought to the attention of the Associate Director of Nursing.

4.4 Equality and Human Rights Impact Analysis (EHRIA)

4.4.1 The trust aims to design and implement services, policies and measures that are both sensitive to and meet the needs of our diverse service user population and workforce, ensuring that none are placed at a disadvantage compared to other groups.

The equality and human rights impact analysis tool is designed to help you consider whether your procedural document is likely to have an adverse impact on different groups and if so, whether the proposed measure could be carried out in alternative ways. **(Appendix 8)** should be completed for each procedural document created or reviewed and submitted as part of the document consultation and ratification process. The completed assessment will need to be submitted to the Equality, Diversity and Human Rights Team no less than 4 weeks prior to the deadline required for coding and approval.

4.4.2 All proposed services, policies and measures should be impact assessed for the effect that they are likely to have on people. This will involve identifying the main aims and objectives of the service, policy or measure, undertaking some data analysis on service users, potential service users and/or staff (measuring both the positive and negative impact). Then utilising the data gathered to think how the policy, service, measure could impact upon different groups.

5. Ratification

5.1 The procedural document sponsor will present the procedural document for ratification with the following accompanying documents:

- Equality and human rights impact analysis (accepted) and signed off by the Equality and Diversity Team) **(Appendix 8)**
- Policy briefing **(Appendix 4)**
- Policy on a page document **(Appendix 3)**

5.2 The process for procedural document consultation and ratification is set out in **(Appendix 2)**.

5.3 Minor amendments (changes that do not change the essence of the document or practice implications) to procedural documents can be approved by the sponsor without requiring full approval. The policy will then be assigned the next version number.

5.4 Ratifying forums are responsible for ensuring that procedural documents comply with legal requirements, regulatory standards and national guidance.

5.5 Multi-agency procedural documents must be agreed at Chief Executive level and signed off by the Chief Executive or delegated appropriate committee / forum.

5.6 All pharmacy procedural documents must be jointly ratified by the Drugs & Therapeutics Committee and the Professional Policy Forum (technical aspect – Drugs & Therapeutics / professional practice & human resource aspects – Professional Policy Forum)

5.7 Mental Health Act procedural documents must be jointly ratified by the Mental Health Act Committee and the Professional Policy Forum (technical aspect – Mental Health Act Committee / professional practice & human resource aspects – Professional Policy Forum)

5.8 Where the cost of implementing a procedural document is above the levels of delegated authority detailed in the Financial Standing Orders the executive sponsor is responsible for escalating the ratification to the Executive Assurance Committee for approval.

5.9 All final drafts of procedural documents must have their respective executive sponsor agreement to present for ratification at the identified ratifying forum.

6. Review, revision and removal arrangements (including version control)

6.1 The Corporate Governance Team will manage the database/ system for procedural document review (excluding pharmacy protocols/procedures and guidelines-see section 8.9) and inform the relevant procedural document sponsor and author that a review is due. (3 months prior to the review date).

6.2 The ratifying forum according to the nature of the procedural document and operational experience will determine subsequent review periods. The review period will be approved from the minimum of six months to the maximum of five years.

6.3 An extraordinary procedural document review will be initiated following any incident that arises which highlights the need to review a particular policy or following new legislation, guidance (e.g. Department of Health & Care Quality Commission) or changes in practice (e.g. the implementation of national Service Frameworks or NICE/SCIE guidelines). This extraordinary review can be initiated by any member of staff (See section 4.1.2)

6.4 Following re-ratification of a procedural document a new document number will be allocated to the document by the Corporate Governance Team. This unique identifier will consist of a number, and policy group e.g. TP/CL/001.

- TP/CL = Clinical
- TP/CO = Corporate
- TP/MHA & MVA = Mental Health Act and Mental Capacity Act
- TP/RHS = Risk, Health & Safety
- TP/WF = Workforce

The numbers will be sequential with added version numbers. This will ensure no duplication of numbers.

6.5 Review of other local CDS' / directorate procedural documents will be carried out at local level in accordance with local arrangements.

6.6 A version number should be included on each procedural document (preferably on the front page, clearly identifiable). This will start at version 1 and will be updated sequentially following any minor amendments that have not required full re-ratification.

6.7 The Corporate Governance Team will maintain an electronic archive of previous versions of procedural documents and will update the central database and website. It is the responsibility of procedural document sponsors and authors to ensure the Corporate Governance Team are alerted to changes and provided with an up to date version.

6.8 The removal of any procedural document from the trust's register must be agreed and requested with the relevant ratifying committee or executive sponsor. To remove a policy the Corporate Governance team are to be notified with a clear rationale and purpose **(Appendix 4, section 4).**

7. Dissemination and Implementation

7.1 Implementation issues and training needs must be identified for each new and reviewed procedural document. Within policies this should be set out in a separate section, as part of the policy document. The procedural document sponsor and document author must consider how the procedural document will be implemented. Where there are training and development implications there must be consideration of where the resources and capacity will be found to design, deliver and administer such training.

7.2 Procedural document sponsors and authors must complete a policy briefing document **(Appendix 4)** to submit with the procedural document at the point of ratification.

7.3 Ratifying forums are responsible for checking with sponsors that implementation and training needs have been addressed and actioned.

8. Document Control and archiving

8.1 Following ratification of all (trustwide and local) procedural documents the ratifying committee Chair will ensure the document is forwarded to the Corporate Governance Team who will allocate an official document number (unique identifier) and log the document on the trust central database (Excluding Pharmacy protocols, procedures and guidelines). The Corporate Governance Team will inform the sponsor and document author of the official document number allocated.

8.2 The Corporate Governance Team will maintain a central database of procedural documents and will be responsible for uploading these documents to the trust website for staff access. Sussex Partnership Policies It is the responsibility of procedural document sponsors and authors to ensure the Corporate Governance

Team are supplied with these documents. If there are forms within the policy which are needed as a standalone form, it is the document sponsors responsibility to ensure this is loaded separately onto the website. The website administration team can advise on the process.

8.3 Procedural documents will primarily be accessed by staff and members of the public via the trust website. Sussex Partnership Policies Where sensitive information is contained within the documents, such as contact names and details or internal procedures, the documents will be available on the trust intranet only. Team members only will have access to these master documents and the central database.

8.4 The Corporate Governance Team will maintain an archive of previous versions of procedural documents and will update the central database and website (as per section 6).

8.5 Procedural documents will be archived in accordance with the trust policy for the management of corporate administrative records.

8.6 Requests from staff to access archived procedural documents can made to the Corporate Governance Team (for all documents dated April 2006 onwards) Requests from other organisations or individuals outside of the trust must be made in accordance with the Freedom of Information Act.

8.7 Terms of reference will be stored, updated and archived by the committee / group secretary. Each version of the terms of reference should be saved electronically for governance and audit purposes. The corporate governance team will maintain a register of all Board & sub-committees TOR.

8.8 All Pharmacy protocols / procedures and guidelines will be stored and uploaded to the trust website by the Pharmacy team. Pharmacy will also maintain a database of their current and archived documents, similar to that maintained by the Corporate Governance Team and will initiate document reviews as appropriate with the procedural document sponsor. Pharmacy will also issue their own official document numbers (unique identifier) Except for trustwide pharmacy policies, which will be issued as per section 8.1.

9. Monitoring Compliance

9.1 An annual audit will be undertaken by person/s appointed by the Professional Policy Forum and a report presented to the audit committee to check that the system for managing the development, ratification, recording, distribution and review of procedural documents is operating effectively and in accordance with this policy.

9.2 As a minimum, the audit should ensure that each completed checklist, if used, shows that the document;

- Is of the required style / format
- Includes a definitions section
- Has received the required consultation as per this policy
- Has been ratified by the required forum identified within this policy
- Has an identified review date
- Contains details of how the document will be published, stored and archived

- Contains the appropriate appendices or cross references to associated documents
- Contains the appropriate cross references to other trust procedural documents
- Was accompanied by a completed Equality Impact Analysis at ratification

9.3 In conjunction with the audit feedback, this policy will be reviewed annually to embed any improvements identified in the audit. The policy review will also ensure ratification routes described in appendix 1 are still current. The review will be undertaken by the Corporate Governance Team or delegated person and ratified by the Executive Assurance Committee or delegated forum.

9.4 Where required, procedural documents will be included in the annual audit plan e.g. record keeping, care programme approach, serious incidents etc. Procedural documents that require audit will be identified by the sponsor and brought to the attention of the lead for the Trust's annual audit plan.

10.0 Development and Consultation Process

10.1 This policy has been developed by the Corporate Governance Team in consultation with trust Health & Social Care Governance leads, the Professional Policy Forum and staff side representatives.

11. References

- HarperCollins Publishers Ltd, PO BOX, Glasgow, Collins Concise Dictionary 5th Edition 2001

Adapted from NHS Litigation Authority template policy 2007: "An organisation-wide policy for the development and management of procedural documents"

Previously adapted from Merseycare NHS Trust Development, Ratification, Distribution and Review of Policies and Procedures Policy, South London and Maudsley NHS Trust Policy Development Procedure and West Sussex Health and Social Care NHS Trust and East Sussex County Healthcare NHS Trust Policy for Policies.

12. Glossary

Policy: A plan of action adopted or pursued by an individual, government, party, business etc.

Procedure: A way of acting or progressing an established method *or*
The established form of conducting the business of a legislature[1]

Guidelines: A principle put forward to set standards or determine a course of action.

Protocol: A formal code of conduct, standard or rules

Terms of Reference (Committees / Meeting Groups):
A document specifying the scope and details of the activity to which it refers and any conditions relating to the appointment of a person(s) to

undertake the activity (usually used in relation to the supply of professional services)

13. Policy cross references

Policy for Corporate Records Management Policy

Corporate Records Management Policy

14. Appendices

APPENDIX1

Trustwide Procedural Document Register

All trustwide procedural documents will be ratified as per this appendix; in addition technical / professional ratification may also be required. The below list is a guide to the ratifying forum and Chair.

Policy Forum	Chair	Reference Number	Policy Title
The Board	**CEO**	TP/CO/085	Standing Financial Instructions
		TP/CO/085	Standing Financial Instructions
Audit Committee	**Non-Executive Director**	TP/CO/062	Anti-Fraud and Bribery Policy
		TP/CO/074	Losses, Compensation & Special Payments Policy
		TP/CO/091	Conflict of Interest Policy
		TP/WF/225	Whistleblowing - Freedom to Speak Up Policy
Estates & Facilities Executive Group	**Director of Estates & Facilities**	TP/CO/082	Security Policy
		TP/RHS/155	Fire Safety Policy (Including Arson Prevention)
		TP/RHS/170	Water Safety Policy
Finance & Investment Committee	**Non-Executive Director**	TP/CO/073	Investment Policy
		TP/CO/086	Treasury Management Policy
Information Governance Group	**Chief Digital & Information Officer**	TP/CL/013	Internet Access for Service Users Only
		TP/CO/051	Access to Health Records Policy
		TP/CO/060	Contacting Service Users by Mobile Phone & Text Messaging (SMS) Policy
		TP/CO/061	Corporate Records Management Policy
		TP/CO/064	Data Protection and Security Policy

Policy Forum	Chair	Policy Code	Policy Title
		TP/CO/065	Data Quality Policy
		TP/CO/066	Digital and Social Media Policy
		TP/CO/067	e-Safety Policy
		TP/CO/068	Freedom of Information Policy
		TP/CO/069	Health Records Policy
		TP/CO/070	Information Governance Policy
		TP/CO/072	IT and Information Security Policy
		TP/CO/076	Mobile Devices Policy
Medical Negotiating Committee	**Chief Medical Officer**	TP/WF/204	Associate Specialist Discretionary Points
		TP/WF/206	Clinical Excellence Awards Policy
		TP/WF/218	Job Planning
		TP/WF/234	Staff Grade Optional Points Policy
Operational Management Board	**Chief Operating Officer**	TP/CL/OP/261	HMP Lewes Integrated Mental Health Team Operational Policy
Professional Policy Forum	**Director of Corporate Affairs**	TP/CL/001	Absent Without Leave (AWOL)
		TP/CL/002	Active Engagement incorporating Did Not Attend (DNA) Policy & Procedure
		TP/CL/004	Duty of Candour (Being Open) Policy
		TP/CL/006	Care Programme Approach Policy (Including Standard Care)
		TP/CL/007	Child Visiting Policy
		TP/CL/008	Clinical Risk Assessment & Safety Planning / Risk Management Policy & Procedure
		TP/CL/009	Electro-Convulsive Therapy (ECT) Policy
		TP/CL/010	Eliminating Mixed Sex Accommodation (EMSA) and Maintaining Safety, Privacy & Dignity
		TP/CL/011	Food & Nutrition Policy

Policy Forum	Chair	Policy Code	Policy Title
Professional Policy Forum Cont'd		TP/CL/012	Infection Prevention & Control Policy
		TP/CL/014	Medicines Code
		TP/CL/015	Open Door Policy
		TP/CL/016	Photographs in Medication Administration Policy
		TP/CL/017	Physical Health Monitoring Policy
		TP/CL/018	Rapid Tranquillization Policy (Including the uses of oral PRN medication)
		TP/CL/019	Resuscitation and Anaphylaxis Policy
		TP/CL/020	Safeguarding Adults Policy
		TP/CL/021	Safeguarding (Trustwide) Children Policy
		TP/CL/022	Searching Patients and Their Property Policy & Procedure
		TP/CL/023	Seclusion & Long Term Segregation Policy & Procedure
		TP/CL/024	Transfer of Service Users Requiring Care within a Local General Hospital
		TP/CL/025	PMVA - Prevention & Management of Violence & Aggression (Formerly Restrictive Physical Intervention)
		TP/CL/026	Complementary Therapies Policy
		TP/CL/027	Identifying & Responding to Domestic & Sexual Abuse
		TP/CL/028	Non-Medical Prescribing
		TP/CL/029	Therapeutic Engagement & Observation Policy
		TP/CL/030	Prevention and Management of Pressure Ulcers
		TP/CL/031	Transitions (Safe & Effective - Internal & External) Policy
		TP/CL/032	Child Sexual Exploitation Policy (Appendix to Safeguarding Policy)
		TP/CL/033	Female Genital Mutilation - FGM (Appendix to Safeguarding Policy)
		TP/CO/053	Bomb Threat Policy and Procedure
		TP/CO/054	Carers & Confidentiality Policy

Policy Forum	Chair	Policy Code	Policy Title
Professional Policy Forum Cont'd		TP/CO/055	Claims Policy
		TP/CO/056	Clinical Audit Policy
		TP/CO/058	Complaints Policy
		TP/CO/059	Confidentiality Policy
		TP/CO/071	Intellectual Property Policy
		TP/CO/075	Media Policy
		TP/CO/077	NICE Guidance Implementation and Audit
		TP/CO/078	Procedural Documents Policy
		TP/CO/081	Research Policy
		TP/CO/083	Service Users & Carers Payment Policy
		TP/CO/084	Smoke Free Policy
		TP/CO/088	Volunteer Policy
		TP/CO/089	Major Incident Policy
		TP/CO/092	Emergency Preparedness, Resilience & Response Policy
		TP/CO/093	Prevent Policy
		TP/CO/094	Business Continuity Management Policy
		TP/MHA & MCA/101	Assessment of Persons under Section 135 & 136 of the MHA
		TP/MHA & MCA/102	Consent to Treatment Policy
		TP/MHA & MCA/103	Conveyance of Patients - S6 MHA
		TP/MHA & MCA/104	Deprivation of Liberty Safeguards (DoLS) Policy
		TP/MHA & MCA/105	Information for Detained Patients & Nearest Relatives (S132 & S133 MHA)
		TP/MHA & MCA/106	Leave of Absence Policy S17
		TP/MHA & MCA/107	Mental Capacity Act 2005
		TP/MHA & MCA/108	Independent Mental Health Advocates Policy
		TP/MHA & MCA/109	Section 117 Practice Guidance

Policy Forum	Chair	Policy Code	Policy Title
Professional Policy Forum cont'd		TP/MHA & MCA/110	Section 5 (Holding Powers) Policy
		TP/MHA & MCA/111	Community Treatment Order Policy S17
		TP/MHA & MCA/112	Victims' Rights under the Domestic Violence, Crime and Victims Act (DVCVA)
		TP/MHA & MCA/113	Visiting Detained Patients in Hospital Policy
		TP/MHA & MCA/114	Associate Hospital Managers Policy
		TP/MHA & MCA/115	Advance Decisions to Refuse Treatment (ADRTs) & Advance Statements Policy
		TP/RHS/151	Bedrails (Safe Use)
		TP/RHS/152	Central Alert System (CAS) Policy
		TP/RHS/153	Display Screen Equipment (DSE) Policy
		TP/RHS/154	Driving Safely at Work Policy
		TP/RHS/156	First Aid Policy
		TP/RHS/157	Health & Safety Policy
		TP/RHS/158	Incidents, Serious Incidents and Learning from Death Policy and Procedure
		TP/RHS/159	Latex Policy & Procedure
		TP/RHS/160	Ligature & Anchor Point Risk Reduction Policy & Procedure
		TP/RHS/161	Medical Devices Management Policy
		TP/RHS/162	Moving & Handling Policy
		TP/RHS/164	Police Liaison Policy
		TP/RHS/166	Slips, Trips & Falls Policy (including patient falls prevention protocol)
		TP/RHS/168	Working Alone (Personal Safety) Policy & Procedure
		TP/RHS/169	COSHH - Control of Substances Hazardous to Health Policy
		TP/WF/212	Mandatory Training & Induction Policy (extension to 31/01/2019)
		TP/WF/223	Preceptorship Policy
		TP/WF/236	Supervision Policy

Policy Forum	Chair	Policy Code	Policy Title
		TP/CL/OP/260	Mental Health Liaison Team Operational Policy
		TP/CL/OP/262	Acute Care Operational Policy
		TP/RHS/164	Police Liaison Policy
Well Led & Workforce Committee	**Chief Operating Officer & Director of HR & OD**	TP/RHS/163	New, Expectant & Nursing Mothers Risk Management Policy
		TP/RHS/167	Stress at Work - Prevention & Management Policy
		TP/WF/201	Access to Personal Records Policy
		TP/WF/202	Alcohol and Substance Misuse Policy
		TP/WF/203	Annual Leave Policy
		TP/WF/205	Managing Performance & Capability Policy
		TP/WF/207	Dignity at Work Policy (Managing Bullying and Harassment Grievances)
		TP/WF/208	Disciplinary Policy
		TP/WF/209	Managing Concerns about Medical Staff
		TP/WF/210	Pre-Employment & Employment Checks Policy
		TP/WF/211	Equality, Diversity, Inclusion and Human Rights Policy
		TP/WF/213	Fixed Term Contract Guidance (Policy)
		TP/WF/214	Flexible Working Policy
		TP/WF/215	Gender Reassignment Policy
		TP/WF/216	Grievance Policy (Individual and Collective)
		TP/WF/217	Travel Costs Reimbursement Policy
		TP/WF/219	Management of Organisational Change Policy (including Redundancy)
		TP/WF/220	Maternity, Adoption, Paternity Support and Leave Policy
		TP/WF/221	Mobile and Home Working Policy
		TP/WF/222	Nurse Revalidation Policy
		TP/WF/224	Protection of Pay and Conditions of Service Policy

Policy Forum	Chair	Policy Code	Policy Title
		TP/WF/227	Recruitment and Selection Policy
		TP/WF/228	Redeployment Policy
		TP/WF/229	Retirement Policy
		TP/WF/230	Rostering Policy
		TP/WF/231	Secondment and Temporary Promotion Policy
		TP/WF/232	Sickness Absence Management Policy
		TP/WF/233	Special Leave Policy
		TP/WF/235	Starting Salary Policy - Non-Medical
		TP/WF/237	Time off and Facilities Agreement for Trade Union Representatives
		TP/WF/239	Working Time Regulations Policy
		TP/WF/240	Employee Support & Wellbeing Policy
		TP/WF/241	Managing Allegations Against Staff Policy
		TP/WF/242	Suspension Policy
		TP/WF/243	Investigation Policy
		TP/WF/244	Incorrect Payments Policy

Sussex Partnership NHS Foundation Trust

APPENDIX 2

Flowchart for the Development, Implementation, Review & Ratification of Procedural Documents

NHS Sussex Partnership NHS Foundation Trust

POLICY ON A PAGE

Title of Policy

1 PURPOSE OF THE POLICY

This states why the policy is necessary. It will include reference to any relevant guidelines, statutory requirements and other recommendations.

2 PRINCIPLES

This will represent the major underlying beliefs on which the policy is based.

3 DUTIES

Duties and accountabilities of directors, committees, specialist staff and authors with responsibilities for the policy.

4 PROCEDURE

A brief step by step account of how the policy is achieved

5 CONTACT

Policy author, executive sponsor and any other relevant contacts for the policy.

policies@sussexpartnership.nhs.uk

Sussex Partnership NHS Foundation Trust

POLICY BRIEFING (New & Reviewed)

The check list is to be completed and attached to any new or reviewed procedural document when submitted to the appropriate committee/forum for consideration and ratification

Section 1 To be completed for any NEW procedural documents
Section 2 To be completed for any existing procedural documents that are being reviewed
Section 3 To be completed by the ratifying committee
Section 4 To be completed for the removal of a policy from the register

Policy Title:	
Reference Number: (If known)	
Date of Expiry: (If applicable)	
Policy Author:	
Executive Sponsor:	

Section 1	**Yes**	**No**	**N/A**	**Comments/Notes**
Content & Layout				
Is the document objective clear, with duties and responsibilities clearly defined?				
Is the document in the standard trust format and style?				
Have associated documents been included as appendices or cross referenced where necessary?				
Have cross references to other trust policy documents been made?				
Have references to other National and Local Guidance been made? If no, reason why not.				
Is the Committee/Group which will approve and ratify the procedural document identified on the front cover?				

Section 1 Cont'd	Yes	No	N/A	Comments/Notes
Dissemination & Implementation				
Has the document clearly identified any training needs and how they will be met?				
Is there agreement from the Head of Education and Training that the training needs can be met and when & how it will be delivered?				

Section 2 – Reviewed Procedural Documents		
Amendment/s	**Reason**	**Intended Impact**

Amendment/s	Reason	Intended Impact

Section 3 – Ratifying Committee				
	Yes	**No**	**N/A**	**Comments/Notes**
Has the policy received the required professional / technical approval? If yes, by whom and when?				
If appropriate, has Human Resources / Staffside committees approved the document?				
Is there evidence of consultation with stakeholders and service users? If no, reason why not?				
Equality and Human Rights Impact Assessment (EHRIA)				
Has the proposed service, policy, measure been screened to determine what effect it is likely to have on different groups? If not, why?				
Has the EHRIA been approved and given an EHRIA code?				
Date:				
Ratification period (6 months to 5 years)				
Any Comments:				

Section 4		
Removal of a policy from the register		
Clear rationale and purpose of removing the policy.	Comments/Reasoning:	
Approval Needed: Executive Sponsor & Ratifying Committee	Confirmation & date of exec Sponsor	Approval from ratifying committee and date

APPENDIX 5

Policy Format

Trust Logo:	Top right hand corner of document on front page
Font throughout:	Arial (except for charts/graphs etc.)
Headings - Including Policy Title:	Arial 14 (bold)
Main body:	Arial 12
Page Numbering:	Bottom right hand corner of each page – Page x of y
Print:	Page set up – portrait (unless charts, forms etc when landscape needed) – single sided, fully justified

APPENDIX 6 – Template policy

Sussex Partnership NHS Foundation Trust

TITLE OF POLICY
(Replaces Policy No. XXXXXX)

POLICY NUMBER	
POLICY VERSION	
RATIFYING COMMITTEE	
DATE RATIFIED	
NEXT REVIEW DATE	
DATE OF EQUALITY & HUMAN RIGHTS IMPACT ASSESSMENT (EHRIA)	
POLICY SPONSOR	
POLICY AUTHOR	

EXECUTIVE SUMMARY:

SUMMARY OR KEY ISSUES, SERVICES/STAFF GROUP POLICIES APPLY TO

If you require this document in another format such as large print, audio or other community language please contact the Corporate Governance Team on: 0300 304 1195 or email: policies@sussexpartnership.nhs.uk

Did you print this document yourself?

Please be advised that the Trust discourages the printing and retention of hard copies of policies and can guarantee that the policy on the Trust website is the most up-to-date version.

As a contingency a full set of up-to-date Trust policies are held by the Corporate Governance Team based at Trust HQ, Swandean

Current status for policies not yet ratified (This to be removed when policy ratified)

Status	**Version number**	**Date**	**Author**	**Consultation**
Draft	Version 01	Date	Name	Forum

CONTENTS

BODY OF THE DOCUMENT

1.0 Introduction

1.1 Purpose of policy

- This states why the policy is necessary. It will include reference to any relevant guidelines, statutory requirements or other recommendations

1.2 Definitions

- List and describe the meaning of the terms used in the context of the document if considered necessary

1.3 Scope of policy

- This defines for whom and where the policy will apply and whether a corporate or local procedure supports the implementation of the policy

1.4 Principles

- This will present the major underlying beliefs on which the policy is based

2.0 Policy Statement

- A statement(s) of the standard that is to be achieved

3.0 Duties

- **Duties within the organisation**
  (Duties and accountabilities of directors, committees, specialist staff, and authors with responsibility for procedural documents)
- **Duties of stakeholders**

4.0 Procedure

A step by step account of how the policy is to be achieved including a flow chart. Or a reference to a separate procedures document.

5.0 Development, consultation and ratification

- An outline of who has been involved in developing the policy and procedure including trust forums and service user and carer groups.
- How the consultation was carried out.
- Who ratified the policy and the process of ratification

6.0 Equality and Human Rights Impact Analysis (EHRIA)

- Undertake an equality and human rights impact analysis.
- Where an impact analysis is deemed unnecessary, record the decision

7.0 Monitoring Compliance

- Outline the organisations process to measure, monitor and evaluate compliance with the minimum requirements stated within the procedural document.
    - This should include: How monitoring will be done? (eg. Audit)
    - Who will monitor?
    - When will monitoring occur?
    - How often will it occur?
    - Process for reviewing results and if there are there deficiencies, how will these be addressed to ensure improvements in performance occur?
    - A description of Key Performance Indicators (KPIs) if applicable

8.0 Dissemination and Implementation of policy

- Explanation of how the policy will be circulated. Should refer to the procedure identified in the Policy for Procedural documents plus any additional local arrangements.
- Explanation of how the policy will be implemented – including any training needs analysis and how these training needs will be met**.**
- Where identified training needs fall under the heading of Essential training, a cross reference to the Essential training policy should be made as standard. This should be discussed with the Learning and Development Manager first.

9.0 Document Control including Archive Arrangements

- Details of process and responsibility for recording, storing, controlling and updating documents detailed in the policy and ultimately archive arrangements.
- This section should cross reference to the Policy for Procedural documents and possibly the Policy for the Management of Corporate Records, Policy for the Management of Health Records and Information Governance Policy.

10.0 Reference documents

- A list of documents referred to in the main body of the text. A reference document is any piece of printed material to which the author refers or quotes directly or any other policy and procedure that has been referred to.

11.0 Bibliography

- A list of works that the author has used as a source of information or evidence, but is not referred to directly in the text

12.0 Glossary

- Definitions of technical or specialised terminology used within the policy

13.0 Cross reference

- List of documents to be read in conjunction with this policy

14.0 Appendices

- Additional material necessary to the delivery of the policy and procedure

APPENDIX 7

Template – Terms of Reference

Name of Committee / Forum / Board			
Ratification Date	DD/MM/YYY	**Owner**	NAME
Purpose			
Insert a sentence or two setting out the purpose of the group/committee			
Duties			
• To • To • To			
Authority			
The *[Insert name of group/ committee]* is authorised by *[Insert name of group/ committee]* to take any decisions which fall within its' terms of reference and are in accordance with the Scheme of Delegation.			
Members		**Quorum**	
List the people who will be members of the group/committee, by title Meetings will be chaired by the [Insert title]. The [Insert title] will be the Deputy Chair. (You may also wish to include the following terms: Other members may be co-opted as required, or other managers may be invited to attend for particular items. Deputies may attend with the prior agreement of the Chair, but will not count towards the quorum. Members must attend a minimum of 'x' number of meetings per annum).		The Chair or Deputy Chair, plus X *number of members are required before a meeting is quorum*	

Frequency	**Calling Meetings**
Meetings will take place *[Insert frequency and other information – e.g. last Wednesday of every month]* All meetings are in accessible venues, taking account of the needs of all attendees	Meetings will be called at the request of the Chair. Notice of each meeting, including an agenda and supporting papers will be sent to the members of the Committee 5 clear days before the date of the meeting.
Reporting	**Communication**
The group reports to the *[Insert name of group / committee]*, and will present an update on progress to *[Insert to whom and how often]*.	The group reports to the *[Insert name of group / committee]*, and will present an update on progress to *[Insert to whom and how often]*. The notes of the meeting will be agreed by the Chair within five working days of the meeting. Action points will be circulated to members within 10 working days of the meeting.
Review	
These terms of reference will be reviewed in *[insert month and year – all TOR to be reviewed annually]* These terms of reference can be made available in alternative formats if required	

Appendix 8

NHS
Sussex Partnership
NHS Foundation Trust

Insert Name of Policy, Strategy or Service

This document is available in alternative formats such as electronic format or large print upon request
Please contact the Equality, Diversity and Human Rights Team on 01903 845724 or email
equality.diversity@sussexpartnership.nhs.uk

1. Equality and Human Rights Impact Analysis (EHRIA)

Help

1.1 Board Lead:		1.2 Analysis Start Date:	
		1.3 Analysis Submission Date:	
1.4 Analysis Team Members: 1.5 If this is a cross agency policy/service or strategy please indicate partner agencies and their formal title 1.6 Completion Statement	1) Author / Editor: 2) Frontline Staff: 3) Patient / End-user: 4) I/We, being the author(s), Service Managers, acknowledge in good faith that this analysis uses accurate evidence to support accountable decision-makers with due regard to the National Equality Duties, and that the analysis has been carried out throughout the design or implementation stage of the service or policy.		
1.7 Policy Aim			

⚠ **Send draft analysis along with the policy, strategy or service to equality.diversity@sussexpartnership.nhs.uk for internal quality control prior to ratification.**

1.8 Quality Assessor sign off	
1.9 Reference Number	

2. Evidence Pre-Analysis – The type and quality of evidence informing the assessment

Help

X	1.10 Types of evidence identified as relevant have **X** marked against them				
	Patient / Employee Monitoring Data		Risk Assessments	Please provide detailed evidence for the areas	
	Recent Local Consultations		Research Findings	highlighted , and also any other Evidence that may be relevant (please state):	
	Complaints / PALS / Incidents		DH / NICE / National Reports		
	Focus Groups / Interviews		Good Practice / Model Policies		
	Service User / Staff Surveys		Previous Impact Analysis		
	Contract / Supplier Monitoring Data		Clinical Audits		
	Sussex Demographics / Census		Serious Untoward Incidents		
	Data from other agencies, e.g. Services, Police, third sector		Equality Diversity and Human Rights Annual Report		

3. Impact and outcome Evaluation – Any impacts or potential outcomes are described below.

Help

Ref	Mark one **X** +	Mark one **X** −	Describe how this policy, strategy or service will lead to positive + outcomes for the **protected characteristics.** Describe how this policy, strategy or service will lead to negative − outcomes for the **protected characteristics.** **(Please describe in full for each)**	**People's Characteristics** (Mark with 'X'): Age	Disability & Carers	Gender Reassignment	Pregnancy & Maternity	Race	Religion & Belief	Sex	Sexual Orientation	Human Rights
3.1												
3.2												
3.3												
3.4												

Add more rows if necessary with new reference numbers in the left column

4. General Duty – Due Regard

Help

Describe how this **policy, strategy or service** will show **due regard** for the three aims of the general duty across the protected characteristics listed. Please describe in full. **(Please make sure that you address each of the protected characteristics in your answers)**		**People's Characteristics** (Mark with 'X'):									
		Age	Disability & Carers	Gender Reassignment	Pregnancy & Maternity	Race	Religion & Belief	Sex	Sexual Orientation	Human Rights
4.1 Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010; Help										
4.2 Advance equality of opportunity between people from different groups; Help										
4.3 Foster Good relations between people from different groups Help										

Add more rows if necessary with new reference numbers in the left column

5. Monitoring Arrangements

Help

5.1 The arrangements to monitor the effectiveness of the policy, strategy or service considering relevant characteristics? E.g. ↘ survey results split by age-band reviewed annually by EMB and Trust Board ↘ Service user Disability reviewed quarterly by Equality and Diversity Steering Group or annually in the EDHR Annual Report	

6. Human Rights Pre-Assessment

Help

The Impacts identified in sections ( ) have their reference numbers (e.g. 4.1) inserted in the appropriate column for each relevant right or freedom	+	–
A2. Right to life (e.g. Pain relief, DNAR, competency, suicide prevention)		
A3. Prohibition of torture, inhuman or degrading treatment (e.g. Service Users unable to consent)		
A4. Prohibition of slavery and forced labour (e.g. Safeguarding vulnerable patients policies)		
A5. Right to liberty and security (e.g. Deprivation of liberty protocols, security policy)		
A6&7. Rights to a fair trial; and no punishment without law (e.g. MHA Tribunals)		
A8. Right to respect for private and family life, home and correspondence (e.g. Confidentiality, access to family etc.)		
A9. Freedom of thought, conscience and religion (e.g. Animal-derived medicines/sacred space)		
A10. Freedom of expression (e.g. Patient information or whistle-blowing policies)		
A11. Freedom of assembly and association (e.g. Trade union recognition)		
A12. Right to marry and found a family (e.g. fertility, pregnancy)		
P1.A1. Protection of property (e.g. Service User property and belongings)		
P1.A2. Right to education (e.g. accessible information)		
P1.A3. Right to free elections (e.g. Foundation Trust governors)		

7. Risk Grading

Help

7.1 Consequence of negative impacts scored (1-5)		7.2 Likelihood of negative impacts scored (1-5):		7.3 Equality & Human Rights Risk Score = Consequence x Likelihood scores:	

8. Analysis Outcome– The outcome (A-D) of the analysis is marked below ('X') with a summary of the decision **Help**

X	8.1 The outcome selected (A-D):	8.2 Summary for the outcome decision (**mandatory**)
	A. Policy, strategy or service addresses quality of outcome and is positive in its language and terminology. It promote equality and fosters good community relations	
	B. Improvements made or planned for in section 9 (potential or actual adverse impacts removed and missed opportunities addressed at point of design)	
	C. Policy, service or strategy continues with adverse impacts fully and lawfully justified (justification of adverse impacts should be set out in section 3 above	
	D. Policy, service or strategy recommended to be stopped. Unlawful discrimination or abuse identified.	

9. Equality & Human Rights Improvement Plan

- Remove negative impacts for people with protected characteristics
- Improve opportunities for people with protected characteristics
- Improve evidence and fill 'gaps' in our knowledge where relevant
- Record changes already made as a result of the impact analysis process
- Actions resulting from public engagement, should include the name and date of the engagement next to it

Actions should when relevant and proportionate meet the different needs of people. **Help**

Impact Reference(s) (from assessment)	What directorate (team) action plan will this be built into ⚠	Action	Lead Person	Timescale	Resource Implications