SPERRIN LAKELAND

HEALTH AND SOCIAL CARE TRUST

Clinical and Social Care Governance

Strategy for Ensuring Quality

September 2000

CONTENTS

Clinical and Social Care Governance:
A blueprint for Sperrin-Lakeland Health and Social Care Trust

1.0 Introduction

Clinical governance is an internal framework for the continuous improvement in the quality of clinical services and the safeguarding of high standards of care within the National Health Service (NHS).

Through clinical governance it will be possible to create an environment where excellence in clinical and social care will flourish.

The government White Paper "NEW NHS - MODERN DEPENDABLE - 1997" and the consultation document "A First Class Service - Quality in the new NHS" outlined the concept and the necessary components of clinical governance.

The precise arrangements for the implementation of clinical governance within Northern Ireland, where Health & Social Care are integrated, have not yet been produced by the HSSE. It can be anticipated that Chief Executives and Boards will have a statutory responsibility to *assure* the quality of the services for which they are responsible in much the same way as they are now responsible for financial matters.

Three core elements of the strategy to improve quality in the NHS are:

- The development of national quality standards through *National Service Frameworks* (NSF) and the *National Institute for Clinical Excellence* (NICE)
- The establishment of mechanisms to ensure local delivery of high quality clinical services, delivered through Clinical Governance and a statutory duty of quality, supported by programmes of lifelong learning and professional self-regulation.
- The improvement of systems to monitor the delivery of quality standards through a new NHS regulatory body, The *Commission for Health Improvement* (CHI) and a NHS Performance Framework. This will include a national survey of patient and user experience.

Within Northern Ireland it is assumed that these elements will also apply to social care creating *Clinical and Social Care Governance*.

Sperrin-Lakeland Health and Social Care Trust should be prepared for clinical and social care governance and this draft paper builds on work from the regional seminar hosted by the Trust in September 1999 and the follow up workshop held in November 1999. This paper aims to outline an appropriate structure and lines of accountability for Clinical and Social Care Governance within the Trust. The guidance produced may have to be amended in line with HSSE policy.

2.0 Principles

One of the most important aspects of the NHS document "A first Class Service" is the emphasis on improving the quality of care. A key component of Clinical and Social Care Governance will be the statutory responsibility for quality at a local level set against nationally agreed standards. The key objectives are to continually improve care, minimise errors, learn from mistakes and ensure decisions made by professionals are based on the best available evidence.

There are four main themes central to the development of Clinical and Social care Governance:

1) The creation of clear lines of accountability for the overall quality of clinical care.
2) Comprehensive programmes of quality improvement.
3) Systems to systematically assess and reduce clinical risk.
4) All professional groups should identify and remedy poor performance.

It is acknowledged that Clinical and Social Care Governance within Sperrin-Lakeland will build on good and effective systems already in place:

- existing systems for quality control
- activity and information already available for quality improvement
- existing professional regulation

In 1997 the Trust adopted its Quality Strategy. This is based on a framework that focuses on the following 4 elements: INPUT; PROCESS; OUTCOME; and EVALUATION. This framework should continue to provide a structure for future action plans.

The participants in the clinical workshops, held within Sperrin-Lakeland, identified a number of principals for the introduction of Clinical Governance:

Fair	to all staff
Clear	in respect of roles and responsibilities
Simple	easily understood and non-bureaucratic
Dynamic	have the capacity to change and be flexible
Effective	it should achieve the quality gains required
Open	transparent and honest to instil confidence in staff and public
Comprehensive	it should be inclusive of all staff groups, recognise all aspects of service provision and the impact on patient/client
Credible	realistic in its aims
Resourced	it requires priority funding
User Involvement	users must be involved in the quality agenda

Clinical and Social Care Governance provides an excellent opportunity to reflect on why quality processes within our trust may not work well and provides us with a mechanism to build on current experience and develop robust and effective methods of reviewing our work and improving clinical care.

3.0 The Steps to Clinical and Social Care Governance

There are a number of key steps all NHS organisations must take to develop Clinical and Social Care Governance:

1 *Establish leadership, accountability and working arrangements*: The new NHS Act places the responsibility for Clinical Governance on the Chief Executives of trusts. It is anticipated that within Sperrin-Lakeland the Chief executive will discharge this responsibility through the Medical Director. The Trust should ensure that Medical Director has been released from a sufficient number of clinical sessions to fulfil this role.

2 *Carry out a baseline assessment of capacity and capability*: The implementation of Clinical and Social Care Governance requires a baseline assessment of the organisation's position Within Sperrin-Lakeland some of the baseline assessments have already begun with reviews of the function, organisation and reporting mechanisms of existing committees. Clinical and Social care Governance will also require a searching and honest analysis of the Trust's strengths and weaknesses in relation to current performance. It must identify services that are inadequate. The quality of all available data must be reviewed and measures taken to ensure that there is integration between the various quality activities and systems. A review of strategies such as information management and technology (IM&T), human resources (HR), continuous professional development (CPD) and research and development (R&D) and how they should relate to Clinical and Social Care Governance will also be required.

3 *Formulating and Agreeing the Development Plan*: Following the baseline assessments the Trust will be expected to formulate and agree an action plan for Clinical and Social Care Governance. This plan must address identified shortfalls in quality care provision, develop the infrastructure to support Clinical and Social Care Governance and identify the training needs for staff, managers and board members in relation to Clinical Governance. Within Sperrin-Lakeland, in addition to the baseline assessment of committees, the Trust has developed a team assessment template. The use of this template should further inform the Trust action plan for Clinical and Social Care Governance.(see appendix 3)

4 *Clarify the Reporting Arrangements for Clinical and Social Care Governance*: Reports to the Trust Board will form an important part of the accountability for Clinical and Social Care Governance. It is proposed that Sperrin-Lakeland Trust Board members meet four times per year *in committee* to specifically address this agenda. The priority given by the

Trust Board to Clinical and Social Care Governance will send a powerful message to the whole organisation. Clinical and Social Care Governance Committee meetings will be, like Trust Board meetings, open and held in public. This should provide reassurance to the local population. Arrangements to enable the Clinical and Social Care Governance Committee to handle some of the more sensitive issues, which have the potential to undermine the confidence of the public in a local service, are required. The balance between openness of debate and the handling of sensitive issues about health service individuals and confidential patient data must be carefully judged.

4.0 Achieving the right Culture

Clinical and Social Care Governance will not be successful without considerable effort from all involved within Sperrin-Lakeland Trust. Whilst the chief executive will ultimately be accountable, Clinical and Social Care Governance is the duty of all staff within the entire organisation. The success of Clinical and Social Care Governance will depend on developing a culture within the Trust that is open and reflective about the standards of care. Good practice should be recognised, valued and shared throughout the organisation. This will require commitment from senior management and *all* clinicians, practitioners and social service personnel.

It must be recognised that a single practitioner rarely manages patients/clients. Most are cared for by multi-professional teams and are part of a wider network of service provision. Central to high quality care delivery will be how health care professionals work together within such teams and how effective is the communication both internally and externally. Sperrin-Lakeland must ensure that the entire system of service provision is well organised and of the highest quality despite the considerable resource restraints.

Each department will have to review models of good practice both from within the organisation and from outside bodies and consider the lessons for future success.

The tradition within Sperrin-Lakeland of actively working with community groups, the general public, primary health care teams and users of the service must continue and develop.

The Trust will be required to ensure that appropriate standards are agreed, maintained and monitored for all areas of service provision.

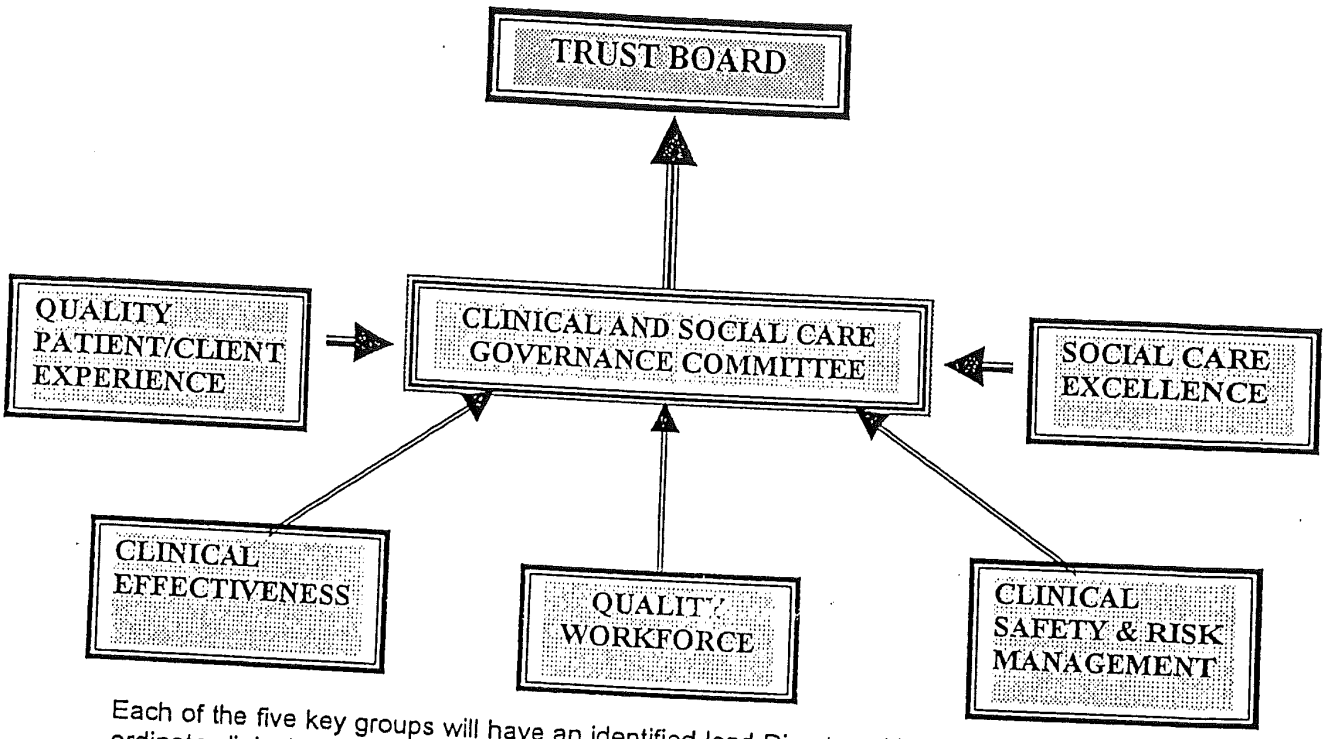
The Trust has an additional responsibility to support its practitioners in meeting their individual professional responsibilities of delivering high quality care. This will include support for training and continuing professional development.

5.0 Structure

The proposed structure for Clinical and Social Care Governance is outlined in Fig 1. This structure draws together many of the existing components of Clinical and Social Care Governance under a series of five key groups that feed into a new *Clinical and Social Care Governance Committee*. This committee is expected to be statutory, reporting to

the Trust Board, in a similar fashion to the Financial Audit Committee. The proposed membership and the terms of reference of the Clinical Governance Committee are outlined in Appendix 1.

Figure 1 : CLINICAL GOVERNANCE STRUCTURE



Each of the five key groups will have an identified lead Director with responsibility to co-ordinate clinical governance activity and ensure appropriate reporting arrangements. It is anticipated that it will not be necessary to create new groups/ committees and where possible existing working and reporting arrangements will continue. It should be stressed that the Trust's normal line management arrangements should not be altered by these changes.

Key Subgroups: Fig.2

Clinical Effectiveness Group : Mr Gabriel Carey.

This group includes two new major subgroups *Standards and Guidelines* and *Audit and Research*. The grouping will be the responsibility of the Director for Mental Health and Elderly Care who currently carries Trust responsibility for Multi-Professional Audit.

The *Standards and Guidelines Subgroup* will include a mixture of existing and new committees. The group will include committees to review the reports from standard setting organisations such as NICE, NSF (if developed within Northern Ireland) and the National Confidential Enquiries. Internal committees such as the Patient Records and CEPOD arrangements will continue. A new committee to oversee development of Care

Pathways may be required. This group will be responsible for clinical guidelines and their implementation. Outcomes, clinical indicators and clinical effectiveness will also be part of the remit of this group. A separate committee should also be developed to review the requirements of future accreditation and to oversee applications for Charter Mark and quality awards.

The *Audit and Research Subgroup* will encompass all aspects of multi-professional audit and include a separate ethical committee and a research committee. This separation provides for a committee to oversee all aspects of research within the trust including ethical approval. The ethics committee would in future concentrate on assisting clinical teams handle the ethical issues that on occasions arise from patient/client care.

Clinical Safety and Risk Management Group: Mr Eugene Fee

This group brings together existing committees that focus on safety and risk management. This will include the Drugs and Therapeutic Committee, Control of Infection, Blood Transfusion Committee, Emergency Planning Group, Health and Safety Committee. Medicolegal risk management will continue through the Scrutiny Committee. New risk management committees for Radiation Protection and Critical Incident Reporting will be developed. Issues relating to risk management will be shared throughout the organisation to ensure a learning culture rather than one of judgement and blame. This group will be the responsibility of the Acute Services Director in light of his professional nurse responsibilities.

Quality Workforce Group: Mr Gerry Mc Laughlin

It is vital that Sperrin-Lakeland has a highly trained, skilled and motivated workforce. Lifelong learning, development of education and training, peer review with personal development programmes will be necessary for Clinical and Social Care Governance. To realise this aim, under the Quality Workforce Group, the Director of Human Resources and Operational Services will be responsible for two subgroups *Education and Continuous Professional Development* and *Workforce Issues*. The Education and CPD subgroup will include the Medical Education committee, a Nurse Education Group and a Nurse Practice Development committee. Education and training development will be continuously reviewed, co-ordinated and yearly action plans produced for the Clinical Governance and Social Care Committee.
The *Workforce Issues* subgroup will include the two existing committees - The Local Task Force and The Staff Joint Forum.

Quality Client Experience Group: Ms Bridget O'Rawe

Patient/client involvement is paramount to the new Clinical Governance structures. A variety of approaches to obtain patient/client views and mechanisms of incorporating these into future service delivery will be developed. These will include a User Feedback and Research group, a Trust User Association and a Complaints Management group. Existing committees such as the Senior Management Team/ General Practice Liaison Forum and the Joint Council Forum will continue and feed into the Clinical Governance committee. The Director of Corporate Affairs should assume responsibility for the

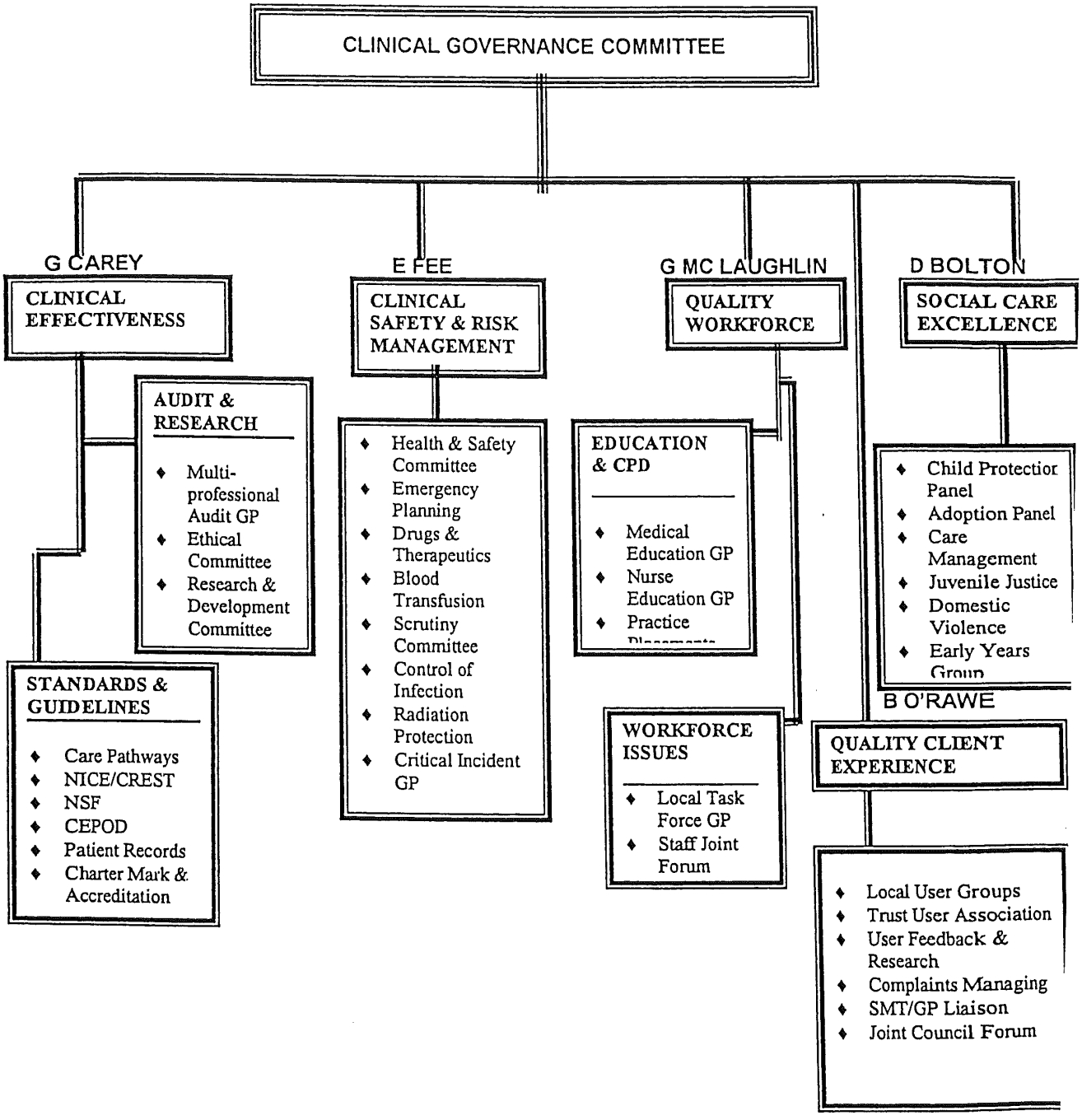
Quality Client Experience Group in view of her ongoing corporate responsibility for quality, complaints and user satisfaction.

Social Care Excellence Group: Mr David Bolton

There is an absence of guidance on what is required to meet Social Care Governance. It is anticipated however that the principal requirements will be similar to that for Clinical Governance. The new arrangements will build on existing social work supervision and practice and standards laid down by the Social Services Inspectorate.

The Director of Community Care, will oversee this group and co-ordinate the committees that review standards and guidelines, policies and procedures and statutory function. These include the Adoption Committee, Juvenile Justice Committee, Early Years Group, Domestic Violence Group and the Care Management Forum.

Figure 2


CLINICAL GOVERNANCE COMMITTEE
G CAREY
CLINICAL EFFECTIVENESS
AUDIT & RESEARCH
Multi-professional Audit GP
Ethical Committee
Research & Development Committee
STANDARDS & GUIDELINES
Care Pathways
NICE/CREST
NSF
CEPOD
Patient Records
Charter Mark & Accreditation
E FEE
CLINICAL SAFETY & RISK MANAGEMENT
Health & Safety Committee
Emergency Planning
Drugs & Therapeutics
Blood Transfusion
Scrutiny Committee
Control of Infection
Radiation Protection
Critical Incident GP
G MC LAUGHLIN
QUALITY WORKFORCE
EDUCATION & CPD
Medical Education GP
Nurse Education GP
Practice
WORKFORCE ISSUES
Local Task Force GP
Staff Joint Forum
D BOLTON
SOCIAL CARE EXCELLENCE
Child Protection Panel
Adoption Panel
Care Management
Juvenile Justice
Domestic Violence
Early Years Group
B O'RAWE
QUALITY CLIENT EXPERIENCE
Local User Groups
Trust User Association
User Feedback & Research
Complaints Managing
SMT/GP Liaison
Joint Council Forum

6.0 Resources

Clinical and Social Care Governance will be a priority for the Trust in the coming years. Whilst recognising that we cannot afford not to deliver on Clinical and Social Care Governance, activity relating to the new agenda will require resourcing:

Time: Health care professionals within Sperrin-Lakeland have little free time and the additional requirements must be recognised in future manpower planning. Future staff appointments should have Clinical and Social Care Governance obligations included in the contract or job plan. Full support by clinical staff for the new agenda may affect clinical duties and have implications for waiting times. Lead professionals will need to have identified free sessions to undertake this work.

Training and Development: Training and development will be required for clinical staff involved in establishing the right environment for Clinical and Social Care Governance. Specific training, education and development needs of different clinical and managerial groups must be identified.

Staff Support: Additional resources, if available, must be carefully targeted to support the staff involved in developing Clinical and Social Care Governance. Where no additional funding is available, a review of the effective use of existing resources will be required. In particular, the role of the audit team will require a new focus towards Clinical and Social Care Governance. The current review of the complaints procedure should also include staff support arrangements.

Information Management and Technology: Investment in IT is crucial if Clinical and Social Care Governance is to succeed. Sustainable information systems that are responsive to the needs of both the clinical teams and the wider organisation will be required. A review of the information requirements to enable clinical teams to monitor and review performance in line with Clinical and Social Care Governance is urgently required.

7.0 The Next Steps for Sperrin-Lakeland Trust

While the Trust awaits the Northern Ireland "Quality Paper" from the HSSE there are preparatory steps that can be taken. Sperrin-Lakeland has therefore developed a first stage activity plan for Clinical and Social Care Governance. (Appendix 2) Additional steps to be undertaken include:

1) Prepare an organisational development plan for Clinical and Social Care Governance that incorporates the needs of the individual, the Clinical Teams, the user and the wider organisation.

2) Design an education and training programme for key staff on the Clinical and Social Care Governance agenda.

3) Develop a monitoring system to review the implementation of Clinical and Social Care Governance within the Trust. This system must determine the criteria for success in the short, medium and long-term.

4) Incorporate the Information Technology requirements to support Clinical and Social Care Governance in the Trust's IM&T strategy and secure early resources for improved IT systems.

5) Identify the resources to support the activity relating to Clinical and Social Care Governance.

Dr J F Kelly
Medical Director

Ms B O'Rawe
Director of Corporate Affairs

September 2000

Appendix 1

TERMS OF REFERENCE
CLINICAL AND SOCIAL CARE GOVERNANCE COMMITTEE

1. **Constitution**

The Trust Board hereby resolve to establish a Committee of the Board to be known as the Clinical and Social Care Governance Committee

2. **Membership**

Full membership of Trust Board including the 4 support directors. All members will have full voting rights. A quorum shall be 5 members, including at least 1 Executive Director and 1 Non-Executive Director. The Committee shall be Chaired by the Trust Chairman or Non-Executive Director nominated by the Chairman. It is also intended to have a number of lead professionals in attendance as ex officio members. Future consideration will be given to the involvement of a representative of service users. This may involve either the WHSSC or the Trust Users Association.

3. **Attendance at Meetings**

Meetings shall be open to the public. Standing orders and conduct of business for the Trust Board shall apply (sections 3.3 and 5.00).

4. **Frequency of Meetings**

Meetings shall be held not less than 4 times a year

5. **Authority**

The committee is authorised by the Trust to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee, and all employees are directed to co-operate with any request made by the committee.

The committee is authorised by the Trust to invite independent professional advisors to contribute to discussions, and to secure the attendance of external advisors with relevant experience and expertise if it considers this necessary. The committee is authorised to obtain legal advice as it deems necessary.

6. **Duties**

The duties of the committee shall be to oversee the implementation of the Trust's Clinical and Social Care Governance arrangements. To provide leadership in creating a culture across the organisation which puts continuous improvement in the quality of clinical and social care services at its foundation.

And through regular monitoring and effective reporting systems is in a position to promote improved care, minimise errors, learn from experience and mistakes and

ensure clinical and professional decisions are based upon the best available evidence.
Specifically, the committee will:

6.1 Establish a regular reporting regime with the five main groups of committees, i.e.

i) Clinical Safety and Risk Management
ii) Quality Workforce
iii) Quality Client Experience
iv) Clinical Effectiveness
v) Social Care

6.2 Review the work of committees at least once annually.

6.3 Report to the Trust Board on a regular basis and provide exception reports as may be necessary.

6.4 Produce an annual Clinical and Social Care Governance report, which shall include a record of work undertaken and confirm compliance with the Trust's statutory responsibilities.

6.5 Ensure the Trust, and all professional and support staff, respond appropriately to future quality standards issued by, and imperatives which may arise from, central government, the DHSSPS, Commissioners, professional regulatory bodies, CHIMP,NICE,CREST, self audit of practice or other sources.

6.6 Review future corporate business plans to ensure they take account of and address the Clinical and Social Care Governance agenda and, where necessary, set targets for improvement.

6.7 Be appraised of significant issues of poor quality, practice or standards and where these arise, ensure appropriate remedial measures/action is undertaken.

7. Reporting

The minutes of the Clinical and Social Care Governance Committee meetings shall be formally recorded and submitted to the Trust Board.

Annual Report will be incorporated in the Trust's Annual Report.

Director of Corporate Affairs and
Medical Director
September 2000

Appendix 2

WORK ACTIVITY PROGRAMME – CLINICAL AND SOCIAL CARE GOVERNANCE IMPLEMENTATION

Activity	Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Structure													
Draft Proposal	Dr Kelly/B O'Rawe												
Brief SMT	Dr Kelly												
Brief Trust Board	Dr Kelly												
Initiate Consultation Arrangements	Dr Kelly/B O'Rawe												
Consultation Across Directorates	Directors (All)												
Assess Feedback and Refine Proposals	Dr Kelly/B O'Rawe												
Structural Proposals to Trust Board for Adoption	Dr Kelly/B O'Rawe												
Establish Committees	Chief Executive												
Involvement													
Develop Staff Involvement Strategy Proposal	B O'Rawe												
- Consult Directors	B O'Rawe												
- Agree Template of Issues for Local Discussion	B O'Rawe/Directors												
- Agree Initiatives	B O'Rawe/Directors												
Identify Lead Staff	Directors - Service												
Ownership													
Assess Implications Locally Using Template	Directors/Leads (Inc Supports)												
Initiate Development Plans (future links to Business Planning Cycle) (2001/2002)	Directors/Leads (Inc Supports)												
Support Work													
Assessment and Refinement of Committee Structures	B O'Rawe												
Develop Policy/Procedure Template/Guidance	B O'Rawe												
Draft Clinical Governance Committee Terms of Reference	B O'Rawe												
Assess Impact on Trust Board Agenda and Meetings	B O'Rawe/Chief Executive												
Agree and set up Reporting Arrangements	Relevant Directors												
Consider other Activities which will/are Contributing to Clinical and Social Care Governance Agenda	Directors - All												
Resource Issues													
▪ Research GB exp for costs	B O'Rawe												
▪ Raise at CRG	M MacCrossan												
▪ Include reference in future contract negotiations	M MacCrossan												
▪ Assess Resource implications locally	Directors - All												
▪ Identify Resource capacity	M MacCrossan												

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Appendix 3

Clinical and Social Care Governance Team Assessment

This template for Team assessment is designed to assist local service, specialism, or professional, teams in assessing their collective understanding of and readiness for Clinical Governance.

It is hoped that this process will lead to the development of local and directorate action plans.

Where the response is no, or in the negative, consideration should be given to how this area/issue can be actioned with the team. The areas listed are not exhaustive.

	THE CONCEPT AND ITS IMPACT	
1	Is everyone in the team aware of the concept of Clinical and Social Care Governance?	YES/NO
2	Have opportunities been taken to discuss what Clinical and Social Care Governance may mean for the team and services provided?	YES/NO
3	Is the team aware of the Trust's proposals?	YES/NO
4	Did the team have an opportunity to contribute to the original proposal?	YES/NO
5	Is Clinical and Social Care Governance seen as a positive development in the pursuit of quality in service provision?	YES/NO
	ACCOUNTABILITY	
6	Is everyone in the team aware of the Trust committees/groups that are relevant to your area of work?	YES/NO
7	a) Are there formal arrangements for raising or reporting issues to these committees/groups? b) Are Team members aware of these?	YES/NO YES/NO
8	Do you receive feedback/information from these committees/groups that help inform local practice?	YES/NO
	ACHIEVING QUALITY	
9	Are there key standards which govern/shape service in your team?	YES/NO
10	Are these standards monitored/evaluated?	YES/NO
11	How are team members involved in (i) developing standards (ii) monitoring outcomes e.g clinical incident reporting?	
12	How is/can information be used to inform practice within the team and beyond?	

13	Are there any barriers and how might these be overcome? e.g. information/data, resources such as time	
	LEADERSHIP	
14	Would it be appropriate for a team member to 'champion' this work?	YES/NO
15	Can that individual be released from some duties to undertake this role?	YES/NO
	EDUCATION, TRAINING & DEVELOPMENT	
16	Is a Training Needs Analysis (TNA) regularly undertaken?	YES/NO
17	Does the TNA reflect on skills, needs and competency related to the teams work.	YES/NO
18	Are Academic research opportunities used to benefit service standards and provision?	YES/NO
	MANAGING RISK (linked toAchieving Quality Section)	
19	Have you considered the risks associated with the delivery of services to: (a) staff (b) patient/client	YES/NO
20	Are there systems/procedures in place to minimise/remove risk	YES/NO
21	Are you aware of legal obligations that govern your work eg statutory duties, code of ethics, legislation eg Human Rights and Equality	YES/NO

JULY 2000

Appendix 4

SPERRIN LAKELAND
HEALTH AND SOCIAL CARE TRUST

Guidelines on Writing Policies, Procedures, Guidelines and Protocols

POLICY STATEMENT

The following guidance will be used by Trust staff when developing and writing policies for use within the Trust.

Background
The implementation of Clinical Governance, the Equality Scheme, and other legislation in the Trust, have further increased the importance of having recognised policy documentation, which governs the way in which the Trust carries out its business. This guidance has been developed to assist staff when they are developing policy documents, and has been laid out in the following manner.

- Step 1 provides advice on how to decide whether it is necessary or not for a policy to be developed.
- Step 2 outlines issues to be considered prior to commencing policy development.
- Step 3 is a policy template, which details all of the sections which should be included in a policy document.
- Step 4 outlines the process for seeking approval of the policy.
- The final section indicates some general points to be considered whilst developing the policy.

Although the following guidance has been written specifically in relation to policy development, many of the principals can be used when developing protocols, guidance etc.

STEP ONE - How to decide whether a policy is necessary.

1. Decide whether a policy document is required or not

   Is there an area which the Trust's position is not clear on, or an issue which staff are unsure about how to deal with, which would benefit from the development of a policy statement.

2. Decide what is required, i.e. policy, protocol, procedure or guideline.

   The following definitions may assist:-

   POLICY

   A policy is a guiding or governing principle, and meets the following criteria:-

   a) It is a governing principle that mandates or constrains actions
   b) It has Trust/Directorate/Department wide application
   c) It will change infrequently and sets a course for the foreseeable future
   d) It helps to ensure compliance to overarching principals/legislation/professional guidance
      OR
      It helps to reduce institutional risk
   e) It requires approval at, at least Senior Management Team level

   PROCEDURE

   A procedure is a series of interrelated steps that are taken to help implement a policy.

   PROTOCOL

   The correct way to act in a specific situation.

   GUIDELINES

   Advise on how something should be done

3. **Does a similar policy already exist?**

If yes – why is this policy no longer applicable. Does it need updating or has something happened to make the existing policy inappropriate, e.g. new legislation.

At this stage, you should now be in a position to decide if it would be appropriate to develop a policy.

STEP TWO – Decisions before developing the policy.

1. ***Who should develop the new policy?***

Who would be the most appropriate person to draft a proposed policy. Could an individual draft the policy, for comment by a larger group, should a group be convened to draft the policy?

2. **Who should be consulted during the development of the new policy?**

Who should be consulted during the development phase of the new policy. Consideration should be given to consulting with user groups, staff, professional bodies etc. (See also Step 4 point 1 later in this document)

3. ***Who should approve the new policy?***

For example, it may be appropriate for the policy to be approved at any of the following levels:-

- Department Level
- Directorate Level
- Senior Management Team Level
- Trust Board Level

This will be determined by the level of impact beyond Departmental / Directorate level. Your head of department or Director will be in a position to advise on this issue.

STEP THREE – Policy Development

The following template should be completed during the policy development

1. Policy Title Use this space to give the policy a title
2. Policy Reference Number This number will be allocated by Registry – Trust HQ when the policy has been adopted as an official Trust policy by SMT/Trust Board/Directorate
3. Responsible Officer/Department This section should indicate the position of the individual, or the name of the department responsible for developing the policy.
4. Date The date indicated here will be the date when the policy was issued to staff, and the date from which the policy was effective from. During the drafting of the policy, the date on which the draft was issued will be indicated here, alongside the word DRAFT
5. Review Date This date will be the date at which the policy should be reviewed. Depending on the nature of the policy, this could be one month/six months/1 year/3years post implementation
6. Background/Reason for policy This section should indicate the reason for the policy being in place, and any background information which relates to the policy. For example, as a result of a piece of legislation such as the Human Rights Act, a professional issue, Clinical Governance, in order to reduce risk, protection of staff/patients/clients etc
7. Objectives of the Policy This section should indicate what the purpose of the policy is, and what it is trying the achieve, and the departmental/service area which it covers.

8. The Policy

This section should detail the governing principle and framework of the policy. It should clearly indicate the responsibility placed on individuals, and departments, and how these should be fulfilled. In essence it will outline what the Trust's position is in relation to a particular issue, for example, smoking in the workplace. It is important to acknowledge under this section, any circumstances when the policy would require discretion or referral to another officer. This section must be clear, and include any constraints and limitations, and if possible should be presented as bullet points.

In some circumstances it may be appropriate that staff sign that they have received and understood the policy. If this is the case, this factor should be indicated here

9. Who should have knowledge of this policy?

This section should list the following groups of staff, as relevant, such as:-

- Who should observe the policy and follow its procedures
- Who must understand the policy in order to do their job
- Who may be affected by the implementation of this policy

10. Responsibilities

This section should outline the responsibilities of any particular individuals in relation to the policy outlined at section 7 above.

11. Reference

This section should include references to

- Any relevant legislation
- Any relevant procedures, which are initiated by the impact of this policy
- Any relevant forms
- Any relevant guidance notes
- Any other relevant documentation

Where references are included, consideration should be given to attaching these to the policies as Appendices.

12. Signature

This section allows for the signature of the policy by the Trust's Chief Executive, Director or Head of Department as appropriate

Whilst developing the policy, consideration also needs to be given to Equality requirements, under section 75 of the Northern Ireland Act 1998. In essence this legislation places a duty on the Trust to ensure that all of its policies promote equality of opportunity and good relations, between persons of different religious beliefs, political opinions, racial/ethnic groups, age, gender, marital status, sexual orientations, those with a disability and those without, and those with or without dependants. The following questions have been developed by the Equality Commission to assist when examining the equality issues around a policy, and these questions should be kept in mind throughout development:-

I. Is there any evidence of higher or lower participation or uptake by different groups?

II. Is there any evidence that different groups have different needs, experiences, issues and priorities in relation to the particular policy?

III. Is there an opportunity to better promote equality of opportunity or better community relations by altering the policy or working with others in government or in the larger community?

IV. Have consultations with relevant groups, organisations or individuals indicated that particular policies create problems which are specific to them?

STEP FOUR – Process for seeking approval

After the policy has been drafted, it should be discussed with your Head of Department and/or Director. Consideration should also be given to providing proposals on the following, which will also form part of these discussions:-

1. Consultation Arrangements

Proposed consultation arrangements, including

- Bodies to be consulted (e.g. Staff groups, Professional bodies, external organisations etc)
- Consultation methods (circulation of document, meetings etc)
- Consultation timescales

The document "How to Consult with Service Users" may be of assistance, when considering this issue.

2. Communication Arrangements

Proposed communication arrangements should be outlined, consideration should be given to the following:-

- Distribution List
- Inclusion in Core Brief
- Publication of an article in Spotlight
- Raising the issue at Staff Meeting
- Inclusion in induction training for new staff
- Inclusion in induction checklist for new staff

3. Equality Screening Form

An Equality Screening Form should also be completed for the new policy, to ensure compliance with the Northern Ireland Act 1998. This form is available from Registry, Trust Headquarters.

The Next Stage of the Approval Process will be agreed with your Director or Head of Department.

GENERAL POINTS

During the drafting process – keep the following points in mind

1. Abbreviations

When an abbreviation is first used, when the abbreviation is first used, the full term should also be outlined. Thereafter, only the abbreviation is necessary. For example:-

Within Sperrin Lakeland Trust (SLT), there are approximately xx employees..... SLT is responsible for .....

2. Definitions

A Definition should be given for unfamiliar or unusual terms in the glossary to the policy

3. Plain English

Use "Plain English" where ever possible. Don't get caught up in the "document writing" mode. Instead write as you would say. For example:-

Don't Use	Use
Accomplish	Do
Terminate	End
Is equipped with	Has
Large Number of	Many

4. Present Tense

Use the present tense when writing the policy. The future tense is not as clear

5. Directive Tone

Use the directive tone. For example

"Trust staff should dispose of sharps in the appropriate clinical waste containers"

reads that although staff should do this, it would be perfectly fine if they do not. Instead consider using

"Trust staff must dispose of sharps in the appropriate clinical waste containers."