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Policy For Policy Management

Version	V3
Supersedes:	V2 Urgent Care 24 Ratification, Governance and Implementation of Policies.
Date Ratified by Board:	24th November 2016
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Title & Department of originator:	Governance
Title of responsible committee/department:	Quality & Workforce Committee
Effective Date:	24th November 2016
Next Review date:	1 year review due to new version of policy. November 2019 (or when there is a change in policy).
Target audience:	All staff with responsibility for writing and revising policy / procedure.
Impact Assessment Date:	26.10.2016
Summary	This document sets out the policy by which all policy documents of Urgent Care 24 will be prepared, approved and implemented.

Version	Date	Control Reason	Title of Accountable Person for this Version
V1.4	Oct 2016	Archived.	Governance Manager
V2.0	Oct 2016	Significant restructuring of the original policy for policy management, to incorporate Equality Impact assessment, Privacy Impact Statement and guidance, Training needs analysis and implementation plan	Associate Director of Quality & Patient Safety
V3.0	Nov 2018	Update following review of policy process & for GDPR	Company Secretary

Reference Documents	Electronic Locations (Controlled Copy)	Location for Hard Copies
Equality Act 2010. Health & Social Care Act 2012. Data Protection Act 2018. UC24 Equality and Health Inequalities Analysis Guidance Notes. UC24 Equality and Health Inequalities Screening Tool. Privacy Impact Assessment Compliance Checklist	Urgent Care 24 Intranet/Policy Documents & Guidance/Governance & Risk/	Policy File, Wavertree Headquarters

Consultation: Committees / Groups / Individual	Date
Quality & Patient Safety Policy Group	19.10.16
Executive Team	November 2018

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1 PURPOSE

1.1 This is the policy for policy management throughout Urgent Care 24. Good policy management underpins all clinical and non–clinical processes within Urgent Care 24 to ensure they are consistent, effective and safe.

1.2 For the purpose of sound governance processes, it is important that such policies and standard operating procedures are appropriately authenticated and regularly updated. This is in order that they form a reliable and valid source of good practice.

1.3 This policy is designed to:

- Implement a coordinated and uniformed approach to policy development and management to ensure there is standardised corporate style and format.
- Ensure that UC24 through its policies adheres to legal requirements, considers equality and diversity principles and complies with the data protection principles in the Data Protection Act (DPA) 2018.
- Provide clarity and consent to the process of policy preparation, approval implementation and review
- Promote consultation to ensure that polices are well researched, evidenced based and reflect the view of the stakeholders
- Ensure all policies are accessible to all relevant staff and are up to date
- Ensure registers and archives of all policies are maintained.

2 SCOPE

2.1 This is a policy that applies to all employees, including clinical and medical staff within Urgent Care 24 who have a responsibility for writing or revising policy / procedures

2.2 This policy should be read in conjunction with the Procedure for the Development of Policies.

2.3 For the purpose of this policy, the word policy refers to policies and standard operating procedures.

3 RESPONSIBILITIES

3.1 All employees have a responsibility to adhere to the terms and conditions of this policy

3.2 Managers, Heads of Departments and Clinicians who are specified as the responsible people within the policy must ensure the correct procedure is carried out.

3.3 Any queries on the application or interpretation of this policy must be discussed with the Company Secretary prior to any action taking place.

3.4 This policy will be reviewed within one year, thereafter, on a three yearly basis and updated as appropriate.

3.5 Outlined below are the specific responsibilities in relation to policy production, development and implementation.

3.5.1 **The UC24 Board –** each must have an Owner. Following the UC24 Governance arrangements for policy approval as described in Appendix 8, the Board will be presented with policies for approval, including those reviewed by the author in line with good practice and the requirements of the Essential Standards of Quality and Safety (March 2010).

3.5.2 **Executive/Associate Directors/Service Delivery Unit Heads & the Medical Director** are responsible for identifying the need for a new policy and for identifying the Owner of the policy.

3.5.3 **The Policy Owner** is a named person for the processes of preparing, consulting on and reviewing policies. The Owner will:

- On behalf of the Leadership Team, oversee the process for approving and ratifying their policy
- Develop/update policy documents, taking account of other organisational policy documents, commissioning requirements, statutory requirements and relevant evidence-based practice and guidance.
- Consult as appropriate with service users / carers, staff and other stakeholders in the development / review of the document in line with the structure in **Appendix 8**.
- Attend the Policy Group to discuss their policy document
- Prepare the appropriate cover sheet and checklist prior to presentation of the policy to the Leadership Team, including a plan for implementation, training needs analysis and communication plan.
- Provide copies of the policy document to the Governance Team once it has been approved and issued.
- Oversee the monitoring of the implementation plan.
- Undertake the impact assessment for the policy, using the Equality and Health Inequalities Screening Tool. **Appendix 1**.
- Liaise with the Governance Team throughput the policy development stages to seek advice were necessary.

3.5.4 **The Governance Team** have the following responsibilities:

- Producing an indexed list of documents developed
- Maintaining, monitoring and overseeing the index of policies
- Notifying policy owners of policy review dates at least 2 months before expiry and forwarding the policy in editable form for review
- Ensure the archiving system is maintained and accessible when required
- Supporting the work of the Policy Group
- Providing “expert” advice when requested

3.5.5 **Line Managers, Heads of Departments and Lead GPs** will be instrumental in disseminating and implementing the policies. They must ensure that, as part of the induction process, all new employees and clinicians are shown how to access Urgent Care 24’s policy documents. They are responsible for ensuring staff have read and understood the policies relevant to their role and that staff training needs on implementation of new and updated policy documents are identified.

3.5.6 They will also monitor working practices via their day to day supervisory role and the staff appraisal system, to ensure these practices are consistent with Urgent Care 24's policies.

3.5.7 They are responsible for ensuring staff are released to attend training as required to enable policies to be successfully implemented.

3.5.8 **All employees and clinicians** have a responsibility to ensure that they are aware of the policies which are relevant to their area of work, and that they act in accordance with these at all times.

3.5.9 **Policy group -** has its membership drawn from across the organisation and is chaired by the Company Secretary. It oversees the policy document approval process and will

- Review, all new policies in line with the procedure set out in Appendix 8.
- Receive new policies from policy owners with the aim of provision of detailed scrutiny and overview, comments before the policy is sent to Leadership Team for consideration.
- Monitor the policy index to ensure that appropriate notice is given to Policy Owners of policy renewal dates

3.5.10 **Policy Author** – the member (s) of staff responsible for writing, the policy document in accordance with the *Policy on Policy Management* and its supporting documents. This may be the Policy Owner.

4 DEFINITIONS

4.1 An **Urgent Care 24 policy** reflects the "rules" governing the implementation of the organisation's processes. It governs or binds employees across the organisation. Examples may include the following; information security policy, incident reporting policy or complaints policy.

4.2 An **Urgent Care 24 standard operating procedure** is a rigid statement of practice allowing little or no flexibility or variation. It details guidance on how a particular

risk should be carried out, a step by step guide which someone not familiar with the work can follow. Examples include the following; administration, operational and clinical standard operating procedures.

5 WRITING A POLICY OR PROCEDURE

5.1 The overall aim is for the design of a policy or procedure to be simple, consistent and easy to use. The requirements of writing a good policy or procedure can be found in (**Appendix 2**).

5.2 A policy or procedure must contain all the essential components and, where appropriate, additional components included. The template defines the style to which the policy should comply and identifies those issues which should be addressed (**Appendix 3**).

5.3 The content of each policy should demonstrably comply with all relevant legal and statutory requirements. These include referencing in the policy, the relevant Essential Standards of Quality and Safety, other national guidance and policy in force at the time of writing or review. In doing so, the document owner must assure themselves and the organisation that they possess adequate and up-to-date knowledge on the subject matter or they have access to this knowledge.

5.4 All policies and standard operating procedures must follow the corporate design as detailed in **Appendix 4 & 5.**

6 THE CONSULTATION AND APPROVAL PROCESS

6.1 The Leadership Team will oversee the production and implementation of the policies of Urgent Care 24. Heads of Department and Service Delivery Units will be responsible for the production and implementation of standard operating procedures. In exceptional circumstances, for example, where the proposed policy aims to change drastically a component of service delivery and/or organisational practice, the Leadership Team will be informed and approval sought.

6.2.1 The UC24 Policy Group will have responsibility for seeking assurance that a policy has been developed, consulted on and has an achievable implementation plan in place to meet the needs of the organisation prior to approval of the policy.

6.3 Heads of Department and Lead GPs are responsible for the production, review and dissemination of all policies. Consultation will take place between the Heads of Departments or Lead GPs and relevant staff, with the final approved policy being sent to the officer assigned to co-ordinating these procedures.

6.4 The document owner will, with the support of the relevant Head of Service Delivery Unit/Department or Lead GP, assign tasks regarding the review or creation of policies to staff who have (or have access to) the necessary skills and knowledge to undertake the work.

6.5 Where policies are identified for review, the review work should be discussed with the document owner before the forecast review date. A member of the Governance Team will notify the policy owner of the expected review date within two months prior to review date.

6.6 ***The policy owner will then within a specified period,*** ensure the policy is revised as necessary in liaison with interested parties from inside and outside Urgent Care 24 as appropriate. The interested parties may include, for example, professionals contracted to work with the organisation. Where appropriate, formal "local" approval from the relevant committee(s) should be obtained

6.7 The updated policy will be presented to the Policy Group with the required checklist including the detailed implementation plan and ensuring that the document complies with the style and content requirements.

6.8 The Policy Group will determine whether the policy is ready to be presented to the Leadership Team with the appropriate coversheet and checklist having considered:

- a summary of the key points of the document

- the process used in developing the document to demonstrate that it was robust, identification of the people involved and consulted, experts used, literature reviewed
- implications for the organisation, such as the changes in ways of working, staff training and additional resources might be required
- implementation plan and people responsible for implementation

6.9 The Leadership Team will then consider the policy for initial approval and either agree that it is ready to be presented to the relevant committee or request further re-drafting from the Policy Owner.

6.10 When the policy is fit for purpose it will be submitted to the relevant committee of the Board for review and commendation to the full Board for approval.

7 RATIFICATION, PUBLICATION AND DISSEMINATION OF POLICY

7.1 All corporate policies will be approved by the Board. It is then the responsibility of the policy owner, to ensure that implementation plan is completed, including an appropriate training programme, that the policy is disseminated and that senior staff are aware of the implications of the policy and can advise staff accordingly.

7.2 The Company Secretary will be responsible for ensuring policies are considered by the appropriate committees of the Board.

7.3 Line Managers, Heads of Departments and senior staff play a key role in the effective dissemination and implementation of all policies. They must:

- Ensure that staff are made aware of any policies which are relevant to carrying out their duties in a safe and acceptable manner

- Direct new staff towards those documents that are relevant to their role at the local induction, ensure that they have read and understood the documents and to keep a signed record

- Ensure that, where required staff are in receipt of any training or update to assist in the introduction of amended or new policies and standard operating procedures.

8 REVIEWING POLICIES

8.1 New policies will be current and reviewed after one year, thereafter at the discretion of the policy owner they will be reviewed no later than three yearly or as required when a change policy is required in order to meet organisational need, address risk or comply with legislation.

8.2 Where documents are approaching their agreed review date, the assigned member of the Governance Team will notify the owner at least two months before the scheduled review date. The owner will determine if the degree of revision required to update the policy and procedure is minor or major.

8.3 These provisions do not preclude the early review of a policy in light of e.g. changing practice or national guidance etc. Where such a need is identified, the policy owner should be informed, and the process managed as outlined above.

8.4 Whenever a policy and procedure is reviewed, the document history detailed on the front page of the policy document (**Appendix 4 & 5**) must be updated accordingly.

8.5 Whenever a policy is to be developed or reviewed, the policy owner will need to complete an Equalities and Health Inequalities Screening which will help assess whether a full Equalities and Health Inequalities Analysis will need completing. A policy cannot be accepted by the Policy Group without the completion of an Equalities and Health Inequalities Screening.

8.6 Whenever a policy is to be developed or reviewed, the policy writer will need to assess if any personal information is identified within the document. If so, a Privacy Impact Assessment will need to be completed. The policy document will need to state that a Privacy Impact Assessment has been considered and whether

it is needed or not. If the policy document needs a Privacy Impact Assessment, this will need to be submitted to the Policy Group with the policy.

9 IMPLEMENTATION

9.1 This Policy will be implemented via the policy owner with the support of the Service Managers and any relevant Committees.

9.2 The policy owner will outline the plan for implementation in conjunction with the production of the policy (**Appendix 6**). Training needs should be assessed and identified. Where additional resources may be required, this information should be attached with a full breakdown of financial resources required.

9.3 **Dissemination.** Once this policy has been approved, it will be uploaded to the staff intranet, this will be supported by a message through UC24's newsletter, NEWS24 by the Governance Team.

9.4 **Monitoring Compliance.** Monitoring compliance should be included in the policy. Targets for this policy are:

Element	Lead	Tool	Frequency	Reporting arrangements
100% of policies in date	Company Secretary (supported by Governance Team)	Audit of the policies on the intranet register	Quarterly	Through the Audit Committee

9.5 **Review of arrangements.** All policies must be reviewed by their authors at least every three years, or as and when a change is required or new evidence becomes available. All new polices, must be reviewed within 12 months of issue to ensure the effectiveness of implementation.

9.6 **Control and archiving arrangements.** All staff employed in UC24 must ensure that they are working with the most up to date version of the policy, obtained from

the intranet. The Governance Team are responsible for ensuring the most up to date version is in place.

10 LOCATION OF POLICIES

10.1 All policies can be found on Urgent Care 24's Intranet. It is the responsibility of the Policy Owner to ensure that the revised policy has been forwarded to the Governance Team with the instruction to upload the policy to the intranet.

11 EQUALITY & DIVERSITY

UC24 is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and will mainstream equality and diversity principles through its policies, procedures and processes. This policy has been implemented with due regard to this commitment. To ensure that the implementation of this policy does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full equality impact analysis conducted where necessary. UC24 will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

12 PERSONAL INFORMATION

UC24 is committed to the protection of personal information in the development of its policies. All policies must comply with the data protection principles in the Data Protection Act 2018. All individuals with responsibility for reviewing/writing policies should consider Privacy Impact Assessment compliance. Appendix 7.

This policy complies with the Data Protection Act 2018, therefore no Privacy Impact Assessment is necessary.

13 TRAINING NEEDS ANALYSIS

Training Programme	Course Length	Frequency	Delivery Method	Staff Group	Recording Attendance	Strategic & Operational Responsibility
Level 1 Equality & diversity Mandatory Training		On appointment then 3 yearly	E-Learning	All staff	Attendance is recorded on the Training database	
Awareness Raising of the Equalities and Health Inequalities Guidance notes		On appointment	Face to face / self-study	100% of staff who have a responsibility to review or write policies.	n/a	
Awareness Raising of the Privacy Impact Assessment Guidance notes		On appointment	Face to face / self-study	100% of staff who have a responsibility to review or write policies.	n/a	

Appendix 1 Equality and Health Inequalities Screening Tool

Equalities and Health Inequalities – Screening Tool

Version number: V1

First published: November 2016

To be read in conjunction with Equalities and Health Inequalities Analysis Guidance, Quality & Patient Safety Team, Urgent Care 24, 2016.

Prepared by: Quality & Patient Safety Team.

1 Introduction

The purpose of this Screening Tool is to help you decide whether or not you need to undertake an Equality and Health Inequalities Analysis (EHIA) for your project, policy or piece of work. It is your responsibility to take this decision once you have worked through the Screening Tool. Once completed, the Head of your SDU or the Quality & Patient Safety Team will need to sign off the Screening Tool and approve your decision i.e. to either undertake an EHIA or not to undertake an EHIA.

The Quality and Patient Safety Team can offer support where needed. It is advisable to contact us as early as possible so that we are aware of your project.

When completing the Screening Tool, consider the nine protected characteristics and how your work would benefit one or more of these groups. The nine protected characteristics are as follows:

1. Age
2. Disability
3. Gender reassignment
4. Marriage and civil partnership
5. Pregnancy and maternity
6. Race
7. Religion and belief
8. Sex
9. Sexual orientation

A number of groups of people who are not usually provided for by healthcare services and includes people who are homeless, rough sleepers, vulnerable migrants, sex workers, Gypsies and Travellers, Female Genital Mutilation (FGM), human trafficking and people in recovery. Urgent Care 24 will also consider these groups when completing the Screening Tool:

The **guidance** which accompanies this tool will support you to ensure you are completing this document properly. It can be found at: http://extranet.urgentcare24.co.uk/

2 Equality and Health Inequalities: Screening Tool

A	General information		
A1	Title: What is the title of the activity, project or programme?		
A2.	What are the intended outcomes of this work? Please outline why this work is being undertaken and the objectives.		
A3.	Who will be affected by this project, programme or work? Please identify whether the project will affect staff, patients, service users, partner organisations or others.		
B	**The Public Sector Equality Duty**		
B1	Could the initiative help to reduce unlawful discrimination or prevent any other conduct prohibited by the Equality Act 2010? If yes, for which of the nine protected characteristics (see above)?		
	Yes	No	Do not know
	Summary response and your reasons:		
B2	Could the initiative undermine steps to reduce unlawful discrimination or prevent any other conduct prohibited by the Equality Act 2010? If yes, for which of the nine protected characteristics? If yes, for which of the nine protected characteristics?		

	Yes	No	Do not know
	Summary response and your reasons:		
B3	Could the initiative help to advance equality of opportunity? If yes, for which of the nine protected characteristics?		
	Yes	No	Do not know
	Summary response and your reasons:		
B4	Could the initiative undermine the advancement of equality of opportunity? If yes, for which of the nine protected characteristics?		
	Yes	No	Do not know
	Summary response and your reasons:		
B5	Could the initiative help to foster good relations between groups who share protected characteristics? If yes, for which of the nine protected characteristics?		
	Yes	No	Do not know
	Summary reasons:		
B6	Could the initiative undermine the fostering of good relations between groups who share protected characteristics? If yes, for which of the nine protected characteristics?		
	Yes	No	Do not know
	Summary response and your reasons:		
C	**The duty to have regard to reduce health inequalities**		
C1	Will the initiative contribute to the duties to reduce health inequalities?		
	Could the initiative reduce inequalities in access to health care for any groups which face health inequalities? If yes for which groups?		
	Yes	No	Do not know
	Summary response and your reasons:		
C2	Could the initiative reduce inequalities in health outcomes for any groups which face health inequalities? If yes, for which groups?		
	Yes	No	Do not know
	Summary response and your reasons:		
D	Will a full Equality and Health Inequalities Analysis (EHIA) be completed?		
D1	Will a full EHIA be completed? Bearing in mind your previous responses, have you decided that an EHIA should be completed? Please see notes. [1] Please place an X below in the correct box below. Please then complete part E of this form.		
	Yes	Cannot decide	No

[1] Yes: If the answers to the previous questions show the PSED or the duties to reduce health inequalities are engaged/in play a full EHIA will normally be produced. No: If the PSED and/or the duties to reduce health inequalities are not engaged/in play then you normally will not need to produce a full EHIA.

E	Action required and next steps
E1	If a full EHIA is planned: Please state when the EHIA will be completed and by whom. Name: Date:
E2	If no decision is possible at this stage: If it is not possible to state whether an EHIA will be completed, please summarise your reasons below and clearly state what additional information or work is required, when that work will be undertaken and when a decision about whether an EHIA will be completed will be made. Summary reasons: Additional information required: When will it be possible to make a decision about an EHIA?
E3	If no EHIA is recommended: If your recommendation or decision is that an EHIA is not required then please summarise the rationale for this decision below. Summary reasons:

F	*Record Keeping*		
Lead originator:		Date:	
Director signing off screening:		Date:	
Directorate:		Date:	
Screening published:		Date:	

Appendix 2

Characteristics of good policies or procedures

The overall aim for any document is for the design to be simple, consistent and easy to use.

Policies should:

- Be written in clear, concise and simple language
- Address what is the rule rather than how to implement the rule
- Be readily available to the community and their authority should be clear
- Indicate designated "experts" who can interpret policies and resolve problems
- Represent a consistent, logical framework for action

Standard Operating Procedures should:

- Be clear how the procedure helps Urgent Care 24 achieve its aims and objectives
- Be developed with the procedure users (the organisations' employees) in mind. Well developed and thought out standard operating procedures provide benefits to the procedure user
- Involve procedure users in their development to engender a sense of ownership
- Be understandable and written is such a way that what needs to be done can be easily followed by procedure users

Writing Style

- Concise with a minimum of verbiage
- Factual - accuracy should be double checked
- Should not provide information that may be quickly outdated (e.g. names)
- If an acronym is used, it should be spelled out the first time
- Not excessively technical, must be simple enough to be understood by a new member of staff

Design and Layout of Policy/Procedure/Guideline Documents

- Use Arial 12 point text
- The format is justified with spacing of 1.5
- Number the paragraph and pages
- Generous use of white space

- Presentation is structured so that the reader can quickly focus on the aspect of policy/procedure relevant to the decision in hand
- Use headings to indicate key points. Headings need to be consistent, e.g. location on each page, type size, bold etc.
- Contain a "cover sheet" indicating name and reference number of policy/procedure, date of ratification, owner details, date of review/update, and next forecast review date reference to associated relevant Essential Standards and other legislation and guidance in the policy.

Appendix 3

Components of a Policy

The document ***must*** contain the following components:

Cover Sheet

This must include name and reference number of policy, date of ratification, owner details, date of review/update. Any changes should be documented on the cover page, outlining the main change/s.

1.0 PURPOSE

A concise statement of the rationale for the document, including where necessary reference to external regulations or other relevant guidance
This policy is ………………
(Font: Arial, Size 12, number each section and subsection)

2.0 SCOPE OF THE POLICY

Exactly who the document applies to and the consequences for non-compliance if necessary this section makes explicit if this is a corporate or specific document

3.0 RESPONSIBILITIES

This should describe the responsibilities and duties of both management and employees. It should include any particular responsibilities or functions that a particular post or department may have, relevant to the document or its implementation

4.0 DEFINITIONS

Definition of terms where required

5.0 POLICY PROCEDURES

Reference to detailed procedures that are recommended in order to carry out the intent of the document This will be the main part of the

document, generally divided into sections and describe in detail what has to be done in order to comply with the document's intent, aims and objectives

6.0 GETTING HELP

The specific office or person to contact for interpretations, resolution of problems and other special situations.

7.0 RELATED POLICIES

Information about related policies, procedures or guidelines this should include a complete reference and ensure that any documents cited are readily available

8.0 MONITORING COMPLIANCE

Please refer to section 9.4 in this document.

9.0 INFORMATION, INSTRUCTION AND TRAINING

This section should detail what information, instruction, training and supervision is necessary for both employees and managers in order to meet the policy requirements. It should detail when, how often and by whom the above items should be given. The requirement for training records should be indicated

10.0 EQUALITY AND HEALTH INEQUALITIES

UC24 is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and will mainstream equality and diversity principles through its policies, procedures and processes. This policy has been implemented with due regard to this commitment. To ensure that the implementation of

this policy does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full equality impact analysis conducted where necessary. UC24 will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

11.0 MAIN REFERENCES

Below is a list of the relevant statutory provisions which influence Urgent Care 24's operation in relation to the policy/procedure:

- Equality Act 2010.
- Health & Social Care Act 2012.
- Data Protection Act 1998.

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Appendix 4 Corporate Design Template for Policies (front sheet)

Name of Policy

Version	
Supersedes:	
Date Ratified by Board:	
Reference Number:	
Title & Department of originator:	

Title of responsible committee/department:	
Effective Date:	
Next Review date:	
Target audience:	
Impact Assessment Date:	
Summary	

Version	**Date**	**Control Reason**	**Title of Accountable Person for this Version**
Reference Documents		Electronic Locations (Controlled Copy)	Location for Hard Copies
Consultation: Committees / Groups / Individual			Date

Appendix 5 Corporate Design Template for Standard Operating Procedure

Title			**Doc. No.**	
Scope				
Purpose				

NHS
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Guidelines		
PROCEDURE		**RESPONSIBILITY**
1		
2		
3		
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11		
12		
13		

STANDARD OPERATING PROCEDURE DOCUMENT (SOP)

Title		**Doc. No.**	

Version	
Supersedes	
Approving Managers/Committee	
Date Ratified	
Department of Originator	
Responsible Executive Director	
Responsible Manager/Support	
Date Issued	

Next Review Date	
Target Audience	

Version	Date	Control Reason	Accountable Person for this Version

Reference documents	Electronic Locations	Locations for Hard Copies
	Urgent Care 24 Intranet / Corporate Policies/ Current SOPS/ ……	Standard Operating Procedures File in the Call Centre.

Document Status: This is a controlled document.
Whilst this document may be printed, the electronic version maintained on the UC24 Intranet is the controlled copy. Any printed copies of the document are not controlled.

Appendix 6 Policy Implementation Plan

Question	Response	Additional resources If so identify	Timescale
Who does the policy affect	All staff who have a responsibility to write policy, including clinical and medical staffing.	Nil	4 weeks
What additional Standard Operating Procedures or forms	As outlines in the appendices	Nil	As above

need to be included in the policy			
What is the proposed date of implementation	December 2018	Nil	As above
Is training required	Refer to TNA embedded in document.	Nil	
If so what training is required (attach separate training outline)	Refer to TNA embedded in document.	Nil	
Who will facilitate the training	Quality & Patient Safety Team and Human Resources	Nil	
What audit processes have been identified	Refer to Monitoring and Compliance within the document.	Nil	

Appendix 7 Privacy Impact Assessment Template

Data Protection Act 2018

PRIVACY IMPACT ASSESSMENT (PIA)

Compliance Checklist

Privacy

Privacy has become a much larger consideration for business and government in recent years. New information technologies have increased public concerns about intrusion into their privacy.

Beyond the recognition of privacy as a human right, specific laws have been introduced to deal with particular areas of concern. Much of the legislative attention to date has been focused on information about people that is collected, stored, used and disclosed by organisations. The handling of personal data is regulated by the Data Protection Act 2018, which the Information Commissioner's Office oversees.

Privacy impact assessment

Privacy Impact Assessment (PIA) is a process which enables organisations to anticipate and address the likely impacts of new initiatives, foresee problems, and negotiate solutions. Risks can be managed through the gathering and sharing of information with stakeholders. Systems can be designed to avoid unnecessary privacy intrusion, and features can be built in from the outset that reduces privacy intrusion.

This Privacy Impact Assessment (PIA) aims to assist Urgent Care 24 when proposing change to investigate whether the personal information aspects of their project comply with the data protection principles in the Data Protection Act (DPA).

The checklist has been designed for use by any employee proposing change. The Quality & Patient Safety Team should be consulted about the completion of this checklist.

It should be noted that many terms used in the **principles** have meanings specific to the **Data Protection Act**, and it would be prudent to refer to the Act for definition for those terms. Another useful reference is the specific guidance on the Information Commissioner's website **https://ico.org.uk/**

A) BASIC INFORMATION - New or existing Project, System, Technology or Legislation

1 Lead Directorate and project name	
Directorate	
Department	
Project	

2 Contact position and/or name, telephone number and e-mail address. (This should be the name of the individual most qualified to respond to the PIA questions)	
Name	
Title	
Phone Number	
E-Mail	

3 Description of the programme / system / technology / legislation (initiative) being assessed.
If this is a change to an existing project, system, technology or legislation, describe the current system or programme and the proposed changes. *(N.B. if the initiative does **not** collect, use or disclose personal data* - see definition and statement below).*

4 Purpose / objectives of the initiative (if statutory, provide citation/reference).	
Purpose	

5 What are the potential privacy impacts of this proposal?

IF THERE IS NO PERSONAL DATA INVOLVED,
GO TO SECTION C DPA COMPLIANCE - CONCLUSIONS (on the last page)

***IMPORTANT NOTE:**
'Personal data' means data which relate to a living individual who can be identified:

(a) from those data, or
(b) from those data and other information which is in the possession of, or is likely to come into the possession of, the data controller, and includes any expression of opinion about the individual and any indication of the intentions of the data controller or any other person in respect of the individual.

(Data Protection Act 2018)

B) DATA PROTECTION PRINCIPLES (DPPs) (General Data Protection Regulations (GDPR))

PRINCIPLE 1 LAWFUL AND FAIR PROCESSING	
Personal data shall be processed fairly and lawfully and, in particular, shall not be processed unless – (a) at least one of the conditions in Chapter 2 GDPR is met, and (b) in the case of sensitive personal data, at least one of the additional conditions is also met	
1.1 Preliminary	
What type of personal data are you processing?	Personal Confidential Data of the deceased and of the living
1.2 Conditions relevant for purposes of the first principle: processing of any personal data	
Describe the purposes for which you will be processing personal data.	
List which of the grounds you will be relying on as providing a legitimate basis for processing personal data.	
1.3 Conditions relevant for purposes of the first principle: processing of any *sensitive* personal data	
If this project does not involve the processing of sensitive personal data, please go to section 1.4	
Identify the categories of *sensitive personal data* that you will be processing.	
Identified *the purposes* for which you will be processing *sensitive personal data*.	
Identify which of the grounds you will be relying on as providing a legitimate basis for processing *sensitive personal data*?	
1.4 Obtaining consent	
Are you relying on the individual to provide consent to the processing as grounds for lawful and fair processing?	Delete as appropriate Yes No
If yes, when and how will that consent be obtained?	.
For the processing of *sensitive personal data*, are you relying on *explicit* consent?	Delete as appropriate Yes No

If yes, when and how will that consent be obtained?	
1.5 Lawful processing	
How is compliance with the Human Rights Act being assessed?	Via this PIA Review and the Data Sharing Agreement - Information is limited to a need to know and informed consent is provided to ensure no breach of Human Rights occurs.
Are you assessing whether your processing is subject to any other legal or regulatory duties?	Delete as appropriate Yes No
If yes, how is that assessment being made? If no, please indicate why not.	
1.6 Fair processing	
How are individuals being made aware of how their personal data is being used?	
How individuals are offered the opportunity to restrict processing for other purposes?	
When is that opportunity offered?	
1.7 Exemptions from the first principle	
The Act requires that in order for personal data to be processed fairly, a data controller must provide the data subject with the following information:- 1. the identity of the data controller 2. the identify of any nominated data protection representative, where one has been appointed 3. the purpose(s) for which the data are intended to be processed 4. any further information which is necessary, having regard to the specific circumstances in which the data are or are to be processed, to enable processing in respect of the data subject to be fair *Data Protection Act:* ***https://ico.org.uk/for-organisations/guide-to-data-protection/exemptions***	
Do you provide individuals with all of the information in the box above?	Delete as appropriate Yes No
If no, which exemption to these provisions is being relied upon?	

<table>
<tr><td colspan="3">PRINCIPLE TWO:
THE PURPOSE OR PURPOSES FOR PROCESSING PERSONAL DATA</td></tr>
<tr><td colspan="3">Personal data shall be obtained only for one or more specified and lawful purposes, and shall not be further processed in any manner incompatible with that purpose or those purposes.</td></tr>
<tr><td colspan="3">2.1 Use of personal data within the organisation</td></tr>
<tr><td>What procedures are in place for maintaining a comprehensive and up-to-date record of use of personal data?</td><td colspan="2"></td></tr>
<tr><td>Is any data processing carried out on your behalf (e.g. by a subcontractor)?</td><td colspan="2">Delete as appropriate
Yes
No</td></tr>
<tr><td>If yes, please identify</td><td colspan="2"></td></tr>
<tr><td colspan="3">2.2 Use of existing personal data for new purposes</td></tr>
<tr><td>Does the project involve the use of existing personal data for new purposes?</td><td colspan="2">Delete as appropriate
Yes
No</td></tr>
<tr><td>If no, go to section 2.3</td><td colspan="2"></td></tr>
<tr><td rowspan="2">If yes, How is the use of existing personal data for new purposes being communicated to:-
a) the data subject:
b) the Data Protection Officer (responsible for Notification)</td><td>a)</td><td></td></tr>
<tr><td>b)</td><td></td></tr>
<tr><td colspan="3">2.3 Disclosure of data</td></tr>
<tr><td>How individuals / data subjects are made aware of disclosures of their personal data?</td><td colspan="2"></td></tr>
<tr><td colspan="3">PRINCIPLE 3:
DATA MINIMISATION</td></tr>
<tr><td colspan="3">Personal data shall be adequate, relevant and not excessive in relation to the purpose or purposes for which they are processed.</td></tr>
<tr><td colspan="3">3.1 Adequacy and relevance of personal data</td></tr>
<tr><td>How is the adequacy of personal data for each purpose determined?</td><td colspan="2"></td></tr>
<tr><td>How is an assessment made as to the relevance (i.e. no more than the minimum required) of personal data for the purpose for which it is collected?</td><td colspan="2"></td></tr>
<tr><td>What procedures are in place for periodically checking that data collection procedures are adequate, relevant and not excessive in relation to the purpose for which data are being processed?</td><td colspan="2"></td></tr>
</table>

PRINCIPLE 4: ACCURATE AND UP TO DATE		
Personal data shall be adequate, relevant and not excessive in relation to the purpose or purposes for which they are processed. Every reasonable step must be taken to rectify or erase inaccurate or incomplete data.		
4.1 Accuracy of personal data		
How often is personal data being checked for accuracy?		
How is the accuracy of the personal data being checked with the Data Subject?		
4.2 Keeping personal data up to date		
How is personal data evaluated to establish the degree of damage to: (a) the data subject or (b) the data controller That could be caused through being out of date?	a)	
	b)	
PRINCIPLE 5 NO LONGER THAN NECESSARY		
Personal data processed for any purpose or purposes shall not be kept for longer than is necessary for that purpose or those purposes.		
5.1 Retention policy		
Is the project subject to any statutory / sectorial requirements on retention?	Delete as appropriate Yes No	
If yes please state relevant requirements		
5.2 Review and deletion of personal data		
When data is no longer necessary for the purposes for which it was collected: a) How is a review made to determine whether the data should be deleted? b) How often is the review conducted? c) Who is responsible for determining the review? d) If the data is held on a computer, does the application include a facility to flag records for review / deletion?	a)	
	b)	
	c)	
	d)	
If yes, please explain		

Are there any exceptional circumstances for retaining certain data for longer than the normal period?	Delete as appropriate Yes No
If yes, please provide justification	

PRINCIPLE 6 INTEGRITY & CONFIDENTIALITY (SECURITY OF PERSONAL DATA)	
Personal data must be processed in a manner that ensures appropriate security of the personal data, including protection against unauthorised or unlawful processing and against accidental loss, destruction or damage, using appropriate technical or organisational measures**.**	
6.1 Security Policy	
Is the level of security appropriate for the type of personal data processed?	Delete as appropriate Yes No
If yes please explain	
6.2 Unauthorised or unlawful processing of data	
Describe security measures that are in place to prevent any unauthorised or unlawful processing of: a) Data held in an automated format e.g. password controlled access to PCs b) Data held in a manual record e.g. locked filing cabinets	a) b)
Is there a higher degree of security to protect *sensitive personal data* from unauthorised or unlawful processing?	Delete as Appropriate Yes No
If yes, please describe the planned procedures. If no, please indicate why not.	
Describe the procedures in place to detect breaches of security (remote, physical or logical)? **logical (such as hacking etc.)*	
6.4 Destruction of personal data	
Describe the procedures in place to ensure the destruction of personal data no longer necessary?	
6.5 Contingency planning	
Is there a contingency plan to manage the effect(s) of an unforeseen event?	Delete as Appropriate Yes No

If yes, please give details		
Describe the risk management procedures to recover data (both automated and manual) which may be damaged/lost through: a) human error b) computer virus c) network failure d) theft e) fire f) flood g) other disaster.	a)	.
	b)	
	c)	
	d)	
	e)	
	f)	
	g)	
6.6 Choosing a data processor		
How do you ensure that the Data Processor complies with these measures?		

SUBJECTS RIGHTS/SUBJECT ACCESS	
Personal data shall be processed in accordance with the rights of data subjects under this Act.	
7.1 Subject access	
How do you locate all personal data relevant to a request (including any appropriate 'accessible' records)?	
7.2 Withholding of personal data in response to a subject access request	
Are there any circumstances where you would withhold personal data from a subject access request?	Delete as appropriate Yes No
If yes, on what ground. If no, go to 7.3	
How are the grounds for doing so identified?	
If yes, please provide justification	
7.3 Processing that may cause damage or distress	
Do you assess how to avoid causing unwarranted or substantial damage or unwarranted and substantial distress to an individual?	Delete as appropriate Yes No
If yes, please specify proposed procedures. If no, please indicate why not.	
Do you take into account the possibility that such damage or distress to the individual could leave your organisation vulnerable to a compensation claim in a civil court?	Delete as appropriate Yes No If yes, please explain

7.4 Right to object	
Is there a procedure for complying with an individual's request to prevent processing for the purposes of direct marketing?	Delete as appropriate Yes No N/A Other
If yes, please explain	
7.7 Automated decision	
Are any decisions affecting individuals made solely on processing by automatic means?	Delete as appropriate Yes No
If yes, what will be the procedure(s) for notifying an individual that an automated decision making process has been used?	
7.6 Rectification, blocking, erasure and destruction	
What is the procedure for responding to data subject's notice (in respect of accessible records) or a court order requiring: a) rectification; b) blocking; c) erasure or; d) destruction of personal data?	a) a) b) . c)
OVERSEAS TRANSFER (OUTSIDE OF THE EEA)	
Personal data shall not be transferred to a country or territory outside the European Economic Area unless that country or territory ensures an adequate level of protection for the rights and freedoms of data subjects in relation to the processing of personal data.	
8.1 Adequate levels of protection	
Are you transferring personal data to a country or territory outside of the EEA[2]? [1] The European Economic Area (EEA) comprises the 27 EU member states plus Iceland, Liechtenstein and Norway.	Delete as appropriate Yes No
If no, go to Part III If yes, where?	

What types of data are transferred? (e.g. contact details, employee records)	
Is *sensitive personal data* transferred abroad?	Delete as appropriate Yes No
If yes, please give details	
Are measures in place to ensure an adequate level of security when the data are transferred to another country or territory?	Delete as appropriate Yes No
If yes, please describe. If no, please indicate why not.	
Have you checked whether any non-EEA states to which data is to be transferred have been deemed as having adequate protection?	Delete as appropriate Yes No
If yes, please give details	

C) DPP COMPLIANCE - CONCLUSIONS

Please provide a summary of the conclusions that have been reached in relation to this project's overall compliance with the DPPs. This could include indicating whether some changes or refinements to the project might be warranted.

IG Manager Name:

IG Manager Signature: **Date:**

Project Manager:

Project Manager Signature: **Date:**

NHS Urgent Care 24
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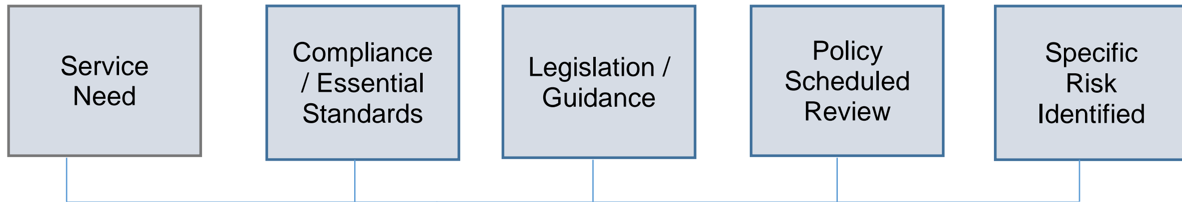
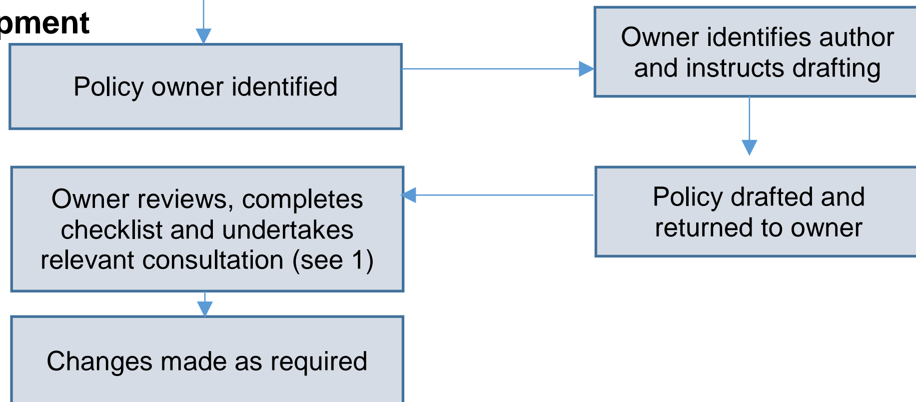
Appendix 8 Summary of Process - Policies

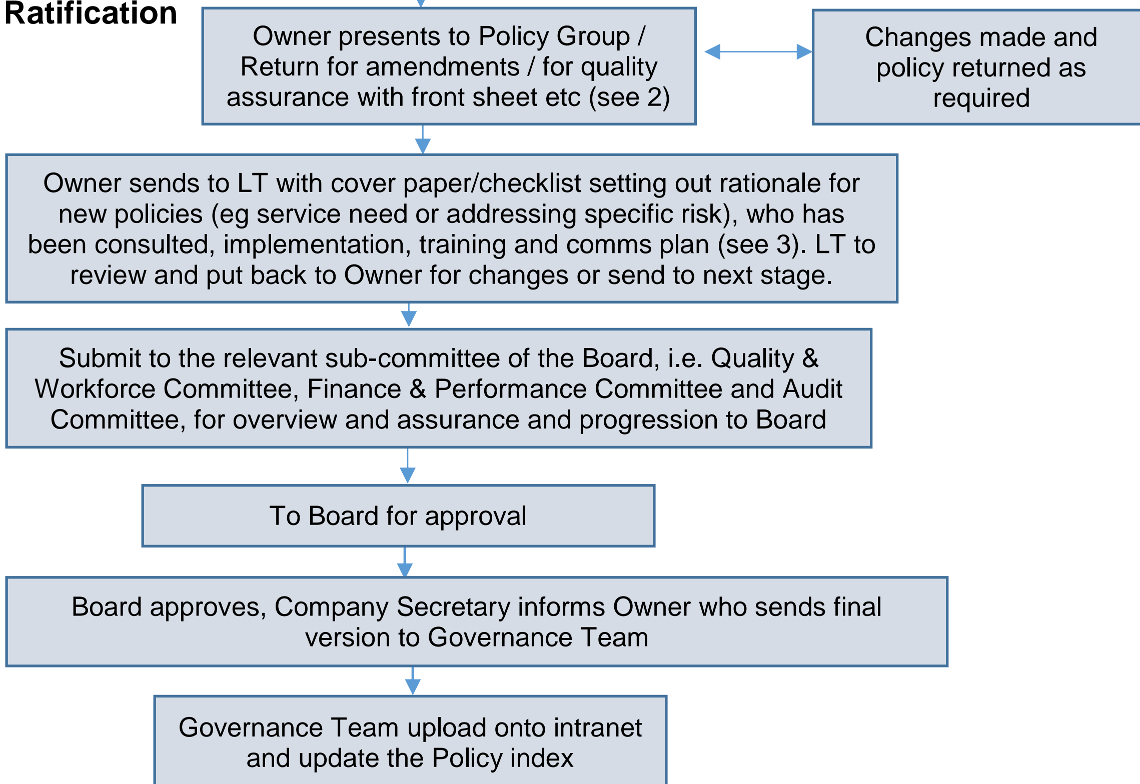
1 Decision for Policy



2 Policy Development

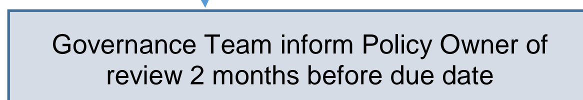


3 Ratification



4 Implementation

5 Review



Notes on Process Summary stages

A member of the Governance Team will have responsibility for maintaining the register of policies and ensuring Policy Owners are alerted in good time when policies are due for renewal.

1. Consultation by the policy owner should include individuals/groups relevant to the subject matter of the policy. Consultation may recommend amendments to the policy but does not mandate them unless they are required to secure compliance with legislation or regulation.

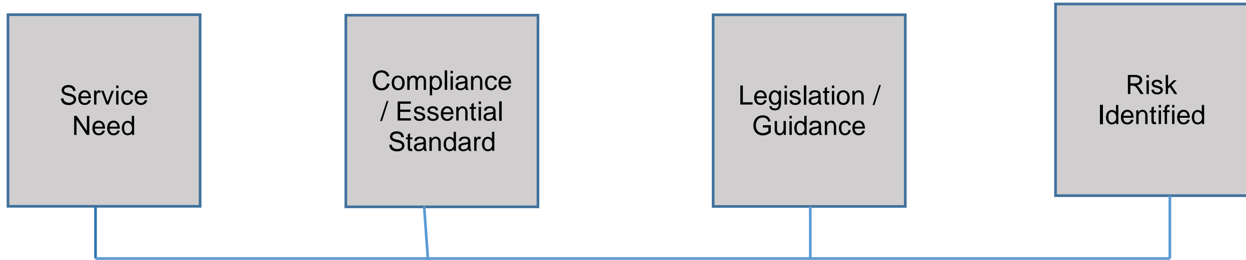
   The following may be relevant when planning consultation:

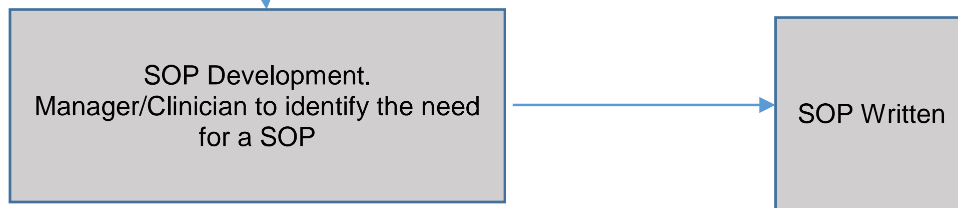
   a. Executive Directors
   b. Those with specific expertise eg IT, HR, Finance, Governance
   c. Groups who are required to implement the policy or deliver training
   d. Staff Council
   e. Clinical or pharmacy leads
   f. Heads of service
   g. Patient groups eg PPGs, Healthwatch

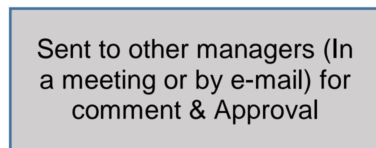
2. The Policy Group would be expected to draw in relevant individuals when reviewing policies eg Health & Safety or Medical Director
3. Cover paper for Leadership team should:
   a. Include a list of those individuals or bodies consulted during the policy preparation/review process
   b. Set out the implementation plan and training needs analysis, highlighting any particular issues in relation to the implementation of the policy
   c. Alert LT to any significant risks or changes in service which triggered the need for a new policy
   d. Outline training and communication plans showing who will be responsible and the timeline
4. Implementation, including the training and communication plan, should be monitored through an action log reported, along with other live policy implementation plans, monthly to Leadership team

Appendix 9 Summary of Process - Standard Operating Procedures

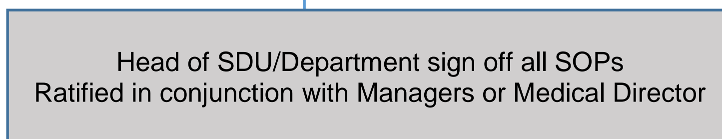
1 Decision for Standard Operating Procedure

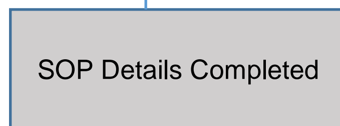


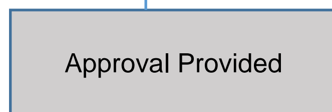




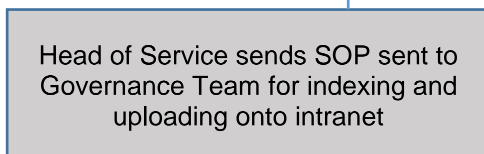
2 SOP Development



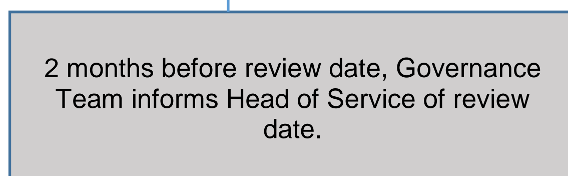




3 Ratification



4 Review



Appendix 10

Checklist for Policies

Policy Title **Policy Owner**

	Notes	Done and by whom
Reason for new policy, please specify any specific risks being addressed or state review/renewal		
Policy Owner consultation undertaken		
Implementation and training plan		
Identify any particular implementation challenges		

Communication plan		
Date considered by Policy Group and any additional consultation undertaken		
Completion of document history		

	Date	**By**
Submitted to Leadership Team		
Submitted to Board Committee		
Submitted to Board		
Forwarded to Governance Team		
Uploaded to Intranet		
Communication to Staff		
Training/implementation plan completed		

END OF POLICY