Document Control

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Guidance for Writing Policies, Procedures and Guideline			
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CONTENTS

1 Purpose

1.1. This document sets out Northern Devon Healthcare NHS Trust's system for the development, implementation and management of procedural documents such as. policies, standard operating procedures and guidelines. The policy applies to

1.2. The Trust supports staff by providing information and guidance in the form of procedural documents to ensure that procedures and processes are carried out in the correct way. The procedural documents must be accurate, up to date, readable, fit for purpose and available to relevant staff at all times. Procedural documents may define best practice, latest standards or regulations, or new legislation, and are routinely used as evidence for external regulation e.g. Care Quality Commission, NHS Resolution, or in courts of law.

1.3. The purpose of this policy is to ensure that the Trust meets nationally recognised best practice for the development, implementation and management of its procedural documents by providing clear guidance for authors and easy to use templates.

2 Definitions

2.1. Consultation

A process by which stakeholders are requested to provide comment on a draft document. It is advisable for an author to consult relevant stakeholders before a document is submitted for approval and clarify their input in the version control.

2.2. Equality Impact Assessment

An Equality Impact Assessment is a special type of risk assessment designed to assess whether different groups of people are, or could be disadvantaged o Equality Impact Assessment

2.3. Publication

When the term publication is referred to, this means the document is posted onto the Trust's intranet/web pages to ensure availability for all staff..

2.4. Review

Most procedural documents will require a review after three years to ensure it is still relevant, still reflects local practice and complies with any new recommendations or legislation. The author will receive a reminder to review their document approximately three months prior to the review date.

2.5. Version Control

The process used for tracking the development of a document is called version control. The version number of the document and the date form part of the electronic filename of a document.

3 Procedural Documents

3.1. Policy

A policy details the processes and procedures a service follows in its implementation. A member of staff should be able to read the policy to understand how a service is delivered

A policy should contain the responsibilities of staff and who to contact.

An author will base the processes on the Trusts requirement in line with evidence based, best practice.

3.2. Procedure

A procedure details the process that is to be followed. Flow charts are often used to illustrate procedures, supported by narrative.

3.3. Standard Operating Procedure

A standard operating procedure relates to the steps to follow for a define process or procedure. It will provide the detail of a procedure and will often contain dosages or settings for equipment. It will provide guidance on options available and escalation procedures. This can often be better illustrated as a flowchart rather than a written document.

3.4. Protocol

A protocol defines a specific procedure to be followed, usually in medical treatment or procedures.

3.5. Patient Group Directives

Patient Group Directions provide a legal framework allowing specific health care professionals to supply and administer medicines to relevant groups of patients that fit the criteria laid out in the Patient Group Directions.

3.6. Guidelines

A guideline is guidance to support staff to undertake a process.

3.7. Strategy

Strategy usually defines an organisation's scope and direction over the long term, and refers to a plan of action designed to achieve a particular goal.

4 Responsibilities

4.1. The Role of the Trust Board

The Board is responsible for:

Seeking assurance that the systems for the development and management of procedural documents are robust and effective.

4.2. Role of the Director of Nursing, Quality and Workforce

The Director of Nursing, Quality and Workforce is responsible for:

Ensuring the Trust has a system for the management and timely publication of an appropriate Policy Management System

Ensuring a timely review process is implemented to ensure procedural documentation is updated as per the guidance.

Escalating any shortfalls in policy requirement to the Executive Directors Group

4.3. Role of the Health and Safety Manager/LSMS

Ensuring the process for the development and management of Trust Procedural documents is maintained and robust

Providing escalation reports on the status of policies when required

4.4. Role of the Governance Administrator (Compliance)

The Governance Administrator (Compliance) is responsible for:

- Ensuring the process for the development and management of Trust procedural documents is robust.
- Providing reports on the status of policies as required
- Maintaining and improving the Trust's process for procedural document development and management.
- Ensuring that a robust archiving system for procedural documents is in place.
- Ensuring the publishing approved procedural documents on the Trust's Intranet/Web site.
- Communicating to staff when new or revised procedural documents have been published.
- Providing guidance to authors regarding the development of procedural documents
- Maintaining a registry of procedural documentation
- Alerting authors of procedural documents that their review dates are approaching.

4.5. Role of the Author

The author is responsible for:

- Identifying when a document is required and ensuring if follows the agreed practice and procedure
- Ensuring the content and details of the procedural document are accurate, meet best practice and national guidance, and conform to relevant legislation.

- Ensuring that the appropriate template is used and completed.
- Consult with stakeholders in the development of the document.
- Follow the agreed approval process and gain approval from the necessary specialists
- Maintaining and updating the document control report.
- Ensuring the document is archived in the relevant department or team procedural document archive.
- Reviewing the document at the agreed interval.
- Arranging for the withdrawal of the document if required.

4.6. Role of line managers

Line managers are responsible for:

- Ensuring their staff are aware of relevant procedural documents relating to their roles and responsibilities.
- Implementing the procedural documents for the areas in which they apply.

4.7. Role of staff

All staff are responsible for:

- Complying with relevant Trust policies and other procedural documents where they apply.

4.8. Role of the members of approving committees or groups

The members of Trust committees and groups will need to provide the approval authority for policies and procedural documents within their specialty area.

Groups and Committees approving documents are required to document their approval in their meeting minutes.

4.2.1 For policies and strategies

Approval of policies and strategies should be provided by the most appropriate group or committee. The Terms of Reference of the group or committee should list the policies that the group have responsibility for approving.

Approval of local policies relating to a department, service, team or professional group may be agreed locally, e.g. at a team meeting. The agreed approval process must be recorded in the document control report.

4.2.2 For local guidelines and non-policy procedural documents

Approval of procedures, standard operating procedures and guidelines can be approved by the Head of Department or Lead Clinician.

Patient Group Directions will need to be approved in line with the PGD Policy found on the Trust Intranet.

4.9. Role of Staffside

Staffside are responsible for:

- Reviewing all relevant Human Resources policies and commenting where appropriate.

5 Development of procedural documents

When the need for a procedural document is identified, the author will use the relevant template which is published on Trust Intranet in the policies section of the intranet.

It is intended that the author will populate the template detailing the process or procedure that is locally used. Then pass the document to the stakeholders for comment, once the comments have been received the author will amend the policy and arrange for approval at a relevant group or committee.

The document needs to be written in plain English with no jargon. The section for definitions should be used to explain complex descriptions or named procedures.

Wherever a procedure can be illustrated as a flowchart this should be included to provide a clear process without lengthy explanation and words.

When the document has been approved it can be sent to the Compliance team who will publish the document confirm this has been done to the author.

An implementation plan should accompany a policy sent to a group or committee for approval. This plan should detail how the author intends to let Trust Staff know that the policy/procedural document is now available.

Documents should be written in plain English with little use of abbreviations and acronyms. Abbreviations and acronyms should only be used if they have been written in full the first time they are referred to.

Most Standard Operating Procedures or Procedures can be illustrated as a flowcharts showing the procedures, this will negate the requirement for a full document..

Job titles should be used rather than individual names.

Sub processes should be added as appendices.

The title of the document should reflect what the document is for. Titles should not start with policy or guideline.

5.2 Templates

Templates are available on the Trust Intranet in the policies section. There are several templates available:

- Policy template

- Guideline template
- Standard Operating Procedure template
- Strategy
- Competency template

The templates are the corporate style of Arial Size 11 font.

5.3 Document title and version control

When a document is first written as a draft the version numbering should start as 0.1, with each subsequent revision given in sequential order. Once the document has been approved and is ready for publishing it will be given the next whole number, such as 1.0. This version number will form part of the electronic filename along with the date of publishing.

5.4 Equality Impact Assessment

All procedural documents will need to have an Equality Impact Assessment (EIA) undertaken. The EIA is a process designed to ensure that a policy or procedure does not discriminate against any disadvantaged or vulnerable people

The author is required to assess whether the policy or procedure has any negative or positive impact on the following:

- Age
- Disability
- Gender
- Gender reassignment
- Human Rights (rights to privacy, dignity, liberty and non degrading treatment), marriage and civil partnership
- Pregnancy
- Maternity and breastfeeding
- Race (ethnic origins)
- Religion (or belief)
- Sexual orientation.

Where an impact is identified the author will be required to detail any adjustments that will need to be made.

5.5 Fraud

Where policies have the potential to be open to fraud of any nature, an electronic copy of the document must be sent to the Local Counter Fraud Specialist for consultation. Examples of potential fraud include policies with a financial element (e.g. claims policy, procurement policy) or any policy that

includes making or signing a declaration. The Local Counter Fraud Specialist will advise of any amendments that are required. This consultation should be recorded in the Document Control Report.

5.6 Approval Groups or Committees

Procedural documents are usually reviewed after three years to update any organisational changes or new legislation. However some clinical procedures may need to be reviewed annually. It is the decision of the author to identify the review period.

The group or committee to provide the approval will need to be the local group or meeting regarding the service. The approving group or committee will need to incorporate the review process in their Terms of Reference as part of their responsibilities or tasks.

For documents such as guidelines, the approval may be provided by a Lead Clinician or Head of Department as appropriate.

5.7 Publication

Once a document has been approved, the author will send a copy to the Compliance team for publication on the Trust's intranet site.

The latest version of a procedural document will be available to staff on the Trust's intranet site.

The document will be published as a PDF by the Compliance Team and a listing will be posted on the front page of the policies site of the most recently published documents.

5.8 Search tags

Search tags need to be added to a procedural document to enable the success of intranet searching by staff that may not be familiar with the specific title. These tags are additional words that can be searched for in the Trust's policy intranet site.

5.9 Archive

A 'Word' copy of the document will be sent by email to the author to acknowledge it has been published. The author should keep the word version for their own archive files. Copies of all of the document are kept by the Compliance department for legal purposes.

Investigations may need to be undertaken and claims may be received at a later date whereby the policies or procedural documentation what was current at the time of the incident will need to be referred to.

5.10 Monitoring

The author will need to identify what form of monitoring will be used to enable assessment of compliance. Monitoring may take the form of audits, reports, feedback, results of complaints or incidents, sample surveillance, spot checking, documented observations, or feedback. Revision

A document can be revised to reflect minor changes such as departmental changes.

This can be recorded on the document control report but the document can be published with the revision until the review date without going through the full approval process.

5.11 Review

The Compliance Officer will remind the author 6 months before the policy is due for review. A further reminder will be sent 3 months prior to review. If no response is received and escalation process will be implemented, where the line manager will be asked if the policy is still required or can it be removed.

Procedural documents must be reviewed at least every three years to ensure they are in relevant.

The author will review the document and consult with the Stakeholders prior to arranging for approval at the relevant group or committee, prior to re-publishing.

5.12 Policy intranet site

Procedural documents are published on the Trust's intranet site under the heading of Policies: http://ndht.ndevon.swest.nhs.uk/policies.html

The Compliance team will maintain and develop this site with support from the Website Manager.

6 Monitoring Compliance with and the Effectiveness of the Policy

6.2 Standards/ Key Performance Indicators

The key performance indicator is the:

- Percentage of procedural documents in date.

6.3 Process for Monitoring Compliance and Effectiveness

Compliance of this policy will be monitored on a regular basis with quarterly reporting and assessment of documents required as a result of inspections, complaints and incidents.

The Commercial Director will monitor performance via the reports supplied by the Senior Governance Manager (Compliance) as part of the monthly Governance KPI reports.