NHS
Worcestershire
Health and Care
NHS Trust

# Policy for the Development and Management of Policies, Guidelines, Documentation and Standard Operating Procedures.

**Working together**
**for outstanding care**

**Guideline / Policy on a Page – Summary of Key Points**

Worcestershire Health and Care NHS Trust is committed to producing procedural documents, such as policies and guidelines, to a consistently high standard. This Policy has been written to ensure all procedural documents:

- Have are structured format
- Provide staff with a clear approval and ratification process
- Ensure patients receive care that is evidence based
- Assure and improve quality
- Minimise unacceptable or undesirable variations in practice
- Support staff in clinical practice to ensure a high quality of care to our patients.
- Increase collaboration between professionals

# Policy for the Development and Management of Clinical Policies and Guidelines

| | |
|---|---|
| **Document Type** | Corporate Policy |
| **Unique Identifier** | |
| **Document Purpose** | This policy sets out the standards for producing Worcestershire Health and Care NHS Trust's procedural documents such as policies and guidelines |
| **Document Author** | Louise Seeney, Head of Education & Clinical Development |
| **Target Audience** | All staff who are involved in writing procedural documents, clinical policies and guidelines in Worcestershire Health and care NHS Trust. |
| **Responsible Group** | Clinical Policies Group |
| **Date Ratified** | 27th February 2019 |
| **Expiry Date** | 27th February 2022 |

The validity of this policy is only assured when viewed via the Worcestershire Health and Care NHS Trust website (hacw.nhs.uk.). If this document is printed into hard copy or saved to another location, its validity must be checked against the unique identifier number on the internet version. The internet version is the definitive version.

If you would like this document in other languages or formats (i.e. large print), please contact the Communications Team on 01905 681770 or by email to WHCNHS.Communications@nhs.net

**Version History**

| Version | Circulation Date | Job Title of Person/Name of Group circulated to | Brief Summary of Change |
|---|---|---|---|
| V1 | 14/08/2015 | Deputy Director of Nursing, Corporate Secretary, Clinical Policies Group Members, Associate Director Human Resources | |
| V2 | 22/10/2015 | Director of Nursing, Corporate Secretary, Clinical Policies Group Members, Associate Director Human Resources | |
| V3 | 26/03/16 | Clinical Policies Administrator | Inclusion of Co-production Statement of Intent |
| V4 | 10/08/2018 | Head of Education & Clinical Development. | Removal of reference to Offender Health, Policy re-written in line with updated procedures for approval and ratification of procedural documents. |
| | 28/12/18 | Safeguarding Services Manager | |
| | 28/12/18 | Audit, Research & Clinical Effectiveness Manager | |
| | 28/12/18 | Lead for Allied Health Professionals | |
| | 28/12/18 | Chief Pharmacist | |
| | 28/12/18 | Nurse Consultant Infection Prevention Control | |
| | 28/12/18 | Head of Quality Governance | |
| | 28/12/18 | Medical Director | |
| | 28/12/18 | Director of Nursing & Quality | |
| | 28/12/18 | Deputy Director of Nursing | |

| | | | |
|---|---|---|---|
| | 28/12/18 | SDU Lead for Community Hospital and OAMH Inpatients | |
| | 28/12/18 | SDU Lead for Community Teams | |
| | 28/12/18 | SDU Lead for Mental Health | |
| | 28/12/18 | SDU Lead for Children's Services | |
| | 28/12/18 | Quality Lead for Children's Services | |
| | 28/12/18 | Quality Lead for Community Care | |
| | 28/12/18 | Quality Lead for Integrated Community Services | |
| | 28/12/18 | Quality Lead for Learning Disabilities | |
| | 28/12/18 | Quality Lead for Mental Health | |
| | 03/01/19 | Quality and Governance Lead for Community Care/Integrated Community Services | Change of title from 'Policy for the Development and Management of Procedural Documents' to current. Minor amendments to formatting/wording. |

**Accessibility**

Interpreting and Translation services are provided for Worcestershire Health and Care NHS Trust including:

- Face to face interpreting;
- Instant telephone interpreting;
- Document translation; and
- British Sign Language interpreting.

Please refer to the intranet page: http://nww.hacw.nhs.uk/a-z/services/interpreting-and-translation-services/ for full details of the service, how to book and associated costs.

**Training and Development**

Worcestershire Health and Care NHS Trust recognises the importance of ensuring that its workforce has every opportunity to access relevant training. The Trust is committed to the provision of training and development opportunities that are in support of service needs and meet responsibilities for the provision of mandatory and statutory training.

All staff employed by the Trust are required to attend the mandatory and statutory training that is relevant to their role and to ensure they meet their own continuous professional development.

**Co-production of Health and Care – Statement of Intent**

The Trust expects that all healthcare professionals will provide clinical care in line with best practice. In offering and delivering that care, healthcare professionals are expected to respect the individual needs, views and wishes of the patients they care for, and recognise and work with the essential knowledge that patients bring. It is expected that they will work in partnership with patients, agreeing a plan of care that utilises the abilities and resources of patients and that builds upon these strengths. It is important that patients are offered information on the treatment options being proposed in a way that suits their individual needs, and that the health care professional acts as a facilitator to empower patients to make decisions and choices that are right for themselves. It is also important that the healthcare professional recognises and utilises the resources available through colleagues and other organisations that can support patient health.

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1. **Introduction**

   a. Worcestershire Health and Care NHS Trust is committed to producing procedural documents to a consistently high standard.

   b. Formal written documents communicate organisational ways of working. They help clarify strategic and operational requirements and bring consistency to day to day practice.

   c. All staff are supported in clinical practice to ensure a high quality of care to our patients.

   d. A structured format and approval process for such documents provides assurance that those in use are current and conform to best practice. It also assists employees in swiftly identifying key issues within key documents

2. **Purpose of document**

   a. This policy sets out the process for developing, ratifying, communicating, managing and reviewing procedural documents within Worcestershire Health and Care NHS Trust. Appendix 1 provides a flowchart for the process for the ratification of Clinical Policies, and Appendix 2 provides detail of the process for ratification of Corporate Policies.

2. **Scope**

   a. This policy applies to all policies, guidelines, documentation and Standard Operating Procedures written for implementation within Worcestershire Health and Care NHS Trust.

   b. This policy applies to all staff employed by Worcestershire Health and Care NHS Trust.

3. **Definitions**

   The definitions that apply to this policy are as follows:

   a. **Policy:** A national or corporate framework that directs the organisation's practice in fulfilling statutory and organisational responsibilities and is contractually binding on all employees. It is a statement of the standard of service that is to be provided to enable management and staff to make correct decisions, deal effectively and comply with, relevant legislation, rules and good working practices.

b. **Guidelines:** Guidelines define best practice and guide conduct in an advisory way. Clinical guidelines advise healthcare professionals on caring for people with specific clinical conditions or diseases taking into account the best available evidence and views of clinicians (definition adapted from the National Institutes for Health and Clinical Excellence). Staff are expected to follow clinical guidelines and to be able to justify and document any deviation from guidelines for individual patients.

c. **Standard Operating Procedure:** Sometimes also called a protocol. These are a set of detailed step-by-step instructions that describe how tasks or activities should be carried out to achieve the highest standards possible and to ensure efficiency, consistency and safety. Deviation from such documents should only be by agreement with senior management.

d. **Clinical Documentation, Carenotes Documentation and Patient Leaflets**
Clinical documentation and patient leaflets are used to capture record and provide clinical information, either in real time whilst a patient is present, or information recorded and/or shared following a referral, assessment or treatment. Clinical documentation can be presented as forms which are completed by patients or health professionals, or could be flowcharts, assessment tools or patient leaflets providing clinical advice. Sometimes this clinical documentation is used in electronic format only and for Carenotes, which is the Trust Electronic Patient Record System. Appendix 3 provides detail of the process for ratification of clinical documentation and Carenotes documentation. For ratification of patient leaflets, please contact the Lead for the Patient and Carers Experience Group.

e. **Stakeholders:** People with an interest in a procedural document and who can usefully contribute, comment and agree to the content of the document. This includes specific committees, groups or forums, Trust solicitors, individual clinicians, whole departments, service users and their families and carers.

f. **Consultation**: Consultation is a core standard for all procedural documents. Stakeholders should be identified and included in this process, and for Clinical Policies members of the core circulation list must also be consulted before a procedural document is presented to the Clinical Policies Group for approval. Appendix 4 provides a checklist for authors to guide them through the approval process and details members of the core circulation list.

g. **Equality Analysis Assessment:** An assessment of the impact that procedural documents have on those who are affected by them to ensure equality of provision.

h. **Approved**: Formal confirmation by a group or committee that the document meets the required standards and may be put forward for ratification.

i. **Ratification**: The document is approved for publication by a designated sub-committee of the Board.

## 4. Training/Competencies

There are no formal training requirements associated with the writing and management of procedural documents, however the author of a policy must have the appropriate knowledge and skills to develop a procedural document.

## 5. Responsibilities and Duties

### a. Trust Board

The Trust Board has overall responsibility for ensuring compliance with all legal, statutory, best practice and quality requirements and for ensuring staff have good quality, ratified procedural documents to work with.

### b. Chief Executive

The Chief Executive has ultimate responsibility for quality and governance including ensuring a process is in place to support good procedural document development, management and implementation.

### c. Executive Directors

Executive Directors have responsibilities within their portfolios for ensuring that procedural document development, management and implementation meet the needs of the trust, its staff and its patients.

### d. Directors/Associate Directors/Managers/Clinical Leads/Leads within Sub-contracted services

I. All of the above group of staff must be able to demonstrate that clear processes are in place to ensure all the staff that they manage, and the staff they oversee which includes agency, contracted and volunteer staff, know where to find policies, and have read and understood the key documents applicable to their area of work.

II. Managers must monitor, through staff management arrangements, the implementation of appropriate procedural documents and put in place performance management or disciplinary measures where issues arise.

III. Managers are responsible for helping to ensure that procedural documents meet the needs of their staff.

IV. Managers must ensure that document authors/owners are advised of any changes in practice, legislation or contacts or if the document becomes out of date.

e. **Author**

i. The author has a responsibility to review existing documents to ensure that the subject area is not already covered in another document. The author should also consider whether an amendment or addition to an existing policy is more appropriate than a new stand-alone document.

ii. The author has the responsibility for ensuring the procedural document template (Appendix 5) is followed.

iii. It is the responsibility of the author to determine if the proposed document requires financial support. If it does a business case should be presented and agreed prior to the document being presented for approval.

iv. It is the responsibility of the author to determine if there is any new or revised staff training requirements in the proposed document and to address this in consultation with the Head of Education and Clinical Development prior to approval.

v. The author will be responsible for producing written drafts of the new document and managing the document throughout the approval process. This may be a shared responsibility depending on the size and complexity of the document.

vi. The author will be responsible for ensuring that the relevant stakeholders, committees and groups are consulted about the document.

vii. The author will be responsible for ensuring that the version submitted for approval meets the standards outlined in this policy.

viii. The author will be responsible for initiating and seeing through to completion the Equality Analysis Assessment (EA). All procedural documents are required to be assessed for their impact on nine protected groups to ensure that there is equality of provision.

f. **All Staff including those sub-contracted**

i. All staff have a duty to read procedural documents relevant to their practice and comply with them. Failure to do so may result in performance or disciplinary measures being taken.

ii. All staff should identifying their training needs in respect of procedural documents and bring these to the attention of their manager.

iii. All staff should know how to access procedural documents.

iv. All staff have a responsibility to highlight any part of a procedural document that is incorrect, out of date or no longer relevant.

v. All staff have a responsibility to highlight any part of a procedural document that may have a negative impact on individuals or groups.

vi. All staff have a responsibility to ensure that agency or contracted staff know where to find policies, abide by their contents and are made aware of any that are particularly relevant to their role.

## g. Stakeholders

a. Consultation with relevant stakeholders secures ownership and provides an opportunity to identify and eliminate potential barriers to implementation.

b. All stakeholders involved in producing the document have a responsibility to engage in consultation, and are also responsible for passing on draft versions for comments to parties who they are aware may have an interest but have not yet been consulted and should in turn inform the author that they have done this.

c. Anyone who is asked for comments or to make a contribution to the document has a responsibility to respond to the request within the identified time frame, even if it is only to confirm that they are satisfied with the document as it stands.

## h. Groups, Sub-Committees and Committees

a. The Trust Board, Quality and Safety Committee, Joint Negotiating and Consultative Committee are responsible for ratifying procedural documents that have been signed off by the relevant sub-committees.

b. The **Joint Negotiating and Consultative Committee** is the forum for consultation and negotiation on Trust wide issues and provides a mechanism by which issues relating to contracts of employment, terms and conditions of employment, policies and procedures of staff are discussed and negotiated.

c. **The Quality and Safety Committee** is a sub-committee of the Trust Board and has been delegated the responsibility to provide assurance that effective quality arrangements are in place with regard to procedural documents.

d. **The Clinical Policies Group** is a sub group of the Quality and Safety Committee. This Group is responsible for monitoring and approval of all clinical policies, clinical documentation and Standard Operating Procedures that have Trust wide implications, ensuring that their content is evidence based, up to date and that the appropriate people have been consulted in the development process. The group is also responsible for initiating the Policy for Escalating Clinical Policies and Guidelines CL-143 should a clinical document be at risk of approaching its expiry date and becoming overdue.

e. There are several other groups and sub-committees servicing the approval of a wide range of procedural documents before they are submitted for ratification. Occasionally documents may be submitted to more than one group or sub-committee where there is a shared interest or responsibility e.g. Clinical Policies Group may submit a clinical form completed by patients to the Lead of the Patient and Carers Experience Group prior to ratification.

f. Groups and sub-committees must only approve documents when they are fully satisfied that the document meets the Trusts high quality standards outlined in this policy. Any documents that are not approved should be returned to the author with a clear explanation for the decision.

6. **Style**

a. All procedural documents should be presented in a concise and clear style using, whenever possible, everyday terminology. Where a technical or clinical term is required for the document which would not be understood by a lay person, an explanation of that term should be provided either in the text or as a footnote. A Glossary of Terms should be considered for particularly technical or complex documents.

b. Documents should evidence a link with service priorities together with national and other relevant organisational policy documents.

7. **Format**

a. A template for the front pages and general formatting (Appendix 5) is available on the Trust intranet and can also be provided by the Clinical Policies Administrator.

8. **Review and Revision Arrangements**

a. All procedural documents must be reviewed at least every 3 years. Changes in legislation or professional guidance may necessitate an unexpected review of any document, and any changes required to a procedural document should be undertaken in a timely fashion. All documents must have an Equality Analysis undertaken when they are under review and the Equality Analysis form completed and attached to the end of the policy.

b. The ratified date and the planned expiry date will be clearly identified on the title page when it is published. When the document has been ratified and published, the previous version should be archived.

## 9. Dissemination and Implementation

a. Once the document is formally approved and ratified, the final version will be uploaded to the appropriate policies page on the Trust's intranet. The document will be given a unique reference number and the author will be notified when the document has been placed on the intranet.

## 10. Interpretation

a. All staff should be aware that the trust Interpreting and Translation services are provided for Worcestershire Health and Care NHS Trust including:
   - Face to face interpreting;
   - Instant telephone interpreting;
   - Document translation; and
   - British Sign Language interpreting. Please refer to the intranet page: http://nww.hacw.nhs.uk/a-z/services/interpreting-and-translation-services/ for full details of the service, how to book and associated costs.

## 11. Publication

a. Procedural documents which are placed on the Trust's website should only be done by members of the Communication Team.

b. Following approval authors, managers and clinical leads all have the responsibility of ensuring that all employees or other stakeholders who will be affected by the document are proactively informed and made aware of any changes in practice that will result.

c. All approved documents will be posted on the intranet, and the persons responsible for uploading policies onto the Trust's intranet should also notify the

Trust's Communication Team so communications can be put out to employees across the Trust advising them of new or amended procedural documents.

d. Staff are strongly discouraged from printing off or photocopying procedural documents as the most up to date version will always be on the intranet.

e. The internet version of the document is the definitive version.

## 12. Document Control and Archiving

a. All procedural documents will have a stated expiry date, after which the procedural document becomes redundant.

b. When a new or reviewed procedural document is uploaded onto the intranet, the old version is archived should they be required in future.

## 13. Monitoring implementation

a. Monitoring tools must be built in to all procedural documents in order that implementation, compliance and effectiveness can be demonstrated. The approach adopted for this will depend on the policy type but could include:

i. Audits

ii. Patients' views and experiences

iii. Benchmarking

iv. Staff surveys

v. Environmental impact analysis

vi. Complaints monitoring

vii. Trend analysis

viii. Incident reporting and monitoring

ix. Monitoring ethnicity/diversity access.

b. How and when the policy will be monitored must be made explicitly clear within the policy document. This should identify:

i. Who is responsible for undertaking the monitoring or audit

ii. The method to be used

iii. Frequency of monitoring or audit

iv. How the results will be used to inform or improve practice

## 14. References and Associated documentation

Procedural documents should be evidenced based with up to date references. References must be cited in full, using Harvard Referencing style

## 15. Appendices

a. **Appendix 1 – Clinical Policies and Guidelines Approval and Ratification Process.** Guidance on this process is available on the Trust's Clinical Policies intranet page. To view please CLICK HERE

b. **Appendix 2 – Corporate Policies Approval and Ratification Process.** Guidance on this process is available on the Trust's Corporate Policies intranet page. To view please CLICK HERE

c. **Appendix 3 – Approval Process for Clinical Documentation.** Guidance on this process is available on the Trust's Clinical Policies intranet page. To view please CLICK HERE

d. **Appendix 4 – Authors Checklist and Members of Core Circulation List**. The checklist is available on the Trust's Clinical Policies intranet page. To view please CLICK HERE

e. **Appendix 5 – Policy and Guideline Template.** The template is available on the Trust's Policies intranet page. To view please CLICK HERE

## 16. References

HAVARD REFERENCING (20017) A short guide to Harvard Referencing at the University of Worcester (Online) University of Worcester. Available from: https://drive.google.com/file/d/0B2wGAyiHm0nAUzdIWFlTbm5vcDg/view

ROSADO, L (2017) CL-143 Policy for Escalation of Clinical Policies & Guidelines (Online) Worcestershire Health & Care NHS Trust. Available from: http://nww.hacw.nhs.uk/EasysiteWeb/getresource.axd?AssetID=46883&servicetype=Attachment

# Equality Impact Analysis Screening Form

| | | | |
|---|---|---|---|
| Title of Activity | *Policy for the Development & Management of Procedural Documents* | | |
| Date form completed | *13/08/2018* | Name of lead for this activity | *Louise Seeney* |

Analysis undertaken by:

| Name(s) | Job role | Department | Contact email |
|---|---|---|---|
| *Louise Seeney* | *Head of Education and Clinical Development* | *Learning and Development* | *Louise.seeney@nhs.net* |
| *Carole Roberson* | *Lead for Professional and Clinical Development* | *Learning and Development* | *C.roberson@nhs.net* |
| *Lesley Way* | *Preceptorship and Practice Facilitator* | *Learning and Development* | *Lesley.way@nhs.net* |

| | |
|---|---|
| What is the aim or objective of this activity? | This policy sets out the process for developing, ratifying, communicating, managing and reviewing procedural documents within Worcestershire Health and Care NHS |
| Who will this activity impact on?<br>*E.g. staff, patients, carers, visitors etc…* | |

## Potential impacts on different equality groups:

| Equality Group | Potential for **positive** impact | Neutral impact | Potential for **negative** impact | Please provide details of **how** you believe there is a potential positive, negative or neutral impact (and what evidence you have gathered) |
|---|---|---|---|---|
| **Age** | ❑ | ✠ | ❑ | *This policy would be used in the development of all policies within the Trust regardless of the age or the user.* |

| Equality Group | Potential for **positive** impact | Neutral impact | Potential for **negative** impact | Please provide details of **how** you believe there is a potential positive, negative or neutral impact (and what evidence you have gathered) |
|---|---|---|---|---|
| | | | | |
| **Disability** | ✠ | ❑ | ❑ | *By providing a structure to work with this policy may have a positive impact on some individuals who have difficulty in producing documents due to a disability.* |
| **Gender Reassignment** | ❑ | ✠ | ❑ | *This policy is specifically related to the development of procedural documents and is aimed at all staff who develop these policies and does not relate to individual members of staff or patients.* |
| **Marriage & civil partnerships** | ❑ | ✠ | ❑ | *The marriage and civil partnership status of an individual would have no impact on their ability to implement this policy.* |
| **Pregnancy & maternity** | ❑ | ✠ | ❑ | *The policy can be implemented by all regardless of pregnancy or maternity status.* |
| **Race** | ❑ | ✠ | ❑ | *No adaption would be required for race/culture, in this respect the policy applies equally to all* |
| **Religion & belief** | ❑ | ✠ | ❑ | *An individual's religious beliefs would not preclude them from using this policy.* |
| **Sex** | ❑ | ✠ | ❑ | *This policy applies to all in the same way and therefore has a neutral impact* |
| **Sexual Orientation** | ❑ | ✠ | ❑ | *A person's sexual orientation would not alter how this policy was used by an individual.* |
| **Additional Impacts** *(What other groups might this activity impact on? e.g. carers, homeless, travelling communities etc.)* | ❑ | ❑ | ❑ | |

## Level of impact

If a potential negative or disproportionate impact has been identified from this activity:

| | Yes | No |
|---|---|---|
| Could this impact be considered direct or indirect discrimination? | | |
| If yes, how will you address this? | | |
| | | |

*If the impact could be discriminatory, please contact the Inclusion Team to discuss actions*

| | High | Medium | Low |
|---|---|---|---|
| What level do you consider the potential negative impact to be? | | | |

*If the negative impact is high, a full equality impact analysis will be required*

## Action Plan

| |
|---|
| How could you minimise or remove any negative impact identified, even if this is rated low? |
| |
| How will you monitor this impact or planned actions? |
| |
| Future Review Date: **27th February 2022** |

Once completed, please attach this form to the relevant proposal, strategy, policy etc and submit for approval via normal channels