Improving Health
and Wellbeing for Walsall

DEVELOPMENT AND MANAGEMENT OF PROCEDURAL DOCUMENTS POLICY

NHS

Walsall Clinical Commissioning Group

DEVELOPMENT AND MANAGEMENT OF PROCEDURAL DOCUMENTS POLICY

For Walsall Clinical Commissioning Group

The Audit & Governance Committee approved this document on:

Date: 17 September 2018
Signed: Chair of the committee
Signed: Designated Senior Officer

Please note that the Intranet version of this document is the only version that is maintained. Any printed versions should therefore be viewed as 'uncontrolled' and may not be the most up-to-date

Document Reference Information

Version:	Version 3.0
Status	
Lead Director/Manager responsible	Strategic Lead for Integrated Governance and Organisational Development
Role of author:	Risk and Assurance Manager
Ratifying committee:	Audit & Governance Committee
Date ratified:	17 September 2018
Date Policy is Effective From	Ratification date
Review date:	July 2020
Expiry date:	September 2020
Date of Impact Assessment	
Target audience:	Walsall CCG Governing Body and staff Any member of staff working on behalf of the CCG
National or NHS Walsall CCG linked documents	
Distribution of the document	To all staff via team meetings, strategic leads and website
Implementation of the document	
Document Control and Archiving	
Monitoring Compliance and Effectiveness	Central monitoring through the Integrated Governance department

CONTRIBUTION LIST

Key roles involved in developing the document

Role
Strategic Lead for Integrated Governance and Organisational Development
Risk and Assurance Manager

Circulated to the following for consultation

Committee/Group/Role	Comment
Safety Quality and Performance Committee	Definition of Procedural documents Wording for version control Dissemination responsibility and documents with are for multiple organisations
Strategic Leads	
Heads of service	
CCG managers	
Equality and Diversity Lead	

Version Control Summary

Significant or Substantive Changes from Previous Version.

Version	Date	Comments on Changes
V 1.1	March 2014	Revised to reflect CCG structure
V.3	August 2018	Document reviewed, no changes made

Contents

1.0 Introduction

This policy is to ensure that Walsall CCG implement a robust and clear governance framework to develop and implement strategies, policies and other procedural documents that are appropriate and practical.

The organisation creates procedural documents to advise and guide staff, patients and visitors on organisational procedures, compliance with statute and the relevant functions and responsibilities of the organisation. It is therefore important that all organisational policies and procedural documents are developed in accordance with best practice.

The web version of any document is the definitive version.

2.0 Purpose

The purpose of this policy is to produce a unified corporate approach to the development and management of approved procedural documents. This will ensure that appropriate information is presented in a standard format, is easily accessed by staff and patients and that the drafting, ratification and review process is clear to all.

A wide range of procedural documents are currently produced by the organisation. This policy specifically refers to strategies, policies, guidelines, and protocols that require Governing Body, Governing Body Committee or formal group/meeting approval. Documents that cover more than one organisation i.e. safeguarding policy, the governance arrangements for the function will determine the ratification, review and dissemination requirements.

Policies or protocols that are purely for departmental use should apply the same principles but should be agreed by processes within the department. Each department should agree a process for maintaining departmental policies and protocols.

The recommended standards for all procedural documents are that they should:

1. Be determined on the basis of sound information and appropriate consultation
2. Be compliant with all relevant statutes
3. Be structured in such a way as to be capable of guiding those making decisions
4. Be named/titled in the most relevant way
5. Be written in a clear and understandable style
6. Be capable of implementation and monitoring

3.0 Principles

Policy will be followed in the latest version even if is past its review date until a revised version is ratified. There may be circumstances where it is not appropriate for policies to be reviewed within the allocated timeframe or through organisational change it is necessary to continue to follow the current policy until it is reviewed.

4.0 Duties

4.1 Accountable Officer

The Accountable Officer is responsible for ensuring that a structured approach to procedural document development and interpretation is in place.

Final accountability for corporate procedural documents will reside with the Accountable Officer, although responsibility for procedural document development may be delegated to other officers.

4.2 Strategic Lead

The Strategic Lead will be responsible for the management of all procedural documents in their directorate and for the services areas that they are responsible for which may be provided through a commissioning support arrangement, for example Human Resources.

They will have overall responsibility for the following:

1. Identify that a procedural document is needed and whether this is a strategy, policy, protocol etc.
2. Appoint a lead author
3. Ensure that the formulation of procedural documents is compliant with the requirements of this policy
4. Agree the key stakeholders and committees involved with the consultation and where appropriate method of consultation. This will include public and patient consultation.
5. Identify the committee/group who will ratify the document
6. Identify the level of consultation and ratification for reviewed documents
7. Agenda the document for ratification to the appropriate committee
8. Ensure that any monitoring arrangements are implemented and appropriately reported
9. Ensure a robust process is in place for reviewing policies and protocols prior to their expiry date
10. Arrange for the policy to be put onto the website
11. Ensure that the review process is followed in a timely manner

4.3 Strategic Lead for Integrated Governance and Organisational Development

The Strategic Lead for Integrated Governance and Organisational Development is responsible for ensuring that the website is monitored on an annual basis to ensure that documents are in PDF and in date. This will be reported annually to the Governing Body.

4.4 Author(s)

The procedural document author will be identified by the Strategic Lead and is responsible for to following:

1. Ensure that the procedural document is written in the policy template format, see appendix 1
2. Manage the version control to indicate when the document is in the process of review and when it is a ratified version.
3. Ensure that they are aware of changes in legislation, practice or other guidance to enable them to ensure the procedural document considers and minimises risk and potential adverse consequences for the organisation
4. Ensure that appropriate consultation takes place
5. Consider any training and resource implications
6. Complete impact assessments which must be submitted with the final policy to the Governing Body or Committee approving the document
7. Once ratified amend the ratification date and version control and PDF the document ready for publication on the appropriate area on the website.
8. Ensuring the policy is disseminated to the appropriate groups and arranging awareness and or training sessions if necessary

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

4.5 Stakeholders

All those involved in producing the document have a responsibility to make sure that consultation has taken place with appropriate stakeholders. 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.

4.6 All Employees

All staff have a duty to read and work within current policies. All staff should know where policies are stored and how to gain access to them. If a member

of staff identifies that any part of a procedural document is no longer relevant they have a responsibility to contact the author to inform them of this.

4.7 Governing Body Committees

Designated committees have responsibilities to ensure that correct process has been followed in the creation of procedural documents for ratifying the document for use within the organisation. This will ensure that a uniform approach is taken to document ratification.

5.0 Style and Format of Procedural Documents

5.1 Document Template and Checklist

The document template outlining the minimum content for procedural documents is at Appendix 1**.** There is a check list at Appendix 2 as an aide memoir for the author to ensure that procedural documents are written to the agreed standard.

5.2 Guidance on the style of procedural documents

Guidance on the style of procedural documents is as follows:

1. Organisational logo in the top right hand corner.
2. They should be presented in a concise and clear style using, whenever possible, everyday terminology. The organisation recognises that it has a role to play in ensuring that all members of society including non-English speakers and people with visual or hearing loss can have full access to all our services. Any requirements for these services should be directed to the communications department for advice.
3. Documents should be titled in Arial 16 bold print and written throughout in Arial font, size 12, with single line spacing and justified.
4. Abbreviations should only be used after the term has been displayed in full e.g. Area Prescribing Committee (APC). These terms are usually included in the definitions section.
5. The footer must give the version control, document title and page of page number
6. Section headings must be numbered and in bold text
7. Where applicable documents should provide an evidence base with up to date references using footnotes

6.0 Producing a Procedural Document

6.1 Identification of Stakeholders and Consultation

The organisation is committed to involving staff and key stakeholders in the development, review and monitoring of procedural documents. The involvement of relevant groups, committees and stakeholders is key to the

review and development of effective documents. This is the responsibility of the Strategic Lead.

The Equality and Diversity lead should be part of the consultation process to ensure that they are compliant with the Strategy and Equality Act.

This process may involve formal consultation with representatives at the Staff Council for Human Resources Policies and if there is any impact on the working practices and patterns of work for employees.

Consultation will be evidenced by the circulation list in all documents and by the resultant version changes during consultation. The Strategic Lead will advise the author who the key stakeholders and committees would be.

6.2 Equality Impact Assessment

The organisation aims to design and implement its services, policies and measures to meet the diverse needs of our service users, population and workforce ensuring that none are placed at a disadvantage over others. An Equality Impact Assessment for each procedural document is a legal requirement and is a way of assessing the effects that a proposed or existing procedural document is likely to have on people from different groups. A structured and systematic approach to this is necessary due to the wide range of documents that are used within the organisation.

The equality impact assessment would normally be the responsibility of the author/s but in some instances may be delegated to another appropriate representative. The Equality Impact Assessment tool can be found at Appendix 3.

7.0 Approval and Ratification Process

The Strategic Lead will identify the committee/group which will approve the procedural document.

7.1 Consultation

Full consultation (including external stakeholders where necessary) is required for;

1. New procedural documents
2. Procedural documents with extensive or substantive changes

These documents must be formally ratified following the agreed procedure.

Limited consultation (internal stakeholders) is required for

1. Minor changes
2. Changes because of problems arising due to misinterpretation or confusion around use of previous version

The ratifying committee/group must be formally notified of the reason for the changes and the changes following the consultation process.

No consultation is required for

1. Correction of typographical errors
2. Changes arising from organisational changes in the structure, staff roles or responsibilities
3. Changes in direct response to a change to an overarching document
4. Change to external standards which require a direct change to a trust document
5. Documents that do not require any change following review

These documents do not need to be formally ratified; however, the ratifying committee may need to be informed that the document has been reviewed and that no significant changes were made. This will be at the discretion of the Strategic Lead.

All reviews and reasons for changes to a procedural document will be tracked in the document version control summary.

7.2 Ratification

Once the document has been agreed via the consultation process and then ratified by the identified committee, the author of the document is responsible for updating the document to reflect the ratification date and version control for it to be put into PDF format and posted on the appropriate area on the website. Ratified documents posted on the website which are out of date will remain in force and current until such time as updated documents are ratified and published on the website. See appendix 4 for the illustration of the policy process including the process with Commissioning Support Unit for Human Resource policy.

8.0 Review and Revision Arrangements

8.1 Review

All procedural documents must be regularly reviewed at least every 3 years unless the ratifying committee indicate otherwise for example when key procedural documents are considered to address areas of high risk documents may need to be reviewed at more regular intervals. Changes in legislation or professional guidance may necessitate an unexpected review.

Comments on procedural documents can be submitted to the author at any time and will be taken into consideration when the document is reviewed.

Staff who become aware of changes to statutory requirements, changes in practice, revised professional or clinical standards that could potentially affect organisational documents must inform the document author to consider whether to review the document earlier than the set review date.

8.2 Version Control

This is controlled by the author of the document.

8.21 New procedural documents

The version control for a new document will be v 0.1 whilst the document is being produced. Once it is ratified it will be v 1.0. Each subsequent version will be numbered sequentially i.e. v1.0, v2.0 etc. with the date it was produced.
For example:
New document starts at v 0.1
First ratification v 1.0
Review v 1.1
Second ratification v 2.0

8.22 Reviewed Procedural Documents

When a document is being reviewed each stage will be recorded as a different version, indicated as V1.1, V1.2 etc.
This will be necessary whether or not changes need to be made to the content of the document in order to record that the review has been carried out.

The website version of this document is the only version that is maintained.

Any printed versions should therefore be viewed as ‘uncontrolled’ and may not be the most up-to-date.

9.0 Dissemination and Implementation

9.1 Dissemination

Following approval of procedural documents, it is imperative that all employees or other stakeholders who will be affected by the documents are proactively informed and made aware of any changes in practice that will result. All approved documents will be posted in PDF format on the extranet.
The author is responsible for ensuring the policy is disseminated to the appropriate groups and arranging awareness and or training sessions if necessary.

9.2 Implementation

Implementation issues including resources and training needs should be identified for each new and reviewed procedural document as an integral part of the approval process. Where necessary it is recommended that an implementation plan is produced to cover such issues as training, resources, involving service users and communications. Clarification of resource availability must be addressed and resolved prior to the approval process.

10.0 Document Control and Archiving

10.1 Document control

The Integrated Governance team will maintain a register of procedural documents which are ratified at Governing Body level. The Strategic Lead is responsible for maintaining a document control for any other documents

10.2 Document Archiving

Obsolete or superseded documents will be removed from the website and where relevant replaced with an updated version. Previous versions will be archived by the Integrated Governance team in accordance with the Records Management NHS Code of Practice; disposal and retention schedule.

11.0 Monitoring Compliance and Effectiveness

Monitoring tools must be built into all procedural documents in order that compliance and effectiveness can be demonstrated including where applicable monitoring under the Equality Strategy.

The approach adopted for this will depend on the document type but could include:

1. Audits
2. Patients' views and experiences
3. Benchmarking
4. Staff surveys
5. Annual reports
6. Environmental impact analysis
7. Complaints monitoring
8. Trend analysis
9. Incident reporting and monitoring
10. Monitoring ethnicity/diversity access.

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

1. Who is responsible for undertaking the monitoring or audit
2. The method to be used
3. Frequency of monitoring or audit
4. How the results will inform or improve practice

The adherence to this policy will be monitored through the procedure for producing a procedural document.

12.0 References

All procedural documents must include an accurate list of references used when compiling the document.

For this policy the following references apply:

- Template Policy for the Development and Management of Procedural Documents, NHSLA 2007

13.0 Associated Documentation

All documents must include details of any supporting/linked procedural documents which should be recorded on the Document Reference Information section on page 2.

Walsall Clinical Commissioning Group

TITLE OF DOCUMENT
in Arial 16 point Bold

The title must not start with the word policy to aid with alphabetical filing

The NHS Walsall CCG committee name approved this statement on:

Date: ……

Signed:
……
Chair of the committee

Signed:
……
Designated Strategic Lead

Please note that the Website version of this document is the only version that is maintained. Any printed versions should therefore be viewed as 'uncontrolled' and may not be the most up-to-date.

The footer must give the file name and pathway of the master version of the policy, page of page number and the title of the policy

Document reference information

Black narrative is suggested wording to explain/give the required information
Blue narrative is a guide to what you need to include in the section

Version:	Each version will be numbered sequentially i.e. v1.0, v2.0 etc. with the date it was produced. When a document is being reviewed each stage will be recorded as a different version, indicated as V1.1, V1.2 etc.
Status	Approved, Work in progress, Circulated for Consultation, Ratified
Strategic Lead/Manager responsible	Title
Title of originator/author:	Identified by the responsible Manager
Ratified by:	The committee/group who formally ratify the policy which is identified by the Strategic Lead
Date ratified:	Date that it went to the ratifying committee/group and was agreed
Date Policy is Effective From	This may be necessary in order to complete a training programme prior to implementation of the policy.
Review date:	This should be 3 months prior to expiry date
Expiry date:	This should be no longer than 3 years from ratification date
Date of Impact Assessments	See appendix 5 and 6
Target audience:	This a description of the groups of staff who will be affected by the document. It is important to include external agencies if relevant.
National/NHS Walsall CCG linked documents	List the existing policies that support or link to this policy. It is important to make reference to National and or NHS Walsall CCG documents that may cover the same areas of work.
Distribution of the document	Cascaded to Strategic Leads/managers/team leaders via email. Information agenda item for team meetings. Available on NHS Walsall CCG website.
Implementation of the document	How the document is going to be implemented. NB. Implementation issues including resources and training needs should be identified. Clarification of resource availability should be addressed and resolved prior to the approval process.

Document Control and Archiving	Obsolete or superseded documents will be removed from the website and where relevant replaced with an updated version. Previous versions will be archived by the Integrated governance team in accordance with the Records Management NHS Code of Practice; disposal and retention schedule.
Monitoring Compliance and Effectiveness	This should identify : Who is responsible for the monitoring The method used Frequency of monitoring How the results will inform or improve practice
References	All procedural documents must include an accurate list of references used when compiling a document

The topics covered in the grey shaded area above can be kept in this table but if the narrative for them is lengthy then it is best if they are put into the main body of the document.

CONTRIBUTION LIST

Key roles involved in developing the document

Designation

Circulated to the following for consultation

Committee/Group	Designation

Version Control Summary

Significant or Substantive Changes from Previous Version

A new version number will be allocated for every review even if the review brought about no changes. This will ensure that the process of reviewing the document has been tracked. The comments on changes should summarise the main areas/reasons for change.

When a document is reviewed the changes should using the tracking tool in order to clearly show areas of change for the consultation process.

Version	Date	Comments on Changes	Role

A contents page must be included for documents where the main body of the document is over 3 pages long.

Contents **Pg**

The shaded grey topics may be included in the document or included in the document reference section on page two.

Appendix 2 Checklist for the Review and Approval of Procedural Document

Title of document being reviewed:	✓ x	Comments
Title		
Is the title clear and unambiguous? It should not start with the word policy.		
Is it clear whether the document is a guideline, policy, protocol or standard?		
Rationale		
Are reasons for development of the document stated? This should be in the purpose section.		
Development Process		
Is the method described in brief? This should be in the introduction or purpose.		
Are people involved in the development identified?		
Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?		
Is there evidence of consultation with stakeholders and users?		
Content		
Is the objective of the document clear?		
Is the target population clear and unambiguous?		
Are the intended outcomes described?		
Are the statements clear and unambiguous?		
Evidence Base		
Is the type of evidence to support the document identified explicitly?		
Are key references cited?		
Are the references cited in full?		
Are supporting documents referenced?		
Approval		
Does the document identify which committee/group will approve it?		
If appropriate have the staff council approved the document?		

Title of document being reviewed:	✓ x	Comments
Dissemination and Implementation		
Is there an outline/plan to identify how this will be done?		
Does the plan include the necessary training/support to ensure compliance?		
Document Control		
Does the document identify where it will be held?		
Have archiving arrangements for superseded documents been addressed?		
Process to Monitor Compliance and Effectiveness		
Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?		
Is there a plan to review or audit compliance with the document?		
Review Date		
Is the review date identified?		
Is the frequency of review identified? If so is it acceptable?		
Overall Responsibility for the Document		
Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the documentation?		

Appendix 3 Equality Analysis Form

Equality Analysis

Please summarise below, for each Protected Characteristic group identified by the Equality Act 2010, the evidence you have used to determine that an Equality Analysis is not relevant. 'Not relevant' means that you are satisfied that there are no barriers to access or engagement to be considered and that the diverse needs of each group have been considered in the scope of the project. Evidence might draw on national reports; academic research; JSNA; Public Health intelligence; Patient or staff surveys; Complaints; Patient Experience Data; Local Engagement or Consultations. For support on these questions please contact Equality and Diversity Lead.

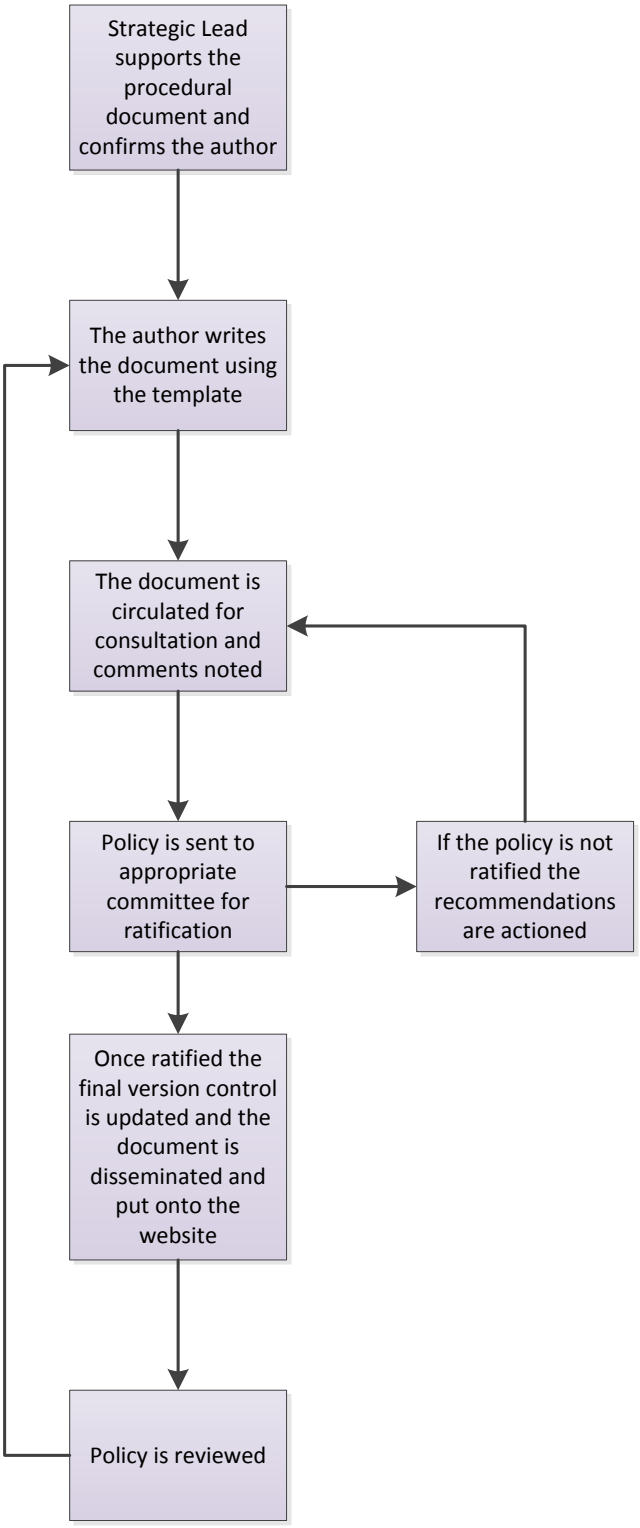
Protected Characteristic	Evidence used to consider anticipated impact of project.	Brief description of why Equality Analysis is not relevant
Age		
Disability		
Gender Reassignment		
Marriage and Civil Partnership		
Pregnancy & Maternity		
Race		
Sex		
Religion or Belief		
Sexual Orientation		
Other Groups (eg carers; transient communities; unemployed people...)		

Has an Equality Analysis been completed for this procedural document? YES ☐ NO ☐

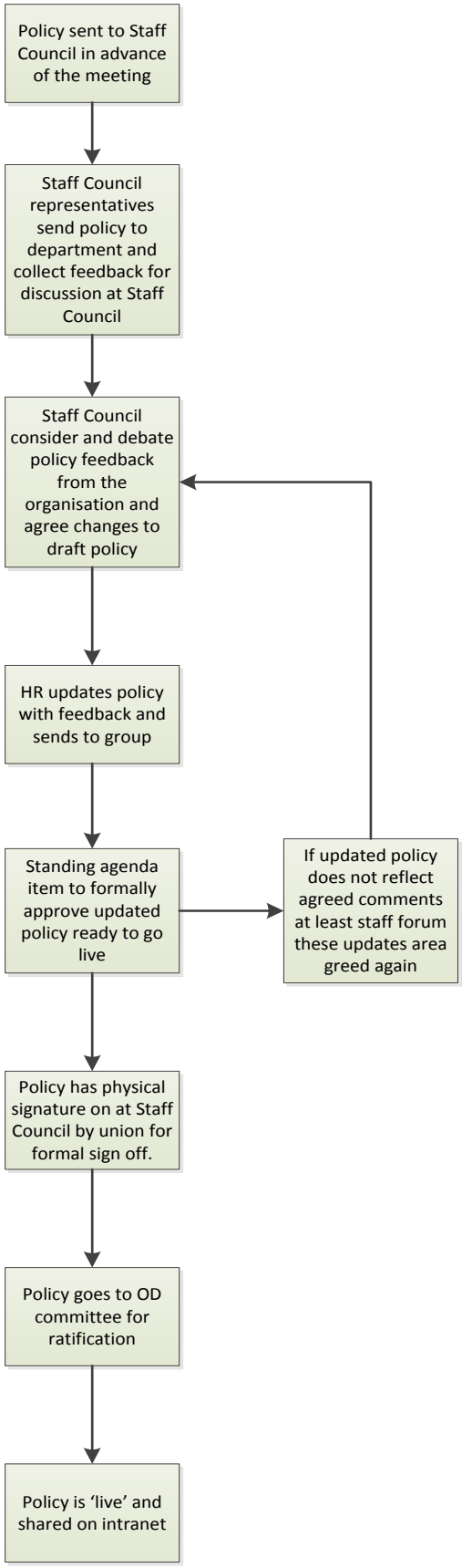
If YES, please contact Equality and Diversity Lead to complete the full assessment.

Appendix 4 Flow Chart for the Process of Policy Development

Process for procedural documents



Process for Human Resource Policy


Policy sent to Staff Council in advance of the meeting
Staff Council representatives send policy to department and collect feedback for discussion at Staff Council
Staff Council consider and debate policy feedback from the organisation and agree changes to draft policy
HR updates policy with feedback and sends to group
Standing agenda item to formally approve updated policy ready to go live
If updated policy does not reflect agreed comments at least staff forum these updates area greed again
Policy has physical signature on at Staff Council by union for formal sign off.
Policy goes to OD committee for ratification
Policy is 'live' and shared on intranet