Policy/Procedure/Guideline

POLICY FOR THE DEVELOPMENT AND MANAGEMENT OF PROCEDURAL DOCUMENTS

Version no: 1.0

Issue Status: Approved

Date of Ratification: April 2016

Ratified by: Clinical Governance & Risk Board

Policy Author: Bradley Woods

Policy Owner: CG&RB

Review Frequency: 2 yearly

Identifiable Document Code: PTUK014

Last Review: April 2020

Next Review: April 2022

POLICY AWARENESS	
People who need to know this policy in detail	All staff who develop policies, procedures and guidelines
People who need to have a broad understanding of this policy	Authors of clinical and non-clinical policies. Policy owners and managers
People who need to know this policy exists	All current staff and those on Induction

CHANGE CONTROL DETAILS			
Date DD/MM/YY	**Version**	**Description**	**Reason for changes**
11/04/2016	1	New policy	New Policy

Policy location:
Main Policy Folder in Control Room and Crew Room
On PTUK Server

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1.0 Introduction

An important element of the governance agenda is a consistent and systematic approach to the delivery of patient care and service processes. The consistency, appropriateness and implementation of policies, procedures and guidelines are essential tools in the delivery of high quality care.

Patient Transport UK (PTUK) is committed to continuous quality improvement and therefore believes that the processes outlined within this document provide a necessary framework to assist in the development, approval, implementation, monitoring and review of procedural documents within the organisation.

2.0 Purpose

The purpose of this policy is to provide all staff with guidance on the format, style approval, distribution and implementation of developing procedural documents within PTUK.

The policy must be used by everyone who is required to develop and implement policies, procedures and guidelines. No document will be passed for approval if this policy is not followed.

3.0 Duties

3.1 Duties within the Organisation

PTUK has ultimate responsibility and accountability for internal control. Internal control is the process whereby the ongoing policies, procedures, practices and organisational structures are designed to provide reasonable assurance that objectives will be achieved and that undesired events will be prevented or detected and corrected.

All Directors are responsible for the implementation of this policy.

The Clinical Governance & Risk Board is responsible for ensuring that procedural documents are updated within the detailed time. When revisions are made to policies, the obsolete policy must be archived for audit and litigation purposes.

3.2 Approval of Procedural Documents

Only the Clinical Governance & Risk Board with delegated powers of ratification can ratify new procedural documents.

4.0 Style and Format of Procedural Documents

For ease of reading, this document will now refer to all policies, protocols and guidelines as procedural documents.

At the time of writing or reviewing procedural documents the contents of the documents must comply with all relevant current legal and statutory requirements, and NHS policies and guidance (including those from NICE, National Service Frameworks, National Patient Safety Agency (NPSA) and NHS Litigation Authority (NHSLA)).

4.1 Style

The key features of a well written procedural document are that it:

- is clear, concise, jargon-free and is written in straightforward language
- has a clear purpose
- clearly states to whom the policy applies

4.2 Format

In order to ensure that procedural documents have a 'corporate' appearance all documents should be produced in accordance with the following:

- A standard front sheet must be used **(Appendix A).** The standard front sheet gives information about the version number, the author, the status of the document, reviews and change control details. The change control details provide information on all previous versions and the current version
- The PTUK logo should be placed in the top right hand corner of the first page
- The page set up should have margins set at 2.4cm.
- Titles should be formatted in Calibri 16 and should be centred
- The main document should be formatted in Calibri 12
- Headings should be numbered
- Sub-headings or paragraphs should be outline numbered e.g. 2.5
- Headings and plain text should be justified
- Footers should include the title of the document Calibri 12
- Page numbers should be included Calibri 12
- Each appendix should start on a new page
- See **Appendix B** for a list of standard contents pages and standard headings

5.0 Definitions

<u>Policy</u>

A policy is a specific statement of principles/guiding actions that provide a basis for consistent decision-making and resource allocation. Policies direct PTUK practice in fulfilling statutory and organisational responsibilities, and are contractually and legally binding on all employees.

<u>Procedure</u>

A procedure is a series of steps followed in regular order taken to implement a policy. Procedures can be mapped using a flow chart.

Guideline
A guideline defines best practice, guides conduct and acts in an advisory way.

Protocols
A protocol defines and restricts what must happen in a particular way. Protocols are a set of measurable, objective standards to determine a course of action.

Care Pathway
A care pathway is a multidisciplinary plan that predicts the course of events in the treatment of patients with similar problems and determines locally agreed practice in accordance with best practice.

6.0 The Development of Organisation-wide Procedural Documents

6.1 Prioritisation of Work

In consultation with the Clinical Governance & Risk Board, the originating author must specify:

- the justification and support for developing the new document
- how it links with service priorities
- how they have ensured that it is not duplicating other work

6.2 Identification of Stakeholders

The author must in conjunction with the Clinical Governance & Risk Board identify the relevant stakeholders and their level of involvement e.g. development, consultation, or receipt of final procedures.

Stakeholders include staff, external stakeholders, including service users for each type of procedural document.

6.3 Responsibility for Document Development

The originating owner in conjunction with the Clinical Governance & Risk Board is responsible for each procedural document under development.

6.4 Equality Impact Assessment

All public bodies have a statutory obligation under the Race Relation (Amendment) Act 2000 to “set out arrangements to assess and consult on how their policies and functions impact on race equality”.

In effect PTUK is required to undertake equality impact assessments on all policies/ guidelines and practices. This obligation has been expanded to include equality and human rights with regard to disability, age, gender and religion.

PTUK aims to design and implement services, policies and measures that meet the diverse needs of our services, population and workforce, to ensure that none are placed at a disadvantage over others. The Equality Impact Assessment Tool **(Appendix C)** is designed to help the author to consider the needs and assess the impact of each procedural document.

7.0 Consultation, Approval and Ratification Process

7.1 Consultation Process

The consultation process should be comprehensive and must include all stakeholders as identified in accordance with 6.2 above.

7.2 Approval Process

All procedural documents should be approved and ratified by the Clinical Governance & Risk Board.

7.3 Ratification Process

The Clinical Governance & Risk Board ratifies all policies.

8.0 Review and Revision Arrangements including Version Control

8.1 Process for Reviewing a Procedural Document

It is recommended that all policies are reviewed every two years or earlier if new legislation and guidance is introduced.

Amended documents will be disseminated and previous versions archived.

8.2 Version Control

The change control details on the front sheet of all procedural documents provide information on all previous versions and the current version.

9.0 Dissemination and Implementation

9.1 Dissemination

All procedural documents must be accessible to all staff in both electronic and paper form. All procedural documents will be placed in the Policy Folders located in the Control Room and Crew Room after they have been ratified by the Clinical Governance & Risk Board.

Communication of the introduction of new procedural documents will be through:

- Staff Notification Board
- Internal e-mails

Through the induction process, newly appointed staff will be made aware of relevant policies, procedures and guidelines and how to access them.

9.2 Implementation of Procedural Documents

Any training requirements associated with procedural documents must be identified. Discussions with the Clinical Governance & Risk Board should be undertaken where appropriate. Training requirements must be communicated to staff on dissemination.
All Directors, managers and clinical leads are responsible for the implementation and compliance of this policy.

NB. *It is the responsibility of individual members of staff to ensure that they are working with the current version of a policy/procedure/guideline.*

10.0 Document Control including Archiving Arrangements

10.1 Register/Library of Procedural Documents

The Clinical Governance & Risk Board will determine, manage and maintain the central library of procedural documents held within PTUK. The library should contain a list of all current procedural documents and the dates documents need to be reviewed by.

The Clinical Governance & Risk Board in association with the Directors are responsible for ensuring that procedural documents are updated within the detailed time.

All procedural documents should be sent to the Clinical Governance & Risk Board for approval and ratification. The document must have the following documents attached:

- a fully completed Equality Impact Assessment Form **(Appendix C)**
- Checklist for the Review and Approval of Approval Document **(Appendix D)**

The Clinical Governance & Risk Board will place the document within the relevant folder on PTUK staff intranet.

10.2 Archiving Arrangements

When revisions are made to policies, the obsolete policy must be archived for audit and litigation purposes. The Clinical Governance & Risk Board is responsible for ensuring this occurs.

Directors should liaise with the Clinical Governance & Risk Board so that PTUK's internet library can be updated. They in turn will liaise with the IT lead to ensure this occurs.

The Directors will hold a central library of paper copies of all procedural documents.

11.0 Monitoring Compliance and the Effectiveness of Procedural Documents

11.1 Process for Monitoring Compliance and the Effectiveness

The Clinical Governance & Risk Board will put in place a programme of audits to monitor the effectiveness of procedural documents, selecting areas perceived to be of risk.

These audits will be included in the audit programme and will be facilitated by PTUK's clinical lead. Results of the audits will be included in the annual report of the Clinical Governance & Risk Board.

12.0 Associated Documentation

In this section staff should detail links with other PTUK documents.

13.0 References

List references in date order (most recent reference first)

13.1 References for this Policy

NHS Litigation Authority Template Policy - An Organisation-wide Policy for the Development and Management of Procedural Documents
Promoting Equality and Human Rights in the NHS - A Guide for Non-Ex*ecutive Directors of NHS Boards (2005) Department of Health*
The Race Relations Act 1976 (as amended by the Race Relations (Amendment) Act 2000)
The Disability Discrimination Act 1995 amended 2005
The Gender Recognition Act 2004
The Civil Partnership Act 2004
Employment Equality (Religion or Belief) Regulations 2003
Employment Equality (Sexual Orientation) Regulations 2003
Health and Social Care Act 2001
Sex Discrimination (Gender Reassignment) Regulations 1999
The Human Rights Act 1998
The Sex Discrimination Act (as amended) 1975
The Equal Pay Act (as amended) 1970

14.0 Appendices

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Appendix A

Policy/Procedure/Guideline

TITLE

Version no: **Issue Status:**

Date of Ratification: **Ratified by:**

Policy Author:

Policy Owner:

Review Frequency: **Identifiable Document Code:**

Last Review: **Next Review:**

POLICY AWARENESS	
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Appendix B

Standard Contents Page

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Appendix C

Equality Impact Assessment Tool

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	No	
4.	**Is the impact of the policy/guidance likely to be negative?**	No	
5.	**If so can the impact be avoided?**	N/A	
6.	**What alternatives are there to achieving the policy/guidance without the impact?**	N/A	
7.	**Can we reduce the impact by taking different action?**	N/A	

If you have identified a potential discriminatory impact of this procedural document, please refer it to Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

Appendix D

Checklist for the Review and Approval of Procedural Document

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Is the method described in brief?	Yes	
	Are people involved in the development identified?	Yes	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?		
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are the references cited in full?	Yes	
	Are supporting documents referenced?	Yes	
6.	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	Yes	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Yes	
	Does the plan include the necessary training/support to ensure compliance?	Yes	
8.	**Document Control**		
	Does the document identify where it will be held?	Yes	
	Have archiving arrangements for superseded documents been addressed?	Yes	
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Yes	
	Is there a plan to review or audit compliance with the document?	Yes	
10.	**Review Date**		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so is it acceptable?	Yes	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Yes	

Individual Approval			
If you are happy to approve this document, please sign and date it and forward to the chair of the committee/group where it will receive final approval.			
Name		Date	11/04/2020
Signature			
Committee Approval			
If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.			
Name		Date	11/04/2020
Signature			