NHS
Orkney

Procedure on the Development, Consultation, Approval and Dissemination of Strategies, Policies, Procedures, Guidelines and Protocols

Policy Author:	Board Secretary
Policy Owner (for updates)	Board Secretary
Engagement and Consultation Groups:	Information Governance Group CMT
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Location of master document	Board Secretariat
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Access to document for staff	Blog
Access to document for public	
Post holders names at last review	
Board Secretary	Jean Aim

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1 Introduction

Policies, procedures, protocols and guidelines help NHS organisations and their staff to work to a set of standards in both clinical and non-clinical functions. NHS Orkney uses best practice policies, procedures and guidelines using national documents and by developing local solutions based on best practice evidence.

Policies, procedures, protocols and guidelines are tools to assist in the delivery of high quality services both by teams and by individuals, and collectively ensure that the organisation strives to offer the best services and outcomes for patients whilst minimising the risks associated with activities.

2 Purpose and Scope

1.1 NHS Orkney has identified the need for a Document Control Policy for the development, implementation and review of organisational policies.

1.2 This procedure will ensure that all NHS Orkney strategies, policies, procedures, guidelines and protocols are developed, consulted on, approved, disseminated, implemented, monitored and reviewed in a standardised manner, in accordance with best practice and NHS Orkney's management and governance arrangements.

3 Definitions

3.1 For the purpose of this procedure the following definitions apply:

Strategy A comprehensive document that defines a plan that the Board will follow to achieve a specified local or national objective and is adopted by the Board.

Policy A written statement, which conveys the general intentions, approach and objectives of the organisation. It enables management and staff to make correct decisions, deal effectively and comply with relevant legislation, organisational rules and good working practices.

Each policy should have a purpose and specific steps (procedures) as to how the policy is to be accomplished.

Procedure A set of detailed, step-by-step instructions that describe the appropriate method for carrying out tasks or activities to achieve the highest standards possible to ensure efficiency, consistency and safety.

Guideline Systematically developed statements which assist in decision

making about specific matters or issues. Guidelines:

- Acknowledge the need for flexibility to meet local needs and requirements;
- Identify clearly that the evidence is judged for its strength in assisting decision making;
- Ensure that appropriate consultation takes place;
- Evolve with time and changing evidence.

Attributes of all good guidelines include validity, reliability, applicability, flexibility, consultation, scheduled review and documentation.

Protocol Much more specific and directive than guidelines and stipulate the locally agreed standard of practice required in order to fulfil the objective. Only when required, in exceptional circumstances, should there be deviation from the protocol.

4 Procedure

4.1 Responsibility and Development

Responsibility for the effective management of NHS Orkney's strategy, policy, procedure, guideline, protocol documentation ultimately lies with the Chief Executive. Delegation for formulating, disseminating and controlling these documents falls to the lead Executive Director.

A strategy, policy, procedure, guideline or protocol will be developed under the direction / responsibility of the lead Executive Director for the service area. The need for the policy will be the responsibility of the lead Executive Director for example following the issue of new legislation or guidelines. However, the need for the policy **may be identified** at operational level however the lead Executive Director must be involved.

4.2 Responsibilities

Executive Lead Officer

The Executive Lead Officers are responsible for:

- Approving the development of a new policy
- Allocating a Policy Manager to lead the process
- Ensuring that policies are reviewed within the agreed timescale / review period

Policy Managers

Policy Managers are responsible for:

- Establishing a policy group to take forward policy development
- Ensuring appropriate consultation and engagement with relevant patients, staff, groups
- Co-ordinating production of draft policy including evidence of Equality and Diversity Impact Assessment
- Submitting the policy for approval and endorsement

All NHS Orkney Managers

Managers are responsible for:

- Communicating details of relevant policies to staff
- Implementing processes to ensure staff are aware of their responsibilities in relation to policies
- Develop method to allow staff an opportunity to address any policy implementation processes

4.3 **Production**

All strategies, policies, procedures, guidelines and protocols must, unless professional accreditation guidelines direct otherwise (for example Laboratory Services), be produced in the standard NHS Orkney corporate format as set out in Appendix 1. A master template is attached as Appendix 2.

4.4 **Consultation**

If the strategy or policy impacts on clinical service delivery the document must be submitted to the Area Clinical Forum for consultation and comment on behalf of the professional bodies (Area Medical Committee, Area Dental Committee, Nursing and Midwifery Committee, Therapy Rehabilitation and Diagnostic Advisory Committee, Area Optical Committee and Area Pharmaceutical Committee). Document to be sent to Board Secretariat.

Advice should be sought from the Employee Director as to whether or not the document should be considered by the Area Partnership Forum. If the document has any impact on staff, formal consultation must take place through the Joint Staff Negotiating Committee and Area Partnership Forum.

If the document impacts on services provided jointly by Orkney Health and Care it will be necessary to submit for comment through the Chief Officer Integration Joint Board.

Patients and service users should be involved in the development of all

strategic and policy documents relating to service provision through NHSO Public Partnership Forum. The Director of Nursing and Allied Health Professions can advise on appropriate route and contact.

Consultation should be carried out with all relevant parties in parallel before being Equality and Diversity Impact Assessed. Parties consulted with should be recorded on matrix on front page of document. The role of established groups in consultation is to obtain the engagement of the relevant stakeholders so that implementation is done positively and substantially.

A record of all comments / suggestions received during the consultation period should be retained and if not incorporated into the document a reason / explanation given as to why not.

4.5 Impact Assessment

NHS Orkney is required to demonstrate that the impact of any strategy or policy has been fully considered so that any part of the community who might be disadvantaged by this strategy or policy direction can be identified before implementation.

Direct and indirect discrimination, harassment and victimisation are all unlawful on the grounds of race, disability, sexual orientation, religion or belief, age, gender reassignment, marriage and civil partnership, pregnancy and maternity and sex (male or female). A rapid impact assessment must be carried out for all strategy and policy development, which may on occasion lead to a full Equality Impact Assessment being undertaken.

Executive Directors are responsible for ensuring that impact assessments are carried out. Training has been provided throughout the organisation and a member of the department / area producing the document should carry out the rapid impact assessment.

4.6 Approval and Dissemination

Strategies and Policies

All strategy documents must be approved by the Board and policy documents by the relevant Board Governance Committee before being implemented by the organisation. (Finance and Performance, Staff Governance, Quality and Improvement). Appendix 4 gives guidance on Executive Leads' areas of responsibilities and a list of all committees.

Policies should be forwarded to the lead Executive Director who will pass them to the Board Secretariat for inclusion on the agenda of the next scheduled Board Governance Committee.

The policy should be submitted with a covering report produced by the lead Executive Director within the agreed timeframe in advance of the meeting. The policy will be reviewed at this meeting and a decision taken regarding

ratification. Should the ratification be made by a Standing Committee of the Board, then it will be formally confirmed, by reference to that Committee Chair's report at the next full Board meeting.

It may be that the author attends the Committee to answer any questions raised.

When approved, the Lead Executive Director will be responsible to ensure appropriate distribution.

If the policy is not ratified it will be returned to the originator with an explanation of why it was not accepted and if applicable advice on changes required for resubmission.

Non-Clinical Procedures, Guidelines and Protocols

It is the responsibility of the relevant lead Executive Director to ensure that non-clinical procedures, guidelines and protocols are developed and consulted upon with anyone involved in or affected by them. Once finalised the procedure, guideline or protocol should be signed off by the appropriate lead Executive Director and implemented.

Clinical Procedures, Guidelines and Protocols

Clinical procedures, guidelines and protocols should be consulted upon with anyone involved in or affected by them (including patients if appropriate). The procedures should then be approved by the clinical group most closely involved. They are then submitted to the Safe and Effective Care Group with the appropriate control sheet

Librarianship

A central register of all strategies, policies, procedures, guidelines is maintained to ensure that documents are kept up to date and are accessible to all staff. The central register is managed by the Policy Register Holder (Board Secretariat). The documents are accessible to staff via a link on the blog.

Documents are currently accessible on the blog in the following spaces:

- Clinical Documentation
- Finance
- Health and Safety
- Human Resources
- Infection Control
- IT
- Management
- Public Health

4.7 **Dissemination to Individuals at local level**

The document will be disseminated to department or ward level. To become effective it must be read and understood by staff. All new staff should be made aware of the Board's primary policies and procedures as part of their mandatory corporate induction process.

Copies of policies and procedures are held on the NHS Orkney blog and staff must be made aware of this. It is the responsibility of the Departmental Head or the Senior Charge Nurse or Midwife to ensure that all staff in their respective teams are able to access the NHS Orkney blog.

It is the Board's responsibility to ensure that staff understand the content of newly issued documents and how the content of these documents may impact on them or their practice.

The communication of new policies and procedures will be reinforced through ward / department meetings, Team Orkney Communication, team briefs, e-mail and newsletters. If required training will be provided to staff.

4.8 **Review and update**

It is essential that a review of a strategy, policy, procedure, guideline, protocol be taken timeously. They should be reviewed at least every two years or earlier in the event of significant change in working practices or organisational structure, and in response to identified deficiencies, incidents or complaints.

It is the responsibility of the lead Executive Director to ensure that there is an effective review process within their department or area of responsibility.

4.9 **Joint Policies**

Some policies especially those relating to adult and child protection are developed with other agencies. It would be deemed good practice to use the guidance contained within this procedure when such joint policies are being developed, reviewed, implemented and monitored.

4.10 **Monitoring and Review**

All strategies, policies, procedures and other documents will be saved in EQIA folder on the G drive when received by Board Secretariat and recorded on the register.

The Policy Register Holder (Board Secretariat) will arrange for quarterly reports to be produced from the register of all documents, stating whether they are up-to-date or not and this will be monitored by the relevant Governance Committee of the Board.

Reminders will be sent by Board Secretariat to the Lead Director three

months before the document is due to be reviewed.

4.11 Version Control

The recommended version control system simply gives a number to each version of a document. For example:

Version 0.1	Draft version
Version 0.2	Draft Version
Version 1	First finalised version
Version 1.1	Subsequent amendments to first issued version
Version 1.2	Subsequent amendments as a result of consultation
Version 2	Finalised version

This is recorded in the table on the front cover of the document.

Once the document is finalised all copies of drafts should be deleted.

A record of comments received and from whom should be maintained by the policy author and included in the covering report when submitted for approval.

Appendix 1

Format required for strategies, policies and procedures (including appendices) – based on RNIB Guidelines 'See it right'

√ Arial font size 12 to be used throughout

√ Text is left aligned

√ Words are not split between lines

√ No large blocks of capital letters

√ No words are underlined (use bold or italics)

√ Section headings are in arial font size14 bold

√ 1 line space between paragraphs within numbered section heading

√ 2 line spaces between numbered section headings

√ Section headings and paragraphs to be numbered

2

2.1

3

3.1

3.2

all numbers to be at left margin

√ Punctuation when using bullet points

The concerns raised were:

- cost
- public perception
- security
  (lower case unless using names)

The concerns raised were the:

- costs that would be incurred, particularly at a time where the organisation is looking for economies;

- public perception of the accessibility of the service;
- security of the staff (there have been five verbal and two physical assaults in the last six months).

If the text is a series of complete sentences, it should be punctuated accordingly (with capital letters and full stops).

√ Page numbering should be contained in the footer, centred and displayed ‘page 1 of 16’

√ No acronyms or abbreviations to be used throughout document unless explained when first used in the document

√ i.e.; e.g.; and etc. not be used

√ no named individuals – job titles only

√ when using flow charts ensure font size is no smaller than 12

√ avoid use of colour

Example document

NHS Orkney

Appendix 2

Name of Policy and Procedure **(font size between 18 and 36)**

Policy Author:	
Policy Owner (for updates)	
Engagement and Consultation Groups:	
Approval Record	**Date**
Equality and Diversity Rapid Impact Assessment	
Version Control	
Version Number	
Date of Original Document	
Last Change and Approval Date	
Last Review Date	
Next Formal Review Date	
Location and Access to Documents	
Location of master document	
Location of backup document	
Location of E&D assessment	
Access to document for staff	
Access to document for public	
Post holders names at last review	

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Telephone: (01856) 888000 ext. ---- or
email xxxx@nhs.net (font size 18)

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1 Heading (Arial 14 font bold)

1.1 Text (Arial 12)

2 Definitions (2 blank lines between headings)

2.1

Appendix 3

Checklist

Area:
Title:
Manager:

Action:	**Completed:**
Before writing a new policy / procedure etc check to see if a document already exists that could be amended or updated	
Agree need for document with lead Executive Director	
Establish Policy Working Group	
Draft document using master template	
Identify who document impacts on	
Consult / get feedback from relevant people / groups	
<u>If regarding clinical and service delivery</u> • Area Clinical Forum – pass to Board Secretariat	
<u>If regarding workforce</u> • Joint Staff Negotiating Forum / Area Partnership Forum – check with Employee Director	
<u>If regarding joint services</u> • Orkney Health and Care – pass to the Chief Officer Integration Joint Board	
<u>If regarding services</u> • Patients and the public – through Public Partnership Forum for Orkney Health and Care services – Director of Nursing and Allied Health Professions to advise for hospital services	

Action:	**Completed:**
Finalise, taking account of comments received, where appropriate	
Once this process has been completed undertaken an Equality and Diversity Impact Assessment	
Once Impact Assessed pass with covering report to the relevant lead Executive Director to submit to Board (strategies) or Governance Committee (policies) for approval	
Following approval arrange to upload final version of document to departmental documentation section on blog	

Appendix 4

Strategies, Policies, Procedures, Guidelines and Protocols within NHS Orkney

All policies and procedures should be developed and signed off by the appropriate Director, Standing Committee or other committees and working groups with an Orkney wide remit

Executive Leads – Areas of Responsibility	
Corporate Lead	***Responsibilities***
Chief Executive	– Accountable Officer – Health Intelligence – Community Planning – Single Outcome Agreement – Communication – Service Improvement – Civil Contingency
Director of Finance	– Financial Balance – Shared Services – Capital Planning – Management of Capital Programme and Capital Projects – Information Technology – Performance and Planning – Support services – Health and Safety – Service Level Agreements
Director of Nursing, Midwifery and Allied Health Professions	– Nursing and Midwifery – Allied Health Professionals – Nursing Quality and Governance – Healthcare Associated Infection – Maternity Services – Spiritual Care – Patient Focus Public Involvement – Patient Experience – Volunteering – Equality and Diversity – Pharmacy
Medical Director	– General Medical Services – General Dental Services – Mental Health – Consultant Services – Medical Workforce – Diagnostics – Clinical Governance – Risk Management

Executive Leads – Areas of Responsibility	
Corporate Lead	***Responsibilities***
	– UNPACS
Head of Human Resources Services	– Staff Governance – Workforce Plan – Organisational Development
Director of Public Health	– Health Improvement – Health Protection – Port Health – Designated Medical Officer to the Local Authority – Information Governance

Governance Committees

Audit Committee
Finance and Performance Committee
Quality and Improvement Committee
Staff Governance Committee
- Remuneration Committee

Advisory Committees to Board

Area Clinical Forum
- Area Dental Committee
- Area Medical Committee
- Area Pharmaceutical Committee
- Nursing and Midwifery Advisory Committee
- Therapy Rehabilitation and Diagnostic Advisory Committee

Other NHS Orkney Committees or Working Groups

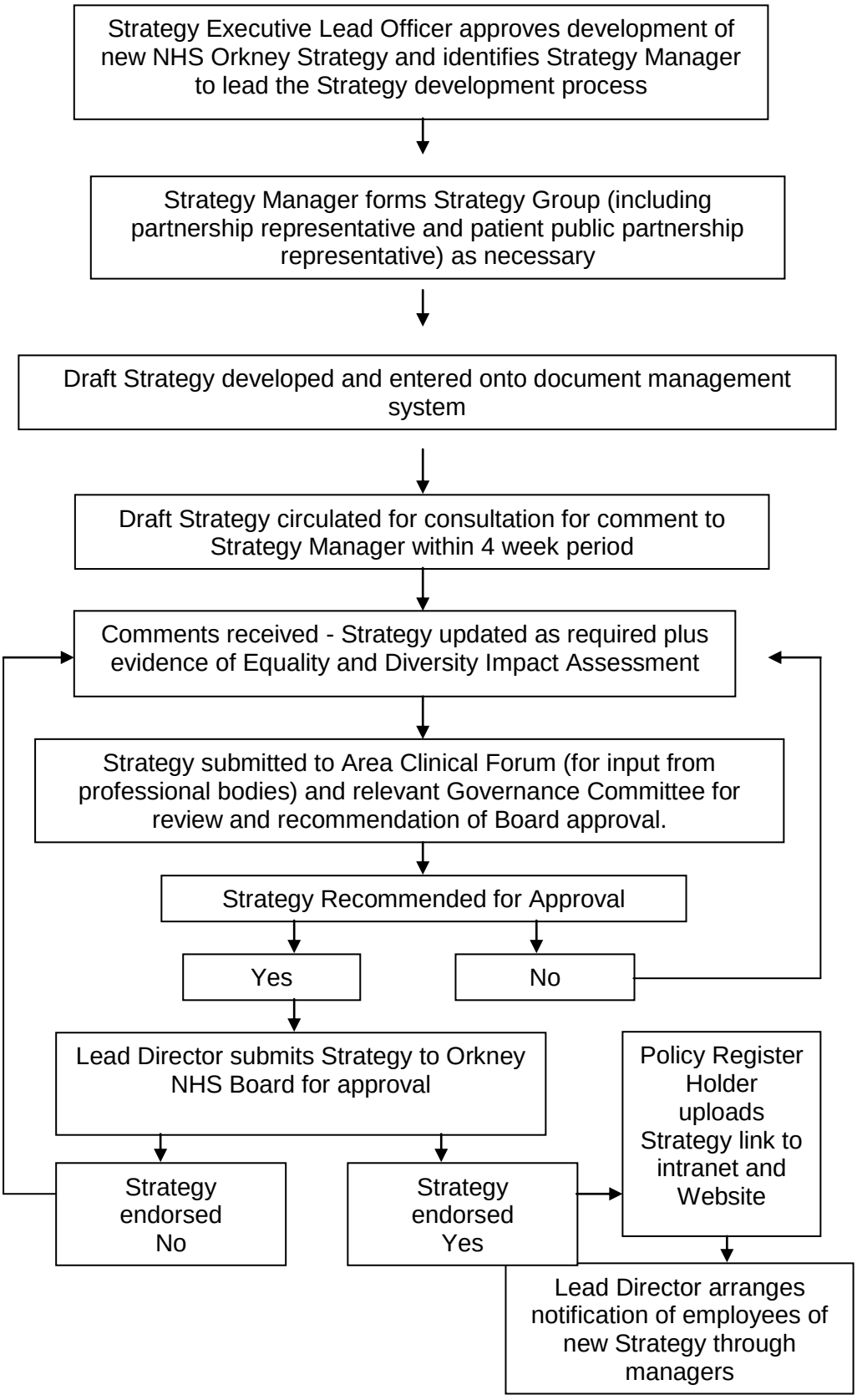
Examples include:

Area Partnership Forum
Safe and Effective Care Group
Person Centred Care Group
Population Based Health Group
Endowment Fund Sub Committee
Occupational Health and Safety Committee
Infection Control Committee
Information Management and Governance Group
Medical Equipment Group
Radiation Protection Committee
Civil Contingencies Steering Group
Area Drugs and Therapeutics Committee

For clarification on the most appropriate Director, Board Standing Committee or other committee and working groups with responsibility for developing and signing off policies and procedures contact either the Board Secretary (888228) or the Health Intelligence and Clinical Governance Manager (888283).

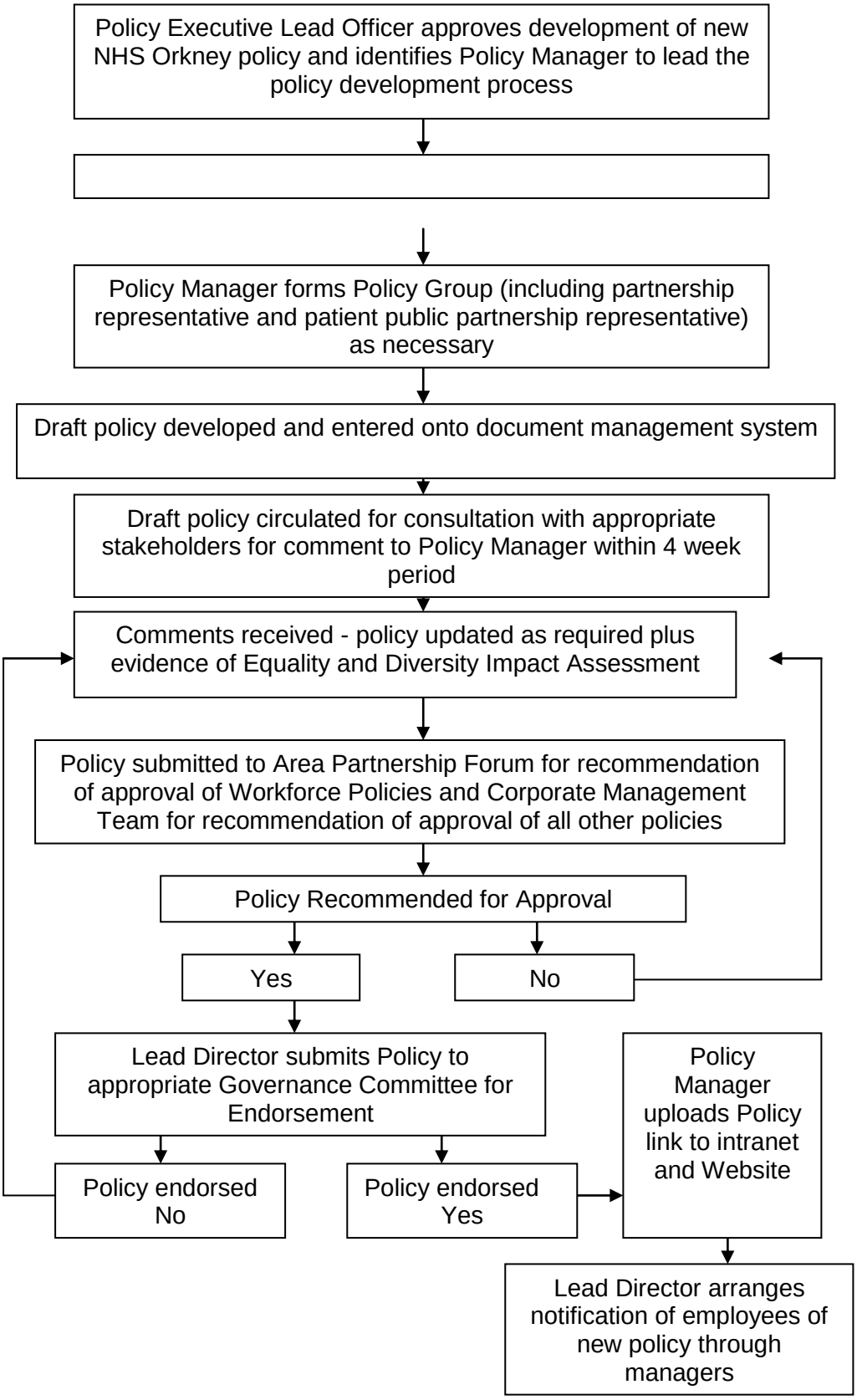
Appendix 5

Route Map for Strategy Development



Appendix 6

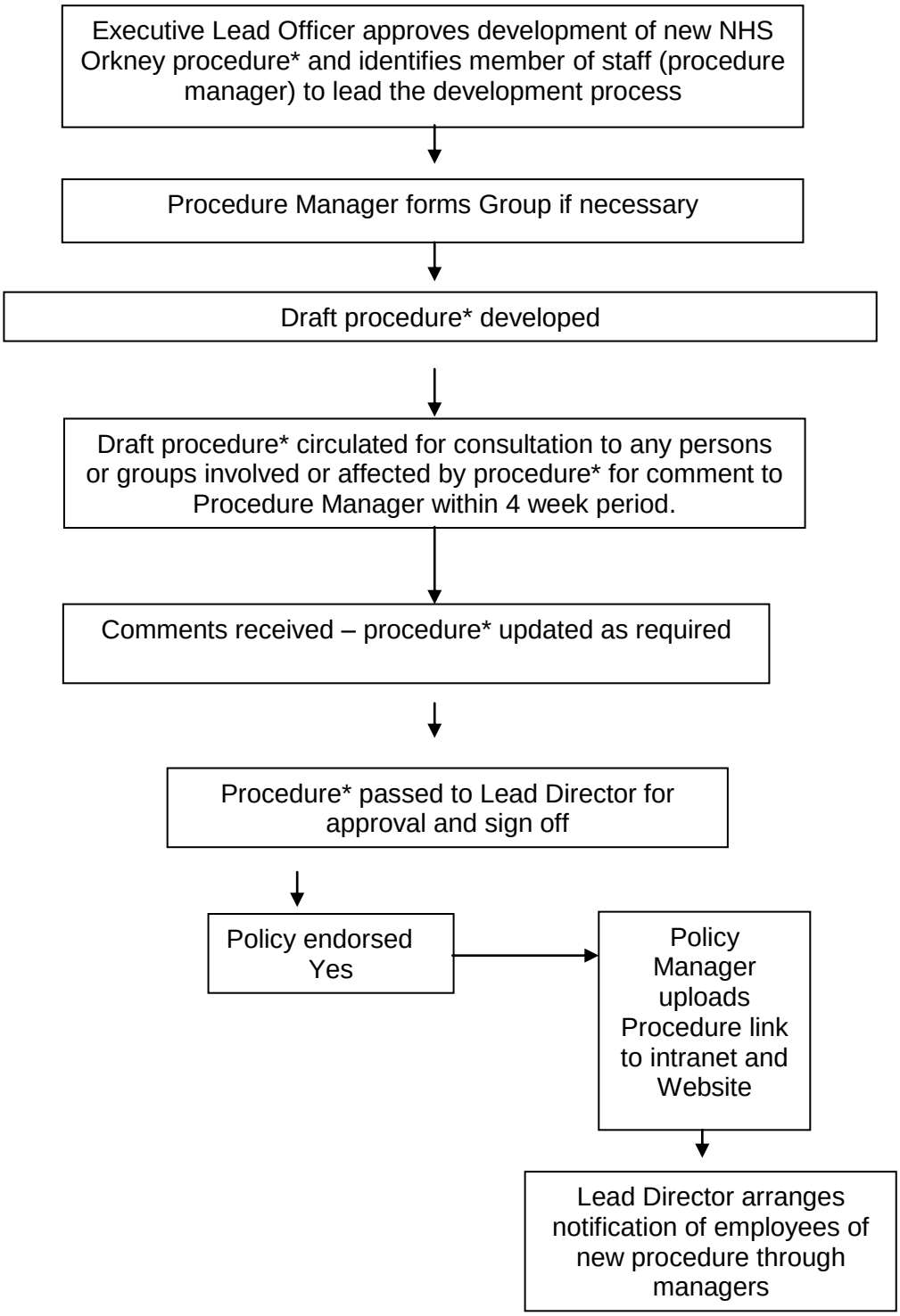
Route Map for Policy Development



Appendix 7

Route Map for non clinical Procedure* Development

(*covering non clinical procedures, guidelines and protocols)



Appendix 8

Route Map for clinical Procedure* Development

(*covering clinical procedures, guidelines and protocols)