NHS

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Related Trust Policies (to be read in conjunction with)	MSBPO-18002 Information Cycle Management

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6.3	Sarah Moon	Clarification to point 11.5.1 & Appendix 1	5th December 2019

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1. Purpose

1.1 The purpose of this policy is to describe the Trust's approach to the development, approval, publication and archiving of Trust documents.
(Refer to MSBPO-18002 Information Cycle Management)

1.2 To provide a robust process for Trust staff to follow that ensures that all Trust procedural documents meet the standards required by:

- Care Quality Commission Outcomes;
- NHS England Corporate Document and Records Management Policy;
- NHS Resolution.

1.3 As the majority of Trust documents are routinely published to the external facing website in accordance with the Trust's obligations under the Freedom of Information Act 2000, it is to ensure all Trust documents are written and presented to a single high standard.

2. Aims

2.1 To ensure that there is a complete audit trail from authorship to Trust ratification via appropriate consultation to satisfy the requirements of internal and external auditors.

2.2 To ensure that there is a structure provided for all authors that clarifies all the essential components irrespective of subject matter.

2.3 To ensure that documents are appropriate, up to date, and reflect best practice.

2.4 That the approval and ratification process is objective, appropriate and robust.

2.5 Provides a process that is fair, accessible and meets the needs of all individuals.

3. Scope

3.1 This policy applies to all documents that contain an element of required action by the Trust, by departments or by individual staff. Furthermore, any document that has any of the following in the title:

- Strategy;
- Policy;
- Clinical guideline;
- Procedure;
- Protocol;
- Handbooks (in some cases).

3.2 This policy excludes:

- Patient information leaflets;
- Local adopted protocols extracted from ratified policies;
- Trust reports; or

- Any document providing information about the Trust.

4. Overview of the Process

4.1 The Trust has to be able to demonstrate that all of its documents set out in 3.1 have been through a proper process to ensure that all the elements of the process can be substantiated specifically:

- Appropriate authorship;
- Appropriate consultation;
- Professional/technical approval;
- Trust ratification at the Document Ratification Group (DRAG);
- Trust Executive sign off.

4.2 The process is set out in detail in the flowchart in Appendix 1.

4.3 Documents cannot be considered cleared for use until the author/s are notified that DRAG has ratified the document and that it has been uploaded to the Trust Intranet/Internet.

4.4 The Trust Board designates the Senior Management Group to sign off the Document Ratification Group (DRAG) minutes on behalf of the Trust Board. The DRAG minutes have all approved and unsuccessful documents embedded within it.

4.5 In the event that the sign-off group consider that there is a problem with any content the document will be removed from the intranet and be replaced by the previous version, the author/owner will be notified and the process recommence from the beginning.

5. Consultation

5.1 Constructive critique is a good thing and owner/authors need to involve appropriate stakeholders prior to the formal submission of any document and record the details on the document covering pages. Consider whether external consultation such as Social Services, PCT or service users would be supportive.

5.2 It is the owner/author's responsibility to identify the appropriate bodies, groups, or committees to be consulted, in the knowledge that DRAG will take the consultation list into account when making its decision as to whether or not to ratify the document.

5.3 The Warner Library staff are also a robust resource for undertaking a literature search to ensure the document is based on the most current evidence and relevant national guidelines.

5.4 Some consultation however is now designated:

- All clinical policies and guidelines that contain drug names, prescriptions, dosages, or intervals between dosages – the specialist pharmacist for that speciality must be consulted;
- All nursing policies must record the Director of Nursing as being either consulted or as being the Professional Approver (refer to section 6);

- All major Human Resources (HR) Policies e.g. sickness, disciplinary or leave policies must demonstrate that the HR policy group has been consulted.

5.5 Where technical or legislative assurance is required, this may be sought from experts in other NHS organisations prior to internal professional approval. An example of this would be health and safety or IT security documentation, where there is no-one in the Trust who would have more knowledge or equivalent knowledge than the author.

6. Professional Approval

6.1 This is the most significant step in the process. The primary responsibility for the document rests with the professional approver.

6.2 By professionally approving a document, a "statement of assurance" is being made to the Trust Board that:

- The document is technically/professionally/legally correct;
- The document represents best practice and meets all current external drivers such as CQC outcomes, British standards, NICE guidance, safety legislation etc.;
- The consultation process has been appropriate;
- That resources are available such that the requirements of the policy can be met;
- The professional approver accepts responsibility for the clinical/technical content.

6.3 The owner/author cannot be the Professional Approver.

7. Document Ratification Process

7.1 DRAG ratifies Trust documents on behalf of the Trust Board.

7.2 Once ratified by DRAG, documents are released promptly to avoid delaying implementation, however DRAG minutes are still open for scrutiny by the nominated executive sign off group or committee.

7.3 DRAG is a representative group as every Trust specialty cannot be represented in one small group, DRAG will expect that the technical information as set out in section 5 will be correct and substantiated.

7.4 The elements that DRAG will particularly be focusing on in each document include the following, (however this is not an exhaustive list):

- Does the presentation meet Trust and Department of Health criteria?
- Is it clear which staff will be affected by the document?
- Have all training issues been identified?
- Are staff communication and implementation details clear?
- Are all required elements covered?
- Is the consultation process adequate?
- Is the professional approver appropriate for the subject matter?
- Is the proposed method of audit and subsequent report satisfactory?
- Is a completed Equality Impact Assessment form attached?

7.5 After each DRAG meeting, the Policy and Document Management Officer will:

- Notify authors of the outcome;
- Send the minutes containing embedded ratified documents to the sign-off committee i.e. Senior Management Group (SMG);
- Ensure documents are posted on the intranet and on the website with the exception of documents deemed to be sensitive. The default position is that all documents will be made public unless there is a significant reason why they should not by the author/professional approver;
- Pass details of uploaded documents to the Warner Library for cataloguing.

8. Group Document Control Ratification Process

8.1 Clear, consistent Trust documents such as strategy, policy, procedure, standard operating procedure (SOP), guidelines, clinical guidelines, healthcare records documents and patient information are essential tools in the effective management of risk. Any member of staff who currently is, or is likely to become involved, in the development or review of a group's document must be aware of the Group Document Control Ratification Process.

8.2 Appendix 8 sets out how documents will be developed across the MSB Group and the format that must be followed and the final ratification process.

8.3 The purpose is to:

- Provide a systematic approach across the 3 Trust sites to the development and approval of documents;
- Sustain a corporate image in all documentation used throughout the 3 Trust sites.

8.4 All new and revised documents must comply with the requirements for document control and use the standard MSB policy template. Once approved by the relevant committee / group, the document should be sent to one of the following contacts listed below for approval at the joint document management group.

- MEHT - Policies.Guidelines@meht.nhs.uk
- SUHFT - document.control@southend.nhs.uk
- BTUH - DocumentControl@btuh.nhs.uk

9. Responsibilities

9.1 Role of the Trust Board

9.1.1 The Trust Board has ultimate responsibility for the approval of all Trust policies of any type but day to day responsibility is delegated to DRAG. There are some cornerstone documents set out in the Trust Scheme of Reservation and Delegation that the Board **must** approve without delegation to DRAG which are currently:

- Code of Conduct including Nolan Principles;
- Risk Management Policy;
- Health and Safety Policy;
- Environmental Policy;
- Communications Policy;
- Major Incident Plan & Business Continuity Plan;
- Complaints Handling Policy;
- Speaking Up How to raise a Concern Policy;
- Plus any that the Board decrees that it requires to approve.

9.1.2 The documents in 3.1 will be first considered by DRAG to ensure that all the standards in 7.4 are covered before referring them to the Board.

9.1.3 The Trust Board delegates signed off of DRAG ratified documents to an executive meeting; this is currently the Risk and Compliance Group.

9.2 Role of the Chair of DRAG

- To agree new members to sit on DRAG;
- To chair DRAG meetings;
- To give Chairman's Action to the ratification of new or amended policies and clinical guidelines as deemed appropriate at any time;
- To approve time extensions of policies and guidelines where the contents have not changed, on an as required basis;
- To provide DRAG minutes at the Risk and Compliance Group monthly meetings.

9.3 Role of the Deputy Chair of DRAG

9.3.1 In the absence of the Chairman, the Deputy Chair can undertake the roles of the Chair of DRAG as outlined in point 9.2.

10. Trust Document Front Page

10.1 The Trust front page is to be completed and updated as necessary for all documents covered by this policy. Version control is set out in section 13; also refer to the author's checklist outline in appendix 3.

10.2 The ratification issue date on the front page denotes the date with which the policy was uploaded to the Trust Intranet and becomes 'live'.

10.3 The ratification issue date, in conjunction with the review date are used to calculate the period of time with which the policy/guideline will remain compliant and subsequently expire i.e. a policy that was uploaded on 15th September 2019 will expire 3 years hence at midnight on 14th September 2022.

10.4 For policies/guidelines that pre-dated this process and for policy/guideline extensions the document will remain compliant until the first day of the month i.e. if a policy is granted an extension until September 2019 (i.e. 30th September 2019); it will only become non-compliant on 1st October 2019.

10.5 For policies/ guidelines granted extension as of 18th October 2019 a precise date will be documented i.e. 30th October 2019.

11. Document Definitions

11.1 Documents are primarily defined by their purpose rather than their title. A policy can be a Trust cornerstone document or it can be a relatively minor document that deals with a detail of Trust business.

11.2 There are three main types of documents and these names will also be the terms used on the intranet and external website, specifically:

- Corporate strategic;
- Policy (Non Clinical);
- Clinical policy and guidelines.

11.3 **Corporate /Strategic**

11.3.1 Refers to basic directional decisions of the organisation, that is, to purposes and missions.

11.3.2 Consists of the important actions necessary to realise these directions.

11.3.3 Answers the question “what should the organisation be doing” e.g. risk management policy. Answers the question “what are the ends we seek and how should we achieve them”.

11.3.4 Includes what the Trust is legally required to have in place in terms of documentation e.g. Standing Financial Instructions.

11.4 **Policy (non-clinical)**

11.4.1 Sets out the commitment of the Trust to follow a particular course of action. Is informed by legislation, professional regulation, national policy directives, codes of practice.

11.4.2 Requires employees to operate within defined boundaries.

11.5 **Clinical Policy or Guideline**

11.5.1 Any document that sets out a clinical or therapeutic procedure/protocol to follow to include clinical care pathways and standard operating procedures.

11.5.2 Any document that provides clinical information on which to base a decision about clinical or therapeutic care.

11.5.3 Informed by NICE (National Institute for Health & Care Excellence), NHS Improvement, other national guidelines, best practice, clinical directives and codes of practice.

11.5.4 May reflect decisions the Trust has made about clinical practice that are not reflected nationally. These may be based on what the Trust can do and has decided to do in view of the constraints (which should be documented).

11.5.5 Any document that answers these types of questions:

- How and when do I undertake this clinical task?
- What do I need to take into account when I undertake this task?
- What is the procedure for undertaking this task?
- How and when shall I administer this medicine?
- How shall I use this equipment?

12. Document Presentation

12.1 It is the responsibility of the author of the document to ensure that every document is prepared in accordance with the Trust presentation standards. However, the Policy and Document Management Officer is available as a resource to guide and support the author.

12.2 The Trust is aiming to achieve a single corporate appearance to its documentation which means that authors need to comply with Trust style guidelines and layout requirements.

12.3 Authors must refer to the following additional documents:

- Guide to producing a document;
  (Refer to Appendix 2)

- Author’s checklist (before submission).
  (Refer to Appendix 3)

12.4 No document should have a review period of more than 3 years.

13. Version Control

13.1 In principle the rules are:

- Each new ratified document will be numbered with the next sequential number before the dot e.g. 1.0, 2.0 3.0.

- Each draft version should be numbered after the dot e.g. 1.05draft and add authors initials.

- A new whole number is only awarded after ratification.

- Where an author revises a policy, the document review history must be completed. The current version number should be recorded with a summary i.e. full revision/ clarification to point/appendix etc., together with the name of the person making the change.

13.2 The exception to this rule is when there are minor amendments required to a document that not amounting to "a revision" and is required whilst a document remains current. For example when a law or core standard changes or when NICE issues a new guideline; or there is simply "something missing" in these cases the document can be reissued with another number **after** the dot i.e. 3.0 is reissued as 3.1. **However this may not occur if the document has reached its revision date.**

13.3 Minor amendments between revisions can be carried out without the necessity for resubmission to DRAG. For those minor amendments that relate to clinical issues, the clinical lead must approve the revision. Otherwise approval may be given by any of the following:

- The Trust Board Secretary (Chair of DRAG);
- Deputy Chair of DRAG (in the absence of the Chair)
- The Caldicott Guardian;
- The CQC lead.

13.3.1 All policies and guidelines that are granted Chair's action should be embedded in the DRAG agenda for information and final comment.

13.4 **Trust Secretary (DRAG Chair)**

13.4.1 Where a document must be developed urgently in response to an identified need, an interim document may be issued as a "working draft" until such time as it can be submitted to DRAG for formal ratification. In these cases the document must be clearly marked 'Working Draft' and be subject to review in no more than 6 months' time.

13.4.2 The Trust Secretary may approve a document by Chair's Action if:

- A document that is urgently needed has missed the deadline for consideration by DRAG. Chair's action should be ratified at the next DRAG meeting;
- A document that is deemed by DRAG to need additional work to enable it to be published. In these circumstances the DRAG Chair can ratify the document after the meeting on checking that the required work has been done.

13.5 **Deputy Chair**

13.5.1 In the absence of the Chairman, the Deputy Chair can undertake the roles of the Chair of DRAG as outlined in point 13.4.

13.6 Once a new version is ratified, all previous versions will be removed from view from the intranet and website, but archived electronically by the Policy and Document Management Officer. Additionally all published versions are also retained in the manual of archived policy/guideline folders (electronically and hard copy).

13.7 In addition, the Policy and Document Management Officer should complete the DRAG process for upload of policies and guidelines checklist to ensure that the archive process is complete and therefore reducing the risk of non-compliance.

14. Trust Document Register

14.1 All documents must have a Trust register number. The Trust Policy Register is held by the Policy and Document Management Officer who can provide register numbers for staff when reviewing existing and creating new policies/guidelines.

14.2 The Trust Policy Register records the basic details from the front page.

14.3 The Trust Policy Register is colour coded:

- Green — Current policy and within date;
- Red — Non- compliant policy and out of date;
- High Amber — Review of policy due in next month;
- Low Amber — Review of policy due in next 3 months;
- Purple — Review of policy due in next 6 months.

15. Keeping Policies Up to Date

15.1 The Trust Policies Webpage is available on the Trust Intranet via the Document tab bar on the front page; and then click Trust Policies. The following links and information can be resourced:

- Trust Policy and Guidelines Register;
- MSB Policy Document Log;
- External Policy Register;
- Search for Trust policies by Division;
- Search for Trust policies by key word or phrase;
- Joint MSB policies listed;
- External policies and guidelines listed.

15.2 In addition, the information regarding antimicrobial prescribing can be resourced via MicroGuide accessed via the link on the front page of the Trust Intranet. The MicroGuide app stores all previous versions of antimicrobial prescribing.

15.3 The Mail Merge system is set up to automatically send email reminders to both authors (asset administrators)/ owners (asset owners) at 6 months, 3 months, 1 months prior to the out of date status and also when the policy is flagging red noted as non-compliant status.

15.4 It is the responsibility of the Clinical Directors/Associate Directors of Nursing (asset owners) to be aware of the revision dates of the documents and to ensure revised versions are drafted before the recorded revision date of the documents is reached.

15.5 Documents should routinely cover a period of no more than 3 years however, this can be extended unchanged as per point 9.2 (refer to point 10.2 to 10.5)

16. Auditing & Monitoring

16.1 An annual audit of policy documents to ensure compliance with process as set out within this policy will be undertaken by the Policy and Document Management Officer. This audit will review at least 20 data sets as a representative sample of policies to assess the key criteria below in table 1 (page 13):

16.2 The audit report will be submitted to the Document Ratification Group and where deficiencies are identified an action plan will be developed and implemented. The action plan will identify actions, leads responsible for implementation and timescales. Progress with implementation will be monitored at subsequent DRAG meetings.

16.3 The audit report and the resultant action plan will be reported to the Risk and Compliance Group.

Table 1:

Criteria	Exceptions	Standard
Meets all policy style and format requirements	All policies published prior to 2007	90%
Meets consultation process requirements	Policies pre-dating these requirements	90%
Meets professional approval process requirements	Policies pre-dating these requirements	100%
Front sheet completed	Policies pre-dating these requirements	100%
Minutes of DRAG meetings evidence approval	Policies pre-dating DRAG	100%
Approved documents are all available on the Intranet/Internet	As noted in section 7.5	100%
All available documents are within their review date	None	90%
Only current versions of documents are available on the Intranet	None	90%
The 'title' of documents saved to the Intranet includes name, version number and registration number in the title and date	None	100%
The version history is complete?	Policies predating these requirements all version 1 policies	90%
Archived versions are available on the document database	All policies published prior to 2007	100%

16.4 In addition, the Policy and Document Management Officer will conduct monthly internal compliance visits or any successor to question and assess the ability of staff to access policies via the Trust Intranet. The findings will be reported to DRAG and the Risk and Compliance Group on a monthly basis.

16.5 Furthermore, monthly reporting of policy compliance to include highlighting hotspots and forecasting policies due for revision at 1, 3 and 6 months ahead. The findings will be reported to DRAG and the Risk and Compliance Group on a monthly basis.

17. Equality Impact Assessment (EIA's)

(Refer to Appendix 4 or 5 for EIA template and guidance notes)

17.1 The Trust is required when drawing up procedural documents to consider whether or not the proposals adversely impact on any particular groups of service users or staff.

17.2 In relation to 08042 Document Provenance Policy, Mid Essex Hospital Services NHS Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.
(Refer to Appendix 9)

18. Communication and Implementation

18.1 The details of all documents approved for use in the Trust will be routinely listed in the Trust newsletter Staff Focus on a bi-monthly basis. It is the responsibility of all staff to read the newsletter or to make sure they have read a printed copy.

18.2 It is the responsibility of each division to make sure that where manual copies of documents are kept and relied upon that these are always up to date and that old versions are routinely removed.

18.3 The Trust currently employ Information Governance Assistants who specialise in data quality, confidentiality and document availability issues.

19. Archiving of Documents

19.1 It is the Trust's responsibility to keep a record of all approved versions of all policy and guideline documents.

19.2 The security of all retained documents is essential irrespective of whether they are kept manually or electronically.

19.3 **Responsibilities of Authors/Creators**

- To ensure that the location of these documents is known widely within a department in order that they can be accessed irrespective of whether their usual "carer" is present in case they are needed for Freedom of Information or legal purposes;
- To ensure that each document is properly titled with its version numbers at the time of saving or storing.

19.4 **Corporate Responsibility**

19.4.1 **The Policy & Document Manager:**

- To retain electronic versions from 01.01.2007 of all clinical guidelines ratified at CDAG (Clinical Document Approval Group) or its successor, DRAG;
- To retain electronic versions from 01.04.2008 of the Trust policies and guidelines ratified at CDAG or its successor, DRAG;
- To retain electronic copies of all DRAG agendas and minutes from 01.04.2008.

20. Quality and Safety Risk Assessment

20.1 As part of the Quality Impact Assessment, authors developing newly created policies/ guidelines are required to consider any risks, for the following domains, which should be added to the Operational Risk Register. High risks should automatically form part of the Corporate Risk Register.

- Patient Safety;
- Clinical Effectiveness;
- Patient Experience.

20.2 Risks identified will be reviewed at Clinical Directorate Governance meetings and the risk register updated accordingly.

20.3 A Quality & Safety assessment form should be completed if risks are identified as above. (Refer to Appendix 10)

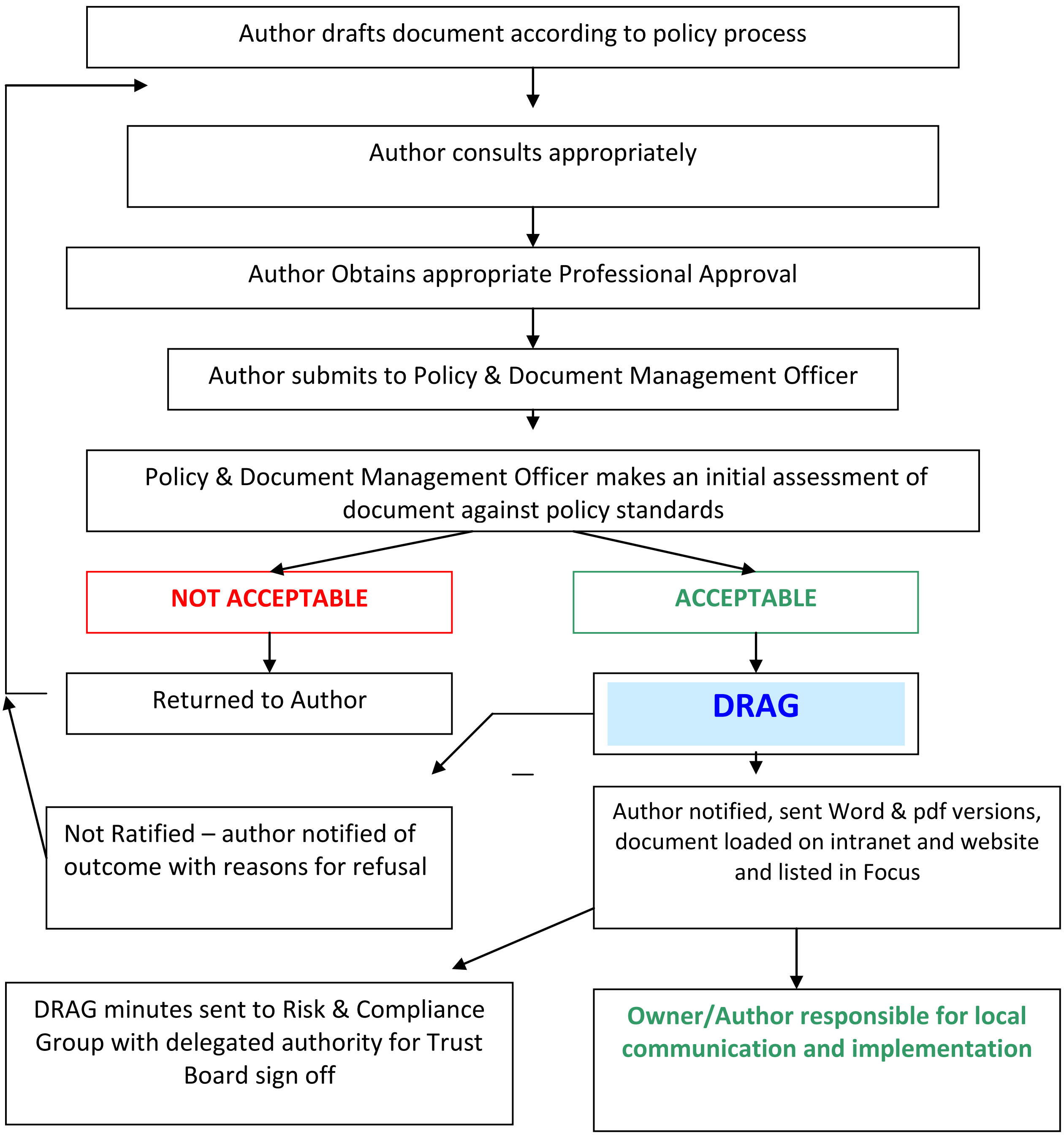
21. References

Gavin, J, Ward, E. (2018) Corporate Document and Records Management Policy. Leeds: NHS England
https://www.england.nhs.uk/publication/corporate-document-and-records-management-policy/

Freedom of Information Act 2000 (c.36) London: HMSO
http://www.legislation.gov.uk/ukpga/2000/36/contents

Appendix 1

Approval of Trust Documents Flow Chart



Appendix 2

Guide to Producing a Document

1. Making a Start

The best way to approach writing a policy or strategy is to first:

- "Brainstorm" all the elements that need to be somewhere in the document without worrying about whether they are in the right order at this stage;
- Draft just the main headings of the Contents Page;
- Now add the subheadings that will be needed under each main heading;
- Check that all the elements of the brainstorm are going to fit in somewhere;
- Start filling out the headings (in any order) and tick off the brainstorm list as each element is covered.

2. Essential Content of Clinical Documents

2.1 The content needs to be set out roughly as follows – it is **not** a clinical textbook or an academic work so any long background information or rationales can be attached as appendices but only if absolutely necessary – think of it more as a "Haynes Manual".

.2.2 Write every document as if you are writing for a junior doctor in their first week, alone on a ward at 2 am. These should be written from the perspective that someone who is unfamiliar with it may require the key information quickly, no rambling or repetition.

Purpose	Why does this document exist?
Equality and Diversity	Include the statement: "The Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals." This should not merely be a tick box exercise, but real consideration should be given to the impact of this document.
Scope	Who are the target group of patients? Make sure that all clinical documents include whether it also applies to children. If its adults only, include the fact that the target patient group is 16+. Is anyone excluded for any reason?
Staffing & Training	Exactly what level of staff is this CG aimed at and what training need they have in order to carry out this procedure/use this equipment. If different grades of staff have different responsibilities make this clear.
Infection Control	Specific infection control (IC) measures required e.g. handwashing, gloves and aprons – remember to identify the IC policies in "Related Policies" box on the front page.
The Clinical Instructional Sections	This is where you input the instructional information – it may be short or long and require just one or many main headings. If you are describing a clinical procedure, consider splitting it up into Pre-procedure, During the Procedure, After the Procedure and Documentation?

Breach Reporting	Ensure that the need to complete a Risk Event Form in the event that the guidance is not followed is in there – you can link learning from risk events into your audit function.
Audit	How will you know that it's been followed? Consider the following: • What the key standards of the document are; • How these could be monitored e.g. formal audit, quarterly spot checks, review of reported incidents and complaints, patient or staff surveys, sickness levels, training records; • Who will be responsible for this and how often will the process be done; • Which forum should review the findings; • Who will be responsible for implementing any required actions.
References	Lists of references which provide some evidence that the instruction is current and up to date. (In the case of equipment, this could be the manufacturer's instructions). Contact the Warner Library for an evidence search and assistance with references.
Appendices	**Essential:** if there are any patient information leaflets that apply, these must be referred to. Where there are forms applicable to the document these must be attached or embedded. If there are forms attached that will be required to be input or other directional detail such as flowcharts, patient data forms or procedures then these much be attached as complete documents and should not be embedded. Reference material such as DoH guidance can be embedded, particularly if bulky. Don't forget you can also use web links if reference documents are on line.

3. Content of Strategic and Policy Documents (Non Clinical)

3.1 The principles about the content are the same as for clinical information with some additions.

3.2 Roles & Responsibilities and Glossary may not be essential for all documents.

Purpose of Document or Introduction	Overview of why it exists. Keep detailed references to legal frameworks or Acts of Parliament to a minimum – you will be listing them in the references, just include the main drivers here.
Aims	The specific targets that the document is setting out to meet. Look at the first 2 paragraphs of this policy as an example. The aims should be auditable.
Scope	Who is it aimed at or what does this document cover and most importantly who or what is excluded.
Roles & Responsibilities	Who has ultimate responsibility? Is the day to day management devolved? What are the roles for each staff group. This section may

	not be necessary for small or minor documents.
Equality and Diversity	Include the Equality and Diversity Statement "MEHT is committed to the provision of a service that is fair accessible and meets the needs of all individuals". Complete appendix 4 and consider appendix 5 dependent on outcome of appendix 4.
Subject Matter	Now start on the content, there may be many paragraphs or just a few. The most important thing to remember is "logical sequence" Where there are forms applicable to the document these must be attached or embedded.
Audit	How will you know that it's been followed? Consider the following: • What the key standards of the document are; • How these could be monitored e.g. formal audit, quarterly spot checks, review of reported incidents and complaints, patient or staff surveys, sickness levels, training records; • Who will be responsible for this and how often will the process be done; • Which forum should review the findings; • Who will be responsible for implementing any required actions.
References	List all the references that have been sourced particularly important are Acts of Parliament, Codes of Practice etc. Contact the Warner Library for an evidence search and assistance with references.
Appendices	If there are forms attached or other directional detail such as flowcharts, patient data forms or procedures then these much be attached as complete documents and should not be embedded. Reference material such as DoH guidance can be embedded, particularly if bulky. Don't forget you can also use web links if reference documents are on line.
Glossary/Definitions	Consider whether an explanatory section of terms used would be helpful to the readership but this is not essential.

Appendix 3

Document Presentation Guidelines – Authors' Checklist

Before submitting a document for consideration by DRAG, please ensure that you have included or checked the following:

1. Cover pages

- Consultees are appropriate and listed/dated;
- Professional approval has been recorded;
- All affected staff groups are recorded;
- All relevant associated Trust policies or guidelines are recorded;
- If it's a revised document, that the document history box has been completed;
- That you have not included a whole number as a version number e.g. 1.0, 2.0.

2. Style

- Completed in Ariel 12 point;
- Text is not justified;
- Headings are bold and not in Capitals;
- There are no a) b) c) etc. or any latin numbering;
- **All** paragraphs are numbered, sub-numbered or sub-sub-numbered (if you need more than that, then you have insufficient main headings);
- Bullet points are not indented;
- Bullets are basic Microsoft standard not "arrows";
- There are at least 6 spaces between the main paragraph number and the start of the text;
- Bold text or italics are used sparingly for more impact;
- There are no "orphan headings" left at the bottom of a page;
- Every page is numbered on the bottom right of the page;
- There are no full stops after bullets (with the exception of the last).

3. Spelling, Punctuation and Grammar

3.1 There should be no spelling mistakes or typographical errors.
Good grammar rules apply – (you are after all writing for others to read and follow)
Do not finish a sentence with a preposition e.g. "to whom will audits be reported" NOT "who will audits be reported to").
Proof read your document.

4. Content

4.1 All documents must minimally:

- Be assessed for the need to include an Equality Impact Assessment, there should still be an Equality & Diversity statement within the document;
- Have a non-formatted index or contents page including detail of any appendices;

- Have “Purpose of Policy” as first paragraph;
- Have a “Scope” section i.e. what is included and what is excluded;
- Have staffing and training sections – think about whether any special training would be required, how it would be delivered and recorded, if there is none needed – then say so;
- Have a Communication and Implementation section – is it clear how the owner/author will communicate this document to the appropriate staff groups;
- Have an Audit & Monitoring section – e.g. what will be the evidence that this policy or guideline has been followed, and to whom will audits be reported and how often?
- If the policy or guideline is breached, how will this be reported? How will the Trust learn from this mistake and improve? Have you included the need to complete a risk event form?
- There is a final section on references – check the dates and web links – are they up to date? If the is most recent is say 2005, the document may not be credible. Contact the Warner Library for help finding the most current evidence.
- Don’t forget a section on definitions if required.

4.2 Responsibilities must be clearly defined - consider whether a separate responsibilities section would be helpful.

Appendix 4: Preliminary Equality Analysis

This assessment relates to: (please tick all that apply)

A change in a service to patients		A change to an existing policy		A change to the way staff work	
A new policy		Something else (please give details)			

Questions	Answers
1. What are you proposing to change?	
2. Why are you making this change? **(What will the change achieve?)**	
3. Who benefits from this change and how?	
4. **Is anyone likely to suffer any negative impact as a result of this change?** If **no**, please record reasons here and sign and date this assessment. If **yes**, please complete a full EIA.	
5. a) Will you be undertaking any consultation as part of this change? **b) If so, with whom?**	

Preliminary analysis completed by:

Name		**Job Title**		**Date**	

Appendix 5: Equality Impact Assessment

If you have identified any negative impact in the preliminary analysis above, please complete this full Equality Impact Assessment.

Based on the results of consultation, any data or research you have considered, please record and evidence your analysis of the implications of organisational or service change for the various groups of people affected. Please be specific about how you have arrived at your conclusion in relation to impact. Please describe the analysis undertaken and interpretation of evidence.

Please consider any impact that the changes may have on people because of:	Is there potential for negative impact? YES or NO	Are there opportunities for positive impact? YES or NO	Please give details of negative impact	Please give details of positive impact
Race or culture e.g. people who are black or from a minority ethnic background (BME), gypsies and travellers				
Age e.g. older or younger people				
Disability e.g. learning disabilities, physical disability, sensory impairment and mental health problems				
Gender (e.g. women, men, people who are transitioning from one gender to another)				

Nationality (e.g. where English may not be the person's first language)				
Religion or belief (including those who do not have a religion or belief)				
Sexual orientation e.g. lesbian, straight, gay or bisexual				
Family circumstances e.g. expectant parents, pregnant women, people who are married or in a civil partnership, those with caring responsibilities e.g. for children or adult dependents				
Other (please give details)				

Full Equality Impact Assessment undertaken by:

Name		Job Title		Date	

Decision:

- **Accept the proposal** - no evidence of discrimination and/or opportunities to advance equality identified
- **Adjust the proposal** - take steps to remove barriers (detail to be completed on the following page)

- **Continue the proposal** - despite potential adverse effects the proposals do not unlawfully discriminate or there is objective justification
- **Stop the proposal –** the policy show unlawful discrimination and adverse effects that cannot be mitigated

For each impact identified, please complete the following section:

Negative Impact Identified	Can the impact be avoided? YES/NO	If yes, what action will you take to avoid the impact? Include: - Action to be taken - Person responsible - Timescale - Monitoring arrangements	If you cannot avoid the impact, is there an objective justification? [see guidance below]

Objective Justification

In some cases, it may be that we cannot avoid doing something which may affect some people more than others. However this should be very rare. If you think this is the case, please consider the following:

1. Is what you are trying to achieve a legitimate aim? Cost alone is not enough of a reason for treating certain groups less favourably.
2. Is what you are doing proportionate i.e. is it appropriate and necessary?
3. Could you achieve the same aim in a different way?

Additional template for use with proposals which impact on staff

1) **Does the proposed change put staff at risk of redundancy or significant change** e.g. relocation, major changes to working hours or patterns? Yes/No

2) If yes, please record details of all staff potentially affected in the table below:

Employee Name	Job title	Pay Band	Gender	Ethnicity	Age	Disability	Sexual orientation	Hours worked	Potential impact
John Example	*Secretary*	*3*	*Male*	*White*	*47*	*Yes – mobility (wheelchair user)*	*Homosexual*	*30 hours per week over 3 days(8 – 6:30)*	*The proposed changes are designed to ensure that there is greater staff cover across the week. This would mean John working shorter days which would mean him travelling in during rush hour rather than coming in early and leaving late as he does at present. He travels by public transport as he does not have a car and this may affect him adversely as trains are more crowded during peak hours and this creates greater difficulties for wheelchair users.*

3) **What are the proposed criteria for selecting staff for any new post?** (Criteria may include performance history, competence based interview, test, attendance records, disciplinary record. All decisions on appointment and selection procedures, identification of 'at risk' staff and redundancy criteria must be fair and transparent, wherever possible competence based and compliant with equalities legislation.)

4) Would there be any staff who could be discriminated against as a result of the selection criteria proposed? Yes/No

5) If yes, please list what actions you will take to mitigate the impact

Adverse impact	Actions to be taken

Assessment undertaken by:

Name		Job Title		Date	

Appendix 6

Document Provenance Policy Audit Tool

Date: **Auditor/s:**

Policy Name	
Policy Number	
Specialty	
Criteria	

Is the document available on the Intranet/hard copy in archive folder?	
Is the version number the same in all pertinent documents?	
Are there more than 2 documents uploaded?	
Is the registration number in the title of the uploaded document?	
Is the version number in the title of the uploaded document?	
Is the name in the title of the uploaded document?	
Style: i. Is the document written in Arial 12 point? ii. Is the text justified? iii. Are there upper case paragraph headings?	
Format: i. Is there an index page? ii. Are there indented sub-paragraphs? iii. Are the sub-paragraph as follows: 1. then 1.1, then 1.1.1? iv. Are there bullet points after second sub- paragraph? v. Is there Latin numbering i, ii, iii, iv or a) b) c) etc? vi. Are there headings in boxes?	
Definitions present where appropriate	
Consultation process - appropriate level	
Professional approval – appropriate person	
Ratification – with all boxes on front sheet completed & correctly completed	
DRAG minutes evidence approval	
Review arrangements – within review date	
Version history completed to describe document management	
Archiving - are old versions archived as per policy process	
Associated documents identified – related policies identified on front page and body of text	
Supporting references – are appropriate references included? NICE/RCOG etc.	
Comments Box	

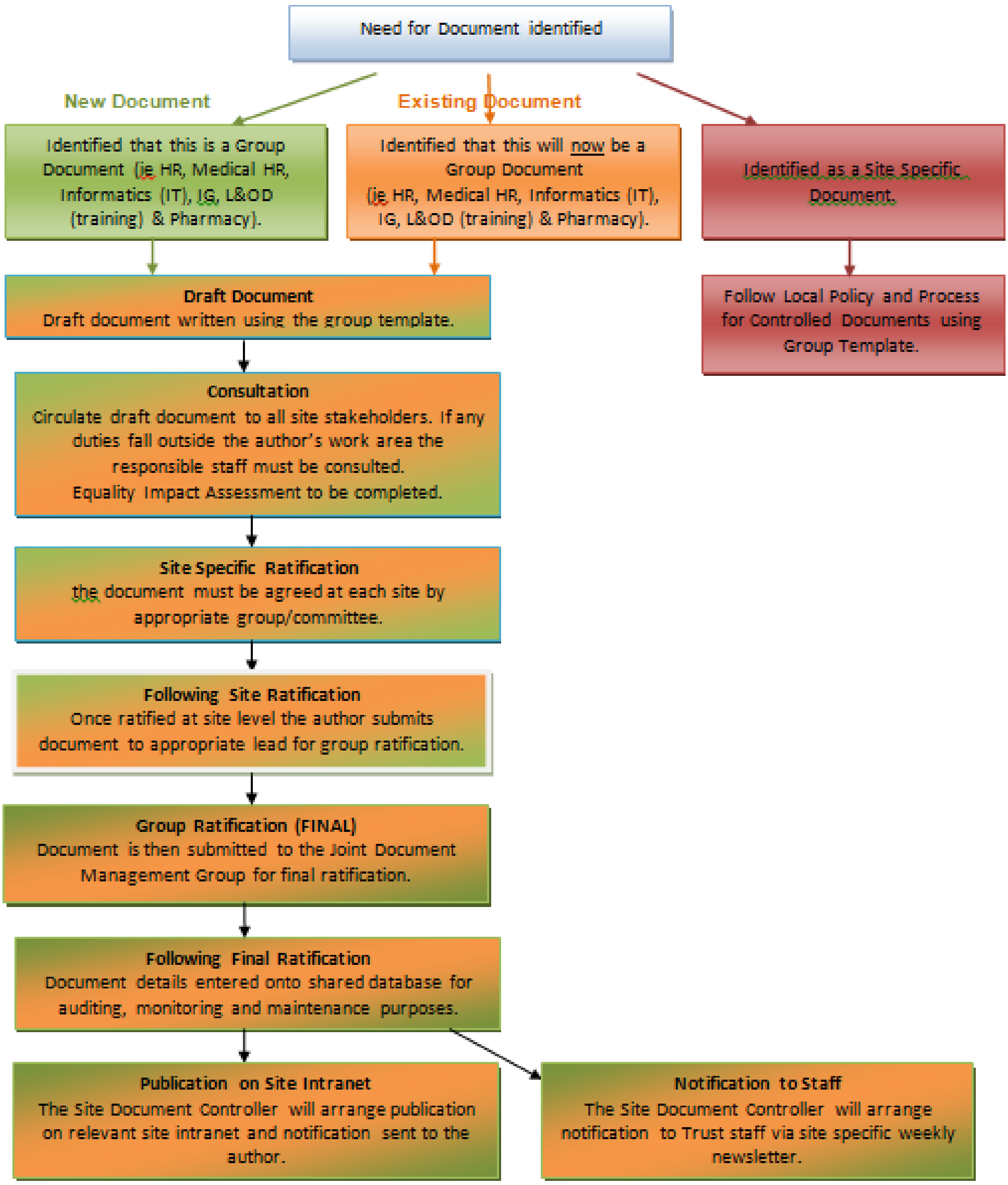
Appendix 7

DRAG Process for Upload of Ratified Policies and Guidelines Checklist v.2

Register No:	Document moved to Electronic Archive Folder Yes/No	Remove old version from Intranet/ Internet:	Intranet upload current ratified version:	Internet upload current ratified version:	Print copy for file:	Hard copy filed in Archive Folder/cupboard:	Update Electronic Policy Register:	Email Asset Administrator/ Author:

NHS
Mid Essex, Southend and Basildon
Hospitals

Appendix 8 - Group Document Control Ratification Process



Appendix 9: Preliminary Equality Analysis

This assessment relates to: 08042 Document Provenance Policy

A change in a service to patients		A change to an existing policy	X	A change to the way staff work	
A new policy		Something else (please give details)			

Questions	Answers
4. What are you proposing to change?	08042 Document Provenance Policy
5. Why are you making this change? (What will the change achieve?)	Due 3 year full policy review
6. Who benefits from this change and how?	Patients and clinicians. Authors of policy documents.
7. **Is anyone likely to suffer any negative impact as a result of this change?** If **no**, please record reasons here and sign and date this assessment. If **yes**, please complete a full EIA.	No
8. a) Will you be undertaking any consultation as part of this change? **b) If so, with whom?**	Yes Consultee list (pages 1 & 2)

Preliminary analysis completed by:

Name	Sarah Moon	**Job Title**	Policy & Document Management Officer	**Date**	23rd January 2019

Appendix 10: Quality and Safety Assessment - (policy title/register number)

1.0 Benefits	
1.1 What evidence has been used to develop this proposal e.g. NICE, NCEPOD, audit, patient or staff surveys?	
1.2 What changes does this proposal make to the care pathway?	
1.3 Describe the positive impact on:	
• Patient safety	
• Clinical effectiveness	
• Patient experience	
1.4 What current or new clinical outcome measures will monitor these benefits?	

2.0 Impact Assessment	
2.1 Describe how the impact of the change has been considered in relation to: • Infection Prevention and Control • Safeguarding vulnerable adults/ children • Current quality indicators • Quality Account priorities • Patients/ carers/ members of the public • Promoting self-care for people with long-term conditions • Tackling health inequalities	
2.2 How will you monitor the impact of this proposal? Provide details of how this will be done, by whom, and when.	

Trigger points early warning indicators	Escalate to ?	When ?	Responsible person

(E.G Staff not engaging with the pathway process)	Matron/General Manager	Immediately	Ward Manager/Ward team member

2.3 You must also complete an Equality Impact Assessment (Refer to Appendix 4 & 5)