Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Please Note: This policy is currently under review and is still fit for purpose.

Approved Procedural Documents (APDs) Development and Management Policy

[APDs include: Policies, Procedures, Guidelines and Standard Operating Procedures (SOPs)]

This procedural document supersedes: CORP/COMM 1 v.6 – Approved Procedural Documents (APDs) - Development and Management Process.

Did you print this document yourself?

The Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust website is the most up-to-date version. **If, for exceptional reasons, you need to print a policy off, it is only valid for 24 hours.**

Executive Sponsor(s):	Moira Hardy – Acting Director of Nursing, Midwifery and Quality and Sewa Singh – Medical Director
Author/reviewer: (this version)	Richard Dickinson –Acting Deputy Director of Nursing, Midwifery and Quality
Date revised:	January 2017
Approved by (Committee/Group):	Board of Directors
Date of approval:	31 January 2017
Date issued:	7 July 2017
Next review date:	January 2020 **– extended to January 2022**
Target audience:	All staff, Trust-wide

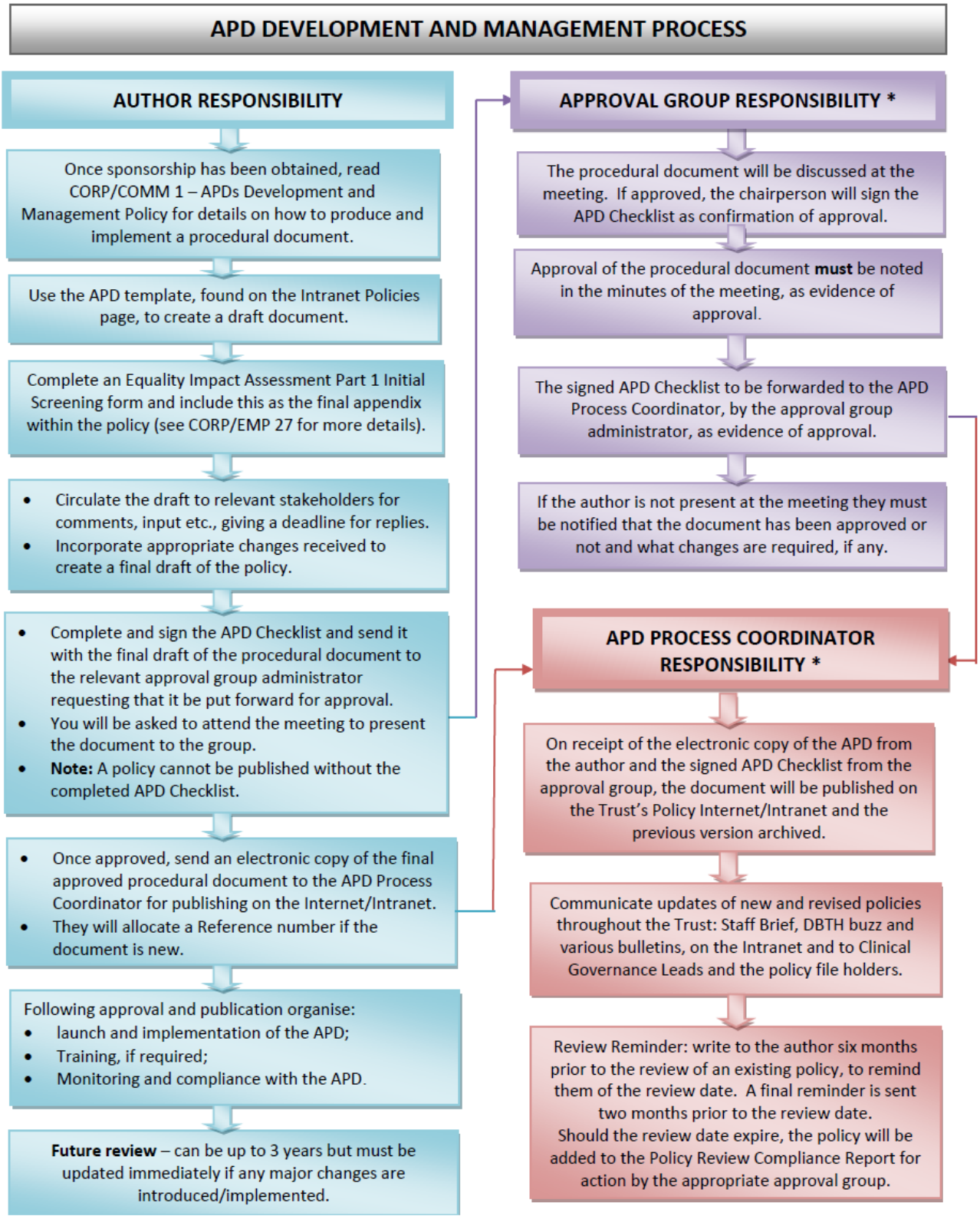
Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 7	7 July 2017	• Updated restructure terminology. • Updated Duties and Responsibilities. • Adjusted Policy Approval Committee and Groups. • Updated Equality and Diversity assessment principles and links to Ethics Committee. • Refreshed Monitoring Compliance principles. • Overdue review process described. • Implementation added to Dissemination section. • Updated format and use of Style function in MS Word on the template.	R Dickinson
Version 6	February 2012	**Major changes made throughout, including:** • Title change • New APD Process Flow Chart – Appendix 2 • Format and style change and order of contents re-arranged. Always use 'Align Left' margins. • 'Warning' statement replaced by 'Did you print this document yourself'? • New section 'Training and Support' added. • Monitoring Compliance section substantially revised. • Updated approval group list and locations of paper copy files. • APD template reviewed and updated in line with the above changes.	APD Process Co-ordinator and APD Process Group
Version 5	February 2010	• **Major changes made throughout - PLEASE READ IN FULL.** • Title changed to: Development and Management of Procedural Documents within the Trust • Updated in line with the NHS Litigation Authority guidance. • Reference made to the NHS Constitution • APDs referred to as 'procedural documents' • Numbering and order of contents changed for greater clarity. • Mental Capacity Act and Privacy and Dignity Policy to be considered and referred to when writing or revising procedural documents regarding patient care. • **Appendix 1** - Procedural Document Development Checklist – title changed, updated and condensed onto one page. • **Appendix 3** - List of Approval Groups updated. • New **Appendix 5** - Allocation of Unique Reference Numbers for Procedural Documents. • New **Appendix 6** - Procedural Document Format	Mandy Dalton

Contents

Link to APD Template (here)
Link to SOP Template (here)



*** CARE GROUP PROCESS FOR LOCAL PROCEDURAL DOCUMENTS -** The same principles above should also be followed for 'local' procedural documents by Care Groups. However, these will be approved at the relevant Care Group Clinical Governance meetings and an administrator should be nominated to carry out the duties of the APD Process Coordinator at 'local' level.

1 INTRODUCTION

An **'A**pproved **P**rocedural **D**ocument' (APD) is a procedural document which has been approved by the relevant body within the organisation. APDs are developed to inform staff on how they must proceed to meet professional organisations' and the Trust's goals. They also form an important strand of the Trust's Governance framework. In order to provide safe and effective care, a robust mechanism for the management of APDs must be in place.

For the purpose of this document, Approved Procedural Documents (APDs) include: policies, procedures, guidelines and Standard Operating Procedures (SOPs). See definitions below:

Policy - a prudent course of action, a principle of action adopted by a government party, business or individual. In general, policy defines what an organisation expects to do whilst procedure and guidance define how the organisation wants to do it.

Procedure - a set of actions which is the official or accepted way of doing something. Reasons for deviation from the procedure must be recorded.

Guideline/Standard Operating Procedure (SOP) - a document setting out the process steps required for the preferred method and process of operation. Other methods are not prohibited but a reason for deviation from guidance must be fully justifiable and line management agreement sought in all cases of any doubt.

The APD process does not cover Trust Strategy documents. The Board of Directors is the approval body for key organisation strategies, in line with the Standing Orders and Standing Financial Instructions.

2 PURPOSE

The purpose of this document is to inform and support all staff who are involved in writing or reviewing a procedural document, describing how to develop and manage Corporate, Care Group and departmental (local) policies. It has been developed to unify the processes involved and to ensure that every member of staff throughout the Trust has easy access to consistent, up-to-date, relevant and evidence-based documents.

This document outlines:

- best practice guidelines for developing and writing procedural documents;
- the process to be followed in developing, disseminating, implementing, reviewing and archiving procedural documents;
- the management and review of procedural documents;
- access to procedural documents.

3 DUTIES AND RESPONSIBILITIES

3.1 Board of Directors

The Board of Directors is responsible for the management and governance of the Trust. The Executive Directors are accountable for the management of the services they manage.

The Board of Directors is the approval body for key organisation strategies and policies, in line with the Standing Orders and Standing Financial Instructions.

3.2 Executive Directors

An Executive Director is required to sponsor the development of any new policy and procedure. The process of policy development and management is delegated to the Director of Nursing, Midwifery and Quality and the Medical Director.

3.3 Director of Nursing, Midwifery and Quality/Medical Director

The Director of Nursing, Midwifery and Quality/Medical Director are accountable for ensuring that APDs are in place and accessible to staff and delegates the responsibility to the Deputy Director of Quality and Governance.

3.4 Deputy Director of Quality and Governance

The Deputy Director of Quality and Governance is responsible for ensuring that the management and process of APDs is in place.

3.5 Sponsorship

Every APD will be sponsored by the appropriate level of management within the organisation. Sponsorship must be sought and agreed with the relevant director (see appendix 2). The sponsor must be involved in the review of policies and agree to changes, extensions or making no change to a policy.

3.6 Authors of Approved Procedural Documents (APDs)

Once sponsorship has been agreed, the author is responsible for developing the procedural document in line with the requirements of this document (see section 4 – 'Procedure for Writing a Procedural Document' for details).

Before creating a procedural document; determine whether it is Trust-wide, Care Group specific or for multiple Care Groups. The grid below clarifies the requirements; follow the APD

Development and Management Process flowchart at the front of this document and use the APD Template to create your procedural document:

Requirements
• Consider and apply as necessary the requirements of the Freedom of Information Act 2000, the Mental Capacity Act, the Equality Analysis Policy (CORP/EMP 27) and the Privacy and Dignity Policy (PAT/PA 28).
• Contact the APD Process Co-ordinator for a unique APD reference number, determined by the subject matter of the document. See Appendix 2.
• Carry out literature review demonstrating the checks for best practice/latest evidence.
• Consult and communicate with stakeholders and groups or committees relevant to the subject matter, including the Ethics Committee where applicable (See sections 4.3 & 4.4)
• Complete the APD Checklist (see Appendix 1) which is available on the Intranet. The checklist **must** accompany the final draft copy of the APD at the approval group**.** APDs will **NOT** be published without a completed and signed Checklist.
• Complete the Equality Impact Assessment Part 1 Initial Screening form (see CORP/EMP 27) and include it as the final appendix to the APD.
• Obtain approval from the relevant committee by submitting the final draft of the APD, along with the completed and signed Checklist to the group administrator, requesting it to be put forward for approval.
• Where appropriate, provide a summary of the key points of the APD which will be accessible at the front of the APD (e.g. flowchart showing procedure/process – policy on a page principle).
• Once confirmation of approval has been received from the approval group, forward the final approved version electronically to the APD Process Co-ordinator for publication and distribution.
• Ensure implementation of the APD (includes identifying training requirements and raising awareness with appropriate staff groups etc.)
• Ensure there is a process in place for monitoring compliance with the APD.
• The review and approval of APDs **MUST** be completed no later than the next review date. When new national or international guidance is received or newly published evidence demonstrates the need for change to current practices, the document must be revised immediately.

No specific format for 'guidance' or SOP is stipulated but the format chosen must be appropriate to the subject matter and the intended audience. See example SOP Template (here)

3.7 General Managers, Heads of Nursing/Midwifery/Therapy and Care Group Directors

The Care Group Management Team are responsible for ensuring that:

- there is a process in place for the management and review of all Care Group and department specific procedural documents.

3.8 Line Mangers

All line managers are responsible for ensuring that:

- staff are made aware of the Trust's APDs at 'Corporate' and 'Local' induction – see CORP/EMP 29 – Statutory and Essential Training (SET) Policy;
- staff receive appropriate training in order to comply with the Trust's APDs;
- staff are compliant with the Trust's APDs;
- APDs are accessible to all staff;
- staff are informed of new APDs and any revisions;
- staff are aware of the location of the 'emergency access' paper copy files.

3.9 All Staff

All staff and volunteers working within the Trust are expected to comply with approved procedural documents to ensure their own safety and that of patients, colleagues, visitors and any other person who may be affected by their actions at work.

3.10 Clinical Governance Leads & Heads of Nursing, Midwifery, Therapies

These roles have leadership responsibilities for quality and clinical governance in Care Groups and are responsible for ensuring that:

- All APDs are complied with and are audited as per the requirements in the APD – Link in with each Care Group annual audit calendar.
- Care Group and Specialty Guidelines are consulted on and approved in line with the principles of this policy.

3.11 APD/Policy Approval Committees and Groups

The Trust has a structured approach to the approval of APDs which is illustrated in Appendix 2. Each approval forum is authorised to approve the allocated range of documents. The Policy Approval and Compliance Group has the overarching duty for monitoring and tracking of each approval forum and has approval rights for any APD though it would not usually approve key organisational strategies or policies (see Appendix 2). The duties of the Policy Approval and Compliance Group are:

- Review of policy for approval, following appropriate consultation with the relevant committees/members of staff, by the author;
- Determine that the key steps have been taken with regard to policy structure, consultation depth and linked to relevant committees and work-streams within the Trust;
- Ensure the policies put forward for approval meet the criteria of the Approved Procedural Document (APD) Checklist prior to approval;
- Provide specialist knowledge to inform the policy approval process and ensure appropriate cross reference to other approved policy documents, in order to fulfil any regulatory or organisational requirements;

- Provide an appropriate level of critique on the principles of plain English to enable ease of use by staff;
- Ensure the author is informed when the policy is approved and published and ensure they are aware of the need to implement it and monitor compliance with it;
- Ensure the author is informed of any rejected policy and the reason for rejection. Ask author to make necessary changes and re-present the policy at a future meeting;
- Monitor compliance of review of all Trust-wide policies through tracking systems;
- Provide reports to the Patient Safety Review Group on the policy approval status for the Trust and escalate concerns when necessary.

The group or committee approving the procedural document is responsible for:

- ensuring completion, signature and compliance with the APD Checklist (see Appendix 1),
- ensuring the content is compatible with the Trust's obligations under the Freedom of Information (FOI) Act 2000.
- ensuring that adequate resources have been identified for implementation.

The Chair of the group is responsible for:

- signing the Checklist, as confirmation of approval, and forwarding a copy to the author of the document and to the APD Process Co-ordinator, (paper or electronic completion is accepted);
- ensuring formal, minuted approval. The minutes may be used as evidence of approval;
- agreeing the withdrawal of any procedural document with the appropriate sponsor of the document and notifying the APD Process Co-ordinator.

3.12 APD Process Co-Ordinator

The APD Process Co-ordinator is responsible for:

- coordinating the approved procedural document process;
- advising and supporting staff on the APD process;
- APD update distribution;
- maintaining/updating the APD database;
- updating and maintaining the APDs on the policy website and removing any superseded APDs;
- communicating monthly updates of new and revised APDs in Staff Brief, DBTH buzz and other Trust bulletins and notifying Clinical Governance Leads;
- archiving superseded APDs on the Trust's network.
- Providing paper copies of new/revised/amended policies to the Emergency Access policy file holders.

4 PROCEDURE FOR WRITING A PROCEDURAL DOCUMENT

4.1 Justification

The need for a new procedural document must be justified; linked with service priorities and must not duplicate or conflict with those already in existence. Authors must satisfy themselves that implementation is achievable within available or identified resources and demonstrate this on request. Sponsorship must be sought and agreed with the relevant director.

4.2 Style and Format

Use the standard APD Template for policies and procedures which is available on the Policies Intranet page.

To enable all procedural documents to have a 'corporate' appearance, the document must be produced using 'Calibri' font, 12 point and use 'Align Text Left' margins. Authors must follow the Trust's 'House Style' when writing a procedural document. This is detailed in CORP/COMM 5 - Developing Information for Service Users and Visitors Policy and Guidelines.

All new and revised procedural documents must be developed using the APD Checklist at **Appendix 1** and written using the standard APD Template format. Headers and footers must be populated appropriately and updated with each version change as a suffix to the APD reference number. The main body text of the document must be written in a style which is concise and clear, using unambiguous terms and language.

4.2.1 Guidance/SOPs

No specific format for 'guidance' or SOP is stipulated but the format chosen must be appropriate to the subject matter and the intended audience. See example SOP template (here).

4.2.2 Abbreviations and Definitions

Abbreviations and definitions must only be used after they have been fully clarified. Explanation of terms used must be listed alphabetically under the 'Definitions' section of the template.

4.2.3 Associated Trust Procedural Documents

Where appropriate; any associated Trust procedural documents must be listed under the 'Associated Trust Procedural Documents' section of the template.

4.2.4 References

Any supporting references must be listed alphabetically, using the Harvard style, under the 'Reference' section of the template.

4.2.5 Cross-Referencing

Cross referencing to other APDs is encouraged when applicable. When cross-referencing another APD within a procedural document, the version number must not be used as that will change periodically.

4.3 Identifying and Communicating with Stakeholders

Whether writing or revising a procedural document, authors must identify and liaise with all stakeholders who will be included in the consultation process. This will include all areas/groups where the procedural document will have an impact e.g. heads of department, clinical management teams and specialist groups as well as external organisations etc.

4.4 Consultation

Authors must ensure that new and revised procedural documents undergo an appropriate review and consultation process. Draft procedural documents must be circulated widely, e.g. Management Teams, Care Group Directors, representation of staff groups affected by the policy, specialist staff groups and any other identified stakeholders, giving clear deadlines for feedback and comments, to ensure that they are complete, correct and acceptable. Comments generated from this consultation must be considered by the author responsible for developing the procedural document. The membership of the policy approval committee relevant to the sign off of the policy will be consulted as a routine part of the consultation process.

4.5 APD Approval Process

Following consultation, when the final draft has been agreed, the author will complete and sign a copy of the APD Checklist and submit this with the procedural document to the relevant committee or group for approval/ratification. Approval groups are shown at **Appendix 2**. The approval of the procedural document must be noted in the minutes of the meeting which may be used as evidence of approval. **NOTE:** an APD will not be published without the completed and signed APD Checklist.

4.6 Monitoring Compliance

The author is responsible for completing the monitoring compliance section within the document under review. Evidence as set out in the monitoring compliance section must be agreed by any contributor prior to APD approval.

The author must use the framework below to identify and detail the key issues within the policy which need to be monitored to ensure compliance.

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
Example: List identified key issues relevant to this policy…….	Include title of person or group carrying out the monitoring …	Include the frequency e.g. weekly, monthly, quarterly, annually etc…	Include how reviewed, where reported and who will address any shortfalls …

5 REVIEW AND REVISION ARRANGEMENTS, INCLUDING VERSION CONTROL

5.1 Process for Reviewing an Approved Procedural Document

All APDs must be dated and include a review date. The review date is the date by which the APD must be reviewed, approved and in place by. The author responsible for each procedural document will ensure the review is carried out. The 'review date' can be up to a maximum of three years from the approval date, with the exception of those APDs where there is a requirement for them to be reviewed annually. However, any changes in practice, legislation, national guidance, health and safety, risk issues etc., that affect the APD must be implemented and the APD reviewed immediately, irrespective of the next review date, using the full approval process.

Six months prior to the documents review date the APD Process Co-ordinator will write to the author responsible for the review to remind them of the due date. A **FINAL REMINDER** will be sent to the author two months prior to the due date if there has been no correspondence.

The author is responsible for reviewing and sending the revised document to the Sponsor. When they are in agreement to the changes, it will need to be sent to the relevant approval group (see **Appendix 2).** Following approval the group will forward a copy of the signed APD Checklist to the APD Process Co-ordinator as confirmation of approval. The author will send an electronic copy of the approved procedural document to the APD Process Co-ordinator for publishing on the Trust's Policy Website and for distribution to the emergency access policy file holders. **NOTE:** an APD will not be published without the completed and signed APD Checklist.

Reviewed, no changes needed - If, after consultation and review, no changes are required, this should be agreed by the Sponsor. The review dates and approval dates etc. must be included on the front of the document and 'revised without change' must be logged on the amendment form. **Note:** The document still needs approval and must be sent to the relevant group for approval, along with a completed APD Checklist. Once approved, the author must send an electronic copy to the APD Process Co-ordinator for publishing on the Policy Website and for distribution.

Extension of Review Date

Occasionally the review of a policy may be delayed, e.g. awaiting receipt or implementation of National guidance, which will affect the review. In such circumstances, the author must first obtain agreement from the sponsor to extend the review date and then write to the APD Process Co-ordinator giving the reasons and outcome of the agreement to extend the review date rather than allow the policy to lapse.

Overdue reviews

The chair of the relevant approval committee will receive a monthly tracking document (Policy Review and Compliance Report) of all pending and overdue policies. They will be expected to discuss this at their committee meeting and to note it in the minutes. They will document on the action log for that committee the action points being taken to resolve the overdue APDs,

including any escalation to the author's line manager when initial actions have not resolved the completion of the APD review. The Policy Approval and Compliance Group will monitor and report on the overdue status, based on feedback provided from the relevant approval committee. The Chair can and will be required to escalate non-compliance to the relevant Director for their intervention should the situation persist.

5.2 Version Control

The APD Process Co-ordinator will allocate a Trust-wide reference number and version number for each APD to facilitate document control. Version numbers will be recorded on the policy and procedure database.

A summary of changes from one version to the next must be recorded in the procedural document 'Amendment Form'. If there are no changes then 'No changes' must also be recorded and the version number will remain the same.

6 DISSEMINATION & IMPLEMENTATION

6.1 Dissemination

The APD Process Co-ordinator is responsible for distributing details of new and revised APDs electronically, via the following mechanisms:

- Publish new and revised APDs on the Trust's Policy Website (Internet)
- Trust Intranet
- DBTH buzz
- Staff Brief
- Clinical Governance Leads
- Distributing paper copies to the 'Emergency Access' policy file holders.

Managers are responsible for ensuring dissemination of APD updates to their members of staff (see 3.6).

6.2 Implementation

The author will be responsible for undertaking the appropriate implementation planning and delivery of the change. It is recommended that the author describes their process and uses the Trust management structures to cascade specific changes. The dissemination methods of Buzz, Trust Intranet may provide opportunities for highlighting changes required. Spot-check processes are recommended when there are potential compliance issues or risks identified by approval committees and the author.

7 ACCESS TO PROCEDURAL DOCUMENTS

The Trust's APDs are available on the Policy Website and can be accessed and viewed by clicking on the 'Policies/APDs' link on the top right of the home page on the Trust's website – see https://www.dbth.nhs.uk/about-us/our-publications/our-policies/. It is a requirement that all

staff have access to them, either directly or via their line manager. Staff must not print paper copies of APDs for long-term retention and use.

Individual Trust-wide APDs **must not**, under any circumstances, be published on other local Intranet pages. However it is permissible to create an electronic link from other local Intranet pages to the Trust's policy Website. The 'local' Web page owner will be responsible for establishing a process to check the ongoing patency of the hyperlink.

7.1 Policy File Holders (Emergency Access Files)

A set of paper copy policy files are available on the three main Hospital sites; they are held in the following locations for use in the event of an IT system downtime:

Area	Location of Files	Responsible Person
DRI:		
Clinical Site Management Office	Operations Room Suite, Level 4	Clinical Site Manager
Montagu Hospital:		
Rehab 2 (Adwick Ward)	Rehab 2 (Adwick Ward)	Ward Sister/Charge Nurse
Bassetlaw Hospital:		
Clinical Site Management Office	Clinical Site Manager's Office, ground floor (opposite General Office)	Clinical Site Manager
Audit and Effectiveness Office, Old Education Centre	Policy Co-ordinator's Office (Master copy)	APD Process Coordinator

Each location has a nominated post-holder who is responsible for maintaining/updating the files and monitoring the contents. The files must be stored in a place that is accessible by staff 24 hours a day, and must not be locked away.

Managers are responsible for ensuring that staff are aware of the nearest location of the 'emergency access' policy files.

8 DOCUMENT CONTROL AND ARCHIVING ARRANGEMENTS

8.1 Register/Library of APDs

The APD Process Co-ordinator will maintain a database of all Trust APDs. The active list of APDs are located on the Internet/Intranet under their relevant sections. See https://www.dbth.nhs.uk/about-us/our-publications/our-policies/.

8.2 Archiving Arrangements

Withdrawn and superseded procedural documents are retained electronically by the APD Process Co-ordinator. Some historical procedural documents may only be available in hard copy. A paper copy archive is also maintained by the APD Process Co-ordinator, along with the corresponding documentation.

8.3 Process of Retrieving Archived APDs

Archived approved procedural documents can be obtained on request from the APD Process Co-ordinator. These may be relevant to historical investigations.

9 TRAINING AND SUPPORT

No specific training is required, however, you can contact the APD Process Co-ordinator for support and advice.

10 MONITORING COMPLIANCE

The author must complete an APD Checklist for all new and revised APDs, this must be presented along with the APD for approval.

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
Completion of APD Checklist (signed by author and chair of approval group)	Relevant approval group APD Process Co-ordinator	At the monthly * group meeting * some groups meet quarterly Prior to publishing approved APDs	If the author has not followed the APD process, follow-up with author and approval group.
Timely review of APD. (Email sent to the author as a reminder to review the APD.)	APD Process Co-ordinator	Email sent 6 months prior to review. Final reminder at 2 months prior.	If the review date expires, add to the 'Policy Review and Compliance Report' for action by the relevant approval committee/group.
Receipt of APD updates distributed to the 5 nominated 'emergency access' policy file holders.	APD Process Co-ordinator	Approximately once a month	If acknowledgement slip not received, follow-up with policy file holder and action.
Content of 'emergency access' policy files.	Nominated Policy File Holder	Approx. monthly to coincide with APD updates	Logged on monitoring form which is kept alongside the files.
Audit of contents of the 5 paper copy policy files.	APD Process Co-ordinator	Annually	Report back any shortfalls to the policy file holder.

11 CARE GROUP SPECIFIC PROCEDURAL DOCUMENTS

All Care Group specific (local) procedural documents must be consistent with the Trust's APD process. Each Care Group or Corporate Directorate must identify someone to take responsibility for the management and review process and dissemination, and to link with the 'local' Website Administrator.

The following must be in place within each Care Group or Corporate Directorate:

- an index/database or spreadsheet which includes the name of the 'local' procedural document, reference number, the name of the author, date implemented, date revised and the date of the next review;
- a 'bring forward' mechanism to facilitate the review;
- a robust dissemination and implementation process;
- a local system for archiving and retrieval.

'Local' and Care Group specific reference numbers must avoid any confusion with the Trust's APD unique reference numbers – see **Appendix 2**.

12 DEFINITIONS

APD – Approved Procedural Document
Clinical Management Teams – Care Group Directors, General Managers, Heads of Nusing/ Midwifery/Therapies and Quality
Corporate Senior Managers – Direct reports to the Executive Team
EIA – Equality Impact Assessment
PA&CG – Policy Approval and Compliance Group
SOP – Standard Operating Procedure
Strategy - A plan of action designed to achieve a long-term or overall aim

13 EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.

Each procedural document must be screened by the author/manager responsible for its development, to consider whether there is an equality dimension or whether it is applicable to the Trust's duty to promote equality.

An Equality Impact Assessment (EIA) form must be completed for all new and revised procedural documents (see policy CORP/EMP 27). The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age,

sexual orientation or religious belief. [Note: please include completed form and insert as the final appendix to your document].

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4). No detriment was identified - See Appendix 3.

14 ETHICS, CAPACITY AND RIGHTS OF PATIENTS AND STAFF

All procedural documents must be developed and reviewed in line with the statutory duty contained within the NHS Constitution to have regard for the rights and pledges for both staff and patient. (ref: The Handbook to the NHS Constitution. DoH Jan 2012).

When writing or reviewing a 'Patient Care' procedural document, please ensure you consider the Trust's Mental Capacity Act 2005 Policy and Guidance, including Deprivation of Liberty Safeguards (DoLS) – (see PAT/PA 19) and the Privacy and Dignity Policy (see policy PAT/PA 28) and refer to them, if relevant.

We have an ethical duty towards patients and should consider if there is any impact or conflict between the principles of doing good, doing no harm, promoting patient autonomy and being just and fair to all. Where there is an 'Equality and Diversity' assessment that identifies a potential equality issue, patient capacity or choices that impact on patients welfare, and these cannot be adequately resolved or mitigated, the Ethics Committee should be contacted for advice as part of the consultation.

15 OTHER ASSOCIATED TRUST PROCEDURAL DOCUMENTS

- Equality Analysis Policy (CORP/EMP 27)
- Statutory and Essential Training (SET) Policy (CORP/EMP 29)
- Freedom of Information (FOI) Policy (CORP/ICT 15)
- Information Records Management – Code of Practice (CORP/ICT 14)
- Mental Capacity Act 2005 Policy and Guidance, including Deprivation of Liberty Safeguards (DoLS) (PAT/PA19)
- Developing Information for Service Users and Visitors Policy and Guidelines (CORP/COMM 5)
- Privacy and Dignity Policy (PAT/PA 28)
- Clinical Records Policy (CORP/REC 5)
- Fair Treatment for All (CORP/EMP 4)

16 REFERENCES

- Department of Health (2012) *The Handbook to the NHS Constitution (2012) [online]:* last accessed 1 May 2012 at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132961

- Great Britain (2000) *Freedom of Information Act 2000.* London, HMSO

- NHS Litigation Authority (2013) *NHSLA Risk Management Standards 2013-14 for NHS Trusts providing Acute, Community, or Mental Health & Learning Disability Services and Non-NHS Providers of NHS Care.* http://www.nhsla.com/safety/Documents/NHS%20LA%20Risk%20Management%20Standards%202013-14.pdf

- NHS Executive (1996) *Promoting Clinical Effectiveness: A Framework for Action in and Through the NHS*. London, HMSO

APPENDIX 1 – APD CHECKLIST

This Checklist is a requirement of CORP/COMM 1 – Approved Procedural Documents (APDs) Development and Management Policy

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

APPROVED PROCEDURAL DOCUMENT (APD) CHECKLIST

Author MUST complete sections 1 to 3 of this checklist and attach it to the final draft copy of the new/revised procedural document/policy when submitting it for approval to the relevant approval group. **Chair of the approval group MUST** sign and date section 4 as confirmation of approval.

Procedural Document Title:		**Reference No:**	

Criteria to consider when developing a procedural document/policy:

1. STYLE, FORMAT AND STRUCTURE Indicate compliance with each aspect by marking a ✓ or X in the relevant box. Where X is marked, the reason **must** be given in the comments box.		**Yes** ✓	**No** X
a	Document developed using the style and format of the Approved Procedural Document (APD) Template.		
b	The front sheet is fully completed with the relevant details.		
c	Definitions of terms used are provided.		
d	Relevant duties of directors, managers, employees and other workers are described.		
e	The content is clearly and concisely written.		
f	The process for monitoring implementation and effectiveness is described within the monitoring table.		
g	I have got evidence of monitoring compliance.		
h	Other relevant associated procedural documents or information sources and references are included.		
i	Completed Equality Impact Assessment Part 1 Initial Screening form is included as the final appendix in the policy. (See CORP/EMP 27)		
j	The Mental Capacity Act 2005 (see policy PAT/PA 19) and the Privacy and Dignity Policy (see policy PAT/PA 28) has been considered.		
COMMENTS: Continue on reverse, if necessary			

2. CONSULTATION List individuals and committees consulted: (Where there may be an impact on equality or patient choice, then the consultation should also include the Ethics Committee Chair.)

3. AUTHOR/REVIEWER APPROVAL:
Author to sign and date below and forward, with the final draft copy of the procedural document/policy to the appropriate committee/group for approval. You may be asked to supply evidence to support the above.

Name of Author: (please print name)	Department:
Signature:	Date:

4. COMMITTEE/GROUP APPROVAL:
Chair of approval committee/group to sign and date below and forward to the APD Process Co-ordinator as confirmation of approval.
NOTE: Approval of the document MUST be noted in the minutes of the meeting.

Name of Chairperson: (please print name)	Committee/Group:
Signature:	Date:

Following Approval: **Approval Group MUST** send the completed checklist to the APD Process Co-ordinator at the Education Centre, Bassetlaw Hospital as confirmation of approval. **Author MUST** send an electronic copy of the approved document to the APD Process Co-ordinator at the Education Centre, Bassetlaw Hospital to enable the document to be published on the Trust's Internet/Intranet and for the historical copy to be archived. Please contact ext. 2737 if you have any queries.

APPENDIX 2 – APPROVAL COMMITTEES AND GROUPS

Sponsors of policies are set out below:

Type of Document	Sponsor
Corporate policies (any document covering more than one Care Group)	Executive Director
Procedures (any document covering more than one Care Group)	Executive Director
Guidelines/Standard Operating Procedures (SOPs)	Care Group Management Teams and Corporate Senior Managers.

Following consultation, the author will submit the final draft of the procedural document, along with a signed copy of the APD Checklist to the relevant group or committee for their approval. The author will be asked to attend the meeting to present the policy. Approval must be noted in the minutes of the meeting and the APD Checklist signed off by the chair of the group.

The approval group administrator will inform the author that the document has been approved and return the signed APD Checklist to the APD Process Co-ordinator as confirmation of approval. If the document has not been approved, the administrator must notify the author of the reasons.

NOTE: Some documents may need the approval of more than one approval group e.g. if a patient safety related document has medicines contained within it then it must go to the Patient Safety Review Group and to the Drug and Therapeutics Committee.

Allocation of Unique Reference Number for Procedural Documents

Every APD is allocated a unique reference number which is determined by the subject and content of the document, in accordance with the list below.

APDs are divided into two streams: 'Corporate' policies (prefix CORP) and 'Patient Care' policies (prefix PAT). These are then divided into sections by specific subject and given the next available number. For example, CORP/COMM 1 is a 'Corporate' document found in the 'Communication/General' section and PAT/IC 1 is a 'Patient Care' document found in the 'Infection Control' section.

CORPORATE DOCUMENTS

KEY ORGANISATIONAL POLICIES

Overarching Trust policies would usually be approved by the Board of Directors and any new such policies should be considered first by the Board who then may delegate approval to one of its governance committees. Examples of key organisational and policies include:

- MAJAX – Major Incident Policy
- Access Policy
- Health and Safety Policy
- Organisation Change Policy

- Security Management Policy
- Bed Plan
- Operational Plan
- Operational Resilience Plan

Below these key organisational documents sit a number of policies and procedural documents whose approval routes are set out below.

Prefix	Document Subject	Most Appropriate Approval Committee/Group
CORP/HSFS	Health and Safety, Fire and Security (depending on content)	• Health and Safety Committee • Optical Radiation Safety Committee • Radiation Safety Committee • Decontamination and Water Safety Group
CORP/EMP	Employment and Work Life Balance	• Workforce and Education Committee
CORP/ICT	Information Communication and Technology (ICT)	• Information Governance Group
CORP/FIN	Finance	• Audit and Non-Clinical Risk Committee
CORP/RISK	Risk Management Emergency Planning (depending on Content)	• Clinical Governance and Quality Committee • Management Board
CORP/FAC	Facilities	• Facilities Management Committee • Health and Safety Committee
CORP/PROC	Procurement	• Medical Equipment Sub-Committee
CORP/REC	Records Management	• Clinical Records Committee • Policy Approval & Compliance Group (PA&CG)
CORP/COMM	Communication/General	• PA&CG

PATIENT CARE DOCUMENTS

Prefix	Document Subject	Approval Committee
PAT/IC	Infection Control	• Infection Prevention and Control Committee
PAT/T	Treatments/Investigations (depending on content)	• PA&CG • Blood Transfusion Committee
PAT/EC	Emergency Care	• PA&CG
PAT/MM	Medicine Management	• Drug and Therapeutics Committee
PAT/PS	Patient Safety	• PA&CG • Resuscitation Committee • DBTH Strategic Safeguarding People Board
PAT/PA	Patient Administration	• PA&CG
Note: For any policies where there is a high profile issue - there may be an overriding need for		• Trust Board • Executive Team

Prefix	Document Subject	Approval Committee
management or Board approval.		• Management Board • Clinical Governance and Quality Committee • Audit and Non-Clinical Risk Committee

Note: Some APDs may need to go to more than one approval group e.g. where medicines are referred to these will need to go to the Drug and Therapeutics Committee in addition to the approval group.

'Local' APDs – Care Groups

Prefix	Document Subject	Approval Committee
Specific to each Care Group	Care Group specific documents (depending on content)	• Relevant Care Group Clinical Governance Committee • Cancer Management Group • Strategic Safeguarding People Board • Maternity Guideline Group

APPENDIX 3 – EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	Care Group/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
APDs – Development & Management Process	*Director of Nursing, Midwifery & Quality*	*Richard Dickinson*	*Existing Policy*	*September2016*

1) Who is responsible for this policy? Name of Care Group/Directorate: *Directorate of Nursing, Midwifery & Quality*

2) Describe the purpose of the service/function/policy/project/strategy? Who is it intended to benefit? What are the intended outcomes? *To support the authors in the development and review of APDs and create a unified process*

3) Are there any associated objectives? Legislation, targets national expectation, standards: *Trust standard*

4) What factors contribute or detract from achieving intended outcomes? – noncompliance within services

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? Details: [see Equality Impact Assessment Guidance] - *No*

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] –

6) Is there any scope for new measures which would promote equality? [any actions to be taken] *No*

7) Are any of the following groups adversely affected by the policy? No

Protected Characteristics	Affected?	Impact
a) Age	*No*	
b) Disability	*No*	
c) Gender	*No*	
d) Gender Reassignment	*No*	
e) Marriage/Civil Partnership	*No*	
f) Maternity/Pregnancy	*No*	
g) Race	*No*	
h) Religion/Belief	*No*	
i) Sexual Orientation	*No*	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form – see CORP/EMP 27

Date for next review: ***January 2020***

Checked by: ***Richard Dickinson*** **Date: 22 January 2017**