ADULT SERVICES PROCEDURE

Developing, writing and reviewing departmental policies and procedures

EFFECTIVE DATE: October 2014

CATEGORY: Adult Services

SUMMARY: This document provides a step by step guide to the development and review of all Adult Services policy and procedural documents

KEYWORDS: Policies, Procedures, Protocols, Guidance, Practice Manuals

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SPONSOR: CONTACT:

SIGNED: DESIGNATION: DATE:

YOU SHOULD ENSURE THAT:-

- You read, understand and, where appropriate, act on this information
- All people in your workplace who need to know see this procedure
- This document is available in a place to which all staff members in your workplace have access
DEVELOPING, WRITING AND REVIEWING DEPARTMENTAL DOCUMENTATION

PURPOSE

The purpose of this procedure is to set out the arrangements within Adult Services for the development and review of departmental documentation in the form of policies, procedures, protocols, guidance and practice manuals.

It seeks to:

- Standardise the process
- Provide guidance on the creation of such documents
- Set out the governance arrangements

SCOPE

This procedure applies to all staff writing or amending policies, procedures, protocols, guidance and practice manuals on behalf of Adult Services. This includes residential and nursing staff.

REFERENCES

None

AUTHORITY TO VARY PROCEDURE

Departmental Management Team

STAKEHOLDER CONSULTATION

Consultation has taken place with a selected group of managers and operational staff.
# Developing, Writing and Reviewing Departmental Documentation

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ROLES

Authors – people writing Adult Services policy, procedures, standards, protocols, practice manuals and guidance who must comply with this procedure.

Policy Sponsors – the policy sponsor is the DMT Member, Senior Manager or Chair of the meeting or committee who agreed the need for the policy or procedure.

Quality and Governance Team – the team responsible for overseeing Adult Services documentation, maintaining a log of historic documents and assisting authors with this procedure. The Quality and Governance Team are the custodians of this procedure and can be contacted through a central inbox SSGOVERN.

Web Team – the team that publish approved Adult Services documents on Hantsweb and Hantsnet.
INTRODUCTION

Good policy management is essential for the delivery of care services that are safe, consistent and effective.

This document is designed to assist any author who is developing new policies or procedures or who is involved in reviewing or updating an existing document to ensure a co-ordinated and uniform approach is taken which meets the need of the Adult Services Department and external requirements.

It is essential that Adult Services is able to identify which policies or procedures documents are in place at any given time and controls are required to ensure consistency. The overall management of policies, procedures and standards sits with the Quality and Governance Team who oversee the development, review and monitoring of all new departmental policies and procedures.

Approval must be sought from a policy sponsor before starting work on a new procedure or policy as outlined below.

Creating new guidance will not, in itself, create better services. It is therefore necessary to think through how new procedures should be implemented, how they will be communicated and whether training is required.

IDENTIFYING THE NEED FOR NEW POLICIES, PROCEDURES, STANDARDS, PROTOCOLS OR PRACTICE MANUALS

The correct type of document should be chosen to deliver the proposed message. See Appendix 3 for description of the most appropriate document to create.

New policies or procedures may be required for several reasons. The following are indicators of when a new document is required:

- There may be a change in national legislation or guidance
- There is a change in HCC corporate strategy or policy
- The need may have arisen due to an investigation or review where significant and ongoing risk has been identified and there is no current guidance for staff
- There is no existing policy which covers the suggested topic or if such a document exists it is out of date

Consideration should always be given to whether there is already a policy or procedure in place which could be reviewed to include any new requirements.

Please see Appendix 5 for the stages to be followed to create a new policy or procedure.

Multi-agency documents

Multi-agency documents are not subject to the standards outlined in this procedure. Where the author of a multi-agency document is an HCC employee and the
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document covers HCC services the use of HCC templates and logos will be actively encouraged.

Integrated Services

HCC has in place formal partnership arrangements with other agencies to provide services jointly. In the case of the provision of services for adults with mental health issues these formal agreements allow for NHS partner organisations to manage services on behalf of HCC Adult Services. There are therefore a suite of jointly agreed policies and procedures with NHS partner organisations.

However, where the responsibility of the local authority is not delegated to a partner organisation the responsibilities of Adult Services staff should be set out in Adult Services policies and procedures following this guidance. The appropriate meeting or committee may be a Joint Partnership Board and the sponsor may be employed by another agency but this policy or procedure must be followed to ensure Adult Services governance and accountability.

WRITING ADULT SERVICES POLICIES AND PROCEDURES

All Adult Services policies need to be written on the standard Adult Services Template (see Appendix 1&2 for control sheet and contents).

The following standards apply to all documentation:

- Documents should be in word template.
- Documents need to be clear and concise.
- It should be clear as to which service or area the document applies to and any other policies/documents to be referred to and supporting references should be clearly referenced.
- Abbreviations must only be used after being written in full for the first time and the body of the text should be in Arial, font size 12.
- Sentences should be kept short and should be positive, telling the reader what they should do.
- All documents must remain watermarked as DRAFT until they have been approved by the appropriate person or committee.
- All documents will be given a unique reference number. Before commencing work, contact should be made with the Quality and Governance team to obtain the correct reference number. Updates will then be made via version numbers.
- All policies and procedures are public documents, available under the Freedom of Information Act 2000 so they should therefore be written in
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plain English. (For guidance on plain English visit http://www.plainenglish.co.uk/free-guides.html).

- All policies must have an Equality Impact Assessment Tool (see Appendix 4 for further information).

BEST PRACTICE

A literature review should be undertaken to ensure a policy or procedure includes the most up to date and evidence based practice. Examples of useful resources include:

- Department of Health
- Care Quality Commission
- College of Social Work, Royal Colleges and Professional Bodies
- Social Care Institute for Excellence, National Institute for Health & Care Excellence
- Skills for Care

IDENTIFYING THE POLICY SPONSOR

The Policy Sponsor is the DMT Member, Senior Manager or Chair of the meeting or committee who agreed the need for the policy or procedure.

The policy sponsor will identify the appropriate policy author, agree and support the implementation and consider whether there are necessary resources available for the implementation of the policy.

CONSULTATION

In developing a policy or procedure, it is essential to gain an understanding of different perspectives and experiences, policies should therefore be peer reviewed. For example, if a procedure applies to care staff then care staff should be asked to read the draft and comment on it. This will improve the quality of the final approved document.

The policy author must therefore identify relevant internal and external stakeholders to be consulted in the development of the policy. This may include:

- Service users/carers
- Advocacy groups or interested parties such as care associations
- Staff including specialist groups such as Medicines Management
- Relevant external stakeholders
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- Elected members

The consultation period should be realistic to enable those involved time to fully review the policy.

The front sheet of the document should detail who has been consulted with to develop the document.

In the event that there are major changes to the policy during the consultation period a brief follow up consultation should be considered.

**APPROVAL, RATIFICATION AND DISSEMINATION**

The necessity to write a new document should be agreed by the most appropriate meeting or committee. These are:

- Directorate Management Team
- Senior Management Team
- DMT & SMT Sub Groups
- Service Management Meetings
- Partnership Boards or Practice Operational Groups (in the case of integrated services)

Following a full consultation the policy must be submitted to the relevant Management Team or Partnership Board for agreement.

On occasion, elected members will need to approve certain policies where there are significant resource or reputational implications. The policy sponsor should decide if this is the case.

All policies and procedures will then be ratified at the Care Governance Steering Group for final approval and noting. The Care Governance Steering Group is a sub group of DMT. Policies and Procedures will be considered in advance of ratification by the Care Governance Working Group who will make a recommendation to the Care Governance Steering Group.

The Quality and Governance Team will advise on which committee/meeting to seek approval from.

In order to ensure that all policies are implemented appropriately it is important that sponsors and authors give consideration to what needs to happen to get the policy or procedure embedded into practice. A number of options will be available, ranging from raising awareness that the document exists to intensive training to ensure competence.

Policy authors must consider an implementation plan with their policy when it is sent for approval as part of the ratification process. Within the implementation plan the financial and resource implications need to be considered.

Any policy or procedure requiring urgent sign off and publication will only be agreed
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by the Deputy Director in exceptional circumstances only.

MONITORING AND REVIEW

The effectiveness in practice of all policies and procedures should be routinely monitored through review and audit arrangements.

All new policies and procedures must be audited within 12–18 months of issue to ensure they are working effectively in practice. Audits will be programmed in to the audit schedule managed by the Quality and Governance Team.

All existing policies and procedural documents must be reviewed at least every 3 years from the date of last issue.

The Policy Sponsor and Author will be responsible for agreeing the review date for each policy, frequency of reviews and this will be agreed by the committee/meeting who agreed the policy in the first instance.

An annual review will be carried out by the Quality and Governance Team to ascertain whether policy owners are correct, whether documents are still current and to prompt authors to review their documentation as required.

UPDATING AN EXISTING DOCUMENT

Changes to a part of, or all of, an existing departmental policy or procedural document can be made subject to the approval of the Policy Sponsor.

Amendments to policies and procedural documents are subject to the same controls as occur when a new document is written.

Version numbers must be used when documents are updated and a record of these version changes will be kept by the Quality and Governance Team.

A master copy of each version of the document will be kept in HCC Adult Services archives so the original document can be referred to in the event of a complaint, freedom of information request or legal case relating to a previous period.

The author of the document should contact the Quality and Governance Team to advise them of the need for an addition/amendment to an existing document.

The Quality and Governance Team will then:

- Allocate an identification number to the document
- Give advice and support in relation to formatting and the process to be followed
- Ensure the document is added to the monitoring log of new documents
- Archive signed copies of previous documents
CONTROL OF DOCUMENTS

All documents will be given a policy/procedure number, maintained on a central log. This will allow for the tracking of documents. Each time a document changes, the version number, rather than the original number will change.

A control sheet must be completed for all documentation (see Appendix 1) in order to identify effective dates, key contacts, and links to other sources and provide a brief summary of the document.

All documents relating to the same theme will follow the same numbers.

Each page of the document must have the document name, version number and date in the footer of the document.

The header line should give the title of the document.

The main body of the document must begin with a contents list, including appendices (see Appendix 2 for contents list).

PUBLICATION

All presentation of published documents must be consistent across the department, presented in a professional and standardised way.

Documentation will be published by the Web Team once it has been ratified.

Before sending for publication the document should be stored in Hantsfile as a pdf version and marked as ‘for publication’.

Staff can access all documentation via Hantsnet by following the links to procedures. An on-line index of documents will be available in chronological order.

All policies will be published on the external website for public access. Other documentation such as procedures and guidance can be available on request.

Where new documents are published, the attention of staff will be drawn to this through notification on the website and on some occasions through publication in team brief. It will be the responsibility of the policy sponsor and author to direct where a policy or procedure should be advertised beyond publication on the website.

The Communications Team should be contacted if support is required to advertise and communicate to wide groups of staff or across the department.

Consideration should be given to which staff are directly affected by any new policy or procedure.

Where information is circulated to staff via team brief a short summary no longer than 50 words should be produced and forwarded to the Communications Team for inclusion.
The Social Care Practice Manual is an internal web based manual available to all social care staff. It contains a collection of information for staff gathered together in one place. This includes links to policies and procedures but it also includes guidance and the tools staff need to enable them to undertake their role such as forms which are not covered by formal policies and procedures but essential for the delivery of services.

The Social Care Practice Manual is covered by the Adult Services Procedure 06/12 Social Care Practice Manual: Governance and Maintenance.

For all policies and procedures an impact assessment must be undertaken to ensure that the impact on disadvantaged groups is considered. Authors need to consider how the procedure may adversely impact certain groups of people. Equality Impact Assessments are explained at Appendix 4.

No customer groups are likely to be disadvantaged as a result of the procedure, because this procedure seeks to give guidance to staff when they write or review procedures.

The Quality and Governance Team will check draft copies of procedures and allocate identification numbers within 3 working days of requests.

The Quality and Governance team will carry out a yearly audit each year.

New policies and procedures will be audited within 12 to 18 months.

The Web Team will add an electronic version of a new procedure to Hantsweb within 5 working days of receiving evidence of appropriate sign off of the document as outlined on the control sheet.
ADULT SERVICES POLICY/ PROCEDURE/PROTOCOL TITLE  001
VERSION NUMBER 1

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APPENDIX 2 – TEMPLATE

PURPOSE

SCOPE

REFERENCES

AUTHORITY TO VARY

CONTENTS

DUTIES/RESPONSIBILITIES/ROLES

INTRODUCTION

MAIN CONTENT

IMPLEMENTATION CONSIDERATIONS (TO INCLUDE PUBLICITY AND TRAINING REQUIREMENTS)

MONITORING COMPLIANCE

DOCUMENT REVIEW

REFERENCES

APPENDICES (Examples)

TRAINING NEEDS ANALYSIS (TNA)

EQUALITY IMPACT ASSESSMENTS (EIA)

POLICY IMPLEMENTATION PLAN
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APPENDIX 3 – IDENTIFYING THE RIGHT TYPE OF DOCUMENT TO CREATE

Policies

Policies are written in response to changing legislation or national guidance, corporate plans or departmental priorities. They say what the department wants or needs to achieve, but do not go into detail about how a service will be delivered. They set a broad objective or direction of travel and should be short and succinct. For example:

- The department will offer a service to everyone who has an eligible social care need
- Adult Services staff using their own vehicles for work will comply with legal requirements.

Procedures

Procedures describe what staff must do in specific circumstances in order to carry out their responsibilities set out in the departmental policies. They give instructions and provide the detail and must be clear, concise and easy to understand. They should enable staff to implement corporate policy and strategy, legislation or financial regulations. For example:

- Service users will be offered an assessment of need and anyone assessed as having critical or substantial needs will be offered a service
- Staff who use their own vehicle for work purposes must ensure it is taxed, insured appropriately and holds a valid MOT certificate.

Procedures should not contain too much background information and it should be possible for staff to comply with a procedure without knowing too much of the background information as to why it is required. For example, staff following a medication management procedure do not have to know why and how the prescribed medication works when administering medication.

Procedures should use words such as must, will, should and have to, in order to reinforce to the reader that the procedure sets out what staff are required to do.

Standards

Standards set out the level of service that the department expects to deliver if procedures are followed correctly. For example:

- The acceptable time for assessment from first contact to completion of the assessment is 4 weeks.
- All staff will provide their manager with a copy of a valid MOT certificate annually.
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Protocols

Protocols are agreements within Adult Services or between Adult Services and other departments or organisations. They identify an accepted way to meet needs or deliver services. They usually agree actions to be undertaken by services and differ from procedures in that they do not specify what planning or services must be applied.

- Where service users reaching adulthood will require transition to Adult Services they will be referred by Children’s Services in the year preceding their eighteenth birthday.

Practice manuals and other guidance

Practice manuals are collections of information for staff gathered together in one place. These may include links to policies, procedures, standards and protocols. They may also include best practice, forms, training plans and induction guides which are not covered by formal policies and procedures but essential for the delivery of services.

Adult Services has in place a Social Care Practice Manual (see section )

The type of document(s) required will vary, depending on the circumstances. Whatever form of document is chosen it will be subject to the controls described. The general rule is that if staff are being asked to comply with a set of instructions then the document should be a procedure.
What is an Equality Impact Assessment?

An Equality Impact Assessment is a tool aimed at improving the quality of local services by ensuring that individuals and teams think carefully about the likely impact of their work on different communities or groups. It involves anticipating the consequences of policies and services on different communities and making sure that any negative consequences are eliminated or minimised and opportunities for promoting equality and equity are maximised.

A negative or adverse impact is an impact that could disadvantage one or more equality groups or communities.

A positive impact is an impact that could have a positive effect on one or more equality groups or improve equal opportunities and/or relationships between communities.

Why should we carry out an EIA?

We should carry out an Equality Impact Assessment because all policies/procedures, services, functions and strategies need to be considered in terms of their relevance to promote equality of opportunity, eliminate unlawful discrimination and promote good working relations between different groups of the community.

We have a duty to undertake Equality Analysis in respect of Protected Characteristics under the Equality Act 2010.

When should an EIA be carried out?

An equality impact assessment should be carried out when developing a new policy, procedure or guide and when reviewing existing documents.

What areas should the impact assessment cover?

Equality Impact Assessments must cover the ‘protected characteristics’ as stipulated by the Equality Act 2010. These are:

Age, Disability, Gender Reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion or Belief, Sex and Sexual Orientation.

How do I carry out an Equality Impact Assessment?

1. Decide who will contribute to the Equality Impact Assessment

2. Identify the aims of the document

3. Consider existing data or research
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4. Assess likely impact

5. Consult relevant stakeholders

6. Sign off and publish the results of the EIA
## APPENDIX 5 – STEPS IN THE PROCESS

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<th>STEP</th>
<th>ACTIVITY REQUIRED</th>
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<td><strong>Agreement</strong></td>
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<td>Agreement from the relevant meeting or committee to commence work</td>
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<td>2.</td>
<td><strong>Identify the policy sponsor and author</strong></td>
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<td>This should be done by the meeting or committee who agreed the need</td>
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<td>3.</td>
<td><strong>Document control</strong></td>
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<td></td>
<td>Notify the Quality and Governance Team and obtain reference numbers via inbox SSGOVERN</td>
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<td>4.</td>
<td><strong>Writing</strong></td>
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<td></td>
<td>Author should write the document on the correct template in accordance with the standards in this procedure</td>
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<td>5.</td>
<td><strong>Consultation</strong></td>
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<td><strong>Approval</strong></td>
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<td><strong>Quality checking</strong></td>
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<td><strong>Ratification</strong></td>
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<td>Ratification by Care Governance Steering Group</td>
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<td>9.</td>
<td><strong>Publicity</strong></td>
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<td>Publication on website and other means identified depending on level of dissemination required</td>
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<td>10.</td>
<td><strong>Policy implementation</strong></td>
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<td>The sponsor and author should implement in line with the implementation plan set out in the document</td>
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<td>11.</td>
<td><strong>Policy review</strong></td>
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<td></td>
<td>Review and audit within 12 to 18 months</td>
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