London Ambulance Service NHS
NHS Trust

Procedure for the Development and Management of Procedural Documents

DOCUMENT PROFILE and CONTROL.

Purpose of the document: To describe in detail the system to be followed for a single approach to the effective development, implementation, monitoring and review of procedural documents.
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Sponsor Department: Governance Development Unit

Author/Reviewer: Head of Records Management & BC. To be reviewed by September 2011.

Document Status: Final

Amendment History			
Date	*Version	Author/Contributor	Amendment Details
02/10/08	2.5	Head of Records Management	Minor - Further changes following HR input and review by IGG
04/09/08	2.4	Head of Records Management	Minor - Further additions and updates in light of NHSLA requirements and organisational changes
17/07/07	2.3	Documentation Co-ordinator, Head of Records Management	Minor - changes
25/06/07	2.2	Head of Records Management	Minor - Further additions and updates in light of NHSLA requirements
23/01/07	2.1	Documentation Co-ordinator	Minor - To review and update contents and narrative in line with recommendations of the Policies and Procedures Report
01/05/04	2.0	Documentation Co-ordinator	Major – Second revision
01/01/01	1.0	Documentation Co-ordinator	Major – First version

***Version Control Note:** All documents in development are indicated by minor versions i.e. 0.1; 0.2 etc. The first version of a document to be approved for release is given major version 1.0. Upon review the first version of a revised document is given the designation 1.1, the second 1.2 etc. until the revised version is approved, whereupon it becomes version 2.0. The system continues in numerical order each time a document is reviewed and approved.

For Approval By:	**Date Approved**	**Version**
SMG	06/10/08	3.0
Ratified by:		
RCAG	16/02/09	3.0

Published on:	**Date**	**By**	**Dept**
The Pulse	06/10/08	Records Manager	GDU
LAS Website	09/03/09	Records Manager	GDU

Links to Related documents or references providing additional information		
Ref. No.	**Title**	**Version**
TP/001	Policy for the Development & Management of Procedural Documents	
TP/029	LAS Records Management Policy	
	Draft Report to Information Governance Panel (March 2006)	

Document Status: This is a controlled record as are the document(s) to which it relates. Whilst all or any part of it may be printed, the electronic version maintained in P&P-File remains the controlled master copy. Any printed copies are not controlled nor substantive.

1. Introduction

The London Ambulance Service (LAS) Policy for the Development and Management of Procedural Documents sets out a framework that clearly defines the Trust's approach to the management and application of its procedural documents and describes in outline the system to be put in place to maintain a single approach to the effective development, implementation, monitoring and review of procedural documents. This Procedure details this approach which will result in greater staff awareness and ready access to all relevant procedural documents to enable staff to carry out their duties efficiently and effectively.

2. Scope

This procedure applies to all policies and procedures produced by the Trust with the exception of those produced for local use only which have not been formally adopted by the Trust.

3. Objectives

1. To describe in detail a single approach system for the effective development, implementation, monitoring and review of procedural documents.

2. To produce all procedural documents following an agreed corporate style and format.

3 To bring all procedural documents together and manage them in such a way that they will be available as part of one electronic system accessed through the Trust's intranet.

4. To issue all policies and procedures following formal approval and ratification and embed full management accountability for document implementation, staff awareness, and compliance that is monitored for effectiveness.

4. Procedure

4.1 Development and approval of draft procedural documents.

4.1.1 All requests for the development of new procedural documents must be registered by the author with the GDU by the online completion of form LA415 (sample at Appendix 1) available on the Pulse. All such applications will be submitted by email and acknowledged by the GDU.

4.1.2 The GDU may circulate applications received to the Policies and Procedures Core Consultation Group (PPCCG) (see Appendix 5) for comment before notifying the applicant to proceed to draft.

4.1.3 For policies and procedures the author then drafts the document using the template at Appendix 3. This must include the completion of a draft Implementation Plan .

4.1.4 The author will carry out an Equality Impact Assessment (see Appendix 4) for each policy and procedure. Where appropriate external bodies will also be approached as part of the consultation process. The Equality Impact Assessment must be returned to the GDU who will arrange for it to be submitted to the PPCCG and with the procedural document to the appropriate committee (see Appendix 6) for approval.

4.1.5 Once the proposed document has been drafted the author must send it by email to GDU for submission to the PPCCG and stakeholders that the author and GDU have identified for consultation.

4.1.6 Should the PPCCG and other stakeholders recommend or make changes to the draft, the author will be notified and invited to amend and return the document to GDU.

4.1.7 Once the document has reached the final draft stage it will routinely be submitted by the author or GDU to the appropriate committee as listed in Appendix 6. Should a procedural document require urgent approval a committee senior to the one normally designated may take on this role Any further changes to the draft and/or notification of approval will be submitted to the GDU who will arrange for issue and ratification by the appropriate senior committee in Appendix 6.

4.1.8 The GDU will allocate an alphanumeric reference number to each document according to the type of document, e.g., a **P**olicy or Procedure will commence with the letter **P.** This is followed by a running number starting at 001- followed by 4 numbers to indicate the month and year of approval. It is completed with a number to indicate the Review status of the document where the first issue of a policy will be designated ‘0’. So for example the first new policy reference number to be issued in November 2008 will be P-001-1108-0. This new system will be introduced as and when new procedural documents are introduced or existing ones are revised.

4.2 Corporate style and format.

The following format specification will be applied to create an approved corporate style document (see example template Appendix 3):-

4.2.1 Document title box to follow the format as in Appendix 3.

4.2.2 All text entered in the 'Document Title' box and throughout the document to be in font style **Arial** font size 12 for both upper and lower case entries and **bold** type except for the Document Profile and Control section which will be in Arial 11. All text in the title box, headings and sub-headings should be in **bold** font.

4.2.3 The Document Profile and Control section must be completed by the author and the GDU as appropriate in order that version control is maintained. References will comprise relevant source information, policies and procedures, research data, training and guidance documents, health standards, legislation and accreditation systems that have a bearing on or relevance to the document. Where possible hyperlinks will be provided to enable easy access to this related documentation.

4.2.4 If abbreviations are used in any part of the document these will be written out in full where they first occur, immediately followed by the abbreviation typed inside brackets, e.g., London Ambulance Service NHS Trust (LAS).

4.2.5 **Introduction.** This provides the background narrative explaining the purpose and reason for the document.

4.2.6 **Scope.** It should be clearly stated what areas the procedural document covers and what is excluded from the coverage of the document.

4.2.7 **Objectives.** To set out concisely (by number if necessary) what the document aims to achieve and provide.

4.2.8 If the document is a **Policy,** it will normally provide a high level statement of intent that describes how an aspect of service provision or governance will be achieved. If the document is a **Procedure,** it will provide a formal set of detailed, evidence based actions in order to achieve a successful and consistent outcome. There will be instances where for clarity of governance or administrative convenience a policy and procedure are combined in one document.

4.2.9 It is the responsibility of the author to decide on the review period and add this to the Document Control Grid. The standard review period for a procedural document will be three years and this is the maximum period allowable before a review must take place. However, procedural documents may be reviewed at any time and may require an annual review to remain relevant with changing trends and/or technology. Any review, which in the opinion of the PPCCG results in only minor updates of an administrative or organizational nature, will not require further approval by the appropriate Trust committee.

4.2.10 All headings will be numbered consecutively from **1. Introduction** and sub-headings and sub-sections will be numbered consecutively as shown in Appendix 3.

4.2.11 Where concise or succinct text is necessary for greater impact within a paragraph, bullet points may be used as indicated in Appendix 3.

4.2.12 **Appendices.** Any standard forms, local protocols and checklists that come within the scope of the document should be numbered and referenced at the appropriate place in the text, e.g. 'see Appendix 1' Each appendix should be attached at the back of the document and numbered in bold upper case letters and figures at the top right hand corner of the page. Alternatively where documents are referred to in the text they may be accessed through electronic hyperlinks (see 4.3.1).

A list of **Definitions of Terms** used must be provided in an appendix where required for clarity.

4.2.13 **Document Control Footer**: This footer will be added by the GDU and contains the document reference number (see Section 1.8), the title of the document and the page number and total number of pages.

4.3 Issue and implementation of new and revised documents.

4.3.1 The issue of documents will be announced in the Routine Information Bulletin (RIB) and GDU will place a full electronic version and a summary of the document on *'the pulse'*. All procedural documents will normally be converted to PDF format prior to placement on the Trust's intranet and internet sites. For ease of use policies and procedures on the intranet will be bookmarked. Hyperlinks to related listed documents will be added wherever possible.

4.3.2 An **Implementation Plan** will be provided for each document by the author (see template at Appendix 3).

4.3.3 All members of staff have a responsibility to read and be aware of the content of appropriate new and revised documentation at the earliest opportunity following issue or publication.

4.3.4 Where appropriate the author will identify training needs for staff that will be delivered prior to or at the time of implementation of a new procedural document. The training will be detailed in the Implementation Plan.

4.4 Document control

4.4.1 The master copies of procedural documents are those made available by the GDU on the Pulse. Because these are controlled documents staff will no longer be issued with personal copies although all documents may be downloaded and/or printed. However, such documents are only current at the time of download/print and as they are uncontrolled are not to be regarded as definitive documents.

4.4.2 The GDU will maintain archived electronic copies of all superseded and obsolete procedural documents for 25 years and previous versions are available upon application.

4.5 Review System

4.5.1 The GDU will maintain a monitoring system and will notify the originator/ sponsor /group responsible for the review of a document approximately 3 months prior to the document's specified review date.

4.5.2 Review of a document will require a further Equality Impact Assessment to be carried out if major changes are made. Any review which, if the evidence suggests it would be reasonable to do so, results in only minor updates of an administrative or organisational nature, will not require further approval by the appropriate Trust committee.

IMPLEMENTATION PLAN	
Intended Audience	All LAS Staff
Dissemination	Available to all staff on the Pulse
Communications	Revised Procedure to be announced in the RIB and a link provided to the document
Training	
Monitoring	This procedure will be monitored through the Information Governance Group (IGG) by the Head of Records Management and Business Continuity and Records Manager. The IGG will meet quarterly and on an ad hoc basis as required. The monitoring will take the form of a review of the status of procedural documents by the IGG at six monthly intervals

APPENDIX 1

LA 415

New Document or Form Application

Name of Applicant:

Department / Sector:

Date:

Note: A (*) next to a field indicates a dropdown menu. All fields **must** be completed

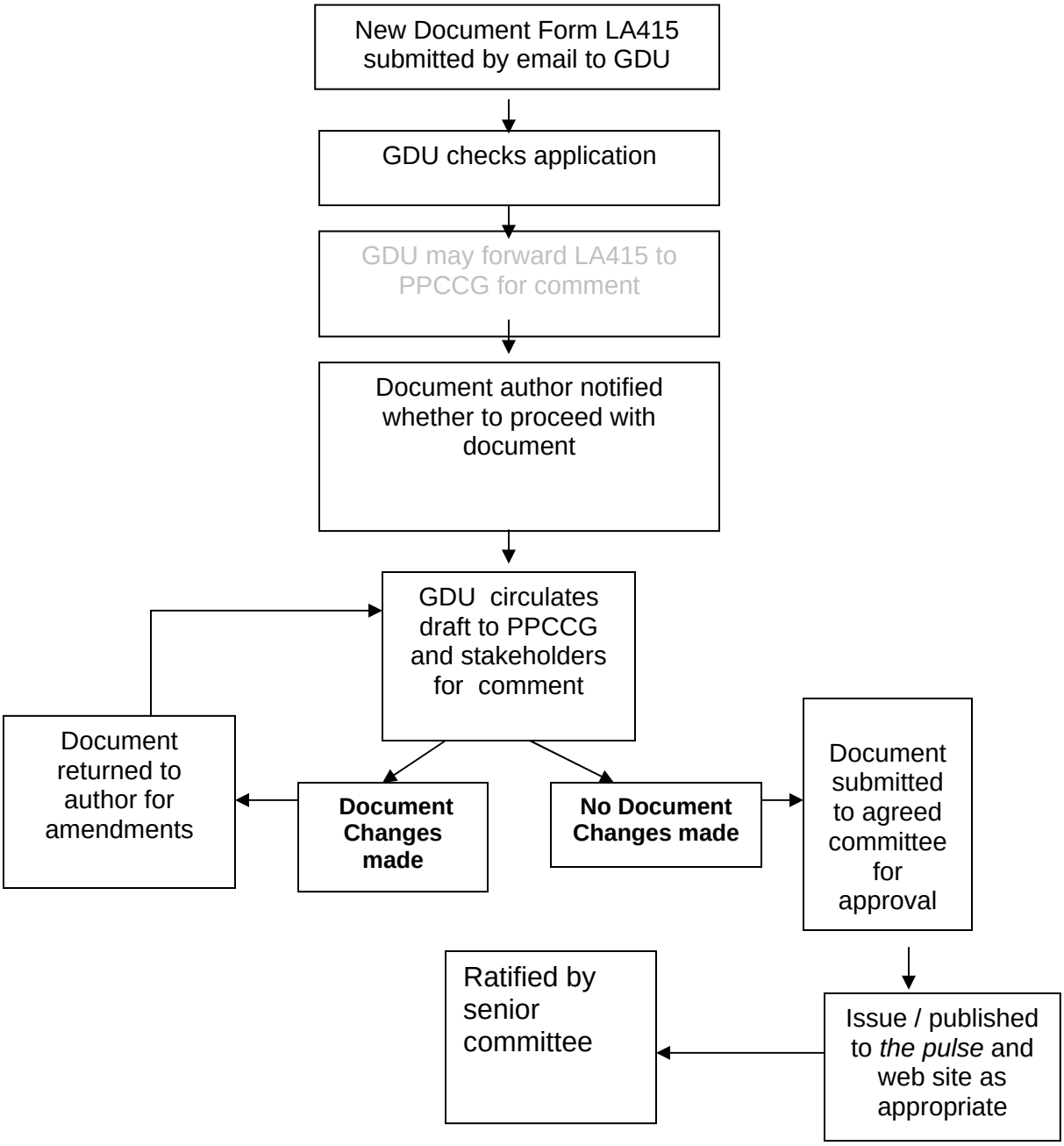
Document title / name:
What is the document type? Policy ☐ Procedure ☐ Form ☐
Give a brief reason and purpose for the document.
If the document is a policy or procedure: How frequently should the document be reviewed? * Annually
If the document is a form: How long should the form be retained once completed? Reason for this retention period
Who will be responsible for the review? Position of the individual to take responsibility: Name of department:

If the document is a form: Which departments/ teams will use the form?
Please list the details of the people consulted/ or to be consulted, in the creation of the document.

Please email the completed form to RecordsManagement@lond-amb@nhs.uk

APPENDIX 2

Stages and time scales for Procedural Document Development



APPENDIX 3

London Ambulance Service NHS
NHS Trust

Document Title

Document Profile and Control

1. Introduction

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2. Scope

3. Objectives

1. **********
2. * **********

4. Policy / Procedure

4.1 First Heading

4.1.1 **********

4.1.2 **********

4.2 Second Heading

4.2.1 **********
****

4.2.1.1**********
4.2.1.2**********
4.2.1.3**********

4.2.2 **********
****

- **********
- **********

Implementation Plan

IMPLEMENTATION PLAN TEMPLATE		
		Notes
Intended Audience		Indicate whether the document applies to all staff or certain sections of staff
Dissemination		Detail where document is to be made available e.g. on The Pulse and the LAS Website
Communications		Indicate how staff will be informed of the document and made aware of its contents
Training		If training is required indicate how this will be provided to relevant staff
Monitoring	In this section specify: ▪ Which aspect of the document will be monitored ▪ How that monitoring will be achieved, e.g., Audit ▪ Who will have the responsibility for the monitoring ▪ When the monitoring will take place and the frequency of it, e.g., annually in September ▪ How the results from the monitoring will be fed back into the document and/or monitoring process	If a policy/procedure or similar document indicate how adherence to the content will be monitored, i.e., through Internal Audit; Committee; quality checks.

Appendices

To include **Definitions of Terms** used where required for clarity.

APPENDIX 4

Equality Impact Assessment Tool

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

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

Please return this Assessment to the Governance Development Unit together with any suggestions as to the action required to avoid/reduce any impact identified. For advice in respect of answering the above questions please contact the LAS Diversity Manager.

APPENDIX 5

POLICIES AND PROCEDURES CORE CONSULTATION GROUP

Head of Records Management & Business Continuity

Assistant Director Organisation Development

Assistant Director Employee Support Services (for HR and Staff Side)

Information Security Manager

PALS & Complaints Manager

Diversity Manager

Head of Legal Services

Head of Policy, Evaluation & Development

Patient & Public Involvement Manager

APPENDIX 6

PROCEDURAL DOCUMENT ROUTINE APPROVAL & RATIFICATION		
	COMMITTEE/GROUP	
SUBJECT AREAS	**APPROVAL**	**RATIFICATION**
Finance, Audit, Fraud	Audit Committee	Trust Board
Non Health & Safety Risk including Assurance Framework, Business Continuity, vehicle and equipment risks, and legal issues.	Risk Compliance and Assurance Group	SMG/Trust Board
Procedural documents which relate to clinical matters including infection control.	Clinical Governance Committee	SMG/Trust Board
IM&T and Information Governance including Records Management, Data Protection and Freedom of Information.	Information Governance Group	Risk Compliance and Assurance Group /SMG
A&E Ops, Control Services, PTS, Logistics	SMG	Trust Board
HR, Training, Diversity	Staff Council[1] [2]	SMG[2]
Health and Safety	Corporate Health & Safety Group	Risk Compliance and Assurance Group
Complaints, SUIs	Complaints Group	Risk Compliance and Assurance Group
Driving & care of Trust vehicles	Motor Risk Group	Risk Compliance and Assurance Group
Emergency Preparedness	Emergency Preparedness Strategy Group	SMG
Other, not covered by above.	SMG	Trust Board

[1] Or delegated authority of Staff Council

[2] Most HR documents. Each document will detail the approval/ratification route.