London Ambulance Service NHS Trust

Policy and 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.

Sponsor Department: Governance and Compliance

Author/Reviewer: Information Governance Manager. To be reviewed by October 2012.

Document Status: Draft

Amendment History			
Date	*Version	Author/Contributor	Amendment Details
20/09/11	2.2	IG Manager	Changes to S.6.7, 6.9, 6.10, and 6.13
	2.1		Inclusion of monitoring table
06/09/10	1.6	Director of Corporate Services & Head of RM	New S.6.12; Revised Appendix 4
16/08/10	1.5	Head of RM	Appendix 1 & S.6.7 removed. New section 6.11 added. S. 8.1 revised. Monitoring section revised.
14/06/10	1.4	Head of RM	Appendix 5 further revised; section 6.11 and Appendix 2 revised
24/05/10	1.3	Head of RM	New section 6.10 on Privacy Impact Assessments added.
21/05/10	1.2	Director of Corporate Services, Head of Records Management and Business Continuity	Revised appendix 5
16/03/10	1.1	Equality and Inclusion Manager	Revised appendix 4, LA035
11/08/09	0.4	Director of Corporate Services	Appendix 4 inserted
30/07/09	0.3	Head Records & BC. Head of Governance, Records Manager	scope, responsibilities, definitions, 7.5, 7.10, 8.1, appendices
16/06/09	0.2	Head Records & BC. Head of Governance, Records Manager	amendments made throughout
17/3/09	0.1	Head Records & BC	Amalgamation & revision of TP/001 & 002

***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
ADG	26/10/11	3.0
SMG	15/09/10	2.0
SMG	19/08/09	1.0
Agreed by Trust Board (If appropriate):		
Trust Board	29/09/09	1.0

Published on:	Date	By	Dept
The Pulse	28/10/11	Governance Administrator	GCT
LAS Website	28/10/11	Governance Administrator	GCT
Announced on:	**Date**	**By**	**Dept**
The RIB	01/11/11	IG Manager	GCT

EqIA completed on	By
27/09/10	Director of Corporate Services
Staffside reviewed on	**By**

Links to related documents or references providing additional information		
Ref. No.	**Title**	**Version**
TP/029	LAS Records Management & Information Lifecycle Policy	

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

As an organisation the London Ambulance Service NHS Trust (LAS) acknowledges that the effective management of document creation within the Trust is an essential part of good governance practice.

Effective control, management and monitoring of procedural documents (as defined in the scope (section 2) contributes to the assurance of:

- safe operations
- risk reduction
- staff awareness of current practice
- delivery of high quality patient care
- effective quality control
- transparency for external stakeholders

2. Scope

This policy and procedure applies to all LAS policies, procedures, protocols, strategies, and plans produced or reviewed by the Trust. It details the approach that the LAS will take in the development, management, implementation, and monitoring of these procedural documents. It also applies to guidance documents except where these are of purely a local nature.

3. Objectives

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

2. To produce 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 define roles and responsibilities for staff, committees and groups of the Trust.

5. To define an approval, and, where appropriate, ratification route for all policies and procedures and embed full ownership and management accountability for document implementation, staff awareness, and compliance that is monitored for effectiveness.

6. To develop and consult on relevant policies and procedures in partnership with Staff Side colleagues.

4. Responsibilities

4.1 The LAS Information Governance Group has overall responsibility for monitoring compliance with this Policy and Procedure and the effectiveness of the system for managing procedural documents.

4.2 The LAS Trust Board, Committees and Groups have responsibility for approval, ratification and monitoring policies and procedures

4.3 Directors/Senior managers have responsibility for approving the development of new procedural documents apart from guidance of a purely local nature. They are also responsible for defining the approval process for all other procedural documents.

4.4 The Information Governance Manager is responsible for operational management and development of the system.

4.5 The Governance and Compliance staff are responsible for the day-to-day management of procedural documents and co-ordination of the system.

4.6 Document authors are responsible for:

- ensuring that they follow this policy and procedure when developing new procedural documents;
- consulting widely with all stakeholders when developing or reviewing a document;
- ensuring that all requirements laid down by legislation and standards are considered and incorporated in their documents;
- reviewing them in a timely manner when requested by the Governance and Compliance department and within the timeframe specified in the procedural document itself;
- managing the review process and securing the approval of the new/ reviewed procedural document.

4.7 Managers throughout the Trust are responsible for ensuring that staff are aware of, and comply with, all relevant procedural documents.

4.8 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.

5. Definitions

5.1 Procedural Document

The term ‘procedural document’ is used throughout this document as an umbrella term for all document types within scope and as detailed below..

5.2 Policy

A policy is a high level statement of principles for action or intent that guides the decision-making and activities of the organisation and describes how an aspect of service provision or governance will be achieved.

5.3 Procedure

A written, approved specification for execution of an activity - often composed of steps, using established methods or forms - designed to achieve a uniform approach to compliance with applicable policies.

5.4 Protocol

In the context of the LAS a protocol is a convention or a predefined written procedural method which guides how an activity, normally clinical, should be performed.

5.5 Guidance

Practically advises how a task may be completed or best practice within which to work. The exercise to which the guidance applies may not be Trust wide and may vary between divisions/ departments / stations. Guidance may also be produced to supplement a procedure.

5.6 Strategy

A long term plan of action, designed to achieve a particular goal in relation to the Trust's strategic aims.

5.7 Plans

A detailed scheme setting out a number of steps or decisions that may be followed in the future in order to achieve a certain aim or objective.

5.8 A document may be one or a combination of the above. The Information Governance Manager will advise if required.

5.9 **Consultation** - the process where internal/ external Stakeholders are asked for their comments and agreement of the document. It will include groups such as staff, staff side, HR, finance, service users, *Note*: to consult does not infer negotiation.

5.10 **Approval** - to sanction and officially confirm that a document is appropriate to the Trust and projects the Strategic Objectives. This is carried out through the committees and groups which provide assurance to the Trust Board.

5.11 **Ratification** – to confirm formal approval of the decision made by a lower committee.

6. Development of documents

6.1 Any member of staff may identify a need to develop a new document or amend an existing document that affects the way services, functions and activities are performed and delivered.

6.2 All documents to be developed / reviewed must have the prior approval of the relevant **Director/ Senior Manager**. If appropriate, the relevant Human Resources Policy Lead should be involved. The **Director/ Senior Manager** will identify whether to proceed to draft with the application.

6.3 The relevant **Director/ Senior Manager** will identify an **author (Owner)** to develop the new document. The task may be delegated to a group of individuals or an appropriate manager. Staff Side representation will be included if appropriate.

6.4 Once approval for the creation of the document is obtained, the **Director/ Senior Manager** will send an email notification to Information Governance stating that approval has been given, the working title of the document and name of author. A document reference number should be requested and will be allocated by the Information Governance Manager.

6.5 The author of a document is required to consult widely with all stakeholders whenever a new document is being developed, or an existing document is due for review. Where appropriate the author should forward a copy of the draft to Staff Side and approach external bodies as part of the consultation process. The author will keep a record of this consultation process.

6.6 All draft documents should follow the trust document template (see Appendix 2). Note: the Implementation Plan must be completed.

6.7 An Equality Analysis must be completed by the owner for each procedural document, with the exception of some guidance material. Once completed the owner must ensure that the EqIA is signed off by the appropriate Director before it is sent to the Information Governance Manager who will arrange publication on the LAS website. The owner must record the date of completion of the Equality Analysis on the Document Profile and Control sheet at the front of the document. No policies/procedures should normally be accepted onto the agenda of a group/committee for approval without an Equality Analysis in place.

6.8 If a procedural document is developed as a result of a new project the author should check with the project manager to see whether an Initial Privacy Impact Assessment has been carried out. If not, it is the responsibility of the project manager to carry this out before any related procedural document is approved.

6.9 All policies and procedures developed or reviewed within the Operations Directorate will initially be tabled at the weekly ADOs meeting for discussion and

agreement. Following agreement the document will be presented by the lead Assistant Director/Head of Department (or equivalent) to the next Associate Directors' Group (ADG) meeting for approval. Any changes/amendments agreed will then be made by the author and re-submitted if required. If it is a new policy/procedure or one that has been substantially changed the document, once approved, will be sent to SMG for ratification.

6.10 All other policies and procedures will be submitted by the lead Assistant Director/Head of Department (or equivalent) to the next Associate Directors' Group (ADG) meeting for approval. Any changes/amendments agreed will then be made by the author and re-submitted if required. If it is a new policy/procedure or one that has been substantially changed the document, once approved, will be sent to SMG for ratification.

6.11 The Associate Directors' Group will produce a monthly report for the SMG on policies reviewed and those approved.

6.12 Should a procedural document require urgent approval, a committee senior to the one normally designated may take on this role.

6.13 Following approval/ ratification, the author will finalise the Document Profile and Control sheet except for the 'Published' and 'Announced' sections and forward the approved document to Information Governance for conversion into a PDF read only file.

6.14 An approved master copy of the document will then be stored electronically by the Governance and Compliance department. The document will be added to the LAS Intranet site (The Pulse) for staff to access. All policies will also be made publicly available through the Trust's Publication scheme on the LAS website and procedures will also be added to the Publication Scheme if considered suitable for release under the Freedom of Information Act 2000 (FOIA).

The flowchart for the stages for procedural document development is at Appendix 1.

7. Issue, implementation and monitoring of new and revised documents

7.1 Issue

The issue of documents will be announced in the Routine Information Bulletin (RIB) by Governance and Compliance who will place a full electronic version and a summary of the document on *'the pulse'* and where appropriate a copy on the LAS website. The date of the announcement will be recorded in the Document Profile and Control section. 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.

7.2 Implementation Plan and Monitoring

The Implementation Plan is an integral part of each policy and procedure and will be provided by the author. This records the intended audience, details of dissemination and distribution, communications and awareness, training to be provided if required, and monitoring of compliance. (see template at Appendix 2 for further details).

Methods of monitoring compliance will include the identification of relevant standards and key performance indicators. Policies and Procedures may also be subject to internal or external audit, to ensure full compliance is taking place as required.

To ensure effective compliance with Procedural documents the possibility of introducing an electronic system which will manage their lifecycle and enable staff to receive training on, and increase awareness and understanding of, procedural documents will be investigated.

8. Review system

8.1 It will be the responsibility of author/ Owner to ensure that policies and procedures and other documents that have been allocated a review period are reviewed in a timely manner. To facilitate this Information Governance will notify the owner six months prior to the review date and a list of document review dates will be made available on the Pulse. If after three months prior to the review date no progress has been made the owner will receive a reminder email with a copy sent to the sponsor.

8.2 Review of a document will require a further Equality Analysis to be carried out if major changes are made.

8.3 The standard review period for a policy or procedure will be three years and this is the maximum period allowable before a review must take place. However, the author may decide on a shorter review period as it is the responsibility of the author of a document to ensure that it is kept up to-date, relevant and evidence based in light of best practice. The review period should also be set to reflect external requirements or anticipated changes where these are less than three years. Documents may be reviewed, following the consultation process in section 7, at any time if required. Any policy and procedure review, which in the opinion of the Governance and Compliance department results in only minor updates of an administrative or organisational nature, will not require further approval by the appropriate Trust committee.

9. Style and Format

9.1 Procedural documents will conform to the approved Trust style, as detailed on the Pulse.

9.2 The following format specification will be applied to create an approved corporate style document (see example template of a policy or procedure in Appendix 2.

9.3 **Document title box** to follow the format as in Appendix 2.

9.4 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.

9.5 The **Document profile and control** section must be completed by the author and the Governance and Compliance department as appropriate in order that version control is maintained. Authors must add references to 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.

9.6 Where 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).

10. Document and version control

10.1 Document Control and Archiving

The Document Profile and Control section at the start of each document provides important metadata – information on the ownership, document status and development history, version, approval, publication, and details of references and related documents.

The master documents will be electronic and maintained by the Governance and Compliance department in linked areas of the Trust's intranet, the Pulse. All current policies will also normally be placed in the Trust's Freedom of Information Publication Scheme on the external Website. Procedures may also be included in the Publication Scheme where there may be a particular public interest in the subject area concerned. All policies and procedures may be downloaded and/or printed from these sites but as these are controlled documents staff will no longer be issued with personal copies and they are only current at the time of download/print and are not to be regarded as definitive documents.

The Governance and Compliance department will maintain archived electronic copies of all superseded and obsolete policies and procedures for 25 years and previous versions are available upon application to Records Management.

10.2 Version Control

Version control will be used to manage all procedural documents and will follow major or minor versions (i.e. v.1 or v1.1) format.

The Information Governance Manager will allocate an alphanumeric index number to each document according to the type of document:

- **T**rust **P**olicies and procedures will commence with **TP**
- **O**perational **P**rocedures will commence **OP**
- Service forms will be allocated a new **LA** number
- **Pl**ans will commence with **PL**
- **St**rategies will commence with **ST**
- **Pr**otocols will commence with **PR**
- **Gu**idance will commence with **GU**
- **H**uman **R**esource will commence **HR**
- **H**ealth and **S**afety will commence with **HS**
- **C**ontrol **S**ervice **O**perational **P**rocedures will commence with **CSOP**

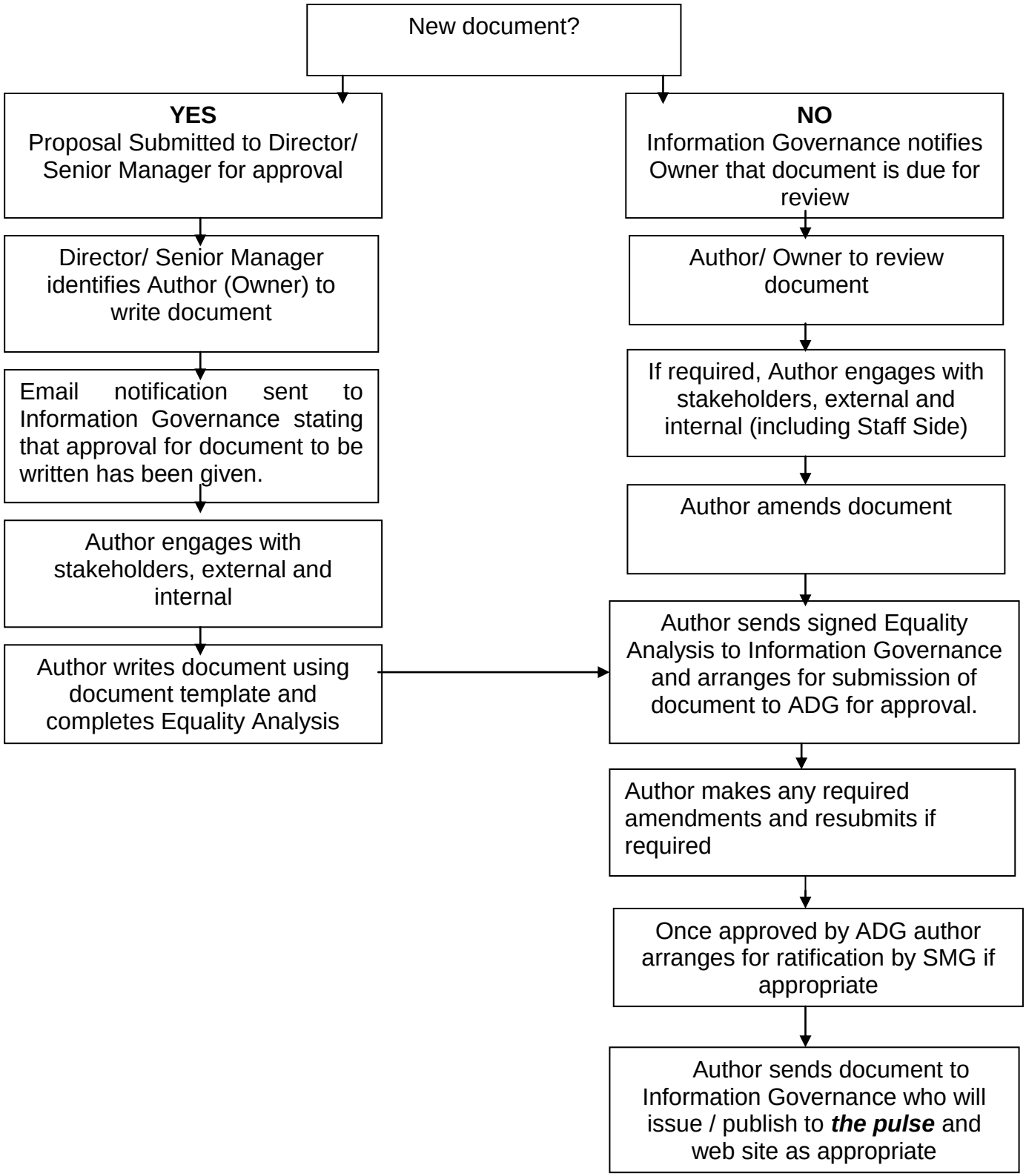
A document control footer will be completed by the author which should contain the document reference number, the title of the document and the page number and total number of pages. For filing and archiving purposes the filename and path should be included as a footer to the document.

Implementation Plan

IMPLEMENTATION PLAN	
Intended Audience	All LAS Staff
Dissemination	Available to all staff on the Pulse and to the public on the LAS website. This will be co-coordinated by the Governance and Compliance Team.
Communications	Revised Policy and Procedure to be announced in the RIB and a link provided to the document by the Governance Compliance department.
Training	It is planned to provide specific training from 2010 onwards for those members of staff who are required to develop, write and review procedural documents. Governance and Compliance Team.will co-ordinate this.
Monitoring	It is expected that all documents within the defined scope will comply with this policy and procedure. The Policy and Procedure Approval Process will be monitored on an annual basis by the Head of Records Management and a report compiled on the effectiveness of the process and any changes required will be made to the Information Governance Group An audit of the procedural documents management system will be undertaken every two years by Internal Audit to check that this policy and procedure is being followed. This will involve a random sample of all documents, including those archived within the previous two years. The results of the audit will be presented to the Information Governance Group who will ultimately be responsible for the development and monitoring of any identified actions within the scope of the audit. The Information Governance Group (IGG) reports through to the Risk Compliance and Assurance Group who will monitor outcomes and recommendations from these reports.

Appendix 1

Stages for Procedural Document Development



Appendix 2

London Ambulance Service NHS Trust
Document Title

DOCUMENT PROFILE and CONTROL.

Purpose of the document:
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Sponsor Department: **********

Author/Reviewer: **********. To be reviewed by xxx 2012.

Document Status: Draft/ Final

Amendment History			
Date	*Version	Author/Contributor	Amendment Details
XX/XX/XX	0.2	**********	Minor - **********
	0.1		

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For Approval By:	**Date Approved**	**Version**
**********	XX/XX/XX	1.0
Ratified by (If appropriate):		
**********	XX/XX/XX	

Published on:	**Date**	**By**	**Dept**
The Pulse	XX/XX/XX	Records Manager	GCT
LAS Website	XX/XX/XX	Records Manager	GCT
Announced on:	**Date**	**By**	**Dept**
The RIB		Records Manager	GCT

Equality Analysiscompleted on	**By**
Staffside reviewed on	**By**

Links to Related documents or references providing additional information		
Ref. No.	**Title**	**Version**

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1. Introduction

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

2. Scope

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

3. Objectives

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

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

4. Responsibilities

The responsibilities and duties of postholders and committees must be clearly defined.

Post Holder 1 - ********** Post holder 2 - **********

5. Definitions (optional)

List and describe the meaning of terms used in the context of the document where required for clarity.

********** **********
********** **********

This is where the author writes the details of the specific document. There will be instances where for clarity of governance or administrative convenience a policy and procedure are combined into one document.

6. First Heading

6.1 **********

6.2 **********

7. Second Heading

7.1 **********
****

7.1.2**********

7.1.3**********

7.1.4**********

7.2. **********
****

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

Implementation Plan

To be completed by the author

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: ***List aspects/Key elements of the policy that will be monitored,*** *e.g., training records, employment checks, etc* ***What tool will be used and how often will this take place*** *,e.g., annual audit of x, monthly report, quarterly statistical analysis of x, weekly inspection of x, etc* ***Who is responsible for carrying this out? Title of individual/team that will do this,*** *e.g., Head of Legal Service, Director of Finance, Clinical Audit Team, etc* ***Name of Group/committee where the results will be reported,*** *e.g., Learning from Experience Group, Information Governance Group, Infection Control Steering Group, Assessment Steering Group, HR, H&S, etc* ***Who monitors outcomes/ recommendations?*** ***Name of Higher level group/committee that will monitor outcomes/ recommendations and how learning will take place****, e.g., Trust Board, Audit Committee, RCAG, Quality Committee, Clinical Safety and Effectiveness Committee*

[Appendix x]

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.

Appendices must be made reference to within the main body of the document. They should provide additional evidence or explanation of a subject.