East of England Ambulance Service NHS Trust

Policy for the Development of Procedural Documents

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DOCUMENT CHANGE HISTORY		
Initiated by	**Date**	**Author (s)**
Integrated Governance Committee (IGC)	18th July 2008	Associate Director of Corporate Affairs
Version	**Date**	**Comments (i.e. viewed, or reviewed, amended approved by person or committee)**
V1.0	8th August 2008	Approved at Trust Board
V2.0	1st October 2008	Approved at Trust Board
V3.0	September 2011	Approved at Trust Board
V4.0	30th July 2012	Approved at EMT
V5.0	17 November 2016	Approved by ELB
V5.0	September 2018	6 month extension approved at IGG
V5.0	11 October 2018	Approved by SLB
V5.1	February 2019	Review by Corporate Records Manager/FOI Officer
V5.1	12 March 2019	Approved by IGG
V6.0	20 March 2019	Approved by Management Assurance Group

Document Reference	Directorate: Clinical Quality and Improvement
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Valid Until Date	March 2021
Equality Analysis	Completed
Linked procedural documents	Records Management Policy and Procedures Information Governance Strategy Information Governance Policy
Dissemination requirements	All personnel, via staff bulletins and the intranet
Part of Trust's publication scheme	Yes

The East of England Ambulance Service NHS Trust has made every effort to ensure this policy does not have the effect of unlawful discrimination on the grounds of the protected characteristics of: age, disability, gender reassignment, race, religion/belief, gender, sexual orientation, marriage/civil partnership, pregnancy/maternity. The Trust will not tolerate unfair discrimination on the basis of spent criminal convictions, Trade Union membership or non-membership. In addition, the Trust will have due regard to advancing equality of opportunity between people from different groups and foster good relations between people from different groups. This policy applies to all individuals working at all levels and grades for the Trust, including senior managers, officers, directors, non-executive directors, employees (whether permanent, fixed-term or temporary), consultants, governors, contractors, trainees, seconded staff, homeworkers, casual workers and agency staff, volunteers, interns, agents, sponsors, or any other person associated with the Trust.

All Trust policies can be provided in alternative formats.

Contents

Paragraph		Page
1.	Introduction	5
2.	Purpose and Scope	5
3.	Duties	5
4.	Definitions	6
4.1	Strategies	6
4.2	Policies	6
4.3	Procedures	7
4.4	Guidelines	7
5.	Document Development	7
5.1	Development	7
5.2	Consultation	7
5.3	Format	7
5.4	Monitoring Table	8
5.5	Equality Analysis	8
5.6	Version Control	8
5.7	Document Reference Numbers	9
5.8	Recommendation and Approval	9
6.	Implementation and Monitoring	9
7.	Operational Documents	10
8.	Review and Revision Arrangements	11
9.	Document Control including Archiving Arrangements	11
10.	Associated Documents	12
11.	References	12

Paragraph Appendices		Page
Appendix A	Director and Committee responsibility	13
Appendix B	Procedural Documents which must be NHSLA compliant	16
Appendix C	Trust Procedural Document Template	17
Appendix D	Flowchart for the Creation and Implementation of Procedural Documents	21
Appendix E	Operational Procedural Documents Approval Process	23
Appendix F	AOC ESOPs and Instruction Approval Process	24
Appendix G	Monitoring Table Template	25
Appendix H	Completed Monitoring Table	26
Appendix I	Equality Impact Assessment	28

1.0 Introduction

NHS organisations must to have in place procedural documents which are clear and comply with relevant legislation and national directives. Such documents should be appropriate, practical and assist staff in the application of consistent best practice across the East of England Ambulance Service (EEAST).

All procedural documents, including policies, procedures, guidelines etc, must be approved and sent to the Corporate Records Manager/FOI Officer for publication and to ensure they meet all aspects of this document.

2.0 Purpose

This Policy details the approved process for creating, renewing, approving, distributing, implementing and monitoring all EEAST procedural documents.

3.0 Responsibilities

3.1 Information Governance Group

The Information Governance (IG) Group has overall responsibility for this Policy and the processes for the development and management of procedural documents.

3.2 Directors/Senior Managers

Directors/Senior Managers are responsible for the development, implementation and review of approved procedural documents within their delegated portfolios. They are also responsible for identifying and agreeing the need for such documents.

3.3 Head of Governance

The Head of Governance has over-arching responsibility through the Information Governance (IG) Group for the processes involved in the development and management of procedural documents across EEAST.

The Head of Governance has responsibility for independently assessing compliance with this Policy and for reporting to the Audit Committee.

The Head of Governance is responsible for ensuring that the Policy and Procedure Action Log (see Appendix B) is completed following each Management Assurance Group (MAG) meeting and other Trust Board Sub-Committees and sent to the Corporate Records Manager/FOI Officer. Where no documents have been presented, they must complete the log stating this.

3.4 Approving Committees/Groups

Once a document has received final approval it is the responsibility of the chair/minute taker of the approving group/committee to ensure that the completed Policy and Procedure Approval Action Log (see Appendix B) has been sent to the Corporate Records Manager/FOI Officer.

For the purposes of any Trust Board or Trust Board Sub-Committee approval the Head of Governance is responsible for ensuring that the Policy Action Log is completed following each Management Assurance Group (MAG) meeting and other Trust Board Sub-Committees and

sent to the Corporate Records Manager/FOI Officer. Where no documents have been presented, they must complete the log stating this.

Appendix A sets out which Committees/Groups can recommend and approve identified procedural documents.

3.5 Compliance and Standards Lead

The Compliance and Standards Lead has overall responsibility for the safe systems and processes in place for the management of procedural documents.

3.6 Information Governance Manager

The Information Governance Manager is responsible for escalating any procedural documents that have not been reviewed and updated 30 days after their Valid Until Date

3.7 Corporate Records Manager/FOI Officer

The Corporate Records Manager/FOI Officer is responsible for generating the reference numbers for each procedural document, as well as uploading approved documents to the Document Library and managing the Policy module within HealthAssure. They are also responsible for this Policy and the ensuring that it is complied with.

Authors will receive an initial reminder before a procedural document's review date, followed by a 3 month reminder to ensure that there is plenty of time to review or draft a replacement before the current document becomes out of date.

3.8 Authors and Document Leads

Authors and Leads are responsible for ensuring that the document has been recommended by the relevant committee/group and is sent to the Management Assurance Group for approval.

3.9 Communications Team

The Trust Communications Team will assist in the distribution of procedural documents where required.

3.10 All Members of Staff

All members of staff involved in the production of procedural documents must follow the processes and requirements in this Policy.

4.0 Definitions

4.1 Strategies

An organisation-wide, high-level plan designed to achieve a particular long term aim. It is not static but evolves in response to changing circumstances.

4.2 Policies

A policy is a ratified corporate plan of action that outlines how the Trust will comply with legislation or directives, or is developed to ensure the implementation of a particular Trust strategy. It is mandatory for all staff members to comply with Trust policies.

4.3 Procedures/Manuals (includes Clinical Standard Operating Procedures)

A procedure is a standardised series of actions to accomplish an objective (sequence, timing, execution etc.) usually developed to describe the methods for implementing policy. This will apply to all relevant members of staff as a 'must do' document.

4.4 Guidelines/Guidance (includes Standard Operating Guidelines, Operational Instructions etc)

A guideline is a formal document that outlines Trust and accepted national best practice, and acts in an advisory way. Guidelines are not mandatory, however it is expected that staff members will follow guidelines except in exceptional circumstances.

For further information regarding Operational Instructions, Standard Operational Guidelines, Clinical Standard Operating Procedures and Manuals please see section 7.0.

5.0 Document Development

5.1 Development

Please see flow chart – Appendix D

All procedural documents must be approved by the relevant lead Director/Senior Manager prior to creation. The Director/Senior Manager will then delegate responsibility for this procedural document to a member of staff as the author.

The author must then email the Corporate Records/FoI Officer requesting a document reference number. (see section 5.7)

5.2 Consultation

The author is responsible for ensuring that all relevant stakeholders are involved in the development of the draft document. Anyone with an interest in a procedural document can be considered a stakeholder. They may be representatives of personnel or third parties. Documents for consultation should be circulated widely to ensure that all opinions are noted.

5.3 Format

Procedural documents must be written in plain English and in accordance with the following layout and font styles:

Title	**Arial, font size 16, Bold**
Headings	**Arial, font size 12, bold**
Sub-headings	**Arial, font size 11 bold**
Plain text	Arial font size 11, justified
Titles	Justified to the left
Headings	Justified to the left
Crown Badge	Top right hand corner of the first page

Trust Logo	Next to Crown Badge
Header	Include title of document (except on first sheet)
Footer	Include page numbering (page number of total number of pages) in bottom right hand corner and document name and version number in bottom left hand corner
Sub-headings or paragraphs	Outlined numbered e.g. 3.4
All text	Use plain, jargon-free English and avoid acronyms where possible
Glossary	Include when necessary

Authors are advised to use the Template in Appendix C or in the Document Library which already has the correct format, style and layout already set; the relevant information can just be added straight in. As well as consulting http://east24/Communications/Guidance/Trust-style-and-identity-guidelines.pdf

5.4 Monitoring Table

All procedural documents should have a Monitoring Table attached (see section 7.0)

5.5 Equality Impact Assessments

Equality Impact Assessments (EIA) processes by which we assess the impact of the way we provide our services. They are a legal requirement of the Equality Act 2010.

The purpose of EIA here is to improve the way EEAST develops procedures and policies by ensuring that there is no discrimination in the way they are designed, developed or delivered.

All procedural documents should have a completed Equality Analysis attached. This analysis should be undertaken as the procedural document is being developed (not afterwards) and must be approved by the relevant Director/Senior Manager. No procedural documents where an Equality Analysis is required should be accepted onto the agenda of a group/committee for recommendation/approval without an attached Equality Analysis.

The EIA template, as well as guidance to assist with completing this, can be requested from records.management@eastamb.nhs.uk.

Please see Appendix I for the EIA for this Policy.

5.6 Version Control

All procedural documents should include the document change history on the front page. This will specify the version of the document, and for revisions, list the main items revised within the document.

The following numbering system should be followed:

- All new draft documents should be labelled V0.1, V0.2 etc.
- The approved version will be labelled V1.0
- Draft reviews (significant or minor changes) will then become V1.1, V1.2 etc.
- The subsequent approved version will be V2.0 etc.

5.7 Document Reference Numbers

The Corporate Records Manager/FOI Officer will allocate an alphanumeric index number to each document according to the type of document:

Trust Policies	POL
Plans	PL
Strategies	ST
Guidelines	GU
Standard Operational Procedures (including Clinical and AOC)	SOP
Standard Operating Guidelines (including Clinical and AOC)	SOG
Operational Instructions	OI

5.8 Recommendation and Approval

All procedural documents must be recommended and approved by the appropriate groups/committee with designated or delegated Board authority. At each meeting where procedural documents receive final approval a completed Policy and Procedure Approval Action Log must be sent to the Corporate Records Manager/FoI Officer.

Appendix A sets out which Committees/Groups can recommend and approve identified Procedural Documents.

6.0 Implementation and Monitoring

All procedural documents should have an implementation schedule, where appropriate. This should include the intended audience, dissemination, training (if required) and monitoring of compliance.

Where training has been identified as a requirement, the author will work with the Learning and Development Unit and/or the author to develop a training strategy.

6.1 Dissemination

The author will determine how the procedural document should be disseminated and communicated. This should include clear information on where and how the document can be accessed and retrieved.

Staff will be made aware of any new procedural documents via the Trust's intranet page. If dissemination needs to be carried out more swiftly then local managers will be responsible for this.

Procedural documents must be made available on the Trust intranet, via the Document Library, and key documents must also be made available on the Trust's public website.

6.2 Monitoring Compliance

Monitoring provides assurance that prescribed systems are working and involves collecting information that will help answer questions about the Trust's systems, including:

- Are we managing risk?
- How well are we doing?
- Are we doing the things we said we should?
- Are we making a difference in doing those things?

All policies must include details of how the policy will be monitored, ideally in the form of a completed Monitoring Table. This will include the key standards/areas to be monitored and how this will be done.

It is important that the frequency and detail of the monitoring process is specified and that it can realistically be achieved.

6.3 Process for Monitoring Compliance and Effectiveness of This Policy

The Corporate Records Manager/FoI Officer will monitor compliance and effectiveness in the document review and renewal process on an on-going basis. They will look at:

- the timeliness of review
- the use of the Trust template
- the consultation and approval process

The outcomes and conclusions of this monitoring will be reported to the IG Group as required..

Appendix E shows the Template for Monitoring Table; Appendix F shows the completed Monitoring Table for this Policy.

7.0 Operational Documents

Operational Documents include Operational Instructions, Standard Operational Guidelines, Clinical Standard Operating Procedures, Standard Operating Procedures and Manuals. Due to the nature of these documents it is not practical or necessary for these to go through the whole process detailed above. However, the following steps must be taken:

- Document Numbering – if this is a new document then a number must be requested from the Corporate Records Manager/FoI Officer
- Version control – this must follow the guidance laid out in sections 5.6 and 5.7
- Equality Impact Assessment – an Equality Impact Assessment must be undertaken and documented where appropriate.
- Approval – the document must be approved as per section 5.8
- Monitoring – the document should include a process for monitoring compliance if necessary
- Review – the document should be reviewed as per section 9.0
- Document Control – as per section 10.0

8.0 Review and Revision Arrangements

All Trust documents must have a Valid Until Date. As a minimum, procedural documents should have a full review at least every three years or more frequently if required.

The review process should start 6 months before the Valid Until Date to ensure that the procedural document does not become out of date. The Corporate Records Manager/FOI Officer will send an initial review reminder to the Author 6 months and a follow up 3 months before the procedural document's Valid Until Date.

The author(s) reviewing the document should either:

- Resubmit the Document to the appropriate Committee/Group explaining how it still meets the current requirements and standards.
- Revise and/or rewrite the existing document and repeat the consultation process, where necessary.
- Explain why the document can be safely withdrawn without replacing it with a revised version.

9.0 Document Control including Archiving Arrangements

The Policy Module within HealthAssure is the internal system in place to manage all procedural documents. It is the responsibility of the Corporate Records Manager/FOI officer to ensure that this is kept up to date with information received from authors and approving committees.

9.1 Register/Library of Procedural Documents

The Corporate Records Manager/FOI Officer is responsible for the maintenance of the Document Library (i.e. the register of the Trust's procedural documents held on the intranet).
Once a procedural document has been recommended and approved the minute taker of the approving committee will then send this in Word format to the Corporate Records Manager/FOI officer who will ensure that this is uploaded to both HealthAssure and that a PDF format is uploaded to the Document Library

Each member of staff is responsible for ensuring that any printed version in use is the current approved version of the document.

9.2 Archiving Arrangements

Procedural Documents will be archived when they are no longer 'live' documents but must be retained in case future reference is required or mandated by legislation.

10.0 Associated Documents

These are all of the documents that are associated with the Procedural Document under development, and may include:

- Equality Analysis
- Data Protection Impact Assessment
- Other related Trust policies

11.0 References

Where applicable, all procedural documents must include references to legislation and national directives, e.g.:

NHS Act 2006
Health and Social Care Act 2012
Bribery Act 2010
Equalities Act 2010
Human Rights Act 1998
Data Protection Act 2018
Records Management Code of Practice for Health and Social Care 2016 (Information Governance Alliance)
NHS Constitution

12.0 Appendices

A	Director and Committee responsibility
B	Policy and Procedure Action Log
C	Trust Procedural Document Layout
D	Flowchart for the Creation and Implementation of Procedural Documents
E	Operational Procedural Documents Approval Process
F	AOC ESOPs and Instruction Approval Process
G	Template for Monitoring Table
H	Completed Monitoring Table (for this Policy)
I	Equality Impact Assessment (for this Policy)

Appendix A – Director and Committee responsibility for Procedural Documents
The tables below are to be used as guidance for the approval of procedural documents.

Strategy

Procedural Document Area	Lead	Recommending Group	Approving Committee/Group
Constitution: Standing Orders, Reservation of Powers to Trust Board and Scheme of Delegation	Head of Governance	Audit Committee	Trust Board
Finance: Standing Financial Instructions	Director of Finance and Commissioning	Audit Committee	Trust Board
Business Plans		Executive Leadership Board	Trust Board
Clinical Strategy	Director of Clinical Quality & Improvement	Quality Governance Committee	Trust Board
Fleet Strategy	Director of Strategy & Sustainability	Executive Leadership Board	Trust Board
Health & Safety Strategy	Director of Clinical Quality & Improvement	Executive Leadership Board	Trust Board
Information Governance Strategy	Director of Clinical Quality & Improvement	Audit Committee	Trust Board
Research Strategy	Director of Clinical Quality & Improvement	Quality Governance Committee	Trust Board
Risk Management Strategy	Head of Governance	Audit Committee	Trust Board

Policy

Procedural Document Area	Lead	Recommending Group	Approving Committee/Group
Policy for the Development of Procedural Documents	Director of Clinical Quality & Improvement	IGG	Management Assurance Group
Risk and Safety Management Policies/ Procedures including, Duty of Candour, Management of Incidents including Serious Incidents, Investigations Guidance, Learning from Experience etc	Director of Clinical Quality & Improvement	CQSG	Management Assurance Group
Human Resources	Director of People & Culture	Staff Partnership Forum	Management Assurance Group
Equality and Diversity	Director of People & Culture	Equality, Diversity and Human Rights Steering Group	Management Assurance Group
Information Management & Information Technology	Director of Strategy & Sustainability	Information Governance Group	Management Assurance Group
Communications, Engagement and PPI	Director of Communications	Management Assurance Group	Trust Board
Patient Experience Policies/Procedures, including Complaints	Director of Clinical Quality & Improvement	CQSG	Management Assurance Group
Health and Safety	Director of Clinical Quality & Improvement	Health and Safety Committee	Management Assurance Group
Patient Group Directives	Medical Director	CQSG	Management Assurance Group
Information Governance, including: Release of Information, Freedom of Information, Information Governance, Records Management Policy and Data Protection	Director of Clinical Quality & Improvement	Information Governance Group	Management Assurance Group

Procedural Document Area	Lead	Recommending Group	Approving Committee/Group
Claims and Litigation	Director of Clinical Quality & Improvement	CQSG	Management Assurance Group
Emergency Operations	Director of Service Delivery	SSDG	Management Assurance Group
Civil Contingency Planning	Director of Service Delivery	Executive Leadership Board	Trust Board
Clinical and Clinical Quality	Director of Clinical Quality & Improvement Medical Director	CQSG	Management Assurance Group

Procedures

Procedural Document Area	Executive Lead	Recommending/approving Committee/Group	To receive notes of approval for information only
Clinical Standards Operating Procedures/Guidelines	Director of Clinical Quality & Improvement Medical Director	CQSG	Management Assurance Group
Standard Operating Guidelines (SOGs)	Director of Service Delivery	Operational Leadership Board	Management Assurance Group
Emergency Operations Centre	Director of Service Delivery	Operational Leadership Board	Management Assurance Group
Procurement: Equipment, vehicles and uniforms	Director of Finance and Commissioning	Trust Operations Procurement Group	Management Assurance Group

Appendix B

Policy and Procedure Approval Action Log

Committee/Group name	
Date of meeting	

Document title:	**(Embed document)**	**Author:**	**Agenda item number**	**Outcome (e.g. Approved / Recommended / Approved subject to changes / Requires further clarification)**

If no documents have been presented for approval/recommendation please complete as a 'Nil Return'
Please return completed logs to Records.Management@eastamb.nhs.uk after the respective meeting

Appendix C – Trust Procedural Document Template

NHS
East of England
Ambulance Service
NHS Trust

Title of Procedural Document

Document Reference	To be assigned by Corporate Records Manager
Document Status	Draft [change to Approved once approved]
Version:	When in draft change from V0.1 to V 0.2 and when approved V1.0, or 2.1 – 2.2 – 3.0, etc.

DOCUMENT CHANGE HISTORY		
Initiated by	**Date**	**Author (s)**
[Committee etc. originally requiring/ commissioning]	[Completion date of first Version]	[individual(s)' name], [job title]
Version	**Date**	**Comments (i.e. viewed, or reviewed, amended approved by person or committee)**
Draft V0.1	[date]	Circulated to xx [Group] for comments / Sent to xx Group for approval / reviewed following xxx [impact / event / input] / etc.
(etc.)	[date]	(etc.)
(etc.)	[date]	(etc.)
(etc.)	[date]	Approved by [Management Assurance Group / Trust Board / etc.]

Document Reference	[e.g. NHSLA – Relevant to standard x …] Directorate: [name of owning Directorate]
Recommended at Date	[name of Recommending Specialist Working Group] [Date of Recommendation for Approval]
Approved at Date	[name of Approving Committee / Group] [Date of Approval]
Valid Until Date	[Date by which this Version must be reviewed and updated / replaced by NEXT Version]
Equality Analysis	Completed [Date]
Linked procedural documents	Xxx Policy Yyy Strategy
Dissemination requirements	[To whom? By what method(s) ?]
Part of Trust's publication scheme	Yes / No?

The East of England Ambulance Service NHS Trust has made every effort to ensure this policy does not have the effect of unlawful discrimination on the grounds of the protected characteristics of: age, disability, gender reassignment, race, religion/belief, gender, sexual orientation, marriage/civil partnership, pregnancy/maternity. The Trust will not tolerate unfair discrimination on the basis of spent criminal convictions, Trade Union membership or non-membership. In addition, the Trust will have due regard to advancing equality of opportunity between people from different groups and foster good relations between people from different groups. This policy applies to all individuals working at all levels and grades for the Trust, including senior managers, officers, directors, non-executive directors, employees (whether permanent, fixed-term or temporary), consultants, governors, contractors, trainees, seconded staff, homeworkers, casual workers and agency staff, volunteers, interns, agents, sponsors, or any other person associated with the Trust.

All Trust policies can be provided in alternative formats.

Contents

Paragraph		Page
1.	Introduction	4
2.	Purpose	4
3.	Duties	x
3.1	[First duty-holder(s)]	x
3.2	[Second duty-holder(s)]	x
(etc.)	[Further duty-holder(s)]	x
3.n	Consultation and Communication with Stakeholders	x
4.	Definitions	x

Appendices

Appendix A	[Title of this Appendix]	x
Appendix B	[Title of this Appendix]	x
Appendix C	[Title of this Appendix]	x
(etc.)		

1. Introduction

[Introductory section to this document]

2. Purpose

[What is the aim of this document? Why is it being written?]

3. Duties

3.1 [First Duty-holder(s) e.g. Chief Executive]

[Clarify the duties of each of those responsible for all or aspects of this document]

3.2 (etc.) [Second etc. Duty-holder(s) e.g. specific Assistant Director]

4. Definitions

[Explanations of key words and phrases]

5. [Main body of document – first heading]

(etc.) [Main body of document – further headings]

Appendices

A	Monitoring Table
B	Equality Analysis
(etc.)	

Appendix D - Flowchart for the Creation and Implementation of Procedural Documents

Step 1
Rationale & Priority

↓

Read “Policy for the Development of Procedural Documents”

↓

Prioritisation – is this document needed?

↓

Ensure proposed document does not duplicate work internally or externally

↓

Gain approval from relevant Director/Senior Manager

Step 2
Development Plan

↓

Who will develop and write the Document?

↓

Email Corporate Records Manager/FOI Officer for document reference number

↓

Identify all relevant stakeholders

Step 3
Content

↓

Identify objectives – what do you want to achieve?

↓

Target audience – who is the document aimed at?

↓

Plan to develop any necessary support information, leaflets, etc

Step 4
Evidence Base

↓

Identify and categorise all evidence require – local and national

↓

Include references cited in full

Step 5
Dissemination, Implementation & Access

↓

a) Identify who will be responsible for disseminating the Policy and when it will begin being implemented

↓

If necessary discuss with Learning & Development

↓

How and where will personnel access the Document (at operational level)?

Step 6
Consultation & Approval

↓

Consult all relevant stakeholders

↓

All Procedural Documents with HR implications must go to staff side/HR committee

↓

Complete the Template

↓

Complete Monitoring Table and Equality Analysis during document development

↓

Gain approval of the appropriate delegated Group/Committee as outlined Appendix A of this Policy or as outlined in the Trust Board's Scheme of Delegation

↓

Once approved resend the Document Corporate Records Manager/FOI Officer for Document Library upload

Step 7
Monitoring, Compliance, Review

↓

Implement monitoring arrangements as in the Monitoring Table

↓

Implement necessary changes to improve compliance and effectiveness

↓

Review as required or when the review date is reached

↓

Are the proposed changes minor or is full review required?

↓

Re-approve document at appropriate committee/group

↓

Corporate Records Manager/FOI Officer will archive old versions of the document

Step 8
Responsibility

↓

Who will co-ordinate development, implementation and review of the document?

Appendix E: Operational Procedural Documents Approval Process

STAGE	REQUIREMENTS	Signed off by / GROUP
INITIAL PROCESS IDENTIFIED	• Document is written in draft & shared with relevant committee for initial discussion & approval to continue • Standard template to be used	**Committee as per Appendix A**
TESTING	• Document is reviewed & tested by appropriate departments	
FIRST DRAFT	• Draft version is reviewed by relevant Senior Managers for comments • Document to be labelled (V0.1 , V0,2 etc) and must have a 'draft' watermark	**Senior Managers**
EXTERNAL APPROVAL by stakeholders	• Where identified that process will have impact on other directorates the author will send to appropriate contacts for review	**Other directorates as required**
SECOND DRAFT	• Author to review second draft and prepare for distribution • Risk assessment to be produced if required (if patient risk identified) • Unique reference number to be assigned by Corporate Records Manager	
SIGN OFF	• CQSG sign off document (risk assessment where applicable) • Documents to be sent to SLB for final approval	**CQSG SLB**
RELEASE	• Document number to be revised for final version (v1.0, V2.0 etc) • Release date and review date to be added • Document must have record of author and sign off • Document to be saved in PDF format • Released to appropriate staff via Communications	

Appendix F: AOC ESOP and Instruction Approval Process

STAGE	REQUIREMENTS	Signed off by / GROUP
INITIAL PROCESS IDENTIFIED	• Document is written in draft & shared with AOC Leadership Team for initial discussion & approval to continue • Standard template to be used	**AOC Senior Leadership team**
TESTING	• Document is reviewed & tested by appropriate departments (AOC Leadership Team confirm who needs to test / review).	**AOC Senior Leadership team**
FIRST DRAFT	• Draft version is reviewed by relevant Senior Managers and AOC Audit & Training Manager for comments • Document to be labelled (V0.1 , V0,2 etc) and must have a 'draft' watermark	**AOC Senior Leadership team**
EXTERNAL APPROVAL by stakeholders	• Where identified that process will have impact on other directorates AOC Audit & Training Manager will send to appropriate contacts for review (noted at AOC Leadership Team meeting)	**May include OLB, SPF**
SECOND DRAFT	• Head of AOC / SEMs / AOC Audit and Training Manager to review second draft and prepare for distribution • Risk assessment to be produced if required (if patient risk identified) • Unique reference number to be assigned • AOC Audit and Training Manager to add to Document Control List	**AOC Senior Leadership team**
SIGN OFF	• Head of AOC to send to AOC Clinical Focus Group where appropriate (all documents that require CQSG sign off) • CQSG sign off document (risk assessment where applicable) • Head of AOC to sign off where no CQSG sign off required (memos or other updates that *only* impact AOC users, normally minor in nature)	**AOC Clinical Focus Group (ACFG) CQSG Head of AOC**
RELEASE	• Document number to be revised for final version (v1.0, V2.0 etc) • Release date and review date to be added • Document must have record of author and sign off • Document to be saved in PDF format • Released to appropriate staff via AOC Communications email • AOC SEMs to ensure sign off at each AOC • AOC Audit and Training Manager to update document control record • AOC Audit and Training Manager to send to Communications Team for updating on intranet • AOC Leadership Team to note at team meeting • AOC Audit and Training Manager to save in p drive with link to Health Assure	

Additional notes: Documents should be read and signed by staff prior to Go-Live date or at the beginning of their first shift following 'Go-live' (as per sign off process – currently hard copy signature file by team).Documents requiring urgent release to be highlighted as such All new Call Handling processes to be given an 'audit grace' period where performance standards / scoring changes are required (written feedback will be provided advising of new process under all circumstances)

Appendix G – Template for Monitoring Table

Use this template to show the monitoring process of the document

What	Who	How	Frequency	Evidence	Reporting arrangements	Acting on recommendations	Change in practice and lessons to be shared
What key element that need monitoring	**Role or group who will lead on this aspect of monitoring?**	**What tool will be used to monitor/ check/ observe/ asses/ inspect/ authenticate that everything is working according to this key element**	**How often is monitoring needed** **How often should a report be completed?** **How should a report be shared?**	**What type of evidence will be presented**	**Who or what committee will the completed report go to and how will this be monitored.** **How will each report be interrogated to identify the required actions and how thoroughly should this be documented in e.g. meeting minutes**	**Which committee, department or lead will undertake subsequent recommendations and action planning for any or all deficiencies and recommendations within reasonable timeframes?**	**How will system or practice changes be implemented lessons learned and how will these be shared.**
				.	*The lead or committee is expected to read and interrogate any report to identify deficiencies in the system and act upon them*	*Required actions will be identified and completed in a specified timeframe.*	*Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.*

Appendix H – Completed monitoring table for this Policy

What	*Who*	*How*	*Frequency*	*Evidence*	*Reporting arrangements*	*Acting on recommend-ations*	*Change in practice and lessons to be shared*
Ensure the style and format of the document is in line with the Trust's requirements	Information Governance Team	The Corporate Records Manager/FOI Officer will review this aspect of the document prior to it being proposed for recommendation for approval, and if necessary it will be returned to the author for amendment	At each review of the document.	The document register / library will act as an audit trail	Reported to the Information Governance Team and where necessary discussed and minuted at the Information Governance Group	The document author will address any actions or changes required.	Required changes to practice will be identified and actioned. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.
All ambiguous language and non generic terms are explained and elaborated to ensure the understanding of the audience is fully gained	Information Governance Team	The Corporate Records Manager/FOI Officer will review this aspect of the document prior to it being proposed for recommendation for Approval, and if necessary it will be returned to the author for amendment	At each review of the document.	The document register / library will act as an audit trail	Reported to the Information Governance Team and where necessary discussed and minuted at the Information Governance Group	The document author will address any actions or changes required	Required changes to practice will be identified and actioned. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.
The document has been circulated to all relevant stakeholders for information and feedback	Information Governance Team	The Corporate Records Manager/FOI Officer will review this aspect of the document prior to it being proposed for recommendation for Approval, and if necessary it will be returned to the author for amendment	At each review of the document.	The document register / library will act as an audit trail	Reported to the Information Governance Team and where necessary discussed and minuted at the Information Governance Group	The document author will address any actions or changes required	Required changes to practice will be identified and actioned. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.
The document has passed through the correct route for approval to ensure that the relevant group / committee has given the final sign off.	Information Governance Team	The Corporate Records Manager/FOI Officer will review this aspect of the document prior to it being accepted and added to the register/library and made available and if necessary it will be returned to the author for correct approval	At each review of the document.	The document register / library will act as an audit trail	Reported to the Information Governance Team and where necessary discussed and minuted at the Information Governance Group	The document author will address any actions or changes required	Required changes to practice will be identified and actioned. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.
For the document to be reviewed in advance of its formal review date to ensure changes can be consulted on and approved in good time for it to be re-published before 'expiry'	Information Governance Team	The Corporate Records/FOI Officer will note and record this aspect of the document's development process at respective stages	At each review of the document.	Using minutes from Recom-mending and Approving Groups / commit-tees, the document	Reported to the Information Governance Team and where necessary discussed and minuted at the Information Governance Group	The document author will address any actions or changes required	Required changes to practice will be identified and actioned. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

				register / library will act as an audit trail			
Ensure that the document has clear version control and archiving arrangements are outlined	Information Governance Team	The Corporate Records/FOI Officer will review this aspect of the document prior to it being proposed for recommendation for Approval, and if necessary it will be returned to the author for amendment	At each review of the document.	The document register / library will act as an audit trail	Reported to the Information Governance Team and where necessary discussed and minuted at the Information Governance Group	The document author will address any actions or changes required	Required changes to practice will be identified and actioned. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.
All other procedural documents that either have an impact on or are to be read in conjunction with this document are clearly identified within its body	Information Governance Team	The Corporate Records/FOI Officer will review this aspect of the document prior to it being proposed for recommendation for Approval, and if necessary it will be returned to the author for amendment	At each review of the document.	The document register / library will act as an audit trail	Reported to the Information Governance Team and where necessary discussed and minuted at the Information Governance Group	The document author will address any actions or changes required	Required changes to practice will be identified and actioned. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.
All legislative references are recognised within a section of the document using their full titles and dates	Information Governance Team	The Corporate Records/FOI Officer will review this aspect of the document prior to it being proposed for recommendation for Approval, and if necessary it will be returned to the author for amendment	At each review of the document.	The document register / library will act as an audit trail	Reported to the Information Governance Team and where necessary discussed and minuted at the Information Governance Group	The document author will address any actions or changes required	Required changes to practice will be identified and actioned. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

Appendix I – Equality Impact Assessment Guidance and Template

Guidance Notes

Equality Impact Assessments (EIA) and Equality Analysis are processes by which we assess or test the impact of the way we provide our services be it services to our communities or staff. They are relevant to all of our services, policies and procedures and functions. They are a legal requirement and adhere to the EDS2 and Equality Act 2010.

EIA's are primarily used to help us demonstrate that we have considered equality and is designed to make us challenge our own assumptions about whether a policy or service is fair to all? We need to ensure and provide evidence that people are not being excluded or treated unfairly. We collect this evidence via equality analysis.

Providing information

We have a wealth of information that we can call on to help us assess the impact of our services, policies and procedures from an equality perspective. This could include data that is routinely collected. It can also include minutes from management or team meetings. It could simply be conversations we have with our staff and communities / service users who have used a particular service. Information could come from outside the service l, such as our partners or visitors. Anything that helps inform our understanding can be included.

Protected Characteristics

Through the EIA process, we are asking managers and staff to think seriously about equality based on the protected characteristics which we are bound by law to consider:

Race	**Religion/belief**	**Marriage/Civil Partnership**
Gender	**Disability**	**Sexual orientation**
Age	**Gender re-assignment**	**Pregnancy/maternity**

Action Plans

You may find that you need more information to help make a full assessment. Please put down what information you need and identify in the action plan, how you intend to collect it. When completing your action plan it is important that you clearly state where within existing management structures those actions will be performance monitored.

Guidelines	
Written policy involving staff and patients	
Strategy	
Changes in practice	
Department changes	
Project plan/Action plan	
Other (please state) Training Programme	

Please do not view EIAs as a simple tick box exercise designed to placate or meet the needs of some bureaucratic government department and something which can be ignored. Should we ever face a legal challenge on the grounds of discrimination, we will be asked to demonstrate to the courts that we have met the full requirements of the law. The completed EIA is ours/your written evidence of our commitment to equality, diversity, inclusion and human rights.

Equality Impact Assessment

EIA Cover Sheet	
Name of process/policy	
Is the process new or existing? If existing, state policy reference number	
Person responsible for process/policy	
Directorate and department/section	
Name of assessment lead or EIA assessment team members	
Has consultation taken place? Was consultation internal or external? (please state below):	
Internal	
.	
The assessment is being made on: Please tick whether the area being assessed is new or existing.	Guidelines Written policy involving staff and patients patients Strategy Changes in practice Department changes Project plan Action plan Other (please state) Training programme.

Equality Analysis

What is the aim of the policy/procedure/practice/event?

Who does the policy/procedure/practice/event impact on?

Race	☐	**Religion/belief**	☐	**Marriage/Civil Partnership**	☐
Gender	☐	**Disability**	☐	**Sexual orientation**	☐
Age	☐	**Gender re-assignment**	☐	**Pregnancy/maternity**	☐

Who is responsible for monitoring the policy/procedure/practice/event?

What information is currently available on the impact of this policy/procedure/practice/event?

Do you need more guidance before you can make an assessment about this policy/procedure/ practice/event? Yes/No

Do you have any examples that show that this policy/procedure/practice/event is having a positive impact on any of the following protected characteristics? Yes/No, If yes please provide evidence/examples:

Race	☐	**Religion/belief**	☐	**Marriage/Civil Partnership**	☐
Gender	☐	**Disability**	☐	**Sexual orientation**	☐
Age	☐	**Gender re-assignment**	☐	**Pregnancy/maternity**	☐

Please provide evidence:

Are there any concerns that this policy/procedure/practice/event could have a negative impact on any of the following characteristics? Yes/No, if so please provide evidence/examples:

Race	☐	**Religion/belief**	☐	**Marriage/Civil Partnership**	☐
Gender	☐	**Disability**	☐	**Sexual orientation**	☐
Age	☐	**Gender re-assignment**	☐	**Pregnancy/maternity**	☐

Please provide evidence:

Action Plan/Plans - SMART **S**pecific **M**easurable **A**chievable **R**elevant **T**ime Limited

Evaluation Monitoring Plan/how will this be monitored? Who How By Reported to

Appendix J – Equality Impact Assessment

EIA Cover Sheet

Name of process/policy	Policy for the Development of Procedural Documents
Is the process new or existing? If existing, state policy reference number	POL001
Person responsible for process/policy	Gail Butler
Directorate and department/section	Nursing & Quality Improvement – Compliance & Standards
Name of assessment lead or EIA assessment team members	Gail Butler
Has consultation taken place? Was consultation internal or external? (please state below):	
Internal	Information Governance / IGG
.	
The assessment is being made on: Please tick whether the area being assessed is new or existing.	

Guidelines	
Written policy involving staff and patients patients	X
Strategy	
Changes in practice	
Department changes	
Project plan	
Action plan	
Other (please state) Training programme.	

Equality Analysis

What is the aim of the policy/procedure/practice/event?
To ensure staff are clear on how to develop Trust procedural documents, including the correct format, approvals process, and any relevant supporting documents.

Who does the policy/procedure/practice/event impact on? All staff who are responsible for procedural documents

Race	☐	**Religion/belief**	☐	**Marriage/Civil Partnership**	☐
Gender	☐	**Disability**	☐	**Sexual orientation**	☐
Age	☐	**Gender re-assignment**	☐	**Pregnancy/maternity**	☐

Who is responsible for monitoring the policy/procedure/practice/event?
Gail Butler, Corporate Records Manager / FoI Officer

What information is currently available on the impact of this policy/procedure/practice/event?

Do you need more guidance before you can make an assessment about this policy/procedure/ practice/event? ~~Yes~~/No

Do you have any examples that show that this policy/procedure/practice/event is having a positive impact on any of the following protected characteristics? ~~Yes~~/No, If yes please provide evidence/examples:

Race	☐	**Religion/belief**	☐	**Marriage/Civil Partnership**	☐
Gender	☐	**Disability**	☐	**Sexual orientation**	☐
Age	☐	**Gender re-assignment**	☐	**Pregnancy/maternity**	☐

Please provide evidence:

Are there any concerns that this policy/procedure/practice/event could have a negative impact on any of the following characteristics? ~~Yes~~/No, if so please provide evidence/examples:

Race	☐	**Religion/belief**	☐	**Marriage/Civil Partnership**	☐
Gender	☐	**Disability**	☐	**Sexual orientation**	☐
Age	☐	**Gender re-assignment**	☐	**Pregnancy/maternity**	☐

Please provide evidence:

Action Plan/Plans - SMART

Specific

Measurable

Achievable

Relevant

Time Limited

Evaluation Monitoring Plan/how will this be monitored?

Who

How

By

Reported to