Document Control Policy
(C-003)

Version Number:	3.0
Author (name & job title)	Head of Corporate Affairs (Stella Jackson)
Executive Lead (name & job title):	Chief Executive (Michele Moran)
Name of approving body:	EMT
Date full policy approved:	9 July 2024
Date Ratified at Trust Board:	31 July 2024
Next Full Review date:	July 2027

Minor amendments made after full review date above (see appended document control sheet for details)	
Date approved by Lead Director:	
Date EMT as approving body notified for information:	

Policies should be accessed via the Trust internet to ensure the current version is used.

Contents

1 Introduction

This policy sets out the requirements that must be met for approval, ratification and dissemination of all Humber Teaching NHS Foundation Trust policies.

Organisations have a duty to have appropriate procedural documents in place that comply with legislation and/or reflect best practice to enable staff to fulfil the requirements of their roles safely and appropriately.

The management and control of procedural documents is essential, not only to comply with corporate and clinical governance requirements, but as a key means of ensuring standardisation in the provision of safe care and a safe working environment across the organisation.

This policy will guide staff through the process, standards and format that authors must follow in the development and management of a policy.

2 Scope

This policy applies to all staff involved in writing and / or implementing policies. All staff must adhere to the standards laid out in this policy to ensure quality and consistency of all policies.

3 Definitions

Policy	Is a statement of intent, describing the approach or course of action the Trust is taking in respect of a particular issue
Strategy	A formal document which provides a corporate framework or plan of action as to how certain broad aims will be addressed by the Trust
Plan	A plan sets out how the Trust will support delivery of the overarching ambition of the Trust held within its Strategy
Procedural Document	A description of a process in support of a policy
Standard Operating Procedure	Is a defined way or method of undertaking a task or series of actions
Guidelines	Guidelines provide a recommended process for delivering an outcome which affects a broad group within a flexible framework
Protocol	A protocol addresses the key questions of what should be done, when, where and by whom. It provides a framework for working in multi-disciplinary teams to standardise practice and reduces variation in the treatment of patients.
Standard	A standard is a statement which outlines an objective, with guidance on how to achieve it, including the required resources, activities and predicted outcomes

4 Duties and Responsibilities

All procedural documents must set out the roles and responsibilities of individuals, departments, groups and committees in relation to the document.

These are set out below in relation to the development and ratification of policy documents.

Chief Executive
The Chief Executive is responsible for ensuring the Trust has governance processes for the development, review, approval and monitoring of all Trust policies.

Executive Directors
All Directors are responsible for identifying, producing and for implementing Trust policies relevant to their area.

Trust Board
Trust Board are responsible for ratifying any new policies or any policies with significant changes that have been approved by the Executive Management Team.

Executive Management Team
The Executive Management Team, as the approving body for all Trust policies, will oversee the process for the production of new policy documents prior to ratification at the board.

EMT will approve policies which have been reviewed where there is a significant change i.e. financial or capacity impact, changes to director accountability or other fundamental changes.

EMT will be notified of policies approved by QPaS or ODG by the executive lead (minor changes).

Quality and Patient Safety Group and Trust Operational Delivery Group.
QPaS and the Trust's ODG will review and approve policy documents in line with this policy. Significant amendments (above) and new policies will be referred to EMT for approval.

Changes to the procedural element of any policy will be agreed by the QPaS or the Trust's ODG with escalation to EMT for approval at the discretion of the Chair.

Author
The Author (the person drafting or developing or reviewing the policy) is responsible for following the requirements set out within this policy document when developing new or reviewing existing policies and ensuring that the policy is cross-referenced to other policies and not duplicated. It is the responsibility of the author to ensure that the appropriate version control is included at the time of review and revision.

All Staff
All staff have a duty to comply with all policies in use at the Trust.

5 Process for the Development of Policies

The key steps in the process of developing policies are summarised below (a flowchart is provided at Appendix C). Table A describes the type of change and process to follow.

- Identify need for new document or revision to existing document.
- Develop or revise document.
- Consult with relevant stakeholders until opinions and expert advice has been considered and, where appropriate, incorporated.
- Prepare final document for agreement with Lead Executive Director for the policy at QPaS or the Trust's ODG.
- Final approval by the Executive Management Team (new policies or significant changes)
- Ratification by Trust Board (new policies or significant changes)
- Publication and dissemination
- Review of Document

Other documents, for example procedures, SOPs, guidelines, protocols and standards do not require approval at EMT or ratification at the Trust Board. The development, approval and review of clinical documents should follow the Clinical Procedural Documents - Control, Review and Dissemination Proc481

Table A: Types of changes to Policy Documents

Type of Change	Definition	Process
Minor change	Changes to policy review dates, staff titles and changes which **do not** have financial or capacity impact or change lines of executive accountability.	Very minor amendments, for example changes to review dates or author, can be signed off by the executive lead outside of ODG or QPAS at the lead executive's discretion. All other changes that are not considered significant will be approved by the Lead Executive Director through QPaS or the Trust's ODG. Changes to procedural elements of the policy can be escalated to EMT at the discretion of the Chair.
Significant Change	Changes to policy which have a financial or capacity impact. Changes to director accountability or other fundamental changes.	Approval at EMT. Ratification at Trust Board – a list of policies for ratification to be presented to the Board via the Chief Executive report.
Removal of Policy (no longer required)	Policy no longer required due to changes in processes or statute	Lead Executive Director sign off. EMT as approving body notified via the lead executive.

6 The Development of Policy Documents

Before developing a policy, authors should:

- Justify the need for the document.
- Ensure the document is not duplicating other documents.
- Consult with colleagues and stakeholders either individually or through designated groups in order to identify who will undertake and lead the work, who should be involved and how it will be done.
- Ensure relevant expertise is used to ensure that the introduction of the policy reflects desired practice.
- Consider external requirements pertinent to the contents of the policy.
- Identify who will be responsible for what e.g., dissemination, implementation, training, and review.
- Advice on “fraud proofing” documents can be obtained from the local counter fraud specialist (LCFS).
- Confirm that implementation is reasonably achievable.
- Identify how the document links with service priorities, Trust Strategy, NHS policy directives, legislation, and best available evidence.

7 Style and Format of Documents

All documents should be written in a style which is concise and clear using unambiguous terms and language.

The format and font of documents should be based on this policy which should be used as a template. The policy template will be used (available from the Policy Management Team and on the Forms page of the intranet).

A flowchart is recommended where appropriate to assist the user and this should be appended to the policy.

All policies and procedural documents will conform to the standards set by the Trust in this document to ensure that:

- Documents are accessible and understood by all staff.
- Documents are developed, approved and ratified by the appropriate bodies.
- Documents are underpinned by the appropriate education and training.
- Documents are kept up to date.
- That previous documents are archived for reference by the policy management team.

8 Consultation

After the initial draft of a document is produced the author should consult with key personnel and any appropriate stakeholders. Expert or working groups should peer review and validate the document prior to seeking policy approval.

For clinical policies this will include the Quality Patient and Safety Group (QPAS) who have a role in agreeing clinical policies before they are presented for approval. For non-clinical policies this will include the Trust's Operational Delivery Group (ODG).

Consultation may include members of appropriate sub-committees, expert working groups, senior staff forums and EMT who should have the opportunity to contribute to the document before it is presented formally for EMT approval. The Lead Executive Director for a policy must agree the final version of a policy before it is presented for approval.

This process of consultation should be detailed, in full, on the document control sheet.

9 Equality Impact Assessment

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service population and workforce, ensuring that none are placed at a disadvantage over others. The Equality Impact Assessment (EIA) is designed to help you consider the needs and assess the impact of your document.

All strategies and policies must have an EIA completed. The author of the document is responsible for carrying out an Equality Impact Assessment and providing assurance to EMT as the approving body that this has been considered and any issues addressed or being managed. The EIA document should be appended to all policies.

10 Approval

The Executive Management Team (EMT) is responsible for approving policies after expert working group(s) have developed and peer reviewed them. Where specialist knowledge is required it may be necessary to seek external advice.

Policies will only be presented to EMT for approval after full consultation and agreement, which will often include committee and EMT members at an earlier stage.

The document control sheet must be fully completed to present to EMT as the approving body to provide assurance that the correct procedure has been followed and that the policies conform to the required expectations.

Human Resource policies that are developed in conjunction with the Trust Consultation and Negotiation Committee (TCNC), a committee without sub-committee status, will be presented to the Executive Management Team for approval prior to any required Trust Board ratification. TCNC involvement in any policy should be identified by the author at the consultation stage.

Any policy presented for approval must have a completed document control sheet attached to confirm that:

- Consultation with relevant staff and groups has been undertaken.
- The document conforms to Trust guidelines and format.
- That methods of dissemination have been identified and, where necessary, supported by a planned training programme.
- An Equality Impact Assessment has been carried out (or the rationale provided if one is not required).

The minutes of the EMT as the approving body for policies must clearly state if the policy was approved.

11 Ratification

All policies require ratification by the Trust Board (after EMT approval) if new policies are introduced or significant changes are applied to existing policies. The full policy does not need to be presented to Trust Board, a list of policies for ratification is to be presented to Trust Board with assurance provided by the EMT that the correct procedure has been followed and that the policies conform to the required expectations and standards.

Minor changes to policies do not require Trust Board ratification. See Table A.

12 Review and Revision

Authors are expected to keep their documents up to date to reflect changing practices, legislation, demands and expectations. Documents must be reviewed once every three years and should be reviewed earlier if there is a significant change in practice e.g., revised NICE guidance.

Authors should ensure a review of policies is included in a forward work plan to ensure timely review and update prior to expiry. A centrally generated Trust prompt will be sent to authors six months prior to expiry of a policy.

If a policy document has been updated with no financial or capacity impact or changes to accountability, final approval can be granted by QPaS or the Trust's ODG with EMT notified as the approving body without the need to re-consult. Changes to the procedural element of the policy will be agreed by QPaS or the Trust's ODG and escalated to EMT at the discretion of the Chair.

Amendments to documents should be recorded within the version control schedule on the document control sheet.

A document shall remain in force until replaced or decommissioned.

If you are including clinical forms as part of the policy these should be added as an appendix marked 'Example' with a note to use the form within the electronic patient record.

13 Dissemination and Implementation

The author is responsible for ensuring that, once approved and/or ratified the document is made available on the intranet/internet by sending the final approved version to the policy management team.

Staff will be notified of relevant new or revised Trust documents in the Global email system.

Implementation into practice is the responsibility of the relevant division/directorate.

It is the responsibility of the executive director to ensure that any staff training identified is progressed.

14 Document Control Including Archiving Arrangements

All Trust policy documents will be centrally stored by the Policy Management Team and managed on the InPhase system and will be available on the Trust's Policies, Procedures and SOPs intranet pages.

15 Monitoring Compliance with the Document

All Trust policies should be monitored for compliance and have an appropriate narrative description of how the policy will be monitored.

Appendix-A - Document Control Sheet for the Document Control Policy

Document Type	Policy – **Document Control Policy**		
Document Purpose	This policy details the process to be used when developing, reviewing, approving and ratifying Humber Teaching NHS FT policies		
Consultation/ Peer Review:	Date:	Group / Individual	
list in right hand columns consultation groups and dates - >	11/8/17	EMT, Senior Care Group Managers, IT, IG, Deputy Director of HR, Asst Director Estates and Facilities, Trust Secretary, Head of Informatics, Risk Manager, Communications	
	25/8/17	Executive Management Team	
	Oct 2021	Executive Management Team	
	June 2024	QPaS (27/06/24) and Trust ODG (24/06/24)	
Approving Body:	EMT	Date of Approval:	09-07-24
		(see document change history below for minor amendments and dates)	
Ratified at:	Trust Board	Date of Ratification:	31-07-24
Training Needs Analysis: *(please indicate training required and the timescale for providing assurance to EMT as the approving body that this has been delivered)*	There are no training requirements for this document	Financial Resource Impact	There are no financial resource impacts
Equality Impact Assessment undertaken?	Yes [√]	No [ ]	N/A [ ] Rationale:
Publication and Dissemination	Intranet [√]	Internet [ ]	Staff Email [√]
Master version held by:	Policy management team [√]	Inphase [√]	
Implementation:	*Describe implementation plans below - to be delivered by the Author:*		
	Implementation will consist of: • Ratified policy to be shared with Executive Directors for sharing across directorates and with lead authors highlighting the new process • All staff email highlighting the key changes with a link to the full policy • Sub-groups (QPaS and Trust ODG) to add assurance of policies to their work-plan		
Monitoring and Compliance:	Monitoring and compliance of the policy will be evidenced through the process of consultation, approval and ratification of policies.		

Document Change History:			
Version Number / Name of procedural document this supersedes	*Type of Change i.e. Review / Legislation*	*Date*	*Details of Change and approving group or Executive Lead (if done outside of the formal revision process)*
V1.0	*Review*	*Sept'17*	*Full review and update*
V1.1	*Minor Change*	*13/11/17*	*Updated to clarify need for EIA to be appended to all policies and for a flowchart to be included.*
V1.2	*Minor Change*	*8/10/18*	*Description of operational policy removed at section 3 to avoid confusion with overall policy description. Logo changed to Teaching trust.*
V1.3	*Minor Change*	*4/3/19*	*additional note page 7 for clinical forms to be included as a draft example and for the form to be used within the electronic patient record.*
V1.4	*Minor Change*	*30/9/19*	*Policy reviewed. Minor change to reflect HR policies to be approved by Workforce & OD Committee (p6)*
V1.5	*Minor Change*	*4/10/21*	*Front sheet updated to reflect when/who approved minor amendments to policy. Trust Branding added.*
V2.0	*Review*	*8/11/21*	*Change to reflect EMT now the approving body for all Trust policies*
V3.0	*Full review*	*June 2024*	*Full review – action from internal audit. Clarification regarding minor and significant amendments. Clarification with roles and responsibilities of QPaS, ODG, EMT and Board. Removal of policy template from the body of the policy (including template EIA and template document control sheet) – add link in policy, to be held on the intranet and by policy management team. Policy changes approved by the Trust's ODG (24/06/24) and QPaS (27/06/24) with additional minor changes – Trust's ODG, and caveat to support exec sign off of very minor amendments (Table A).* *Policy approved at EMT (09/07/2024) and ratified at Trust Board (31/07/2024).*

Appendix B - Equality Impact Assessment (EIA) Toolkit for the Document Control Policy

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or Process or Service Name: Document Control Policy (C-003)
2. EIA Reviewer (name, job title, base and contact details) Head of Corporate Affairs.
3. 3. Is it a **Policy**, Strategy, Procedure, Process, Tender, Service or Other? Policy

Main Aims of the Document, Process or Service To set out the requirements that must be met for approval, ratification and dissemination of all Humber Teaching FT policies.
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma

Equality Target Group	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?	How have you arrived at the equality impact score?
1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender re-assignment	Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people, Young people, Children, Early years	Low	
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory, Physical, Learning, Mental Health (and including cancer, HIV, multiple sclerosis)	Low	
Sex	Men/Male, Women/Female	Low	
Married/Civil Partnership		Low	
Pregnancy/ Maternity		Low	
Race	Colour, Nationality, Ethnic/national origins	Low	
Religion or Belief	All Religions Including lack of religion or belief and where belief includes any religious or philosophical belief	Low	
Sexual Orientation	Lesbian, Gay Men, Bisexual	Low	
Gender Re-assignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Low	

Summary

Please describe the main points/actions arising from your assessment that supports your decision above	
EIA Reviewer – Head of Corporate Affairs	
Date completed~~,~~ 10-06-24	Signature Stella Jackson

Appendix C - Flowchart Process to be Followed when Developing a Policy