DOCUMENT CONTROL POLICY

Policy Type	Non-Clinical
Directorate	Corporate
Policy Owner	Director of Governance and Risk
Policy Author	Corporate Governance and Risk Manager
Next Author Review Date	1st April 2024
Approving Body	Corporate Governance 10th September 2020
Version No.	4.0
Policy Valid from date	1st September 2020
Policy Valid to date:	30th September 2024

'During the COVID19 crisis, please read the policies in conjunction with any updates provided by National Guidance, which we are actively seeking to incorporate into policies through the Clinical Ethics Advisory Group and where necessary other relevant Oversight Groups'

NB: The Policy Template contains the sections that must be included in a policy; any additional references or referencing are subject to requirements of the policy lead director or stakeholders.

DOCUMENT HISTORY
(Procedural document version numbering convention will follow the following format. Whole numbers for approved versions, e.g. 1.0, 2.0, 3.0 etc. With decimals being used to represent the current working draft version, e.g. 1.1, 1.2, 1.3, 1.4 etc. For example, when writing a procedural document for the first time – the initial draft will be version 0.1)

Date of Issue	Version No.	Date Approved	Director Responsible for Change	Nature of Change	Ratification / Approval
Nov 15			FT Programme Director/Company Secretary	Policy replaces Procedural Document Policy	
16 Dec 15	0.1		FT Programme Director/Company Secretary		Ratified at Risk Management Group
19 Jan 16	0.1		FT Programme Director/Company Secretary		Ratified at Policy Management Group
25 Jan 16	1		FT Programme Director/Company Secretary		Approved at Trust Executive Committee
14 Jun 16	1.1		Company Secretary		Policy Management Group
30 Jun 16	2	30 June 16	Company Secretary		Trust Executive Committee
13-12-16	3	13-12-16	Company Secretary	review	Corporate Governance and Risk Sub-committee
December 2017	3.1		Director of Quality Governance	Policy review and update to reflect changes but never completed	
July 2020	3.2		Associate Director of Corporate Affairs	Policy review and update to reflect changes	
21 Aug 2020	4.0		Associate Director of Corporate Affairs	Policy draft approved with comments	Corporate Governance
10 Sep 2020	4.0	10 Sep 20	Associate Director of Corporate Affairs	Final approved version ready to upload	Corporate Governance
29 Jan 2021	4.0	10 Sep 20	Associate Director of Corporate Affairs	12-month blanket policy extension due to covid 19 applied with author review date 6 months prior to Valid to Date.	Quality & Performance Committee
6 May 2021	4.0	10 Sep 20	Associate Director of Corporate Affairs	Extended policy uploaded and linked back with new cover sheet	Corporate Governance

NB This policy relates to the Isle of Wight NHS Trust hereafter referred to as the Trust

Contents

1 Executive Summary

The Isle of Wight NHS Trust is committed to ensuring that all documentation utilised is fit for purpose and compliant with the most up to date legislation and best practice. In order to achieve this, the Trust has adopted a robust process of document production, ratification, and dissemination.

No documentation must be utilised unless it has been ratified through the appropriate channels, commensurate with the importance of the document, and all documents, once approved must be made available to all staff via the most appropriate page of the Trust intranet.

The following principles must be adopted when introducing new documentation or reviewing existing documentation across the organisation.

- The author/reviewer of any document must be the 'most appropriate' or competent person. This will be based on their role, experience and/or qualifications.

- The author/reviewer may be an employee of the Trust; however, there may be occasions when external or specialist support will be required to ensure documentation is robust.

- The ratification process must be commensurate with the significance of the document in line with the procedure outlined below.

- Review periods set must be proportionate, however, reviews must be brought forward under the following circumstances: -

    - The issue of pertinent NICE guidelines
    - Changes in legislation and guidance
    - Changes in Best Practice
    - To address identified risks, or trends
    - To address changes in service provision, or governance arrangements
    - To incorporate advancements in technology or clinical practice as identified through relevant governing bodies.
    - In response to regulator recommendations and directives.

NB this list is not exhaustive

Once ratified all documentation must be stored on the Trust Intranet for ease of accessibility for staff. In the event that the intranet is not available, all policies are available from the Corporate Governance Team. Hard copies of all Standard Operating Procedures, Guidelines and Policy Group Directives must be made available by each respective department in the Trust. In addition, certain documentation will be made available to the public via the Trust website including all policies and strategies.

2 Introduction

The Trust recognises that it is important that it has in place a robust process for the creation, ratification, approval, dissemination, revision, and review of all documentation.
It is imperative that documentation has been through an appropriate ratification and approval process prior to adoption by the Trust to ensure that it complies with relevant legislation and best practice. Similarly, a robust document control process will ensure consistency of approach across the Trust.

The Trust recognises that untoward (or adverse) incidents may occur because staff are unaware of what is expected of them, both individually and collectively. Therefore, the purpose of this document control policy is to implement a co-ordinated and uniformed approach to document management throughout the Trust and to reduce risk via a comprehensive and consistent application of a document control framework.

3 Definitions

The Trust has adopted the following definitions: -

3.1 Consultation

The process of engaging with subject matter experts or those to whom a document will apply or impact on in order to ensure their views are adequately considered and responded to within a document.

3.2 Ratification and Approval

Approval of a given document will take one of two forms: -

Ratification and final approval is where the document has reached the end of the approval process i.e. it has reached the meeting where the final decision to adopt the document will be taken.

Interim approval is where the document is still progressing through the approval process and has not yet reached the forum where the final decision to adopt the document will be taken, for example a document may be interim approved at the Information Governance Sub-Committee but achieve final approval at the Trust Leadership Committee. It is only when a document has achieved final approval that it is ready for dissemination and implementation.

3.3 Strategy and Strategic Plans

A strategy or strategic plan is an overarching document that focuses on the direction of travel and includes a vision of what the Trust aims to achieve. Strategy therefore will include as a minimum analysis of the following: -

- The current position i.e. where are we now;
- The vision, i.e. what is it we want to achieve.
- How will we get there i.e. what steps do we need to take.

A strategy often also incorporates an action plan to be followed in order to achieve the vision.

The Trust utilises two forms of strategy document, namely corporate and operational.

Corporate strategies span the breadth of the organisation, whereas operational strategies relate to a specific service (including Corporate Services), or area of business.

3.4 Policy

A policy is an organisational wide framework which applies in all circumstances as relevant to all staff. All staff must comply with policies at all times. Policies set out the main duties of staff and how they should be carried out. Many policies incorporate legal or statutory duties, how they apply and how staff are able to meet these duties through applying the policy.

3.5 Protocol

Protocols dictate what we do, and audits of protocols ensure that we are doing what we say we will. A protocol is a document setting out the actions or steps to be followed by staff relevant to the subject set out in the document. Protocols can be associated with a policy and describe how a policy is carried out. Protocols are step by step instructions on how operational activities will be carried out. They are precise and detailed and must be adhered to by all staff to which they are relevant. Protocols can be in pictorial form.

3.6 HR Policy

An HR policy is a decision or a set of decisions, relating to an employment issue. HR policies provide general and practical advice and must be adhered to by all those detailed in the scope of the document.

HR procedures support and supplement HR policies, where appropriate, by giving step by step accounts of specific arrangements that apply in particular circumstances.

3.7 Standard Operating Procedure (SOP)

Standard Operating Procedures take two forms, generic SOPs and Clinical SOPs.

A SOP is simply a written document that details all steps and activities of a process or procedure that must be followed by staff. A clinical SOP is a document that details all steps and activities of a clinical process or procedure.

3.8 Patient Group Directives (PGD)

A Patient Group Directive is a written instruction for the supply and/or administration of a named licensed medicine for a defined clinical condition. PGDs allow a range of specified registered health care professionals to supply and/or administer a medicine directly to a patient with an identified clinical condition without them necessarily seeing a prescriber. Please see the Patient Group Directives Policy for further information.

3.9 Guidelines including clinical guidelines

Guidelines are statements that are developed systematically to assist staff in decisions about the appropriate action to take in specific circumstances. They advise on best

practice and consist of a set of recommendations and are advisory as opposed to instructive.

3.10 Form

A form is a special document (printed or electronic) from which records are generated to evidence compliance to the management system and statutory requirements. (NB there are other forms of records).

3.11 Leaflets and Publicity Materials; including patient information leaflets.

The Trust utilises a range of leaflets and publicity materials, these are designed to impart information or gather information from a range of stakeholders.

3.12 Business Continuity Plan

A Business Continuity Plan is a service level plan, which identifies departmental core functions that have to be delivered within a pre-determined timeframe. The document identifies the supporting requirements to deliver core functions, whilst introducing all other functions within a phased approach.

3.13 Terms of Reference (TOR)

Terms of Reference for a meeting, outline the purpose, structure and responsibilities of the given meeting and should cover all of the following (who, what, where, when, how, why). They should also include reference to any statutory obligations for the Trust internally or externally.

4 Scope

This policy applies to all staff and extends to cover all services where the Trust owes a statutory duty of care and responsibility to employees, patients and visitors, this includes: volunteers, contracted staff, students and the public in general. It outlines the system for managing the drafting, consultation, final approval, dissemination and implementation (training and awareness) of all Trust documents.

5 Purpose

The purpose of this document is to set out the expectations of all staff in relation to Trust documentation. It is vital that all staff adhere to this policy and ensure that any documentation that they use has been through the appropriate ratification and approval channels to ensure it is fit for purpose and does not breach any legislation or copyright.

This policy also sets out the format to be used in relation to Trust policies, ensuring consistency of use.

6 Roles and Responsibilities

6.1 The Trust Board

The Trust Board is responsible and accountable for the appropriate ratification and approval of all corporate strategy documents relating to the organisation, and all Corporate Governance Framework documents including (but not limited to) the following: -

- Standing Financial Instructions
- Standing Orders
- Scheme of Reservation and Delegation
- Statutory and Formal Roles
- Risk Management Strategy and Policy
- Incident Response Plans

6.2 The Chief Executive

The Chief Executive has responsibility for ensuring the Trust has in place an effective and efficient document control process, however, a number of associated responsibilities have been delegated in line with the schedule below.

6.3 Associate Director of Corporate Affairs

The Associate Director of Corporate Affairs is responsible for ensuring that the Trust has in place a robust and embedded document control policy, setting out requirements across the Trust.

6.4 Executive Directors

The Executive Directors are responsible for ensuring that this policy is adhered to across their areas of responsibility, and that adequate resources are deployed in order to support the Trust having in place relevant and up to date documentation.

6.5 Trust Leadership Committee (TLC)

The Trust Leadership Committee is the senior Executive Committee of the Trust and as such will lead on all policy management matters on behalf of the Board, and in doing so takes responsibility for ensuring robust governance in relation to document control.

The TLC have delegated approval authority for all policy documents as set out in the approvals section of this policy.

The TLC will receive a monthly exception report from the Corporate Governance Team which will include the following as appropriate: -

- Decisions regarding the final ratification and approval of policies.
- Barriers to ensuring that policies remain in date and live.

The TLC have a specific responsibility to liaise with policy authors and to redirect resources to ensure that policies or indeed other required documents are produced in a timely manner.

6.6 Executive Led Sub-Committees

The Trust has in place a suite of Executive Led Sub-Committees including (but not limited to) those below:-

- People and Organisational Development Sub-Committee
- Financial Recovery Board/ Divisional Boards
- Information Communication Technology (ICT) Sub-Committee
- Patient Safety and Experience Sub-Committee
- Health and Safety and Security Sub-Committee
- Estates Sub-Committee

These Sub-Committees have a number of responsibilities in relation to document control as follows:-

1) Oversee the production of operational strategy, within its areas of responsibility, for example, Health and Safety and Security Sub-Committee (HSSC) is responsible for overseeing the production of any operational strategies relating to Health and Safety and Security. These strategies will then be presented to the Sub-Committee, for ratification and approval. Where the strategy extends beyond the delegated authorities of the Sub-Committee, final ratification and approval will be via the Trust Leadership Committee.
2) Final and Interim approval of policies that span its areas of responsibility, as per the sub-committee terms of reference, and onward referral to the Trust Leadership Committee for final ratification and approval where necessary.
3) Final ratification and approval of protocols, standard operating procedures, business plans, including business continuity plans and guidance documents relating to its areas of responsibility as per the sub-committee terms of reference. However, each Sub-Committee may determine to delegate approval of protocols, standard operating procedures, and business plans to a group reporting to it as appropriate. For example, the approval of standard operating procedures relating to Information Governance may be delegated to the Information Governance Sub-Committee. The Group or Sub-Committee who has taken the final ratification and approval decision is responsible for ensuring the document is uploaded to the Trust intranet within 2 working days.

NB the Divisional Boards have determined to delegate a number of these responsibilities to the Care Group Leadership Meetings as per below.

6.7 Clinical Directors, Director of Operations or services (including Deputy Directors, Associate Directors) and Heads of Nursing

Clinical Directors, Directors of Operations or services and Heads of Nursing are responsible for ensuring that all required documentation across their areas of responsibility are in place, and have been through the appropriate ratification and approval process. It is essential that they remain vigilant to changes in legislation or best practice and ensure that documentation is amended to reflect these changes in a timely manner.

6.8 Corporate Governance Team

The Corporate Governance Team has a very specific role in relation to the policy management process. The team administer the register of policies, and take responsibility for sending out 6, 3 and 2 monthly reminders to policy authors prior to a policy reaching its

expiration date, to remind them of the need to review the policy, and ensure it progresses through the relevant ratification and approval process as required prior to expiry.

The Corporate Governance Team is responsible for the maintenance of the Policy intranet and website which will include details of all policy lead directors, authors and dates for review.

Therefore when a policy document becomes obsolete the author should notify the Corporate Governance Team to ensure that the revised policy is transcribed in the most up to date Trust template and the obsolete policy is transferred from the live policy intranet site to the obsolete policy list.

6.9 Clinical Standards Group (CSG)

All Patient Group Directives must be ratified by the Clinical Standards Group.
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All clinical policies must pass through the CSG for comment and clinical oversight where they will reach final ratification and approval.

6.10 Finance Department

The production of all finance related Standard Operating Procedures, official procedures and protocols must be overseen by the finance department.

All finance policies must pass through the finance department for comment and professional oversight where they will reach final ratification and approval.

The finance department will also approve any leaflets relating to finance matters.

6.11 People and Organisational Development Sub-Committee

The production of all people or organisational development related Standard Operating Procedures, official procedures and protocols must be overseen by the relevant people or organisational development groups.

All people or organisational development policies must pass through the relevant people or organisational development groups for comment and professional oversight where they will reach final ratification and approval.

The relevant people or organisational development groups will also approve any leaflets relating to people or organisational development matters.

6.12 Health and Safety and Security Sub-Committee

The production of all health and safety and security related Standard Operating Procedures, official procedures and protocols must be overseen by the relevant health and safety and security group.

All health and safety and security related policies must pass through the relevant health and safety and security group for comment and professional oversight where they will reach final ratification and approval.

The relevant health and safety and security group will also approve any leaflets relating to health and safety and security matters.

6.13 Estates Sub-Committee

The production of all estates related Standard Operating Procedures, official procedures and protocols must be overseen by the relevant estates group.

All estates related policies must pass through the relevant estates group for comment and professional oversight where they will reach final ratification and approval.

The relevant estates group will also approve any leaflets relating to estates matters.

6.14 Information Governance Sub-Committee (IGSC)

The production of all Information Governance Standard Operating Procedures, official procedures and protocols must be overseen, ratified and approved by the IGSC.

All Information Governance policies must pass through the IGSC for comment and professional oversight where they will reach final ratification and approval.

The IGSC will also approve any leaflets relating to Information Governance matters.

6.15 Care Group(s) and Director of Operations meeting(s).

The Divisional Boards and Seminars meetings will finally approve and ratify the following documents spanning their areas of responsibility:-

- Standard Operating Procedures,
- Official procedures
- Protocols
- Leaflets
- Service specific business plans
- Business Continuity Plans
- Policies

All Care Group related policies must pass through the relevant leadership meeting (and where appropriate Clinical Standards Group) for comment and professional oversight where they will reach final ratification and approval.

6.16 Document Lead Director

The lead director relevant to the service area most appropriate to the document subject matter/ specialty is responsible for coordinating the development and consultation process of any documentation, prior to its submission to the relevant ratification and approval meeting. Indeed they will ultimately determine who should be included in any consultation process.

NB this does not mean that they will facilitate this; rather they will advise the document author what is required in relation to consultation to ensure relevant staff buy in to the new document.

6.17 The Author of the Document

The author of any document is responsible for:-

- Ensuring compliance with this policy.
- Ensuring compliance with legislation, national guidance, best practice and copyright.
- Liaising with the relevant lead director to ensure all appropriate consultation is undertaken prior to a document being submitted for ratification and approval.
- Ensure the document is updated in accordance with its specified review period or earlier if required.
- Ensuring the document is on the correct template has been spell checked and formatted correctly. NB this may be through the administrative function within their department.

6.18 All staff

All staff are required to understand and comply with this and all other Trust policies. Staff should refrain from printing hard copies of documentation such as policies wherever possible, due to the fact that a printed copy is uncontrolled. Staff should where possible refer to versions of documents available to staff via the intranet.

6.19 Line Managers

All line managers are responsible for ensuring that documentation utilised across their services has been through the appropriate consultation, ratification and approval routes and that their staff understand the importance of adhering to this policy. Managers are required to ensure adherence to this and all other Trust policy at all times.

7 Policy Detail/Course of Action

7.1 Document development

Once a need for new or revised documentation has been identified it must be allocated to the most appropriate individual for action.

The allocation of such work will necessarily take into consideration:

- Expected timescales for completion
- Capacity of the individual
- Role of the individual
- Experience, skills, competence and qualifications of the individual

The individual with responsibility for producing the document must do so utilising the appropriate template (if available). They must ensure that all sections including appendices are fully completed in a timely manner, and submitted to the appropriate group, committee or meeting, following consultation.

The timescales for doing this will be dependent on the complexity of the document required and the level of risk associated with the document not being available to staff, and also current expiration dates.

Should the author wish to extend the date by which they will submit a revised policy, they must first seek the authorisation and approval of the relevant Executive Director, and then inform the Corporate Governance Team, in order that they may formally document the extension.

NB - Policies may only be extended for a maximum period of 6 months. If the policy has not been reviewed in this time the policy shall be considered for removal from circulation until such time that a revised and updated version is provided to the relevant Sub-Committee.

Upon completion of the required document it must be submitted for ratification prior to implementation in line with appropriate timescales ratification and approval process outlined below.

7.2 Document templates

The Trust has adopted the use of the following templates which are available to staff on the Trust intranet, within the document template store:-

- Policy Template (this includes two appendices, an equality impact assessment and a resources impact assessment, both of which must be completed at the time a policy is written or reviewed). NB: The Policy Template contains the sections that have to be included in a policy; any additional references or referencing are subject to requirements of the policy lead director or stakeholders.
- Standard Operating Procedure Template
- Business Plan Template
- Business Continuity Plan Template
- Patient Information Leaflet Template

7.2.1 Version Control

All Policies, Standard Operating Procedures and Protocols will indicate on the front sheet the current stages and progress of the working version(s) up to the point of final approval as set out below.

Procedural document version numbering convention will follow the following format: - whole numbers for approved versions, e.g. 1.0, 2.0, 3.0 etc. with decimals being used to represent the current working draft version, e.g. 1.1, 1.2, 1.3, 1.4 etc.

Upon final approval, the approval date will be entered into the Version Control Section of the document.

For example, when writing such a document for the first time – the initial draft will be version 0.1, as amendments and changes are made this becomes 0.2, 0.3 and so on until it is finally approved at the relevant meeting, at this time the document will become Version 1.0.

When reviewing an existing document, if the original is version 1.0, the first reviewed version will become version 1.1, and as it progresses will go on to be 1.2, 1.3 and so on until it is reviewed– when it will become Version 2.0.

7.3 Document Consultation, Ratification and approval

The Trust acknowledges that there are significant differences between consultation and final ratification and approval, however, these are both fundamental parts of a process to ensure that any documentation adopted by the Trust is robust, fit for purpose, and can be adhered to by all staff at all levels.

The process to be followed when consulting on or seeking the final ratification and approval of particular documentation will depend on the nature of the document and should be undertaken at a commensurate level across the Trust.

The table below sets out the route for final ratification and approval of a given document. It also suggests the most likely consultation routes, however, it must be acknowledged that this is only a guide and on many occasions wider consultation will be required. Please consult with your line manager for further guidance. If the query persists contact the Corporate Governance Team.

The extent of consultation must therefore be agreed with the Lead/ relevant Executive Director.

Document Type	**Suggested Consultation requirements.** **NB the following are the minimum requirements in terms of consultation. The full consultation programme must be agreed by the relevant lead Director.**	**Final Ratification and Approval requirements**
• Trust Strategy • Standing Financial Instructions • Standing Orders • Scheme of Reservation and Delegation • Statutory and Formal Roles • Standards of Business Conduct. • Trust Board and Board Committee, and Trust Leadership Committee Terms of Reference • Incident Response Plan • Risk Management Strategy & Policy	Consultation to be agreed by the relevant Lead Director; but will usually include Board Committees as well as associated Trust employees via relevant Sub-Committees and groups.	**Trust Board**. *Consideration must be given to key stakeholders, who may be required to agree to strategy documentation progressing to the Board for final ratification.*
• Operational Strategies	As a minimum the relevant Executive Led Sub Committees.	**Trust Leadership Committee**
• Policies	As a minimum relevant groups reporting to the Executive Led Sub-	**Relevant (Exec Led) Sub-Committee(s)**

	Committees.	
• Care Group Business Plans • Care Group Business Continuity Plans • All Protocols • All Standard Operating Procedures • All Guidance NB the Divisional Board has delegated a number of these responsibilities to the Care Group Leadership Meeting as per below	As a minimum the relevant Divisional Boards	**Executive Led Sub-Committees or their nominated sub-group:-** 1. Turnaround Sub- Committee 2. People and Organisational Development Sub-Committee 3. Finance, Contracts and Information Sub- Committee 4. Divisional Board 5. Information Communication Technology (ICT) Sub- Committee 6. PSE Sub- Committee (Quality) 7. Health, Safety and Security Sub-Committee 8. Estates & Facilities Sub--Committee
• Service Business Plans • Service Business Continuity Plans • All Protocols • All Standard Operating Procedures • All Guidance	As a minimum individual service team meetings	**Divisional Board Leadership Meeting:-** 1. Acute/ Ambulance – Planned and Unplanned 2. Ambulance 3. Mental Health and Learning Disabilities 4. Community and Nursing 5. Human Resources 6. IM&T 7. Finance NB all Pathology related SOPs are managed through the document management system Q-Pulse, and relevant staff have access through controlled passwords and security settings.
Patient Group Directives	Pharmacy and relevant clinicians for consultation depending on the subject matter. Also relevant Care Group Leadership Meetings or service team meetings.	**Clinical Standards Group.**
Forms and templates	Dependant on the level of risk associated with the document and its significance for the Trust.	It is acknowledged that the Trust will utilise a number of forms and templates, across the breadth of the organisation for a variety of purposes. Ratification of such documents must be commensurate with their importance across the organisation and fall in line with the following:- Forms and templates relating to one service, including a corporate service such as People must be approved by one of the following:- • Director of Operations (Planned/ Unplanned) • Care Group Director • Head of Nursing and Quality

		Forms and templates to be adopted across a range of services must be approved by the Care Group Leadership Meeting or the Executive Led Trust Leadership Committee. Clinical pathways must be ratified and approved by the Clinical Standards Group
Leaflets and Publicity Materials		As with other documentation all leaflets and publicity material must also be ratified through a robust process at a commensurate level to ensure they are appropriate, accurate, and anti-discriminatory. The level at which such documentation will be ratified must be proportionate. All Clinical Information Leaflets must be ratified by the relevant Care Group Leadership Meeting. All Health and Safety leaflets must be ratified by the Health and Safety and Security Sub-Committee. Information Governance leaflets must be ratified by the IGSC People leaflets must be ratified by the People Group.
Business Continuity Plans (either at Service or Care Group level)	As a minimum those working within a service or suite of services	Individual Service Business Continuity Plans must be ratified at the relevant Care Group Leadership Meeting or by the relevant Executive Director for Corporate Services. Care Group Business Continuity Plans must be ratified via the Sub-Divisional Board.
Terms of Reference		The Terms of Reference for Trust Board and other Board Committee must be ratified at the Trust Board as must the Trust Leadership Committee Terms of Reference, Executive Led Sub- Committee Terms of Reference must be ratified by the Trust Leadership Committee. Terms of Reference for Groups reporting to the Exec Led Sub-committees must be approved by the most appropriate sub-committee. It is best practice that each meeting TOR

		will be ratified by the next meeting up in the hierarchy in line with the meeting governance structure available on the intranet.

Documentation requiring ratification must be directed through the relevant Director of Operations who will coordinate the passing of the document to the relevant process administrator.

7.4 Identification and use of documents of external origin

It will be necessary on occasion for the Trust to utilise or adopt documents of external origin, for example Department of Health documentation, or NHSE documentation. In order to do this safely, it is imperative, that agreement to utilise such documents is also undertaken at a commensurate level across the Trust. Therefore the document must be submitted to the relevant meeting for approval to adopt in line with the schedule set out above. Approval to adopt can be time limited where appropriate or it can be for the lifetime of the document this will be determined by the ratification and approval meeting.

It is imperative that where such documents are adopted, the correct and most up to date version of the document is available to all staff, therefore where possible a link from the Trust intranet site must be used, however, where this is not possible the currency of the document should be checked on a 6 monthly basis as a minimum.

7.4.1 Royal Marsden

In order to ensure that clinicians are operating safely and in line with the most up to date legislation, best practice, and guidelines including NICE, the Trust has purchased and made available to staff the Royal Marsden Manual of Clinical Nursing Procedures which is available to staff on line https://www.rmmonline.co.uk/

7.4.2 Joint Royal Colleges Ambulance Liaison Committee (JRCALC)

The Joint Colleges Ambulance Liaison Committee (JRCALC) under instruction from the Association of Ambulance Chief Executives (AACE) produce a set of guidelines for UK ambulance service clinical practice to be used nationally and therefore attempt to lay out a standardized set of best practice guidelines.

The Isle of Wight Ambulance Service uses this as a baseline for its clinical practice. Ambulance Staff have Access to JRCALC via a phone app, via the Clinical Support Officers, via the Clinical Support Desk in the Emergency Operations Centre.

Staff are provided with a précised pocket book version of the guidance.

When the guidance is updated a full gap analysis of the incoming versus the outgoing guidance is undertaken. This is reported to the Ambulance Clinical Quality Effectiveness Group who then decides locally what elements to adopt, to partially adopt or to not support. Any decision to not support JRCALC guidance will be due to local factors, service factors or other provider factors. These amendments are then conveyed to the staff via a Clinical Notice, which is available on the intranet, and with continued support from the Clinical Support Officers and Clinical Support Desk.

7.4.3 National Ambulance Resilience Unit (NARU)

The NARU produce national ambulance service documentation, which is ratified and approved by the Association of Ambulance Chief Executives (ACCE) that must be adopted by the Trust, this will not need to be approved by the Trust, however, the Trust must ensure staff have access to these documents and that staff adhere to them.

7.4.4 Multi Agency documents

The Trust recognises that increasingly it will be necessary to adopt multi agency documentation in order to support excellent patient care. In order to do this safely, multi-agency documents or documents of external origin will be required to go through the Trust's consultation, and ratification and approval process as set out above. Where this is the case it may be necessary to undertake an equality impact assessment or resources impact assessment of the document to ensure it is suitable for the Trust to adopt, this must be undertaken by the staff member submitting the document for approval.

In the majority of instances these documents will have been produced by the lead agency for a given work stream, but will need to be adopted by all agencies/providers, key examples include:-

- Safeguarding Adults
- Safeguarding Children
- Information Sharing Charters and agreements
- Incident Response Plans
- HMP
- Discharge Planning Policy

Where this is the case, the Trust will make every effort to provide a link from the Trust intranet site to the document direct, to ensure that the version available to staff is the most up to date version. On occasion this may not be possible, where this is the case, the document will be uploaded to the Trust intranet, and the version will be checked with the relevant organisation on a 6 monthly basis, and endorsed accordingly.

7.5 Document dissemination

Once a document has passed the final ratification and approval stage it must be sent to the Corporate Governance Team to be uploaded onto the Trust's intranet site document store or where appropriate Q-Pulse (Pathology SOPs) or the Trust website within 5 working days.

Co-ordination for the uploading of ratified and approved documentation will be undertaken by the administrator for the meeting taking the final ratification and approval decision.

(NB this will only be possible when the relevant team have been provided with the most up to date version and the proof of ratification and approval). All newly approved documents will be notified to all staff via the e-bulletin. Where specific staff groups need to be notified of a change, or briefed about its impact on their role, it is the responsibility of the document author, with support of the Lead Director, to ensure that this occurs.

7.6 Document Review

All documents will have an expiration date. This date will depend on the nature of the document taking into account the anticipated pace of change, external requirements and risk, however, as mentioned above documentation may need to be reviewed earlier than anticipated under certain circumstances.

Business Continuity Plans from clinical service areas require an annual review; non-clinical areas are required to review every two years unless circumstances warrant a more frequent review.

All policies, official procedures and Standard Operating Procedures must be reviewed within 3 years as a minimum, however, medicines policies, and clinical standard operating procedures must be reviewed every two years, or before, if required.

Once reviewed the reviewer may take any one of 3 courses of action:-

- Review and Revise the document and seek re-ratification through the appropriate channels.
- Delete the document if it is no longer applicable (this must be agreed by the relevant ratification process).
- Review the document but leave it unchanged (NB when the reviewer decides to leave the document unchanged they must explain their reasons to the relevant ratification body and records must be retained in the minutes).

As indicated above review periods set must be proportionate, however, reviews must be brought forward under the following circumstances:-

- The issue of pertinent NICE guidelines
- Changes in legislation and guidance
- Changes in Best Practice
- To address identified risk, or trends
- To address changes in service provision
- To incorporate advancements in technology or clinical practice as identified through relevant governing bodies.
- In response to regulator recommendations and directives

NB this list is not exhaustive

8 Archiving Documents

The Trust is required to keep an archive of previous versions of certain documentation in line with the Records Management Policy and in order to be able to provide a robust audit trail. The responsibility for archiving documents is set out below.

- Archiving of policies is the responsibility of the Corporate Governance Team.
- Archiving of strategies is the responsibility of the Head of Strategy and Planning.
- Archiving of other procedures, including Patient Group Directives and Guidance is the responsibility of the ratifying committee/meeting.

9 Retrieving archived documents.

Documents as they become obsolete and/or are superseded will be removed from circulation and replaced, if appropriate, with an updated version. A 'master' copy of each document will be archived in line with the Records Management Policy.

- Archived policies will be accessible through the Corporate Governance Team
- Archived strategies will be accessible through the Business Planning Manager
- Achieved procedures and guidance will be accessible through the relevant ratifying committee.

10 Consultation

This document has been considered by the Corporate Governance Team for final ratification and approval. Other key stakeholders with specific responsibilities have been consulted to ensure that the policy is fit for purpose and deliverable.

11 Training

This Policy does not have a mandatory training requirement or any other training needs.

12 Monitoring Compliance and Effectiveness of this Policy

Conformance to the Trust's format, style and with the required attachments will be monitored by the approving committee. Where documents do not conform the relevant approving committee/body will refer the author to the Document Control Policy or appropriate template. This should be noted in the appropriate minutes of the meeting;

13 Links to other Trust Documents

- Equality Delivery System Self-Assessment
- Records Management: NHS Code of Practice
- Counter Fraud and Corruption Policy
- Standing Financial Instructions

14 References

- Health and Social Care Act 2012
- The Civil Partnership Act 2004
- The Human Rights Act 1998
- Equality Act 2010
- NHS Equality Delivery System
- Promoting Equality and Human Rights in the NHS - A Guide for Non-Executive Directors of NHS Boards (2005) Department of Health

15 Appendices

Appendix A - Financial and Resourcing Impact Assessment on Policy Implementation
Appendix B - Equality Impact Assessment (EIA) Screening Tool

Appendix A

Financial and Resourcing Impact Assessment on Policy Implementation

NB this form must be completed where the introduction of this policy will have either a positive or negative impact on resources. Therefore this form should not be completed where the resources are already deployed and the introduction of this policy will have no further resourcing impact.

Document title	**Document Control Policy**

Totals	**WTE**	**Recurring £**	**Non-Recurring £**
Manpower Costs	**No changes**		
Training Staff	**No changes**		
Equipment & Provision of resources	**No changes**		

Appendix B

Equality Impact Assessment (EIA) Screening Tool

Document Title:	**Document Control Policy**
Purpose of document	*The purpose of this policy is to ensure that staff and managers are aware of their roles and responsibilities in relation to writing and approving of documents*
Target Audience	*All staff*
Person or Committee undertaken the Equality Impact Assessment	*Corporate Governance and Risk Manager*

1. To be completed and attached to all procedural/policy documents created within individual services.

2. Does the document have, or have the potential to deliver, differential outcomes or affect in an adverse way any of the groups listed below?

If no, confirm underneath in relevant section the data and/or research which provides evidence e.g. JSNA, Workforce Profile, Quality Improvement Framework, Commissioning Intentions, etc.

If yes please detail underneath in relevant section and provide priority rating and determine if full EIA is required.

		Positive Impact	**Negative Impact**	**Reasons**
Gender	Men	*NA*	*NA*	
	Women	*NA*	*NA*	
Race	Asian or Asian British People	*NA*	*NA*	
	Black or Black British People	*NA*	*NA*	
	Chinese people	*NA*	*NA*	

	People of Mixed Race	*NA*	*NA*	
	White people (including Irish people)	*NA*	*NA*	
	People with Physical Disabilities, Learning Disabilities or Mental Health Issues	*NA*	*NA*	
Sexual Orientation	Transgender	*NA*	*NA*	
	Lesbian, Gay men and bisexual	*NA*	*NA*	
Age	Children	*NA*	*NA*	
	Older People (60+)	*NA*	*NA*	
	Younger People (17 to 25 yrs.)	*NA*	*NA*	
Faith Group		*NA*	*NA*	
Pregnancy & Maternity		*NA*	*NA*	
Equal Opportunities and/or improved relations		*NA*	*NA*	

Notes:

Faith groups cover a wide range of groupings, the most common of which are Buddhist, Christian, Hindus, Jews, Muslims and Sikhs. Consider faith categories individually and collectively when considering positive and negative impacts.

The categories used in the race section refer to those used in the 2001 Census. Consideration should be given to the specific communities within the broad categories such as Bangladeshi people and the needs of other communities that do not appear as separate categories in the Census, for example, Polish.

3. Level of Impact

If you have indicated that there is a negative impact, is that impact:			
		YES	**NO**
Legal (it is not discriminatory under anti-discriminatory law)			
Intended			

If the negative impact is possibly discriminatory and not intended and/or of high impact then please complete a thorough assessment after completing the rest of this form.

3.1 Could you minimise or remove any negative impact that is of low significance? Explain how below:
3.2 Could you improve the strategy, function or policy positive impact? Explain how below:
3.3 If there is no evidence that this strategy, function or policy promotes equality of opportunity or improves relations – could it be adapted so it does? How? If not why not?

Scheduled for Full Impact Assessment	Date:
Name of persons/group completing the full assessment.	Daniel Robinson
Date Initial Screening completed	6th August 2020