journey to change

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Public – To be published on the Trust external website

Governance of policies, procedures, protocols and guidelines

CORP-0001-v7.2

Status: Ratified
Document type: Policy

Table of Contents

1 Introduction

The Trust requires an effective operational system for managing policy and procedural documents to achieve its strategic goals:

To co-create a great experience for our patients, carers and families, so you will experience:
- **Outstanding** and compassionate care, all of the time.
- **Access** to the care that is right for you.
- **Support** to achieve your goals.
- **Choice** and control.

To co-create a great experience for our colleagues, so you will be:
- **Proud**, because your work is meaningful.
- **Involved** in decisions that affect you.
- **Well led** and managed.
- That your workplace is **fit for purpose**.

To be a great partner, so we will:
- Have a **shared understanding** of the needs and the strengths of our communities
- Be **working innovatively** across organisational boundaries to improve services.
- Be **widely recognised** for what we have achieved together.

This policy defines:

- How documents are developed and governed to ensure these goals have been considered, and that the goals and Trust values are reflected in their wording.

Respect
- Listening
- Inclusive
- Working in partnership

Compassion
- Kind
- Supportive
- Recognising and Celebrating

Responsibility
- Honest
- Learning
- Ambitious

2 Why we need this policy

2.1 Purpose

- To ensure a consistent and systematic approach to the governance of policies throughout Tees, Esk Wear Valleys NHS Foundation Trust
- To ensure documents within the Trust's policy portfolio involve and are co-created by the right people

- To ensure documents are inclusive of the population they serve
- To promote evidence-based practice and reduce variation across the Trust.

2.2 Objectives

The objectives of this approach are to:

- co-create and support a positive experience for our patients, carers and families, our staff and our partners
- provide direction and promote good practice
- minimise risk to service users, carers, the public and staff
- adhere to mandatory national standards and legislation
- protect to the organisation
- provide staff with consistent, easy to use documents
- ensure that no documents are published to the external website that have potential to cause harm to individuals.

3 Scope

Any reference to 'policy/policies' shall be interpreted as meaning any document that is within the scope of this policy, including procedures, protocols and guidelines.

3.1 Who this policy applies to

The policy applies to:

- Staff who develop, implement and review Trust-wide and service-specific clinical and corporate policies
- Staff who perform the Policy Coordinator role
- Groups and committees who approve and ratify Trust policies

Standard work that is developed within the scope of the Trust's Quality Improvement System (QIS) must take into consideration and must not contravene ratified Trust policies.

3.2 Limitations of this policy

This policy does not apply to Council of Governors' policies which are outside the remit of the Board and Management Group.

This policy does not apply to assurance documents that:

- have been created by a team or department; **and** which
- describe how that team/department or individuals in it perform their daily tasks (for example standard operating procedures or technical operating instructions).

This policy, therefore, does not directly apply to:

- Operational policies
- System specific policies
- Clinical operational policies
- Business Operational policies
- Standard Process Descriptions
- Technical Operating Instructions

This policy does not apply to policies in relation to risk management and investments, the approval of which has been retained by the Board under the Constitution.

However, it is good practice to apply the principles contained within this policy and the associated procedural guidance to all assurance documentation.

3.3 Roles and responsibilities

Role	Responsibility
Directors of the Trust	• Lead on those Trust-wide and/or service specific policies relevant to their individual portfolio • Ensure a coordinated approach to policy development and accountability • Identify or agree which policies are required relevant to their individual portfolio to ensure every policy has a designated named director.
Named Director	• Nominate a policy development lead for each policy • Agree all policies prior to ratification • Ensure all policies within individual portfolios are reviewed as required.
Trust Board	• Has delegated the function of ratification of all policies to the Management Group.
Management Group (MG)	• Has delegated authority from the Trust Board to ratify all Trust policies • Ratifies policies after approval by the relevant MG sub-group

	• If there is not a relevant MG sub-group, MG both approves and ratifies the policy. This is determined by the Director responsible for the area of the policy concerned. • Policies might need urgent approval. In these exceptional circumstances, the policy can be approved and ratified by the MG. The Executive Director responsible for the policy will decide if this is appropriate. • Ensures all policies have a completed Equality Analysis before they are ratified.
Quality Assurance Committee (QuAC)	• Is available to provide a view on policies which are regarded as potentially controversial due to ethical issues.
Sub-groups to MG	• Approve non-clinical policies before being ratified by the MG, e.g. Clinical Leaders Group, Workforce Group
Mental Health Legislation Committee	• Approval of MHA policies before they are ratified by MG

Leads	• Gain MG Director approval to develop policy **before** starting work (see Policy Scoping Template).
	• Register the policy with the Policy Coordinator
	• Either:
	  ○ undertake the policy development; or
	  ○ establish a time limited development group.
	• Consider if input from specialist services is needed, e.g. when developing policies for older peoples, children and young people and learning disability services
	• Carry out an Equality Analysis
	• Ensure the policy follows the appropriate governance process, with support from the Policy Coordinator as needed
	• To undertake regular review and timely update of policies and procedures for which they are responsible. This includes relevant updates to reflect changes in the evidence base
	• Ensure the policy reflects National guidance (e.g., NICE), where appropriate.

Associate Directors/ General Managers	Will ensure that:
	• Systems are in place for all staff to have an awareness of and have access to all current Trust policies. If policies cannot be accessed via the Trust's intranet, paper copies must be made available
	• Each ward and department has identified those policies which:
	  ○ are of specific relevance to the area
	  ○ staff need to have a detailed knowledge of; and
	  ○ will be included in local workplace induction.
	• Ensure compliance and that regular monitoring of implementation takes place
	• Audit action plans are usually developed by clinical audit leads and approved by appropriate governance groups.

	• Advise the relevant Director if a review of policy is needed, e.g. as a result of audit.
Policy Coordinator	• Ensure the governance of policies as required by the Trust. • This role is undertaken by the Directorate of Corporate Affairs and Involvement's Communications Team.
Department, team and ward managers	• Ensure that all staff are aware of and have read relevant new and amended policy documents. • Ensure compliance with policy and that regular monitoring of implementation takes place

4 Document types

4.1 What is a policy?

- A plan or course of action to influence or determine decisions, actions or other matters
- A statement of principles and standards
- Tells us how the Trust will implement strategy
- Underpinned by law, standards or codes of practice
- Deals with what needs to happen and why, and who is responsible

4.2 What is a procedure?

- A series of related steps designed to achieve:
    - A specific task
    - In a specified order
- Procedures accomplish the goals and directives of a related policy
- Deals with what action is carried out, who does it, how and when.

For more information on policies, procedures, processes, protocols and guidance, see Policies and Procedures – Guidance for Writers section 6 'Document Types'.

5 Writing/reviewing documents

The process for writing new and reviewing existing documents is defined in the document Policies and Procedures – Guidance for Writers.

The introduction of a new document of change to an existing document which involves a new or changed processing activity involving personal data may need a new or amended Data Protection Impact Assessment (DPIA). Email tewv.dpia@nhs.net for support.

All policies will be due for review three years from ratification date unless the named director agrees otherwise. An earlier review may be needed due to audit findings, new/revised government legislation or changes to the evidence base or best practice.

A policy located on the intranet is assumed to be current and the one by which the Trust stands even if the review date has passed. An expired date does not automatically indicate that the policy has been superseded. If in doubt, check with the Policy Coordinator.

Documents in the Trust portfolio will be co-created and involve people on whom those documents impact. See Policies and Procedures – Guidance for Writers section 5.3

6 Equality analysis

- Equality analysis is a way of considering the effect of policies and procedures on different groups protected from discrimination by the Equality Act 2010 (the Act).
- All public bodies have statutory duties under the Act to set out arrangements to analyse the effect of their policies and functions on equality for all protected characteristics.
- The equality analysis process also considers the needs of service personnel (including reserve personnel), veterans and their families. All public bodies have statutory duties under the Armed Forces Act 2021 to help prevent service personnel and veterans being disadvantaged when accessing public services. As an organisation we have signed the Covenant which outlines the nation's obligation to look after those who have served and their families, ensuring that members of the Armed Forces community face no disadvantage because of their service, and that special consideration be given in certain circumstances.

- All policies and procedures will undergo equality analysis:
  - When the documents are new or have changed
  - When the services or process they describe is new or has changed
  - Not less than once every three years.
- The process for completing an equality analysis is described in the Trust's Equality Analysis Guidance
- For more information on how to carry out an equality analysis for policies and procedures, see Policies and Procedures – Guidance for Writers

7 Consultation

Consultation means seeking views, opinions and advice from people and groups, both internal and external to the Trust, as appropriate to the content of the policy.

Consultation improves decision-making by ensuring:

- decisions are based on all available evidence
- decisions take account of the views and experience of those affected by them
- we consider innovative and creative options
- new arrangements are workable.

Consultation is needed on:

- All new policies, or;
- If the document or the service/process it describes has undergone major change.

8 Approval and ratification process

The groups and committees that have delegated authority to approve and ratify documents, and the route that documents take to ratification, are shown in Appendix 3.

Final ratification of all policies is the responsibility of the Management Group.

All policies, procedures, protocols and guidelines are assessed to ensure they do not describe detail of ligature points, ligatures, or detail of any other means of self harm. This review is evidenced in the approval checklist. Any documents that contain such detail will not be published externally. National Patient Safety Alert NatPSA2020/001/NHSPS issued 03/03/20 refers.

⚠ In exceptional circumstances, determined by the responsible director, the Management Group can both approve and ratify all policies.

9 Freedom of Information Act and Publication Scheme

For all new policy and procedure documents, the Policy Lead updates the front cover, document control section and approval checklist to identify whether the document is to be published externally via the Trust's website.

⚠ Most documents will be published unless the risk of publishing outweighs the risk of not (e.g. a procedure showing how to obtain a staff ID badge would not be published because of the risks associated with making that process known and available publicly).

10 Dissemination

Ratified documents are published on the Trust Intranet and, unless advised otherwise, on the Trust's external website.

Managers must ensure that paper copies are available to staff who cannot access the Trust's intranet.

Documents that have been ratified and published are notified to staff via the 'LATEST NEWS' section of the intranet, a monthly update in the 'All staff weekly briefing', a monthly all staff email 'Important policy updates from (Month & Year)', and a monthly update to the Senior Information Risk Officer (SIRO) network for dissemination via team brief. This will include a summary of key changes provided by the lead. Documents are also published to the Trust's external website unless the Lead has indicated otherwise via the document's front cover and document control section.

Department, team and ward managers must ensure that all staff are aware of and have read relevant new policy documents. Additionally, new documents should be discussed at team meetings to consider relevance to the department.

11 Implementation and monitoring

Directors, Associate Directors and General Managers are responsible for ensuring policies are effectively implemented.

• All policies must identify training needs associated with the implementation of the policy and how there will be met.
• Policy authors must ensure the training department are aware of and agree with any identified training needs to ensure the requirements are compatible with the learning and development policy.
• To demonstrate effective care delivery and compliance, policy authors are required to include how monitoring of this policy is linked to auditable standards/key performance indicators.

The date of implementation should be agreed at the appropriate operational governance group, having taken into consideration all the necessary requirements / implications of the policy.

Consideration should be given as to the time required for a policy to become an integral part of the organisation. There are three significant issues to be considered and the time required for these to become established:

- training needs and training department agreement
- cascading timescales
- resource implications

The policy should show the target date for full implementation and if appropriate an action plan for implementation monitored by the relevant operational governance group. The action plan should detail the target date along with the target number of trained staff relevant to the policy.

The appropriate operational governance group will receive the outcomes of policy monitoring and agree any action planning if gaps are identified and how learning will take place.

12 Archiving

12.1 Register of documents

The Policy Coordinator maintains the policy register and is responsible for recording, storing and controlling policies.

The library of current published policies is available on the Trust's Intranet.

12.2 Archiving arrangements

The Policy Coordinator will maintain an archive of all policies that have been developed. When policies are revised, the original policy will be archived.

Archived policies will be stored electronically on a database maintained by the Policy Coordinator. Where only paper policies exist, these will be stored centrally by the Policy Coordinator.

Archived policies will be held for ten years from the date of archive.

12.3 Process for retrieving archived documents

The Policy Coordinator controls the archived policy information and can provide copies of archival information on request.

13 How this policy will be implemented

Implementation Action Plan				
Activity	**Expected outcome**	**Timescale**	**Responsibility**	**Means of verification/ measurement**
Publication on intranet and external website with notification to policy leads	Governance of documents follows the correct process	Immediately on ratification	Policy Coordinator	Quality Assurance of policies and procedures within the governance workflow

13.1 Training needs analysis

Staff/Professional Group	**Type of Training**	**Duration**	**Frequency of Training**

Policy leads	Writing Policies – internal training for policy leads	1.0 hrs	As required

14 How the implementation of this policy will be monitored

Auditable Standard/Key Performance Indicators		Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).
1	QA of policies and procedures within the governance workflow	Weekly/Manual review of documents/Policy Coordinator	Concerns/issues raised to MG

15 References

Equality Act 2010, London: Stationery Office [Online] Available at: http://www.legislation.gov.uk/ukpga/2010/15/contents

Armed Forces Act 2021, UK Public General Acts [Online] Available at: https://www.legislation.gov.uk/ukpga/2021/35/contents

16 Definitions

Term	Definition
Consultation	The process of seeking views, opinions and advice from people and groups as appropriate to the content of the document.
Equality Analysis	The process and documentary evidence that the Trust has considered the effect of policies and procedures on different groups protected from discrimination by the Equality Act 2010 and the Armed Forces Act 2021.
Guideline/guidance	• A rule or set of rules that tell us how to behave in a given situation • Recommended practice, not compulsory or mandated • Allows leeway in its interpretation, implementation or use.
Lead	The 'owner' of a document who is responsible for its development and review, and ensuring the document undergoes the correct governance processes.

Major change	A significant change in the document to address changes in legislation, working practices and processes, errors or omissions.
Minor change	Changes to address typographical or grammatical errors, contact details or small clarifications.
Policy	• A plan or course of action to influence or determine decisions, actions or other matters • A statement of principles and standards • Tells us how the Trust will implement strategy • Underpinned by law, standards or codes of practice • Deals with what needs to happen and why, and who is responsible

Procedure	• A series of related steps designed to achieve:
	  ○ A specific task
	  ○ In a specified order
	• Procedures accomplish the goals and directives of a related policy
	• Deals with what action is carried out, who does it, how and when.

Process	• A process outlines what to do to comply with policy • Process gives more detail to what needs to happen.
Protocol	• A local variation of a procedure.
Significant change	See major change

18 Document control (external)

To be recorded on the policy register by Policy Coordinator

Date of approval	14 December 2022
Next review date	14 December 2025
This document replaces	CORP-0001-v7.1 Governance of Policies
This document was approved by	IG Group (DPIA changes only)
This document was approved	15 June 2022
This document was approved by	Digital and Data Management Meeting (DPIA changes only)
This document was approved	12 July 2022 (DPIA changes only)
This document was approved by	Executive Directors (all changes)
This document was approved	14 December 2022 (all changes)
This document was ratified by	Executive Directors
This document was ratified	14 December 2022
An equality analysis was completed on this policy on	06 December 2022
Document type	Public
FOI Clause (Private documents only)	n/a

Change record

Version	Date	Amendment details	Status
5	18 Jan 2017	Policy and guidance merged into one document. Addition of training needs analysis and monitoring framework	Withdrawn
5.1	06 Sep 2017	Sections 4 and 12 amended to include changes in evidence base within responsibility for reviewing policies. Hyperlinks updated.	Withdrawn
5.1	06 Feb 2020	Review date extended from 18 January 2020 to 28 February 2021 to enable complete re-write of policy.	Withdrawn

5.2	04 Jun 2020	Section 10 wording amended with assessment for harm prior to publication	Withdrawn
6	25 Nov 2020	Revised to include review for harm and updated policy template. Minor amendments throughout.	Withdrawn
7	25 Aug 2021	Reviewed for Our Journey To Change References to Executive Management Team (EMT) changed to Senior Leadership Group (SLG) 8. Ratification – removed monthly notification to Board of Directors	Withdrawn
7.1	15 June 2022	Minor amendment:- • Section 6 Equality analysis – added veterans text "The equality analysis process also considers the needs of service personnel (including reserve personnel), veterans and their families. All public bodies have statutory duties under the Armed Forces Act 2021 to help prevent service personnel and veterans being disadvantaged when accessing public services. As an organisation we have signed the Covenant which outlines the nation's obligation to look after those who have served and their families, ensuring that members of the Armed Forces community face no disadvantage because of their service, and that special consideration be given in certain circumstances." and • Section 16 Definitions amended to reference Armed Forces Act 2021 "The process and documentary evidence that the Trust has considered the effect of policies and procedures on different groups protected from discrimination by the Equality Act 2010 **and the Armed Forces Act 2021**."	Withdrawn
7.2	14 Dec 2022	Full review with minor amendments: • Section 3 'Roles and responsibilities' minor clarification for Associate Directors/ General Managers • section 5 'Writing / reviewing documents' - addition of Data Protection Impact Assessment requirement. • document updated to reflect restructure • Section 10 'Dissemination' updated to reflect changes required by Policy Audit • Appendix 3 – Approval groups updated	Ratified

Appendix 1 - Equality Analysis Screening Form

Please note: The Equality Analysis Policy and Equality Analysis Guidance can be found on the policy pages of the intranet

Section 1	Scope
Name of service area/directorate/department	Corporate Affairs and Involvement
Title	Governance of Policies, Procedures, Protocols and Guidelines
Type	Policy
Geographical area covered	Trust-wide
Aims and objectives	To promote and enable an organisational and systematic approach to the development and writing of policies, procedures, protocols and guidelines throughout Tees, Esk Wear Valleys NHS Foundation Trust To ensure that Trust policies, procedures, protocols and guidelines are developed with the involvement of people and groups as appropriate to the content of the policy. To ensure documents are inclusive of the population they serve. To promote evidence-based practice and reduce variation across the Trust.
Start date of Equality Analysis Screening	05 November 2022
End date of Equality Analysis Screening	06 November 2022

Section 2	Impacts
Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?	All Trust policy authors
Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups?	• **Race** (including Gypsy and Traveller) **NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO**

	• **Sex** (Men, women and gender neutral etc.) **NO** • **Gender reassignment** (Transgender and gender identity) **NO** • **Sexual Orientation** (Lesbian, Gay, Bisexual and Heterosexual etc.) **NO** • **Age** (includes, young people, older people – people of all ages) **NO** • **Religion or Belief** (includes faith groups, atheism and philosophical beliefs) **NO** • **Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave) **NO** • **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **NO** • **Veterans** (includes serving armed forces personnel, reservists, veterans and their families **NO**
Describe any negative impacts	None
Describe any positive impacts	Following this policy ensures that all Trust policy and procedure documents give due consideration to all protected characteristics, that people and groups are involved in the development of the documents and that all new and significantly amended documents undergo full consultation.

Section 3	**Research and involvement**
What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	See references section
Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups?	Yes
If you answered Yes above, describe the engagement and involvement that has taken place	Previous versions of the policy have had full consultation that includes all Trust staff and would include individuals from each of the protected characteristic groups. The changes since this full consultation add rights under the Armed Forces Act 2021, add additional dissemination routes to benefit staff and clarify governance structure.

If you answered No above, describe future plans that you may have to engage and involve people from different groups	

Section 4	**Training needs**
As part of this equality analysis have any training needs/service needs been identified?	No
Describe any training needs for Trust staff	n/a
Describe any training needs for patients	n/a
Describe any training needs for contractors or other outside agencies	n/a

Check the information you have provided and ensure additional evidence can be provided if asked

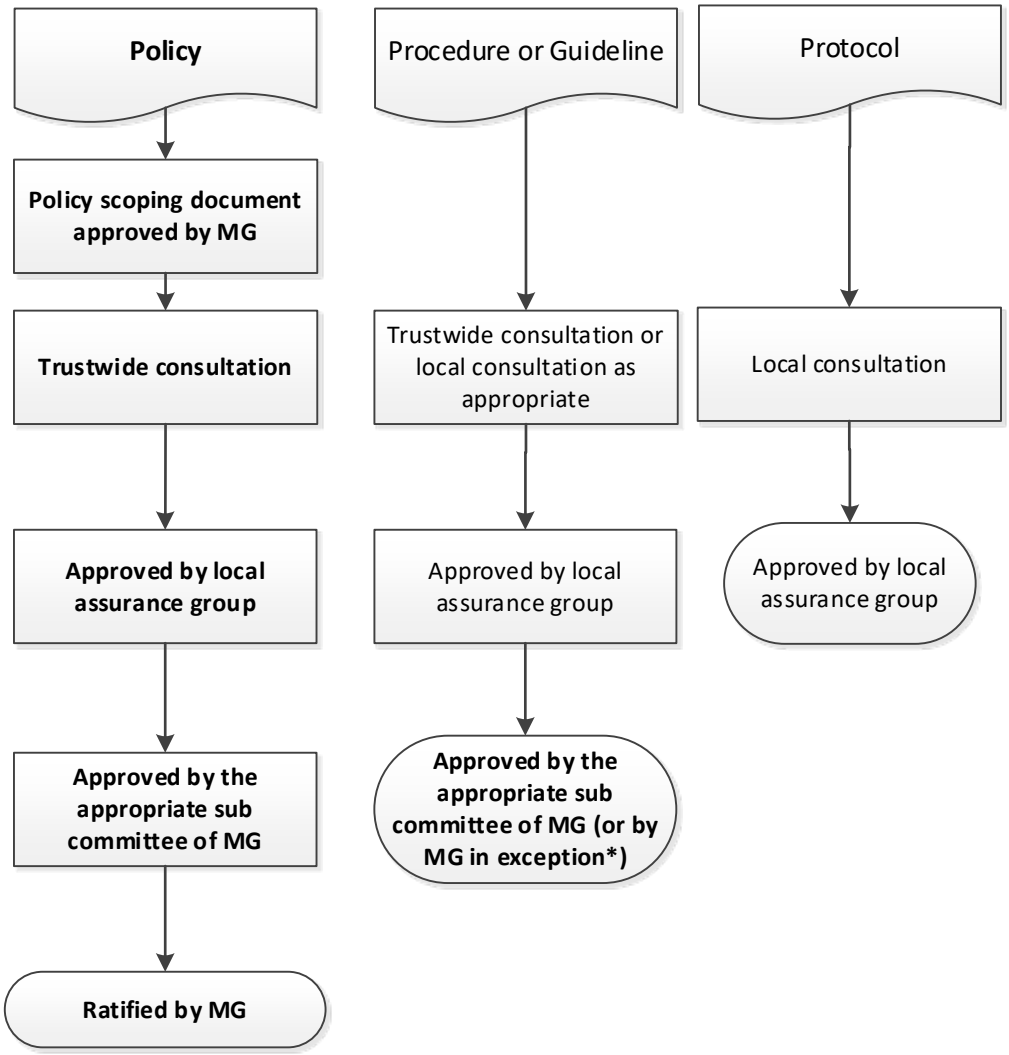
Appendix 2 – Approval checklist

To be completed by lead and attached to any document which guides practice when submitted to the appropriate committee/group for consideration and approval.

	Title of document being reviewed:	Yes/No/ Not applicable	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Are people involved in the development identified?	Yes	
	Has relevant expertise has been sought/used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
	Have any related documents or documents that are impacted by this change been identified and updated?	Yes	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are supporting documents referenced?	Yes	
6.	**Training**		
	Have training needs been considered?	Yes	
	Are training needs included in the document?	Yes	
7.	**Implementation and monitoring**		

	Title of document being reviewed:	Yes/No/ Not applicable	Comments
	Does the document identify how it will be implemented and monitored?	Yes	
8.	**Equality analysis**		
	Has an equality analysis been completed for the document?	Yes	
	Have Equality and Diversity reviewed and approved the equality analysis?	Yes	
9.	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	
10.	**Publication**		
	Has the policy been reviewed for harm?	Yes	
	Does the document identify whether it is private or public?	Yes	Public
	If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	N/A	

Appendix 3 – Approval groups



*At the discretion of the relevant Board Director

Document Owners	Approval route	Frequency of meetings
Finance	Senior Finance Operational Group/Audit Committee	Monthly
	Then to Joint Consultative Committee for staff side approval (document specific)	As required
Health and Safety	First review by Health, Safety, Security & Fire Working Group	Monthly
	Then to EFM DMT for approval	Monthly
People and Culture	Change/new document produced via Policy Working Group	Monthly
	Then to Joint Consultative Committee for staff side approval	Monthly

Infection Prevention and Control	IPC Committee	Quarterly
Digital and Data Services – Trustwide documents	First review via Digital and Data Management Meeting (DDMM)	Monthly
	Then to Digital Performance and Assurance Group (DPAG) (policies only)	Monthly
Digital and Data Services – internal documents only	Digital and Data Management Meeting (DDMM)	Monthly
Information Governance	First review at Information Governance Group	Monthly
	Digital and Data Management Meeting (DDMM)	Monthly
	Then to Digital Performance and Assurance Group (DPAG) (policies only)	Monthly
Mental Health Act	Mental Health Legislation Committee	Quarterly
Operational policies (DTV&F)	Service Delivery Improvement group (as defined by Care Group)	Monthly
	Care Group Subgroup – Quality Assurance and Improvement	Monthly
Operational Policies (NYY&S)	Service Delivery Improvement group (as defined by Care Group)	Monthly
	Care Group Subgroup – Quality Assurance and Improvement	Monthly
Patient Experience / Patient Safety/ Clinical Effectiveness	Executive Quality Assurance Improvement Subgroup (EQAIG)	Monthly
Medication related or Pharmacy	Drugs and Therapeutics Committee	Monthly
Medical Devices	Medical Devices Trust Group	Quarterly
Physical Health Care	Physical Health Trust Group	Bi-Monthly
Resuscitation	Resuscitation Committee	Bi-Monthly
Safeguarding	Safeguarding and Public Protection Group	Quarterly
Service specific	First review at Care Group Board Cell	Weekly
	Care Group Board (as required)	Monthly