Governance of Trust Policies and Procedural Documents

This policy describes the governance processes for the development, review, consultation, maintenance, approval, and distribution of policies, guidelines, procedures and protocols

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Which Relevant CQC Fundamental Standards?	Good Governance	

Key individuals involved in developing the document

Name	Designation
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Circulated to the following individuals for consultation

Name	Designation
Members of the Trust Policy Committee	

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Version Control and Summary of Changes

Version number	Date	Comments
Version 1	August 2011	New Policy
Version 2	March 2012	Amendments made to take account of new structures in organisation.
Version 3	April 2015	Revised duty disbandment of policy group by QAC March 2015.
Version 4	January 2016	Clarifying the procedure for checking policy before the policy is finally agreed by the lead committee. Changes to the checklist procedure.
Version 5	February 2016	Minor corrections not made in Version 5.1 to reflect Policy Support Team.
Version 6	March 2018	Full Review and amendments made
Version 7	October 2019	Full Review and amendments made as a result of establishment of Trust Policy Committee. Change to flowchart to reflect new structure. New paragraph to advise on electronic patient records. Name of policy changed.
Version 8	May 2020	Amendment made to Para:13 to include statement with regards to those polices that should not be uploaded to the public websites
Version 9	June 2022	Comprehensive re-write to update and include the use of the Ulysses module for centralised management, removal of reference to a Trust Policy Lead and the removal of the Policy Committee. Updated to also include guidelines, procedures and protocols.

All LPT Policies can be provided in large print or Braille formats, if requested, and an interpreting service is available to individuals of different nationalities who require them.

1. Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

Please be advised that the Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust website is the most up-to-date version.

If you would like any public Trust Policy in an accessible format please email lpt.corporateaffairs@nhs.net and we can send them to you.

1.1 Due Regard

LPT will ensure that Due regard for equality is taken and as such will undertake an analysis of equality (assessment of impact) on existing and new policies in line with the Equality Act 2010. This process will help to ensure that:

- Strategies, policies and procedures and services are free from discrimination.
- LPT complies with current equality legislation.
- Due regard is given to equality in decision making and subsequent processes.
- Opportunities for promoting equality are identified.

Please refer to due regard assessment (Appendix 3) of this policy

2. Definitions that apply to this Policy

Policy	A policy document is a statement of corporate intent that is regarded as a legally binding; therefore, its purpose, definitions and the responsibilities outlined within its content, must be upheld in order that it may be used to support an individual or the Trust during legal action. It contains details which relevant Trust employees are expected to adhere to, as part of their terms of employment. It is a high-level statement of approach detailing the way that national legislation or directives will be applied across the Trust with mandatory and organisation-wide application. It is developed in consultation and with engagement from key teams/officers (including subject matter experts). It is mandatory for all staff, (permanent or temporary) volunteers and others as appropriate (e.g., contractors) and is considered binding
Procedure	A procedure is a standardised method of performing clinical /non-clinical tasks by providing a series of actions that must be completed in a certain order or manner to accomplish a safe, effective outcome. Such a document would place greater emphasis upon providing step-by step instructions, to ensure all concerned undertake the task in an agreed and consistent way. The procedure is a formal document and must be complied with as it may be used to support an individual or the Trust during legal action. A procedural document must follow from a particular policy. It is a description of operational tasks to be undertaken to implement, or support, a policy. Procedural documents apply across the Trust to all relevant sites and services.
Protocol	These are a written code of practice that may include recommendations/detail competencies or delegation of authority. Less rigid than a procedure, they are locally adapted to offer a broad statement of good practice which includes national guidelines, defining the management of patients or categories of patients, agreed by health care professionals. Procedures / Protocols are held locally and reviewed by the specific professionals.

Guideline	Guidelines are designed to guide clinical practice and to provide evidence-based and detailed advice on the appropriate treatment and care of people with specific diseases and conditions. It outlines accepted best practice and must be up to date. As such it is expected that staff will follow guidelines in all but exceptional circumstances, based on the judgement of the practitioner. Clinical guidance documents allow individuals to use their professional judgement and decision-making skills. It may be organisation-wide or division-specific. Its format can be mainly diagrammatic. Clinical guidelines are flexible and act as a support and guide, they are not prescriptive.
Standing Operating Procedure (SOP)	A standard operating procedure (SOP) is a set of step-by-step instructions compiled by a service to help workers carry out the complex routine of the service SOPs aim to achieve efficiency, and quality output and uniformity of performance, while reducing miscommunication. regulations.

3. Purpose of the policy

The purpose of this policy is to:

3.1 Describe the process for developing, approving and distributing policies, guidelines, procedures and protocols.

3.2 Summarise the areas of responsibility that each Directorate and governance forum has in the policy, guidelines, procedures and protocols development, approval and distribution process.

3.3 Explain the arrangements for distributing policies, guidelines, procedures and protocols.

3.4 Summarise the arrangements for ensuring that policies, guidelines, procedures and protocols are regularly reviewed to reflect changing practice.

4. Summary and scope of the policy

4.1 Policies, guidelines, procedures and protocols should be reviewed between one and three years (to be determined by the relevant Director).

4.2 Policies should be approved by the relevant level 2 or 3 delivery group. This approval is documented on the highlight report for the relevant level 1 assurance committee for ratification.

4.3 Guidelines, procedures and protocols are approved by the relevant level 2 or 3 delivery group and do not need level 1 assurance committee ratification.

4.4 The Corporate Affairs Office is responsible for uploading all policies onto Ulysses where they are kept centrally and where relevant, onto the Trust's website.

4.5 Authors / Lead Directors should endeavour to reduce the quantity of policies, guidelines, procedures and protocols within their Directorates whenever possible.

They should consider retiring, merging or reducing the length of policies to ensure that users are able to access relevant material quickly.

4.6 Any request for extension to a policy, procedure, guideline or protocol beyond its review date should be reviewed by the relevant delivery group, and a recommendation and rationale sent to the Corporate Affairs Office (lpt.corporateaffairs@nhs.net). Policies may only be extended once for up to 12 months without a review as long as they are considered to be safe to use.

5. Introduction

5.1 This policy applies to the development of policies, guidelines, procedures and protocols.

5.2 The Trust's policies must be designed to support staff to perform their duties and to meet legal requirements, and must be consistent with the Trust's other processes, guidelines, procedures and protocols.

5.3 Each policy, guideline, procedure and protocol should be reviewed periodically and/or when scheduled for formal review (between 1 and 3 years). An automated reminder will remind the author and owner that their policy, guideline, procedure or protocol is scheduled for review. When reviewing, the author will need to consult relevant key stakeholders for their input and comments prior to approval by the relevant delivery group. All policies, guidelines, procedures and protocols need to be uploaded to Ulysses by the Corporate Affairs Office after ratification by the relevant level 1 Committee.

5.4 Only policies need to be ratified by the relevant level 1 Committee. Guidelines, procedures and protocols do not need to be ratified by a Board Committee.

5.5 In line with the Freedom of Information Act (2000), where appropriate, approved procedural documents will be published on the Trust website. This version of any document published on the Trust website is the definitive version.

5.6 All procedural documents apply across the Trust. Localised policies should only be drafted in exceptional circumstances where prior agreement has been obtained from the Corporate Affairs Office.

6. Consultation

6.1 All Policies shall initially be written/reviewed by subject matter experts and the core policy reviewer group which includes;

- Corporate Governance Lead with a responsibility for policies
- Head of Quality Governance and Quality Improvement
- Deputy Head of Nursing
- Equality and Diversity Lead
- Patient Safety Lead
- Patient Experience and Engagement Lead
- HR representative
- Health and Safety Representative
- Clinical Safety Officer
- Infection Control Representative

- Trust Secretary

6.2 All key stakeholders should be consulted and their engagement recorded in the Policy. All Policies (and Policy changes) must consider the impact on service users and carers.

6.3 Where a policy is likely to have a direct link to or impact on service users and carers, draft documents will be circulated to service user and carer groups for comment. Where any decision is taken that an authorised document is not to be subject to consultation by service users and carers, the reasons for this must be clearly stated on the policy approval form.

6.4 Consultation on policies that will impact on protected groups and other protected characteristics/equality groups should be consulted upon with those concerned. A coordinated approach can enable the results of previous engagement in policy development, avoiding duplication and helping to build confidence among stakeholders, as they can see that their feedback is being acted on. The Commission's Guide on Engagement and the Equality Duty provides further advice on this.

7. Core Standards

7.1 Core standards for the production of approved procedural documents were originally taken from the NHS Litigation Authority (now NHS Resolution) and have been adopted by the Trust as model standards;

- Agreed Trust wide style and format
- Clear introduction and definition of terms used for each document
- Clear consultation process
- Clear adoption process
- Reviewing arrangements for each document
- Identified system for control of documents and archiving
- Standardised references to associated documents
- Clearly identified process for monitoring effectiveness
- If necessary a privacy assessment to be completed

7.2 It is a requirement that all new and existing procedural documents being reviewed are assessed with due regard to relevant employment law and equality legislation; specifically the public sector equality duty (PSED) to ensure that decisions are fair, transparent, accountable, evidence-based and consider the needs and rights of all stakeholders.

7.3 All Trust Policies undergo an Equality Impact Assessment to demonstrate that they are exercising due regard. Therefore stakeholders will have an entitlement to question LPT about its equality work and request evidence on how they are exercising 'due regard' obligations.

7.4 It is a requirement that all relevant, new and existing procedural documents are assessed to ensure compliance with The Modern Slavery Act.

7.5 It is a requirement that all relevant, new and existing procedural documents are assessed with regard to relevant standards and safeguards as set out in the Mental Health Act Code of Practice.

7.6 Stakeholders are key to the review and development of authorised documents. The

policy author has the responsibility to ensure consultation takes place with the appropriate stakeholders.

7.7 The NHS Constitution sets out the principles and values that guide how the NHS should act and make decisions. It brings together a number of rights, pledges and responsibilities for staff and patients alike. Policy authors must take account of the NHS Constitution and identify which of the rights and pledges are applicable to the policy being developed.

7.8 It is a requirement that training needs are identified for policies and must be included in the policy if training is identified. The training template must be completed after training needs have been identified, the policy template includes the table for completion. No training needs have been identified for this policy.

7.9 Policy authors must complete the NHS Constitution checklist and attach to the policy.

7.10 Privacy impact assessments (PIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet individual's expectations of privacy. The first step in the PIA process is identifying the need for an assessment.

7.11 It is a requirement that all procedural documents are presented in a concise and clear style using plain English. The Trust recognises that it must ensure that documents will need to be available in other formats if they are requested, to meet accessibility requirements.

7.12 LPT recognises that it has a role to play in ensuring that the population it serves including non-English speakers and people with visual or hearing loss can have full access to all our services. Any document can be translated into other mediums or languages. Translations can be arranged by request to the Trust's translating service. For further advice on this issue please contact the Trust's Equality team

7.13 Documents should be written in Arial font, minimum size 11, with single line spacing. Abbreviations should only be used after the term has been displayed in full.

7.14 Policy authors must liaise with Clinical Safety Officers and/or the LPT IM&T Delivery Group if documentation is required within the electronic patient record

7.15 Documents must accurately attribute the sources to which they refer and validates the statements and conclusions you make in your work by providing supporting evidence. They should be also updated to reflect any new guidance.

7.16 Policies, Guidelines or SOP's should not include electronic links or embedded documents to other policies/guidelines.

8. Process for this Monitoring Compliance and Effectiveness

TARGET/STANDARDS	KEY PERFORMANCE INDICATOR
All policy authors follow the guidelines within this policy	Where deficiencies are identified by the policy lead and/or the approving level 2/3 delivery group, the policy will be returned to the author for update prior to approval.
All policies are reviewed and updated before expiration of authorisation	All policies will be deemed as not being in place if expired and no action taken to update or formally extend

All policies are clearly sign posted and easily accessible	All stakeholders can access policies when necessary
Guidelines and procedures are not duplicated within policies but are cross referenced where applicable	Where a concept or principle is duplicated in another policy that policy will be withdrawn from the list and edited accordingly

9. Training Needs

Training needs must be identified. Training is only required if there are specific learning outcomes identified in the policy, where this is the case, the Training template must be completed (see appendix 1 of the policy template).

There is no training requirement identified within this policy

10. Duties and Responsibilities

10.1 Policy, Guideline or Procedure / Protocol Author

10.1.1 Authors of a policy, guideline or procedure / protocol are responsible for creating and/or reviewing it in line with this policy.

10.1.2 A policy, guideline or procedure / protocol must always be created/reviewed using the most up-to-date Policy, Procedure and Guideline Template which is available on the Trust's intranet.

10.1.3 Authors must consult with relevant stakeholders during the development or when reviewing a policy, guideline or procedure / protocol.

10.1.4 If using the Trust's Policy, Procedure and Guideline Template, the final draft policy, procedure or guideline presented for approval at the relevant governance fora must have a completed Equality Impact Assessment Form (EIA).

10.1.5 Authors have the responsibility for reviewing draft policies, guidelines or procedures / protocols and for submitting them to the appropriate governance fora for approval.

10.1.6 Authors should note that any approved policy, guideline or procedure / protocol is only effective when it is uploaded onto Ulysses. The Author will be responsible for making sure that the policy, guideline or procedure / protocol has progressed through the necessary approval process and for arranging for it to be submitted to the Corporate Affairs Team for uploading onto Ulysses using the following email lpt.corporateaffairs.nhs.net

10.2 Lead Director

10.2.1 Lead Directors have the responsibility and accountability for the communication, dissemination and implementation of their policies, guidelines and procedures / protocols to their teams. The policy, guideline or procedure / protocol owner is also responsible for ensuring that appropriate arrangements are in place for managing any effects on resources. These arrangements should include funding for the cost of any training that is required.

10.2.2 Lead Directors must arrange for the Corporate Affairs Team to be kept informed about any policy, guideline or procedure / protocol for which they are responsible, that are being replaced by a new policy, guideline or procedure / protocol and which therefore require to be archived. This is very important to

avoid multiple versions of policies, guidelines or procedures / protocols existing on Ulysses.

10.2.3 It is essential that the Corporate Affairs Team is informed of any policy, guideline or procedure / protocol that should be reviewed that are not fit for purpose so that the can be removed from Ulysses.

10.3 Directors, Senior Managers, Matrons and Team Leads

All Directors, Senior Managers, Matrons and Team Leads have the responsibility for ensuring that:

10.3.1 They have read and understood all the Trust's policies, guidelines and procedures / protocols relevant to their areas;

10.3.2 They have a procedure in place to share the relevant policies, guidelines and procedures / protocols with the members of staff that they are responsible for and that their staff (including new staff) are aware of the Trust's policies guidelines and procedures / protocols;

10.3.3 Their staff understand what is required of them and are implementing the requirements;

10.3.4 Their staff attend any training which is considered to be necessary in order to comply with each policy, guideline or procedure / protocol.

10.4 Staff

Members of staff have the responsibility for ensuring that:

10.4.1 They are familiar with each of the policies, guidelines and procedures / protocols which are relevant to them and to their duties;

10.4.2 They are able to locate them;

10.4.3 They are up-to-date with any changes made to the policies, guidelines or procedures / protocols;

10.4.4 They attend all relevant training sessions.

10.5 Corporate Affairs Team

10.5.1 The Corporate Affairs Team is responsible for maintaining an up-to-date Policy, Procedure and Guideline Template.

10.5.2 The Corporate Affairs Team is responsible for uploading and for archiving policies, guidelines and procedures / protocols on Ulysses.

10.5.3 The Corporate Affairs Team is responsible for quality checking the policy, guideline or procedure / protocol to ensure that it has complied with the Policy for Developing, Approving and Distributing Policies.

10.5.4 The Corporate Affairs Team is responsible for facilitating the process of informing policy authors and Lead Directors (owners) of when a policy, guideline or procedure / protocol is due for review using the Policy Portal. This is undertaken by an automated email reminder being sent to both the author and owner 3 calendar months prior to the policy, guideline or procedure / protocol renewal date. The automated email reminder will only be sent to the owners/authors on one occasion and should be responded to.

11. Fraud, Bribery and Corruption consideration

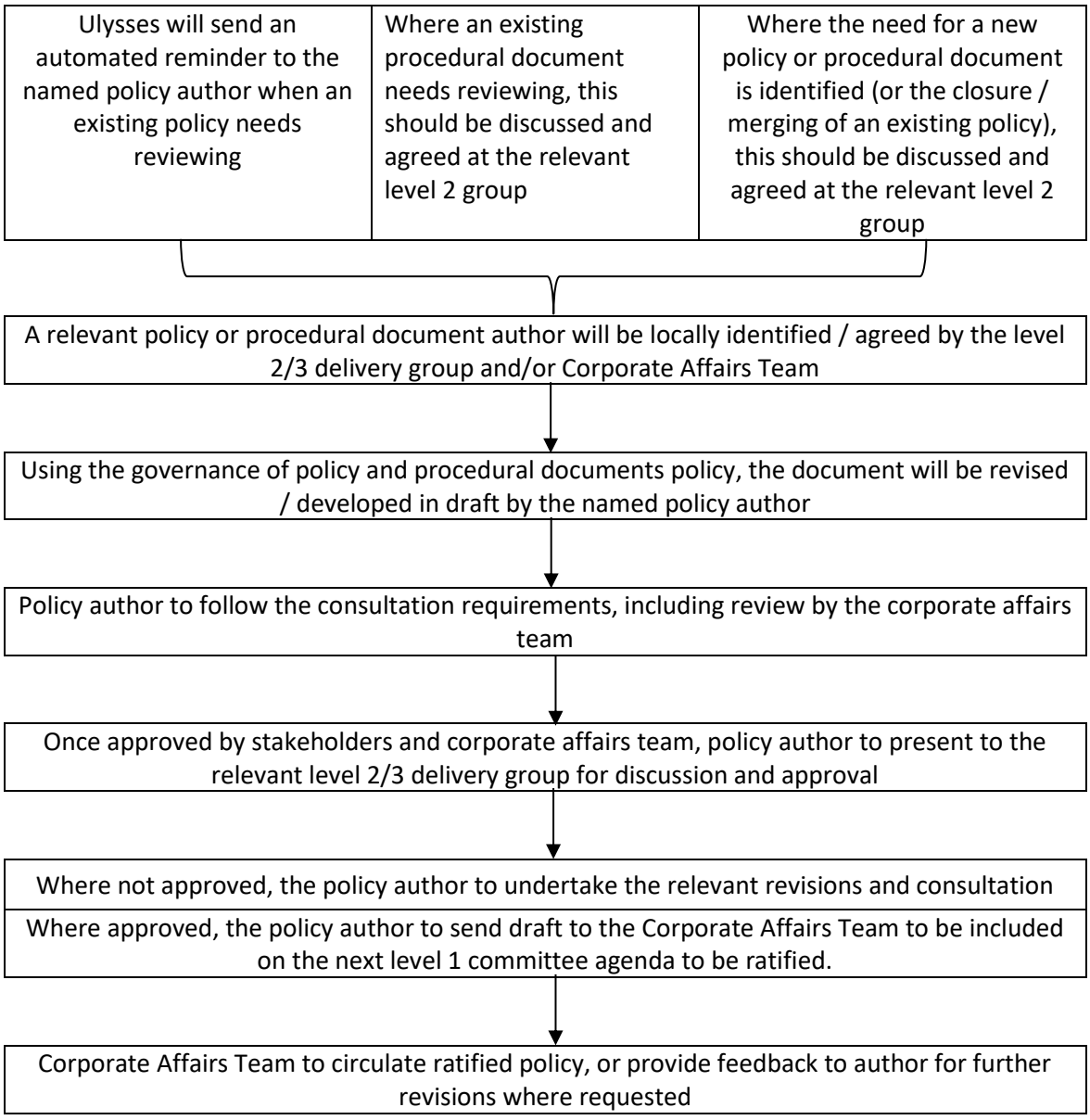
The Trust has a zero-tolerance approach to fraud, bribery and corruption in all areas of

our work and it is important that this is reflected through all policies and procedures to mitigate these risks.

- Fraud relates to a dishonest representation, failure to disclose information or abuse of position in order to make a gain or cause a loss. Bribery involves the giving or receiving of gifts or money in return for improper performance. Corruption relates to dishonest or fraudulent conduct by those in power.
- Any procedure incurring costs or fees or involving the procurement or provision of goods or service, may be susceptible to fraud, bribery, or corruption so provision should be made within the policy to safeguard against these.

If there is a potential that the policy being written, amended or updated controls a procedure for which there is a potential of fraud, bribery, or corruption to occur you should contact the Trusts Local Counter Fraud Specialist (LCFS) for assistance.

12. Pathway for new or revised policies, procedures, protocols or guidelines



Appendix 1 The NHS Constitution

- The NHS will provide a universal service for all based on clinical need, not ability to pay.
- The NHS will provide a comprehensive range of services.

Shape its services around the needs and preferences of individual patients, their families and their carers	✓
Respond to different needs of different sectors of the population	✓
Work continuously to improve quality services and to minimise errors	✓
Support and value its staff	✓
Work together with others to ensure a seamless service for patients	✓
Help keep people healthy and work to reduce health inequalities	✓
Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance	✓

Appendix 2 Due Regard Screening Template

Section 1	
Name of activity/proposal	Policy renewal for the Governance of Trust Policies and Procedural Documents
Date Screening commenced	October 2022
Directorate / Service carrying out the assessment	Corporate Affairs Department
Name and role of person undertaking this Due Regard	Kate Dyer, Deputy Director of Governance and Risk / Trust Secretary
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: This policy describes the governance processes for the development, review, consultation, maintenance, approval, and distribution of policies, guidelines, procedures and protocols	
OBJECTIVES: To describe the required approach to the development and management of procedural documents	

Section 2	
Protected Characteristic	If the proposal/s have a positive or negative impact please give brief details
Age	None
Disability	None
Gender reassignment	None
Marriage & Civil Partnership	None
Pregnancy & Maternity	None
Race	None
Religion and Belief	None
Sex	None
Sexual Orientation	None
Other equality groups?	None

Section 3			
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below.			
Yes		No ✓	
High risk: Complete a full EIA starting click here to proceed to Part B		Low risk: Go to Section 4.	

Section 4			
If this proposal is low risk please give evidence or justification for how you reached this decision:			
This is a neutral policy having no impact on any specific group			
Signed by reviewer/assessor	x	Date	
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed	Kate Dyer	Date	19/10/22

Appendix 3 Data Privacy Impact Assessment Screening

Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy.
The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.

Name of Document:	Governance of Trust Policies and Procedural Documents	
Completed by:	Kate Dyer	
Job title	Deputy Director of Governance and Risk	**Date** October 2022

Screening Questions	**Yes / No**	**Explanatory Note**
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.	No	
2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.	No	
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?	No	
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?	No	
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.	No	
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?	No	
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.	No	
8. Will the process require you to contact individuals in ways which they may find intrusive?	No	

If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk
In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.

Data Privacy approval name:	**Not Required**
Date of approval	**--**

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust

Appendix 4 Data Privacy Impact Screening Guidance Notes

The following guidance notes should provide an explanation of the context for the screening questions and therefore assist you in determining your responses.

Question 1: Some policies will support underpinning processes and procedures. This question asks the policy author to consider whether through the implementation of the policy/procedure, will introduce the need to collect information that would not have previously been collected.

Question 2: This question asks the policy author if as part of the implementation of the policy/procedure**,** the process involves service users/staff providing information about them, over and above what we would normally collect

Question 3: This questions asks the policy author if the process or procedure underpinning the policy includes the need to share information with other organisations or groups of staff, who would not previously have received or had access to this information.

Question 4: This question asks the author to consider whether the underpinning processes and procedures involve using information that is collected and used, in ways that changes the purpose for the collection e.g. not for direct care purposes, but for research or planning

Question 5: This question asks the author to consider whether the underpinning processes or procedures involve the use of technology to either collect or use the information. This does not need to be a new technology, but whether a particular technology is being used to process the information e.g. use of email for communicating with service users as a primary means of contact

Question 6: This question asks the author to consider whether any underpinning processes or procedures outlined in the document support a decision making process that may lead to certain actions being taken in relation to the service user/staff member, which may have a significant privacy impact on them

Question 7: This question asks the author to consider whether any of the underpinning processes set out how information about service users/staff members may intrude on their privacy rights e.g. does the process involve the using specific types of special category data (previously known as sensitive personal data)

Question 8: This question asks the author to consider whether any part of the underpinning process(es) involves the need to contact service users/staff in ways that they may find intrusive e.g. using an application based communication such as WhatsApp

If you have any further questions about how to answer any specific questions on the screening tool, please contact the Data Privacy Team via LPT-DataPrivacy@leicspart.secure.nhs.uk