NHS
Leicestershire Partnership
NHS Trust

The Governance of Trust Policies and Procedural Documents

Effective Policy management forms part of the Trust's Risk Management Strategy and is a requirement of assurance processes

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Target audience:	LPT staff involved in producing LPT procedural documents

Type of Policy	Clinical		Non Clinical √
Which Relevant CQC Fundamental Standards?		Good Governance	

Key individuals involved in developing the document

Name	Designation
Joan Hawkins	Policy Lead
Frank Lusk	Trust Secretary
Laiqaah Manjra	Corporate Affairs Officer

Circulated to the following individuals for consultation

Name	Designation
Members of the Trust Policy Committee	

Contents

Version Control and Summary of Changes

Version number	Date	Comments (description change and amendments)
Version 1	August 2011	Version 4 has been developed for the new organisation.
Version 2	March 2012	Amendments made to take account of new structures in organisation.
Version 5	April 2015	Revised duty disbandment of policy group by QAC March 2015.
Version 5.1	January 2016	Addition 6.4 clarifying the procedure for checking policy before the policy is finally agreed by the lead committee. Changes to the checklist procedure.
Version 5.2	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 7.1	May 2020	Amendment made to Para:13 to include statement with regards to those polices that should not be uploaded to the public websites

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.

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.

Did you print this document yourself?

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.

For further information, contact;
Definitions that apply to this Policy Tel: 0116 2950821
All procedural documents should have a definition of terms.

Definitions are a Core Standard

Approved	Formal confirmation by relevant Committee that the document meets the required standards and may be sent to the relevant Board Committee for adoption
Stakeholder	An individual or organisation with an interest in the subject of the document; E.g. staff, staff side representatives, service users, commissioners.
Procedural Documents	Collective name for Policies, Guidelines, Procedures and Strategies
Policy	A policy is principles and rules formulated or adopted by an organisation to reach its long term goals. Policies are legal documents that will be prescriptive by nature. They will state the Trusts expectations for action in a specific subject area and set the parameters within which individuals will operate.
Procedure	Procedures are specific methods employed to express policies in action in date to date operations of the organisation. **Together policies and procedures ensure that a point of view held by the organisation is translated into steps that results in an outcome compatible with that view.**
Guideline	A standard principle by which to make a judgement or determine a policy or course of action.
Strategy	A strategy is a long-term plan of action designed to achieve a particular goal. The contents of a strategy are generally high level and concise. A strategy should present a vision of what it is intended to achieve, the benefits and how it will be achieved over a defined time period.
Due Regard	Having **due regard** for advancing equality involves: • Removing or minimising disadvantages suffered by people due to their protected characteristics. • Taking steps to meet the needs of people from protected groups where these are different from the needs of other people. • Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

Local Procedure Documents	Those procedural documents that impact only on the local service and have no implications / impact for wider Trust.
Standing Operational 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.

Purpose of the Policy

The purpose of this policy is to describe the Trust's approach to governance of Policies and other Trust procedural documents. It applies to all documents to ensure that there is a unified corporate approach to the development and management of procedural documents. This will ensure that appropriate information is presented in a standard format, is easily accessed by staff and service users, and that the drafting, adoption and review process is clear to all.

A wide range of procedural documents are currently produced by the organisation. This policy refers to all policies, Trust Strategies and Trustwide Guidelines that require Board approval.

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;

1) Agreed Trust wide style and format
2) Clear introduction and definition of terms used for each document
3) Clear consultation process
4) Clear adoption process
5) Reviewing arrangements for each document
6) Identified system for control of documents and archiving
7) Standardised references to associated documents
8) Clearly identified process for monitoring effectiveness
9) If necessary a privacy assessment to be completed.

1.0 Summary

1.1   This policy provides a framework for the management of procedural document development and review which will enable staff to carry out their roles and duties efficiently and effectively. It sets standards to ensure that all Trust procedural documents conform to the agreed standard i.e. that they are necessary, robust, clear, comprehensive, functional, evidence-based, effective and consistent in terms of quality, content and format and are therefore fit for purpose.

It aims to ensure that all staff are aware of and have ready access to all relevant and current policies by establishing clear procedures for consultation, approval, distribution, accessibility and review.

Adherence to this Policy is mandatory and applies to all staff (temporary and permanent) within the Trust involved in writing and/or implementing all new or reviewed procedural documents.

No new policy, procedure, strategy protocol or guideline or SOP should be drafted unless there is a clear and agreed requirement for it. New policies will be commissioned by the relevant committee responsible for the governance arrangements for the particular standard.

Please refer to the policy template (available on Trust website) for developing procedural documents and the guidelines template for developing Trust guidelines/Standard Operating Procedures (SOPs). This will enable a consistent approach on the format and process of producing procedural documents.

2.0   Introduction

This policy outlines the processes for developing and managing procedural documents in LPT. Procedural documents, their consistency, appropriateness and implementation are essential tools in the delivery of safe care. To ensure high quality, new or reviewed documents must undergo a rigorous process of development and monitoring.

Procedural and policy documents form an integral part of the Trust's governance and risk management processes. This policy will provide assurance that all organisational documents that are approved by a governing committee meet compliance with all relevant legislation, statutory requirements and best practice.

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

2.1   This document outlines the processes for developing and managing:
• Why the policy is necessary (purpose)
• The duties of key members of staff (duties)
• The standards to be achieved in the development of procedural documents (policy development)

2.2   This policy will apply to all policies, Trustwide Strategies, Trustwide Guidelines and procedural documents produced by Trust staff for use within the Trust and wherever the Trust carries responsibility for the staff it employs, including seconded, agency and bank staff.

The need for a new procedural document should be justified; it should evidence a link with service priorities together with national and other organisational policy documents. It should highlight the relevant CQC fundamental standards and outcomes. It should be checked that any intended new documents are not duplicating existing ones, and that the aims of the document are achievable within identified resources.

All procedural documents apply across the Trust. Localised policies should only be drafted in exceptional circumstances where prior agreement has been obtained from the service lead with advice from the Policy Support Team.

2.3   Local guidelines/SOPs will be managed at local level in directorates.

2.4   This policy replaces all previous Trust policy development and management documents.

2.5   This policy will apply to staff involved in developing or writing Trust documents and to anyone who has any responsibility for the control, management, implementation or dissemination of these documents.

3.0   Core Standards

3.1   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.

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.

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

3.3   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.

3.4   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.

3.5   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.

Policy authors must complete the NHS Constitution checklist and attach to the policy (Appendix 1).

3.6   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 (Appendix 2).

3.7   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 (Appendix 3).

3.8   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.

3.9   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**

3.10   Documents should be written in Arial font, minimum size 12, with single line spacing. Key phrases should be emphasised in bold rather than underlining. Abbreviations should only be used after the term has been displayed in full, e.g. Quality Assurance Committee (QAC).

3.11 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

3.12 Referencing Policies is good practice
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.

Please refer to the templates available on Trust website for developing Policies, SOPs and Guidelines.

4.0   Process

4.1   All Policies shall initially be written/reviewed by subject matter experts and sent to the Policy Lead for a final check that Trust standards have been addressed. The Policy Lead does not check the technical details of a policy. The

policy will be approved by the nominated responsible committee group before being brought forward to the Trust Policy Committee for adoption.

4.2   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.

4.3   Once adopted, the Policies will be stored in the Trust's shared drive and be uploaded to the Trust website within 2 weeks of the meeting.

4.4   The Policy Lead will ensure that a database of Trust Policies, Strategies and Trust wide Guidelines is maintained with a system alerting which documents are due for review.

4.5   All Policies will generally be reviewed and refreshed on a three yearly cycle unless there is a requirement to do so on a more frequent basis.

4.6   Policy leads will be reminded 6 and then 3 months prior to the review date to ensure policies remain within timescales and up to date. Any exceptions for escalation will be raised with the Executive Board.

4.7   Protocols, Procedures, Strategies and Guidelines where appropriate can be referenced in formally adopted Policies. These do not need to be formally adopted at the Trust Policy Committee and should instead be approved by the relevant responsible committee.

4.8   All such documents are stored on the Trust website for ease of access and to ensure appropriate document control.

5.0   Stakeholders and Consultation

The policy author may take guidance from the Policy Support Team and Equality Team with regards to which stakeholders should be involved in the consultation process.

In undertaking the development of a new document or the revision of an existing one, the relevant responsible (lead) committee will give consideration to the need to consult on the document. Consultation on policies that will have impact on working practices and patterns of work for employees must be consulted upon with staff side.

This does not apply to policies that the Trust must produce in response to legislation and government directive, e.g. Mental Health Act, Health and Social Care Act, Children's Act, etc. Staff side must be made aware of all policies being produced.

The draft document should be circulated to the identified stakeholders clearly

identifying the deadline for responding and the named contact for comments to be forwarded to. Following consultation all persons who responded should receive feedback relating to their specific issue.

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.

Consultation on policies that will impact on protected groups and other protected characteristics/equality groups should be consulted upon with those concerned. A co-ordinated 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.

A clear deadline for receipt of all responses will be given.

6.0   Branding

Policy authors need to consider any potential associations from celebrities, VIPs or major donors (see VIP, Celebrity and Media Visitor Access Policy) with regards to the assessment and management of risks to LPT brand and reputation.

7.0   Electronic Patient Record

Policy author must liaise with Clinical Safety Officers or the LPT Information Management and Technology Committee if any documentation is required within the electronic patient record.

8.0   Reviewing

Reviewing arrangements is a core standard. All procedural documents must be reviewed at least every three years. Key procedural documents or documents that are considered to address areas of high risk should be reviewed at more regular intervals. Changes in legislation or professional guidance may necessitate an unexpected review. The planned review date should be clearly identified on the title page when it is published. The document should also identify an expiry date, after which the document should be archived.

9.0. Responsibility for Document Development

9.1   For each procedural document under development there will be a lead committee and author (subject expert) with responsibility for seeing the process through. Those responsible are identified on the front sheet of the document and will vary depending on the type of procedural document

being produced.

9.2   Corporate governance committees have the mandate to agree all new or revised Trustwide documents and provide assurance to the Trust Board that these documents comply with all relevant standards and legislation. The Trust Policy committee will then adopt the policy.

Other local documents, e.g. guidance, procedures, care pathways will be agreed by the relevant governance procedures within the Directorates.

Local guidelines, procedures and care pathways will be agreed by the relevant Directorate's Governance Committee/group. This will be formally recorded in the meeting's minutes.

10.0 Producing a Procedural Document –Flowchart

Flowchart for Developing, Approving and Adoption of Policies

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┌─────────────────────────────────────────────────────────────┐
│ The need and justification to write/review a procedural      │
│ document is identified by the relevant level 3 Committee     │
│ who will identify a Policy Author                            │
└─────────────────────────────────────────────────────────────┘
                              │
                              ▼
        ┌───────────────────────────────────────────────┐
        │ The Policy Lead will "flag up" need for policy │
        │ review of existing policy to approving         │
        │ Committee and Policy Author                    │
        └───────────────────────────────────────────────┘
                              │
                              ▼
        ┌───────────────────────────────────────────────┐
        │ Document drafted in compliance with            │
        │ Policies/Guidance                              │
        │                                                │
        │ Policy Author should seek expert advice if     │
        │ necessary e.g. Privacy Impact Assessment,      │
        │ Due Regard Template or Monitoring of Policies  │
        └───────────────────────────────────────────────┘
                              │
                              ▼
            ┌───────────────────────────────┐
            │ Consultation process          │
            └───────────────────────────────┘
                              │
                              ▼
        ┌───────────────────────────────────────────────┐
        │ Policy checklist review by Policy Lead.        │
        │ Checklist to be signed off by Chair of         │
        │ Trust Policy Committee                         │
        └───────────────────────────────────────────────┘
                              │
                              ▼
        ┌───────────────────────────────────────────────┐
        │ Relevant level 2 committee will approve the    │
        │ document. Chair to countersign the completed   │
        │ checklist. Both documents to be returned to    │
        │ Corporate Affairs Officer                      │
        └───────────────────────────────────────────────┘
                              │
                              ▼
    ┌───────────────────────────────────────────────────────┐
    │ Trust Policy Committee will review and adopt the       │
    │ policy. QAC will be informed that policy has been      │
    │ adopted                                                │
    └───────────────────────────────────────────────────────┘
                              │
                              ▼
        ┌───────────────────────────────────────────────┐
        │ Policy Lead will ensure adopted policies are   │
        │ uploaded to our website. All staff will be     │
        │ informed when policies have been published.    │
        └───────────────────────────────────────────────┘
```

11.0 Duties within the organisation/ Key duties

11.1   The Trust Policy Committee is the main forum for considering, reviewing and improving the Trust's approach to Policy management and reports to QAC. Therefore the Trust Policy Committee intends that all policies will be scrutinised, and challenged as appropriate, to ensure that it is:
• Absolutely necessary;
• Simple and clearly worded;
• Easily able to be disseminated to relevant staff;
• Able to be complied with; and
• Able to be assessed for effectiveness as well as compliance
• Mandated by Trust Board to adopt policies.

11.2   The Trust Secretary chairs the Trust Policy Committee and acts at the Board's main agent for considering, reviewing, improving and adopting policies.

11.3   The Trust's Policy Lead has responsibility for supporting the Trust Secretary and relevant committees by ensuring Trust documents are updated at appropriate times. The Trust Policy Lead will support the Trust Policy Committee by providing the assurance that all polices have been written to comply with core standards and has responsibility for ensuring effective publication of policies on the Trust's websites.

11.4   The Corporate Affairs Officer supports the Trust Secretary and Policy Lead and gives administrative support to the Trust Policy Committee.

11.5   Trust level Two Committees have a responsibility for ensuring the development, approval and implementation, as well as the review and monitoring effectiveness of all Strategies, Policies and Trustwide Guidelines.

11.6 Trust Level One Committees have the responsibility for agreeing the final document prior to it being adopted and signing off the Policy checklist

11.7   Policy authors are responsible for originating and managing policies relating to their specialist areas.

11.8   Managers, Team Leads and Heads of Service are responsible for ensuring the effective implementation and dissemination of policies within their area.

These arrangements will include:

➢ Distributing information about new policies and procedures in a timely manner throughout the Directorate or Service to a distribution list which will be agreed in advance with local managers.
➢ Ensuring that all staff have access to up to date policies, either through the Trust website or if policy manuals are maintained that the resources are in place to ensure these are updated as required.
➢ Maintaining a system for recording that policies and procedures have been distributed to and received by staff within the Department /Service and

for having these records available for inspection upon request for audit purposes.

➤ Ensuring that all Policies, procedures and SOPs are followed and understood as appropriate to each staff member's role and function. This information must be given to all new staff on induction and to any staff returning from long breaks in service e.g maternity/paternity leave or long term sickness leave. It is the responsibility of local managers and team leaders to have in place a local induction that includes policies and procedures.

11.8   **All Staff**

All staff (including seconded staff) should be aware that despite the above responsibilities of senior staff, every staff member has an individual duty of responsibility to ensure that they:

➤ Know where to locate policies or procedures when necessary
➤ Adhere to all Trust Policies

All staff should be aware of how policies and procedures impact on their practice and be able to follow the specified requirements set out.

11.9 The Director of Human Resources and Organisational Development will retain the over-arching responsibility to ensure that draft documents are circulated to staff side representatives for comment, where appropriate

12.0   Dissemination and Implementation
Following the adoption of procedural documents, it is imperative that all employees or other stakeholders who will be affected by the documents are proactively informed and made aware of any changes in practice that will result. All adopted documents will be posted on the Trust website.
Although there is not a requirement to publicise all policies under Freedom of Information, it is a model of best practice therefore the documents will also be posted on the Trust intranet Policies and guidelines

Step-by-step guide: as well as public websites and communication of their existence should be disseminated in the most appropriate way, depending on the nature of the document, such as:
➤ Via management/departmental/team meetings
   ➤ Articles in e-Newsletter
   ➤ Notice boards
   ➤ The Policy Lead will inform relevant Managers/Clinical Governance leads when the document has been posted to the Trust website.
   ➤ The Corporate Affairs Officer will send a list of adopted policies to the Communications Department for inclusion in the Trust e-Newsletter.
   ➤ Staff are strongly discouraged from printing off or photocopying procedural

documents.

> Designated Directorate Leads will be expected to ensure that staff are informed of all published policies

The version of the document on the Trust website is the definitive version and therefore staff should be directed there to find the latest version.

12.1 Finding trust policies/guidelines/documents on the website

A short YouTube video clip can be found on the website for staff who are unclear as to how to find a policy.

NB: All policies should be shared on the public website unless there is a specific reason not to. This needs to be clearly stated by the author and adopted by the Trust Policy Committee

13.0   Implementation and Resources

Any training or support implications associated with approved documents will need to be identified during the formulation or review of the document. Clarification of resource availability must be addressed and resolved prior to the approval process.

The introduction of some documents may require staff training/briefing sessions to be arranged. These should be planned, publicised and completed before the document is implemented. The process leading up to the approval of any new or revised policy should include the implementation planning process as well as an impact assessment to determine the resource and capacity implications of the policy being implemented, particularly where training and briefing sessions could affect staffing levels in clinical areas.

14.0   Document Control and Archiving

Document control and archiving is a core standard.

14.1   Document control

All documents will be controlled by having a clear expiry date, after which the policy/procedural guidance must be renewed or made redundant.

14.2   Register/Library of Policies

   14.2.1   A master copy of each approved Trustwide policy or procedure will be retained within the Trust by the Corporate Affairs Officer for a minimum period of 10 years in line with the recommendations contained within '*The Records Management. NH*S *Code of Practice' (2006).*

14.3   Archiving Arrangements for Policies

14.3.1   Once this policy is superseded, a copy will be retained by the Corporate Affairs Officer for a minimum of 10 years, in line with the recommendations contained within *'Records Management NHS Code of Practice' (2006)*.

14.4   Process for Retrieving a Policy

If an older version of any policy is required, the requesting member of staff should contact the Corporate Affairs Officer.

15.0   Monitoring Compliance and Effectiveness

How and when the policy will be monitored must be made explicitly clear within the policy document. It is the responsibility of the policy owner (relevant sub-group) to commission an audit/check on an annual basis.

For an audit it must use an approved methodology and must be performance managed by the relevant committee.

This should identify:
➢   Who is responsible for undertaking the monitoring or audit
➢   The method to be used
➢   Frequency of monitoring or audit
➢   How the results will inform or improve practice

15.1   Process for this Monitoring Compliance and Effectiveness

Reference	Minimum Requirements	Self assessment evidence	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
3.4	style and format	All document / Toolkit	Approving Committee	Lead Author/ Responsible Committee	In accordance with identified review of policy – minimum every two years
PG3	an explanation of any terms used	Toolkit page 6 Definitions that apply	Approving Committee	Lead Author/ Responsible Committee	In accordance with identified review of policy – minimum every two years
5.0	consultation process	Section 2.8 , Page 8	Approving Committee	Lead Author/ Responsible Committee	In accordance with identified review of policy – minimum every two years

16.0   Links to Fundamental Standards

The Fundamental Standards of quality and safety came into effect from 1st April and replace the 16 Essential Standards (2010). There are 13 Fundamental

Standards associated with the quality and safety of care which every staff member must comply with to ensure they are demonstrating compliance with the expected legal minimum standards when delivering patient care. It should be identified on the front page which of these standards are relevant to a particular policy.

Standards/Key Performance Indicators

TARGET/STANDARDS	KEY PERFORMANCE INDICATOR
All Policy Leads follow guidelines within this document.	Where deficiencies are identified the policy will be returned to the author for update and not sent for 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
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

References and Associated Documentation

This policy was drafted with reference to the following:

Northamptonshire Healthcare NHS Foundation Trust: Policy for the Governance of Trust documents

Freedom of Information Act (2000) available at legislation.co.uk Freedom of Information Act

Promoting Equality and Human Rights in the NHS - A Guide for Non- Executive Directors of NHS Boards (2005) Department of Health Guide for Non-Execs - Promoting Equality and Human Rights within the NHS

Equality analysis and the equality duty: A guide for public authorities Vol. 2 of 5 Equality Act 2010 guidance for English public bodies (and non-devolved bodies in Scotland and Wales), Equality and Human Rights Commission

The NHS Constitution

NHS Core Principles – Checklist

Please tick below those principles that apply to this policy

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

Appendix 2

PRIVACY IMPACT ASSESSMENT SCREENING

> Privacy impact assessment (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.
>
> The following screening questions will help decide whether a PIA is necessary. Answering 'yes' to any of these questions is an indication that a PIA would be a useful exercise and requires senior management support, at this stage the Head of Data Privacy must be involved.

Name of Document:	The Governance of Trust Policies and Procedural Documents		
Completed by:	Joan Hawkins		
Job title	Policy lead	Date	21/10/19
			Yes / No
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.			**n**
2. Will the process described in the document compel individuals to provide information about themselves? This is information in excess of what is required to carry out the process described within the document.			**n**
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?			**n**
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?			**n**
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.			**n**
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?			**n**
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.			**n**
8. Will the process require you to contact individuals in ways which they may find intrusive?			**n**
If the answer to any of these questions is 'Yes' please contact the Head of Data Privacy Tel: 0116 2950997 Mobile: 07825 947786 **Lpt-dataprivacy@leicspart.secure.nhs.uk** **In this case, ratification of a procedural document will not take place until approved by the Head of Data Privacy.**			
IG Manager approval name:	J.Hawkins		
Date of approval	21.9 19		

Leicestershire Partnership
NHS Trust

Due Regard Equality Analysis

Initial Screening Template

Introduction

This document forms part of the Trusts Due Regard (Equality Analysis) toolkit which can be accessed here.

Leicestershire Partnership NHS Trust has a legal requirement under the Equality Act 2010 to have '' due regard'' to eliminate discrimination. It is necessary to analysis the consequences of a policy, strategy, function, service or project (referred to as activity) on equality groups in respect of service users, patients and staff.

The analysis has to consider people's 'protected characteristics 'age, disability, gender reassignment, marriage / civil partnership, pregnancy and maternity, race, religion / belief, sex, sexual orientation. We also include other vulnerable groups who may not be protected under the Equality Act but their needs should be considered.

There are several tangible benefits in conducting equality analysis prior to making policy decisions, including:

- Higher quality decisions as a result of more complete management information
- Reduced cost as a result of not having to revisit policy that is not fit for purpose
- Enhanced reputation as an organisation that is seen to understand and respond positively to diversity.

Most importantly, through equality analysis we are able to take into account the needs of our different equality groups of staff and patients. Changes being proposed through policy, strategy, transformational programmes or other methods need to be analysed from an equality perspective and the results considered before decisions are made. Where negative impacts are identified, ways to mitigate or minimise them must be put in place.

Before starting if you are unfamiliar with doing an Equality Analysis contact the Equality and Human Rights Team for guidance or visit the Due Regard section on the Trust Intranet here.

Below is the Due Regard Screening Template which aims to assess the likelihood of a negative impact on an equality group/s. For example, a policy change in financial management systems may be considered major but has no negative impact.

The initial screening form needs to be completed to decide if a full Due Regard (Equality Analysis) * should be undertaken. An overview of the various options available are highlighted in a Due Regard fact sheet which includes top tips and a flow chart which can be accessed here.

*A full Due Regard (Equality Analysis) makes sure that any negative impacts have been considered and ways to minimize the impact are specified.

Due Regard Screening Template

Section 1	
Name of activity/proposal	Policy for development of Trust Procedural Documents
Date Screening commenced	Sept 2019
Directorate / Service carrying out the assessment	Legal Affairs Department
Name and role of person undertaking this Due Regard (Equality Analysis)	Joan Hawkins
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: **The document describes the governance's processes for the development, review, maintenance (and subsequent archiving) of authorised policies.** **OBJECTIVES:** To produce a unified corporate 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	n/a
Disability	n/a
Gender reassignment	n/a
Marriage & Civil Partnership	n/a
Pregnancy & Maternity	n/a
Race	n/a
Religion and Belief	n/a
Sex	n/a
Sexual Orientation	n/a
Other equality groups?	n/a

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 <u>tick</u> 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	J.Hawkins	**Date**	2/9/19
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed	Frank Lusk	**Date**	3/10/19

Trust Policy Committee – (insert date)

Submission by the – xxx (insert name of responsible committee)

Purpose of report

All policies indicated in this report have been agreed on (insert date) and are presented to the Trust Policy Committee for final adoption.

Analysis of the issue

The following policies have been reviewed or developed to maintain high quality care/service within all Trust areas in line with Integrated Governance. All policies have been developed or updated in line with the remit of the Trust Governance of Trust documents and Procedures policy

The responsible committee is satisfied that the monitoring mechanisms as described in each policy are appropriate in order for the Trust to be assured that we are providing safe, effective services; and the monitoring mechanisms are being complied with and would stand up to audit scrutiny.

Proposal

1. Below is a list of each policy for adoption, including brief details of any changes made to existing policies and details of evidence received demonstrating compliance with the policy monitoring section. The table below must be completed for each policy submitted to Trust Policy Committee for adoption.

Policy Title:	
Policy Keywords (to assist staff in finding documents on Staffroom, please provide keywords for this Policy):	
Brief outline of changes:	**Tick all that apply:** □ minor amendments-spelling/grammar □ changes in legislation □ changes in working practice □ has training implications
Monitoring Assurance	**Date and type of evidence received**
Please provide details of evidence received demonstrating compliance with the policy monitoring section:	

Monitoring Effectiveness	**Monitoring criteria**
Did the monitoring provide suitable assurance that the policy is effective? Therefore was the committee/group: ☐ Fully assured ☐ Partially assured ☐ Not assured If partial/no assurance please give details of monitoring changes made	☐ remains the same (effective) ☐ needed revising (detailed in attached policy)
Indicate any detail from employment law, national recommendations etc. that impacts this policy and /or should be shared with others.	
If applicable identify and indicate that the policy has been reviewed in line with NICE guidance and the fundamental standards	**Tick all that apply:** ☐ Is compliant ☐ Is not compliant (if not compliant indicate why)

2. It is noted that no extension to a policy can be granted unless there are exceptional circumstances. If a policy requires an extension then the justification is indicated below:

3. Note that the following policies aligned to this committee have been extended due to the need for a lengthier (**List of policies that have been extended)**

4. Since the previous meeting the following guidelines/ procedures or protocols have been reviewed and were submitted to the Trust Policy Lead for uploading on to our website:

Decision required from Trust Policy Committee

- Record, approve and upload policies indicated as complying with their monitoring mechanisms, which are appropriate and assure the Trust that we are providing safe, effective services.
- Review/approve of any request for an extension and feed this back to the paper's author.
- Review/approve the policies that have been extended.
- Review/approve any guidelines, procedures or protocols that have been reviewed and uploaded onto website

Policies, Procedures and Guidelines – What are they?

Policies

Policies relate to issues where LPT requires a certain line of action to be followed. A policy sets out the Trust's position on a specific matter, but does not necessarily prescribe in detail how to perform certain functions. The main characteristics of policies are that they are formally documented, approved and reviewed. Compliance is required, and non-compliance may be actionable through appropriate conduct policy documents. Policies are legal documents and are usually supported by legislation or national guidance

Definition of a Policy

A Policy is a concise formal statement that outlines non-discretionary governing principles and intentions, in order to guide Trust practice. Policies are a formal statement of intent that mandate principles or standards that apply to the Trust's governance or operations, or to the practice and conduct of its staff. In short, policy provides our staff with the approved way of operating in relation to a particular matter.

The Role of Policy

Policy plays an important role within the Trust. It provides the principles which dictate how the members of staff should act.

Those principles are derived from and shaped by: the law and regulations that govern the NHS national standards and community expectations; and the values that the Trust articulates in its annual report.

It is the role of Policy to: Translate values into operation; Ensure compliance with legal and statutory responsibilities; Provide a framework for action;   Set standards; and Improve the management of risk.

Policies are intended to be long term in application. They are reviewed on a regular basis but less frequently than procedures or guidelines.

Procedures

Procedures set out, often in a step-by-step fashion, the Trust's requirements for a particular course or mode of action. Procedures clearly define how a policy will be implemented and by whom. They are reviewed more often than policies as operational systems change in line with the Trust's requirements.

Procedures often elaborate on, and give effect to, a by-law, rule, agreement, code or policy and define the area in which policy is operative. Compliance with procedures

is mandatory and noncompliance may be actionable through appropriate conduct policy documents.

Trust Procedures necessarily require approval usually through either the designated committee such as the Clinical Effectiveness Group, H&S etc. Local Service/team Procedures need approval through the local services Governance committee.

Guidelines

Guidelines set out the Trust's requirement for, or prescription of, best or safest practice. They should not replace the need for a Policy. They are interpretive statements and, as with policies and procedures, they need to be forwarded to the relevant reviewing/approving committee for Trust-wide eg H&S or local service Governance committee.

Similar to procedures, guidelines are reviewed and updated more often than policies.

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.

Standard Operational Procedure

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.

Support

Please consider the Annex in determining what type of document is needed. For further advice/support please contact the Corporate Affairs Department 0116 2957556

Annex: Flowchart to assist type of document needed.

Committee decision
Which document do you need?

Committee needs to decide which document type is the most appropriate.

Policy	**Procedure**	**Guideline**

Policy

A policy ensures compliance with legal and statutory responsibilities. It is a framework for action and it sets standards and improves management of risk.

Developing a policy

The need and justification to write/review a policy document is identified by the relevant committee who will identify a policy author.

Document drafted in compliance with policies/guidance ensuring that it has:
- due regard for equality legislation
- training needs identified and resourced
- monitoring of compliance
- privacy impact assessment screening

Consultation process
Seek expert advice then send to other stakeholders as necessary

Policy checklist review by policy support staff with policy lead. Checklist to be signed off by policy support team.

Relevant committee will approve the document. Chair to countersign the completed checklist.

Trust Policy Committee will be notified that the policy has been reviewed and approved and Policy Committee requested to adopt.

Policy Team will upload adopted policy to website and inform policy author.

The policy database will "flag up" need for policy review to approving committee and policy author.

Procedure

Sets out step by step course of action and it defines how a policy is implemented.

Developing a procedural document

Document drafted with a review date

Consultation process

Relevant committee to agree

Uploaded on website by the service

Service responsibility to inform staff via comms

Guideline

Sets out Trust requirements for best practice.

Developing guidelines

Document is drafted. Refer to guidelines on policy homepage
http://www.leicspart.nhs.uk/_PoliciesDocuments.aspx

Due regard assessment is carried out

Consultation process

Relevant committee to agree

Trust guidelines to policy support staff for database and uploading

Local guidelines (service specific) are uploaded by local committees

Staff informed via comms

Local committees inform relevant staff