Leicestershire Partnership NHS Trust

Policy Management

This policy describes the process for developing and updating policies, guidelines, procedures and protocol.

Key words: Policies, Procedures, Protocols, Governance, SOPs, Guidelines

Version: 11

Approved by: Audit and Risk Committee

Date issued for publication: June 2025

Review date: 1st January 2028

Expiry date: 30th June 2028

Type of Policy: non-clinical

Contents

Policy Approval Process

You have been asked to develop a trust-wide policy

Contact the policy team on lpt.policy@nhs.net so that they can provide the latest policy template, provide you with the Ulysses reference number, provide you with the associated documents pack and advise you further on the process.

Or, you have received an automated reminder to update an existing policy because you have been identified as the policy author. You will be sent the relevant template and associated documents pack

Review or develop the policy in line with any national guidance, ensuring that it is appropriate for the Trust and is in line with any other relevant policies and procedures. Relevant stakeholders must be involved including relevant subject matter experts.

Complete the associated pack of documentation which includes an overarching checklist and an equality impact assessment for the policy. These should be returned to the policy team for upload onto Ulysses.

Provide the drafted policy to the policy team for circulation to the virtual policy review group. Any feedback from this group will be provided to you to inform any further amendments to the draft policy

Provide the final draft policy to the relevant governance group for sign off

Provide the final, approved copy of the policy to the policy team for upload onto the Trust website (or intranet site where appropriate).

1. Version control and summary of changes

Version number	Date	Comments (description change and amendments)
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 because 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.
Version 10	November 2024	Policy reviewed and updated following internal audit recommendations.
Version 11	June 2025	General update, to also include new title, accessible standards and revised monitoring indicators

For Further Information Contact: lpt.policy@nhs.net

2. Key individuals involved in developing the policy

- Director of Governance and Risk
- Deputy Director of Corporate Governance
- Nicola Jackson - Assurance Coordinator
- Trust Policy Review Group

3. 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.

If you would like a copy of this document in any other format, please contact lpt.corporateaffairs@nhs.net or lpt.policy@nhs.net

4. 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.

5. 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 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 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.
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.

6. Introduction

The NHS relies on a strong policy framework to give staff the information they need which underpins all clinical and non-clinical processes and practices within the Trust. This in turn ensures consistent, effective and safe care. This is referenced within the 'three lines of defence model of risk management' (Institute of Internal Auditors, 2013). In this model the second line of defence is in place to:

- provide policies, frameworks, tools, techniques and support to enable risk and compliance to be managed in the first line and
- conduct monitoring to judge how effectively they are doing it, and helps ensure consistency of defining and measuring any associated risk.

The Trust's policies are 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.

7. Purpose

This policy provides the guidance and practical advice for authors of policies and procedural documents to ensure that they are set out in a standardised and consistent way; and are compliant with standards.

8. Core Policy Standards

Core standards to produce approved procedural documents were originally taken from the NHS Litigation Authority (now NHS Resolution) and have been adopted by the Trust as model standards as follows;

- The document should be compliant with accessible standards and should adhere to the Trust's house style and format. A template is available for policy authors.
- Clear consultation process with a range of people who will be using the policy and the Trust's core policy review group.
- Clear adoption process, mapped to the Trust's governance described on the front page of each policy.
- Identified system for control of documents and archiving.
- Standardised references to associated documents. All policies must accurately attribute the sources to which they refer.

- Clearly identified measures for monitoring compliance.

9. Accompanying Documentation

It is a requirement that all new and existing procedural documents being developed and reviewed are assessed in line with the following guidance. Policy authors will complete the relevant documents for retention by the central policy team. Rather than appended to the policy document, these assessments will be stored on the electronic system 'Ulysses' linked to the policy, with a Ulysses number attributed to and listed on all policies;

- Version control and summary of changes document
- A due regard screening template. This includes 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.
- A Data Privacy Impact Assessment Screening template.
- A checklist to capture compliance with The Modern Slavery Act and an assessment with regard to relevant standards and safeguards as set out in the Mental Health Act Code of Practice.
- A Training Needs Analysis form so that any training requirements can be met to ensure that the policy can be embedded.
- An assessment of Fraud, Bribery and Corruption.
- A completed policy checklist which will be subject to auditing to ensure that all required components of a policy are adhered to.

10. Standards

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.

The NHS Constitution sets out the principles and values that guide how the NHS should act and make decisions. It brings together several 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 including;

- 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.

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.
- 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
- Documents should be written in Arial font, minimum size 12, with single line spacing. Abbreviations should only be used after the term has been displayed in full.
- All policies are to be as lean and light as possible and there is a need to consider if the policy could be retired and replaced with a SOP guidance or procedure.
- All Policies shall initially be written/reviewed by subject matter experts.
- Policy authors must liaise with Clinical Safety Officers and the Trust's Information Management and Technology Delivery Group if documentation is required within the electronic patient record.
- 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.
- Where a policy is likely to have a direct link to or impact on service users and carers, draft documents should be circulated to service user and carer groups for comment.
- All policies will be circulated to the virtual policy review group by the policy team once a policy has been drafted.
- Policies, Guidelines or SOPs should **not** include electronic links or embedded documents.
- In line with the Freedom of Information Act (2000), where appropriate, approved procedural documents will be published on the Trust website by the corporate policy team. The version of any document published on the Trust website is the definitive version. Any policies of a sensitive nature will be provided on the internal intranet page.
- 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 when a policy is scheduled for review.
- All policies are assigned to an overarching level 1 assurance committee. Each policy developed or reviewed needs to be approved by the relevant level 2 delivery group which underpins the assurance committee, these are mapped to each policy. Where no level 2 group is available, they are mapped directly to the relevant level 1 committee for approval.

11. Duties within the Organisation

Authors of a policy, guideline or procedure / protocol are responsible for creating and/or reviewing it in line with this policy, using the most up-to-date Policy, Procedure

and Guideline Accessible Template which is available on the Trust's intranet or from the policy team (lpt.policy@nhs.net), the team will also provide the associated document pack for completion.

Authors then need to submit to the appropriate governance group for approval.

If an extension to the document expiry date is required, permission must be sought from the relevant governance group to ensure that it is safe to extend, and that the policy remains fit for purpose. The policy team must be informed of any approvals to extend the expiry date so that the central record can be updated. It is imperative that this is done to ensure that no policy falls out of date.

Lead Director

- Lead Directors have the responsibility and accountability for the communication, dissemination and implementation of their policies, SOP's, guidelines and procedures / protocols to their teams. The policy, guideline SOP 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.
- The committee/group and executive lead are responsible for ensuring compliance with the policy, with any issues being escalated to the committee/group for consideration.
- Lead Directors must arrange for the policy team to be kept informed about any policy, guideline or procedure / protocol updates and archive requirements. This is important to avoid multiple versions of policies, guidelines or procedures / protocols existing on Ulysses.
- If the policy is not assigned to the correct governance group for oversight the Chair of the meeting must agree with another Chair to move the policy for their oversight and inform the policy team so they can amend the records.

Directors, Senior Managers, Matrons and Team Leads

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

- They have read and understood all the Trust's policies, guidelines and procedures / protocols relevant to their areas
- 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
- Their staff understand what is required of them and are implementing the requirements
- Their staff attend any training which is considered to be necessary in order to comply with each policy, guideline or procedure / protocol

Staff

Members of staff have the responsibility for ensuring that:

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

- They can locate them
- They are up-to-date with any changes made to the policies, guidelines or procedures / protocols
- They attend all relevant training sessions

12. Monitoring Compliance and Effectiveness

Monitoring tools must be built into all procedural documents in order that compliance and effectiveness can be demonstrated.

Be realistic with the amount of monitoring you need to do and time scales. Annual reports on compliance with the KPIs for each policy will be required as a minimum. Annual reports on compliance are mapped into the level 2 governance group workplans, and you will be expected to provide the data and evidence to the policy team to support the reporting process.

Where KPIs are not met, an improvement plan will be required by the policy team to monitor improvements in the data, and ultimately support staff in complying with policies.

The monitoring and compliance measures for this policy include;

- That all policies will be in date (quarterly monitoring as reported to the Audit and Risk Committee by the Director of Governance and Risk). A set of four quarterly reports to be reported on at year end to provide compliance against this measure. This will be provided in an annual policy compliance review to the Audit and Risk Committee.
- All new policies or existing policies being renewed will comply with the policy checklist held on Ulysses. (quarterly monitoring as reported to the Audit and Risk Committee by the Director of Governance and Risk). A set of four quarterly reports to be reported on at year end to provide compliance against this measure. This will be provide in an annual policy compliance review to the Audit and Risk Committee.

13. References and Bibliography

Include a list of all documents referred to in the Policy including those from other Trust's policies. The date of the document should be included. Do not include electronic links or embedded documents to other policies/guidelines and are in a standard format.

There are no documents referred to in this policy that need to be referenced.

14. 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.

There is no potential of fraud, bribery or corruption identified in relation to this policy.

Appendix 1 Training Needs Analysis

Training required to meet the policy requirements must be approved prior to policy approval. Learning and Development manage the approval of training. Send this form to lpt.tel@nhs.net for review.

Training topic/title:			
Type of training: (see Mandatory and Role Essential Training policy for descriptions)	✔ Not required ☐ Mandatory (must be on mandatory training register) ☐ Role Essential (must be on the role essential training register) ☐ Desirable or Developmental		
Directorate to which the training is applicable:	☐ Directorate of Mental Health ☐ Community Health Services ☐ Enabling Services ☐ Estates and Facilities ☐ Families, Young People, Children, Learning Disability and Autism ☐ Hosted Services		
Staff groups who require the training: (consider bank /agency/volunteers/medical)	N/A		
Governance group who has approved this training:	N/A	Date approved:	N/A
Named lead or team who is responsible for this training:	N/A		
Delivery mode of training: elearning/virtual/classroom/ informal/adhoc	N/A		
Has a training plan been agreed?	N/A		
Where will completion of this training be recorded?	☐ uLearn ☐ Other (please specify)		
How is this training going to be quality assured and completions monitored?	N/A		
Signed by Learning and Development Approval name and date	N/A	Date:	

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	September 2024
Directorate / Service carrying out the assessment	Corporate Affairs Department
Name and role of person undertaking this Due Regard (Equality Analysis)	Kate Dyer Director of Governance and Risk
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.	
	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:			
Signed by reviewer/assessor	Kate Dyer	Date	5 May 2025
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed	Kate Dyer	Date	5 May 2025

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	**Director of Governance and Risk**		**Date 5 May 2025**
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 more than 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 more than 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		No	

other information that people would consider to be particularly private.		
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:	**N/A**	
Date of approval	**N/A**	

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