Governance of Trust Policies and Procedural Documents Policy

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

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

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Approved by: Audit and Risk Committee

Ratified By: Audit and Risk Committee

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This policy is compliant with the Modern slavery Act.

Contents

1.1 Version control and summary of changes ... 3
1.2 Key individuals involved in developing and consulting on the document ... 3
1.3 Governance ... 4
1.4 Equality Statement ... 4
1.5 Due Regard ... 4
1.6 Definitions that apply to this policy. ... 5
2.0 Why we need this policy ... 6
3.0 Policy Requirements ... 7
4.0 Duties within the Organisation ... 8
5.0 Core Standards ... 12
6.0 Pathway for new or revised policies, procedures, protocols or guidelines ... 13
7.0 Monitoring Compliance and Effectiveness ... 15
8.0 Monitoring of compliance with the processes described in this policy ... 16
9.0 Fraud, Bribery and Corruption consideration ... 17
Appendix 1 Training Needs Analysis ... 18
Appendix 2 The NHS Constitution ... 19
Appendix 3 Due Regard Screening Template ... 20
Appendix 4 Data Privacy Impact Assessment Screening ... 21
Appendix 5 Useful links ... 22

1.1 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.

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

1.2 Key individuals involved in developing and consulting on the document

- Kate Dyer - Director of Governance and Risk
- Nicola Jackson - Risk and Assurance Coordinator
- Trust Policy Expert Group
- Heather Darlow - Trust Lead for QI and Quality Governance

1.3 Governance

Level 2 or 3 approving delivery group – N/A

Level 1 Committee to ratify policy – Audit and Risk Committee

1.4 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

1.5 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

1.6 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.

2.0 Why we need this policy

The purpose of this policy:

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

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

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

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

Summary and scope of the policy:

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

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

Policies that are assigned to Level 1 assurance committees are approved and ratified within their meeting.

Where it is not possible to wait until the next appropriate committee meeting to ratify a policy this can be agreed virtually via email and the Corporate Governance Team are to be included in the correspondence. This must also be documented at the next Committee or Group.

When it is necessary to urgently circulate a policy change until a permanent version is developed and properly ratified, this will be added to the weekly staff communication briefing.

Where a policy has been reviewed and changes made are not material, or there are no changes there is no need for the policy to be formally ratified – it can be adopted without the requirement to go the relevant group meeting, but it should be documented at the appropriate Committee or Group.

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

The Corporate Governance Team is responsible for uploading all policies and procedures onto Ulysses where they are kept centrally and where relevant, once approved the policy, SOP or guideline will be uploaded onto the Trust's website or Staffnet.

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

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

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 Governance Team (lpt.corporateaffairs@nhs.net or lpt.policy@nhs.net). Policies may only be extended once for up to 12 months without a review if they are considered to be safe to use.

3.0 Policy Requirements

Details of the principles and core standards to be used in the development and management of policies.

This policy applies to the development of policies, guidelines, SOP's, procedures and protocols.

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.

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 Team after ratification by the relevant Committee or Group.

Only policies need to be ratified by the relevant level 1/2/3 Committee. Guidelines, procedures and protocols do not need to be ratified by a Board Committee.

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.

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 Team.

Consultation

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

- Corporate Assurance Officer 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
- Director of Governance and Risk
- Medical Director
- Suicide and Self Harm Lead

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 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 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.

Where possible policy authors should consider Co-production when writing the policy. Co-production is a way of working that involves people who use health and care services, carers and communities in equal partnership; and which engages groups of people at the earliest stages of service design, development and evaluation.

4.0 Duties within the Organisation

Policy, Guideline or Procedure / Protocol Author

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

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

Authors must consult with relevant stakeholders and the trust policy expert group and consider Co-production during the development or when reviewing a policy, but it is not necessary to consult the Trust Policy Expert Group whilst developing a guideline, SOP or procedure / protocol.

If using the Trust's Policy, Procedure and Guideline Accessible Template, the final draft policy, procedure or guideline presented for approval at the relevant governance Committee or Group must have a completed Data Privacy Impact Assessment Form (DPIA).

Authors have the responsibility for reviewing draft policies, SOP's guidelines or procedures / protocols and for submitting them to the appropriate governance Committee or Group for approval.

If the Author does require an extension to the document expiry date, they must seek permission from the relevant Committee or Group and they need to inform the Corporate Governance Team of the new expiry date and confirm that the policy is still fit for purpose.

It is the duty of the author to ensure that the policy is monitored in line with the monitoring compliance section of the policy.

If the Author is granted an extension to the document expiry date from the relevant Committee or Group, the Author and Chair are required to note the extension details and inform the Corporate Governance Team of the new expiry date and confirm that the policy is fit for purpose and the rationale of the extension.

Authors should note that any approved policy, SOP, guideline or procedure / protocol is only effective when it is uploaded onto Ulysses and published on the Trust Website or Staff Intranet. The Author will be responsible for making sure that the policy, SOP, guideline or procedure / protocol has progressed through the necessary approval process and for arranging for it to be submitted to the Corporate Governance Team for uploading onto Ulysses and the Trust website/Intranet using the following email lpt.policy@nhs.net

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.

It is the duty of the Lead Director to review the outputs of the policy monitoring and escalate for action as necessary.

Lead Directors must arrange for the Corporate Governance 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.

All policies are to be as lean and lite as possible and there is a need to consider if the policy could be retired and replaced with a SOP guidance or procedure.

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 Corporate Governance 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

Policy Ratification Committee/Group

The relevant Committee/Group/s are responsible for final ratification of a policy following recommendation from the Committee/Group below.

The relevant Committee/Group/s is responsible of informing the Corporate Governance Team of final ratification of policies for central logging and publishing (if applicable).

Only once a policy has been reviewed at the appropriate Committee/Group will it be regarded as fully ratified and uploaded to the Trust Policy Page (if applicable).

The responsible Committee/Group are responsible for ensuring the Method of monitoring is adequate and should schedule an audit of the methods of monitoring to be tested regularly to ensure they are working.

The Monitoring of the monitoring and compliance added to workplan and be included in the annual review document and Terms of Reference.

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

Corporate Governance Team

The Corporate Governance Team is responsible for maintaining an up-to-date Policy, Procedure and Guidelines Template.

The Corporate Governance Team is responsible for maintaining an up-to-date database of Policies.

The Corporate Governance Team will maintain an electronic archive of previous versions of Policies or SOPs and will update the central database and website. It is the responsibility of procedural document sponsors and authors to ensure the Corporate Governance Team are alerted to changes and provided with an up-to-date version. The removal of any procedural document from the Trust's register must be agreed and requested with the Subject Matter Expert Group or Executive Sponsor. To remove a policy, the Corporate Governance Team are to be notified with a clear rationale and purpose.

The Corporate Governance Team is responsible for uploading and for archiving policies, SOP's, guidelines and procedures / protocols on Ulysses.

The Corporate Governance 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.

The Corporate Governance 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. This is undertaken by an automated email reminder being sent to both the author and relevant Committee or Group 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.

Once approved and ratified, the Corporate Governance Team will publish polices and procedural documents on the Trust's Website or Staffnet for staff to access.

The Corporate Governance Team are responsible for extending the expiry dates on the documents when agreement has been sought from the relevant Committee or Group and uploading the amended document on the Trust Website or Staff intranet.

The Corporate Governance Team are responsible for advising staff by the monthly ENews of all new polices and SOP's that have been adopted. This information will be provided by the Communications Team and included in the Monthly Team Briefs. Comments on existing policies can be sent to the Corporate Governance Team.

All Staff

All staff (permanent and temporary / contracted), have an individual responsibility to ensure that they are aware of the organisation's procedural documents relevant to

their role/area of work and act in accordance with these. If any staff have any comments or suggestions on this policy or any policy please email lpt.policy@nhs.net.

5.0 Core 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.

- The document should be accessibility compliant.
- 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.

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 Data Privacy 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.

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

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.

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.

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.

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

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.

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

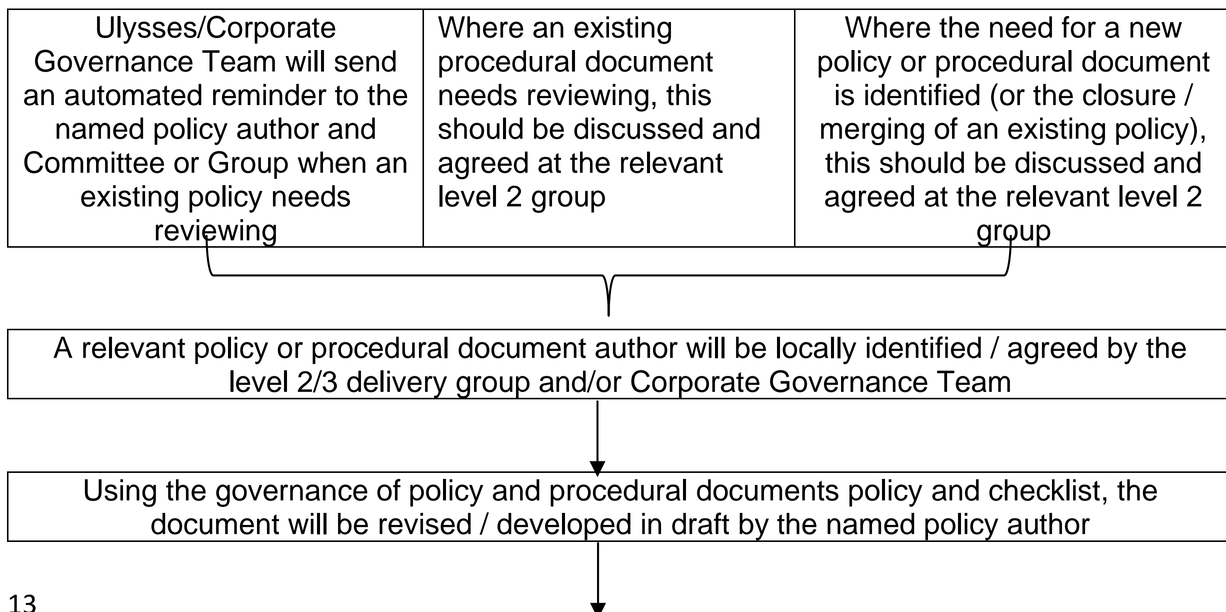
Documents should be written in Arial font, minimum size 12, with single line spacing. Abbreviations should only be used after the term has been displayed in full.

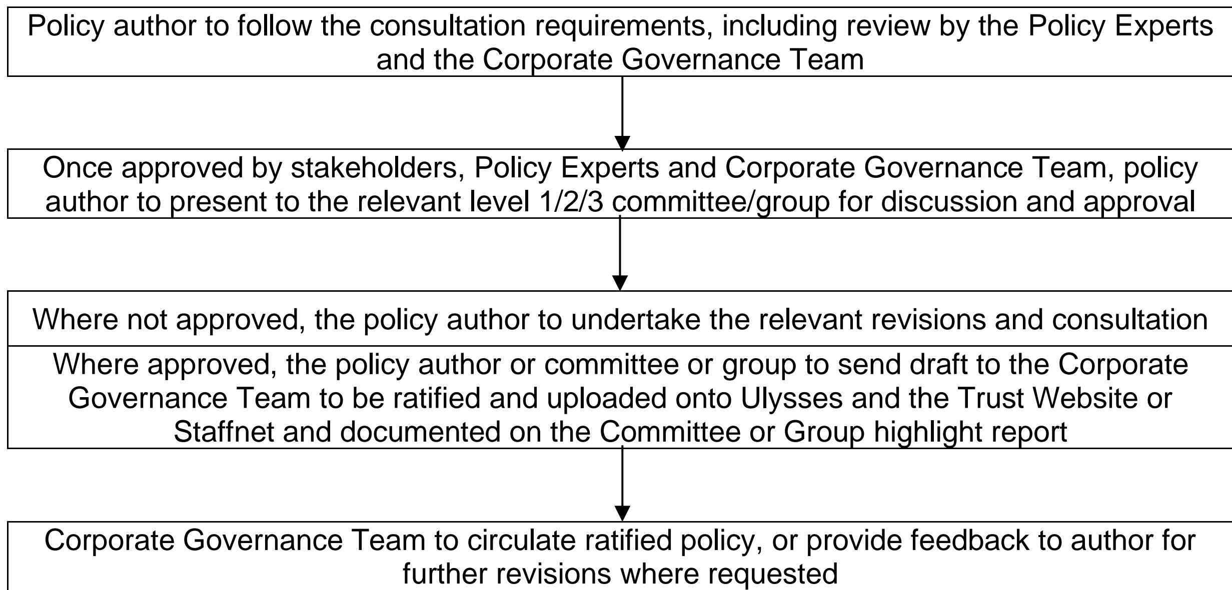
Policy authors must liaise with Clinical Safety Officers and/or the LPT IM&T Delivery Group if documentation is required within the electronic patient record.

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.

Policies, Guidelines or SOPs should **not** include electronic links or embedded documents to other policies/guidelines.

6.0 Pathway for new or revised policies, procedures, protocols or guidelines




Policy author to follow the consultation requirements, including review by the Policy Experts and the Corporate Governance Team
Once approved by stakeholders, Policy Experts and Corporate Governance Team, policy author to present to the relevant level 1/2/3 committee/group for discussion and approval
Where not approved, the policy author to undertake the relevant revisions and consultation
Where approved, the policy author or committee or group to send draft to the Corporate Governance Team to be ratified and uploaded onto Ulysses and the Trust Website or Staffnet and documented on the Committee or Group highlight report
Corporate Governance Team to circulate ratified policy, or provide feedback to author for further revisions where requested

7.0 Monitoring Compliance and Effectiveness

All policies must include details of how compliance will be monitored. For example: this could be done through audits, surveys, performance management, and incident and complaints analysis. However, it is not sufficient to state that it will be subject to audit without a description of how that audit will be carried out. Monitoring of compliance is intended to demonstrate that the processes described in each individual policy are being monitored, and not simply the anticipated outcomes.

Please include at least 1-5 sample to demonstrate assurance and include details of how and when the Committee/Group that will monitor in their workplan. Compliance is more usually achieved through pro-active performance or process management.

Monitoring of compliance in any policy must include a clear description of how the responsible Committee/Group will address gaps in compliance identified through the monitoring process. The Method of monitoring is to be tested 6 months before to ensure they are working by responsible person/group and included on their workplan.

Page/ Section	Key elements to monitor	Method for Monitoring	Responsible Individual /Group and confirmation of inclusion in workplan Method of monitoring to be tested 6 months before to ensure they are working	Frequency and Reporting arrangements (Where results and any Action Plan will be reported to, implemented and monitored; this will usually be via the relevant Governance Group).
Which tool will be used to monitor/ check/ observe/ Assess/ inspect/ authenticate that everything is working according to this key element from the approved policy?				
4.0	All policy authors follow the guidelines within this policy	Ratification and approval process		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

Page/ Section	Key elements to monitor	Method for Monitoring	Responsible Individual /Group and confirmation of inclusion in workplan Method of monitoring to be tested 6 months before to ensure they are working	Frequency and Reporting arrangements (Where results and any Action Plan will be reported to, implemented and monitored; this will usually be via the relevant Governance Group).
				update prior to approval.
4.0	All policies are reviewed and updated before expiration of authorisation	Regular policy compliance reports sent to appropriate Committee or Group – reminders sent to Authors and any out-of-date policies highlighted to Director	Policy Author/Corporate Assurance Team	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		Corporate Assurance Team publish on Trust Website/Intranet	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

8.0 Monitoring of compliance with the processes described in this policy

The Corporate Governance Team will undertake an annual audit policies to review compliance with this policy.

This will include whether:

- Committee minutes reflect the policy approval, implementation and publication processes set out in this document
- The policies are registered and have a unique identification number
- There have been audits carried out of compliance

- The policy register is up-to-date with reference to the sample

The full register is reviewed routinely (monthly) to ensure that all entries are current and relevant policies have been reviewed. Gaps in compliance with this policy are initially the subject of action by the Corporate Assurance Coordinator.

The Corporate Assurance Coordinator routinely does the following:

- A prompt sent to all Relevant Committee/Group and Authors, monthly, notifying them of registered review dates for the following quarter, and the need for polices to be reviewed
- Liaison on agenda management to of each of the ratifying Committees/Groups to ensure due process in the content and compliance rand appropriate recording.

9.0 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.

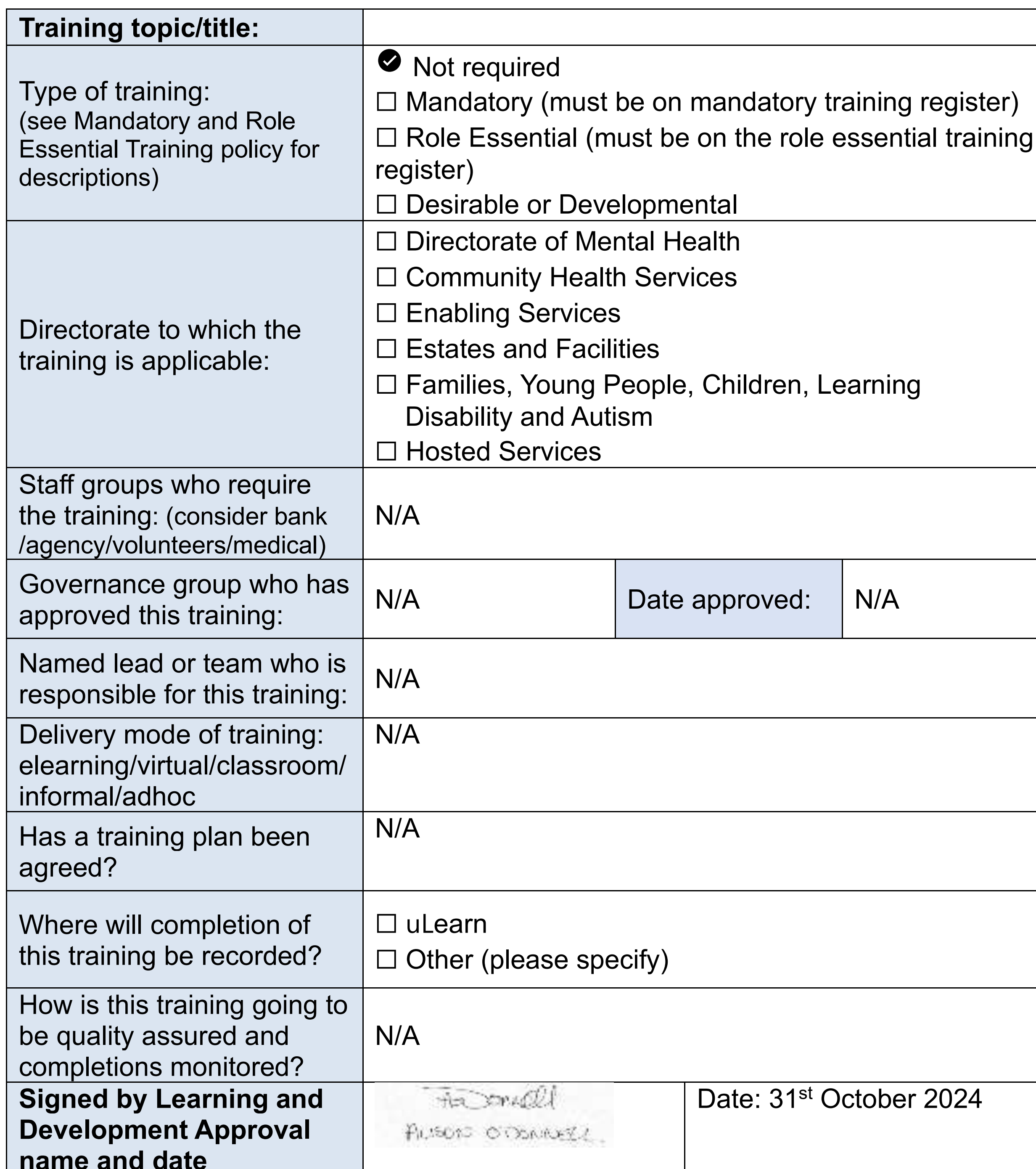
Fraud relates to a dishonest representation, failure to disclose information or abuse of position to make a gain or cause a loss. Bribery involves the giving or receiving of gifts or money in return for improper performance. Corruption relates to dishonest or fraudulent conduct by those in power.

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.

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	[signature]	Date: 31st October 2024	

Appendix 2 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   Answer - yes

Respond to different needs of different sectors of the population - yes

Work continuously to improve quality services and to minimise errors - yes

Support and value its staff - yes

Work together with others to ensure a seamless service for patients - yes

Help keep people healthy and work to reduce health inequalities - yes

Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance - yes

Appendix 3 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	31st October 2024
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed	Kate Dyer	Date	31st October 2024

Appendix 4 Data Privacy Impact Assessment Screening

<table>
<tr><td colspan="4">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.</td></tr>
<tr><td>Name of Document:</td><td colspan="3">Governance of Trust Policies and Procedural Documents</td></tr>
<tr><td>Completed by:</td><td colspan="3">Kate Dyer</td></tr>
<tr><td>Job title</td><td colspan="2">Director of Governance and Risk</td><td>Date 12th September 2024</td></tr>
<tr><td colspan="2">Screening Questions</td><td>Yes / No</td><td>Explanatory Note</td></tr>
<tr><td colspan="2">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.</td><td>No</td><td></td></tr>
<tr><td colspan="2">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.</td><td>No</td><td></td></tr>
<tr><td colspan="2">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?</td><td>No</td><td></td></tr>
<tr><td colspan="2">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?</td><td>No</td><td></td></tr>
<tr><td colspan="2">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.</td><td>No</td><td></td></tr>
<tr><td colspan="2">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?</td><td>No</td><td></td></tr>
<tr><td colspan="2">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</td><td>No</td><td></td></tr>
</table>

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

Appendix 5 Useful links

New accessible Policy-template guidance-for-staff

How to make documents accessible training video

How to make policies accessible

Policy help and guidance for staff

Policies – help and guidance for staff (leicspart.nhs.uk)