Annex A

LTHT POLICY FOR THE DEVELOPMENT AND MANAGEMENT OF TRUST-WIDE POLICIES AND PROCEDURES

Policy Title:	Policy for the Development and Management of Trust-Wide Policies and Procedures
Version:	4.2
Approved by:	Executive Team
Date of Approval:	18 April 2016
Policy supersedes	Policy for the Development and Management of Policies in Leeds Teaching Hospitals NHS Trust Version 4.1, 26 September 2013 (Updated 29 May 2014)
Lead Director:	Chief Executive
Name of policy Lead	Quality Governance Manager
Name of responsible governance committee/group:	Audit Committee
Date issued:	April 2016
Review date:	31 October 2018
Target audience:	Board Directors, Senior Managers in corporate functions and senior operational managers including Clinical Service/Support Unit Management Teams.
Associated Documents	Policy for the Development and Approval of Clinical Guidelines/Protocols and Procedures in Leeds Teaching Hospitals Trust

Key words	Policy, Policies, Guidelines, Procedure, Protocol, Approval, Development, Implementation, Monitoring, Communication, Effectiveness, Consultation, Stakeholders, Review, Register, Archive

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Section **Page**

Annexes

Policy for the Development and Management of Policies and Procedures in Leeds Teaching Hospitals NHS Trust

Staff Summary

This Policy is relevant to all those in the Trust who are responsible for developing, reviewing and implementing Trust-wide policies or non-clinical procedures. It is not of particular relevance to other staff.

All Trust-wide policies, and non-clinical procedures, will be developed and approved in accordance with this Policy and the attached templates.

Definitions of the documents covered by this Policy can be seen in Section 3.

There will be a **Lead Board Director** with overall responsibility for each new and existing policy and non-clinical procedure. The Director will nominate an individual (the Policy or Procedure Lead) to develop and review the document. The lead is also responsible for communicating and monitoring implementation of the policy or procedure.

A Policy, within Leeds Teaching Hospitals NHS Trust is considered to be a binding statement on all employees which specifies what the Trust requires employees to do and/or how they are expected to act.

Policies will be written using a consistent style and format as set out in Appendix C. The process to follow when creating and approving a Policy is set out in figure 1 in Section 4.1

> The key requirements of a policy will be captured in a staff summary and the policy effect section. Appendices will be used for detailed policy requirements. Annexes will be used for checklists that policy users would not need to access. Guidance and toolkits can be referenced from the policy and should be held on the intranet or in a separate document to support the policy.
>
> All Trust policies, and any revisions, will be approved by the Trust Board or a Committee of the Board. Each policy will be overseen by a governance group which will receive routine reports on compliance with the Policy.

All Trust-wide **non-clinical procedures** will be developed using the format in Appendix C. The flowchart to be followed when creating and approving non-clinical procedures is set out in Figure 2 in Section 4.1. They will be approved by the Central Team or the Lead Board Director. A governance group will also oversee their implementation and effectiveness.

The flowchart for **monitoring and review of Policies, and Non-Clinical Procedures** is set out in Figure 3 in Section 4.1

Clinical guidelines, protocols and standard operating procedures must follow the relevant processes set out in the Policy for the Development and Approval of Clinical Guidelines/Protocols and Procedures in Leeds Teaching Hospitals Trust.

Local non-clinical procedures/SOPs specific to an individual specialty/service will be governed by the local governance arrangements.

1. PURPOSE

This policy and associated templates outline the process for development and approval of all clinical and non-clinical policies, and non-clinical procedures. This will ensure that a consistent approach is adopted and that consultation takes place with relevant parties.

2. BACKGROUND/CONTEXT

Policies and procedures need not be lengthy. It is important that their purpose and main principles are not obscured by detail. They may be supported by guidance, or specific toolkits outlining the precise requirements in more detail.

This Policy should be read in conjunction with the Policy for the Development and Approval of Clinical Guidelines/Protocols and Procedures in Leeds Teaching Hospitals Trust.

Local non-clinical procedures/SOPs specific to an individual specialty/service will be governed by the local governance arrangements.

3. DEFINITIONS

Policy - a binding statement on all employees that specifies what the Trust requires employees to do and/or how they are expected to act. All policies will be Trust-wide documents. These may be supported by Procedures and/or by guidance and toolkits which support staff in the implementation of a policy.

Procedure – a **Trust Procedure** sets out a standardised series of actions to be taken, with clear responsibilities, to achieve a task so that everyone undertakes it in an agreed and consistent manner to achieve a safe and effective outcome. When used as part of a policy, procedures will provide the means to fulfil the objectives of the Policy.

Clinical Guidelines, Protocols and Procedures fall under the remit of the Policy for Development and Approval of Clinical Guidelines/Protocols and Procedures . Definitions can be seen in Appendix A.

POLICY EFFECT

A summary table of governance arrangements for all Trust Policies/ Procedures/Guidelines whether local or Trust-wide can be seen in Appendix B.

This Policy covers Trust-wide Policies and Non-Clinical Procedures, as set out below.

4.1 Creating and Approving a Policy or Procedure

The process to be followed when creating and approving a Policy or Procedure are set out in Figures 1 and 2 below.

The flowchart for monitoring and review of Policies and Non-Clinical Procedures is set out in Figure 3 below.

Figure1. - Flowchart for the Creation and Approval of a Policy

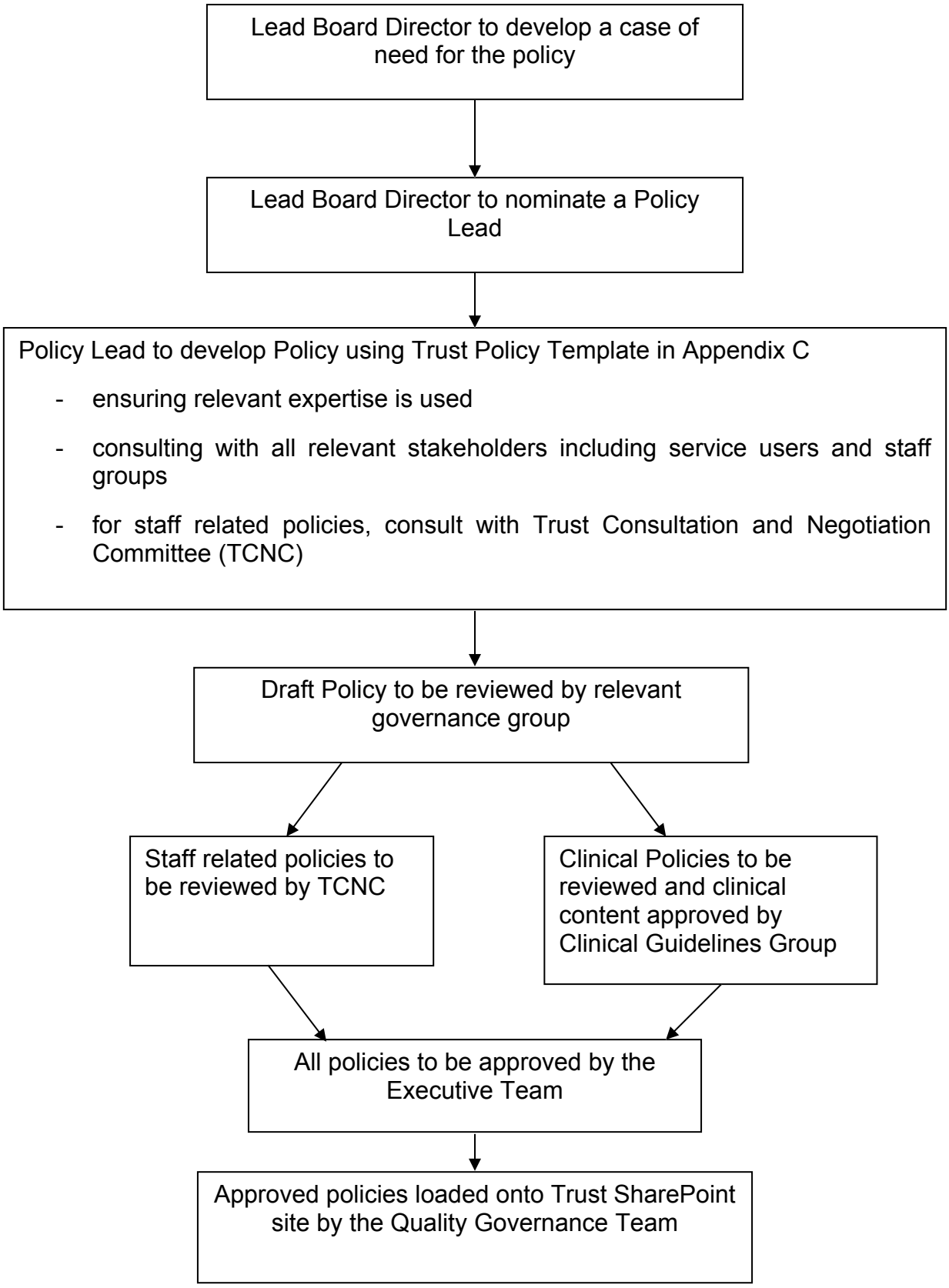


Figure 2. Flowchart for Creation and Approval of a Trust Non-Clinical Procedure

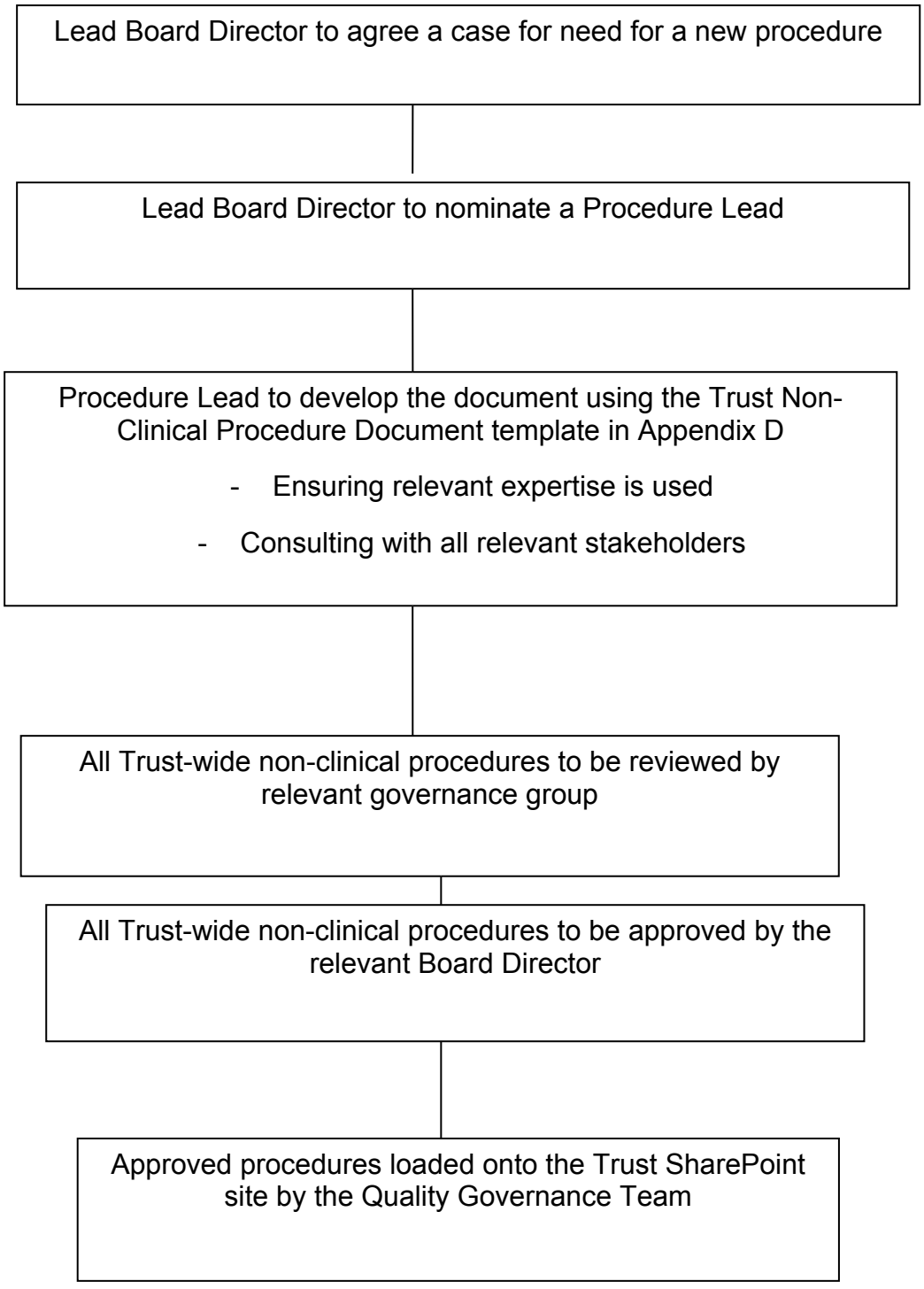
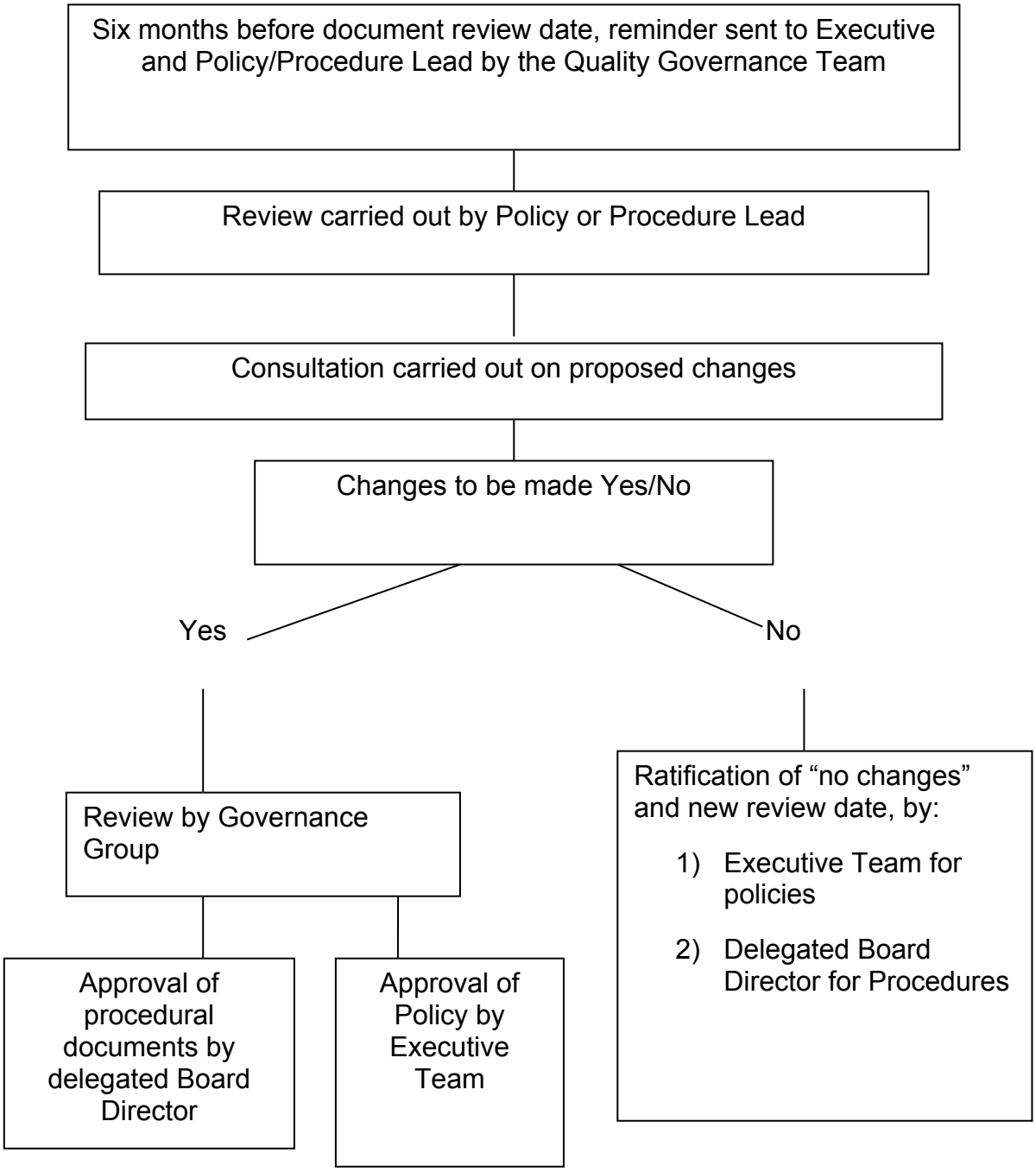


Figure 3. Review of Policies and Procedures



4.2 Style, Format and Content

All policies will be written using a consistent style and format as set out in Appendix C. The key points of the policy will be captured in a staff summary. Appendices will be used for detailed policy requirements. Annexes will be used for checklists that policy users do not need to access. Guidance, toolkits and supporting procedural documents can be referenced from the policy and should be held on the SharePoint site and linked to the policy.

All non-clinical procedures will use the format set out in Appendix D.

All policies and procedures will include a 'definitions' section giving an explanation of any key terms used.

4.3 Development Process

The process to be followed when developing or reviewing a policy or non-clinical procedure is set out below. The following sections (4.4 - 4.10) provide more detail on the process.

For any new policies, the Lead Director will:

- establish a clear justification for developing the new policy
- establish how it links with service priorities
- ensure that it is not duplicating other work.

For each document under development, the Lead Director will identify a Lead Manager who has responsibility for ensuring this policy is followed. In addition to this Policy/Procedure Lead, a steering group may also be established.

A staff side lead should also be nominated to work with the management lead for staff related policies.

4.4 Identification of Stakeholders

The Trust will seek the involvement of stakeholders in the development of new policies and procedures and any major review of existing documents. On occasion, this may include relevant staff representatives and service users. Key stakeholders outside the organisation will be informed during development or when the document has been approved, prior to implementation, at the discretion of the Lead Director.

4.5 Equality Analysis

The development of Trust policies must comply with the aim of equalities legislation which is to promote equality and eliminate unlawful discrimination. Guidance on Equality Analysis of policies is available on the Trust intranet.

An equality analysis must be undertaken on all policies and ratified prior to presentation of the policy for approval: see the equality analysis tool on the Equality and Diversity web page. This analysis must be held in an Annex to the policy.

All policies must include an equality statement such as: "The Leeds Teaching Hospitals NHS Trust is committed to reflecting individual needs, promoting equality and avoiding unfair discrimination against any particular individual or group. This applies to both the way that we provide services and the way we recruit and treat staff".

4.6 Consultation Process

All Policy/Procedural Documents

Relevant staff should be involved or consulted on the development of all policies and procedures. Where a policy or procedure is determined by a legal or regulatory requirement, Trust staff may expect to be consulted on how to implement it, rather than on the substantial requirements.

- Relevant practitioners must be involved in the development and review of clinical policies
- Where relevant, the views of people from different ethnic minority groups, of different gender, disabled people, and other groups should be sought (in accordance with the Trust's Equality and Diversity Policy)
- For policies that directly affect patients and service users, it will generally be appropriate to involve some patients, carers and public at the outset as well as consulting more widely on the drafts
- There is a statutory duty to consult with staff on all Health and Safety related policies
- Any major actions taken as result of involvement/consultation feedback should be documented on the version control sheet retained as an Annex to the Policy.

All draft documents issued during the consultation process must clearly indicate the date and draft number of the document (in the footer) to avoid confusion.

Staff Related Policies

Policies which fall into one of the categories listed below should go to either the Trust Consultation and Negotiation Committee (TCNC) or the Joint Consultation and Negotiation Committee (JCNC) for consultation

- Policies which affect terms and conditions of employment
- Policies which are authored by the HR Services
- Policies which affect (contractual and non-contractual) employee benefits
- Policies which could potentially affect all Trust employees, regardless of the job role which they are employed to do.

Where a policy falls within the remit of the TCNC/JCNC or Health and Safety Committee, the Lead Director should agree a review process with both Committees.

The consultation plan at Annex 2 of the template policy should be agreed.

When developing Staff Related Policies, due account should also be taken of the following guidelines approved by the TCNC (links are provided in Appendix C):

- Trust partnership policy

- Staff Involvement policy
- Involvement, Consultation & Negotiation Agreement

The involvement/consultation process, and major actions resulting from it, must be documented in an annex to the policy documentation (see Appendix C, Annex 3).

4.7 Approval and Ratification Process

All new or revised policies will be approved by the Executive Team.

Prior to seeking approval from the Executive Team, all new or revised policies will be reviewed by the appropriate governance group.

Staff Related Policies (as defined in Section 4.6) will normally be agreed by the TCNC/JCNC. However, where it is not possible to reach agreement, the Trust reserves the right to refer a Policy to the Executive Team for approval. In such cases the Executive Team will be advised that the TCNC/JCNC has not reached agreement in relation to the Policy.

Where a policy has been agreed by the TCNC/JCNC, the HR Service will be responsible for retaining a copy of the Policy signed by both the Director of HR and Staff Side Chair of the committee.

All Clinical policies will be reviewed and clinical content approved by the Clinical Guidelines Group, prior to approval by the Executive Team.

All draft or proposed Trust-wide policies must be submitted to the Executive Minute Secretary under a covering paper in standard Executive Team paper format. Trust policies will be approved by the Executive Team.

All new or revised non-clinical procedures will be reviewed by the appropriate governance group prior to approval by the delegated Board Director. They will then be forwarded to the Quality Governance Team for posting onto the SharePoint site.

4.8 Process for Reviewing a Policy or Procedure

Policies and Procedures will normally require a review date to be set two years from the approval date. The review date may be extended to three years if the policy requirements are unlikely to change significantly during this period. Review dates may also be brought forward if there are significant changes required, for example due to new national guidance or legislative changes. Policy/Procedure Leads must ensure they have arrangements in place to review the document at that time.

All reviews and revisions to policies and procedures must be approved according to the process described in section 4.7 of this document. Substantial changes would normally require a similar consultation process to the original policy. Changes to supporting guidance and toolkits can be made with approval from the relevant management or governance group.

Where no changes are required to a Policy following review, this will be approved by the Executive Team. A new review date will be agreed.

Where no changes are required to a non-clinical Procedure following review, this will be approved by the appropriate Board Director, and a new review date will be agreed by the Director.

4.9 Version Control

Each new 'final' version should be identified separately and distinctly with appropriate numbering on the cover sheet. Version 1 is the first published version of any policy, minor amendments may be numbered 1.1, 1.2 etc and major revisions/reviews should then become Version 2.

All Trust policy/procedural documents must include a standard section for documentation control purposes. See front page of template policy document at Appendix C for further details.

All Trust policy/procedural documents should contain a footer incorporating the title and approval date.

4.10 Communication, Dissemination and Implementation

All policies must contain a staff summary which communicates the policy succinctly.

All policies will include roles and responsibilities for ensuring staff are aware of the requirements of the policy.

All policies must include a communications and implementation plan before being submitted for formal approval. See Appendix C Annex 5.

All new policies and non-clinical procedural documents will be communicated via the 'InTouch' E-Bulletin. Substantial revisions will also be communicated via the E-Bulletin.

The governance/monitoring requirements of all policies will be summarised in the Governance Portfolio which captures the collective operational and corporate governance requirements.

4.11 Document Control including Archiving Arrangements

4.11.1 Register/Library of Policies and Procedures

The Trust has a central register/library of policies and non-clinical procedures held in SharePoint. This is an intranet-based system with search and archive functionality. To support this development, **all** policies and Trust-wide non-clinical procedures must be notified to the Quality Governance Team who will ensure they are made available on the Trust Intranet site.

The centrally-held version of the policy/procedure must be the only one actually published. If the policy/procedure is referred to within another local site on the Trust intranet it must be hyper-linked to the centrally held version on SharePoint/LHP.

4.11.2 Archiving Arrangements

The Trust will maintain a web-based archive, (via SharePoint and LHP). This will include:

- reviewed or updated policy/procedural documents

- those no longer in place, including the dates where the archived versions were extant.

Archived versions of policies and procedures must be retained in accordance with the Department of Health Code of Practice.

4.12 Monitoring Compliance and Effectiveness

All policies and non-clinical procedures will contain details of how compliance and effectiveness will be monitored including: - .

- Which governance group will oversee its implementation in conjunction with the Policy/Procedure Lead
- What monitoring arrangements for compliance and effectiveness will be adopted, e.g. audit, self-assessment, peer review, survey, or other research/evaluation
- Which specific group or named individual will have responsibility for conducting the monitoring/audit
- Reporting arrangements

Internal auditors will be asked regularly to assess awareness and compliance with Trust policies, including this policy.

4.13 References

Trust policies and procedures will provide references to show the evidence base. Policies and procedures should also reference any significant background or associated documents.

5. ROLES AND RESPONSIBILITIES

5.1 Trust Board - The Trust Board has overall responsibility for Trust policy. The Chief Executive will delegate responsibility for development of policy/procedure to nominated Lead Board Directors. The Trust Board has delegated responsibility for approval of policies to the Executive Team.

5.2 Executive Team - The Executive Team will:

- Approve all Trust Policies, and delegate approval of Trust Procedures to the appropriate Board Director

5.3 Governance Committees, Groups, and Sub-Groups - The Committees, Groups, and Sub-Groups will be responsible for:

- Receiving and reviewing minutes and assurance reports from governance groups
- Referring risks upwards to a Board Committee where appropriate
- Acting as the nominated governance group for policies and procedures for which they provide the first line of oversight.

5.4 Audit Committee - The Audit Committee will be responsible for reviewing the effectiveness of this policy on an annual basis.

5.5 Clinical Guidelines Group - The Clinical Guidelines Group will i) review new or revised clinical policies and approve the clinical content, prior to presentation to the Executive Team, and ii) approve all new or revised clinical procedures and protocols.

5.6 Nominated Governance Groups - The nominated Governance Group will:

- review new or revised policies/procedures prior to presentation to the Executive Team or Board Director, for approval
- receive routine assurance reports as required by each policy/procedure
- commission actions required to improve assurance or compliance.

5.7 Lead Directors - Lead Board Directors have overall responsibility for specific new and revised policies and procedures. This includes:

- Nominating a Policy/Procedure Lead
- Nominating the appropriate Governance Group for the Policy/Procedure
- Establishing a steering group, if required, to steer the development of a Policy, and submission for approval
- Ensuring the document is reviewed prior to its review date
- Ensuring appropriate levels and methods of patient, carer and public involvement
- Ensuring key stakeholders outside the organisation are involved or informed during policy development or when a policy has been approved, prior to implementation
- Confirming that implementation is achievable within the resources of the service/organisation
- Ensuring the document has an appropriate review date, normally two years from the approval date
- Reviewing all policies/procedures before being submitted for approval
- Ensuring that arrangements are put in place to monitor implementation of the policy/procedure, and report on compliance.

5.8 Policy Steering Group (where required) - A Steering Group, if needed, will be a time limited task and finish group with responsibility for:

- Identifying relevant stakeholders, and ensuring a consultation process takes place
- Agreeing what monitoring arrangements for compliance and effectiveness will be adopted, (e.g. audit, self-assessment, peer review, survey, or other research/evaluations) and the frequency and methodology of monitoring.
- Agreeing a communication and implementation plan

5.9 Policy/Procedure Lead -The Lead will be responsible for:

- Coordinating the development of the document
- Leading the development of a communication and implementation plan
- Carrying out consultation
- Proposing how the implementation will be monitored
- Ensuring the policy/procedure is written in plain English, is jargon-free, and follows the formatting conventions stated in Appendix C
- Ensuring the policy has been assessed for relevance to the statutory equality duties. Ensuring an equality analysis has been carried out, and approved by the Head of Equality and Diversity
- Ensuring the correct ratification process is followed
- Notifying the Quality Governance Team when the final document has been agreed and providing the approved version for posting on SharePoint**.**
- Ensure arrangements are in place to review the document at the appointed time.
- Noting when significant changes have occurred which impact on the policy/procedure and contacting the Lead Director to trigger an immediate review, if necessary
- For any policy being considered by the TCNC, the Policy Lead is responsible for providing TCNC with progress reports of the work and achievements against any agreed consultation plan. This is done by liaising with the Management Side Secretary of the TCNC in the HR directorate, who will include this on the TCNC agenda
- Ensuring that the agreed monitoring and reporting arrangements are put in place

5.10 Consultees - When draft copies of a policy/procedure are circulated and comments invited, respondents should make their comments by the date given. Failure to respond to the invitation to comment by the given date will be taken to be consent to their approval.

5.11 Quality Governance Manager - The Quality Governance Manager will be responsible for:

- Maintaining the SharePoint register of Trust Policies and Non- Clinical Procedures
- Proving an annual assurance report on the implementation of this policy to the Audit Committee.

5.12 All Staff

Failure to follow a Trust policy could result in the instigation of disciplinary procedures, in accordance with the Trust Conduct and Discipline Policy.

6. EQUALITY ANALYSIS

This Policy for the Development and Management of Policies and Procedures in Leeds Teaching Hospitals NHS Trust has been assessed for its impact upon equality. The Equality Analysis can be seen in Annex 1.

The Leeds Teaching Hospitals NHS Trust is committed to ensuring that the way that we provide services and the way we recruit and treat staff reflects individual needs, promotes equality and does not discriminate unfairly against any particular individual or group.

7. CONSULTATION AND REVIEW PROCESS

Previous versions of this Policy have been the subject of consultation and discussion with staff side and Trust Consultation and Negotiation Committee.

8. STANDARDS/KEY PERFORMANCE INDICATORS

All Trust Policies and Procedures will be in the required style and format.

All Trust Policies and Procedures will include a Definitions section, explaining frequently used terms.

All Trust Policies and Procedures will reference key associated documents.

All Trust Policies and Procedures will include clear references to its drivers and evidence base.

All Trust Policies and Procedures will have been subject to consultation with identified stakeholders.

All Trust Policies and Procedures will have an identified Lead Director, and a Policy/Procedure Lead responsible for development and monitoring implementation and review.

All Trust Policies and Procedures will be ratified by the appropriate Governance Group prior to approval.

All Trust non-clinical Procedures will be approved by the Central Team, or delegated Board Director, prior to posting on SharePoint.

All Trust policies and non-clinical procedure will be held on the Trust's SharePoint site and reviewed in accordance with the agreed review date.

All superseded versions of policies and procedures will be archived.

9. PROCESS FOR MONITORING COMPLIANCE/EFFECTIVENESS

Policy element to be monitored	Standards and Performance indicators	Process for monitoring	Individual or group responsible for monitoring	Frequency or monitoring	Responsible individual or group for development of action plan	Responsible group for review of assurance reports and oversight of action plan
Style and format	All Trust Polices and non-clinical procedures will be in the required style and format.	Annual Internal Audit Review	Internal Audit	Annual	Quality Governance Manager	Annual report to Audit Committee
Terms used	All Trust Policies and non-clinical procedures will include a Definitions sections, explaining frequently used terms.	Annual Internal Audit Review	Internal Audit	Annual	Quality Governance Manager	Annual report to Audit Committee
Associated Documents and supporting references	All Trust Policies and non-clinical procedures will reference key associated documents. All Trust Policies and non-clinical procedures will include clear references to its drivers and evidence base.	Annual Internal Audit Review	Internal Audit	Annual	Quality Governance Manager	Annual report to Audit Committee
Consultation	All Trust Polices and non-clinical procedures will have been subject to consultation with stakeholders.	Annual Internal Audit Review	Internal Audit	Annual	Quality Governance Manager	Annual report to Audit Committee
Ownership and governance of	All Trust policies and non-clinical procedures will have an identified Lead Board Director, a Policy/Procedure	Annual Internal Audit Review	Internal Audit	Annual	Quality Governance Manager	Annual report to Audit Committee

polices	Lead, and an identified governance group to oversee ongoing implementation and review.					
Approval of Policies	All Trust policies and non-clinical procedures to be ratified by appropriate Governance Group prior to Executive Team or Board Director approval.	Annual Internal Audit Review	Internal Audit	Annual	Quality Governance Manager	Annual report to Audit Committee
Approval of Procedures/protocols	All Trust non-clinical procedures to be approved by the delegated Board Direcot prior to posting on SharePoint.	Annual Internal Audit Review	Internal Audit	Annual	Quality Governance Manager	Annual report to Audit Committee
Review of polices	All Trust policies and non-clinical procedures to be on Trust's SharePoint site and reviewed in accordance with agreed review date.	Annual Internal Audit Review	Internal Audit	Annual	Quality Governance Manager	Annual report to Audit Committee
Archiving of polices	All superseded versions of policies and procedures will be archived	Annual Internal Audit Review	Internal Audit	Annual	Quality Governance Manager	Annual report to Audit Committee

10. REFERENCES/ASSOCIATED DOCUMENTATION

NHSLA Litigation Authority Risk Management Standards 2012/13

Appendix A

Policy for the Development and Management of Policies and Procedures in Leeds Teaching Hospitals NHS Trust

Document Definitions

A Policy is a binding statement on all employees that specifies what the Trust requires employees to do and/or how they are expected to act.

Policies apply to all relevant staff as a 'must do' requirement, and a breach of policy may have contractual consequences for the employee. Policy is a statement of the standard to be achieved rather than how to implement the standard. Policies often arise from legislation, national policy or Trust strategy.

> A **Clinical Policy** is a Trust-wide policy, as described above, which relates to a particular clinical or patient care related issue. (A clinical policy will often have associated clinical guidelines, protocols or procedures - or possibly all three).

Procedural Documents

A Trust Procedure is a standardised series of actions to be taken to achieve a task so that everyone undertakes it in an agreed and consistent manner to achieve a safe and effective outcome. (When a procedure is part of an approved policy it provides the means to fulfil the objectives of the policy and to show how the policy statement is to be achieved).

Clinical Documents - Managed under the Trust Policy for the Development and Approval of Clinical Guidelines/Protocols and Procedures. These give guidance on direction regarding diagnosis, management and/or treatment in specific clinical areas.

A **Clinical Standard Operating Procedure (SOP**) is a step by step description of how to do something at a practical level. An example of a clinical procedure (SOP) is the procedure for insertion of peripheral venous cannula

A **Clinical protocol** is a mandatory course of action that a clinician must take when they decide that the conditions of 'specific clinical circumstances' are met. A protocol may contain procedures within it. An example of a protocol is the Immunisation Protocol for the Neonatal Unit. Clinical Protocols can be seen as more specific than guidelines and defined in greater detail. Protocols provide "a comprehensive set of rigid criteria outlining the management steps for a single clinical condition or aspects of organisation"

Clinical Guideline - A systematically developed, evidence based document that assists employees, including healthcare professionals, to make decisions concerning the appropriate course of action to take or care for specific clinical conditions.

A clinical guideline will often contain embedded protocols and/or procedures.

A Clinical Guideline does not override the individual responsibility of health professionals to make clinical decisions appropriate to the circumstances of individual patients in consultation with the patient and/or their guardian or carer. If such a decision means that a clinical guideline is not followed for an individual patient, the reasons must be fully recorded in the patients' medical records.

Local Procedures/SOPs

Local clinical procedures/SOPs specific to one specialty or service area.

Summary Table of Governance Arrangements

Appendix B

	Policies	**Trust-wide Procedures**		**Trust-wide Clinical Guidelines**	**Local Clinical Guidelines**	**Local Procedures/SOPs**	
		Clinical	Non-Clinical			Clinical	Non-Clinical
Formal Approval	Executive Team	Delegated Executive Director	Delegated Executive Director	Clinical Guidelines Group*	Clinical Guidelines Group*	CSU Governance Forum or delegated specialty group	CSU Governance Forum or delegated specialty group
Reviewed By	Relevant Governance Group, Clinical Policies also through Clinical Guidelines Group, prior to formal approval	Relevant Governance Group prior to formal approval	Relevant Governance Group, Clinical Policies and then Clinical Guidelines Group, prior to formal approval	Peer review determined by the author/specialty. LHP peer review process is available if required		Local peer review process	
Held on	SharePoint Hub	SharePoint Hub	LHP with link to SharePoint Hub	LHP	LHP	On specialty specific shared drive or on LHP	
Monitored By	Through Trust-wide mechanisms including Audit Programme, Staff and Patient Surveys, Risk and Safety Audit. Reported into governance structure as set out in Policy/Procedure Monitoring Tables			As set out in their audit section	Through specialty Audit Programme		

* Guidelines/protocols/procedures relating specifically to:

- Drugs will be approved by the Drug and Therapeutics Group and the Leeds Area Prescribing Committee for final approval.
- Antimicrobials by the Improving Antimicrobials Prescribing Group
- Other specific city-wide steering groups; Safeguarding Adults, Safeguarding Children are also able to approve their clinical guidelines/protocols and procedures through their own governance processes.
- Protocols or SOPs that are specialty specific may be approved through their own CSU governance forum.

Appendix C

Policy for the Development and Management of Trust Wide Policies and Procedures in Leeds Teaching Hospitals NHS Trust

Style Guide and Policy Template

STYLE GUIDE FOR TRUST POLICIES

All policies should:

- Be as concise and focused as possible
- Be fully indexed and include page numbering
- Ensure no discrimination against any groups or individuals and promote equality where possible.
- Be in plain English using short sentence, and simple vocabulary
- Be written in MS Word and use MS Word formatting conventions.

Formatting should be kept as simple as possible. Heading levels should be consistent and reflected in the index.

Tables should be used to align lists and columns of information.

The Trust's FOI Publication Scheme does not support newspaper style columns so these should be avoided.

Appendices should be attached for more detailed information. Very bulky data should be placed on the website and cross-referenced from within the paper.

Consideration should be given to also producing appropriate documents in languages other than English and in different formats dependent on the population groups served by the organisation.

Policies, especially clinical and prescribing policy, should not include abbreviations for clinical dosages or medicines. E.g. 'mcg and 'NaCl' which may lead to confusion and error. Medicines and dosage should be in full. Abbreviations used within the organisation should always be defined at the first use.

Font	Arial
Font size	All text in 12pt apart from the main heading, which should be in 14pt. (For people with visual impairments this should be increased to 16pt or 18pt and be in bold)
Headings	▪ Main section headings in **BOLD AND UPPERCASE** ▪ Sub-section headings in **Bold and Title Case** ▪ Underlining is not used within headings
Numbering Convention	▪ Main headings will be numbered sequentially ▪ Sub-heading numbering will take the format '13.1', '13.2' '13.2.1' etc ▪ All pages will be numbered at the bottom within the footer as per document template
Justification	To comply with 'Plain English' requirements, all text should be left-aligned as opposed to being justified

The Leeds Teaching Hospitals NHS
NHS Trust

Template for Trust Policies

POLICY TITLE

Policy Title	
Version:	*(see Policy Section in 4.8)*
Approved by:	Executive Team
Date of approval:	
Policy supersedes:	
Lead Board Director:	
Policy Lead (and author if different):	
Name of responsible committee/group:	*(Insert the name of the group that will oversee effectiveness of implementation)*
Date issued:	
Review date:	*(Usually 2 years from approval date)*
Target audience:	

Keywords	*(To allow searching on SharePoint)*

Contents

Paragraph **Page**

STAFF SUMMARY - To be on a separate page.

This gives a short **summary** (no more than one A4 side) of the policy effect (process) in simple language readily accessible to staff, and highlights key roles and responsibilities. It should be clear from this summary who the policy is of relevance to and what they can expect to find in it.

This section should signpost any flowcharts in section 4, and any other key sections of particular relevance to staff, so they can easily access key information.

1 PURPOSE

A short paragraph outlining the purpose of the policy.

It is important for policy authors to be able to state clearly in one or two short sentences the purpose of the policy and what it does. The main document is an opportunity to elaborate but this short section in bold text is a key feature that makes a policy more accessible for users.

This will be the description posted on the intranet policies A - Z and will be the first paragraph of the staff summary.

2 BACKGROUND/CONTEXT

This section can be used to explain any relevant background information or context for the policy. It should be kept as short as possible.

3 DEFINITIONS

Any key terms used within the document should be defined.

4 POLICY EFFECT

One or more sections outlining the processes covered by the policy, and what these processes aim to achieve.

These sections should lead into the “Roles and responsibilities” in section 5 by showing how the responsibilities outlined in that section fit together into a process/processes.

Wherever possible, the process(es) should be clarified in a flow chart.

It should go into sufficient detail for someone unfamiliar within the process to understand it.

Counter fraud - The Trust is required to meet the Standards for Providers on Fraud, Bribery and Corruption as set out by NHS Protect. One of these standards requires the Trust to ensure that new and existing policies and procedures are appropriately fraud proofed. Therefore, staff involved in the drafting and revising of Trust policies should, as part of the process, consider any potential risks or loopholes in the policy which may allow fraud to occur. Appropriate measures should be included in the policy to minimise this risk. For further advice, please contact the Trust’s Local Counter Fraud Specialists (LCFS’s).

Retention of Records - It is a fundamental requirement that all of the Trust’s records are retained for the appropriate period of time for legal, operational,

research and safety reasons. The length of time for retaining records will depend on the type of record and its importance to the Trust's clinical and business functions. The Trust has adopted the retention periods set out in the Records Management: NHS Code of Practice (detailed in the Trust's Retention Schedules for Health and Non-Health Records). The retention schedule will be reviewed regularly. Policy Leads should take this into consideration when developing/updating a policy

5 ROLES AND RESPONSIBILITIES

This section should set out responsibilities within the Trust: it must state clearly the requirements of staff in terms of their roles, responsibilities, and expected standards of behaviour. It must also set out who is responsible for implementing all aspects of the policy. Where it is appropriate, acceptable levels of delegation should also be stated.

It should include the responsibilities of relevant committees/groups.

Roles relating to multidisciplinary teams should be taken into account and clearly specified in this section

It should go into sufficient details for anyone at ant level of the organisation to understand their responsibilities.

6 EQUALITY ANALYSIS

This section needs to include two statements as follows:-

"This Policy has been assessed for its impact upon equality. The Equality Analysis can be seen in annex 1."

"The Leeds Teaching Hospitals NHS Trust is committed to ensuring that the way that we provide services and the way we recruit and treat staff reflects individual needs, promotes equality and does not discriminate unfairly against any particular individual or group."

Guidance on Equality Impact Assessment of policies is available on the Trust intranet.

7 CONSULTATION AND REVIEW PROCESS

This section should describe the nature of the consultation process undertaken. The way in which the finalised policy will be communicated back to those involved in consultation will be included in the consultation plan in Annex 2**.** Section 4.5 of the Policy gives details of consultation requirements

"A consultation plan should be attached (See annex 2) for all new staff related Policies"

When developing Staff Related Policies, due account should also be taken of the following guidelines approved by the Trust Consultation and Negotiation Committee (links are provided below):

- Trust partnership policy

http://lthweb/departments/human_resources/Files/PartnershipPolicy.pdf

- Staff Involvement policy

http://lthweb/departments/human_resources/Files/staffinvolvement.doc

Involvement, Consultation & Negotiation Agreement

http://lthweb/sites/human-resources/a-z/InvolvementconsultationandnegotiationJan2010.doc

For all policies, the approving body will normally expect to see evidence of relevant staff involvement and consultation. There may be exceptions to this principle, e.g. where policy is determined by a legal or regulatory requirement, or where the policy is substantially determined by specialist professional advice. Under such circumstances, Trust staff may expect to be consulted on how to implement policy, though not in the substantial provisions of the policy

The electronic consultation forum on Leeds Health Pathways is an excellent means of consulting with named individuals within the Trust.

Prior to seeking approval from Trust Board (or Committee of the Board):

- All new or revised policies will be reviewed by the appropriate governance group
- All staff related policies will be signed off by Trust Consultation and Negotiation Committee
- All Clinical policies will also be considered by the Clinical Guidelines Committee.

The requirement for a new policy will be endorsed by the Central Team prior to work commencing on the development of the policy.

8 STANDARDS/KEY PERFORMANCE INDICATORS

This section must specify any relevant standards and KPIs which will be used to measure the impact/effectiveness of the policy e.g. how will we know if the policy is in place and being effective. Standards/indicators should only be referred to if they are measurable and there are plans referred to in Section 9 for monitoring them

9. MONITORING COMPLIANCE AND EFFECTIVENESS

This section, using the template below, must include details of how compliance and effectiveness of implementation of the policy will be monitored. This will include monitoring for any adverse impact on different groups. This should include the role of the Policy Lead and overseeing governance group in reviewing assurance. See Policy section 4.12 for further details.

Where an audit is required in order to measure compliance or effectiveness, the audit should be included in the Trust Annual Clinical Audit Programme and an audit tool should be made available.

Appendix A

Policy element to be monitored	**Standards/ Performance indicators**	**Process for monitoring**	**Individual or group responsible for monitoring**	**Frequency or monitoring**	**Responsible individual or group for development of action plan**	**Responsible group for review of assurance reports and oversight of action plan**
Include a separate row below for each element required by policy and any other aspects required by the Trust.	*How will we know if the policy is being implemented effectively?*					

10. REFERENCES/ASSOCIATED DOCUMENTATION

A list of any source documents referred to within the policy.

Policy Template Appendix A

To be included as required for the individual policy

Other appendices may be added

Policy Template Annex 1 - Equality Analysis

Use template available on Equality and Diversity web page.

Policy Template Annex 2

CONSULTATION PLAN (For new staff related policies)

This plan should be completed by the management or staff-side sponsor of a policy in advance of the consultation process. Supporting papers should be attached for information and the completed form should be sent to the relevant manager and staff-side representative and tabled at the appropriate forum for agreement.

Sponsor Name: _____ Job Title: _____ Division: _____	**Summary of Policy** e.g. *To transfer staff from ward A to ward Z as part of the Acute Service Reconfiguration*
Why is the policy necessary?	**Which staff/groups are affected?**
What is the potential impact of the policy?	**How will staff be involved in developing the policy?**
Where will formal consultation take place? With local representatives ☐ At JCNC ☐ At TCNC ☐ Other Joint Forum ☐ (Please specify) _____	**What is the target date for:** Completing consultation _____ Implementation _____ (subject to consultation) Review _____
Details of any specific constraints e.g. *Finance, Govt. requirement, etc*.	**Outline Process Agreed** Management Side _____ Staff Side _____ Date _____

Policy Template Annex 3 - Plans for Communication and Dissemination of Policy

This plan for communication and dissemination of the policy must be completed for all policies, and attached to the policy before being submitted to the Executive Team for approval.

Title of document:	
Approving Group/Committee	
Date Approved:	

Target Audience **Eg staff groups or stakeholders**	**Objective**	**Action**	**Person Responsible**	**Target date**
	Include any training requirements			
	Include removal of out of date documents, if relevant			
Narrative for InTouch:	*to highlight key changes (and why, if relevant)*			

GUIDANCE FOR DEVELOPMENT OF PLANS FOR COMMUNICATION AND DISSEMINATION OF POLICY

Objectives - State the outcomes that are required for those affected by the policy eg to: i) know of its existence, ii) understand its purpose, and iii) understand their role in implementation.

Key messages - These are the 'headlines' or key points you want people to be aware of. Readers need to understand the implications and desired effect of the policy and know whether they need to find out more details. These may already be in the Staff Summary.

Target Audience - It is important to understand the perspective of the target groups, e.g. what is their position/opinion/knowledge in relation to the policy; how do they prefer to receive important information; where are they and what are their working conditions like; what do they know already?

Do not adopt an indiscriminate, general or random approach, thinking that if you tell everyone or most people you are bound to reach the groups who need to know.

State as precisely as possible the groups who need to be informed about the policy either so that they can implement it or so that they are aware of the intended effect.

For each group there is likely to be separate information they need to know so it is helpful to segment or break up the overall target audience and specify what information each group needs. Each group may also have other characteristics or needs to distinguish it; try to identify them.

Stakeholders - These are normally people with an interest in the policy or in its impact, often external to the organisation. They may be neither subject to, nor directly affected by it. Think about how you will keep them in the picture about the things that matter to them.

Timing - Dates of communications activity that will happen? Include any key start or end dates; key milestones, anniversaries, events or opportunities to reach the target groups, including existing scheduled corporate, Trust-wide or group-specific communications.

Channels/mechanisms - It is important to select a range of effective channels or mechanisms to reach target groups. People need to see information several times before they take it in fully. It is also helpful to ensure there are multiple opportunities for any target group to see the information they need.

Do not invent new mechanisms, e.g. newsletters, intranet sites, without seeking advice from the Communications Team. This team will help you ensure whether this is likely to be the most effective means of communication with your target audience, whether there are better alternatives, and whether your aim can be supported by, or will undermine, other Trust-wide communications.

Policy Template Annex 4 - Checklist for the Review and Approval of Policy

LEEDS TEACHING HOSPITALS NHS TRUST

Approving Body Checklist for the Review and Approval of Trust Policy or Procedure

To be completed and attached to the policy when submitted to the appropriate committee for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Format and Content**		
	Is it in the correct format?		
	Is the staff summary clear and adequate?		
	Are the intended outcomes clearly described? (the Policy/Procedure Effect)		
	Is there a Definitions section giving an explanation of key terms used.		
	Is there an Equality Analysis signed off by the Head of Equality and Diversity (Policies Only)		
2.	**Consultation and Review**		
	Has there been appropriate consultation with stakeholders and users?		
	Has an appropriate governance group reviewed and supported the document prior to submission for formal approval?		
	For HR Policies only, has the TCNC approved the document?		
	If it is a clinical policy/procedure has it been reviewed by the Clinical Guidelines Group?		
	Has it been reviewed by internal audit for counter fraud?		
3.	**Dissemination and Implementation**		
	Is there a communications plan to identify how it will be communicated and implemented? The Communications Team can help you with advice.		
	Does the communications plan include a summary for InTouch?		
4.	**Process to Monitor Compliance and Effectiveness**		
	Is there a monitoring table setting out measurable standards or KPIs together with clear monitoring and reporting mechanisms (to ensure there is assurance of implementation)		
5.	**Review Date**		
	Is the review date in 2 years? If not is there a justified reason?		

If the document needs urgent approval before all of the above are satisfactorily addressed, please bring this to the attention of the appropriate committee so conditional approval can be given.

Committee Approval *(This section only required for staff- related policies)*			
If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.			
Name		Date	
Signature			
Name		Date	
Signature			

Policy Template Annex 5 - Version Control Sheet

This document to be maintained by the Policy/Procedure/Protocol Lead, and a copy attached to each version as it is circulated for consultation/input.

Version	Date	Author	Status	Comment (including actions taken)

Appendix D

Template for Non-Clinical Procedure

TITLE OF PROCEDURE

Date approved	
Approved by:*(Board Director)*	
Version	
Executive Lead	
Procedure Lead	
Procedure Author *(if different from Lead)*	
Governance Group	
Review Date	
Link to Policy	*Where applicable please state the policy which this procedure/protocol is governed by.*
Other Associated Documents	*Please list other documents which have direct links to this procedure.*

Contents

Paragraph **Page**

Staff Summary

STAFF SUMMARY - To be on a separate page.

This gives a short **summary** (no more than one A4 side) of the policy effect (process) in simple language readily accessible to staff, and highlights key roles and responsibilities. It should be clear from this summary who the policy is of relevance to and what they can expect to find in it.

This section should signpost any flowcharts in section 4, and any other key sections of particular relevance to staff, so they can easily access key information.

1. PURPOSE

This whole section should be concise and relevant. No more than a short paragraph is required

This should include;

- *the rationale for the document in a one sentence statement*
- *a brief background to the document in a one or two sentences if this helps to explain the purpose of the document; e.g Previously known as the policy on…., A new national or regional standard or guideline has been published…., New legislation regarding…. etc.*

2. SCOPE

Outline who the procedure applies to (which staff members) and the activity the procedure applies to.

3. DEFINITIONS/ ABBREVIATION

Please list any terminology frequently used throughout the document with a brief definition and any abbreviations you intend to use. Always assume the reader may not have come across terminology which you use consistently in the work environment.

4. PROCEDURE TO BE FOLLOWED

This is the body of the document and should include;

- *Who will perform the task*
- *Where the task will take place*
- *How the task will be performed*

This should be written as simply as possible, either in short sentences, numbered bullet points or clearly listed statements.

Wherever possible, please include a flow chart diagram. Please note if you cannot translate the described procedure into a flow chart it is possible it is too complex or does not provide enough detail. Always assume the person reading this does not know anything about the procedure.

5. ROLES AND RESPONSIBILITIES

This section should set out the responsibilities within the Trust. It must state clearly the requirements of staff in term of their roles, responsibilities, and expected behaviours. It must set out who is responsible for implementing all aspects of the procedure. It should also include the responsibilities of relevant groups/committees.

This presents similar information as in section 3 above, arranged under a role title so that each person can clearly see what's expected of them.

6. LINKS TO OTHER DOCUMENTS

Please list any policies, procedures or protocols this procedure or protocol is linked to.

7. MONITORING ARRANGEMENTS

This section should be set out in the attached table and must specify any standards/KPIs which will be used to measure the impact/effectiveness of the procedure ie how will we know if the procedure is in place and being effective.

Standards should be specific, measurable, achievable, realistic, and timed?

It should also state how these standards/KPIs will be monitored, how frequently, who by, and who will be responsible for reporting to the Governance Group/Committee.

If this monitoring is carried out as part of the monitoring process for a Trust Policy, this needs to be stated here.

8. REFERENCES

PROCEDURE MONITORING TABLE

Procedure element to be monitored	Standards and Performance indicators	Process for monitoring	Individual or group responsible for monitoring	Frequency or monitoring	Responsible individual or group for development of action plan	Responsible group for review of assurance reports and oversight of action plan

Procedure Template Annex 1 - Plans for Communication and Dissemination of Procedure

This plan for communication and dissemination of the policy must be completed for all Trust-wide non-clinical procedures, and attached to the policy before being submitted to the Board Director for approval.

Title of document:	
Approving Group/Committee	
Date Approved:	

Target Audience **Eg staff groups or stakeholders**	**Objective**	**Action**	**Person Responsible**	**Target date**
	Include any training requirements			
	Include removal of out of date documents, if relevant			
Narrative for InTouch:	*to highlight key changes (and why, if relevant)*			

Annex 2 - Checklist for the Review and Approval of a Procedure

LEEDS TEACHING HOSPITALS NHS TRUST

Approving Body Checklist for the Review and Approval of Trust Policy or Procedure

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	Is there a Definitions section giving an explanation of key terms used.		
	Is there an Equality Analysis signed off by the Head of Equality and Diversity (Policies Only)		
2.	**Consultation and Review**		
	Has there been appropriate consultation with stakeholders and users?		
	Has an appropriate governance group reviewed and supported the document prior to submission for formal approval?		
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	Is there a communications plan to identify how it will be communicated and implemented? The Communications Team can help you with advice.		
	Does the communications plan include a summary for InTouch?		
4.	**Process to Monitor Compliance and Effectiveness**		
	Is there a monitoring table setting out measurable standards or KPIs together with clear monitoring and reporting mechanisms (to ensure there is assurance of implementation)		
5.	**Review Date**		

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	Is the review date in 2 years? If not is there a justified reason?		

If the document needs urgent approval before all of the above are satisfactorily addressed, please bring this to the attention of the appropriate committee so conditional approval can be given.

Committee Approval *(This section only required for staff- related policies)*			
If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.			
Name		Date	
Signature			
Name		Date	
Signature			