University Hospitals of Leicester NHS
NHS Trust

# Policy for Developing and Approving Clinical and Non-Clinical Policies and Other Guidance[1] Documents

## (known as 'Policy for Policies')

| | |
|---|---|
| **Approved By:** | **Policy & Guideline Committee Chairman 11th May 2020** |
| **Date of Original Approval:** | **9th June 2004** |
| **Trust Reference:** | **B16/2004** |
| **Version:** | V6 |
| **Supersedes:** | V1 (B16/2004 original approved by Trust Executive)<br>V2 (B16/2004 revision approved by Trust Executive)<br>V3 (B16/2004 revision approved by Trust Executive 21 October 2011)<br>V4 (B16/2004 revision approved by P&G Committee 18th May 2012)<br>V5 (B16/2004 revision approved by PGC 16th December 2016) |
| **Trust Lead:** | Steve Murray<br>Assistant Director of Corporate and Legal Affairs |
| **Lead Board Director:** | Stephen Ward, Director of Corporate and Legal Affairs |
| **Date of Latest Approval** | 16 December 2016 |
| **Next Review Date:** | **May 2024 6 Month Extension approved at November PGC** |

## CONTENTS



[1] Guidelines, Procedures, Standard Operating Procedures, Protocols and any other document that provides guidance to staff.

## REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

**2004** – V1 of this Policy was written and subsequently revised in 2007.

**November 2010** – V2 of this policy was completely re-written to take into account the changes to NHSLA requirements, UHL's Divisional structure and the experiences of the UHL Policies & Guidelines Committee in implementing the Policy recommendations.

**September 2011** – V3, a further review was carried out to incorporate the changes made to the trust's archiving system of policies and guidelines and also to include explicit guidance on 'associated documents' and 'supporting references' in line with the NHSLA standard

**April 2012** – V4, following the NHSLA Assessment for Level 1, the Policy has been again reformatted to incorporate the changes suggested by the NHSLA Assessor

**October 2016** – V5 following consultation the policy has been revised to change format requirements and strengthen governance.

**May 2020** V6 following consultation the policy has been revised to include questions in the governance proformas asking submitting authors of Category, A B and E Policies and Guidelines to say if they wish them to be made availavle on the trust's external policies and guidelines website.

## KEY WORDS

Policy for Policies

Developing and Approving Policies

Policy and Guidelines Policy

P&G Policy

PAGL

Writing policies

Writing guidelines

## 1 INTRODUCTION AND OVERVIEW

1.1 Organisations need formal written documents (policies, guidelines, procedures) which communicate standard organisational ways of working. These help clarify strategic and operational requirements and bring consistency to day to day practice. In addition they can improve the quality of work and increase the successful achievement of objectives.

1.2 A common format and approval structure for such documents helps to reinforce corporate identity and, more importantly, helps to ensure that policies, guidelines or procedures in use are current and reflect an organisational approach.

1.3 Having a standard format also helps to avoid confusion and to assist staff (and patients) in following the requirements of this Policy. Equally important are the use of plain English and the avoidance of jargon.

1.4 It is the responsibility of the Trust to ensure that all policies, guidelines or procedural documents (clinical and non-clinical) are appropriately evidence based, rigorously developed, formally approved, effectively implemented and routinely monitored and reviewed.

1.5 For the purposes of this policy the term 'guidance' includes Guidelines, Procedures, Standard Operating Procedures, Protocols and any other document that provides guidance to staff (definitions are given in Section 3).

## 2 POLICY SCOPE- WHO THIS POLICY APPLIES TO AND ANY SPECIFIC EXCLUSIONS

2.1 This Policy applies to all members of staff working within UHL who are involved in any aspect of Policy and Guideline development and use.

2.2 This policy applies to all policies and guidance documents (P&Gs) used in the Trust, as defined in Section 3 and includes those P&Gs that apply to single departments as well as those with Trust-wide implications.

2.3 The policy does not apply to the development and approval of strategy documents. These should be reviewed and approved by the relevant Trust committee.

## 3 DEFINITIONS AND ABBREVIATIONS- IN ALPHABETICAL ORDER

3.1 **Approval Body** is the body authorised to approve certain categories of P&Gs. For Category A documents this is the Trust Board. For Categories B and E this is the Policy and Guideline Committee and for Category C this is the CMG Board with responsibility for Quality and Safety.

### 3.2 Associated Documents

3.3 Associated documents are other UHL policies or guidelines that are separate from but have relevance to the P&G in question

### 3.4 Document Categories

The scope of P&Gs documents will vary with some just being applicable to one department or a specific staff group whilst others will apply to every member of staff in the Trust.

Definitions of Categories used within UHL are as follows:

**Category A– Trust wide P&G Documents –** are those which the document must be approved by the Trust Board. They will fall into two types; either the Trust Board will have reserved to itself the power to approve such documents or otherwise an external body will require that the Trust Board must approve the document.

**Category B –** are those P&Gs that are to be used by staff outside of one CMG or Corporate Directorate.

**Category C** – are those P&Gs that are to be used entirely within one CMG or one Corporate Directorate. but which do not require explicit Trust Board approval.

**Category E – External P&Gs –** are those P&Gs which have been developed by UHL alongside external organisations and where PGC have authorised a deviation from Trust format at the request of the Trust lead for the document.

### 3.5 Guideline

A **guideline** is a statement by which to determine a course of action. A guideline aims to streamline particular processes according to a set routine or sound practice. By definition, following a guideline is never mandatory. Guidelines are not binding. Reasons for deviation from the guideline are possible but must be fully justifiable and agreement from senior management sought in all cases of any doubt. Guidelines are mainly used in the clinical setting where they provide a clear indication of the best choices for the management of a patient's clinical condition. Guidelines may relate to an overarching policy but can be stand-alone. Where more specific clinical detail is required this may be contained within a supporting procedural document.

### 3.6 Policy

***A statement of the Trust's agreed position and governing principles relating to particular issues or situations***

An overarching statement of what is required by the Trust and describes the scope of that statement and associated roles and responsibilities. The procedural methods of how this will be achieved, may be contained within the policy document, often as an appendix.

### 3.7 Procedures, Protocols, Standard Operating Procedures

Policies and Guidelines will often have at least one or two of the above, which support implementation of the Policy of Guideline.

All of these documents should have an overarching Policy or Guideline.

**a) Procedures**

***A set of actions which is the official or accepted way of doing something. Reasons for the deviation should be recorded.***

Procedures define the practical steps to be taken to achieve compliance with a policy and / or guideline. Procedures can be clinical (e.g. inserting a nasogastric tube, administering an intravenous drug, etc) or non-clinical (e.g. applying for a car parking pass).

**b) Protocol**

**A detailed plan of how to carry out an action (clinical or non-clinical) and predominantly used in research**

**c) Standard Operating Procedure**

**Prescribed or established methods to be routinely followed in respect of designated procedures or in designated situations. Standard Operating Procedures are a nationally recognised term in Pathology and Pharmacy and should not be confused with the term 'Procedures' as defined above.**

*Very often SOPs are written to minimise health and safety risks. Senior management agreement must be obtained for any proposed deviation.*

### 3.8 Supporting References

Supporting references will be the list of external evidence used to underpin the P&G document e.g. national policies and guidelines, published research, journal articles, internal audit reports.

## 4. ROLES – WHO IS RESPONSIBLE FOR WHAT

### 4.1 Board Director Responsibility

4.1.1 The Director of Corporate and Legal Affairs has executive responsibility for this policy and is the person charged with notifying the Trust Board of any developments in this area.

4.1.2 The Chief Nurse, acting through the Director of Clinical Quality has responsibility for ensuring that the Policy and Guideline Library (PAGL) is adequately maintained and that management reports about the state of PAGL and all Guidance documents covered by this policy are produced as required.

4.1.3 The Medical Director has responsibility for the appointment of the Chair of the Policy and Guideline Committee (PGC).

### 4.2 Corporate and Clinical Directors

4.2.1 Directors, whether Clinical or Corporate, are responsible for identifying the need for guidance documents that support the services for which they have responsibility which will include appointing a Trust Lead for each guidance document . In addition they must ensure that any such documents are developed in line with this policy, appropriately stored, reviewed and archived, and that the guidance within the document does not conflict with any other guidance document within the Trust.

4.2.2 Directors,whether Corporate or Clinical, are responsible for ensuring that processes for approving P&Gs in their area (Category C) fulfil the requirements of this policy.

### 4.3 Trust Lead for a policy of guidance document

A Trust Lead has responsibility for

4.3.1 Ensuring the development, contents (including the maintenance of any hyperlinks used within the guidance), consultation, approval, storage, dissemination and archiving of their guidance documents. Where the document is stored and archived within PAGL then CEPSO upload and archive the document.

4.3.2 Ensuring that there is appropriate representation of 'experts' in the development stage including any requirement to involve a Non-Executive Director or Trust committee.

4.3.3 Ensuring robust evidence and national guidance documents such as NICE are used to inform the P&G recommendations where applicable

4.3.4 Making sure any policy covering new roles and procedures are in line with service need and other policies, i.e. the UHL Core Training Policy, Trust Ref B21/2005.

4.3.5 Ensuring the consultation is appropriate and involves all necessary staff groups and specialties

4.3.6 Implementing the P&G including identification and actioning of any training, financial or other implementation issues including appropriate monitoring and audit.

4.3.7 Ensuring dissemination of approved guidance to all necessary staff groups

4.3.8 Identifying appropriate timescales and leading on the review of the P&G

4.3.9 Ensuring the document content and layout meet the standards as detailed in this policy.

4.3.10 Ensuring the submission of both the draft guidance document and required proformas to the approval body (see Appendix 4)

4.3.11 Following submission to the Approval Body for its consideration to ensure that any required action is undertaken within two months of consideration of the guidance by the Approval Body.

### 4.4 UHL Staff Members

4.4.1 All members of staff are responsible for complying with guidance which applies to them.

4.4.2 All UHL staff are responsible for informing relevant managers and clinical leads if there are any implementation or compliance issues with policies or guidance and for participating in the monitoring of compliance as applicable.

### 4.5 UHL Policy and Guidelines Committee

4.5.1 The Policies & Guidelines Committee reports directly to the Executive Team.

4.5.2 The Committee is responsible for reviewing all category A; B and E policies and guidelines (as defined in section 3.4) and either approving them for adoption, (with or without further amendments), or recommending them onward for approval and adoption by the Trust Board where appropriate.

4.5.3 The Committee is responsible for receiving details of all Category C policies and guidelines approved by the CMGs for noting.

4.5.4 The Committee is responsible for approving Policy and Guideline Libraries.

## 5 DELIVERING/IMPLEMENTING THE POLICY – WHAT TO DO AND HOW TO DOIT

**This section provides detailed information on the format, content and approval of a P&G document which is further supported by Appendices**

### 5.1 Developing Policies and Guidance Documents

Prior to commencing work on developing a new P&G, confirmation should be sought, as to whether a similar P&G is already under development, or is planned; also to identify whether any related or overlapping P&G exists.

In order to confirm the above, one of the following should be contacted:

a) CMG Quality and Safety Board (if one in place and is applicable to the P&G being developed)

b) The Trust Administration Office or Clinical Effectiveness Project Support Officer (CEPSO) can also be contacted for advice. (claire.stanley@uhl-tr.nhs.uk)

(c) Appendix 4 should be used to confirm that all aspects of P&G development have been appropriately considered. This checklist is used by the P&G Committee to appraise submitted Trust-wide P&Gs and should be used by appropriate committees approving Category C P&Gs.

### 5.2 Format of Policies and Guidance Documents

#### 5.2.1 Format

The UHL policy and guideline templates are given in Appendices 1-3 must be used depending whether the document is a policy, Category B guideline or Category C guideline respectively. Following these templates will ensure that all P&G requirements are met.

Any existing P&Gs not using the UHL P&G format and structure must be re-formatted, using the new template, at their next review.

#### 5.2.2 P&G Front / Back Page

All Policy documents must have the following on their front page (see Appendix 1 for Trust Policy Template):

a) University Hospitals of Leicester NHS Trust logo
b) Clear Title which succinctly and accurately reflects the content
c) Name of approving committee or group
d) Date of Original Approval
e) Trust Reference Number
f) Version Number
g) Previous version reference
h) Trust Lead
i) Board Director Lead
j) Date of latest Approval
k) Next review date
l) UHL Standard Footer Format – as used in this document

For guidelines some of this information will be elsewhere within the document (see Appendix 2 for trust guideline template).

### 5.2.3 P&G Footers

The following information must be included in the footer of all policies and guidelines

| **Insert title of document** | **Page x of y** |
|---|---|
| Version No [x] Approved by: [insert approving committee] on [insert date] Trust ref: [xx]Next Review: [insert date] | |
| **NB: Paper copies of this document may not be most recent version. The definitive version is held on INsite Documents** | |

### 5.2.4 Technical Requirements

The Policy and Guideline templates are available as stand alone documents on PAGL for use by the authors of policy and guidance documents. The technical requirements are:

a) All documents to be in Arial font size 11 or 12pt
b) Margins to be justified
c) Line spacing should be set at 1 or single
d) Paragraph spacing should be set as 6pt after the paragraph
e) Paragraphs should be numbered and sub-numbered for ease of reference, use alphabet bullet points for long lists.
f) The use of bold and / or underline may be used to help headings and / or sections stand out.

## 5.3 Content of Policies and Guidance Documents

### 5.3.1 Policy Information

Policy documents must contain the following (see Policy template in Appendix 1 for further information unless otherwise stated):

a) Contents Page
b) Details of any changes made
c) Suitable key words that will aid with search in PAGL
d) Introduction and Overview

e) Policy Scope

f) Definitions and Abbreviations – where applicable- if None write 'None'.

g) Roles- Who does what

h) Delivering the Policy–what needs to be done including details of any Associated Documents or associated procedures (which may be appendices to the policy)

i) Educational and training requirements

j) Process for monitoring compliance with clearly stated audit indicators, timescales and lead (see the table as part of the template)

k) Equality Statement (see section 6.6.2 for further information)

l) Supporting references, evidence Base and Related Policies

m) Process for version control, document archiving and review of the Policy (see section 6.8 for further information)

n) Appendices – where applicable

**5.3.2 Guideline documents must contain:** (see guideline template in Appendix 2 for further information unless otherwise stated):

a) Document Header

b) Introduction and details of who the Guideline applies to

c) Standards and Procedures (including flowchart)

d) Education and Training Requirments

e) Details of how compliance will be monitored

f) Details of supporting references

g) Keywords

h) Contact and Review Details.

**5.3.3** Protocols, Procedures and SOPs must also use the guideline template to ensure standardisation of documents.

## 5.4 Legal Implications of Policy and Guidelines Documents

Policy and Guideline Leads (both at drafting stage and at review stage) should consider possible legal implications of any practices introduced, authorised, or prohibited. For further advice contact: Head of Legal Services on 0116 258 8960.

## 5.5 Approval mechanism for Policies and Guidelines

5.5.1 All proposed category A,B and E P&G documents must be submitted by the Trust Lead to the UHL Policies and Guidelines Committee via the Trust Administration Office along with the required proformas which appear as Appendix 4 to this policy.

5.5.2 Any P&G submitted for approval, either at CMG or Trust level, must have been through an appropriate review and consultation process beforehand.

5.5.3 All new P&Gs, of whatever category, must be formally approved and given a Trust Reference Number via Trust Administration before being implemented.

## 5.6 Process for Submitting Policies and Guidelines to the Approval Body

5.6.1 All submitted P&G documents must be accompanied by a completed:

a) P&G Checklist (Appendix 4)

### 5.6.2 Equality Issues

a) When drafting P&Gs, due care should be taken to ensure they do not contain or could be interpreted as containing any matters of a discriminatory nature, including but not limited to age, sex, race, culture or sexual orientation.

b) When drafting a policy an impact assessment must be completed using, in the first instance, the Initial Equality Impact Assessment Screening Tool contained within Appendix 3.

c) If an adverse impact is likely a full impact assessment should be undertaken with support from the Service Equality Team (ext 4382). Any changes made as a result of the impact assessment need to be consulted on (UHL's Service Equality Panel undertake this function) and the full impact assessment submitted to the Approval Body alongside the policy and Appendix 3.

d) All P&G documents should include the following statement to confirm that an Equality Impact assessment has been carried out:

> **The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.**
>
> **As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.**

e) For further advice on these issues, contact the Service Equality Manager on 0116 258 4382

### 5.6.3 Consultation

a) Consultation should confirm that appropriate elements of the P&G have been considered, and that plans are in place to address any issues identified.

b) Consultation should specifically include key stakeholders.

c) Where consultation has been included as part of a meeting, this should be clearly documented in the meeting minutes and must be made available as part of the P&G Document Approval process if requested by the Approval Body.

d) Areas for the Trust Lead to consider for consultation could include but are not limited to:

- Finance
- IM&T
- Estates
- Human Resources
- Safety and Risk
- Legal
- Equal opportunities
- Education/training/research

e) If the policy has an impact upon patients or is a major departure from current practice, patient or patient representatives must form part of the consultation process as required by section 242 of the Health and Social Care Act (2001).

### 5.6.4 Administration Process

There are several aspects of P&G implementation that need to be taken into consideration as part of their development. These details must be fully documented in the Admin Proforma which forms part of Appendix 4 which must be submitted with the policy or guideline for approval to the Approval Body

**a) Financial Implications**

Where there may be financial implications to implementing a policy or guideline, these should be discussed with the relevant managers in the early stages of development.

**b) Education and Training**

Advice should be sought from the relevant Education / Training teams if the policy or guideline is introducing a new area of practice or will require different skills.

Details of education and competency assessment must be provided in those policies and guidelines concerning extended working practices.

Where training needs are identified as part of the implementation plan, a 'training needs analysis' should be undertaken, to include details of which staff groups require training, the frequency of training, and who will be responsible for providing the training

Anything that may be deemed statutory or mandatory must be approved by the UHL Workforce Education Development Group before the Policy is put forward for approval.

**c) Dissemination of Policies & Guidelines**

The responsibility for dissemination remains with the Trust Lead. Details of how a P&G will be disseminated to the relevant staff groups should be stated on the P&G Admin Proforma (Appendix 4).

Although all P&Gs will be uploaded onto PAGL or other approved library (see paragraph 6.8.4 below) for immediate accessibility, it cannot be assumed that all staff will be aware of the new / revised version. Therefore part of the dissemination plan needs to consider raising awareness and encouraging staff to read the document.

## 5.7 Process for Approving Policies and Guideline Documents

### 5.7.1 Category A – P&G Documents requiring Trust Boad approval

Category A P&Gs require Trust Board approval but should be initially submitted to the UHL Policies & Guidelines Committee for review as detailed in section 6.7.2.

### 5.7.2 Category B – P&G Documents for implementation beyond one CMG or Corporate Directorate

a) Category B P&G Documents will be approved by the Policies & Guidelines Committee (P&G Committee) on behalf of the Trust Board or may be referred to the Trust Board for further review and approval, if felt more appropriate by the P&G Committee.

b) Where a P&G has significant Trust-wide implications it is expected all relevant CMG Directors, Managers and Executive Directors will be consulted as a minimum before the document is submitted to the P&G Committee for approval.

c) Following review of the P&G document, the UHL P&G Committee will either:

   i. Approve in full

   ii. Approve subject to required changes to be made within 2 months of conditional approval.

   iii. Not approve – any changes to be made and P&G to be resubmitted for future P&G Committee's review within two months of meeting at which decision wasmade.

### 5.7.3 Category C – Local P&G Documents

a) Once final draft stage is reached Category C P&G documents must be submitted for approval to the relevant CMG or Corporate Directorate Approval Body. Such Approval Body shall also be required to consider a completed version of Appendix 4 of this policy to assist members of the Approval Body with their decision making.

### 5.7.4 Adoption of Category E – External P&Gs – UHL's Approval Process

a) All guidance documents that have been written by external bodies to the Trust, but which are to be adopted by the Trust, must have a UHL Trust Lead Officer and UHL Board Director Lead identified to confirm their relevance to the organisation. The Lead Officer may have been involved in the development of the external guidance document.

b) If the P&G is to be implemented in only one CMG or Corporate Directorate then the document should be approved by the Category C approval process.

c) If the P&G affects more than one CMG or Corporate Directorate then the document must be submitted to the UHL P&G Committee for approval.

d) P&G Committee may raise areas of concern in which case the UHL Trust Lead will be expected to feed these concerns back to the external guidance lead author for consideration at the next P&G review.

### 5.7.5 Trust P&G Documents Requiring Urgent Approval

a) Where there is a policy or other guidance document that needs to be 'fast tracked' due to clinical expediency or legal requirements, the Chair of the Policy and Guideline Committee has authority to approve category B and E documents and should be contacted via Trust Administration for Chair's action.

b) When sending the policy or guidance for Chair's action, the Trust Lead also needs to provide a completed Appendix 4.

c) Once contacted, the Policy and Guideline Committee Chair will consider the necessity of fast-tracking and, once satisfied, will ensure there is clarification about the development process of the document. The Chair will thereafter seek specific consultation from at least two relevant Policies and Guidelines Committee members as a matter of urgency.

d) Following review of the P&G and supporting documentation, in collaboration with other Policy and Guideline Committee members as applicable, the Chair would then be able to advise whether the policy or guidance document met the agreed criteria for approval. All such approvals must be reported to the next meeting of PGC for ratification.

## 5.8 Process for P&G Document Registration, Version Control and Archiving

### 5.8.1 Registration of P&Gs

a) Following approval, P&Gs need to be sent to the Trust Administration Office for allocation of a Trust reference number before being implemented.

b) All UHL Category A, B, C and E P&Gs are recorded on the Trust's P&G Register, maintained and kept up to date by Trust Administration.

c) All versions of documents on the same subject will aim to keep the same Trust Reference Number with a different version number used for each update

### 5.8.2 P&G Referencing ('Key-wording')

a) To ensure effective searching, the P&G document should identify relevant keywords which will be support easy identification. These should be listed on the Contents Page.

### 5.8.3 P&G document control

a) All P&Gs should identify the current version of the document.

### 5.8.4 P&G Archiving

a) All Policies and Guidelines must be archived within PAGL unless expressly agreed otherwise by the Policy and Guideline Committee in writing. P&Gs will be archived by the Clinical Effectiveness Team. The only other systems accepted within the Trust where archiving is permitted are eQMS for Pathology SOPs, Q Pulse for Cancer and Clinical Haematology Category C P&Gs and Badger for Neonatal Category P&Gs.

## 5.9 Uploading of Category A, B and E P&Gs

All Category A, B and E policies and guidelines must be referred to the CEPSO for uploading.

## 5.10 Uploading of Category C P&Gs

a) Following approval by the Approval Body all Category C documents must be sent to CEPSO together with a copy of the minute approving the document. CEPSO shall then ensure that the document is uploaded into PAGL and that any previous version is archived.

b) PAGL automatically archives previous versions of the new document when the new version is uploaded. Where, following agreement in writing from PGC, documents are not stored within PAGL (see 6.8.4) suitable alternative arrangements must be in place to ensure expired versions of P&Gs are removed from circulation but are accessible if needed for reference (e.g. as part of a claim or investigation). Advice on retention periods can be sought from Trust Administration or the Head of Privacy.

c) UHL's previous intranet document management systems may continue to hold previous versions of archived P&G documents. For access to archived documents contact the CEPSO (claire.stanley@uhl-tr.nhs.uk ext 4307).

## 5.11 Freedom of Information

Policy authors should note that as part of our legal commitment to maintain a Freedom of Information Act Publication Scheme, Trust-wide policies may be published on the Trust's external public website.

## 5.12 Policy and Guideline Review

### a) P&G Review Dates

The first review of a new policy or guideline by the Appoval Body mudt takek place within 18 months of the date of first approval. Subsequently each Approval Body should review a policy or guideline no later than three years past the latest approval date.

### b) Minor Changes

If minor changes are required to the policy before its formal review date, then these can be presented to PGC. The Chairman of PGC has discretion to invoke the Minor Approvals Process which does not require the amendment to be placed before a full committee and which,in effect, mirrors the fast-tracking process **(see paragraph 5.7.5 above).**

Minor changes could be an update to a form that is attached to the document as an appendix, job title changes or due to new national guidance which does not materially change the scope or intention of the P&G.

**c)** Approval of minor changes without full consultation, submission of proforma etc will be at the discretion of the Chairman of PGC or the PGC itself where the Chairman has decided that use of the minor amendments process is inappropriate. **All such approvals must be reported to the next meeting of PGC for ratification.**

### 5.13 Submitting Reviewed P&Gs for Approval

The process for submitting fully reviewed and / or updated documents to the Approval Body is the same as for the development and approval of new documents.

**a) Changes made**

Upon submission of a reviewed and/or revised P&G, details of changes or additions to the policy must be described within the document. Where only a few changes made, these should be detailed after the contents page. If substantial changes made, a covering letter describing these should accompany the document. Where the P&G has been completely rewritten, this should be explicitly stated after the contents page.

**b) No changes made**

If a P&G has been reviewed and supporting evidence checked but no changes are needed, there should be a statement to say that the document has been reviewed and is 'fit for purpose' and that the original supporting evidence is still applicable. This should be documented under the Contents page.

### 5.14 Delayed Reviews and Extending the Review Period

a) Any document not submitted to the Approval Body by the Review Date must be referred to the Approval Body with details of

- rationale for delay
- anticipated timescales for submission to Approval Body.
- any associated risks and how they will be managed.

b) The Approval Body will then assess whether the Review Date can be extended or whether the document needs to be removed from circulation

c) Any delayed Category C P&Gs must be referred to their approving committee for review in line with the above

## 6 EDUCATION AND TRAINING FOR THIS POLICY

6.1 For further advice or clarification regarding the developing P&Gs or the approval process, please contact:

- Corporate Policies - the Trust Administration Office – (0116 258) 8950
- Clinical Policies & Guidelines – Senior Nurse – Clinical Practice Development (0116 250) 2747 or Head of Outcomes & Effectiveness – (0116 258) 4330
- Category C P&Gs – the Clinical Effectiveness Project Support Officer (0116 258) 4307

6.2 Training sessions on policy and guidance development, literature searching and reviewing the clinical evidence is available via UHL Libraries – http://www.uhl-library.nhs.uk/

## 7 PROCESS FOR MONITORING COMPLIANCE

7.1 The audit criteria for this policy and the process to be used for monitoring compliance are given in the table below:

| Element to be monitored | Lead | Tool | Frequency | Reporting arrangements |
|---|---|---|---|---|
| All P&Gs will have a Trust Reference Number | STA | Report run from PAGL on annual basis to cross match with Trust Admin P&G Register | Annually | PGC |
| All P&Gs will be reviewed to | HOE | Report run from PAGL on monthly basis to confirm | 1 mthly | PGC |

| | | | | |
|---|---|---|---|---|
| monitor that they are within their stated review date | | which P&Gs are within review timescales | | |
| No P&G's to be visible outside of permitted Library | HOE | Audit | Quarterly | PGC |

## 8 EQUALITY IMPACT ASSESSMENT

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

## 9 SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

11.1 Related Policies

a) Equal Opportunities Policy

b) UHL Clinical Audit Policy

## 10 PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

10.1 Once this Policy has been approved by the UHL P&G Committee, Trust Administration will allocate the appropriate Trust Reference number for version control purposes.

10.2 The updated version of the Policy will then be uploaded and available through INsite Documents and the Trust's externally-accessible Freedom of Information publication scheme. It will be archived through the Trusts PAGL system

10.3 This Policy will be reviewed every three years and it is the responsibility of the Trust Lead for this Policy to commission the review

**APPENDIX 1**

**POLICY TEMPLATE (available as a stand alone document on INsite)**

University Hospitals of Leicester NHS
NHS Trust

# Policy Title

| | |
|---|---|
| **Approved By:** | |
| **Date of Original Approval:** | |
| **Trust Reference:** | |
| **Version:** | |
| **Supersedes:** | |
| **Trust Lead:** | |
| **Board Director Lead:** | |
| **Date of Latest Approval** | |
| **Next Review Date:** | |

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### REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

Details of changes made to the policy since the previous version must be clearly identified here or if significant changes are made these should be attached as a separate Appendix. If the document is a complete re-write then this must also be documented here.

### KEY WORDS

List of words, phrases that may be used by staff searching for the Policy in PAGL

### FOOTER

The Policy 'footer' must contain details of Policy Title and approval date, etc as per example in this template

In addition to guidance in section 6.2 of the main policy please note the following:

Unless otherwise stated a heading with an underline must be used as it is integral to the template.

If a heading is not underlined this is to be removed from the template as this is for information only

## 1 INTRODUCTION AND OVERVIEW

Overview of the document/setting the scene – example of opening sentence given below.

**1.1** This document sets out the University Hospitals of Leicester (UHL) NHS Trusts Policy and Procedures for …….

## 2 POLICY SCOPE –WHO THE POLICY APPLIES TO AND ANY SPECIFIC EXCLUSIONS

Who does this policy apply to?

**2.1** All UHL Policies must clearly state the staff groups / professions that they apply to.

**2.2** They should also identify whether there are any qualifications and competencies that must be held by staff using the Policy and cross reference made to the education and training section if specific training is required.

**2.3** Where Policies relate to patient care, the scope should also clearly state which group of patients, areas of the Trust are covered by the document

**2.4** If it would be helpful to emphasise that certain areas are excluded from the policy then do so here and signpost where further guidance can be sought for those areas.

## 3 DEFINITIONS AND ABBREVIATIONS

A description of any terms used in the document – remove this section if none state 'None'. If there are any then place them in alphabetical order for ease of identification.

## 4 ROLES – WHO DOES WHAT

An overview of the individual, departmental and committee roles and responsibilities, including levels of responsibility and any education and training requirements

### 4.1 Responsibilities within the Organisation

Include all those who are required to support/use/comply with the policy for example (use job titles rather than names):

a) Identify the Board Director Lead- every Policy must have one.

b) Does a Non-Executive Director have a role to play?- if so state it.

c) Consider who will support the implementation process and if appropriate describe their roles so that it is clear who is responsible for what.

d) All staff-if your policy applies to all staff (or a broad range) then describe what the least knowledgeable staff member will need do-if only to state who they to seek further guidance from eg their Line Manager

e) If relevant describe the role of committees that support the policy.

## 5. POLICY IMPLEMENTATION AND ASSOCIATED DOCUMENTS –WHAT TO DO AND HOW TO DO IT

This section should detail the requiremens of the policy and how they will be achieved.

Where appropriate include details of Associated Documents. If there are no Associated Documents state: Associated Docuements –None.

## 6 EDUCATION AND TRAINING REQUIREMENTS

Identify whether there are any training requirements or required competancies needed to implement your policy. Where it is safe to do so you may wish to simply cross-reference to the

## 7 PROCESS FOR MONITORING COMPLIANCE

7.1 All Policies must include details of audit standards or key performance indicators that will be used for monitoring compliance and effectiveness and the frequency of monitoring / audit. These must be set out in the Policy Monitoring table set out below.

7.2 Key indicators should relate to the aims and objectives of the policy and be based on policy standards

7.3 The monitoring table must also identify who is responsible for conducting and or leading the monitoring, the methodology to be used and process for reviewing results and taking action to improve performance where appropriate.

7.4 Advice on the most effective methodology, both in terms of measuring the success of the document and using the minimum resources in doing so, can be sought from the Clinical Audit Team.

## 8 EQUALITY IMPACT ASSESSMENT

If the policy will have any impact on equality, this should be described here. Otherwise the statements below should be inserted (see section 6.6 of the UHL Policy for Policies for more detail):

8.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

8.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

## 9 SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

Part of the Policy development should be to review other similar documents and published literature in order to ensure the P&G recommendations are based on latest evidence.

Policy documents should include details of any evidence used, this will be particularly relevant to clinical policies.

Any supporting Policies or Guidelines referred to in the P&G document should be 'signposted'.

Key supporting references should be cited in full and should include name of author, title of article / book and publisher / date of publication

Provide details of supporting references and the type of evidence used, as applicable.

## 10 PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

This section should identify the process for tracking version control and archiving both current and previous versions of the document.

Example wording:

Review details must be described in the Policy and must give details of timescale and who will be responsible for review and updating of the document.

The updated version of the Policy will then be uploaded and available through INsite Documents and the Trust's externally-accessible Freedom of Information publication scheme. It will be archived through the Trusts PAGL system

## POLICY MONITORING TABLE

The top row of the table provides information and descriptors and is to be removed in the final version of the document

| What key element(s) need(s) monitoring as per local approved policy or guidance? | Who will lead on this aspect of monitoring? Name the lead and what is the role of other professional groups | What tool will be used to monitor/check/ observe/asses/ inspect Authenticate that everything is working according to this key element from the approved policy? | How often is the need to monitor each element? How often is the need complete a report ? How often is the need to share the report? | How will each report be interrogated to identify the required actions and how thoroughly should this be documented in e.g. meeting minutes. |
|---|---|---|---|---|
| **Element to be monitored** | **Lead** | **Tool** | **Frequency** | **Reporting arrangements Who or what committee will the completed report go to.** |
| | | | | |
| | | | | |
| | | | | |
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| | | | | |
| | | | | |

**Category A or B or E GUIDELINE TEMPLATE (available as a stand alone document on INsite)**

| **……..Guideline..** | University Hospitals of Leicester NHS<br>NHS Trust<br>**Insert Trust Reference Number here** |
|---|---|

## 1. Introduction and Who Guideline applies to

*Brief explanation of purpose of guideline **and users**, i.e. does it cover all staff, specific groups of staff or specific patient groups and in what circumstances i.e. when*

## 2. Guideline Standards and Procedures

*This section may include or comprise a flow chart but in any event should be set out in a logical order.*

## 3. Education and Training

*Are there any new skills required to implement the guideline? Is a training programme being provided to support implementation or is it more a case of 'awareness raising'*

*If there are no education or training requirements please state 'None'.*

## 4. Monitoring Compliance

| What will be measured to monitor compliance | How will compliance be monitored | Monitoring Lead | Frequency | Reporting arrangements |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

## 5. Supporting References (maximum of 3)

*If None say NONE*

## 6. Key Words

List of words, phrases that may be used by staff searching for the Guidelines on PAGL If none – state none.

| CONTACT AND REVIEW DETAILS | |
|---|---|
| **Guideline Lead (Name and Title)** | **Executive Lead** |
| **Details of Changes made during review:** | |

**Category C GUIDELINE TEMPLATE (available as a stand alone document on INsite)**

| **Insert Title which must include details of the CMG / Directorate that it applies in.** | University Hospitals of Leicester NHS<br>NHS Trust<br>**Insert Trust Reference Number here** |
|---|---|

## 1. Introduction and Who Guideline applies to

*Brief explanation of purpose of guideline **and users**, i.e. does it cover all staff, specific groups of staff or specific patient groups and in what circumstances i.e. when*

## 2. Guideline Standards and Procedures

*This section may include or comprise a flow chart but in any event should be set out in a logical order.*

## 3. Education and Training

*Are there any new skills required to implement the guideline? Is a training programme being provided to support implementation or is it more a case of 'awareness raising'*

*If there are no education or training requirements please state 'None'.*

## 4. Monitoring Compliance

| What will be measured to monitor compliance | How will compliance be monitored | Monitoring Lead | Frequency | Reporting arrangements |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

## 5. Supporting References (maximum of 3)

*If None say NONE*

## 6. Key Words

List of words, phrases that may be used by staff searching for the Guidelines on PAGL. If none – state none.

| **CONTACT AND REVIEW DETAILS** | |
|---|---|
| **Guideline Lead (Name and Title)** | **Executive Lead** |
| **Details of Changes made during review:** | |

| P&G GOVERNANCE ASSURANCE TEMPLATE | University Hospitals of Leicester NHS<br>NHS Trust<br>**Appendix 4 updated April 2020** |
|---|---|

| **Name of P&G:** | | | |
|---|---|---|---|
| **P&G Author / Reviewer** | | **Senior Responsible Officer / Committee** | **Board Lead** |
| | | | |
| **Is it a New or Reviewed P&G?** | **New / Review** | **If Review, is this because due for Review or because of Local/National Changes etc?** | |
| **If Review, Have any changes been made?** | **Y / N** | **If Changes, are these clearly indicated at the beginning of the document, to include removed sections if applicable?** | **Y / N** |

| **Key Words to be assigned to the document in the P&G Library in order to facilitate searching** *(to include frequently used/recognised words not in the title but in the document content):* |
|---|
| |

**Who does this document apply to?**

| **Key Individuals; Committees/Groups; Specialties/Departments Staff Groups, Patients and Others)**<br>*(please specify each of the above as applicable. Add more rows if required)* | **Consulted Yes/No** | **Accepted Yes / No*** |
|---|---|---|
| | | |
| | | |

*If No, please provide details below or on separate sheet.

**Which of the following have been undertaken and approved by the relevant Senior Responsible Officer /Committee or Board Level Lead?**

| **P&G Governance** | **Under-taken?** | **Approving Senior Responsible Officer / Committee or Board Level Lead** |
|---|---|---|
| Consultation Process | | |
| Education/Training Requirements Assessed and Plans to address made | | |
| Equality Impact Assessment | | |
| Process for Monitoring Compliance/Risk Assessment of non-compliance | | |
| Plans for Implementation and Dissemination | | |
| Associated Local/National Guidelines/Policies and Published Literature Reviewed and any relevant changes reflected in the Document | | |

All documents within PAGL are also published automatically on the Trust's external website, **unless** such publication would enable a person to endanger their own health/safety or that of another person. An example of this is the Anti Ligature Policy, which is not available on the Trust's external website due to a national Patient Safety Alert.

| **Publication on the Trust's external website** | |
|---|---|
| Will publishing this guidance document on the Trust's external website enable a person to harm themselves or others? If YES please explain. | **Yes/No*** (delete as appropriate) |

In submitting this Governance Assurance Template I confirm that the above governance process has been endorsed by [INSERT Name and Job Title of Senior Responsible Officer / Committee or Board Level Lead].

Author Name: Job Title Date

## P&G GOVERNANCE ASSURANCE TEMPLATE – COMPLETION GUIDE

| **Name of P&G:** | *Title of the Policy or Guideline that is being submitted to the relevant Approving Committee* |
|---|---|

| **P&G Author / Reviewer** | **Senior Responsible Officer / Committee** | **Board Lead** |
|---|---|---|
| *Name of the person who has been asked to write the P&G or review it* | *Name of the Senior Manager/Clinician (eg Head of Service, CMG Director/Head of Ops, Corporate Head of Department, Head of Nursing, Director) who has senior responsibility for the area of scope covered by this P&G or Committee which has 'commissioned' the P&G and oversees implementation and monitoring* | *Member of the Trust Board who has this P&G in their Portfolio (eg Medical Director, Chief Nurse, Director of OD)* |

| **Is it a New or Reviewed P&G?** | **New / Review** | **If Review, is this because due for Review or because of Local/Changes etc?** | *Eg New NICE Guidance, Changes to Legislation, 3 year Review* |
|---|---|---|---|

| **If Review, Have any changes been made?** | **Y / N** | **If Changes, are these clearly indicated at the beginning of the document, to include exclusions?** | **Y / N** |
|---|---|---|---|

*If using the old P&G format template, a summary of key changes should be described at the beginning of the Policy after the Title, Author etc or at the end of the Guideline. In the new template changes are at the bottom for both P&Gs*

| **Key Words to be assigned to the document in the P&G Library in order to facilitate searching:** |
|---|
| *For example in the Guidelines to Prevent Venous Thrombo-embolism document these could be VTE Prevention, Thromboprophylaxis, LMWH,* |

**Who does this document apply to and who therefore needs to have been consulted prior to submission for approval?**

| **Key Individuals; Committees/Groups; Specialties/Departments - to include Staff, Patients and Others** ***(add more rows as applicable)*** | **Consulted Yes/No** | **Accepted Yes / No*** |
|---|---|---|
| *Departments/Specialties – to consider if applies specifically to just one area of the Trust or will apply to multiple Departments/Specialties, all areas of the Trusts.*<br><br>*To also consider if associated Departments will need to support implementation eg Nutrition Guidelines may apply to Facilities, Catering Department as well as Medical, Nursing, Dietetic and Speech and Language Therapy staff* | *Consultation should be a proactive process, particularly for any new P&Gs*<br><br>*Even if no changes made following Review of a P&G, it would still be appropriate to consult key 'stake holders'. It may be they are aware of other associated guidance that has changed or have experienced implementation challenges.*<br><br>*The amount of consultation will obviously depend on the scope of the P&G.* | *Where Consultees feedback any concerns or queries regarding the P&G, these should be considered by the Author / Reviewer, with input from the Senior Responsible Officer / Committee as applicable*<br><br>*Where concerns raised or changes suggested are not considered to need action or to be appropriate, this information and rationale should be included in the Proforma* |
| *Key Individuals – staff groups eg Nursing, Portering Staff, All Clinical Staff, All UHL Staff, All staff working in xxxxxxxxxx Department, All Staff caring for xxxxxxxx patients*<br><br>*Think about which level of management needs to have been consulted - Director, Head of Department, All staff in Department* | | |
| *Patients – to consider which areas of the Trust patients may present and confirm if included or not eg, ED and Assessment Areas, Inpatient Areas only, Adults only, Children only. Patients with confirmed diagnosis*<br><br>*Whilst it may be not appropriate /practical to consult patients for all P&Gs, consideration of patient groups should prompt consultation of the staff involved in their care* | | |
| *Others – anyone not covered above* | | |

**Which of the following have been undertaken and approved by the relevant Senior Responsible Officer /Committee or Board Lead?**

| P&G Governance | Under-taken? | Approving Senior Responsible Officer / Committee or Board Level Lead |
|---|---|---|
| Consultation Process – *as described above* | | *Where there are Specialist Groups/ Committees overseeing work-streams covered by the P&G, then this should be asked to confirm that appropriate governance has been undertaken for both New and Reviewed P&Gs*<br><br>*Where there are senior clinical / managerial leads (SROs), then they should be asked to review and confirm.*<br><br>*If the P&G author/reviewer is a senior manager/clinician and there is not a relevant Committee, then the Board Level Lead should be asked to confirm.* |
| Education/Training Requirements Assessed and Plans to address made – *brief details may be included in the P&G document itself but where applicable a Training Needs Analysis and Education Programme should be discussed and approved by the relevant SRO or Committee or the Board Level Lead as applicable* | | |
| Equality Impact Assessment – *to confirm if any groups treated differently by the P&G* | | |
| Process for Monitoring Compliance – *The current P&G format template includes a Monitoring table and even if the table is not used, details of the monitoring process may be included in the P&G document itself but are not essential.*<br><br>*However, plans to monitor compliance with the P&G standards should be reviewed and approved by the relevant SRO or Committee or the Board Level Lead as applicable* | | |
| Plans for Implementation and Dissemination – *this should include consideration as to how relevant staff will be made aware of either a new or revised P&G - in addition to uploading in the P&G Library on Sharepoint* | | |
| Associated Local/National Guidelines/Policies and Published Literature Reviewed and any relevant changes reflected in the Document – *details of supporting references, relevant literature does not need to be included in the P&G but how these have been reviewed and considered should be discussed with the relevant SRO or Committee or Board Level Lead as applicable* | | |