South Norfolk Clinical Commissioning Group

Agenda item: 7.2

Subject:	**Approach to Managing Policies**
Presented by:	**Amanda Brown on behalf of Karen Barker Head of Corporate Affairs**
Submitted to:	**NHS South Norfolk CCG Governing Body**
Date:	**14 January 2014**

Purpose of paper:

To obtain the Governing Body's approval of the CCG's draft "Policy for the management of policies and standard operating procedures" attached to this paper.

Executive Summary:

It is important that the CCG has a clear and documented process for developing and reviewing its policies. This will ensure that policy development and updates reflect current guidance and legislation. In addition by ensuring a clear approach to the development and management of all policies we can make sure that risks to the organisation (including to patient care) are mitigated.

This overarching policy which sets out the CCG's process for developing policies has been produced to meet the most current NHS LA risk management standards 2013/14.

In particular section 3 of the attached policy sets out the main bulk of the proposed process for drafting and approving policies. Appendix 1 sets out a policy template for all CCG policies to follow.

Recommendation to Governing Body:

It is recommended that the Governing Body approve the attached policy.

Key Risks	
Clinical:	This policy contributes to risk management arrangements.
Finance and Performance:	Not applicable.
Impact Assessment (environmental and equalities):	N/A
Reputation:	This policy contributes to achievement of corporate standards.
Legal:	This policy contributes to the good practice guidelines incorporated into NHS LA risk management standards 2013/14.
Resource Required:	None.
Reference document(s):	NHS LA risk management standards 2013/14.

GOVERNANCE

Process/Committee approval with date(s) *(as appropriate)*	Leadership Team 19 November 2013, Governing Body 14 January 2014.

South Norfolk Clinical Commissioning Group

POLICY FOR THE MANAGEMENT OF POLICIES AND STANDARD OPERATING PROCEDURES

Ref Number:	**Version:** 1	**Status:**	Pending Approval	**Author:** A Brown/K Barker
Approval body	Governing Body		**Date Approved**	
Date Issued			**Review Date**	November 2016
Contact for Review: Corporate Affairs				

Prepared by	This Policy has been prepared and reviewed by the CCG Corporate Affairs team.
Impact Assessment	Completed.
Consultation	This is an internal document that does not need further engagement or involvement at this time.
Authorised by	Pending approval by the Governing Body
What is it for?	This document is an updated version of the former Norfolk PCT Policy *'An Organisation-wide Policy for the Development and Management of Procedural Documents'*. The purpose of the Policy is to ensure that there is a corporate approach to the development of all documents and that these reflect guidance and legislation. This will help the organisation reduce risks and ensure compliance.
Who is it aimed at and which settings?	The Policy is for use by all CCG staff and the Governing Body.
Evidence	NHS LA risk management standards 2013/14.
Other relevant approved documents	Not applicable.
References	Not applicable.
Training and competences	Not applicable.
Monitoring and Evaluation	This policy will be monitored and reviewed for effectiveness by the Corporate Affairs team on a regular basis.
Appendix	1. Template for policies. 2. Policy development checklist. 3. Checklist for review and approval of policy documents.

CONTENTS

Policy for the Management of Policies

1. Introduction and Purpose

1.1. Policies and standard operating procedures communicate the standardised approaches and decisions of the CCG to the organisation's staff and stakeholders. These documents are an essential tool of governance that bring consistency and transparency as well as contributing to the achievement of strategic objectives.

1.2. The rigorous development and management of these documents is a control mechanism for the CCG that provides assurance to the Governing Body on the consideration of relevant legal and statutory requirements, NHS policy and guidance. The purpose of this policy is to provide a standardised approach to the development, approval, management and review of policies in accordance with the NHS Litigation Authority (NHSLA) Risk Management Standards 2013/14 and other relevant guidance.

2. SCOPE AND DEFINITIONS

2.1. This policy applies to all staff working with NHS South Norfolk Clinical Commissioning Group ("the CCG").

2.2. For the purpose of this policy, the word 'policy' refers to all procedural documents i.e. policies, protocols, guidelines, strategies and pathways etc. The following definitions may be useful:

Strategy:	An overall plan to achieve longer-term objective
Policy:	A statement representing a principle adopted course of action
Standard Operating Procedure (SOP):	The established form of conducting or performing an activity as a defined series of steps or actions to meet the requirements of a policy
Protocol:	A detailed description of the steps taken / rules of behaviour
Guideline:	Advisory or good practice principles put forward to set standards or determine a course of action. Clinical guidelines do not replace professional judgement and discretion
Desk Top Procedure:	A step-by-step guide to perform a task
Patient Group Directive:	Written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment
Integrated Care Pathway:	The most appropriate care for a patient group based upon the evidence available and a consensus of best practice
Standard:	Specification of a required level of performance
Code of practice:	Specification of standards which must be met within a legal framework
Code of conduct:	Specification of standards which must be met by members of that profession

2.3. For the purpose of this document the title “Document Manager” will mean the original author and any subsequent person who is responsible for reviewing or revising the document.

2.4. A “Stakeholder” is defined as a person, group or organisation that has direct or indirect input into the CCG because it can affect or be affected by the organisation’s actions, objectives and policies.

3. Policy Development Process

This section contains the principles to be used in the development of policies.

3.1. Corporate style and format of documents

3.1.1. All policies should be written in a style which is concise and clear using unambiguous terms and language. The standard template to be used for all policy development is set out at **Appendix 1**. The basic format requirements are as follows:

- The organisational logo should be at the top right corner of the title page. If the policy is a joint policy then the partner organisation logo should be on the top left side of the title page. It should be noted that joint policies will require ratification by all partner organisations concerned prior to implementation.
- Headings should be written using font Arial with a size of 11. Bold and capitalisation may be used. Underlining should be avoided;
- The body text should be written using black Arial 11 font with additional emphasis added by use of bold. Underlining and italics should be avoided;
- All sections of the document should be numbered sequentially;
- All documents should include a footer detailing the title of the document, version number and page number.

3.1.2. The policy should be written in plain English, be concise and jargon should be avoided. Abbreviations should be explained in their first use and subsequently where necessary. For extensive documents it is appropriate to include a glossary as an appendix.

3.1.3. A checklist to help with the step by step drafting and review of a policy can be found at **Appendix 2**.

3.2. Registration

3.2.1. To avoid duplication and to promote the involvement of all relevant stakeholders the intention to develop or review a policy must be registered with the Head of Corporate Affairs. Registration of a policy can be achieved by putting in writing to the Head of Corporate Affairs the name of the new policy and what you wish it to achieve, together with any other salient details.

3.2.2. Suggestions for additional stakeholders to contact during development and/or details of similar work being undertaken will be provided as well as what would constitute appropriate consultation. The pathway for formal approval will be confirmed.

3.3. Adopting external policies

3.3.1. If the CCG intends to adopt policies of other organisations such as NHS England, or the Department of Health it is not necessary to re-write these policies into the CCG format. Where possible the policy template at Appendix 1 should be attached and completed, with a nominated Document Manager who will be responsible for CCG approval and reviews. The policy will need to follow the standard approval process.

3.4. **Consultation**

3.4.1. It is the responsibility of the Document Manager to agree and undertake the appropriate consultation on the policy document, prior to presenting the document for approval. Advice on groups/individuals to be consulted may be sought from the Head of Corporate Affairs. Any groups/individuals consulted during the development or review of the policy should be listed at the front of the policy.

3.4.2. It is good practice to give consultation periods of at least one month to ensure that staff on leave and/or staff prioritising workloads are able to give the document appropriate attention. At the end of a consultation period, where some staff have not responded, a view should be taken as to whether an appropriate proportion of those consulted have responded (given the nature of the policy) and/or whether particular individuals expected to have a key opinion have responded.

3.4.3. Staff consultation is a fundamental part of the policy approval process and should be included for most policy types but particularly for Human Resources policies where this will be facilitated by the CSU. A trial or pilot of a policy may be the most suitable method of testing. Trials may be limited to a set period of time. Document Managers should be aware that approval of the basic policy should be given before a trial, as the service will be required to act within the requirements of the new policy rather than any existing policy. The policy document will have increased legal standing and will be relevant for any investigations and for release under the Freedom of Information Act 2000.

3.4.4. The consultation undertaken will be considered at approval. Policies showing insufficient consultation for the policy topic will not receive approval. Please refer to Appendix 3 for the Checklist for Review and Approval of Policy Documents. Standard Operating Procedures are not required to follow this consultation process but consultation should still be documented and be appropriate to the subject.

3.5. **Equality, Diversity and Mental Capacity**

3.5.1. The CCG aims to design and implement services, policies and measures that meet the diverse needs of the population we serve. The public sector Equality Duty (section 149 of the Equality Act 2010) came into force on 5 April 2011. The Equality Duty applies to public bodies and others carrying out public functions. It supports good decision-making by ensuring public bodies consider how different people will be affected by their activities, helping them to deliver policies and services which are efficient and effective; accessible to all; and which meet different people's needs.

3.5.2. The Equality Duty is supported by specific duties**,** set out in regulations which came into force on 10 September 2011. The specific duties require public bodies to publish relevant, proportionate information demonstrating their

compliance with the Equality Duty; and to set themselves specific, measurable equality objectives.

3.5.3. In accordance with the CCG's commitment to Equality and Diversity, the CCG undertakes to assess the document to ensure there is no discrimination of any form that leads to disadvantage, including discrimination due to race, religion or belief, disability, gender, age and sexual orientation.

3.5.4. The CCG's Equality Impact Assessment (EIA) Tool is designed to systematically assess the impact of any document or decision. Results of the assessment must be detailed under the section heading 'Equality, Diversity and Mental Capacity Act' in the policy document. The completed EIA will need to be submitted as part of the policy approval process and will be published on the internet.

3.5.5. The CCG also undertakes to assess the document against the requirements of the Mental Capacity Act (MCA) 2005 to ensure that the rights of the patients are supported during any time when they are temporarily or permanently unable to make a decision.

3.6. **Success criteria / Monitoring effectiveness**

3.6.1. It is important to ensure that the policy document achieves its aims by successful implementation and reviewed outcome measures.

3.6.2. The Document Manager must consider monitoring arrangements to assess general implementation of the policy. The Document Manager should determine when implementation will be reviewed, by whom, using what tool and, where applicable, what sample size.

3.6.3. Non-compliance introduces risk for the individual, organisation and stakeholders. In rare circumstances, if staff members are unable to follow policy, as policy requirements cannot be applied in a specific set of circumstances, this must immediately be reported to the Line Manager who will consider remedial steps to manage the risk. Non-compliance must be reported immediately in writing to the Head of Corporate Affairs. This may prompt an early review of the policy. Compliance with CCG policies is a requirement of staff employment contracts and CCG Standing Orders. Non-compliance, other than in circumstances above and reported as such, may result in disciplinary action.

3.7. **Policy approval and ratification**

3.7.1. The Scheme of Delegation in the Constitution shows where approval has been delegated to committees. The Governing Body is accountable for CCG policy. The Governing Body may delegate to the Audit Committee, Quality & Patient Safety Committee, or the Remuneration Committee. The Governing Body will be informed of policy approvals via committee minutes.

3.7.2. There is a requirement placed on the CCG by external agencies, such as the NHS Litigation Authority, that some policies are formally approved by the CCG Governing Body and this may not be delegated (for example the Risk Management Policy). The CCG Governing Body will also be expected to approve policies with significant public interest or where enactment would require a significant change in the way the CCG operates.

3.7.3. The form in **Appendix 3** 'Checklist for the review and approval of Policy Documents' is used by the CCG Governing Body or delegated committee when approving policy documents.

3.8. **Communication and dissemination**

3.8.1. All approved policies will be made available on the CCG Staff Internet. Attention will also be drawn to new and renewed policies by staff newsletters. Relevant SOPs with Stakeholder interest will also be published on the internet. Document Managers must consider whether additional articles or dissemination routes would be appropriate, for example to stakeholders or partner organisations. This must be detailed in the policy.

3.9. **Policy implementation, training and awareness**

3.9.1. It is the responsibility of the Document Manager to ensure that any policy introduced includes consideration for the provision of training or guidance for managers and staff.

3.9.2. Advice on training arrangements must be sought via the organisation's Human Resources Team at the Commission Support Unit. Where appropriate, Human Resources will facilitate or commission on behalf of the CCG organisation wide training to accompany the implementation of policies.

3.9.3. Alternatively, it may be considered more appropriate by the Document Manager to discuss with departments or to meet individually with staff to offer general guidance or discuss specific aspects of the policy. A pragmatic approach should be taken to assessing the staff to be trained and the frequency of training. As part of the arrangements for the implementation of individual policies, the Document Manager will need to detail the specific education and training requirements for the staff operating the policy, including type and frequency of training elements.

3.9.4. Training requirements and attendance monitoring must be detailed in the policy and reflected in an update to the Training Needs Analysis (TNA). Document Managers must ensure that arrangements are in line with relevant Learning & Development Policy. Training arrangements will be considered as part of the approval process. Policies showing insufficient or unresourced training arrangements will not receive approval. Please refer to **Appendix 3 for** the Checklist for Review and Approval of Policy Documents.

3.10. **Policy review**

3.10.1. All policies will be dated using the meeting date of the approving committee. Policies will usually be given a review date of three years from this date unless otherwise agreed when the document is approved. Some documents, such as the Records Management Policy, must be reviewed on an annual basis. Where arrangements detailed in the policy are new, contentious or particularly subject to organisational change, it may be appropriate to assign a review date of 6 months, one year or a key date.

3.10.2. On occasion it may be necessary for a document to be reviewed earlier than the agreed review date, e.g. in the light of changing legislation or national guidelines. Document Managers are responsible for ensuring that documents

are reviewed following any changes to relevant legal and statutory requirements, NHS guidance and policy or applicable organisational changes.

3.10.3. The Head of Corporate Affairs will issue a reminder to the Document Manager six months prior to the stated review date. The review date must be registered with the Head of Corporate Affairs. All reviewed policies where there have been significant amendments to the content of the policy must be re-approved by the appropriate committee. Where there are no changes, or only minor changes, made to the policy this can be reported to the approving committee without sight of the policy and approval recorded in the minutes. Upon review, Document Managers should ensure that any references or links used within the document are still relevant and current.

3.10.4. After review and re-approval the policy version number and the review date will be advanced by the Document Manager (Version 1.0 would move on to Version 2.0 for example). The new document will be uploaded to the internet.

3.11. **Policy control and archiving**

3.11.1. The Head of Corporate Affairs will hold a Policy Register that will detail all policies with dates of approval, operational date and date of withdrawal (for previous versions). The Register will also list policies under development and review.

3.11.2. Record retention periods are defined in Records Management: NHS Code of Practice. The Head of Corporate Affairs is responsible for arranging the upload of the renewed policy and archiving all previous versions of documents with their relevant active dates, as part of the corporate record. Where policies are withdrawn without a replacement, this must be approved by the CCG Governing Body.

4. Roles and Responsibilities

CCG Chief Officer
The Chief Officer of the CCG has ultimate accountability for the strategic and operational management of the organisation, including ensuring all policies are adhered to.

CCG Governing Body
Responsibility for ensuring that there is comprehensive policy coverage in the organisation and direct approval of some policies.

Approving Committees
Delegated responsibility for the consideration and approval of policies.

Head of Corporate Affairs
Responsible for maintaining the CCG policy register, providing advice on policy development, notifying Document Managers when a policy is 6 months from review date, uploading current policies to the intranet and maintaining a policy archive.

Document Manager
Responsible for ensuring that:

- documents for which they are responsible (as determined by their role) are reviewed, approved and ratified;
- the Head of Corporate Affairs has been notified of any policies under development in writing

- policies follow the corporate format and include all required information;
- the effectiveness of the policy is monitored, evidenced and reported;
- any issues identified through monitoring are followed up and appropriate actions taken.

Staff

Staff are required to adhere to all policies and report any incidences of noncompliance to the Head of Corporate Affairs in writing.

5. Training

No specific training is available to support this policy. Any queries relating to policy development should be addressed to the Head of Corporate Affairs.

6. Equality, Diversity and Mental Capacity

An Equality Impact Assessment (EIA) has yet to be completed for this policy but no significant issues are expected. The EIA will be published on the CCG internet when completed. This policy has been assessed and meets the requirements of the Mental Capacity Act 2005.

7. Success Criteria/Monitoring Effectiveness

The Evaluation Standard in **Appendix 4** has been developed to provide assurance for monitoring compliance and effectiveness of any policy. The Head of Corporate Affairs will, on an annual basis (starting 6 months after approval of version 1 of this policy), commission an audit to sample at least 15% of the number of policies to assess compliance against the Evaluation Standard and cross check against the Policy Register. Findings will be reported to the Chief Officer with recommendations to improve compliance. Implementation of these actions will be monitored at the next annual assessment. Any non-compliance with this policy should immediately be reported in writing to the Head of Corporate Affairs.

8.0 Review

This document may be reviewed at any time at the reasonable request of any staff but will be reviewed after three years.

9.0 References and Links to Other Documents

Legislation.gov.uk
Freedom of Information Act 2000
Mental Capacity Act (MCA) 2005
Good Governance Institute
The Advisory, Conciliation and Arbitration Service (ACAS)
Records Management: NHS Code of Practice
Records Management Policy
Risk Management Policy
Learning & Development Policy
Equality & Diversity Policy

Appendix 1

South Norfolk Clinical Commissioning Group

NAME OF POLICY

Ref Number:	**Version**	**Status**		**Author**
Approval body	Type of meeting that policy was agreed at (e.g. Governing Body Audit Committee).		**Date Approved**	Date of meeting
Date Issued	Date the policy was signed off by the CCG		**Review Date**	Date the policy needs to be reviewed and by whom – role not name.
Contact for Review:				

Prepared by	List all people involved in developing the document, including job title/profession.
Impact Assessment	Ensure this is carried out (a legal requirement of the CCG to ensure Race Equality & Disability Equality). Refer to the Impact Assessment guidelines.
Consultation	List all people the policy has been circulated to for consultation, including staff, PPI, Patients, Public *(clarify levels of involvement required).*
Authorised by	Either CO/CFO on behalf of the CCG or Chair of the Audit Committee on behalf of the Audit Committee.
What is it for?	Two or three sentences that describe what the document will enable you to do – the objective of the policy/guideline/procedure. For example, the Retirement policy exists to provide as smooth a transition as possible from work to retirement. Its purpose states, "to lay down the principles and practices that will govern the approach to all staff retirement". Its aim is to do this by providing guidance for staff to prepare, plan and adjust to retirement incorporating the requirements of the Employment Equality (Age) Regs 2006.
Who is it aimed at and which settings?	This section indicates the group(s) of staff and the range of settings that the document applies to. It should also describe the criteria for inclusion & exclusion.
Evidence	Detail the literature and sources of evidence reviewed. Is the policy/guideline/ protocol based on national guidance e.g. statutory obligations.
Other relevant approved documents	List related policies.
References	Reference sources of evidence (where possible) throughout the text and then list the references here.
Training and competences	Include here details of training required to use the policy/protocol/guideline and a competency tool.
Monitoring and Evaluation	Include details of how the policy will be monitored for implementation and effectiveness.
Appendix	Any supporting documentation as necessary/appropriate which adds clarity to the document's core content.

CONTENTS

APPENDIX 2

POLICY DEVELOPMENT CHECKLIST
Checklist

1	Before Development	Have you checked the policy list to see if any other policy covers the area?	Yes / No
2	Consultation Have you involved the appropriate stakeholders?	Are other departments involved, communities or partnership agencies?	Yes / No
3	Format Are you using the correct template and have all the sections of the policy document control sheet been completed?	Version Number / Operative date / Review date etc.	Yes / No
		Are all terms used explained?	Yes/No
		Does the document follow the organisation's format? The body text should be written using • black Arial 11 font etc. • Each paragraph numbered	Yes / No
		Are the standard sections included? • INTRODUCTION & PURPOSE • SCOPE & DEFINITIONS • PROCESS / REQUIREMENTS • ROLES & RESPONSIBILITIES • TRAINING • EQUALITY, DIVERSITY AND MENTAL CAPACITY • SUCCESS CRITERIA / MONITORING EFFECTIVENESS • REVIEW • REFERENCES AND LINKS TO OTHER DOCUMENTS	Yes / No
4	Scope	Does the document state what staff groups and any other stakeholders it relates to?	Yes / No
5	Training Implications	Have the training and educational implications of the document been considered, discussed with your head of department/Head of Corporate Affairs and documented?	Yes / No
6	Impact Assessments	Has an Equality Impact Assessment been completed?	Yes / No
		Has a Mental Capacity Act Assessment been completed?	Yes / No
7	References	Is relevant national guidance/evidence present in the document?	Yes / No
8	Monitoring	Has the process and timescales for	

	Effectiveness	monitoring the document's implementation and its effectiveness been identified?	
9	Approval	Have you booked an agenda item with the approving committee/Governing Body?	Date
		Have you completed any minor amendments following approval?	Yes / No
10	Archiving	If the document is a review/amendment of an existing document, have you ensured that the Head of Corporate Affairs has been advised and archived the previous copy?	Yes / No
11	Intranet uploading	Have you provided a final approved version to the Head of Corporate Affairs to upload to the intranet?	Yes / No
12	Accessibility	Have you checked that the new version is now on the internet and is accessible?	Yes / No
	Awareness	Have you completed proposed awareness exercises / publicity to inform staff?	Yes / No

APPENDIX 3
CHECKLIST FOR REVIEW AND APPROVAL OF POLICY DOCUMENTS
To be completed and attached to any policy submitted to an appropriate committee for consideration and approval
Document Title: Yes/No/Unsure
Comments / Amendments to be made

Question	**Yes/No**
Is the title clear and unambiguous?	
Is it clear whether the document is a guideline, policy, protocol or standard?	
Is the purpose of the document stated?	
Is the target population clear and unambiguous?	
Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	
Is there evidence of consultation with stakeholders, where relevant?	
Is the objective of the document clear?	
Are the statements clear and unambiguous?	
Does the plan include the necessary training/support to ensure compliance?	
Is the type of evidence to support the document identified explicitly?	
Does the document have a reference number?	
Does the document have a version and draft number? (e.g. V1.5)	
For reviewed policies, has the review log been completed?	
Is there a plan to support the monitoring of compliance with and effectiveness of the document?	
Is an Evaluation Standard included?	
Is there a plan to review or audit compliance with the document?	
Is the review date identified?	
Is the frequency of review identified? If so is it acceptable?	
Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the documentation?	

APPENDIX 4

EVALUATION STANDARD

Policy Name: Policy for the management of policies and SOPs
Policy Reference: TBC

Standard statement

The CCG will ensure that all policies meet the required format as stated in the Policy on the Management of Policies & SOPs.

Criteria

1. Each policy gives complete document control information.
2. Each policy details the consultation process that has been undertaken prior to seeking approval.
3. All policies have a front sheet in the approved format and contain details against the section headings in the template at appendix 1.
4. All policies requesting approval follow the basic requirements of corporate identity and format.
5. All policies detail where ultimate responsibility for adherence lies under Roles and Responsibilities.
6. Each policy considers the training needed to implement the policy and on-going training commitments cross-referencing to the Training Needs Analysis and Learning & Development Policy as necessary.
7. Each policy includes an evaluation standard or similar tool.
8. Each policy clearly details monitoring arrangements and identifies success criteria
9. An Equality Impact Assessment (EIA) and a Mental Capacity Act Assessment have been carried out prior to approval and details of the result, consultation and monitoring process are included in the Equality and Diversity section.