Northern, Eastern and Western Devon
Clinical Commissioning Group

Policy and Procedural Framework

Date		June 2016		
Report title		Policy and Procedural Framework		
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Supporting Executive(s)		Janet Fitzgerald, Director of Corporate Governance		
Supporting Executive Approval Date:			March 2016	
Purpose of Report		**Decision**	✓	
		Assurance	✓	
		Information	✓	
FOI Status		**Public**	✓	
		Private		
Category of Paper		**Decision**	✓	
		Position Statement	✓	
		Information	✓	
Does this document place Individuals at the Centre		**Y**	**N**	
		✓		
Actions Requested		To approve and support governance process		
Which other committees has this item been to?		Staff Forum		
Reference to other documents		NHS Constitution NHS NEW Devon CCG Constitution Records Management Policy		
Have the legal implications been considered?		Yes		
Does this report need escalating?		No		
Equality Impact Assessment				
Who does the proposed piece of work affect?		Staff ✓ Patients ✓		
		Carers ✓ Public ✓		

	Yes	No
1. Will the proposal have any impact on discrimination, equality of opportunity or relations between groups?		✓
2. Is the proposal controversial in any way (including media, academic, voluntary or sector specific interest) about the proposed work?		✓

3. Will there be a positive benefit to the users or workforce as a result of the proposed work?	✓	
4. Will the users or workforce be disadvantaged as a result of the proposed work?		✓
5. Is there doubt about answers to any of the above questions (e.g. there is not enough information to draw a conclusion)?		✓

If the answer to any of the above questions is yes (other than question 3) or you are unsure of your answers to any of the above you should provide further information using **Screening Form One** *available from Corporate Services*
If an equality assessment is not required briefly explain why and provide evidence for the decision.

Reference to Core Strategies and Corporate Objectives

Core Strategies, we will:	**Corporate Objective**	**Does this report reference to the Core Strategies/ Corporate Objectives**	
		✓	**X**
1. Take joint ownership with partners and the public for creating sustainable health and care services	1.1 Develop people, and those who support them, to value strengths and personal qualities in all that they do	✓	
	1.2 Listen to people and take action on what they say about services	✓	
2. Implement systems that make the best use of valuable health resources, every time	2.1 Innovate to increase productivity and reduce waste	✓	
	2.2 Commission safe services and reduce avoidable harm	✓	
3. Commission to prevent ill health, promote wellbeing and help people with long-term conditions to live well	3.1 Support people to make healthy lifestyle choices and understand the care, treatment and services available to them		
	3.2 Commission services with partners to reduce health inequalities and improve people's lives	✓	

Document Status:	**POLICY AND PROCEDURAL FRAMEWORK - APPROVED**
Version:	V1.1

DOCUMENT CHANGE HISTORY		
Version:	**Date:**	**Comments (i.e. viewed, or reviewed, amended, approved by person or committee)**
V0.1	May 2014	New branding information for CCG.
V0.2	December 2014	Update with Committee structure – delegated responsibility for policy ratification – flow chart
V0.3	November 2015	Update with Committee structure flowchart and Document Prefix Information
V1.0	June 2016	Ratified March 2016 subject to amendments including definition of strategy
V1.1	02/03/2017	Amended to reflect change in job titles and approval route in flow chart
Authors:	John Harle, Governance Manager Vicki Pothecary, Governance Projects Co-ordinator	
Scrutinised by: (name & title) Date:	Clare Doble, Head of Corporate Governance November 2015	
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Appendix E – Consultation feedback form.

Linked strategies, policies and other Documents	NHS Constitution NHS NEW Devon CCG Constitution Records Management Policy

1. Introduction

1.1 This policy framework aims to ensure a consistent and evidence-based process for the development, approval, ratification, implementation and distribution of documents, such as strategies, policies, procedures and guidelines (clinical and non-clinical) across NHS Northern, Eastern and Western Clinical Commissioning Group (hereafter referred to as NEW Devon CCG).

1.2 This policy must be read by any member of staff who is, or will become, involved in the development of a policy or procedural document.

1.3 The NHS Constitution safeguards the enduring principles and values of the NHS; it sets out the rights to which patients, public and staff are entitled, and describes the pledges which the NHS is committed to achieve. NHS bodies and local authorities are required by law to take account of this Constitution in their decisions and actions; therefore all policy documents should consider and take into account the **NHS Constitution** pledges, as well as our own CCG Constitution – **NHS NEW Devon CCG Constitution**

2. Purpose

2.1 This framework provides the guidance and practical advice for authors of strategies, policies, procedural documents, templates to use and the approval routes so that authors can set out their documents in a standardised way that communicates effectively with the reader.

2.2 The framework also details the process for these documents to be initiated, developed, ratified and implemented. This includes:

- Maintaining a corporate image in all procedural documentation used throughout the organisation;
- Support CCG staff to identify organisational practice at the relevant time; and
- Ensure a systematic/consistent document development, version control and approval process.

2.3 For the purposes of this policy, the term 'document' refers to the following document types:

2.3.1 **Strategy**

Strategy can be defined into two stands which outline and identify and aspect of the organisation over a defined term and are specifically created with the purpose of achieving a goal.

The two main areas under this are strategic plans and operational plans. Strategic plans can be defined as the plan highlighting the direction of the organisation over a defined period of time (for example the CCG annual plan), whereas operational plans highlight specific projects which will assist the organisation in achieving its strategic plans.

2.3.2 **Policy**

A statement of NEW Devon CCGs agreed position and governing principles relating to particular issues or situations. Policies are statement of the ethos and values of an organisation. They clarify roles, relationships and responsibilities and can serve as a basis for decision-making. Policies guide staff on what to do in any given situation. Policies will be written as overarching statements and will be relevant for all staff within NEW Devon CCG. **A policy sets out what you must know or do.**

2.3.3 **Procedure**

A procedure is a set of actions which is the official, or accepted way of doing something. Reasons for deviation from the procedure should be recorded. A Standing Operating Procedure (SOP) is a laid-down procedure for doing something. Very often SOPs are written to minimise health and safety risks or to describe local processes and make them consistently available to other staff. A procedure is an unambiguous document that describes the responsibilities and the procedures, including audit, which are necessary to safely and accountably manage that set of processes. Procedures inform staff of what processes need to take place in order to implement a policy. It will be the responsibility of individual managers to ensure that these are used in conjunction with appropriate policies. **A procedure sets out how it must be done.**

2.3.4 **Guideline**

A document setting out a preferred method of operation, which may be clinical or non-clinical. Other methods are not prohibited but a reason for deviation from guideline should be fully justifiable and line management agreement sought in all cases of any doubt. A set of actions based on best available evidence or practice. **A guideline sets out how it should be done.**

2.3.5 **Clinical guidelines**

A document that is a systematically developed statement, to assist practitioner and patient decisions, about appropriate health care for specific clinical circumstances. A guideline is often informed by national guidance, e.g. National Institute of Clinical Excellence (NICE), clinical directives and copes of practice.

2.3.6 **Protocol**

Protocols enable NHS staff to put evidence into practice by addressing the key questions of what should be done, when, where and by whom at a local level. It sets out how it should be done.

3. Duties

3.1 **Executive Director** will determine if a new strategy or policy, approved document is required. They will support policies appropriate to their responsibilities and ratify strategy or the policy once it has received proper scrutiny.

3.2 **Policy Authors** are staff charged with producing policies and must follow the guidance contained in this policy when writing their documents. They will be identified by the Director or relevant senior officer and tasked with producing a draft policy and where appropriate forwarding to the Staff Forum or other appropriate group for feedback. They will then work through and consider any feedback on the policy. Policy authors will also be responsible for the review process which occurs on a regular basis.

3.3 **Authors of Procedural and Approved Documents** must adhere to the standard document layout, formatting and document control. The latest information can be found **Brand guidelines**

3.4 NEW Devon CCG will consider producing appropriate public documents in languages other than English. Further details regarding this should be made available on the policy document. Patient Advice and Liaison team will act as a source of information and advice on tracking down documents on behalf of the public.

3.5 All documents should be written in "Plain English", as defined in the corporate style guide **Brand guidelines**. Plain English is "something that the intended audience can read, understand and act upon the first time they read it. Plain English takes into account design and layout as well as language".

3.6 During development, consideration should be given on how the policy will be implemented across NEW Devon CCG so its effectiveness can be monitored. Rarely will every single member of staff be required to have a working knowledge of all policies so the policy author should define who the policy applies to on the cover sheet of the document under the Equality Impact assessment section.

3.7 Should staff be unsure about how to develop policies and procedures, additional advice can be obtained from the CCG Governance Team on **d-ccg.governance@nhs.net**.

3.8 Policy templates are available via the organisations intranet and are maintained by the corporate office

4. The development of organisational wide documents

4.1 **Prioritisation of Work (refer to the first section in Appendix A)**
Identify the following:

- the justification and support for developing the new document;
- how it links with service priorities and training needs analysis;
- ensure that it is not duplicating other work, either nationally or locally via governance, including checking with NEW Devon CCGs policy database and website as to whether or not an existing or similar document is available; and
- that implementation is achievable within the resources of the service/ organisation.

4.2 **Identification of and Consultation with Key People**

Identify the following:

- relevant people, i.e. all CCG staff, trade unions, Staff Forum, Executives, external groups, including service users for each type of document. This list is not exhaustive;
- relevant committees that need to consider the document in draft format; and
- level of involvement, i.e. development, consultation, or receipt of final documents.

4.3 **Responsibility for document development**

Each document under development should have:

- a nominated individual who will act as "Editor" for overseeing the document's progress in accordance with this framework;
- a nominated individual who will act as "Author" for its development, who has appropriate knowledge and experience of the document subject matter; and
- for each document under development, it is recommended that a "Working Group", consisting of a multi-professional membership, including service users where appropriate, be temporarily established to assist the "Author" and be responsible for monitoring the document's development process where necessary.

4.4 **Quality, Equality, Impact Assessment (QEIA)**

All public bodies have a statutory duty under the Race Relation (Amendment) Act 2000 to "set out arrangements to assess and consult on how their policies and functions impact on race equality." In effect to undertake impact assessments on all documents. This obligation has been increased to include equality and human rights with regard to disability, age, gender and religion or belief. This is the QEIA screening form referenced on the coversheet for all documentation for approval by committee. NEW Devon CCG aims to design and implement services, with associated policies and measures that meet the diverse needs of our services, population and workforce, to ensure that none are placed at a disadvantage over others. The broader Impact Assessment Tool **QEIA** is designed to help the Author and Working Group to consider the needs and assess the impact of each document where required.

4.5 **Document History**

Every document produced by NEW Devon CCG must have a document change history table. This should appear straight after the core strategies and objectives and before the contents of documents, as set out in the template. This aids the tracking and retrieval of documents and ensures that everyone is working to the current document.

4.6 The Governance Team manages NEW Devon CCGs policy database of ratified documents only. The database includes, strategies, policies and other formal procedural documents, it also includes date of ratification and review details of author and executive..

4.7 Policies should be indexed using one of the following categories in the box below and numbered with the prefix below, and consecutive numbers starting with 01, for example: **GEN01 Policy on procedural documents framework. This number will be issued by Governance upon approval.**

4.8 The numbering system is as follows:

- All drafts should be 0.1, 0.2, etc.;
- The first ratified version is numbered V1;
- Draft reviews are the responsibility of the Editor/Author V1.1, 1.2 etc; and
- The next ratified version is numbered V2, etc.

4.9 The list of categories is as documented below:

Code	**Area**
GEN	**General (all policies not included In the list below)**
CP	Clinical Effectiveness & Medicines Optimisation (including all clinical policies)
FIN	Finance (including Contracting)
HR	Human Resources
NQ	Nursing (Including PALS, PSQ, Safeguarding, Equality and Diversity, CHC, Complex care)

4.10 Current and ratified policies or procedural documents are up-loaded to NEW Devon CCG's website in the pages marked policies and procedures. It is the responsibility of staff to ensure that they are using the most recent guidance if downloading or printing off via NEW Devon CCGs website.

4.11 **Archiving Arrangements**

When a policy document is to be replaced with a new version, the previous document version is archived into the governance drive in accordance with the retention and disposal schedule held in records management policy. The date of the archive will be recorded on the document control sheet and on the electronic file name. All electronic files should be in PDF format.

Access to archived policies can be via request to the Governance Team.

5. Consultation, approval and ratification process

5.1 Consultation, if required, should begin at the development stage, where it may be appropriate to complete a specific consultation with key people such as the Staff Forum / HR to highlight spot and change obvious errors.

5.2 The Lead Executive will support staff to progress consultation through established networks.

Approval Process (use Flow Chart in Appendix A & Audit Tool in Appendix B)

Part of the approval process may involve the completion of a full Quality

Equality Impact Assessment (QEIA) the Completion of the EIA on the coversheet will inform if this is required (usually a QEIA would only be required if an impact to a commissioned service is identified) to identify which groups of people the policy affects and to identify if the policy in any way detriments members of staff or the general public.

5.3 The document will be sent to the Executive Lead for review and ratification. Where it is a policy it will require appropriate approval by committee, this is detailed in the Accountability Table held by the Head of Governance.

5.4 If a policy is not approved, the reviewers are required to feedback issues and comments to the policy Author, making it clear about the next steps to achieve approval, including timescales.

5.5 **Ratification Process**
All policies are approved by an appropriate committee with delegated powers from the Governing Body.

5.6 **Interagency Policies, Procedures and Guidelines**
NEW Devon CCG is signed up to a number of countywide interagency documents which support local practice and collaborative working arrangements as part of integration. For these documents, the lead agency is responsible for the style and format, distribution and archiving arrangements of the publication, regardless of whether it adheres to NEW Devon CCG's recommendations. Wherever possible, each interagency document must have a relevant member of NEW Devon CCGs staff on its working group to ensure that appropriate consultation at the development stage is achieved.

5.7 Further assistance with this process can be obtained from the CCG Governance Team on **d-ccg.governance@nhs.net**.

6. Review arrangements

6.1 Unless otherwise stated, all documents should have their review date on them. A review should take place following a significant change (i.e. change of practice / location, processes or staff) or from a directive, professional regional or national guidance. The review period commences from the ratification date of the document, and will be clearly identified on the reader Information sheet of the document.

6.2 It is the responsibility of the policy owner, to review the document before the agreed ratification period has elapsed, and amend accordingly.

6.3 The review should take account of:

- audit of the previous version;
- issues highlighted by users;
- complaints/incidents/near misses; and

- new evidence.

6.4 Evidence that appropriate reviews of policies have taken place (including those adopted from outside bodies - to be known as shared protocols) must be clearly minuted, reflecting the discussions and actions proposed, and that an Impact Assessment has been carried out.

6.5 Six months prior to the review date, a reminder will be sent by governance to the policy owner requesting that the document is updated. This reminder is repeated after three months with a copy to the Executive Lead. Should the policy owner require an extension to complete the review, this must be requested from the Governance team. Policies due for renewal, where no review takes place, will be highlighted with the consideration to be included in the organisational Risk register. Documents that have passed their review date without request for extension will be removed from NEW Devon CCGs website by the Governance Team.

6.6 Each time a document is reviewed the version number will be updated, indicated by an increase in its chronological numeric value. This will be clearly identified in the Document History table, as outlined in Section 4.8 of this document.

6.7 Technical amendments are made in response to changes in statute, organisational structure or posts, which need to be included in revised policies but do not fundamentally change the purpose or philosophy of the policy. Technical amendments do not require consultation or re- submission to the appropriate committee. For example technically amended documents version control will be the current version number then add .1. for example **GEN01 Policy on procedural documents version 1.1**

6.8 Substantive amendments that fundamentally change the policy require appropriate consultation and re-submission through the appropriate governance approval routes. Any updates to these policies should be highlighted via track changes and yellow highlight for ease.

7. Dissemination and implementation

7.1 The Author and relevant senior officer will assess the cascade requirements of the document. Evidence of distribution must be retained (see Appendix D). The Author may consider that confirmation of receipt may also be required in some circumstances (Appendix E).

7.2 It is required that an approved / ratified copy of all new or newly revised documents will be forwarded to the Governance Team to be placed within NEW Devon CCG's central database of ratified documents. The document will then be placed on to the NEW Devon CCG's website and publicised in "The Week".

7.3 **Implementation of Documents** (refer to Appendices B, D & E)

Implementation of the document must include undertaking the training or support identified within the training needs analysis. This should include existing staff, new and temporary staff to the department or CCG.

All staff must be made aware of CCG / departmental policies at local induction. Evidence may be required to verify that staff have been informed appropriately. It is recommended that the manager use (Appendix C) for this, which verifies that staff have read and understood the policy, and agreed to comply with it.

8. Monitoring compliance and effectiveness of documents

8.1 The executive lead and policy author are responsible with ensuring that all documents presented to a committee for approval / ratification follow the guidance identified within this policy framework.

8.2 To ensure compliance and effectiveness of this policy framework an audit of policies, procedures and guidelines will be undertaken every two years by governance. This will involve a random sample of all current documents ratified / approved within the previous two years.

8.3 It is expected that all documents will comply with this policy framework. The results of the audit will be presented to the CCGs Audit and Assurance Committee who will be make decisions for the development and monitoring of any identified actions within the scope of the audit.

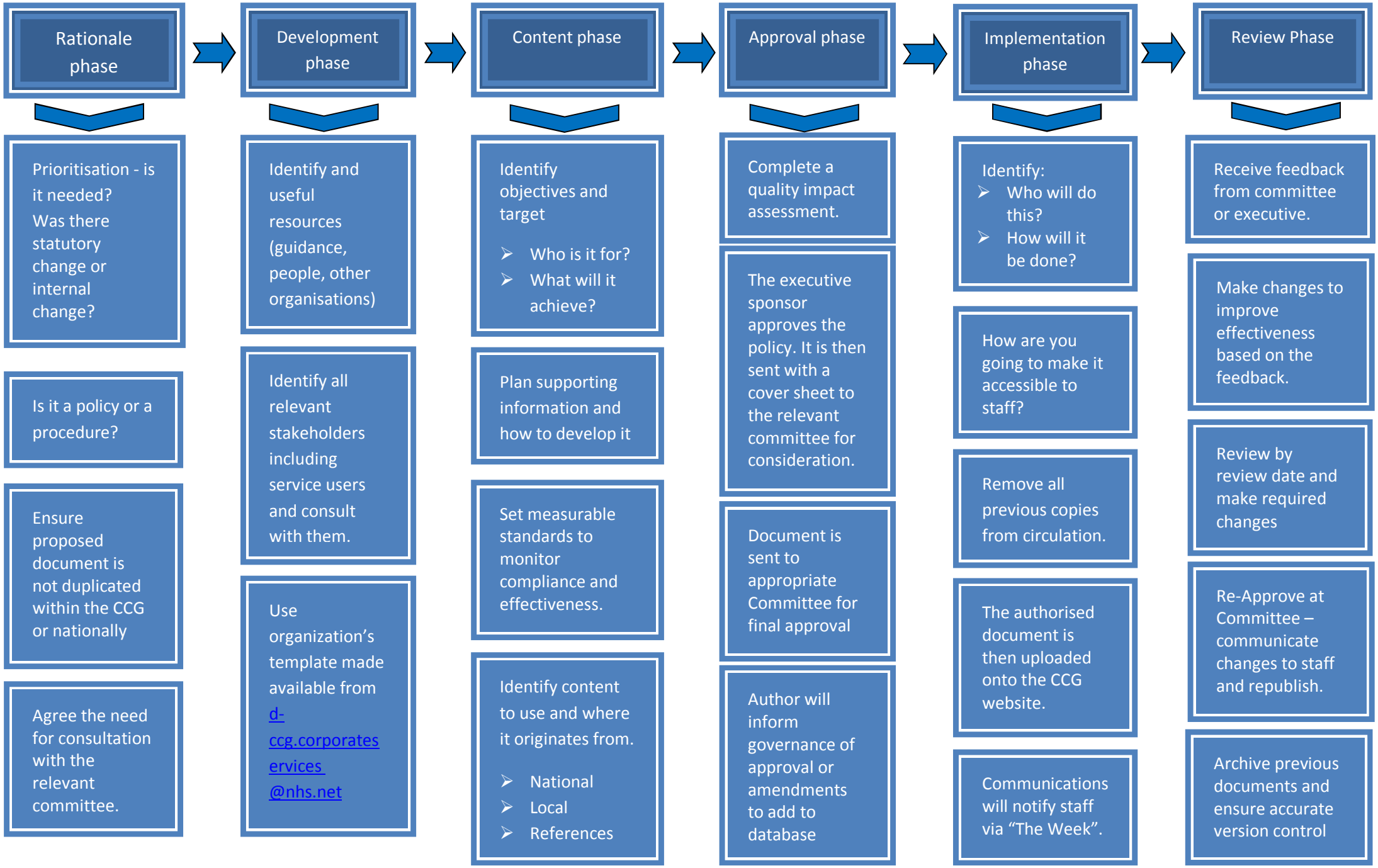
9. Associated documentation and supporting references

9.1 Policy documents must always be based on established practice in NEW Devon CCG and complement existing operations. The policies should work in harmony with other policies or higher government standards. Policy Authors should reference and provide links to associated documents where further information may be found. A good policy is one that is short enough to contain what the reader needs to know and contains sign posts to where they can find more in depth information.

9.2 Any relevant references should be recorded as accurately as possible using the Harvard method of referencing where appropriate to the policy/document being complied

Appendix 1

Quick Guide - How to create and implement policy and procedural documents



Appendix B

Audit Tool for the Review and Approval of Procedural Document

Part of the approval process will involve the completion of an Equality Impact Assessment to identify which groups of people the policy affects and to identify if the policy in any way detriments members of staff or the general public. Additionally, the document being sent to the Staff Forum where appropriate, who will provide feedback. To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

	Title of document being reviewed:	Y/ N/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?		
	Is it clear whether the document is a strategy, policy, protocol, procedure, integrated care pathway or guidelines?		
2.	**Rationale**		
	Are reasons for development of the document stated?		
3.	**Development Process**		
	Is the method described in brief?		
	Are people involved in the development identified?		
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?		
	Is there evidence of consultation with People and users?		
4.	**Content**		
	Is the objective of the		

	document clear?		
	Is the target population clear and unambiguous?		
	Are the intended outcomes described?		
	Are the statements clear and unambiguous?		
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?		
	Are key references cited?		
	Are the references cited in full?		
	Are supporting documents referenced?		
	Does the document identify which committee/group will approve it?		
	If appropriate have the joint Workforce Development/staff side committee (or equivalent) approved the document?		
6.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?		
	Does the plan include the necessary training/support to ensure compliance?		
7.	**Document Control**		
	Does the document identify where it will be held?		
	Have archiving arrangements for superseded documents been addressed?		
8.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards to support the		

	monitoring of compliance with and effectiveness of the document?		
9.	**Review Date**		
	Is the review date identified?		
	Is the frequency of review identified? If so is it acceptable?		
10.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for coordinating the dissemination, implementation and review of the document?		
Policy Ratification Group Approval - If the group 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 prior to approval at committee.			
Date:			

Appendix C

Plan for Dissemination of Procedural Documents

To be completed and attached to any document which guides practice when submitted to the appropriate group / committee.

Title of document:			
Date finalised:		**Dissemination lead: Print name and contact details**	
Previous document already being used?	**Yes / No** (Please delete as appropriate)		
If yes, in what format and where?			
Proposed action to retrieve out-of-date copies of the document:			
To be disseminated to:	**How will it be disseminated, who will do it and when?**	**Paper or Electronic**	**Comments**

Appendix D

Northern, Eastern and Western Devon
Clinical Commissioning Group

Staff Distribution Signature Sheet for Approved & Ratified Documents (including Policies, Procedures, Strategies and Guidelines)

Name of Policy.....

Policy No:.....

Statement:

I have read the above approved and ratified document and understand its contents. If there are any difficulties regarding implementation or any training needs, I have raised and resolved these with my line manager. I agree to implement the content of the above approved and ratified document.

Staff Name (please print)	Signature	Date

On completion of this record, this sheet will be kept by the line manager and become part of the training record

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Appendix E

Consultation Feedback Form

Northern, Eastern and Western Devon Clinical Commissioning Group

(Complete one for each group consulted)

Name of Document :
Circulation to :
(name of forum) and members / titles to whom the document is to be circulated for consultation – to be completed by the forum's members)

Name of Forum Member	Title of Member

Date Received:
Comments (enter document author's name/title/address)

(Please feel free to continue any comments on the reverse of this sheet. Thank you.)

Signed (name of individual on behalf of consultation forum)
Return date: