NHS
Frimley
Clinical Commissioning Group

FRIMLEY CLINICAL COMMISSIONING GROUP

DEVELOPMENT AND MANAGEMENT OF POLICIES AND PROCEDURAL DOCUMENTS POLICY

Policy number	Corp 004
Version	1.0
Approved by	Executive team
Document Author	Governance Manager
Date of approval	January 2021
Next due for review	January 2024

Version control sheet

Version	Date	Author	Status	Comment
1.0	January 2021	Governance Manager	Final	

Equality Statement

Frimley Commissioning Group aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who have shared a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it;
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and in securing that services are provided in an integrated way where this might reduce health inequalities.

Members of staff, volunteers or members of the public may request assistance with this policy if they have particular needs. If the member of staff has language difficulties and difficulty in understanding this policy, the use of an interpreter will be considered.

We embrace the four staff pledges in the NHS Constitution. This policy is consistent with these pledges.

Contents

1. Introduction

1.1 Policies and procedural documents (for definition please see paragraph 4 below) are a key component of the Frimley Commissioning Group's (the CCG's) corporate governance framework and risk management system, which keep the organisation and its staff safe, protect the same from challenge, reputational damage and claim for redress.

1.2 The CCG uses policies and procedures to enable staff working for, and with us, to do so in a way that is efficient, consistent, safe and in keeping with our values, objectives and purpose.

1.3 The development, approval and monitoring of the use of our policies, also ensures that we meet statutory, legal and insurance requirements as well as best practice in relation to corporate and clinical governance.

2. Purpose

2.1 To provide a framework for the above in accordance with our values regarding transparency and openness.

2.2 The environment within which we operate is one of constant change, and we must be in a position to respond to the challenges posed by these changes. This document seeks to ensure that our policies and procedures remain relevant by setting out our process for their development and management.

3. Scope

3.1 This policy applies to all staff employed by, and staff working on behalf of the CCG and applies to all strategies, policies, procedures, protocols, guidelines and plans being issued under our CCG logo.

3.2 This policy sets out the expectations of quality and there are specific, limited circumstances where exceptions may apply:

- Where procedural documents are shared with other CCGs and/or the Commissioning Support Unit, the format and approval process may differ.
- Where procedural documents have been 'inherited' as part of collaborative or partnership working with other bodies. In this case, procedural documents will be reviewed in accordance with this guidance, as and when they come up for review.
- Strategies (and other operational/business planning documents) will conform to the corporate standards set out in this policy; however, the contents/headings may differ and will typically be nationally driven.

3.3 We may also utilise procedural documents developed for us by third parties. This policy should be used for the purposes of approval and monitoring as well as assistance to those third parties in the development and format of such policies bearing our CCG logo. (See Section 8 for further information). The CCG expects its commissioning partners and service providers to have in place an equivalent policy reflecting their own corporate standards of documentation.

4. Definitions

4.1 A **STRATEGY** is a plan designed to achieve a longer term aim or goal. These timeframes can range from 2-3 years through to 15-20 years.

4.2 A **POLICY** sets out an organisation's statement of intent and defines the course of action to be taken to meet this. It outlines processes specific to the particular organisation.

4.3 A **PROCEDURE** is a set of detailed step-by-step instructions that describe the appropriate method for carrying out tasks or activities to achieve the stated outcome.

4.4 A **PROTOCOL** is an explicit detailed plan of a procedure (usually locally defined).

4.5 A **GUIDELINE** is a broad statement of good practice. There is a degree of flexibility in the application of guidelines. Guidelines can themselves assist in determining strategies, policies, procedures etc.

4.6 A **PLAN** is a detailed document of what needs to be done and how this will happen.

4.7 The term **PROCEDURAL DOCUMENT** refers to all the above-mentioned documents.

5. Roles and responsibilities

5.1 **Accountable Officer** – has ultimate accountability for the strategic and operational management of the organisation, including ensuring all policies are adhered to.

5.2 **CCG Governing Body** – is responsible for ensuring that all policies in use in the organisation are ratified by the CCG Governing Body

5.3 **Director of Governance** – is responsible for advising staff/office holders on the contents of this policy and will ensure that the formal approval procedure set out in this policy is followed.

5.4 **Approving committees** - the Scheme of Delegation identifies the committee that has been delegated responsibility for approval of policies by the CCG Governing Body/Clinical Delivery Group. This is also confirmed in appropriate committee terms of reference.

5.5 **Stakeholders** – are responsible for:

- reviewing this policy and providing feedback
- ensuring the policy has been implemented.

5.6 **Governance Manager** - is responsible for ensuring the following:

- maintaining a central policy register
- ensuring the ratified documents are uploaded to the intranet and CCG website in a timely manner

- contacting the Document Author when a policy is nearing its review date.

5.7 **Document Author** – is responsible for ensuring that:

- documents they are responsible for (as determined by their role) are regularly reviewed and maintained
- the Governance Manager has been notified of any new policies or reviewed policies/procedural documents
- policies that they are responsible for are formally ratified following the correct procedures
- that documents are cascaded appropriately
- that all documents follow the corporate format
- that the effectiveness of the policy is monitored and evidenced
- that any issues identified through the standard monitoring are followed up and appropriate actions taken.

5.8 **Line managers** - are responsible for ensuring their staff are aware of, and adhere to, this policy.

5.9 **Staff and others engaged in the business of the CCG** - should ensure that they follow this policy when developing procedural documents.

6. Development of new and the revision of existing polices and procedural documents

6.1 Process

6.1.1 A flow chart for the policy development, approval and ratification process can be found in **Appendix 1**.

6.1.2 All proposed procedural documents must be registered with the Governance Manager for inclusion on the central policy register.

6.1.3 The Governance Manager will issue each procedural document with a reference consisting of a number (from 01 upward) and two letters depending on the approving committee (see section 11 for the type of procedural documents):

Reference	Approving Committee
AC	Audit Committee
QC	Quality Performance and Finance Committee
RC	Remuneration Committee

6.2 Justification

6.2.1 The grounds for creation of a new procedural document must be justified by the Document Author who check must ensure that they avoid duplication.

6.3 Timescales

6.3.1 Document Authors must be mindful of the timescales required to obtain formal approval. All procedural documents are subject to an Equality and Quality Assessment (EAT) which must take place during the development stage and be signed off prior to approval of the procedural document. It is essential that sufficient time is allowed for undertaking the EAT.

7. Statutory requirements

7.1 All policies etc. must comply with relevant statutory requirements, any subsidiary legislation and subsequent amendments, including but not limited to the following Acts:

- Health & Safety at Work Act 1974
- Health and Social Care Act 2008 (Regulated Activities), Regulations 2010
- Health Act 2009
- Care Quality Commission (Registration), Regulations 2009.
- Equality Act 2010, Equality Act 2010 (Specific Duties) Regulations 2011
- Human Rights Act 1998
- Promoting Equality and Human Rights in the NHS: a guide for Non-Executive Directors of NHS Boards (2005) Department of Health
- Mental Health Act 2007
- Mental Capacity Act 2005
- Civil Contingencies Act 2005
- Finance Act 2011
- Freedom of Information Act 2000
- Re-use of Public Sector Information Regulations 2005
- Data Protection Act 1998 and 2018
- Environmental Information Regulations 2004
- Corporate Manslaughter & Corporate Homicide Act 2007

7.2 **Equality Act 2010** - **Equality and Quality Analysis** - In accordance with the CCG's commitment to equality and diversity, we aim to eliminate discrimination, harassment and victimisation, advance equality of opportunity, and promote good relations between groups. We need to do this for the nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. The Document Author must undertake an Equality Impact Assessment and a Quality Impact Assessment using the templates provided in the Quality and Quality Impact Process Document which can be found on the

7.2.1 Document Authors must complete an assessment for all procedural documents. Results of the assessment, consultation and monitoring process should be detailed under the section heading "Equality and Quality Analysis" in the procedural document. Existing policies should already have been assessed and so only a review will be necessary where this is the case.

7.2.2 The completed EAT should form part of the policy and will need to be submitted as part of the approval process, and may be published to demonstrate compliance with the specific equality duty to publish such information.

7.2.3 The CCG aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

7.3 **Bribery Act 2010** – the CCG has a responsibility to ensure that all staff are made aware of their duties and responsibilities arising from The Bribery Act 2010. The Bribery Act 2010 makes it a criminal offence to bribe or be bribed by another person by offering or requesting a financial or other advantage as a reward or incentive to perform a relevant function or activity improperly performed. The penalties for any breaches of the Act are potentially severe. There is no upper limit on the level of fines that can be imposed and an individual convicted of an offence can face a prison sentence of up to 10 years.

For further information, see https://www.gov.uk/government/publications/bribery-act-2010-guidance

Due consideration has been given to the Bribery Act 2010 in the review of this policy and no specific risks were identified.

7.4 **Data protection legislation (as defined in the Data Protection Act 2018)** – the implications of this legislation must be considered in the development of all procedural documents and Document Authors should refer to the Information Governance Framework for assistance.

8. NHS Constitution

8.1 The CCG is committed to:

Designing and implementing services, policies and measures that meet the diverse needs of its population and workforce, ensuring that no individual or group is disadvantaged.

8.2 This Policy supports the NHS Constitution as follows:

"The NHS aspires to the highest standards of excellence and professionalism in the provision of high-quality care that is safe, effective and focused on patient experience; in the planning and delivery of the clinical and other services it provides; in the people it employs and the education, training and development they receive; in the leadership and management of its organisations; and through its commitment to innovation and to the promotion and conduct of research to improve the current and future health and care of the population".

9. Style and format

9.1 All procedural documents must be presented in accordance with the standard template **(see Policy Toolkit on intranet).**

9.2 The basic style and format requirements are as follows:

- The title (cover page) must be written in black, capitals in Arial, bold, font size 14 or greater
- The CCG logo must 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
- The body text must be written using black Arial 12 font, with headings written in bold
- The procedural document should be written in plain English. Jargon should be avoided and abbreviations must be explained in their first use and subsequently where necessary
- All sections of the procedural document must be numbered sequentially, including paragraphs and appendices

9.3 Non-compliance with the corporate standards detailed in this policy must be exceptional, and justified on presentation for approval and adoption.

10. Content

10.1 It is evident that each procedural document will contain information specific to the subject area however, the basic content requirements are as follows:

- Document title
- Version Control Information
- Contents page
- Introduction and/or background
- Purpose
- Scope
- Definitions
- Roles and responsibilities
- Development and management of policies and procedural documents
- Equality and Quality Analysis
- References (where these have been used as evidence base in the document)
- Training considerations
- Consultation and stakeholder information (for Human Resources (HR) policies where there is a substantial change, recognised unions will need to be consulted. This is done through the Commissioning Support Unit HR team who will send policies to staff side representatives for commentary with an attached deadline. HR policies will also be shared with staff partnership forums at an early stage.
- Dissemination
- Monitoring arrangements
- Roles and responsibilities for that particular document

11. Non CCG policies/special circumstances

11.1 Local authority, Local NHS, Local Area Team or Department of Health policies do not need to be rewritten in the CCG format if the CCG is intending to adopt them. However, a separate front sheet (see **Appendix 3**) should be attached to the policy showing the title and CCG policy reference. Details of the consultation process and the standard document control requirements must also be given on this sheet with a nominated CCG owner, rather than the Document Author, who would be responsible for reviews and CCG adoption.

12. Approval process

12.1 If appropriate (e.g. a policy or strategy) the procedural document should be presented to the relevant CCG sub-committee for approval prior to final ratification by the CCG's Governing Body. The checklist attached as **Appendix 3** must be completed when submitting a procedural document for approval.

12.2 The Governing Body may wish to delegate this role to one of its sub-committees e.g. the Quality Performance and Finance Committee (for quality policies), this should also be reflected in the CCG Scheme of Delegation. See **Appendix 1** for approval process.

12.3 The Governing Body is responsible for the final ratification of policies for use within the CCG. Final ratification will be made via the use of a list of those policies approved by the delegated committee that shows the:

- Policy name in full
- Unique reference number
- Approving Committee
- Date of approval
- Outstanding conditions to approval

Policies approved with outstanding conditions may be ratified by Chair's action dependant on the type of condition. This request should be made of the Chair at the time of ratification.

12.4 There is a requirement placed on the CCG by external agencies such as NHS Resolution, that some policies are formally approved by the Governing Body and this may not be delegated (for example Risk Management Policy). The 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. Policies presented to the Governing Body for approval should first have been considered and agreed at the appropriate sub-committee.

12.5 Ratification is the point at which the approved policy is presented to the CCG Governing Body as final and accepted as ready for publication, and is signed by the Chair of the CCG. Please note that CCG Governing Body minutes must reflect the ratification by policy name and unique policy reference number.

12.6 It is accepted that following approval of a procedural document by the appropriate committee or group there needs to be an allowance of time before the policy becomes fully operational in order to allow appropriate dissemination of the new/revised policy within the CCG. It is therefore expected that any procedural

document approved will be fully operational within three months of the date of approval unless otherwise notified.

13. Dissemination//publication

13.1 The procedural document must set out clearly how it will be disseminated to staff and relevant staff holders via the intranet.

13.2 The Document Author may also wish to consider other routes of dissemination e.g. notification via newsletters, direct mailings to stakeholder organisations etc.

13.3 It is the responsibility of the Governance Manager to ensure that ratified procedural documents are uploaded on to the intranet (for staff) and the website (for the general public) and that previous copies are archived in accordance with information governance guidelines.

14. Monitoring

14.1 How procedural documents will be monitored for effectiveness must be set out in this section and include the frequency and nature of monitoring. If policy compliance is the subject of an Internal Audit review, this will represent the audit of effectiveness and compliance.

14.2 Where there are gaps or omissions, an action plan should be generated. The committee with oversight of this information will be the approving committee.

14.3 Compliance with each policy will be undertaken every two years by auditing a sample of procedural documents and measuring them against the quality criteria set out in each policy.

14.4 Monitoring of each document will be undertaken on an individual basis and should be identified within the document, including the relevant committee or group responsible for carrying out the monitoring.

15. Review and revision

15.1 Unless otherwise specified, all procedural documents should be reviewed every three years or sooner as required, and resubmitted for approval to the approving committee, with a schedule of proposed changes. More frequent review may be required if there are significant changes in practice or law. The next scheduled date for review must be detailed on the cover of each procedural document, and it is the responsibility of the Document Author to carry this out.

15. 2 Minor variations are permitted without the need to follow the full approval process (see flow chart in Appendix 1 below (existing policies). Additional advice can be sought from the Governance Team

15.3 Each policy will be reviewed every three years by the Document Author to ensure continued validity and relevance.

16. Version control

16.1 The version of the document should be clearly displayed on the cover sheet.

16.2 The first draft of a new policy is version 1.0, with each iteration or amendment prior to final approval increasing the version number by 0.1 (i.e. 1.0, 1.1, 1.2, 1.3).

16.3 When the document is revised following approval, the version control number should increase to 2.0 (then 2.1, 2.2, 2.3 etc.).

16.4 The version control table is provided in the template to keep track of each iteration of the document and the reason for the change, for example, amendments following a consultation or changes in legislation.

17. Extending the lifespan of policies (by exception)

17.1 The authorising committee may, temporarily extend the lifespan of a policy in exceptional circumstances, to enable robust and comprehensive review e.g. where new guidance is anticipated, but not yet issued. This extension is subject to confirmation from the Document Author of its continued validity and organisational relevance; the extension should not exceed a period of six months.

17.2 If the lifespan is extended, the Document Author must note this on the current policy's front cover and advise the Governance Manager for updating of the central policy register and arranging for its upload to the CCG's intranet and website.

18. Training requirements

18.1 The procedural document must set out any training requirements for its implementation.

18.2 There is no training requirement identified within this policy. A toolkit is available on the intranet and any specific queries should be addressed to the Governance Manager.

18.2 All stakeholders involved in policy development should be aware of the contents of this 'Development and Management of Policies and Procedural Documents Policy".

19. Review of this policy

19.1 This Policy will be reviewed every three years and follow the process as set out in paragraph 15.

20. References and links relating to this policy

- The Advisory, Conciliation and Arbitration Service (ACAS).
- Good Governance Institute
- NHS Resolution
- Department of Health and Social Care

Appendix 1 – Process

POLICY DEVELOPMENT PROCESS – FLOW CHART PROCESS (NEW)

STEP	INDICATIVE TIMESCALE	POLICY DEVELOPMENT PROCESS – FLOW CHART PROCESS (NEW)
1.		Procedural document requirement identified
		
2.		Author and Executive Lead identified
	Within first 28 days	
3.		Author to Register New Policy with Governance Team using Governance inbox
		
4.		Governance Team to register NEW policy on Central Register and confirm receipt back to author
5.		Author to draft policy and obtain initial approval from Exec Lead
	Within next 56 days	
6.		Author to co-ordinate consultation with key members of staff and unions (where appropriate) update as required.

STEP	INDICATIVE TIMESCALE	POLICY DEVELOPMENT PROCESS – FLOW CHART PROCESS (NEW)
		For HR via Staff Partnership Forum. 
7.		Final version to be reviewed by authorising group/ committee (see table below) 
8.		Once approved Final Version returned to Governance Team using Governance inbox 
9.		Governance Team to register NEW policy and publish on the Website/ Intranet as required. 
10.		Governance Team will send out reminder to document author at least three months prior to next formal review
		Policy review procedure to be followed as set out in the policy for policies.

POLICY APPROVAL NEW or SIGNIFICANT UPDATE

POLICY APPROVAL NEW or SIGNIFICANT UPDATE – PROCESS		
Type	**Approval Body**	**Ratification by**
Non-Clinical/ Corporate	Executive Directors	Governing Body
Finance SFIs	Audit Committee	Governing Body
HR	Remuneration Committee	Governing Body
Commissioning	Quality, Performance and Finance Committee	Governing Body
Clinical / Quality	Quality, Performance and Finance Committee	Governing Body
IG	IG Steering Group	Audit Committee
IT	CSU	IG Steering Group (for adoption only)

POLICY DEVELOPMENT PROCESS – FLOW CHART PROCESS (EXISTING)

STEP	INDICATIVE TIMESCALE	POLICY DEVELOPMENT PROCESS – FLOW CHART PROCESS (EXISTING) NB IF IT IS A MINOR VARIATION E.G. CHANGE OF JOB TITLE GO STRAIGHT TO STEP 5.
1.	3 months ahead of review date	Governance Team will send out reminder to document author at least three months prior to next formal review 
2.	Within first 28 days	Author to update policy and obtain initial approval from Exec Lead
		
3.	Within next 56 days	Author to co-ordinate consultation with key members of staff and update as required. For HR via Staff Partnership Forum.
		
4.		Final version to be reviewed by authorising group/ committee
5.		Once approved final version returned to Governance Team using Governance inbox
		
6.		Governance to register policy as updated and publish on the Website/ Intranet as required.

STEP	INDICATIVE TIMESCALE	POLICY DEVELOPMENT PROCESS – FLOW CHART PROCESS (EXISTING) NB IF IT IS A MINOR VARIATION E.G. CHANGE OF JOB TITLE GO STRAIGHT TO STEP 5.
		
		Governance Team will send out reminder to document author at least three months prior to next formal review
		
		Policy review procedure to be followed as set out in the policy for policies.

POLICY approval for in-year changes

POLICY approval for in-year changes – PROCESS		
Type	**Approval**	**Group for information only**
Non-Clinical/ Corporate	Executive Directors	Quality Performance and Finance Committee
Finance SFIs	Director of Finance	Audit Committee
HR	Executive Director of Improvement and Development	Remuneration Committee
Commissioning	Executive Directors	Quality Performance and Finance Committee
Clinical / Quality	Executive Director of Quality and Nursing	Quality Performance and Finance Committee
IG	Director of Finance	IGSG
IT	Director of Finance	Audit Committee

Appendix 2 – Cover sheet for joint policy

INSERT LOGOS OF BODIES/ORGANISATIONS

INSERT POLICY TITLE

CCG Policy number	
Version	
Approved by	
CCG owner	
Date of approval	
Next due for review	
Consultation process	

Appendix 3 - Procedural Document - checklist for approval

Procedural document checklist for approval			
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: Policy framework for the development and management of procedural documents	**Yes/No/ Unsure**	**Comments/Details**
A	**Is there a sponsoring director?**		
1.	**Title**		
	Is the title clear and unambiguous?		
	Is it clear whether the document is a guideline, policy, protocol or standard?		
2.	**Rationale**		
	Are reasons for development of the document stated?		
3.	**Development Process**		
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?		
	Is there evidence of consultation with stakeholders, unions (where appropriate) and users?		
4.	**Content**		
	Is the objective of the document clear?		
	Is the target group clear and unambiguous?		
	Are the intended outcomes described?		
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?		
	Are key references cited?		
6.	**Approval**		
	Does the document identify which committee/group will approve it?		
7.	**Dissemination and Implementation**		

Procedural document checklist for approval			
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: Policy framework for the development and management of procedural documents	**Yes/No/ Unsure**	**Comments/Details**
	Is there an outline/plan to identify how the document will be disseminated and implemented amongst the target group? Please provide details.		
8.	**Process for Monitoring Compliance**		
	Have specific, measurable, achievable, realistic and time-specific standards been detailed to monitor compliance with the document?		
9.	**Review Date**		
	Is the review date identified?		
10.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for implementing and reviewing the documentation i.e. role of author/originator?		
Director Approval			
On approval, please sign and date it and forward to the chair of the committee/group where it will receive final approval.			
Name		Date	
Signature			
Committee Approval			
On approval, Chair to sign and date.			
Name		Date	
Signature			