CORP01

Framework for the Production of Policies and Procedural Documents

NHS Guildford and Waverley CCG	✓
NHS North West Surrey CCG	✓
NHS Surrey Downs CCG	✓

Policy number	CORP01
Version	1.0
Approved by	Governing Body
Name of author/ originator	Jo Silcock/ Natasha Moore
Owner (director)	Elaine Newton, Executive Director of Communications and Corporate Affairs
Date of approval	December 2018
Date of last review	Varied Oct 2017 – Oct 2018
Next approval due	December 2020

Version Control Sheet

Supersedes the following individual CCG policies:				
GW 3.0 NWS SD	July 2016 July 2013 Oct 2017	Liz Patroe H. Corp. Serv. Justin Dix	Final Final Final	Approved by QCG Approved by Governing Body Approved by Audit Comm.

Version	**Date**	**Author**	**Status**	**Comment**
0.4	01/11/18	Jo Silcock	Draft	
0.6	05/11/18	Natasha Moore	Draft	Minor formatting and comments
1.0	Nov 2018	Elaine Newton	Final	Reviewed by Audit Committees and approved by Governing Bodies

Equality Statement

The Surrey Heartland's CCGs aim 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. We take into account the Human Rights Act 1998 and promote equal opportunities for all. This document has been assessed to ensure that no employee 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.

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.

See next page for an Equality Analysis of this policy.

Equality Analysis

Equality analysis is a way of considering the effect on different groups protected from discrimination by the Equality Act, such as people of different ages. There are two reasons for this:

- to consider if there are any unintended consequences for some groups
- to consider if the policy will be fully effective for all target groups

Name of Policy: Framework for the Production of Policies and Procedural Documents	**Policy Ref:** CORP 01	**Is this** **New?** [ ] **Or Existing?** [✓]
Assessment conducted by (name, role): Natasha Moore		**Date of Analysis:** Oct 2018
Directorate: Comms and Corporate Affairs	**Director's signature:**	
Who is intended to <u>follow</u> this policy? Explain the aim of the policy as applied to this group. All CCG staff. Owners in particular will need to follow the Policy when updating or developing new policies or procedure documents.		
Who is intended to <u>benefit from</u> this policy? Explain the aim of the policy as applied to this group. The CCG will benefit from its policies following an approved format; this will strengthen its governance and compliance with legal and statutory duties.		
1. Evidence considered. Best practice guidance for writing procedural documents as detailed in the bibliography.		
2. **Consultation.** The Joint Staff Partnership Forum (JSPF) has been consulted.		
3. Promoting equality. Neutral effect. As detailed in the Equality Statement, policies can be made available in different formats for CCG staff with different communication needs.		
4. Identifying the adverse impact of policies		
a) People from different age groups: No adverse impact predicted from this policy.		
b) Disabled people: No adverse impact predicted from this policy.		
c) Women and men: No adverse impact predicted from this policy.		
d) Religious people or those with strongly help philosophical beliefs: No adverse impact predicted from this policy.		
e) Black and minority ethnic (BME) people: No adverse impact predicted from this policy.		
f) **Transgender people**: No adverse impact predicted from this policy.		
g) Lesbians, gay men and bisexual people: No adverse impact predicted from this policy.		

h) Women who are pregnant or on maternity leave: No adverse impact predicted from this policy.
i) People who are married or in a civil partnership: No adverse impact predicted from this policy.
5. Monitoring The Head of Corporate Governance will keep a log of any difficulties that CCG staff have with updating and developing new policies and monitor for any equality trends.

Contents

1. Introduction and Policy Objective

1.1. Policies are a key component of 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 main objective of the '**Framework for the Production of Policies and Procedural Documents**' is to provide:

- a consistent framework for the development, management and control of the CCG's procedural documents including Policies and Frameworks, Procedures, Protocols, Guidelines, Tool-kits and Patient Group Directions (PGDs);
- guidance on corporate identification and standards (style, format and content) to which documents, including strategies and operational/business plans, should conform as far as possible;
- guidance on the relevant approving/ratifying committee and the source of assurance, where relevant. The former is informed by the CCG's Constitution (Scheme of Reservation and Delegation).

1.3. This will ensure that appropriate information is presented in a standard format, is easily accessed by staff and relevant stakeholders (including partners and the public) and that the drafting, ratification and review process is clear.

1.4. It is a requirement that all new and existing procedural documents are assessed with due regard to relevant employment law and equality legislation - specifically the public sector equality duty (PSED) - to ensure that decisions are fair, transparent, accountable, evidence based and consider the needs and rights of all stakeholders. This ensures compliance with legislation, national guidance and best practice.

1.5. Policies that are developed in collaboration with other CCGs, the local authority or other bodies may differ from the proscribed Surrey Heartland's format. In these instances, should the policy itself be adopted by the CCG, the reason for deviations from the Policy outlined in this policy will be explained on the front page.

2. Legislative Framework/Core Standards

2.1. This Policy is based on the NHS Litigation Authority's core standards for the production of approved procedural documents (http://www.nhsla.com/home.htm), which are as follows:

- agreed CCG-wide style and format;
- introduction and definition of terms used for each document;
- clear consultation process;
- clear ratification process;
- reviewing arrangements for each document;
- identified system for control of documents and archiving;
- standardised references to associated documents; and
- clearly identified process for monitoring effectiveness and compliance.

2.2. Non-compliance with the corporate standards detailed in this Policy should be exceptional and justified on presentation for approval and adoption.

3. Scope

3.1. This Policy covers the development of procedural documents within the CCG, setting out the expectations of quality. There are specific 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; and
- 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.

3.2. The CCG would expect its commissioning partners and service providers to have in place an equivalent policy reflecting their own corporate standards of documentation.

4. Definitions

- **Authors:** are senior managers responsible for the editing and updating content of procedural documents.
- **Guidelines**: set out what constitutes best practice for a given subject and, whilst not mandatory, they set out the expectations of quality that should be adhered to. Any variance from guidelines would need to be justified.
- **Owners:** are Executive Directors who are responsible for the accuracy and management of their procedural documents.
- **Patient Group Directives (PGDs):** provide a legal mechanism by which medicines can be supplied and/or administered to patients by a specified range of healthcare professionals without first seeing a doctor or dentist. The principal use within Surrey Heartland's CCGs will be to enable Practice Nurses to administer vaccines without the need for a patient specific direction from a GP.
- **Policies**: documents that set out a statement of intent and form a set of rules around a given topic. Adherence to the rules set out in these documents is mandatory and may form part of the organisation's compliance with statutory duties.
- **Procedural documents:** may include policies (frameworks), procedures, protocols, guidelines, toolkits and patient group directives.
- **Procedures and Protocols**: set out in detail how compliance with policies is achieved.
- **Review Date**: the planned date when the procedural document will be reviewed. Changes in legislation or national guidance may require the document to be reviewed earlier.
- **Toolkits**: provide practical tools for the implementation and day to day application of the policy or guideline.

5. Roles and Responsibilities

5.1. The Governing Bodies and Committees

5.1.1. The Governing Bodies and their Committees have responsibility on behalf of the CCGs, as a public sector body, to demonstrate proper accountability and transparency and to operate within the law. This requires a robust policy, with procedural documents adopted and assurance that they are adhered to and/or carried out effectively.

Responsibility for high level policy approvals is set out in the Scheme of Reservation and Delegation.

5.1.2. If the responsibility for approving procedural documents has been delegated to a committee of the Governing Body, that committee is responsible for their development, implementation, review and monitoring effectiveness in the following way:

- sanction the development of new procedural documents;
- identify a Lead or 'Owner';
- sign off the checklist for review and approval;
- approve relevant policies and procedures where authority has been delegated, and/or provide the appropriate level of assurance to the Governing Body where ratification is reserved;
- agree implementation/dissemination/training plans;
- review whether practices are effective; and
- ensure regular monitoring of compliance is undertaken.

5.2. Directors and Managers are responsible for:

5.2.1. Policy Compliance:

- ensuring adherence to this policy when procedural documents are developed and/or reviewed within their directorate;
- ensuring timely review of policies within their remit, with consultation and an appropriate level of assurance to support the approvals process;
- ensuring arrangements for dissemination/training for staff, where necessary; and
- ensuring upload of the final approved version on to the intranet, via the Policy Development Manager.

5.2.2. Staff Awareness and Relevant Training:

- ensuring staff awareness of the CCG's Policy; that staff know how and where to access relevant, up-to-date procedural documents, are sighted on any changes and participate in recommended training; and
- ensuring that policies and procedures are followed and understood as appropriate to each staff member's role and function. This information forms part of the Corporate Induction Pack, which is given to all new staff on induction.

5.3. Head of Corporate Governance and Secretariat

5.3.1. The Head of Corporate Governance oversees arrangements that provide the central database of all CCG procedural documents. In addition, the Head of Corporate Governance has responsibility for:

- providing advice to staff on the development and adoption of procedural documents; and
- monitoring and reporting on compliance with this policy.

5.4. Secretariat

5.4.1. The Head of Corporate Governance will arrange for the secretariat to administer a centralised database of procedural documents, working with Owners/Authors and the Website Coordinator, ensuring that:

- a single centralised policy electronic database of all CCG procedural documents, identifying Owners/Authors, dates of

approval and scheduled review and appropriate ratifying committee, is maintained;
- final versions of agreed policies are uploaded in a pdf format on the CCG's website;
- staff are informed, via internal staff communications, when a new procedural document has been placed on the CCG's website; and
- the policies and strategies published on the CCG's website are up to date.

5.5. **Owners/Authors** of procedural documents must ensure:
- policies are kept up-to-date, valid and reflect the latest statutory framework, national guidance and best practice;
- adherence to the standards set out in this policy, including adoption of the Policy, when developing or adapting any procedural documents for adoption by the CCG;
- liaison with the Head of Corporate Governance and Secretariat to ensure the appropriate level of consultation, assurance, approval, dissemination, and that the final version is uploaded.
- liaise with other Surrey Heartland's CCGs to design identical/similar procedural documents; and
- monitoring and review of compliance.

5.6. **All Staff** must ensure that they:
- know how and where to access relevant, up-to-date procedural documents;
- comply with all CCG procedural documents;
- participate in any training or undertake a self-assessment against competencies, as required; and
- are aware of how procedural documents impact on their practice and be able to follow the specified requirements.

6. Procedure

A flow chart for the development of procedural documents is attached as Appendix 1- Flow Chart for the Development of Procedural Documents".

6.1. **Adapting Existing Procedural Documents**

6.1.1. Where the CCG does not have an existing procedural document to cover a particular activity, a relevant procedural document from another organisation may be adopted, subject to the Owner:
- sourcing and obtaining permission from the owners in the first instance;
- seeking appropriate assurance that the document is clinically correct, if the document is a PGD or clinical protocol;
- ensuring compliance with the requirements set out in this Policy – e.g. in terms of style, format (content), quality standards, consultation, Equality Impact Analysis, implementation (training/dissemination) and monitoring of effectiveness/compliance; and
- submitting the existing procedural document to the approving committee, in accordance with the Scheme of Reservation & Delegation.

6.2. Writing New Procedural Documents

6.2.1. Where the CCG does not have an existing procedural document which covers a particular activity and there is no suitable pre-existing document that can be sourced from another organisation, a new document may be drafted subject to the following:

- the requirement for the procedural document has been agreed at JET;
- ownership by an Executive Director who will then nominate the Author;
- if the document is a Patient Group Direction (PGD) or clinical protocol, the appropriate assurance has been sought that the document is clinically correct;
- ensuring compliance with the requirements set out in this Policy; and
- submission to the approving committee, in accordance with the Scheme of Reservation & Delegation.

6.3. Style, Format and Content

6.3.1. Appendix 2 provides detailed guidance on writing procedural documents. Sample policy and procedural templates are available on the CCG intranet or at request from the Governance Team. Alternatively, this policy can be used as a template for writing a new policy. A policy must contain the corporate quality standards for style, format, content (headings), policy reference and version control.

6.3.2. All procedural documents are managed by their Owner/Author. However, the CCG Corporate Team provides support for compliance with style, content and review. This is specifically delivered through two gateways:

- **Before Approval –** When an Owner has created or updated a procedural document and wishes the Governing Bodies or Committees to Review or Approve the document, the document must be first checked by the Corporate Team for compliance with this policy.
- **Before Publication –** After the document has been approved, the Owner must supply the approved version to the Corporate Team for logging in the Master Procedural Documents Register (Appendix 3).

6.4. Consultation

6.4.1. Before a procedural document is presented for approval, it must be subject to a consultation process to provide the necessary level of assurance that the document is accurate and reflects the needs of the CCG. Consultation may be with professional bodies, specialists, staff members (e.g. the Joint Staff Partnership Forum) and/or public engagement groups. Procedural documents should set out clearly to whom the document has been circulated for consultation.

6.4.2. Consultation on this Policy will be via the Joint Staff Partnership Forum as it is intended for use by staff as the framework for standard development of CCG documents.

6.5. Equality Impact Analysis

6.5.1. All procedural documents must be analysed to test for intended or unintended equality bias. This assessment must be completed by a person who has had suitable training and who is neither the Owner nor the Author.

6.6. Assurance

6.6.1. Some procedural documents require formal assurance from specialists or professional groups set up by the CCG. Such documents for instance may contain elements of clinical practice or be grounded in employment law or Health and Safety legislation. Relevant directors, Joint Staff Partnership Forum and Governing Body committees will also provide a level of assurance in advance of authorisation. Assurance requirements are set out in Table 1 below.

6.6.2. Assurance for this Policy will be via the Executive Director of Communications and Corporate Affairs, Head of Corporate Governance and Secretariat and the Joint Staff Partnership Forum.

6.7. Approval and Ratification

6.7.1. Before a procedural document can be approved, the author is required to complete the checklist for review attached as at Appendix 4 - Procedural Document Checklist for Approval", signed off by the Owner, in advance of approval by the authorising committee. The flow chart in Appendix 1- Flow Chart for the Development of Procedural Documents" sets out the stages for approval.

6.7.2. The authorising committee for policies is set out in the Scheme of Reservation and Delegation, which forms part of the CCG's Constitution. Table 1 below represents a summary guide as to how approvals and assurance should be enacted for key policies and policy areas.

6.7.3. Policies requiring authorising by the Governing Body must be reviewed by the relevant committee of the Governing Body and recommended for approval.

6.7.4. Guidelines, protocols and procedures may be approved for use by the relevant committee of the Governing Body, with expert consultation and assurance as necessary.

6.7.5. Toolkits may be approved for use by the Joint Executive Team, with expert consultation and assurance from the relevant director lead/specialist.

Table 1 Summary of Committees & Assurance Required for Different Policies

Policy or Policy Area	Authorising Committee	Assurance required
Framework for the Production of Policies and Procedural Documents	Governing Bodies	Audit Committees Head of Corporate Governance and Secretariat
Prime Financial Policies	Governing Bodies	Audit Committees
HR policies	Remuneration Committees	Exec. Dir. of Communications & Corporate Affairs (Consultation with Joint Staff Partnership Forum may be indicated)
Overarching Health and Safety Policy	Audit Committees	Health and Safety Committees (Consultation with Joint Staff Partnership Forum may be indicated)
Risk Management Strategy	Governing Bodies	Audit Committees
Emergency Planning Policy and Organisational Business Continuity Plan	Governing Bodies	Audit Committees
Quality and Safeguarding policies	Quality Committees	Executive Director, Quality
Information Governance policies	Audit Committees	Information Governance Working Groups (including Caldicott Guardians and SIROs)
Other corporate (governance) policies including standards of business conduct	Governing Bodies	Audit Committees / Joint Executive Team
Clinical and Medicines Management policies	Quality Committees	Surrey Priorities Committee and/or Prescribing Lead and/ or Medicines Optimisation Groups
Commissioning policies	Strategic Finance and Performance Committees[1]	Clinical Executives / Cabinets and / or others as required; Chief Finance Officer

6.8. Dissemination and Implementation

6.8.1. The procedural document should set out clearly how it will be disseminated to staff/relevant stakeholders, and implemented, for example through training, workshop or self-assessment against identified competencies.

6.8.2. Dissemination of this Policy will be undertaken through staff briefings; the Policy will be available on the intranet with explanation, and the internet as part of the published suite of CCG policies. The Head of Corporate Governance will provide guidance to staff.

6.9. Monitoring for Effectiveness and Compliance

6.9.1. How procedural documents will be monitored for effectiveness should be set out and include the frequency and nature of monitoring. The

[1] There may be exceptions where local clinical commissioning committees/ forums have a role in approving commissioning policies or elements of policies. For any advice, please contact the Governance Team.

appendix entitled Compliance & Audit Table should be completed with this information. If policy compliance is the subject of an Internal Audit review, this will represent the audit of effectiveness and compliance.

6.9.2. Where there are gaps or omissions, an action plan should be generated. The Committee with oversight of this information will be the authorising Committee.

6.9.3. Compliance with this 'Policy' will be undertaken every three years by auditing a sample of procedural documents and measuring them against the quality criteria set out in this policy.

6.9.4. The Audit Committees will also report against this policy within its committee effectiveness report to the Governing Body (for the Annual Governance Statement). This will cover the number of policies within its remit that have been reviewed and approved within date and can be extended to give assurance of compliance with this Policy.

6.10. Review and Revision

6.10.1. Unless otherwise specified, all procedural documents should be reviewed at least every three years, and resubmitted for approval to the authorising committee, with a schedule of proposed changes. More frequent review may be indicated if there are significant changes in practice or law. The next scheduled date for review is detailed on the cover of each procedural document, and it is the responsibility of the Owner to carry this out.

6.10.2. This Policy will be reviewed at least every three years by the Owner/Author to ensure continued validity and relevance, with a schedule of proposed amendments presented to the Audit Committees for review and the Governing Bodies for approval.

6.11. Extending the Lifespan of Policies (by exception)

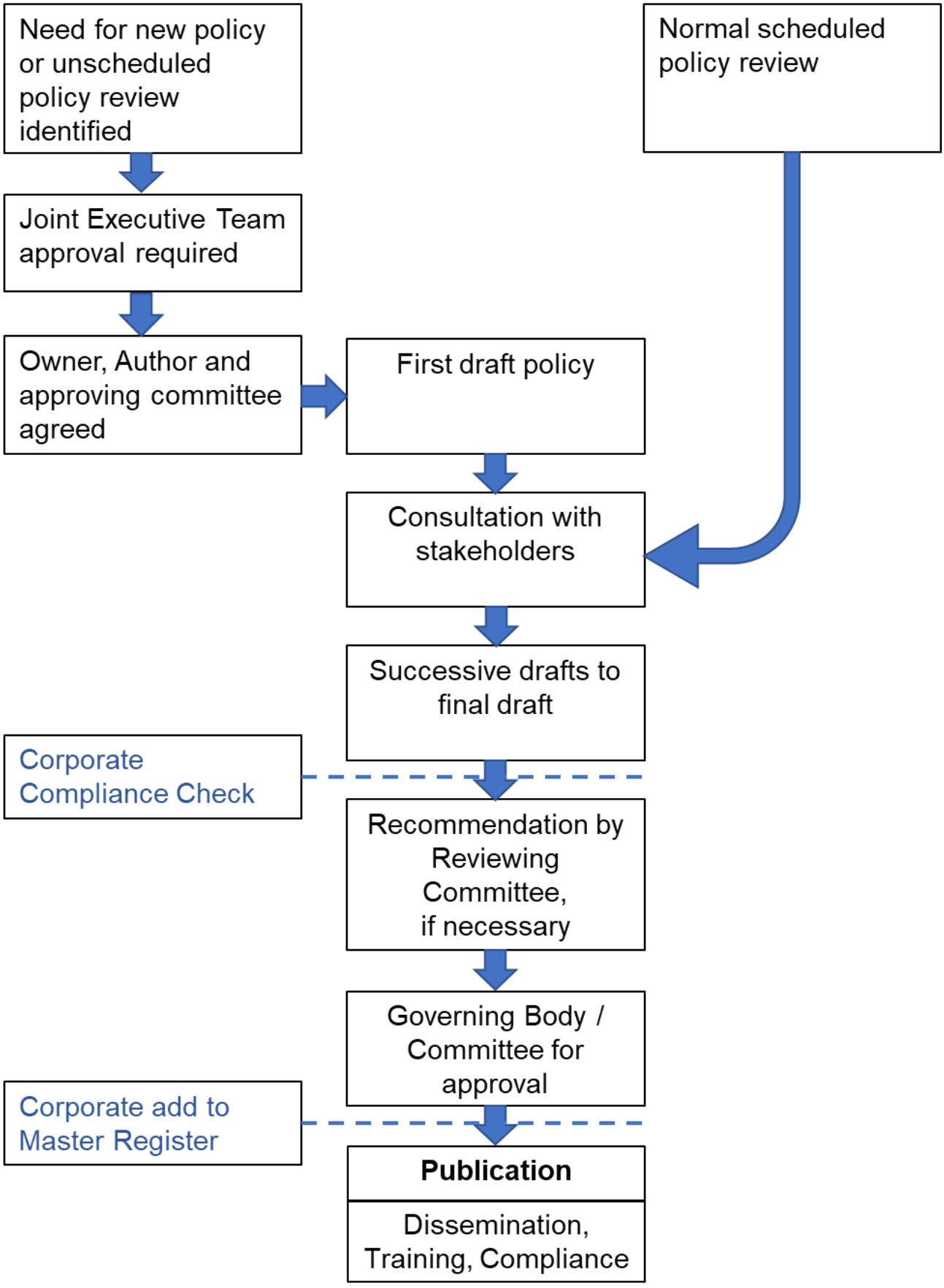
6.11.1. The Joint Executive Team may, on behalf of the Governing Bodies and their Committees, temporarily extend the lifespan of a policy in exceptional circumstances, to enable robust and comprehensive review e.g. where new guidance is anticipated, but not yet issued. This extension is subject to confirmation from the Owner of its continued validity and organisational relevance; the extension should not exceed a period of six months.

6.11.2. If the lifespan is extended this must be noted on the current policy's front cover and published on the CCG's website.

7. Bibliography

- NHSLA core standards, NHS Litigation Authority http://www.nhsla.com/home.htm
- The CCG's Constitution
- The Development and Management of Procedural Documentation in Leicestershire Partnership NHS Trust, Leicestershire Partnership NHS Trust

Appendix 1- Flow Chart for the Development of Procedural Documents



Appendix 2 - Guidance on Writing Policies using Agreed Style

1. Contents

1.1 The procedural content should typically be organised under the main headings as per the policy template.

2. Style

2.1 All formatting and styling should follow that of the policy template.

2.2 Consideration should be given to the language used and any technical terms, abbreviations/acronyms or unusual words should be set out in full on first usage and/or explained in the definitions section.

2.3 CCG branding should be used as per the policy template.

2.4 There should be a footer containing page numbers, the title and policy reference but no date.

3. Format

3.1 The Policy Template can be found on the intranet, or authors can use this policy format as a guide. It is recommended that the Word version be used and that text is either directly typed into the template or copied into the template using the format painter tool to ensure consistency.

3.2 Other procedural documents such as frameworks and procedure documents, where the format has been set nationally or where the policy template is not suitable, may adopt alternative formats providing that:

- exceptions to the format are justified when presented for approval; and
- the agreed style is adhered to where possible.

3.3 Procedures and protocols, where the full policy template is not necessary, authors may use an abbreviated version, provided the above two stipulations are adhered to.

4. Appendices and Toolkits

4.1 Appendices should be kept to a minimum and reserved for the provision of:

- large tables or images that would otherwise disrupt the flow of the document;
- monitoring schedules and audit tools;
- references;
- template files, reports and checklists;
- flow charts and algorithms; and
- pathway diagrams and other tools.

4.2 If there is a significant quantity of information in the appendices or the information contained therein may require more frequent updating than the main policy or guideline, it is recommended that this information is provided in the form of a toolkit. The toolkit may be amended separately from the main body of the policy or guideline e.g. Health and Safety (H&S) overarching Policy, with a 'Toolkit' comprising a suite of policies to cover H&S Regulations.

5. Procedural Document Category and Reference Codes

5.1 Approved Procedural Documents are allocated to a Category. This is used to helps users find the document on the CCG website.

5.2 Approved policies, protocols and toolkits will be assigned a Reference Code consisting of two-four letters (depending on the nature of its content) and a number (from 01 upward):

5.3 Forms, templates, action plans and annual strategy documents do not require reference numbers.

Category	**Reference code**
Clinical	CLIN
Corporate	CORP
Financial	FIN
Human Resources	HR
Information Governance	IG
Medicines Management	MM
Standard of Business Conduct	SOBC

6. Version Control

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

6.2 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 etc.).

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

6.4 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.

Appendix 3 – Master Register of CCG Procedural Documents

Please contact the Governance Team for the most up to date Register of CCG Procedural Documents.

Appendix 4 - Procedural Document Checklist for Approval

Title of document being reviewed:	Yes/No/ Unsure	Comments/ Details
Is there an Owner (Executive Director)?	Yes	ED. of Comms & Corp. Affairs
Title		
Is the title clear and unambiguous?	Yes	
Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
Rationale		
Are reasons for development of the document stated?	Yes	
Development Process		
Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
Is there evidence of consultation with stakeholders and users?	Yes	
Content		
Is the objective of the document clear?	Yes	
Is the target group clear and unambiguous?	Yes	
Are the intended outcomes described?	Yes	
Evidence Base		
Is the type of evidence to support the document identified explicitly?	Yes	
Are key references cited?	Yes	
Approval		
Does the document identify which committee/group will approve it?	Yes	
Dissemination and Implementation		
Is there an outline/plan to identify how the document will be disseminated and implemented amongst the target group? Please provide details.	Yes	
Process for Monitoring Compliance		
Have specific, measurable, achievable, realistic and time-specific standards been detailed to monitor compliance with the document?	Yes	
Review Date		
Is the review date identified?	Yes	
Overall Responsibility for the Document		
Is it clear who will be responsible for implementing and reviewing the documentation i.e. who is the document owner?	**Yes**	**ED. of Comms. & Corp. Affairs**

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	Elaine Newton	Date	
Position	Executive Director of Communication and Corporate Affairs		
Signature			
Committee Approval			
On approval, Chair to sign and date.			
Name		Date	
Signature			

Appendix 5 - Compliance & Audit Table

Criteria	Measurable	Frequency	Reporting to	Action Plan/Monitoring
All procedural documents in Appendix 3 are published.	No. of documents not published	Annually	Audit Committees	Analysis of published procedural documents
All procedural documents reviewed before due date	No. of documents with overdue review date	Annually	Audit Committees	Update Appendix 3 with review dates.
A sample of documents are reviewed for quality compliance	No. of documents reviewed	Every three years	Audit Committees	A sample of 10 documents are reviewed in a rolling programme.
Procedural documents are in active use.	No. of policies with evidence of being implemented/ used	Annually	Audit Committees	A summary report is provided of submissions as set out in Appendix 5 of each procedural document.