NHS
Wiltshire
Clinical Commissioning Group

Clinical Commissioning Group Governing Body
Paper Summary Sheet
Date of Meeting: 25 June 2013

For: PUBLIC session ☒ **PRIVATE Session** ☐

For: Decision ☒ **Discussion** ☐ **Noting** ☐

Agenda Item and title:	**GOV/13/06/10 Policy on Policies**
Author:	Susannah Long, Governance & Risk Manager
Lead Director/GP from CCG:	David Noyes, Director of Planning, Performance and Corporate Services
Executive summary:	The CCG requires an agreed and documented process for developing / reviewing policies and for general policies management. This is captured in the **Policy for the Management of Policies and Standard Operating Procedures**. This policy was initially approved during the CCG authorisation process with an agreed review date falling within the first quarter of 2013/14. The Policy has now been reviewed and minor changes have been made to reflect current CCG/CSU arrangements. The Policy has also been amended to reflect an important procedural change around the approval of policies. It is suggested that the CCG Governing Body will delegate responsibility for approval of policies to the main CCG committees: Quality & Clinical Governance Committee Audit and Assurance Committee Finance & Information Committee The CCG Governing Body will retain accountability for policies and the policy process and will be informed of policy approvals via the minutes of the Committees. The CCG Governing Body will retain the ability to approve policies where this is required or where the subject matter warrants Governing Body consideration. The CCG Scheme of Delegation will need to be updated to reflect this change. It is recommended that the CCG Governing Body approves this policy.
Evidence in support	A Policy for the Management of Policies and Standard Operating Procedures is a requirement of the NHS Litigation Authority.

of arguments:	
Who has been involved/contributed:	The updated policy has been agreed by the Executive Team on 10 June 2013.
Cross Reference to Strategic Objectives:	The Governance Framework contributes to all strategic objectives.
Engagement and Involvement:	This Policy is an internal document and has not received further engagement or involvement at this time.
Communications Issues:	The approved policy will be made available on the CCG intranet.
Financial Implications:	There are no financial implications.
Review arrangements:	The policy will be reviewed on a three yearly cycle.
Risk Management:	The policy contributes to risk management arrangements.
National Policy/ Legislation:	The policy reflects good practice guidelines incorporated into NHSLA risk management standards.
Equality & Diversity:	The policy has no negative E&D impact.
Other External Assessment:	This policy would contribute significantly to any NHSLA assessment.
Next steps:	Use of the policy will be promulgated throughout the CCG.

NHS
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Document information

Document type:	Policy
Document reference:	
Document title:	**Policy for the management of policies and standard operating procedures**
Document operational date:	July 2013
Document sponsor:	David Noyes, Director of Planning, Performance & Corporate Services
Document manager:	Susannah Long, Governance & Risk Manager
Approving Committee/Group:	Governing Body
Approval date:	
Version:	1 Draft 1
Recommended review date:	July 2016
Internet location:	

Please be aware that this printed version of this document may NOT be the latest version. Please refer to the internet for the latest version.

Summary

This policy has been created to standardise the development process, format, approval process, dissemination framework and withdrawal and archiving arrangements for policies and standard operating procedures of the CCG.

Consultation

This policy was developed in consultation with CCG Senior Management. Wider consultation has not been undertaken.

Appendices

The following appendices form part of this document:

Appendix 1: Policy Development Checklist
Appendix 2: Policy Registration Form
Appendix 3: Policy Template
Appendix 4: Checklist for Review & Approval of Policy Documents
Appendix 5: Evaluation Standard
Appendix 6: Non-compliance Form

Review Log

Version	Review Date	Reviewed By	Changes Required? (If yes, please summarise)	Changes Approved By	Approval Date
V1.1	7/6/13	Susannah Long	Minor amendments to reflect emerging CCG; Delegation of approval by Governing Body to Committees		

Acknowledgements

Reference is made to other organisation's policies which were considered to assist in the initial development of this policy:
Solent NHS Trust 'Policy for the Development and Implementation of Procedural Documents' April 2011, Portsmouth City tPCT 'Policy on Corporate & Commissioner Policies' 2009, SHIP Cluster Draft CCG 'Policy For The Management Of Policies And Standard Operating Procedures' April 2012 and NHS Croydon 'Policy for Procedural Documents' July 2009.

POLICY FOR THE MANAGEMENT OF POLICIES AND STANDARD OPERATING PROCEDURES

1.0 INTRODUCTION AND PURPOSE

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 bringing consistency and transparency to day to day practice, contributing to achievement of strategic objectives.

The rigorous development and management of these documents is a control mechanism for the CCG and 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 and standard operating procedures (SOPs) in accordance with the NHS Litigation Authority (NHSLA) Risk Management Standards 2013/14 and other relevant guidance.

2.0 SCOPE AND DEFINITIONS

2.1 Scope

This policy applies to all directly and indirectly employed staff working with the Clinical Commissioning Group (CCG).

2.2 Definitions

For the purpose of this policy, the word 'policy' refers to policies and SOPs.

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:	The 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

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.

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.

3.0 PROCESS / REQUIREMENTS

This section provides details of the principles to be used in the development and management of policies. Appendix 1 is a checklist to be used as a simple companion for the step by step drafting and review of a policy.

3.1 Registration

To avoid duplication, promote the involvement of all relevant stakeholders and to provide general support in the development of policies and SOPs, the intention to develop or review a policy must be registered with the Director of Planning, Performance and Corporate Affairs. Registration of a policy can be achieved by completing the form shown in Appendix 2**.**

A development reference number will be issued along with any suggestions for additional stakeholders to contact during development and/or details of similar work being undertaken. Suggestions may be made regarding what would constitute appropriate consultation. The pathway for formal approval will be confirmed.

3.2 Corporate identity and format

All policies should be written using the standard template (see Appendix 3).

The basic format requirements are as follows:

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- 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 12 or greater. Bold and capitalisation may be used, underlining should be avoided;
- The body text should be written using black Arial 12 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.

The policy should be written in plain English and should be concise and clear. Jargon should be avoided and 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.

3.3 Adopting external policies

Local Authority, Commissioning Support Unit, NHS England, Department of Health and other NHS organisation's policies do not need to be rewritten into the CCG format if the CCG is intending to adopt them. Where possible the standard front sheet should be attached to the policy. Details of the consultation process and the standard document control requirements should be 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

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 Director of Planning, Performance and Corporate Affairs. Any groups/individuals consulted during the development or review of the policy should be listed at the front of the policy.

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.

Staff side 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.

Policy consultation undertaken will be considered at approval. Policies showing insufficient consultation for the policy topic will not receive approval. Please refer to Appendix 4 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

“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. 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.” Source: The Advisory, Conciliation and Arbitration Service (ACAS).

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.

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.

The Equality Impact Assessment (EIA) Tool is designed to systematically assess the impact of any document or decision and can be accessed via the Equality and Diversity Policy. 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.

3.6 Success criteria / Monitoring effectiveness

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

3.6.1 Monitoring compliance (General implementation)

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. The document must state where the results of this monitoring will be presented and how any resulting actions will be taken forward and themselves monitored.

3.6.2 Monitoring compliance (Local implementation)

It is a requirement that all staff adhere to policies. To facilitate local Managers' assessment of compliance within their department each policy should contain an Evaluation Standard (or an appropriate alternative tool). This is a basic tool drawing out the main points of the policy, in the form of questions, which may be used to perform quick local audits. Local Managers will be expected to take local remedial action in response to findings and report as appropriate to the Director of Planning, Performance and Corporate Affairs.

Standards will vary in size and complexity dependant on the policy concerned. Document Managers should aim to keep the tool as simple as possible to promote use and hence compliance. Please see Appendix 5 for the Evaluation Standard for this policy which can be used as a template.

3.6.3 Achievement of aims

The Document Manager should, where possible, identify qualitative and quantitative outcome measures to identify whether the aims are being achieved by implementation of the policy. The Document Manager should

detail the method by which these measures are monitored, how often this will take place and where performance results will be taken.

3.6.4 Non-compliance with policies

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. The Non-compliance form (Appendix 6) must be completed. 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 Approval process

The Scheme of Delegation in the Constitution shows where approval has been delegated to committees. The Governing Body is accountable for CCG policy coverage. Policy approval is delegated by the Governing Body to the Quality & Clinical Governance Committee, Audit and Assurance Committee and Finance & Information Committee. Policies must be presented to the most appropriate and relevant committee for approval. The Governing Body will be informed of policy approvals via committee minutes.

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 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.
Policies presented to the CCG Governing Body for approval should first have been considered and agreed at the appropriate sub-committee.

There is no requirement to formally agree Standard Operating Procedures (SOPs) although there may be some instances where SOPs require approval and ratification depending on the content, potential risk and impact. Where necessary the Clinical Executive Committee will be asked to approve SOPs.

The form in Appendix 4 ‘Checklist for the review and approval of Policy Documents’ is used by the CCG Governing Body or delegated committee when approving policy documents.

3.7.2 Approval prior to CCG authorisation

The CCG was required to have some policies in place for submission at authorisation. These policies were presented to the Clinical Commissioning Committee for approval on behalf of the aspiring CCG.

3.8 Communication and dissemination

All approved policies will be made available on the CCG 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 or via the Publication Scheme.

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

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.

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. Alternatively, it may be considered more appropriate by the Document Manager to visit departments or to meet individually with managers 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.

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 4 for the Checklist for Review and Approval of Policy Documents.

3.10 Policy review

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.

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.

The Director of Planning, Performance and Corporate Affairs will issue a reminder to the Document Manager six months prior to the stated review date.

The review must be registered with the Director of Planning, Performance and Corporate Affairs using Appendix 2. 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.

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.

The CCG will undertake to review all policies approved prior to April 2013 within the first 6 months of the financial year 2013/14 to ensure that they correctly reflect the structure and arrangements of the new CCG.

3.11 Policy control and archiving

The Director of Planning, Performance and Corporate Affairs will hold and publish a Policy Register. This Register 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.

Record retention periods are defined in the Records Management: NHS Code of Practice. The Director of Planning, Performance and 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 approving committee and ratified by the CCG Governing Body.

4.0 ROLES AND RESPONSIBILITIES

CCG Chair
The Chair 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.

Director of Planning, Performance and 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 Director of Planning, Performance and Corporate Affairs has been notified of any policies under development using the registration form in Appendix 2;
- 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 non-compliance (Appendix 6).

5.0 TRAINING

No specific training is available to support this policy. Any queries relating to policy development should be addressed to the Director of Planning, Performance and Corporate Affairs.

6.0 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.

7.0 SUCCESS CRITERIA / MONITORING EFFECTIVENESS

The Evaluation Standard in Appendix 5 has been developed to provide assurance for monitoring compliance and effectiveness of any policy.

The Director of Planning, Performance and 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 Director of Planning, Performance and Corporate Services 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 using the non-compliance form at Appendix 6.

8.0 REVIEW

This document may be reviewed at any time at the request of either staff side or management, 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

POLICY DEVELOPMENT CHECKLIST

Checklist			
1	**Before Development**	**To prevent duplication and to help you in the process, have you completed the policy registration form and sent it to the Director of Planning, Performance and Corporate Affairs?**	Development Number?
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?** • Serial Number / Operative date / Review date etc	Yes / No
		Does the document follow the organisation's format? • The body text should be written using black Arial 12 font etc	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 the CSU 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

Checklist			
7	**References**	**Is relevant national guidance/evidence present in the document?**	Yes / No
8	**Monitoring Effectiveness**	**Has the process and timescales for monitoring the document's implementation and its effectiveness been identified?**	Yes / No
9	**Approval**	**Have you booked an agenda item with the approving committee?**	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 Director of Planning, Performance and Corporate Affairs has archived the previous copy?**	Yes / No
11	**Intranet Uploading**	**Have you provided a final approved version to the Director of Planning, Performance and Corporate Services 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
13	**Awareness**	**Have you completed proposed awareness exercises / publicity to inform staff?**	Yes / No

APPENDIX 2

POLICY REGISTRATION FORM

1. DOCUMENT MANAGER INFORMATION

Name	
Job Title	
Department	
Work Telephone No.	
Email Address	
Work Address	

2. POLICY

Activity	**Development**	**Review**
Proposed Title		
Summary of Policy		
Link with other policies		
Target Audience		
Proposed Approving Committee		
Who will be involved / consulted during development/review of this policy?		

3. REVIEW OF EXISITING POLICIES ONLY

Previous version number	
Review Date	

PLEASE SEND YOUR COMPLETED FORM TO:

DIRECTOR OF PLANNING, PERFORMANCE AND CORPORATE AFFAIRS
Address:
Policy Co-ordination
Corporate Services
NHS Wiltshire CCG
Southgate House

Email Address:
Susannah.long@nhs.net

TO BE COMPLETED BY THE DIRECTOR OF PLANNING, PERFORMANCE AND CORPORATE AFFAIRS AND RETURNED TO THE DOCUMENT MANAGER:

Development reference number	
Committee for approval	
Additional consultation	
Any other comments	
Date	

APPENDIX 3

POLICY TEMPLATE

LOGO

Document information

Document type:	Policy / Standard Operating Procedure
Document reference:	
Document title:	
Document operational date:	
Document sponsor:	
Document manager:	
Approving Committee/Group:	
Approval date:	
Version:	
Recommended review date:	
Internet location:	

Please be aware that this printed version of this document may NOT be the latest version. Please refer to the internet for the latest version.

Summary

Briefly summarise the purpose and content of the policy.

Consultation

Detail the consultation with individuals and/or Groups that was undertaken.

Appendices

The following appendices form part of this document:

Appendix 1:
Appendix 2:

Review Log

Version	Review Date	Reviewed By	Changes Required? (If yes, please summarise)	Changes Approved By	Approval Date

Acknowledgements

It may be appropriate to insert a Contents Table to ease navigation through the document.

INSERT POLICY TITLE

1.0 INTRODUCTION & PURPOSE

1.1 Insert text

2.0 SCOPE & DEFINITIONS

2.1 SCOPE
It is essential that the document explicitly states to whom it applies

2.2 DEFINITIONS
Insert any definitions for any terms used

3.0 PROCESS/REQUIREMENTS

3.1 There is no prescriptive way of detailing this section and the main body of the document will be unique depending on the subject matter. Include subsections as required.

4.0 ROLES & RESPONSIBILITIES

4.1 Outline here (subsections may be necessary) the different roles and responsibilities individuals and committees/groups may have in relation to this document.

5.0 TRAINING

5.1 Outline here any training implications or issues as a result of this document. The Document Manager must ensure that the Training Service have been engaged in the development of the document where any learning or training needs have been identified. Attendance at any training session carried out as a consequence of the policy implementation must be formally recorded and documented and added to the Training Needs Analysis as required.

6.0 EQUALITY, DIVERSITY AND MENTAL CAPACITY

6.1 Include a statement summarising the outcome of the Equality Impact Assessment and Mental Health Assessment that was conducted in relation to this policy. The following standard wording may be used:

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

6.2 Ensure that the EIA accompanies the policy for approval and is then published.

7.0 SUCCESS CRITERIA / MONITORING EFFECTIVENESS

7.1 The Document Manager must be able to demonstrate the effectiveness of the policy at the point of review, for example by; carrying out audits, reviewing incidents that may have occurred related to the policy, discussing the policy at team meetings. Any subsequent issues/findings resulting from the review should be incorporated in the new version of the policy.

7.2 It will be necessary to formally document the results of the evaluation and keep records of any discussions relating to the monitoring of the policy for audit purposes.

7.3 This section should include details of the following (in accordance with NHSLA best practice);

- *Monitoring arrangements for compliance and effectiveness i.e. audit, review etc*
- *Responsibilities for conducting the monitoring/audit*
- *Methodology to be used for monitoring/audit*
- *Frequency of monitoring/audit, i.e. quarterly, on a rolling basis*
- *Process for reviewing the result and ensuring improvements in performance occur.*

7.4 In relation to policies that support any assessment against the NHSLA Risk Management standards, Document Managers should ensure they have referred to the NHSLA guidance to ensure that all the criteria requirements have been met.

8.0 REVIEW

8.1 Include the standard statement: "This document may be reviewed at any time at the request of either staff side or management, but will be reviewed after three years." Or modify to reflect the requirements for the policy.

9.0 REFERENCES AND LINKS TO OTHER DOCUMENTS

9.1 Where applicable, the document must contain a section detailing the Research/Evidence/References that were used to assist with the development of the Policy. Some of this information may be included at the beginning of the document as way of an introduction but should be referenced in full at the back of the policy. The Harvard Referencing System should be used as standard.

9.2 Signpost the reader to other relevant and supporting policies / Standard Operating Procedures. (Ensure these are cross referenced within the main body of the policy where appropriate).

APPENDIX 4

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
1	**Title**		
	Is the title clear and unambiguous?		
	Is it clear whether the document is a guideline, policy, protocol or standard?		
2	**Rationale**		
	Is the purpose of the document stated?		
3	**Development Process**		
	Are people/groups involved in the consultation identified?		
	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?		
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?		

6	**Communication**		
	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 have a reference number?		
	Does the document have a version and draft number? (eg. V1.5)		
	For reviewed policies, has the review log been completed?		
8	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs 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?		
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 co-ordinating the dissemination, implementation and review of the documentation?		

APPENDIX 5

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 9 section headings

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 TNA 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

Conclusion

Please explain any discrepancies below:

Please detail remedial action to prevent re-occurrence, giving details of monitoring arrangements to assess improvement:

Appendix 6

Non-compliance Form

Please complete this form to notify the organisation of non-compliance with approved CCG policy, where the policy requirements cannot be applied to the specific set of circumstances experienced by the service.

Policy name:	
Policy reference number:	
Policy Document Manager:	

Date of first non-compliance:	
Department:	

Please state the section(s) of the policy which cannot be applied and detail the policy requirements

Please detail the reason(s) why compliance cannot be achieved in this instance.

Is this likely to happen again?	YES	NO
In your opinion, does the policy need to be reconsidered to meet the specific circumstances of your department?	YES	NO

Please detail the risk posed by non-compliance, any action taken in this instance (including completion of any Adverse Event Form), addition to Directorate Risk Register and any steps to minimise risk from non-compliance in the future.	
AER form reference:	
Risk Register reference:	

Alternative course of action authorised by:	
Please sign:	
Please print name:	
Please print designation:	

Form completed by:	
Please sign:	
Please print name:	
Please print designation:	
Please date:	

Please send copies of this form to the Document Manager and to the Director of Planning, Performance and Corporate Affairs

Director of Planning, Performance and Corporate Affairs
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