# Policy Development Guide

# Document Reference Information

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| **Version:** | 1.0 |
| **Status:** | Final |
| **Author:** | Tony Ciriello, Corporate Governance Manager |
| **Directorate responsible:** | Corporate |
| **Lead Executive:** | - |
| **Contributors to Policy:** | Members of Corporate Team<br>Human Resources |
| **Approving Committee:** | Clinical Executive Joint Committee |
| **Date ratified:** | 29th August 2018 |
| **Date effective:** | 29th August 2018 |
| **Date of next formal review:** | August 2020 |
| **Target audience:** | All Staff |

# Version Control Record

| Version | Description of change(s) | Reason for change | Author | Date |
|---|---|---|---|---|
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# Contents

# 1. Introduction

## 1.1 Why Policies?

A policy is defined as a "Set of statements documenting the standards, intentions and/or expectations of how a practice or course of action will be implemented and adopted".

It formally and explicitly sets out requirements which all staff are expected to follow.

The purpose for doing so is:

- To define and communicate organisational ways of working
- Clarify strategic and operational requirements
- Achieve consistency to day to day practice

## 1.2 What Could Trigger the Need to Develop a Policy?

The following factors could also trigger consideration for the development of a policy document

- An issue or matter is identified which, if not managed in a systematic and coordinated way, could pose a risk to effective working

- External directive is received which necessitates a change to local practices and procedures

- A change to national policy which would need to be reflected locally, in order to demonstrate compliance

## 1.3 CCG Policies in Place

The CCGs have a suite of policies, which fall under the following broad categories:

- Area Prescribing Committee*

- Commissioning/Individual Funding Requests*

- Corporate which also encompasses Information Governance

- Counter Fraud

- Health & Safety

- Human Resources

- Quality

- Safeguarding – Adults and Children

\* The development of clinical and commissioning policies is subject to a separate process.  Please contact a member of the contracting or medicines management team to obtain further detail regarding commissioning and medicines management policies respectively.

## 2.  Roles and Responsibilities

**Policy Authors –** Refer to the guidance set out within this policy and to follow steps outlined within the charts overleaf regarding the creation of new policies and updating of existing policies.

**Corporate Team –** Corporate Governance Manager to act as operational lead for policy management processes, ensuring all systems operate efficiently and CCGs demonstrate compliance with national guidance and mandated responsibilities.

To provide advice and guidance to policy authors and to assume specific responsibility for all actions detailed within the "Post Submission of Policy" section of the flowchart overleaf.

**Executive Lead –** Assumes lead responsibility for policy area, ensures compliance with national and local guidelines; and oversees successful implementation.

**Approval Committee –** Approval of policy, seeks assurance that appropriate stakeholders have been consulted; and that plan for implementation is in place.

**Stakeholders/Contributors –** All those involved in producing the policy document have a responsibility to make sure that consultation has taken place with appropriate stakeholders/contributors, who may be part of the policy's target audience or are able to provide specialist expertise.

**Staff -** All staff have a duty to read and work within current policies.  All staff should know where policies are stored and how to gain access to them.  If a member of staff identifies that any part of a policy is no longer relevant, they have a responsibility to contact the person responsible for writing or reviewing the policy to inform them of this.

## 3.  Policy Flowcharts (Please see Overleaf)

**Development of New Policies**

## Source Policy Template from CCGs intranet

**Key Considerations:**
Review key headings and populate sections in line with template within appendix 1

## Consult Appropriate Individuals/Groups

**Key Considerations:**

**Corporate Policies (Including IG)** – Corporate Team          **Health & Safety** - Corporate Team

**Counter Fraud** - CCGs Local Counter Fraud Specialist/Corporate Team

**Quality** - Quality Team/Subgroup    **Safeguarding** - CCGs Safeguarding Leads/Quality Subgroup

**Human Resources** - Staff Council*    (*Please see supporting detail on P7)

## Policy Submitted

**Key Considerations:**
Review and populate relevant committee frontsheet.

Authors are also required to:

- State the nature of the change (Scheduled Review & Update, Unscheduled Significant Review/New Policy)

- State key actions to be undertaken post ratification

All policies to be submitted to Clinical Executive for ratification, with exception of:
Counter Fraud, Risk Management, IG and Conflict of Interests which are submitted to Audit Committee

## Post Submission of Policy

**Key Considerations:**
Author's responsibility to notify and send approved policy to Corporate Governance Manager who will:

- Update the CCGs Policy Database. This acts as a single repository for all CCG policies and will be monitored in order to identify when policies are due for review
- Upload policies to the appropriate section of the website
- Store an electronic version locally
- Communicate to staff and relevant stakeholders

6

**Review of Existing Policies**

## Review Date

**Key Considerations:**
Corporate Governance Manager will notify the policy author of the scheduled review date approximately 2 months in advance

## Review Process

**Key Considerations:**

- Release of new guidance to be reflected within the policy?

- Any changes in roles and responsibilities?

- If material changes are made, consult relevant groups/individuals

## Submission of Policy

**Key Considerations:**
Review and populate relevant committee frontsheet

## Post Submission of Policy

**Key Considerations:**
Author's responsibility to notify and send approved policy to Corporate Governance Manager who will:

- Update the CCGs Policy Database. This acts as a single repository for all CCG policies and will be monitored in order to identify when policies are due for review
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- Communicate to staff and relevant stakeholders

## Stage 1 – Communication with CCG staff

The Senior and Assistant HR Business Partner assume overarching responsibility of ensuring HR policies are in line with CCG needs and legislation updates. Policies will be agreed for a period of 3 years and will only be reviewed at an earlier date if there is a legislative or organisational need.

Following the review of each HR policy the draft will be uploaded on to the CCGs' intranet which will be accessible to all staff within the CCGs. Once uploaded on the intranet, staff will be informed through the CCGs' weekly update, to ensure they are aware of the policy review. Staff within the CCGs will have a period of 2 weeks to review the document, ask questions via HR and provide feedback through either HR or their Staff Council representative. The feedback will be taken into consideration and necessary amendments will be made.

Please note that the policy will remain on the intranet in draft form until the final ratification as detailed in Stage 3.

## Stage 2 - Staff Council Review

All HR policies are sent to the members of Staff Council 1 week in advance of the Staff Council meeting. This is to provide opportunity for the members of Staff Council to review the policy, consider any changes and communicate with their team to gather feedback. During the Staff Council meeting, HR attend to ensure a full understanding of any changes being suggested, to answer questions, provide justification and collate the amendments from the members of Staff Council.

Once the final version is confirmed the necessary policies will be sent to the Head of Communications, Organisational Development and Community Engagement.

## Stage 3 – Final Ratification and Publishing

The staff agreed HR Policy will then be taken to the CCGs' Clinical Executive Committee where the Head of Communications, Organisational Development and Community Engagement will feedback regarding the policy changes and process. The CCGs' Clinical Executive Committee will review the policy along with the verbal update and will ratify the policy for implementation throughout the CCGs.

## Further monitoring and support

All HR policies are monitored through an HR policy schedule which is reviewed on a monthly basis by the Senior and Assistant HR Business Partner, to ensure that policies are effective, support the CCGs and adhere to both legislation and best practice.

HR will continuously support managers and staff with the implementation of HR policies, through providing supportive advice, written guidance and management skills training.

Should you have a concern regarding any of the HR policies or this process please contact Tom Grove, Head of Communications, Organisational Development and Community Engagement via t.grove@nhs.net or Maisie Reeves, Assistant HR Business Partner via maisie.reeves1@nhs.net

## 4. Monitoring and Implementation

This guide will be disseminated to staff and published in line with the procedure set out within the "Post Submission of Policy" section above

# **Title of Policy**

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# Contents

| Section | Content | Page |
|---|---|---|
| | | |
| | | |
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# 1.  Introduction

1.1   This section should give an overview as to why the subject is a key priority within the organisation

1.2   Why do we want to develop this document and are there any key drivers
(Legislation, national priorities, best practice etc)?

1.3   State the benefits to patients/organisations/key stakeholders.

# 2.  Purpose

2.1   Give an outline of the objectives and intended outcomes of the process described in your document.

2.2   Keep it short, no more than a small paragraph or a series of bullet points.

# 3.  Scope

3.1   State which members of staff and which groups of patients this document applies to. Are there any eligibility criteria, geographic restrictions or other factors that would determine the scope.

# 4.  Definitions

4.1   This section should provide definitions of the terms that are unique to this document.

4.2   Use key terms only, as the list is only a guide and does not need to be exhaustive.

# 5.  Training/Competencies Required

5.1   Are there any training needs associated with the policy/guideline?

5.2   Should staff have specific qualifications?

5.3   How often do people need training/how long is the training/how do they access it?

# 6.  Responsibilities and Duties

6.1   The roles and responsibilities of staff and stakeholders involved in the process should be documented in this section. Think about the flow of responsibilities across different organisational layers.

## 7. Main Body

## 8. Monitoring and Implementation

8.1   This section should identify how the organisation plans to disseminate the document and monitor compliance with guidance set within it. It should describe how we will know that things are being carried out in the manner described within the document. This section links with the responsibilities and duties section which describes what the post holders' responsibilities are.

8.2   What are the monitoring arrangements and methodologies to check for compliance, i.e. it might be an audit, a report, a review, a check on data base figures etc.

8.3   Who is responsible for conducting the monitoring? Is this shared between individuals/departments?

8.4   At what frequency will the policy be reviewed?  Policy author to determine policy validity. Typically, policies have a validity of 3 years, with the caveat that they are to be reviewed earlier should any key developments or legislative changes arise

8.5   This section could contain auditable standards for key performance indicators.

## 9. Equality Impact Assessment

9.1 Please contact Mohammed Ramzan for guidance ([mohammedramzan@nhs.net](mailto:mohammedramzan@nhs.net))

## 10. Associated Documentation

10.1 This section should provide a cross reference to any other CCG procedural documents that are available on the Intranet [not national or external documents].

## 11. Appendices

11.1 This may contain a wide variety of things such as forms, checklists which policy users may require access to

# Appendix 2 – Policy Formatting Guidelines

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|---|---|
| Paper size | A4 |
| Main text font | Calibri 12 |
| Main Paragraph Headings | Bold text, Sentence case, Calibri 14 and numbered |
| Sub-paragraphs | Sub-paragraphs or key points should be numbered. Headings Calibri 12 bold text |
| Footers | Title and version of document on left hand side which must match the version number on the version control page. Page numbers on right hand side |
| Underlining | None |
| Front page (Title Page) | Standard Template |
| Version Control (second page) | Each draft must be numbered on the Version Control Page. The version control page must be revised and updated following each sweep of amendments. Minor amendments should be reflected by adding or changing after decimal point eg V1.1, V1.2. Major amendments should be reflected by changing the primary number e.g V1, V2. The final version is produced following ratification. All versions up until then must be numbered. |
| Contents List (third page) | Numbered subject paragraphs on left side of page. Page numbers on right side of page. Appendices must also be listed with page numbers. |
| Abbreviations | To be avoided and only to be used after written in full the first time e.g. Area Prescribing Committee (APC). |
| References | Documents should provide an evidence base with up to date references. References must be cited in full using the Harvard referencing style. (http://libweb.anglia.ac.uk/referencing/harvard.htm) |