NHS
Rotherham
Clinical Commissioning Group

Title:	**Policy for the Development and Management of Procedural Documents**
Reference No:	C3
Owner:	Operational Executive
Author:	Ruth Nutbrown – Assistant Chief Officer
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Ratified and Approved by:	OE 16 November 2018 AQuA 8th January 2019 Governing Body 6 February 2019
Distribution:	All staff and GP members of the CCG
Compliance:	Mandatory for all permanent & temporary employees of Rotherham CCG.
Equality & Diversity Statement:	In applying this policy, the organisation will have due regard for the need to eliminate unlawful discrimination, promote equality of opportunity, and provide for good relations between people of diverse groups, in particular on the grounds of the following characteristics protected by the Equality Act (2010); age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief and sexual orientation, in addition to offending background, trade union membership, or any other personal characteristic.

Contents

1. Introduction

Procedural documents are essential, not only to comply with corporate and clinical governance standards, statutory, legal and insurance requirements, but also to ensure standardisation of practice and therefore efficiency, consistency and safety throughout the CCG in line with the CCGs values and purpose.

To ensure the CCG provides a robust and clear governance framework within which core functions can be delivered, the organisation needs to develop and implement procedural documents that are appropriate and practical.

The CCG creates procedural documents to advise and guide staff, patients and visitors on CCG requirements, to ensure compliance with statute and the relevant functions and responsibilities of the organisation. This document aims to ensure that all CCG procedural documents are consistently developed and managed in accordance with best practice.

The environment within which the CCG operates is one of constant change, and the organisation must be in a position to respond to the challenges of the external and internal environment. This policy and procedure seeks to ensure that the organisation's procedural documents remain relevant by setting out a process for developing, ratifying, communicating, managing and reviewing procedural documents and procedures within the CCG

2. Purpose

This policy and procedure applies to all procedural documents produced by the CCG.

It is for use within the CCG and wherever the CCG carries responsibility for the staff it employs.

3. Definitions

There are a number of different names for documents, sometimes these are interchangeable, the CCG prefers to use the following names for documents however, other document names could be used with the approval of the ratifying committee.

a) Plan

A scheme or method of doing, or proceeding, at either a Strategic, Programme or Operational level. Strategic plans are likely to apply for a number of years and

must have an agreed review date. Strategic plans will always be CCG-wide and not local, documents.

b) Policy

A policy is a course or principle of action adopted by an organisation
Policies are statements of an organisation's intentions and the approach to fulfilling its statutory and organisational responsibilities. They are underpinned by relevant evidence and guidelines and enable management and staff to make correct decisions, work effectively and comply with relevant legislation and CCG aims and objectives. They may be supported by relevant procedures. All policies must be approved by CCG committee with prior discussion at AQUA.

c) Procedure/Protocol

A procedure or protocol is a set of detailed step-by-step instructions that describe the appropriate method for carrying out tasks or activities to achieve a stated outcome to the highest standards possible and to ensure efficiency, consistency and safety.

d) Care Pathway

Care pathways are descriptions of the care processes, often in flowchart form, which direct the care of a specific condition from initial access to final outcome. These can be agreed by the following groups: SCE, CRMC, UCMC and MMC. The CCGC will be notified.

e) Top Tips/Guideline

Top Tips/Guidelines are broad statements of good practice, that are systematically developed, which guide practice.

Ref.	Document	Description	Ratification	Agreement
A	Plan	A scheme or method of doing, or proceeding	GB, AQuA, other input decided by OE	
B	Policy	Statement of Intention	GB, AQuA, other input decided by OE	
C	Procedure/protocol	Step by Step instructions		Route decided by

				OE
D	Care Pathway	Description of Process		OE, CRMC, SRG, MMC notification to SCE Approval route to be decided by OE
E	Top Tips/Guideline/PGD	Good practice guidance		OE, CRMC, SRG, MMC notification to SCE Approval route to be decided by OE

4. Duties/Responsibilties

a) Chief Officer

The Chief Officer of the CCG has overall responsibility for ensuring the CCG has appropriate procedural documents in place to ensure the CCG complies with all relevant legislation and works to best practice

b) Members of the Operational Executive

Members of the Operational Executive made accountable for individual procedural documents will be responsible for identifying an Author and ensuring that the requirements of this policy are followed.

The accountable member will ensure that each procedural document is reviewed in accordance with the timescale specified at the time of approval.

Any gaps in procedural documents are to be reported to the accountable member.

c) Managers

All line managers are responsible for:

- Implementing the policy within their sphere of responsibility where appropriate.
- Ensuring all relevant procedural documents are accessible for all their staff.

- Ensuring staff have read and understood and adhere to all relevant procedural documents.
- Identifying local staff training needs on the implementation of new and updated procedural documents.

d) Counter Fraud Specialist

Clear and robust policies and procedures are an essential part of a successful fraud prevention strategy. The CCG's Counter Fraud Specialist must be included in the CCG's policy review process, in accordance with NHS Counter Fraud Authority standards. This is to ensure that all new and existing CCG policies include appropriate counter fraud, bribery and corruption measures, to assist in the prevention of loss to the public purse.

e) All Members and Staff

All members and staff must ensure that their practice is in line with the current procedural documents in use across the CCG and specific to their areas of work. Information regarding the failure to comply with the procedural document (e.g. lack of training, inadequate equipment) must be reported to the Line Manager and the incident reporting system used where appropriate.

Staff, who become aware of changes in practice, changes to statutory requirements, and local or national directives that affect, or could potentially affect, CCG procedural documents should advise the policy author as soon as possible. The author, in liaison with the accountable OE member, will then consider the need to review the procedural document outside of the agreed timescale for revision.

f) Staff Forum

The aim of the staff forum is through partnership working to provide a meaningful consultation, negotiation and communication between staff side and management representation to enable staff to participate in decisions which affect them and their implementation. This includes the negotiation on the development and amendment to procedural documents as appropriate.

g) Consultation and Communication with Stakeholders

The CCG expects that key stakeholder representatives, including GP Members, Users and staff of the CCG will be involved in the development, as appropriate, of relevant procedural documents. The CCG expects that communication arrangements with key stakeholders are robust, inclusive and will use a variety of formats as required.

The originating author must identify the relevant stakeholders and their level of involvement e.g. development, consultation, or receipt of final procedures within the document.

5. Standards

The recommended standards for all procedural documents are that they should:

- Be determined on the basis of sound information and appropriate consultation;
- Be compliant with all relevant statutes, best practice and national, local guidance;
- Be structured in such a way as to be capable of guiding those making decisions;

- Be named/titled in the most relevant way as the finished procedural documents will be saved onto the CCG Intranet
- Be written in a clear and intelligible style;
- Have undergone an Equality Impact Assessment
- Be capable of implementation.

6. Categorising of Policy & Procedures

Procedural documents will be categorised into 7 areas. These will be:

Area	CCG Officer lead
Corporate	Assistant Chief Officer
Finance	Chief Finance Officer
Quality	Chief Nurse
IT	IT lead/ Deputy Chief Officer
HR	HR Lead/ Chief Officer
Individual Funding requests	Head of Contracts & Service Improvement
Partnership	Assistant Chief Officer

7. Consultation, Approval and Ratification Process

Only the Governing Body or its sub-committees with delegated powers of ratification can ratify new procedural documents.

a) Consultation Process

The consultation process should be comprehensive and must include all stakeholders (including the Counter Fraud Specialist) as appropriate.

Consultation may include staff, unions, HR, finance, GP Members and external stakeholders, including service users.

b) Policy Approval Process

The Governing Body will approve all Strategic Plans and Policies

The responsibility for approving other documents not requiring the Governing Body approval has been delegated to individual CCG Committees, Operational Executive will identify the body which will approve the procedural document.

c) Ratification process

Each procedural document will have a cover sheet which will detail the following:

Title:	Insert title of document
Reference No:	If known or to be inserted by the designated staff member for document management on approval
Owner:	Insert Operational Executive name and title

Author:	Insert document author's name & title
First Issued On:	DATE (version 1.0)
Latest Issue Date:	DATE (version no.)
Operational Date:	(usually 3 months from date of issue or date of latest issue if immediate)

Review Date:	Usually 1-5 years
Consultation Process:	List stakeholder groups etc consulted
Ratified and Approved by:	Insert relevant Committee name
Distribution:	e.g. All staff in line with the CCG Policy on Policies
Compliance:	Mandatory for all permanent & temporary employees, contractors & sub-contractors of Rotherham CCG
Equality & Diversity Statement:	This policy has been subject to a full equality & diversity impact assessment

The ratifying committee is responsible for completion of the review and approval checklist in Appendix 1

8. Implementation and dissemination of Procedural Documents

All procedural documents will be disseminated to staff via the intranet/internet.

It is the responsibility of the policy author to co-ordinate the upload of the approved document on to the Intranet/internet and ensure that old versions of the reviewed document are removed from the intranet/internet and archived as per CCG Policy. The documents would normally be placed on intranet pages dedicated to the 7 areas listed in the table on implementation above.

The Governance and complaints officer will notify employees of the existence of any new or reviewed documents via an appropriate communication processes.

Those documents that have been identified as requiring disseminating externally will be published on the CCGs internet by the Governance and Complaints Officer.

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 document within the CCG. It is therefore expected that any procedural document approved by the CCG will be fully operational within 3 months of the date of approval unless otherwise notified.

9. Review

This will be agreed on an individual basis per document.

The review process for procedural document will be overseen on a 6 monthly basis by the Assistant Chief Officer via reports to OE

Appendix 1 Checklist for the Review and Approval of Procedural Documents

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	YES/NO/Unsure	Comments
1. Title		
Is the title clear and unambiguous?		
Is it clear whether the document is a guideline, policy, procedure/protocol or plan?		
2. Rationale		
Are reasons for development of the document stated?		
3. Development Process		
Is the method described in brief?		
Are people involved in the development identified?		
Has relevant expertise has been used?		
Is there evidence of consultation with stakeholders and users?		
4. Content		
Is the objective of the document clear?		
Is the target population clear and unambiguous?		
Are the intended outcomes described?		
Are the statements clear and unambiguous?		
Are cross references accurate?		
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. Approval		
Does the document identify which committee/group will approve it?		
If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?		