NHS
South Lincolnshire
Clinical Commissioning Group

The Development and Management of Procedural Documentation in the South Lincolnshire CCG (SLCCG)

Key words:	CG005	
Version:	1.0	
Approved by:	SLCCG Governing Body	
Date approved:	18 December 2014	
Name and designation of author/originator:	Caroline Hall, Chief Finance Officer and Hugh Barnett, GEM Corporate Governance Manager Jules Ellis-Fenwick, CCG Corporate Secretary	
Name of responsible Committee:	Governing Body	
Date issued for publication:	January 2015	
Review date:	December 2016	
Expiry date:	January 2017	
Target audience:	All staff	
Type of policy (tick appropriate box):	Non-clinical ☐✓	Clinical ☐
Mandatory to read?	Non-clinical staff ☐✓	Clinical staff ☐✓
Which NHSLA Risk Management Standard(s)?	Not applicable	
Which relevant CQC standards (where applicable)?	Not applicable	

This document describes the governance processes for the development, review, maintenance and subsequent archiving of authorised documents, including clinical and non-clinical policies, guidelines, procedures and protocols, throughout SLCCG.

Version	Section/Para/ Appendix	Version/Description of Amendments	Date	Author/Amended By
1		New Policy	September 2014	Caroline Hall Jules Ellis-Fenwick Hugh Barnett

Contents

Version control and summary of changes

Version number	Date	Comments (description change and amendments)
Version 0.1	September 2014	First draft for CCG consideration

All South Lincolnshire CCG policies can be provided in audio, large print, Braille or other formats and languages, if requested, and an interpreting service is available to individuals who require it.

For further information contact:
Julie Ellis-Fenwick Julie.Ellis-Fenwick@SouthLincolnshireCCG.nhs.uk

Did you print this document? Please be advised that the organisation discourages the retention of hard copies of policies and can only guarantee that the policy on the organisation's intranet is the most up-to-date version.

Equality Statement

SLCCG aims to design and implement policy documents that meet the diverse needs of our services, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account current UK legislative requirements, including the Equality Act 2010 and the Human Rights Act 1998, and promotes equal opportunities for all. This document has been designed to ensure that no-one receives less favourable treatment due to their personal circumstances i.e. the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity. Appropriate consideration has also been given to gender identity, socio-economic status, immigration status and the principles of the Human Rights Act.

In carrying out its functions, SLCCG is committed to having due regard to the Public Sector Equality Duty. This applies to all the activities for which SLCCG is responsible, including policy development, review and implementation.

Glossary of Terms

Policy	Principles and/or rules which have been formulated and approved by the SLCCG Governing Body (GB) or by a committee with delegated authority from the GB. It is a set of statements, prescriptive by nature, documenting the standards, intentions and/or expectations of how a practice or course of action will be implemented and adopted. A policy is considered binding, and a breach of policy will result in an investigation into the reasons for the breach, and disciplinary action may follow. Where appropriate, information must be provided for patients and other stakeholders.
Procedure	A specific method employed to enact policies in day-to-day operations of the organisation. A procedure should be detailed guidance about how a particular task should be carried out; a step-by-step guide which someone not familiar with the work can follow.
Guideline	A systematically developed, evidence-based standard principle statement that assists in decision-making to determine a policy or course of action. They are there to provide direction and guidance for staff, but allow for professional judgment. Reasons for deviation from any guidance should be recorded and an investigation might be conducted into the reasons for the deviation depending upon the particular circumstances prevailing at the time. Variations from guidance may be subject to peer review to establish that the variation was appropriate and necessary. Where appropriate, information must be provided for patients and other stakeholders.
Protocol	Intended to be precisely adhered to and cannot generally be varied without reference to a superior authority. They are often used in situations where tasks are being delegated, e.g. from a doctor to a nurse.
Strategy	A long-term plan of action designed to achieve a particular goal. The contents of a strategy are generally high-level and concise. A strategy should present a vision of the goal that is intended to be achieved, the benefits of the achievement, and how the goal will be achieved over a defined period of time.
Pathway	Designed to enable staff to follow a clinical process and formally record that they have done so. A pathway is usually an appendix to a policy and not a stand-alone document.
Directive	An order or official instruction, e.g. Standing Financial Instructions (SFIs).

Stakeholder	An individual or organisation with an interest in the subject of the document, e.g. staff, staff-side representatives, service users, commissioners.
Policy Sponsor	The individual who has the organisational responsibility for the area of work that the policy or procedural document will be operating in. The Policy Sponsor is responsible for ensuring that: • The policy or procedural document is developed in line with this policy; • The policy or procedural document is disseminated to its target audience once it has been approved and adopted; • Appropriate training is given in the use of the policy or procedure; • The policy or procedure is properly implemented; and • The policy or procedure's implementation is monitored and reviewed on a regular basis
Approved	SLCCG's scheme of delegation makes provision for one or more named groups within the CCG to approve policies on behalf of the Governing Body, which has the final authority and responsibility for policies. From time to time these arrangements will change as the CCG develops its business and governance arrangements so for the purpose of this document the phrase **"formal approving body"** will be used to describe the body that will make the decision on behalf of the GB to approve and implement the policy. Once the formal approving body has approved the policy it will be for the Policy Sponsor to activate the implementation plan that will see the policy adopted for use within the CCG.
Due Regard	Having due regard to the Public Sector Equality Duty (PSED) involves a proactive approach to: • eliminating discrimination; • advancing equality of opportunity; and • fostering good relations between persons who share a protected characteristic and those who do not. This also includes taking steps to meet the needs of people from protected groups where these are different from the needs of other people and encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.
SFIs	Where the policy document relates to a service or function that would influence, or be influenced by, the provisions of the NHS Constitution then the document needs to explicitly state that due regard has been paid to the NHS Constitution, and how the policy is affected by it. It will be for the Policy Sponsor to familiarise themselves with the provisions of the NHS Constitution and make a judgement on its relevance to the policy document accordingly.

1.0 Summary

This policy provides a framework that sets out the process used by SLCCG for the management of policy and procedural document development and review, which will enable staff to carry out their roles and duties efficiently and effectively. It sets standards to ensure that all SLCCG policies and procedural documents conform to the agreed standard i.e. that they are necessary, robust, clear, comprehensive, functional, evidence-based, effective and consistent in terms of quality, content and format, and are therefore fit for purpose. The policy applies to the development of clinical and non-clinical policies, procedures, guidelines and protocols.

This policy aims to ensure that all staff are aware of and have ready access to all relevant and current policies etc. by establishing clear procedures for consultation, approval, distribution, accessibility and review.

Adherence to this policy is mandatory and applies to all staff (temporary and permanent) within SLCCG involved in writing and/or implementing all new or reviewed policies and procedural documents.

No new policy, procedure, protocol or guideline should be drafted unless there is a clear and agreed requirement for it. New policies will be commissioned by the relevant Committee responsible for the governance arrangements for the particular standard.

This policy provides a template enabling a consistent approach on the format and process of producing policies and procedural documents.

Consultation must always take place prior to and during the drafting of a policy or procedural document to ascertain its requirement and purpose. Staff are expected to participate in the consultation process during the development of policies and procedural documents and to highlight issues which may impact upon service delivery and quality standards.

It is a requirement that all new and existing policies and procedural documents being reviewed 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.

Final documents are approved for use within SLCCG by the formal approving body(ies) set out in the SLCCG scheme of delegation authorised by the GB.

A central database of policies and procedural documents will be maintained to include an archive of superseded documents.

Policies and procedural documents will be available on the SLCCG staff intranet to ensure that the current version is available.

CCG Executive Team are responsible for the implementation of all relevant policies and procedural documents within their service area(s) and for providing assurance to the GB by means of a tracking system to ensure this takes place.

2.0 Introduction

This policy outlines the processes for managing policies and procedural documents within SLCCG. Policies and procedural documents, their consistency, appropriateness and implementation are essential tools in the delivery of high quality services and delivery of safe care. To ensure high quality, new or reviewed documents must undergo a rigorous process of development and monitoring, including being assessed for an initial case of need – see Appendix 5 for further information.

Policies and procedural documents are an integral part of SLCCG's governance and risk management processes. This policy will provide assurance that all organisational documents that are approved by a governing committee meet compliance with all relevant legislation, statutory requirements and best practice.

In line with the Freedom of Information Act (2000), approved policies and procedural documents will be published on the SLCCG public web site and staff intranet. The intranet version of any document is the definitive version (see printing disclaimer on page 5).

3.0 Purpose

The purpose of this policy is based on the principle that all policies and procedural documents should be developed following a standard format, and it will be used to produce a unified, corporate approach to the development and management of approved policies and procedural documents. This will ensure that appropriate information is presented in a standard format which is easily accessed by staff and service users, and that the drafting, approval and review processes are clear to all. This also aids the auditing process.

This document outlines:

- why the procedural document is necessary (purpose);
- the duties of key members of staff; and
- the standards to be achieved in the development of procedural documents.

The intended users and uses of this policy are:

- all SLCCG staff involved in developing or writing policies and procedural documents;
- anyone who has any responsibility for the control, management, implementation or dissemination of such documents;

- staff who are responsible for training and review of policies, procedures, guidelines, pathways and protocols within the organisation; and
- wherever the organisation carries responsibility for the staff it employs, including seconded, agency and bank staff.

Local guidelines and procedural documents will be managed at local service line level. However, they must also comply with the requirements within this policy.

This policy replaces all previous SLCCG policy and procedural document development and management documents.

This policy may be used as a template for policies and procedural documents.

All policies and procedural documents presented to the appropriate approval body must be accompanied by a completed "Checklist for Review and Approval" (**Appendix 1**).

Consultation should always take place prior to and during the drafting of policies and procedural documents. Staff, service users and carers (where appropriate) are expected to participate in the consultation process during the development of policies and procedural documents and to highlight issues which may impact on service delivery.

Core standards for the production of approved procedural documents are taken from the NHS Litigation Authority Risk Management Standard (http://www.nhsla.com/Pages/Publications.aspx?library=safety%7cstandards) and are as follows:

1) Agreed organisation-wide style and format
2) Clear introduction and definition of terms used for each document
3) Clear consultation process
4) Clear approval and adoption process
5) Reviewing arrangements for each document
6) Identified system for control of documents and archiving
7) Standardised references to associated documents
8) Clearly identified process for monitoring effectiveness

Although all aspects of this policy must be followed, the above core standards are highlighted throughout the text of this policy. No documents should be passed for approval and adoption unless these standards are met.

4.0 Equality Analysis

SLCCG will ensure that due regard (DR) is taken and, as such, will undertake an Equality Analysis (EA) on existing and new policies and procedural documents in line with the Equality Act 2010 and the Human Rights Act 1998. This process will help to ensure that:

- Policies and procedural documents take into account the diverse needs of those affected by them to ensure that all SLCCG services are inclusive and accessible for the communities they serve
- SLCCG complies with current equality legislation
- Decision-making and subsequent processes include proportionate and conscious consideration to equality, inclusion and human rights
- Opportunities for advancing equality are identified

SLCCG has made the commitment to comply with the Public Sector Equality Duty (PSED) and to demonstrate that it is exercising due regard. Therefore, customers and stakeholders may require information from SLCCG staff about the organisation's equality work and request evidence on how these commitments are exercised. It is essential that SLCCG can respond positively to all and any such requests it receives.

5.0 Duties within the organisation

5.1 **The Governing Body** has ultimate responsibility for approving policies and procedural documents, and ensuring that these documents are implemented effectively. This responsibility is discharged through a scheme of delegation to **formal approving bodies** within SLCCG who:

- carry out the approval process;
- report to the GB on the policies that have been approved; and
- report any issues arising from the approval that the GB needs to consider and act upon.

Approval by the formal approving body confirms that the document has been validated and:

- it has been subjected to an Equality Analysis;
- due regard has been given;
- the PSED has been met; and
- a risk assessment has been carried out and any impacts and risks thus identified are being dealt with appropriately by SLCCG.

5.2 **Designated SLCCG Committees** have a responsibility for development, implementation, review and monitoring effectiveness of all policies and procedural documents relevant to its remit. Each such Committee will:

- Sanction the development of new policies and procedural documents within its remit;
- Identify a Policy Sponsor;
- Sign off the "Checklist for Review and Approval";
- Present policies or procedural documents, with implementation plans, to the **Risk and Governance Committee** (R&GC) (or the formal approving body if different); and
- Review whether practices are in line with policy and ensure regular monitoring of implementation is undertaken

These committees might also be the formal approving body and will therefore have the additional responsibility of approving the policy on behalf of the GB and ensuring the policy's implementation by the Policy Sponsor.

5.3 **The Risk and Governance Committee** (R&GC) has been given responsibility under delegated authority from the Governing Body to approve all SLCCG policies and procedural documents for use within the CCG. It shall take as its frame of reference the provisions of this policy document, in conjunction with professional and technical advice from subject experts relevant to the content and scope of the policy.

The Committee will receive polices from Policy Sponsors for approval by the Committee to be implemented within the CCG. In order to approve a policy the Committee will need to see and be assured that:

- A business need for the policy has been established and approved by a relevant body within SLCCG;
- An equality impact assessment has been completed and is attached to the policy for the Committee's consideration;
- The policy is formatted in line with this policy and meets RNIB standards for easy-read documents;
- A risk assessment of the impact of implementing the policy has been carried out and is included with the policy for the Committee's consideration; and
- Consultation has been carried out with relevant stakeholders and the policy takes account of the results of the consultation.

5.4 **The Corporate Secretary** is the central point for administering the distribution of all policies and procedural documents, and shall maintain a database of all SLCCG policies and procedures. The Corporate Secretary will therefore be responsible for:

- Ensuring that all master copies of previous versions are kept in an archive for a minimum period of 10 years in line with the guidance set out in "The Records Management: NHS Code of Practice (version 2, 2009)";
- Ensuring all copies of previous versions of the adopted policy or procedural document are kept in an electronic archive for a minimum period of 10 years
- Maintaining a single register of SLCCG policies and procedures, with Word and PDF versions
- Ensuring that PDF versions of the approved and adopted policies and procedural documents are placed on the entranet and internet, and are regularly kept up-to-date
- Informing Heads of Service when a new policy or procedural document has been placed on the intranet
- Arranging a synopsis of and hyperlink to the new or amended document is sent via email to all members of staff

- Issuing reminders to the Policy Sponsor of the need for a review of the policy in line with the review date stated on the document.

CCG Senior Management Team is responsible for:

- Ensuring that comprehensive arrangements are in place regarding adherence to this policy and ensuring how policies and procedures are managed within their own service area in line with the guidelines in this policy;
- Ensuring other management staff within their service line are given clear instructions about policy and procedure arrangements so that they, in turn, can instruct staff under their direction; and
- Policy and procedural document arrangements, which are to include:

    - Receiving such documents from the Corporate Secretary;
    - Distributing information about new policies and procedures in a timely manner throughout their service area to a distribution list which is to be agreed in advance with local Service Managers/Team Leaders;
    - Ensuring that all staff have access to up-to-date policies and procedures through the SLCCG intranet;
    - Maintaining a system for recording that policies and procedures have been distributed to and received by staff within their service line, and for having these records available for inspection upon request for audit purposes; and
    - Arranging a deputy to cover these duties for times of leave.

5.6 **Local Service Managers/Team Leaders** are responsible for:

- Ensuring that policies and procedures are followed and understood as appropriate to each staff member's role and function. This information must be given to all new staff on induction. It is the responsibility of local Service Managers/Team Leaders to have in place a local induction that includes policies and procedures;
- Ensuring their staff know how and where to access current policies and procedures;
- Ensuring a system is in place for their area of responsibility that keeps staff up-to-date with new policies and procedures and changes within these documents, and to ensure delivery of any recommended training related to policies and procedures. Please be advised that the organisation discourages the retention of hard copies of policies and procedures, and can only guarantee that the document on the organisation's intranet is the most up-to-date version; and
- Ensuring procedures are followed for compliance in other areas through liaison with leads e.g. Information Governance may require hard copy signatures from staff and the Service Manager/Team Leader is expected to comply with such requests

5.7 **All staff** (including seconded and other non-permanent staff) should be aware that despite the above responsibilities of senior staff, every staff member has an individual duty of responsibility to ensure that they:

- Know where to locate policies and other procedural documents when necessary;
- Adhere to all SLCCG policies and procedures; and
- Stay up-to-date with current policy and procedural documents.

5.8 **Stakeholders**

All those involved in producing the document have a responsibility to make sure that consultation has taken place with appropriate stakeholders.

Anyone who is asked for comments or to make a contribution to the document has a responsibility to respond to the request within the identified timeframe, even if it is only to confirm that they are satisfied with the document as it stands.

6.0 Equality, inclusion and human rights

Case law has established that meeting the Equality Act 2010 Public Sector Equality Duty requires "a deliberate approach and a conscious state of mind". This means taking steps to help staff, decision-makers and contractors understand this duty, including the need to undertake an equality analysis when reviewing and developing policies and procedures.

Therefore, an understanding of how to approach Equality Analysis and having due regard will be necessary. It is essential that decision-making in policy and procedure development should include a clear understanding of the analysis of the importance of equality, inclusion and human rights. This means the person who ultimately decides on the policy or procedure (including individual members of the formal approving body) has to be fully aware of the findings and have due regard to them in making decisions. Please see **Appendix 2** for further information.

7.0 Style, format and mandatory content of policies and procedural documents

It is the responsibility of the Policy Sponsor to ensure all documents meet the requirements within this policy before the documents are sent to any group for formal review.

7.1 Style[1]

Documents should be written in "Arial" font, minimum point size 11, with single line spacing, and the text should be left-aligned. Italicised and underlined text must be avoided; key phrases should be emphasised in bold rather than underlined or italicised.

[1] This section is based on the RNIB's guidance for easy read documents for people with visual impairments and is therefore necessary for GEM CSU to show it has paid due regard to its Equality duties. This advice therefore supersedes any previous advice issued in this regard.

All policy and procedural documents must be presented in a concise and clear style using plain English. Complex and/or medical terminology may be used if necessary, but the Policy Sponsor should ensure that a plain English description is included for the term in the "Glossary of Terms" section at the beginning of the document.

Abbreviations should only be used after the term has been displayed in full, e.g. South Lincolnshire CCG (SLCCG).

7.2 Format

7.2.1 Title page (**Appendix 3**)
The title page will contain the following information:

- NHS SLCCG logo in top right-hand corner.
- Title of the policy or procedural document using the most indicative word first, e.g. Annual Leave Policy **not** Policy for Annual Leave (this will assist staff to search for current policies more easily). The title should be written in "Arial" point size 16.
- A short description of the policy or procedure which summarises its content. This will appear in search results to enable users to easily scan to find the relevant document (see title page of this policy for an example).
- Completed table to include:

    - A list of "associated" key words, including common alternatives, e.g. information governance, confidentiality, data protection. This will help users search for a document when they are unclear of its title.
    - "Version number": each re-draft of a document should be recorded as a different version with each version being numbered sequentially. Draft versions must have a "draft" watermark and are to follow the pattern: Version 0.1, Version 0.2 etc. Final versions have no watermark and are to follow the pattern: Version 1.0, Version 2.0 etc.
    - "Approved by" (name of group) – this will be the formal approval body as defined in the SLCCG scheme of delegation.
    - "Date approved": this is the date of the meeting where the formal approving body has approved the policy/procedure etc. for use within SLCCG. It will be an agenda item and will be formally minuted as having been approved.
    - Main author's name and their designation
    - "Name of responsible Committee": this is the group who has sponsored the drafting of the policy or procedural document, e.g. Risk and Governance Committee, Health and Safety Committee etc.
    - "Date issued for publication" is the date that the policy or procedural document will be forwarded to the Corporate Secretary to be uploaded onto the intranet and disseminated to Heads of Service after its formal approval.
    - The "review date" should be at least nine months before the document's expiry date to ensure it is reviewed and any changes are approved within the timeframe before it expires
    - The "expiry date" should be no longer than two years after the date the policy/procedure etc. is approved.

- "Target audience" should be identified; this will help Heads of Service and Service Managers/Team Leaders when disseminating documents to their teams
- State whether it is a clinical or non-clinical policy/procedure etc.
- State whether the policy is mandatory for non-clinical and/or clinical staff to read
- State which NHSLA standard(s) the document relates to – see http://www.nhsla.com/safety/Documents/NHS%20LA%20Risk%20Management%20Standards%202013-14.pdf
- State which CQC standard(s) the document relates to where appropriate – see http://www.cqc.org.uk/content/national-standards

7.2.2 Second page
All documents will have a contribution list identifying those people who have been actively involved in drafting the document, and a second list of people the document has been circulated to for comments.

7.2.3 Table of contents and version control
A table of contents must be included for policies or procedural documents where the main body of the document is more than five pages long.

Following the table of contents, there must be a version control table, the accessibility statement and the warning to staff about printing documents (page 5 of this document).

You must also include the Equality Statement from page five of this document in every policy or procedural document. **It is recommended that this document is used as a template for these sections.**

7.2.4 Glossary of Terms
Each document should include a "Glossary of Terms" which explains complex and/or medical terms, ensuring that the reader's knowledge is not assumed and that any member of staff or stakeholder would be able to read and comprehend the document with relative ease.

7.2.5 Paragraphs and bullet points
Section headings should be numbered, and be in bold "Arial" font at point size 14. Paragraphs and/or key points within a section should be numbered for ease of reference. If bullet points are required, the first set should be filled circles. If another bullet point list is required within an existing bullet point, this secondary set should be unfilled circles.

7.2.6 Footers
Each page of the document must have a footer which states the name and version number of the document on the left hand side. Below this, for draft documents the month and year should be shown, e.g. December 2013, and for final documents being sent for approval, the date should be that of the meeting where the document is due to be approved, e.g. 17 December 2013. The page number should be on the right-hand side in the format "3 of 34" (see bottom of this page for an example).

7.2.7 Final page before Appendices
Where applicable, documents should provide an evidence base with up-to-date references. Referencing guidelines can be found in **Appendix 4**. Referencing is a core NHSLA standard.

7.2.8 Appendices
By their nature, appendices at the end of documents provide supplementary information and/or explanations. They should be used as required and included in the document's table of contents.

7.3 Mandatory content checklist
This list comprises of core content required to be included in this order in every policy or procedural document.

a) Title page - fully completed
b) Contribution list
c) Circulation list
d) Table of contents
e) Version control table
f) Accessibility statement & warning about printing documents
g) Equality Statement
h) Glossary of Terms
i) Summary
j) Introduction
k) Purpose
l) Main body of the policy
m) Footer fully completed
n) Due regard (cite the sections within your document where you can show due regard to the Equality Act 2010 has been taken; advice may be sought from the EIHR team when completing this)
o) References – using the Harvard method
p) Appendices (Every policy or procedural document that relates to an NHSLA standard should have a completed self-assessment tool included as an appendix as illustrated in **Appendix 6** of this document).

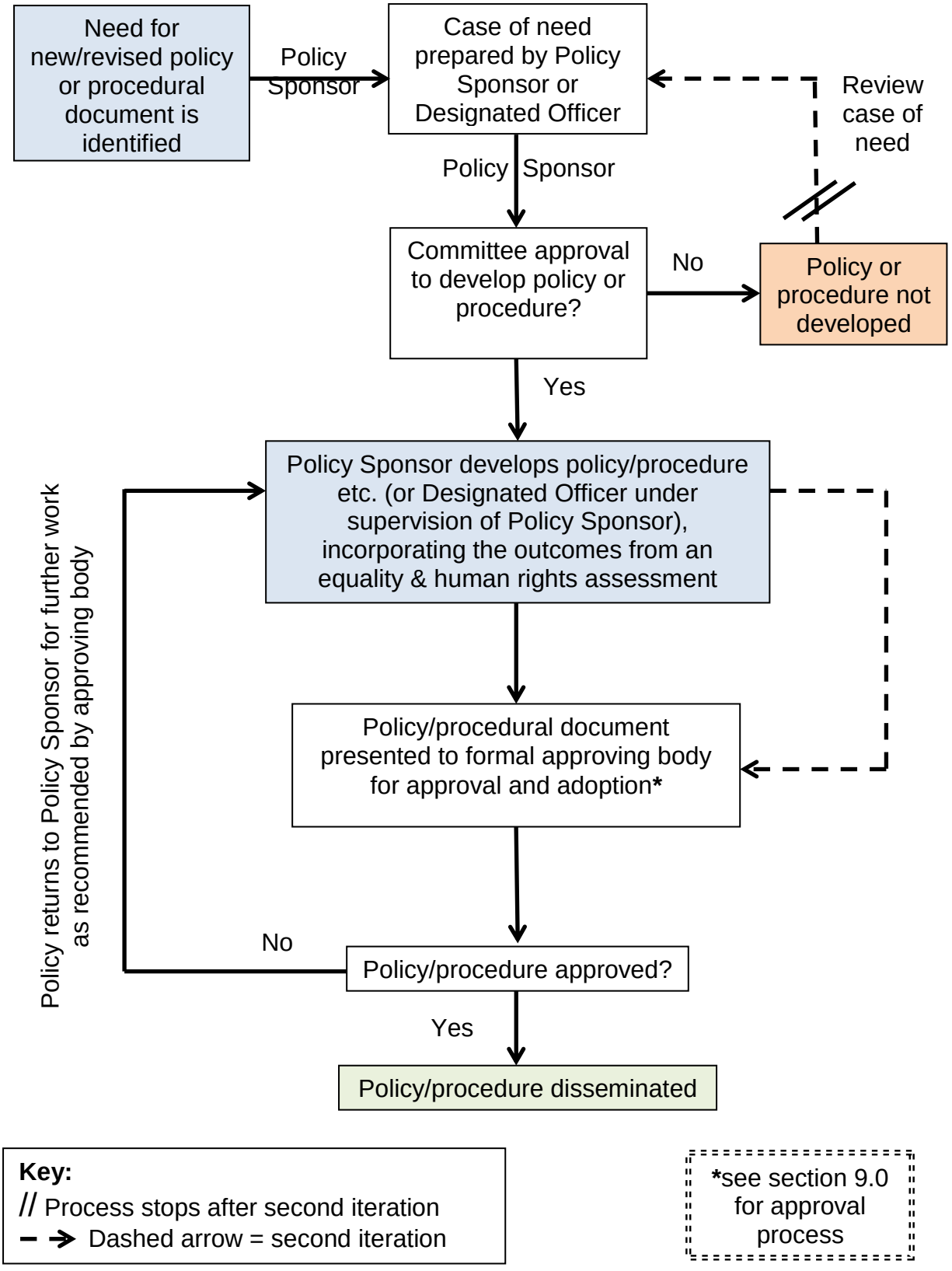
The main content of the policy is expected to be written at section "l" of this checklist. Sections "n" to "p" are to be included after your content.

Other sections in this policy, for instance within this document "Duties within the Organisation", should be included where appropriate and where the inclusion of information adds clarity to the policy or procedural document. This section would detail budgetary and training responsibilities, and so on.

Note: the entirety of "The Development and Management of Procedural Documentation" should be read and followed when undertaking to write a new policy or procedural document; the method and content will be reviewed to ensure compliance. This structure has been created for consistency across SLCCG and in order that staff become familiar with the layout of policies and procedural documents so pertinent information is easy to locate within them. Any queries around formatting

a new policy or procedural document should be directed in the first instance to the Corporate Secretary.

8.0 Flowchart for producing a policy or procedural document



8.1 Case of need/justification for policy or procedural document

The need for a new policy or procedural document should be identified; it should evidence a link with service priorities together with national and other organisational policy documents. See **Appendix 5** for examples of justification of need for a new policy or procedural document.

All procedural documents apply across SLCCG. Localised policies and procedures should only be drafted in exceptional circumstances where prior agreement has been obtained from the Service Lead, and where there is clear evidence of the need for a local policy.

Where the reason for a new document is **not** consolidating predecessor policies and/or procedures, a "case of need" will be required and this is to be presented to the relevant Committee before formulation of any new document. This should include:

- Reason for developing the policy, procedure etc.
- Policy Sponsor and author names
- Target audience
- Other policies etc. that relate to the proposed document
- Any equality, inclusion and human rights issues that it addresses
- Who needs to be consulted
- Any training requirements
- Need for information leaflets (budgets, resources to design etc.)
- Timescale for completing the first draft, to include any risk assessments, Equality Analysis, consultation etc.

The Policy Sponsor and approving Committee have the responsibility of checking that the proposed document does not duplicate an existing one or a document already in development elsewhere in SLCCG, and to confirm that implementation is achievable within the resources of the organisation.

8.2 Formulation of the new policy/procedural document

The author(s) of the new document must follow the guidance set out in this policy and it is the responsibility of the Policy Sponsor to ensure this happens. During the drafting process, particular consideration needs to be given to:

- Use of a valid evidence base
- Engagement of appropriate stakeholders – both internal and external to the organisation, e.g. clinical professionals, Staff Partnership representatives, CCG members, partner organisations etc.
- Patient and public involvement
- Equality Analysis
- A risk assessment that will identify any risks to SLCCG arising from the policy or procedure being developed and adopted
- Education and training requirements
- Audit and evaluation
- Information requirements of patients/the public/service users

Should it be necessary for legal advice to be obtained on a policy before it is sent for approval, the Policy Sponsor should contact the Corporate Secretary in order to arrange this.

8.2.1 Consultation

The involvement of relevant groups, committees and stakeholders is key to the review and development of authorised documents. The Policy Sponsor is responsible for ensuring consultation takes place with the appropriate stakeholders. The Policy Sponsor may take advice from the GEM Equality & Diversity Team with regards to which stakeholders should be involved in a particular consultation process. The draft document should be circulated to the identified stakeholders with support from the GEM Equality & Diversity Team, clearly identifying the deadline for responding and the named contact(s) for comments to be sent to. Following consultation, all persons who responded must receive feedback regarding trends and themes from the consultation and how comments were taken into account during the document's production.

Consultation on policies that will have an impact on working practices and patterns of work for employees **must** be consulted upon with Staff Partnership organisations. The Chief Officer retains the overarching responsibility to ensure that such draft documents are circulated to Staff Partnership representatives for comment, where appropriate. This does not apply to policies that SLCCG must produce in response to legislation and government directive, e.g. Mental Health Act, Health and Social Care Act etc. Staff Partnership organisations must be made aware of all policies being produced.

Consultation on policies that will impact on protected or vulnerable groups (protected characteristics/equality groups) must take place with those concerned.

Where there has been recent stakeholder engagement into policy and procedure development then a co-ordinated approach should be taken that can incorporate the results of, this engagement, which will avoid duplication and help build confidence among stakeholders.

The decision on the appropriateness of involvement of individual stakeholders should be taken on each occasion depending upon the nature of the document being developed or reviewed. This should be considered at the pre-approval stage for the development of new policies, and the reasons for any decision on appropriateness of individual stakeholder involvement should be recorded in case of future challenge to the inclusion or exclusion of particular stakeholders.

In undertaking the development of a new document or the revision of an existing one, the relevant responsible Committee will give due consideration to the need to consult on the document and, as appropriate, the document will be disseminated for discussion/consultation to individual service lines and other Committees by the Policy Sponsor.

8.2.2 Policy/procedure information leaflets

If appropriate, consideration should be given to producing a policy/procedure information leaflet that will help inform how that policy/procedure will be

implemented. Any such information must be written in plain English and be formatted in such a way that is accessible to people with learning disabilities and for those whose first language is not English. Arrangements should be made to produce the leaflets in alternative languages and large text format for those with visual impairments, as well as in Braille and as audio copies. The Communications and Engagement team and the Equality, Inclusion and Human Rights team should always be consulted for such work, and they will be able to support and advise on the optimum means of meeting this requirement.

Any such leaflet must be produced in conjunction with the Communications and Engagement team and relevant clinical professionals, and go through the consultation process alongside the policy/procedural document itself.

Every locally developed leaflet will need to have budgetary approval prior to production.

All locally developed leaflets must be sent to the Communications and Engagement team who will assist in providing contacts to approach for access to any reader panels and to ensure the leaflet goes through the appropriate information process. If an information leaflet is produced for a policy or procedural document, brief summary details should be included in the document's "Summary" section, with a copy of the leaflet added as an Appendix.

8.2.3 Clinical documents - links to regulatory and professional guidance
Where clinical policies and procedures link to other documents, e.g. NMC Code of Practice, this must be noted in an extra box on the title page. Any pertinent information from the related document should be included in a synopsis in a specifically named paragraph where appropriate. This synopsis should include detail on how the document and its implementation will deliver on the outcome or indicator, and tools to show how this delivery will be measured, e.g. audit/evaluation tool etc.

When a clinical document is sent to the formal approval body for approval, it is imperative that at least two clinicians are present to review it in line with this policy and to assess its monitoring tools.

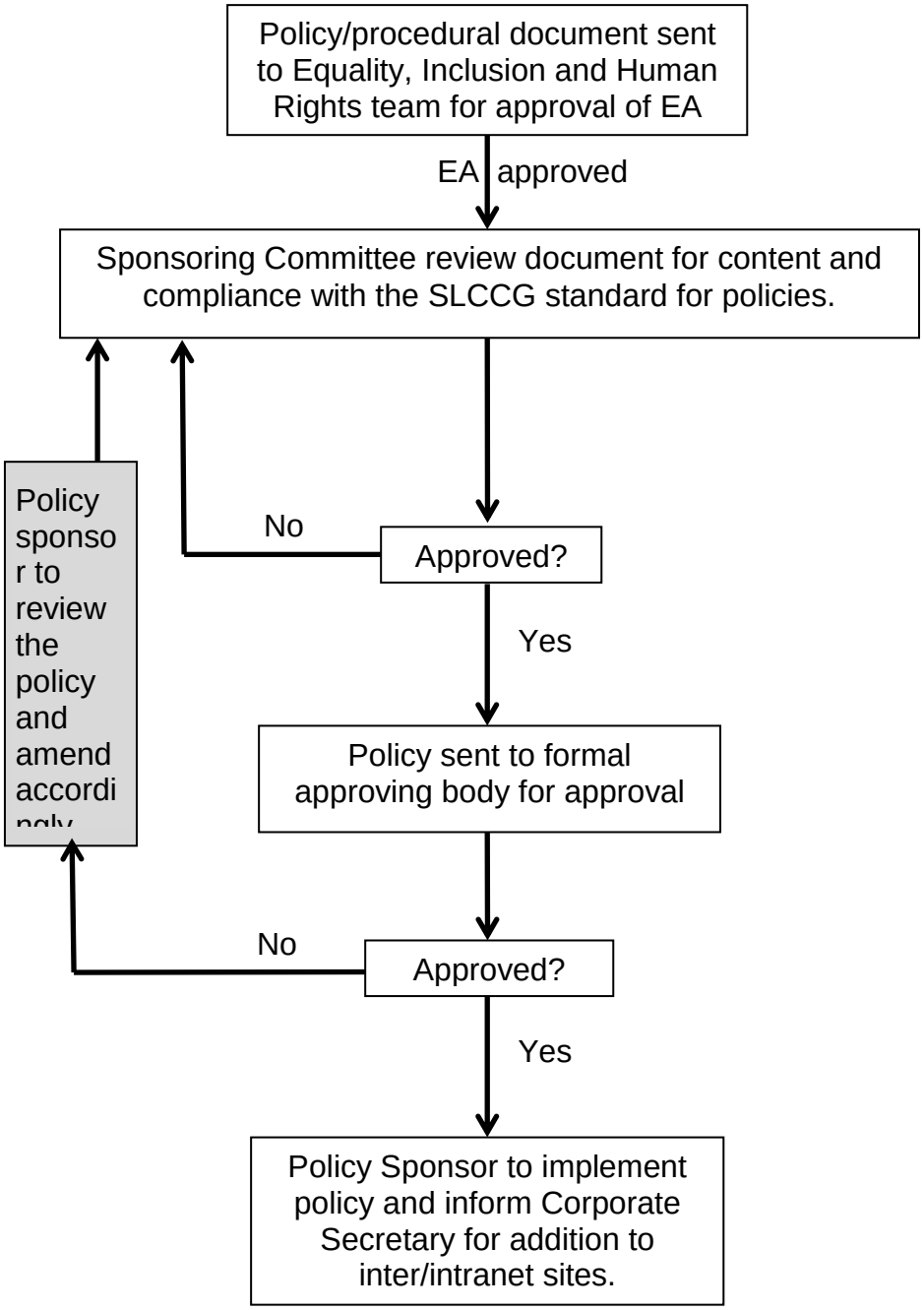
9.0 Approval

No policies or procedural documents will be approved and implemented unless there is specific evidence that due regard has been given in the context of the Public Sector Equality Duty.

Prior to a policy or procedural document being submitted for approval, it must have been reviewed by the relevant Committee for validating its content and approving it in principle, including ensuring the format of the policy or procedural document has followed this policy (which is also a responsibility of the Policy Sponsor throughout the process).

Once the document has been validated by the Committee it is the responsibility of the Committee to forward the document to be added to the next meeting agenda of the formal approving body for adoption and approval. Adoption and approval by the formal approving body then confirms that the document has been validated and has been subject to an EA and risk assessment, and that the impacts and risks thus identified are being dealt with appropriately by SLCCG. At this point it becomes an official document of SLCCG. The formal approving body has the responsibility to inform the Corporate Secretary of the document's adoption in order that it may be uploaded to the intranet and internet and disseminated to Heads of Service.

9.1 Flowchart to show the process of adoption and approval of policies and procedural documents



** Only significant concerns identified by the approving body that have not been addressed should be sent back to the Committee, and this should not occur if the Committee and FAB have exercised their duties effectively. This is not an expected part of the approval process.

10.0 Dissemination and archiving

10.1 Dissemination

Upon email notification of adoption of a policy or procedural document from the formal approving body, the Corporate Secretary will arrange to upload a PDF copy of the document to the staff intranet and the public web site.

The Corporate Secretary will forward the notification email from the formal approving body to the Heads of Service to advise them of a newly adopted policy or procedural document, ensuring the Chairperson of the sponsoring Committee and the Policy Sponsor are copied into the notification email to Heads of Service. It is then the responsibility of Heads of Service to further disseminate the information to their service lines as appropriate. Please refer back to sections 5.5-5.7 inclusive for detailed responsibilities.

Any stakeholders that will be affected by the policy or procedural document should be proactively informed of its adoption and also be made aware of any changes in practice that will occur as a result.

10.2 Archiving

The Corporate Secretary will maintain a database of all SLCCG policies and procedures, and hold a copy of each policy/procedure etc. in Word and PDF formats. All master copies of previous versions will be kept in an archive for a minimum period of 10 years in line with the guidance set out in “The Records Management: NHS Code of Practice (2006)”, and all copies of previous versions of an adopted policy or procedural document will be kept in an electronic archive for a minimum period of 10 years.

11.0 Review and revision arrangements, including version control

All policies and procedural documents must be reviewed at least every two years. Key procedural documents or documents that are considered to address areas of high risk should be reviewed at more regular intervals. Changes in legislation or professional guidance may necessitate an unexpected, earlier review.

The planned review date should be clearly identified on the title page when the document is published. The expiry date should also be identified, and the document should be archived after this date.

The originating Committee responsible for the document will also be responsible for ensuring a review is undertaken. This should occur at least nine months before the document’s expiry date. Doing so will enable a comprehensive review –which may take some time to complete, particularly if there are several Committee stages leading to adoption of the document – and will also give time for a robust EA to be completed.

All reviews and revisions to any official SLCCG document must follow the flowcharts in sections 8.0 and 9.1.

Should a Committee disband, as part of their discharge of responsibilities, the Chair should arrange for an appropriate Committee to take responsibility for policies and procedural documents which were within its remit. If a suitable alternative Committee is not in place, responsibility for the document reverts to the GB until such a Committee is functioning.

11.1 Unplanned or interim reviews

On occasion, there may be a need to review a document in advance of the scheduled review date, for example:

- because of changes in recognised best practice;
- in light of new guidance issued by the NHS;
- changes in legislation;
- lessons learnt from local investigations/incidents etc., or
- because implementing the document in the organisation leads to the identification of issues/processes that need to be captured (or amended) in the document.

In these cases, the Committee initially responsible for the document will be responsible for these amendments along with the original Policy Sponsor or a nominated other if circumstances do not permit their involvement.

If the changes made are minor and do not fundamentally alter the nature of the policy or procedural document, then these can be made without further approval by the formal approving body so long as the version number is updated and it is arranged with the Corporate Secretary to upload the new document immediately. In these cases, the sponsoring Committee is responsible for sending a notice of amendment (including details of what has been altered in the version control table) to the Corporate Secretary with the amended document which the Corporate Secretary will upload to the staff intranet and the public web site, forward to Heads of Service for onward distribution as appropriate, and send to the GB for information.

Any fundamental changes in authorised documents must follow the flowcharts in sections 8.0 and 9.1.

The intranet version of the document is the definitive version and therefore staff should be directed there to find the latest version.

11.2 Version control

A version control table is shown below:

Version number	Date	Comments (description change and amendments)

Once a draft policy or procedural document has been approved, its version changes from “Version 0.4” to “Version 1.0”, for instance. The comment against this change in the version control table should state formal adoption and approval.

For amended documents, the version changes from “Version 1.0” to “Version 1.1”, for instance, with an explanatory comment added to the table and noting the section(s) that have been changed.

When a policy or procedural document is reviewed at its expiry date **or** when fundamental changes have been made, its version status should change from “Version 1.0” to “Version 2.0”, for instance. A synopsis of actions taken should be included in the “comments” box in the table, noting section changes where appropriate.

12.0 Implementation of policy or procedural document and resources

Any training or support implications associated with approved documents will need to be identified during the formulation or review of the document. Clarification of resource availability must be addressed and resolved prior to the approval process.

The introduction of some documents may require staff training/briefing sessions to be arranged. These should be planned, publicised and completed before the document is implemented. The process leading up to the approval of any new or revised policy should include a SMART implementation action plan as well as a risk assessment. The risk assessment will determine the resource and capacity implications of the policy being implemented, particularly where training and briefing sessions could affect staffing levels.

13.0 Monitoring compliance and effectiveness

13.1 Monitoring policies and procedural documents

Monitoring tools must be built in to all policies and procedural documents, clinical and non-clinical, in order that compliance and effectiveness can be demonstrated. See the Monitoring and Audit Tool in **Appendix 6** which sets out the criteria, measurables, frequency, Lead Officer and Committee.

The monitoring may be in the form of audit or evaluation; whichever is most appropriate for the document. The Policy Sponsor is responsible for ensuring the monitoring activities are carried out, and for recording all related documentation (to be produced upon request for wider SLCCG monitoring and audit purposes).

The evaluation or audit tool must use an approved methodology and results must be reported to the responsible Committee for the document at determined intervals. The tool should identify at least:

- Who is responsible for undertaking and monitoring the audit or evaluation (which should include the Policy Sponsor)

- The method to be used
- Frequency of audit or evaluation
- How the results will inform or improve practice

13.2 Monitoring this policy

The use of this policy shall be monitored by the Risk and Governance Committee. It shall receive quarterly reports from the Corporate Secretary on the policies that have been approved in the previous quarter, and any issues highlighted by the policy approval process.

13.3 Standards/Key Performance Indicators linked to this policy

Target/Standards	Key Performance Indicators
All Policy Sponsors follow guidelines within this document	Where deficiencies are identified, the policy or procedural document will be returned to the Policy Sponsor for update and not sent for approval
All policies and procedural documents are reviewed and updated before expiration of authorisation	All policies and procedural documents will be deemed as not being in place if expired and no action taken to update
All policies and procedural documents are clearly sign-posted and accessible within SLCCG	All stakeholders can access policies and procedural documents when necessary
Guidelines and procedures are not duplicated within policies, but are cross-referenced where applicable	Where a concept or principle is duplicated in another policy, that policy will be withdrawn from the list and edited accordingly

14.0 Due regard

This policy has been reviewed in relation to having due regard to the Public Sector Equality Duty (PSED) of the Equality Act 2010 to: eliminate discrimination, harassment, victimisation; advance equality of opportunity; and foster good relations. This can be evidenced in Sections 1, 4, 5, 6, 8, 9 and 11, and Appendices 1, 2 and 5 of this policy.

15.0 References and associated documentation

This policy was drafted with reference to the following:

NHS Derbyshire County, 2010 *Policy Development Framework POLICY NUMBER: PDFv3/10*

Leicestershire Partnership NHS Trust, 2013 *The Development and Management of Procedural Documentation in Leicestershire Partnership NHS Trust*
Lincolnshire Partnership NHS Foundation Trust (2010) *Development, Implementation and Management of Policies* [online]. Available from: http://www.lpft.nhs.uk/assets/files/Accessing%20our%20information/Policies%20and%20Procedures/Corporate/COR11.pdf [Accessed 16 December 2013]

The National Archives (2013a) *Freedom of Information Act 2000* [online]. Available from: http://www.legislation.gov.uk/ukpga/2000/36/contents [Accessed 16 December 2013]

The National Archives (2013b) *Equality Act 2010* [online]. Available from: http://www.legislation.gov.uk/ukpga/2010/15/contents [Accessed 16 December 2013]

Department of Health *Records Management: NHS Code of Practice (2006)* [online]. Available from: https://www.gov.uk/government/publications/records-management-nhs-code-of-practice [Accessed 16 December 2013]

NHS Commissioning Board (2013) *Development & Approval of Policy & Procedure Documents: Policy & Corporate Procedures* [online]. Available from: http://www.england.nhs.uk/wp-content/uploads/2013/05/pol-1001.pdf [Accessed 16 December 2013]

NHS Litigation Authority (2014a) *NHSLA Risk Management Standards 2013-14* [online]. Available from: http://www.nhsla.com/safety/Documents/NHS%20LA%20Risk%20Management%20Standards%202013-14.pdf [Accessed 2 January 2014]

NHS Litigation Authority (2014a) *Template for "An Organisation-wide Document for the Development and Management of Procedural Documents"* [online]. Available from: http://www.nhsla.com/Pages/Publications.aspx?library=Safety%7cHelpfulTools%7cDocumentTemplates [Accessed 2 January 2014]

Care Quality Commission 2014 *Essential Standards of Quality and Safety – Guidance on Meeting the Standards* [online]. Available from: http://www.cqc.org.uk/organisations-we-regulate/registered-services/guidance-meeting-standards [Accessed 2 January 2014]

16.0 Support and additional contacts

Advice and guidance on the application of this policy can be obtained from the Corporate Secretary – see **Appendix 7** for contact details.

Appendix 1: "Checklist for Review and Approval of Policy or Procedural Document" template

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**
Will any sections of this Policy satisfy one or more criteria of the NHSLA Risk Management Standards?*			
If Yes – Have you attached the relevant self-assessment(s) for those criteria as an appendix?*			
* for further guidance consult the Corporate Secretary: "generic email address to be set up for this"			
1.	**Title**		
	Is the title clear and unambiguous?		
	Is it clear whether the document is a policy, guideline, procedure, protocol, strategy or pathway?		
2.	**Key points of or changes to the document**		
3.	**Rationale**		
	Are reasons for the development of the document clearly stated?		
4.	**Development Process**		
	Does the front page include a sentence which summarises the contents of the document?		
	Is the method of development of the document described in brief?		
	Have the people who were involved in the development been identified?		
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?		
	Is there evidence of consultation with stakeholders (with representation from all relevant protected characteristics)?		
5.	**Content**		
	Is the objective of the document clear?		
	Is the target audience clear and unambiguous?		
	Are any relevant professional standards etc. identified (where appropriate)?		
	Are the intended outcomes described?		
	Are the statements clear and unambiguous?		
6.	**Evidence base**		
	Is the type of evidence to support the		

Title of document being reviewed:			
		Yes/No/Unsure	Comments
	document identified explicitly?		
	Are key references cited?		
	Are the references cited in full?		
	Is there evidence to show that there has been due regard for equality legislation (see section 14.0)?		
	Are supporting documents referenced?		
7.	**Approval**		
	Does the document identify with the Committee/Group who will approve it?		
	If appropriate, have Human Resources and/or Staff Partnership representatives approved the document?		
8.	**Dissemination and implementation**		
	Is there an outline/plan to identify how this will be done?		
	Does the plan include the necessary training/support required by the document's implementation?		
9.	**Document control**		
	Is the document version correctly numbered?		
	Does the document identify review and expiry dates?		
	Are the review and expiry dates acceptable?		
10.	**Process to monitor effectiveness and compliance**		
	Are there measurable standards/KPIs to support the monitoring of compliance with and effectiveness of the document?		
	Is there an acceptable plan to review or audit compliance with the document?		
11.	**Overall responsibility for the document**		
	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?		

Committee approval		
If the Committee is happy to approve this document, it should be signed and dated below by the Chairperson, and arrangements made for it to be forwarded to the formal approving body.		
Name:	Date:	Signature:

Formal Approving Body approval		
If the formal approving body is happy to approve this document, it should be signed and dated below by the Chairperson, and arrangements made for the document and this signed sheet to be forwarded to the Corporate Secretary for dissemination.		
Name:	Date:	Signature:

Appendix 2: Equality Analysis/Due Regard

Questions to consider

- Does due regard apply and why?
- Which of the protected characteristics could potentially be impacted negatively?
- What is the potential impact?
- What sort of data would you use to help apply due regard?
- Who do you need to talk to?
- What are the relevant factors? Have all views been considered?
- What mitigations could be considered? Are they practical/ doable?

Protected characteristics

- Age
- Disability
- Gender reassignment
- Marriage & civil partnership
- Pregnancy & maternity
- Race
- Religion & belief
- Sex (gender)
- Sexual orientation

Area of priority		Date	
Service commissioned		Lead (name and designation)	

Aims
Outcomes - may have an Impact (either negative or positive) on any of the protected characteristics?
If negative impact has been identified, what alternatives have you considered to achieve these outcomes?

If there are no proportionate alternatives, how can these impacts be reduced or minimalised if they are negative? If positive impacts, how can these be promoted?
How can you explain the need to continue with achieving these outcomes if no mitigation can be made for any of the negative impacts?
How can you evidence that due regard has been undertaken before decisions were made?

The NHS as a public body has a duty to have due regard to the need to:

1. Eliminate discrimination, harassment and victimisation and any other conduct prohibited by the Equality Act 2010
2. Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not. This involves considering the need to:
    - Remove or minimise disadvantages suffered by people due to their protected characteristics
    - Take steps to meet the needs of people with protected characteristics that are different from the needs of people who do not share them
    - Encourage people with protected characteristics to participate in public life or in other activities where their participation is law
3. Foster good relations between people from different groups. This involves tackling prejudice and promoting understanding between people from different groups.

It is necessary to actively seek opportunities to fulfil the above duties.

If challenged…

Are you confident that the decisions made and the outcomes of this project:

- ✓ Are non-discriminatory
- ✓ Promote equality of opportunity
- ✓ Foster good relations between people with any of the protected characteristics

Can you produce evidence that due regard has been conscientiously and proportionately undertaken and all the necessary views have been considered before any decisions were agreed?

Can you, if after starting a course of action and a problem relating to a protected characteristic materialises, evidence that due regard was then undertaken and used to determine whether to continue or not?

Can you prove that the substance and reasoning of any decisions are not based upon personal bias and values and can be fully supported with documented evidence?

Appendix 3: Title page template

Title

Description: a description of what the policy sets out or describes

Reference number:		
Key words:		
Version:		
Approved by:	SLCCG Executive Management Team	
Date approved:	Click here to enter a date.	
Name and designation of author/originator:		
Name of responsible Committee:	e.g. Health and Safety Committee	
Date issued for publication:	Click here to enter a date.	
Review date:	Click here to enter a date.	
Expiry date:	Click here to enter a date.	
Target audience:		
Type of policy (tick appropriate box):	Non-clinical ☐	Clinical ☐
Mandatory to read?	Non-clinical staff ☐	Clinical staff ☐
Which NHSLA Risk Management Standard(s)?		
Which relevant CQC standards (where applicable)?		

Appendix 4: Referencing guidelines

Harvard referencing

A bibliographic reference should contain sufficient information for someone else, or yourself, to trace the item in a library. It is very important to be consistent and accurate when citing references. The same set of rules should be followed every time you cite a reference. Citations in the text should give the author's name with the year of publication in brackets, and then all references should be listed in full in alphabetical order at the end of the document.

Harvard method of citation within text
All statements, opinions, conclusions etc., taken from another writer's work should be acknowledged, whether the work is directly quoted, paraphrased or summarised. In the Harvard system, cited publications are referred to in one of the following forms:

- Single author:
  In a study by Benner (1989) coping with illness was investigated…
  In a study (Benner, 1989) coping with illness was investigated…

- When an author has published more than one cited document in the same year, these are distinguished by adding lower case letters after the year within the brackets:
  Burnard (1992a) wrote about communication for health professionals that…

- Two authors:
  In the book by Basford & Slevin (1995)…

- More than two authors:
  Benner et al (1996) conclude that…

Harvard method of quoting within text
When quoting directly in the text, use quotation marks as well as acknowledging the author's name, year of publication and page number of the quote in brackets.

- Short quotations, e.g. up to two lines, can be included in the body of the text:
  Weir (1995) states that "defining roles and their remits is not simple" (p10).

- Longer quotations should be indented in a separate paragraph:
  Thomas and Ingham (1995) in discussing staff development state that;
  > "Development is infectious, and staff who previously have recoiled from undertaking a degree or conversion course have been encouraged by the success of others" (p33).

- If part of the quotation is omitted, this can be indicated using three dots:
  Weir and Jendrick (1995) state the "networking is no longer solely within the male domain…" (p88).

Secondary referencing
Secondary referencing is when one author is referring to the work of another and the primary source is not available. You should cite the primary source and the source you have read, e.g. (Fiedler and Chemers 1974, cited in Douglass 1996). Secondary referencing should be avoided if at all possible.

Listing references at the end of the text
References should be listed in alphabetical order first by the author's name, and then by date (earliest first). If more than one item has been published during a specific year, you should add a lower case letter after the year, again in alphabetical order. Wherever possible, details should be taken from the title page of a publication and not from the front cover as they may differ. Each reference should include the elements and punctuation given in the following examples. Author's forenames can be included if they are given on the publication's title page. The title of the publication should be italicised or underlined. The location and publishing house should then be given in the same format as they appear in the publication.

- A book by a single author:
  Benner, P. (1989) *The primacy of caring stress and coping in health and illness* Reading, Mass., Addison-Wesley.

- A book by two authors:
  Burns, Nancy & Grove, Susan K. (1997) *The practice of nursing research: conduct critique & utilisation.* 3rd edition, London Saunders.

- A book by three or more authors:
  Mares, Penny et al. (1995) *Health care in multiracial Britain.* Cambridge, Health Education Council.

- A book by a corporate author (e.g. a government department or other organisation):
  Health Visitors' Association (1992) *Principles into practice: a HVA position statement on health visiting and school nursing.* London, Health Visitors' Association.

- An edited book:
  Basford, Lynn & Slevin, Oliver (Eds.) (1995) *Theory and practice of nursing: an integrated approach to patient care.* Edinburgh, Campion.

- A chapter in a book:
  Weir, Pauline (1995) Clinical practice development role: a personal reflection. In K. Kendrick et al (Eds.) *Innovations in nursing practice.* London, Edward Arnold.

- An article in a journal:
  Allen, A (1993) *Changing theory in nursing practice* Senior Nurse 13 (1) 43 – 5.

- A government publication:

Department of Health (1996) *Choice and opportunity: primary care: the future.* C.m.3390. London, Stationery Office.

- A thesis or dissertation:
  Stones, Marian (1995) *Women, nurses, education: an oral history taking technique.* Unpublished M Ed. Dissertation, University of Sheffield.

- A secondary reference:
  Fiedler, F. & Chemers, M. (1974) *Leadership and effective management.* Glenview, Illinois, Scott Foresman & Co. Cited in Douglass, Laura Mae (1996) The effective nurse: leader and manager 5th edition. St Louis, Missouri, Mosby.

An accepted way of referencing internet documents is useful too. If we host these documents on the intranet, it would help staff to hyperlink to useful sources of further reading/information and include the internet reference within the reference list:

- University of Leeds (2013a) *University of Leeds* [online]. Available from: http://www.leeds.ac.uk/ [Accessed 19 December 2013].

- University of Leeds (2013b) *The University Library* [online]. Available from: http://library.leeds.ac.uk/ [Accessed 19 December 2013].

- Further guidance on this form of referencing can be viewed at: http://library.leeds.ac.uk/skills-referencing-harvard

Appendix 5: Examples of justification of need for a new policy or procedural document

Before embarking upon writing a new policy or procedural document, you first need to identify the need for its creation to address. Such a need must be related to the business of SLCCG, and could arise for a number of reasons. A non-exhaustive list of examples of justification of need for a new policy or procedural document follows:

- Results of a risk assessment process
- Results of Equality Analysis covering all equality and human rights dimensions
- Audit recommendations (clinical, financial or other audit)
- Untoward Incidents
- Near Misses
- National incentives and local priorities
- Consolidation of existing related policies
- Patient or customer feedback, including data from the complaints and customer support function
- Trends arising from the evaluation of Clinical Supervision, Training Needs Analysis and Appraisal (ASPIRE)
- Legislation
- New regulations
- National guidance

Although it is the responsibility of the sponsoring Committee to check for duplications, staff proposing to draft a new policy or procedural document are expected to personally complete a thorough evaluation of current official SLCCG documentation prior to presenting a case of need to a Committee. Support can be obtained for this from the Corporate Governance team.

Appendix 6: NHSLA Policy Monitoring Section (self-assessment)

Criteria number and name: 1.2 Policy on Procedural Documents

Duties outlined in this policy will be evidenced through monitoring of the other minimum requirements

Where monitoring identifies any shortfall in compliance, the group responsible for the policy or procedural document shall be responsible for developing and monitoring any action plans to ensure future compliance.

Reference	Minimum requirements	Self-assessment evidence	Process for monitoring	Responsible individual/group	Frequency of monitoring
1.2 (a)	Style and formatting	All document	Policy Working Group meeting	Policy Working Group	In accordance with identified review of policy – minimum every two years
1.2 (b)	An explanation of any terms used	Glossary of Terms, page 6	Policy Sponsor and Policy Working Group	Policy Sponsor and Policy Working Group	In accordance with identified review of policy – minimum every two years
1.2 (c)	Consultation process	Section 8.2.1, page 18	Policy Working Group meeting	Policy Sponsor and sponsoring Committee	In accordance with identified review of policy – minimum every two years
1.2 (d)	Ratification process	Section 9.0, page 19	Corporate Governance team holds database of all policies	Approving body and Corporate Governance team	In line with procedural document review

Reference	Minimum requirements	Self-assessment evidence	Process for monitoring	Responsible individual/group	Frequency of monitoring
1.2 (e)	Review arrangements	Section 11.0, page 21	Policy Working Group meeting and Corporate Governance team	Policy Sponsor	In accordance with identified review of policy – minimum every two years
1.2 (f)	Control including archiving arrangements	Section 10.0, page 21	Corporate Governance team holds database of all policies	Corporate Governance team	In accordance with identified review of policy – minimum every two years
1.2 (g)	Associated documents	Section 15, page 24	Policy Working Group meeting	Policy Working Group	In accordance with identified review of policy – minimum every two years
1.2 (h)	Supporting references	Section 15, page 24	Policy Working Group meeting	Policy Working Group	In accordance with identified review of policy – minimum every two years

Appendix 7: Contact details

Mrs Julie-Ellis-Fenwick
CCG Corporate Secretary/Manager
South Lincolnshire CCG
Staamford and Peterborough Hospitals NHS Trust
Ryhall Road
Stamford, Lincs
PE9 1UA

Telephone Number: 01522 573939
Mobile: 07825 938794

Email: Julie.ellis-fenwick@southlincolnshireccg.nhs.uk