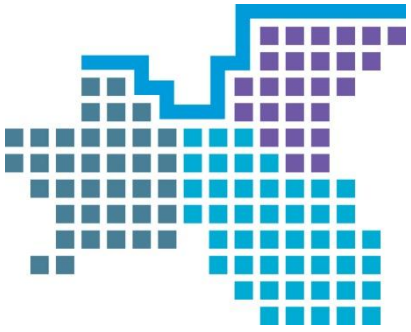
NHS
Wandsworth
Clinical Commissioning Group

Framework for the Development and Management of Policy and Procedural Documents

Version 1.0

Date approved:	**28/03/2014**
Date for review:	**March 2017**
Lead Director:	**Director of Corporate Affairs, Performance and Quality**
Lead Manager:	**Business Manager**

NOTE: This is a CONTROLLED document. Any documents appearing in paper form are not controlled and should be checked against the server file version prior to use.



DOCUMENT CONTROL AND AMENDMENT RECORD

Framework for the Development and Management of Policy and Procedural Documents

Version	Date	Reason for review/update	Author/ Reviewer	Approving Committee(s)	Date of approval
0.1	Jul-13	Document adapted for use by Wandsworth CCG	S Allingham	Integrated Governance Committee	
0.2	Feb-14	Comments received from IGC	S Allingham		
0.3	Mar-14	Comments received from MT	S Allingham		
1.0	Mar-14	Policy reviewed and agreed		Audit Committee	28/03/14

Framework for the Development and Management of
Policy and Procedural Documents

Contents

Framework for the Development and Management of
Policy and Procedural Documents

1. INTRODUCTION

High quality organisation documentation is an essential tool of governance, which will help us achieve our strategic objectives, operational requirements and bring consistency to day-to-day practice. A common format and approved structure for such documents helps reinforce corporate identity, helps to ensure that policies and procedures in use are current and reflect an organisational approach.

All documents must undergo a rigorous process of development and be approved and monitored by the appropriate designed committee or sub-committee. This is to provide assurance to the Wandsworth CCG Board on relevant legal and statutory requirements, NHS guidance and policy.

1.1 Purpose

The aim of this framework for the development and management of policy and procedural documents is to clarify the steps that must be taken to develop and secure approval for all new or reviewed policies, guidelines, procedures or protocols to be used within Wandsworth CCG.

For ease of reading, this framework will refer to all policies, guidelines, procedures or protocols as 'documents' unless specific terminology is more appropriate.

1.2 Aims and Objectives

These are to ensure that:

- The development and review of policies, procedures, protocols and guidelines is commissioned, coordinated and progressed through appropriate channels.
- All procedural guidance is produced in a standard format using a consistent corporate approach.
- The dissemination of procedural documents is coordinated and monitored.
- All relevant documents undergo Equality Analysis to ensure that policy and practice are assessed for impact on equalities.
- The effectiveness of all procedural documents is audited, monitored, reviewed and updated routinely.

1.3 Scope

This framework covers document control for staff employed by the CCG.

2. DEFINITIONS

2.1 Policy

A policy is a set of guiding or governing principles, which meets all or most of the following criteria:

- It is a governing principle that mandates or constrains actions.
- It has service wide application.
- It will change infrequently and sets a course for the foreseeable future.
- It helps to ensure compliance with overarching principles, legislation or professional guidance.
- It helps to reduce organisational risk.

2.2 Strategy
A strategy is a long term plan to translate policy into action.

2.3 Procedure
A procedure is a required series of steps followed in regular order, which enable the requirements of an agreed policy to be discharged.

2.4 Protocol
Protocols are a set of measurable, objective standards which determine a course of action.

2.5 Guideline
A guideline is a set of systematically developed standards or rules, which assist in the decision about how to apply an agreed policy, or may relate to the appropriate management of specific conditions or situations. Guidelines are often used to underpin a policy, and represent good practice.

3. ACCOUNTABILITY

3.1 Chief Officer
The Chief Officer has overall responsibility for the strategic and operational management of the organisation which includes ensuring that documents comply with all legal, statutory and good practice guidance requirements.

3.2 CCG Board
The Board is responsible for setting the strategic context in which organisational documents are developed, and for ensuring the formal review and approval of documents takes place.

3.3 Audit Committee
The Audit Committee will ensure that the formal review and approval of documents relevant to their remit takes place.

3.4 Integrated Governance Committee
The Integrated Governance Committee will ensure the organisation has documents in place to support delivery of key functions and that the document production and development process is in place to do this. Documents can be developed and approved by sub-committees and working groups that feed into the Integrated Governance Committee as set out in the governance structure. The IGC will then seek assurance from relevant sub-committees that documents are appropriate.

3.5 Finance Resource Committee
The Finance Resource Committee will ensure that a robust financial strategy is in place and to oversee the organisation-wide system of financial management. It will work alongside the Audit Committee and Integrated Governance Committee to ensure financial probity in the CCG.

3.6 Management Team
Management Team will review the process used to develop documents and approve them for implementation, or recommend them to the appropriate individual or committee as detailed in section 6 for final approval in accordance with the designated approval level. Documents can be developed by sub-committees and working groups that feed into the Management Team as set out in the governance structure.

3.7 Directors and Clinical Leads

All Directors and Clinical Leads are accountable to the Chief Officer for identifying and developing documents relevant to their area of responsibility. They have the responsibility for ensuring that the documents are implemented and become active documents. Designated Directors and Clinical Leads are responsible for ensuring that the expired policies are reviewed and approved within the given timeframe.

3.8 Document Author

The document author must ensure documents are:

- Developed, reviewed and consulted in accordance with this policy;
- Accompanied by a front sheet;
- Submitted for approval to the relevant committee or sub-committee and accompanied by a paper prior to the date of review;
- Disseminated to appropriate staff;
- Forwarded to the Corporate Affairs Team to be entered on the Policy and Procedure Register of approved documents and placed on the website and intranet.

3.9 CCG Employees

Staff members responsible for developing, reviewing and updating policies must comply with the development and management of the Framework for the Development of Policies and Procedures. All staff should comply with policy and procedures which apply to them as part of their normal duties and responsibilities.

3.10 Temporary or Agency staff, Contractors and Students

Contractors, temporary staff and all other personnel will be expected to comply with the requirements of all relevant documents applicable to their area of operations.

3.11 Corporate Affairs Team

The Corporate Affairs team will:

- Support best practice for the development and review of documents.
- Publish live documents on the CCG website and intranet.
- Update and maintain a Policy and Procedure Register of approved documents with information provided by the author of the document;
- Ensure compliance with review timescales and requirements with reminders being forwarded to the relevant Committee and sub-committee Chairs.
- Quality control documents including clarifying guidance and feeding back suggestions for improvements.

3.12 Commissioning Support Unit

The Commissioning Support Unit is responsible for producing documents, particularly in the areas of Human Resources, Information Technology, and Finance, for use across South West London CCGs. These documents will be developed with the appropriate Wandsworth sub-committee or working group, to be forwarded to the appropriate Committee for approval and inclusion on the Register and website.

4. DEVELOPING DOCUMENTS RELATED TO POLICIES AND PROCEDURES

4.1 Decision to develop a policy

Individuals identifying a need for a particular document should first discuss the proposed development with the Director or Clinical Lead within whose remit the subject matter falls and establish if:

- There is an area in which the provider's position is not clear
- Staff are unclear of how to deal with a specific issue
- There are legal requirements placed on the employer
- A new process is to be introduced
- A similar document already exists (If a similar document exists, enquiries should be made as to why it is no longer applicable, eg circumstances may have changed to make it obsolete such as new legislation).

It is the responsibility of the Director or Clinical Lead to establish whether a new document is required and the pathway for approval. The Corporate Affairs team can support by confirming if the policy overlaps with other documents or if previous ones are in existence.

The decision as to whether a proposed document should be developed must be approved by the relevant Committee. On occasion, the Committee may seek the views of other relevant Committees or Board before reaching a final decision.

A short paper must be submitted outlining why the document is needed, the issue it seeks to address, how the document will address this, who is to be consulted and training issues as well as details of how they will be addressed and what possible impacts the development of the document may have on equalities issues.

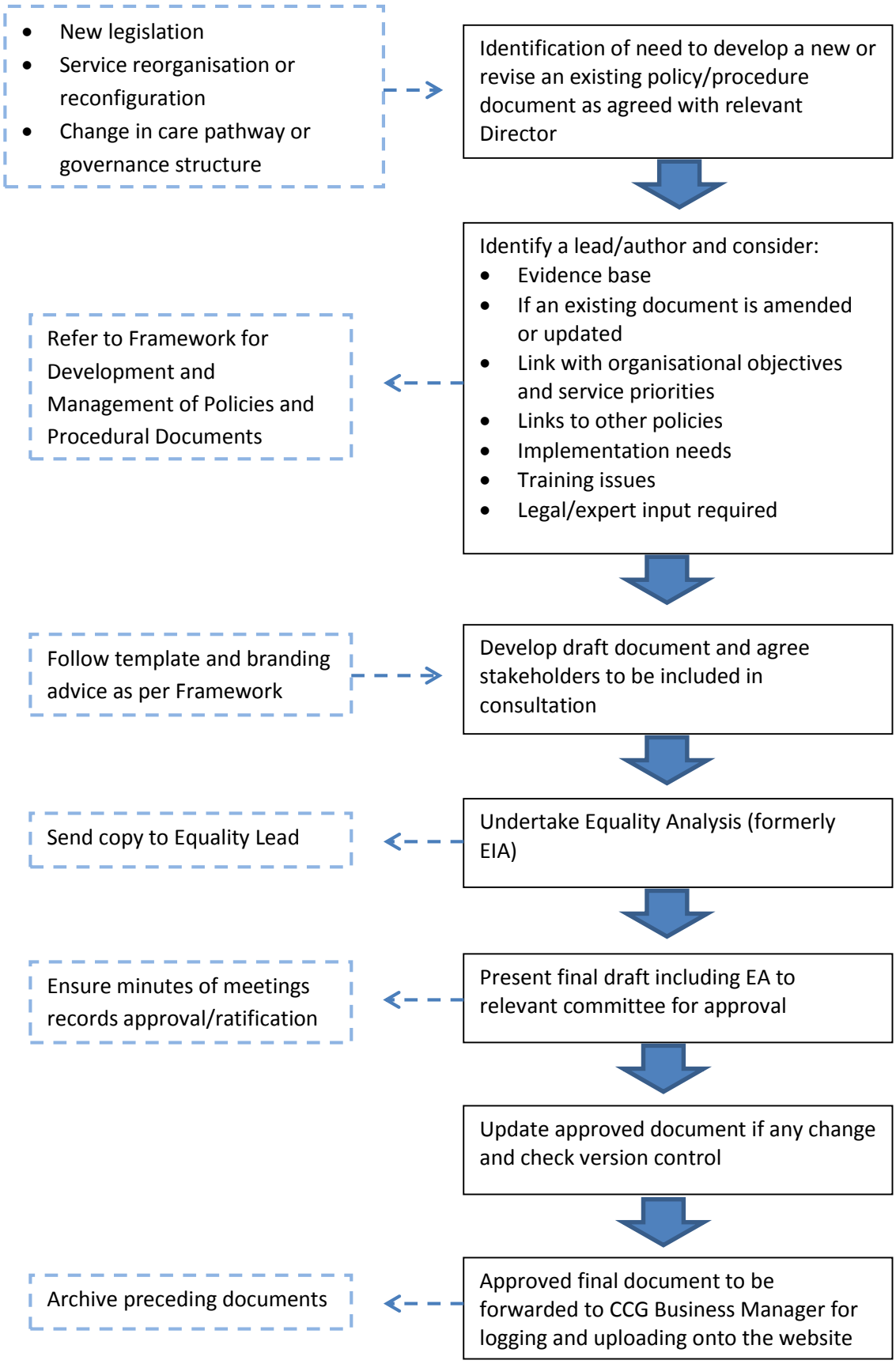
The relevant Committee will formally decide if a policy, procedure, protocol or guideline is to be developed.

4.2 Adopting an existing policy

When adopting a policy already available the following must be considered:

- What is the review date of the policy?
- Does it include up to date guidance?
- Are there areas that are no longer relevant?
- Is the policy in keeping with the style and format required as outlined in section 5?
- Will it require the combining of more than one policy?

Process Flowchart for the Development of Policies/Procedural Documents



4.3 Document Content

The content of each document should demonstrably comply with all:

- Relevant legal and statutory requirements, NHS guidance and policy in force at the time of writing or reviewing the document.
- Prime Financial Policies, Standing Financial Instructions and Scheme of Reservation and Delegation.
- All statutory duties in relation to equalities and human rights.
- Guidance provided in other related policies, ie it should not be contradictory.

The document should:

- Clearly indicate the responsibility placed on the CCG, departments and individuals, and how these should be discharged;
- Where a definition of terms is used, it must be accompanied by an explanation;
- Acknowledge any circumstances, detailed in the document, which may require colleagues to exercise discretion. In such circumstances, the areas of discretion, or freedom to act, must be clear and include any constraints and limitations;
- Where it may be appropriate, ensure that staff sign to indicate that they have received and understood a document (eg Standing Financial Instructions). If this is the case, provision should be made within the wording of the document;
- Include who should be aware of, and understand the document and follow its requirements;
- Include who may be affected by the implementation of the document;
- Include a list of related documents;
- Include an Equality Analysis.

It is the responsibility of the author and the lead Director to ensure they are aware of changes in legislation, practice or other guidance to enable them to ensure the document considers and minimises risk and potential adverse consequences for the CCG.

A model policy is detailed in Appendix 5 and must be followed.

4.4 Consultation

Consultation is a key part of any policy development process and the information gathered may affect the core content of the policy. It is therefore essential that consultation is considered at the outset of the policy development process as it will affect the development timeline.

The policy author should identify any relevant stakeholders and their level of involvement, eg development, consultation or receipt of final policy and/or procedures. This will be dependent on the scope and intended outcome of the policy structure and processes. Is the policy:

- Solely for use within the organisation;
- Has a wider audience as in commissioning policies;
- Is a joint policy with other stakeholders and partner organisations?

See Appendix 1 for further consultation of stakeholder guidance. If the policy is responding to a statutory duty the government may have already set out the groups or individuals that should be consulted as part of the policy development.

The consultation, which seeks advice or opinion from stakeholders and staff side can also include:

- E-consultation (via internet/intranet),
- Legal advice (the giving of a formal opinion regarding substance or procedure of the law by an officer of the court or legal representative of the organisation),
- Expert advice (recommendation from a person who has special skills or knowledge in a particular field).

It is the responsibility of the document author to ensure that the consultation is carried out prior to the document being submitted for approval and that it includes relevant stakeholders that could be affected by the document. This must include consultation with relevant committees or working groups prior to submission to the committee responsible for final approval.

Where reference to other documentation is included in the body of a document, those documents, where possible or where they can be found, must accompany the document until final approval.

4.5 Equality Analysis

The Equality Act (2010) requires public organisations to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people who may or may not share a protected characteristic. The Equality Act has identified nine protected characteristics to test against to ensure equality has been addressed.

To achieve this we are required to analyse the effect of any policy, practice, function or service change. This is what is known as Equality Analysis or what used to be referred to as Equality Impact Assessment.

Equality Analysis is there to enhance your work. It is meant to be a worthwhile but also a challenging process.

- It should be carried out at the beginning of the planning stage of the project.
- Take a common-sense approach to it; step outside your own role and look at this as an outsider would view it.
- Make time for it in your planning and allow for potential collaboration with other stakeholders.
- Where a likely impact is not known, action should be taken to try to acquire that information.
- Your equality analysis will be a public document and published so be prepared to demonstrate the process used, you may be asked.

The Equality Statement below should be inserted within the first three sections of the documentation:

"This document demonstrates Wandsworth CCG's commitment to create a positive culture of respect for all individuals, including staff, patients, their families and carers as well as community partners. The intention is, as required by the Equality Act 2010, to identify, remove or minimise discriminatory practice in the nine named protected characteristics of age, disability, sex, gender reassignment, pregnancy and maternity, race, sexual orientation, religion or belief, and marriage and civil partnership. It is also intended to use the Human Rights Act 1998 and to promote positive practice and value the diversity of all individuals and communities."

Documentation submitted for approval for policy, practice, function or service change will not be approved without the inclusion of this statement.

5. STYLE AND FORMAT

5.1 Style

All procedural documents should be written in a style which is concise and clear using unambiguous terms and language.

- All text, within the front sheet and main body of the document must be in Arial 11, with the text justified.
- All documents must have 'footer' in Arial 10, italics, detailing the title of the document, page number and the date on which the document was written.

5.2 Format

Refer to Appendix 5 for the required front page format for core document content.

5.3 Branding

Documents adopted for use within Wandsworth CCG must follow the same procedure as outlined in this policy and be branded as a Wandsworth CCG policy. Acknowledgement of the source of the policy can be made in the footer.

5.4 Version Control

Documents must have a version control system as outlined in Appendix 3. It is important that staff know which version of the policy or procedure is the most up-to-date.

6. APPROVAL

6.1 Appropriate Committee

The broad principles for approval of policies and procedures are detailed in the table below. Documents are to be taken to an appropriate committee for final approval in accordance with the type of policy.

Category	Approval Route
Strategic and overarching policies	Wandsworth CCG Board
Overarching Risk Management and Assurance policy	Integrated Governance Committee and Wandsworth CCG Board
Strategic Human Resources policies including those incorporating arrangements for appointment, removal, remuneration and organisational change	Workforce Committee and Wandsworth CCG Board
Financial and Fraud policies	Finance Resource Committee, Audit Committee and Wandsworth CCG Board
All other policies including Framework for Development of Policies	Management Team and Integrated Governance Committee
Information Governance policies	Information Governance Steering Group and Integrated Governance Committee
Operational non-clinical procedures and guidelines	Management Team

A front sheet for the appropriate committee must be completed and attached to the document, to ensure clarity over who has responsibility for its development, the purpose of the document, and to establish that the appropriate approval pathway has been followed. This would include key issues or changes as a result of the Equalities Analysis.

The committee responsible for approving a document can also approve an extension to an existing document where extraordinary circumstances exist. These extraordinary circumstances will be agreed by the committee with a maximum extension allowed of six months before the document is no longer valid. It will be the lead Director who requests an extension and clearly states the reasons for the extension.

6.2 Checklist

Appendix 2 is an NHSLA approved checklist for the review and approval of documents. It is to be used by the author to ensure that all aspects have been considered prior to submission of the policy to the appropriate committee for consideration and approval.

7. REVIEW

7.1 Documents will usually be current for a maximum of three years prior to review unless agreed otherwise when the document is approved. There are exceptions to this where some documents must be reviewed on an annual basis, for example, the Prime Financial Policies and related documents.

7.2 When documents are approaching their agreed review date:

- The Corporate Affairs team will contact the document author and responsible Director to initiate the review approximately six months prior to the scheduled review date.
- The author, with the responsible Director, will determine if the document is still required and whether the necessary revisions to update the document are minor or major.
- Where a document is no longer required due to changing practices, etc, then a paper outline those reasons should be submitted by the responsible Director for approval to the appropriate Committee.
- Where minor revisions are necessary these will be completed by the author and the document together with the completed front sheet that clearly summarises the minor changes can be submitted to the appropriate Committee for approval although policies requiring Board approval will require a short covering paper. The document control and amendment record is to be completed.
- Where major (significant) changes are required, the document may be treated as a new document and subject to some or all of the processes outlined above.

7.3 On occasion it may be necessary for a document to be reviewed earlier than the agreed review date, eg in the light of changing legislation or national guidelines. Document authors are responsible for ensuring that documents are reviewed following any changes to relevant legal and statutory requirements, NHS guidance and policy. Where the need for early review is identified the appropriate Committee should be informed and the process managed as outlined in 7.2 above.

8. DISSEMINATION AND IMPLEMENTATION

8.1 Dissemination

The dissemination of all documents is the responsibility of the Corporate Affairs Team, who will ensure that approved new and revised policies are placed on the intranet and website. Staff will be notified about a policy or procedure through general staff announcements, team meetings and other means of communicating the information relevant to the type and subject of the document. The author should ensure that the document is available in any other specifically related areas.

Policies are considered to be public documents and so need to be put on the organisation website. However, there are a small number of documents that may be deemed confidential and not for public viewing. If you are unsure whether the document you are formulating is a public document or not, you must check this with the responsible Director before proceeding any further.

8.2 Implementation

The document author must:

- Inform the Corporate Affairs team when a policy is finally ratified or extended. See Appendix 4 for a copy of notification form.
- Identify what training requirements will be required and any further support that will be needed to implement and monitor compliance of the document through the organisation.

9. DOCUMENT CONTROL INCLUDING VERSION CONTROL

9.1 To ensure all staff have access to current documents all current versions will be available on the intranet with superseded versions removed and archived.

9.2 All documents must be clearly marked with the up-to-date version to aid accurate tracking and retrieval, including date of approval and date for review on the front page. The document control and amendment record is to be completed as part of the document audit trail.

9.3 Archiving Arrangements

The Corporate Affairs Team will ensure that a safe archive and retrieval process is in place for old policies. When a new policy is uploaded onto the intranet or website, the old version will be filed in an electronic archive folder. Archived procedural documents may need to be retrieved, usually due to the investigation of a complaint, incident or claim whereby the policy that was in place at the time of the incident is no longer the most current version.

10. MONITORING COMPLIANCE AND EFFECTIVENESS

10.1 All documents must include details of how they will be monitored including, where applicable, monitoring under equalities requirements.

10.2 As a minimum, the document author must include the review/monitoring of all the minimum requirements within the National Health Service Litigation Authority (NHSLA) Standards.

- Monitoring arrangements for compliance and effectiveness, eg clinical, internal and external audit, performance processes, appraisal, committee reports, risk assessments.
- Responsibilities for conducting the monitoring/audit.
- Methodology to be used for monitoring/audit.
- Frequency of monitoring/audit, ie quarterly, on a rolling basis etc.
- Process for reviewing results and ensuring improvements in performance occur.

11. COMPLIANCE

11.1 All staff have responsibility to ensure that they are aware of policy documents which are relevant to their area of work, and that they act in accordance with these at all times.

11.2 Managers must ensure that departmental systems are in place to enable all staff to access relevant documents and to remain up to date on new and revised documents.

12. OTHER RELEVANT DOCUMENTS

Please refer to policies and procedures relating to:

- Information Governance
- Record Management

13. EQUALITY ANALYSIS INITIAL ASSESSMENT

The initial Equality Analysis assessment has been attached.

EQUALITY ANALYSIS INITIAL ASSESSMENT

Title of the change proposal or policy:

Framework for the development and management of policy and procedural documents

Brief description of the proposal:

The framework has been developed to clarify the steps that must be taken to develop and secure approval for all new or reviewed policies, guidelines, procedures or protocols to be used within Wandsworth CCG.

Name(s) and role(s) of staff completing this assessment:

Sandra Allingham, Business Manager

Date of assessment: 2014

Please answer the following questions in relation to the proposed change:

Will it affect employees, customers, and/or the public? Please state which.

Yes, it will affect all employees who contribute to the development of policy and procedural documents.

Is it a major change affecting how a service or policy is delivered or accessed?

No – the framework will standardise the process for development and format of policies and procedural documents.

Will it have an effect on how other organisations operate in terms of equality?

No

If you conclude that there will not be a detrimental impact on any equality group, caused by the proposed change, please state how you have reached that conclusion:

The Framework has been developed to standardise the development, formal, and approval of policies and procedural documents. There are no statements, conditions or requirements that disadvantage any particular group of people with a protected characteristic.

APPENDIX 1 – CONSULTATION GROUPS

The following lists are given as examples.

Consultation on the initial document development
People to consult include:

(a) National Guidance – all government guidance states the recipients of the guidance and usually recommends the stakeholders to consult.

(b) Local Guidance – local standards or frameworks already in place. For example, Partnership Agreements.

(c) Local Experts – individuals with a specific remit who may have a more detailed level of specialist knowledge. For example, Risk Manager, Information Governance Manager, Records Manager.

(d) Specialist Advice – in view of potential legal or financial challenge.

Wider consultation upon completion of initial draft
People to consult are those who may be affected by the document or have an interest in the document.

For example:

(e) All staff working in the CCG, Staff Consultative Committee representative, Directors, Finance, Human Resources, etc.

(f) Committees and sub-Committees of the Board.

(g) Steering Group and working party members, specialist committees eg Information Governance Steering Group.

(h) Users and potential users of the service and their carers, Interest Groups, Patient representatives.

(i) Commissioning – other contracted services, clinical networks, host providers.

(j) Other organisations – Local Authorities, neighbouring CCGs, voluntary agencies.

Consultation of policies

Type of policy	Consultation Group
All policies (a – d)	• Check national guidance • Seek guidance from specialist experts, eg Information Governance Manager, Risk Manager • Assess for legal and financial challenge and seek specialist advice as necessary
Local policies (e – f)	• As above • All staff, staff side representation • Chief Officer and Directors • Boards and Committee members as part of approval process
Commissioning policies (a – j) As appropriate >	• Specific staff groups • Legal and financial advisors • Specific committees and interest groups • Patient representatives • Boards and Committee members as part of approval process
Joint policies (a – j) As appropriate >	• All staff, staff side representation • Chief Officer • Legal and financial advisors • Specific committees and interest groups • Patient representatives • Board and Committee members as part of approval process

APPENDIX 2 – CHECK LIST

Checklist for the review and approval of documents

	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, protocol or procedure?		
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?		
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?		
	Is there evidence of consultation with stakeholders and users?		
	Has an Equality Analysis been undertaken on the document?		
4.	**Content**		
	Is the objective of the document clear?		
	Is the target population clear and unambiguous?		
	Are the intended outcomes described?		
	Are the statements clear and unambiguous?		
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?		

	Are key references cited? Are the references cited in full?		
	Are supporting documents referenced?		
6.	**Approval**		
	Does the document identify which committee/group will approve it?		
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?		
	Does the plan include the necessary training/support to ensure compliance?		
8.	**Document Control**		
	Does the document identify where it will be held?		
	Have archiving arrangements for superseded documents been addressed?		
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards to support the monitoring of compliance with and effectiveness of the document?		
	Is there a plan to review or audit compliance with the document?		
10.	**Review Date**		
	Is the review date identified?		
	Is the frequency of review identified? If so is it acceptable?		
11.	**Overall responsibility for the document**		
	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?		

APPENDIX 3 – VERSION CONTROL

To ensure that staff know which the most up-to-date version of a policy is, a system of version control will be used.

1. When a policy or procedure is first being written and is in the draft stage, its version number will be **0.1**.

2. If that policy is later amended and a second draft done, its version number should be changed to **0.2** and so on.

NB: It is a good idea to archive older drafts of policies rather than save over them with a new version number, that way it is possible to produce an audit trail of the changes.

3. The version number of the policy should not only be included on the front cover sheet, but in the header of every page of the policy inclusion all attachments to it.

4. As soon as the policy has been ratified by the relevant committee or Board and is ready to be put on to the intranet and website, the version number will change to **1.0**. This is a simple way of showing that the policy has been validated.

5. If there are any further changes to be made to the policy once it has been put on the intranet and website, the version number will change to **1.1, 1.2, 1.3** etc. However, the version number on published documents will remain unchanged while the updating of the document takes place. Only the draft versions that the policy lead is working on will increment by **0.1, 0.2, 0.3** etc.

6. As soon as the new changes have been approved and the updated policy is ready to be published on the intranet and website, it will replace the existing policy (**version 1.0**) and the version number will become **2.0**. This is also true for policies that do not require approval but have had changes made to them. Their version number should also be incremented by 1 and put back on the intranet site. If a policy is reviewed, and there are no changes made to it, the version number does not need to change. In short, only policies with a whole number as a version (**1.0, 2.0, 3.0** etc) should be on the intranet and website. This way it is clear that the policy has been approved and is the one that must be used.

APPENDIX 4 – NOTIFICATION TO CORPORATE AFFAIRS TEAM
Second floor, Watershed House, 1 Adelaide Road, London SW18 1DA

Central Document Database

Please complete the form below for all new and revised policies and return to the Corporate Affairs team for entry onto the Central Document Database
(Email: Sandra.allingham@wandsworthccg.nhs.uk)

If in final draft stage, please attached policy and completed Equality Analysis.

Document Title		
Version number (eg 0.1, 2.0 etc)		
Type of document *Tick appropriate box*	Policy ☐ Procedure only ☐ Strategy ☐ Other (please provide details)	
Scope of Document *Tick appropriate box*	Corporate (applicable across the CCG) ☐ Local (applicable to specific service) ☐	
Status or current stage *Tick appropriate box*	Development ☐ Consultation ☐ Review ☐ Final draft awaiting approval ☐	
Author or lead		
Role or post		
Directorate/Service		
Approving Group or Committee		
Date of approval		
Date of ratification		
Next review date		
Equality Analysis date		
Date superceded	File location link	Website link
OFFICE USE ONLY	OFFICE USE ONLY	OFFICE USE ONLY
Comments		
Form submitted by:		Date

APPENDIX 5 – MODEL POLICY OUTLINE

NHS
Wandsworth
Clinical Commissioning Group

SUBJECT/TITLE

Policy/Guidelines/Procedure/Protocol

Version XX

Date approved:

Date for review:

Lead Director:

Lead Manager:

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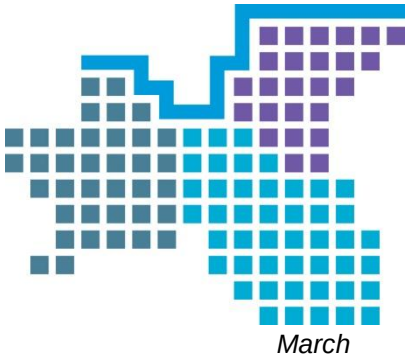

DOCUMENT CONTROL AND AMENDMENT RECORD

(Name of Policy)

Version	Date	Reason for review/update	Author/ Reviewer	Approving Committee(s)	Date of approval

CONTENTS

Table of contents can be compiled using Word references Table if standard font or headings are used:

(Name of policy/procedure)

1. INTRODUCTION

Overview of the importance and role of the document.

1.1 Purpose / Rationale

Purpose of the document including the rationale for development. Outline the objectives and intended outcomes of the process/system being described.

1.2 Aims and Objectives

1.3 Scope

Who is the document for?

2. DEFINITIONS

List and describe the meaning of the terms used in the context of the document if considered necessary.

3. DUTIES

Duties and accountabilities of directors, committees, specialist staff, and authors with responsibility for the document.

4. CONTENT

The content should demonstrably comply with all relevant legal and statutory requirements, NHS guidance and policy in force at the time of writing or reviewing the document. It should include Consultation and Equality Analysis results and any required changes to the document.

5. DISSEMINATION AND IMPLEMENTATION

5.1 Dissemination

Explain how procedural documents will be circulated including arrangements to record distribution of the document and thereby aid retrieval.

5.2 Implementation

Identify arrangements for training, support, etc.

6. MONITORING AND COMPLIANCE

Outline the process to monitor compliance with and the effectiveness of the document. Include a description of the standards and/or Key Performance Indicators (KPIs).

7. OTHER RELEVANT POLICIES

8. REFERENCES

Provide evidence base for documents with up to date references.

APPENDIX 6 – EQUALITY ANALYSIS

Please see full Equality Analysis Guidance and Templates available on the website

Equality Act 2010 – banning unjustifiable age discrimination

The ban and related exceptions came into force on 1 October 2012.

The intention is **not** to outlaw the many instances of different treatment that are either justifiable, or that do not give rise to harm.

Service providers, including the NHS, will still be able to provide different services to different people based on their age, if:

- They can show a sufficient reason (objective justification) if challenged;
- They can justify extra help to an age group with particular needs;
- The different treatment is allowed as required by law, for example, free prescriptions and eyesight tests for older people.

The Government says that it is taking a proportionate approach to ensure that the new law prohibits only harmful or unjustifiable treatment that results in genuinely unfair discrimination and harassment because of, or related to, age.

Please use the link below for specific guidance:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/84987/government-consultation-response.pdf

Further information
To learn more about the Equalities Act (2010) click on this link: Equality Act 2010: guidance - Detailed guidance - GOV.UK

To learn more about Protected Characteristics clink on this link: Discrimination: your rights - GOV.UK

APPENDIX 7 – LIST OF RECOMMENDED POLICIES

Area	Policy
Corporate Governance	• Policy for the Management of Policies and Standard Operating Procedures
	• Constitution
	• Constitution: Appendix C – Standing Orders
	• Conflict of Interest
	• Standards of Business Conduct
	• Complaints, Compliments and Concerns
	• Responding to Unacceptable Behaviour by Members of the Public
	• Sustainability
	• Organisation Development Plan
	• Integrated Risk Strategy and Framework
	• Intellectual Property Rights
Communications	• Corporate House Style
	• Media / Social Media / Web
	• Translation and Interpretation
Finance	• Constitution: Appendix D – Scheme of Reservation and Delegation
	• Constitution: Appendix E – Prime Financial Policies
	• Fraud and Corruption
	• Claims Management and Handling
	• Sponsorship / Commercial Sponsorship
Commissioning	• Joint Needs Assessment
	• Joint Health and Wellbeing Strategy
	• Integrated Plan and Commissioning Intentions
	• Procurement (including tendering and contracting)
	• Sustainable Procurement
	• Collaboration
	• Individual Funding Requests
	• NHS Continuing Healthcare
	• Safeguarding Adults
	• Safeguarding Children
	• Mental Capacity Act – Deprivation of Liberty Safeguards
Human Resources	• Organisational Change
	• Recruitment and Retention
	• Managing Performance at Work
	• Leave: Annual, Maternity, Adoption, Paternity, Study, Special
	• Grievance and Disputes
	• Disciplinary
	• Management of Public Interest Disclosure (Whistle Blowing)
	• Managing Alcohol and Substance Misuse at Work
	• Trade Union Recognition and Facilities
	• Working Time Regulations
	• Induction

	• Professional Registration
	• Clinical Supervision
	• Working Time
	• Dress Code
	• Managing stress in the workplace
	• Bullying and harassment
	• Lone Working
	• Retirement and Flexible Retirement
Emergency and Incidents	• Serious Incidents
	• Incidents
	• Business Continuity
Information Governance	• Information Security
	• Confidentiality and Data Protection
	• Corporate Records and Retention
	• Subject Access Request
	• Management of Freedom of Information Act
	• Data Quality
	• Pseudonymisation and Anonymisation
	• Use of NHS Number
	• Information Communication Technology Security
	• Information Communication Technology Network Infrastructure File Service
	• Laptop and Portable Devices and Remote Access
	• Encryption
	• Acceptable use of Internet/email
	• Disposal and re-use of Computer Equipment
Health and Safety	• Accident and Incident
	• Fire Safety
	• Security
	• Slips, Trips and Falls
	• Manual Handling
	• Environmental Information Regulations and Publication Scheme
	• Smokefree