NHS
West Essex
Clinical Commissioning Group

NHS WEST ESSEX

CLINICAL COMMISSIONING GROUP

Policy on Policies

WE CCG Policy Reference:
WECCG50

Target Audience	This policy applies to all CCG staff, including those working on a temporary or interim basis, contractors on site, lay members and volunteers.
Brief Description (max 50 words)	This policy sets out the arrangements for the development and approval of policies and procedures for use by the CCG in order to undertake its business and duties as a commissioning group.

Version Number	2.3
Accountable Officer	Chief Officer
Responsible Officer	Director of Corporate Services
Date Approved	Executive Committee - 12th November 2020
Approval Ratified	Board – 26th November 2020
Date Summary presented to Board	26th November 2020
Review Date	November 2022
Stakeholders engaged in development/review	HR Policy Review Group, Managing Directors for West Essex CCG, East and North Herts CCG, and Herts Valley CCG.
Equality Impact Assessment	Completed – February 2018

SUSTAINABILITY STATEMENT: SUSTAINABILITY STATEMENT: We declare that NHS West Essex Clinical Commissioning Group will demonstrate commitment to promoting environmental and social sustainability through our actions as a corporate body and as a commissioner.

Amendment History

Version	Date	Reviewer Name(s)	Comments
1.1	13.02.15	Dannii Owens	Comments from Kerry Franklin and Grainne Stephenson
1.2	08.05.15	Executive Committee	Comments from Executive incorporated into document – change to Appendix B and confirmation of Appendix A
2.1	28.04.17	Dannii Owens	Review due – undertaken by Dannii Owens
2.2	20.07.17	Grainne Stephenson	Furthers comments and review
2.3	Nov. 2020	Head of Legal and Governance (Company Secretary); HR Services	Appendix A – inclusion of HR Policy Forum Page 5 and Appendix B – amendment to "relevant review group" as opposed to Policy Review Group.

CONTENTS

1. INTRODUCTION

The NHS West Essex Clinical Commissioning Group's (the CCG) Constitution sets outs how we will undertake our business in exercising responsibility for the commissioning of health services in west Essex. The Standing Orders, Scheme of Reservation and Delegation and the Prime Financial Policies provide the procedural framework.

This 'Policy on Policies' sets out the arrangements for the development and approval of policies for undertaking the CCG's business.

The definitions adopted for this policy are:-

- **A 'policy'** is a comprehensive statement that sets out the CCG's position and governing principles with regard to a specific area of work. A policy must be followed by all staff and is enforceable by management. It may include instructions that must be followed, or prohibit certain behaviour. No member of staff is authorised to deviate from CCG policy in all but the most extreme circumstances. Deviation from a particular *procedure* within a policy can occur where the manager assesses that it is an inappropriate procedure to follow in the particular and / or extraordinary circumstances that are faced and for which documentary evidence is provided to support the rationale for this deviation.
- **A 'procedure'** is a recommended way of working for staff to follow, usually based on evidence of good practice. Procedures are often subsidiary to a policy and if so **may** be contained within policy documents, as an appendix or external reference. A departure to a procedure can occur as previously described.
- **A 'strategy'** sets out a plan of action to meet specific goals. Strategies are usually approved by the Board and are subject to the same delegated authority of the committees as explained in chapter 3.
- **A 'guideline'** is a document which details rules or principles that provide guidance for practitioners and others in their clinical or managerial decision making. It allows choices to be made about how standards are achieved and about appropriate actions or behaviour in a given circumstance. Documentation to support the reasons for variance from the guideline would need to be completed and supported by evidence.
- **'Approval'** means to sign or give formal consent to, making it officially valid.

2. SCOPE

This policy applies to all CCG staff, including those working on a temporary or interim basis, contractors on site, lay members and volunteers.

3. BOARD AND COMMITTEE RESERVATION

All CCG policies will be assigned to either the CCG Board or one of its sub-committees which have the delegated power to review and approve certain policies on behalf of the CCG Board. The policy delegation and governance schedule can be found at Appendix A.

In discharging its responsibilities, the Executive Committee adopts a "portfolio" approach in which individual executives lead on and are accountable for policy areas. In terms of policy development, management and review these portfolios are summarised below:

Policy Area:	**Accountable Executive:**
Human Resources	Chief Officer
Whistleblowing Policy	Chief Officer
Training and development	Chief Officer
Management	Chief Officer
Governance	Chief Officer

Emergency planning and business continuity	Chief Officer
Finance, accounting and claims	Director of Finance, Contracting and Performance
Procurement	Director of Finance, Contracting and Performance
Competition Disputes Resolution Policy	Director of Finance, Contracting and Performance
Risk Management	Director of Finance, Contracting and Performance
Health and Safety	Director of Finance, Contracting and Performance
Fraud and Bribery	Director of Finance, Contracting and Performance
Safeguarding	Director of Nursing and Quality
Clinical	Director of Nursing and Quality Or Chief Medical Officer
Quality	Director of Nursing and Quality
Communications	Director of Corporate Services
Information Governance	Chief Medical Officer

4. DEVELOPMENT OF POLICIES

Reference is made to Appendix B that sets out the governance process for all policies that are subject to review or are to be written.

The Governance Team will maintain a policy management system with approval and review dates. The team will notify the policy owner (or accountable executive if the policy owner's post is vacant) three months in advance of the document's expiry to prompt a review. It is the responsibility of the policy owner to ensure the document is kept up to date and reviewed as determined. If it is envisaged that the review cannot be achieved within this timeframe then the policy owner must notify the accountable executive and their line manager as a policy extension may be required. Extensions for corporate policies are approved via the Executive Committee and clinical policy extensions via the Executive Health and Care Commissioning Committee.

Where there are legislation changes resulting in the requirement for an earlier review, the policy owner shall advise the Governance Team that an earlier review is to be undertaken.

5. ROLES AND RESPONSIBILITIES

5.1 Responsibilities of Policy Owners

The policy owner will be responsible for ensuring that:

- New and reviewed policies are developed or reviewed in collaboration with appropriate and knowledgeable members of the CCG, plus relevant external stakeholders;
- An Equality Impact Assessment (EIA) is completed with the outcome of addressing the feedback being displayed within the draft policy;
- Each individual participant within the review has fully considered whether they have a conflict of interest that must be declared in accordance with the CCG Managing Conflicts of Interests Policy. In the event of any doubt or concern, the policy owner will inform the accountable executive of the facts of the matter. Substantive or potential matters of concern will be reported to the approving committee when it considers the policy.
- The policy is compliant with law, regulation, guidance and / or best practice;

- The policy documentation is accurate, compliant and fit for purpose;and
- Consultation as appropriate with other stakeholders including the relevant review group, Human Resources and Sounding Board (the patient reference group) has taken place prior to presenting to the relevant committee.
- Comments, queries and adaptations received from stakeholders, including the relevant review group, are responded to and incorporated within the policy draft as appropriate or, that a rationale is provided for the stakeholders where this is not the case.

The policy owner will define the requirement for the policy to be maintained, developed or revised by linking it to the relevant primary and secondary legislation and guidance and it will be this review period which is used by the Governance Team if less than once every two years.

Where the policy owner is unable to complete the policy review prior to its expiry date, then the relevant accountable officer and responsible officer should be informed and a formal policy extension request raised with the responsible committee. Following formal extension, the Governance Team should be made aware of the new expiry date.

Policy authors may choose to complete a stakeholder map for both new and reviewed policies; an example of which can be seen in Appendix C. Using a stakeholder map is good practice and will help to ensure that those people or organisations which need to take account of the policy are included in the development or review process.

The role of patients and / or carer representatives in the review of policy will be clearly defined. The views of vulnerable groups can be sought via Patient Participation Groups in the corresponding area.

To ensure proper awareness and application of the policy the owner will, where applicable, complete a training and implementation plan, an example of which can be viewed in Appendix D. This will identify actions that need to be taken and by whom. This may include:

- incorporation into mandatory training or team training;
- revision of contracts; and
- changes to current CCG practice.

The policy owner will identify the associated resources, where necessary, to achieve effective implementation. This could include time, funding or specialist resources (such as facilitators for workshops or legal advice) and these will be validated with the Finance Department.

5.2 Accountable Executive Responsibilities

The accountable executive for each policy will identify an appropriate individual as policy owner.

The accountable executive will have overall responsibility for the development and review of a policy.

5.3 Committee and Board Responsibilities

The relevant committee or Board will confirm the review period for each policy as part of the approval process. As a minimum, each policy must be reviewed at least once every two years. New policies will be reviewed after one year.

5.4 Governance and Corporate Services Team

A summary of approved policies will be presented at the next available Board meeting by the Director of Corporate Services. Those policies detailed in Appendix A as going to the Board in full are the only exceptions of this rule.

The Governance Team will ensure that following approval, the latest version of the policy is uploaded onto the CCG intranet and where applicable, the public facing website. Staff will be informed of the policy via the regular brief from the Communications Team and through the noticeboards.

Only the Governance Team, working with the Communications Team, will publish or remove CCG policies from the intranet.

Once a policy has been replaced or been made redundant, it will be lodged in an archive maintained in accordance with retention of records standards by the Governance Team.

6. POLICIES WITHIN THE CCG'S CONTRACT REQUIREMENTS

The policy owner will liaise with the relevant CCG staff member, or provider of commissioned services where appropriate, such as a Commissioning Support Unit (CSU), or other relevant organisations to incorporate the policy into contracts and agree the relevant monitoring or audit plan.

The CCG project lead on any procurement will:

- identify any additional CCG policy or legislation that affects the planned procurement;
- incorporate the policy or legislation within the specification; and
- incorporate the requirement within the evaluation.

7. DEFINING PROCEDURES SUBSIDIARY TO POLICIES

In general, detailed procedures subsidiary to CCG policies need **not** be incorporated within the policy documents, nor created as separate documents unless the policy owner and approving committee consider otherwise.

Wherever possible, the procedure should not be described within the main body of the document, but presented either as:

- an appendix to the policy; or
- a hyperlink to another website (such as the Essex safeguarding procedures).

If the procedure is for a specific departmental task, then it should be referred to within the policy document as a departmental Standard Operating Procedure (SOP). Any SOP so referred to must be maintained and updated within the CCG or CSU department concerned (such as a financial accounting procedure).

If a procedure for applying the policy is expected to be applied across multiple organisations then those organisations will be required to include both the policy and procedure in the appropriate section or schedule of any contract, multi agency agreement or "transfer of funding" document.

8. FORMAT FOR POLICIES

Each policy will be allocated a unique policy number~~,~~ which will be stored in the Policy Management System. When a new policy is being written~~,~~ the Governance Team should be approached for the next available policy reference number and should be given all relevant information to begin logging the process on the Policy Management System.

Policy documents will be produced:

- In Arial font size 11;
- With narrow margins;
- With a contents page;
- Using, as a minimum, the template provided in Appendix G;

- Including the CCG Sustainability Statement;
- Using the front page as appears in Appendix G;
- With pages numbered;
- Containing a footer in font size 8 showing the policy reference / version number and date approved / date for review;
- Will include an amendment history box for version control; and
- Using, as a minimum, the chapter headings shown in Appendix G.

Abbreviations may be used and full details must be given in the first instance followed by the abbreviation in brackets. Where applicable, a glossary will be included at the front of the policy.

The format for the policy audit template is set out in Appendix H to this policy.

It is recognised that those policies which are developed by external sources, to be used by the CCG, will not be held to account against this policy.

Appendix A – Policy Approval Process

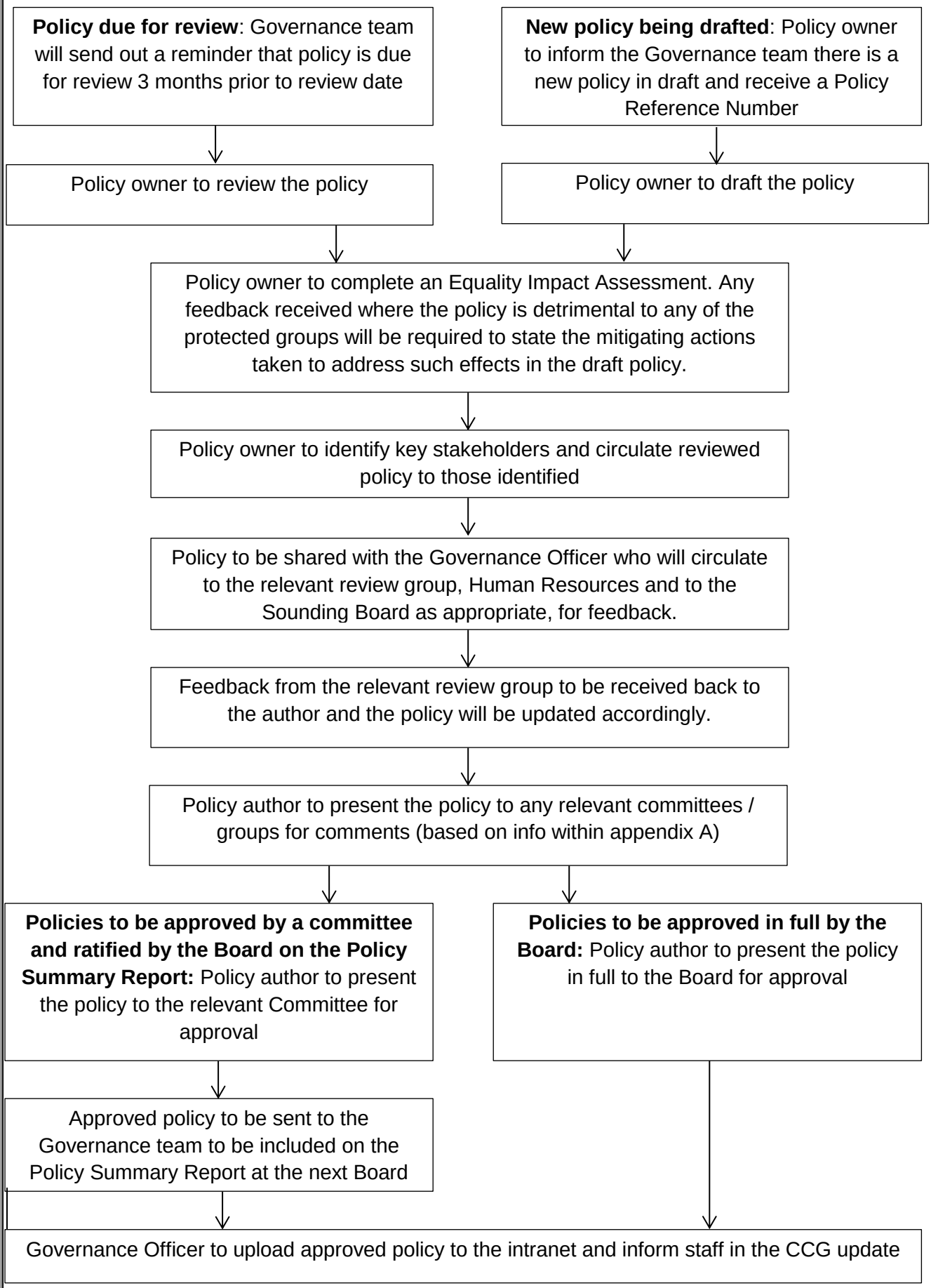
Policy area	Audit Committee?	Quality Committee	Executive Committee?	HR Policy Forum	Board?
Human Resources	No	No	No	For approval	On Policy Summary Report for ratification
Training and development	No	No	For approval	No	On Policy Summary Report for ratification
Management	No	No	For approval	No	On Policy Summary Report for ratification
Governance	No	No	For approval	No	On Policy Summary Report for ratification
Emergency planning and business continuity	No	No	For approval	No	On Policy Summary Report for ratification
Communications	No	No	For approval	No	On Policy Summary Report for ratification
Whistleblowing Policy	No	No	For review and comments – recommendation to the Board for approval	For approval	In full for approval
Competition Disputes Resolution Policy	No	No	For review and comments – recommendation to the Board for approval	No	In full for approval
Health and Safety	No	No	For review and comments – recommendation to the Board for approval	No	In full for approval
Risk Management	For review and comments	No	For review and comments – recommendation to the Board for approval	No	In full for approval
Fraud and Bribery	For review and	No	For approval	No	On Policy Summary Report for

	comments				ratification
Finance, accounting and claims	For review and comments	No	For approval	No	On Policy Summary Report for ratification
Procurement	For review and comments	No	For approval	No	On Policy Summary Report for ratification
Information Governance	No	For review and comments	For approval	No	On Policy Summary Report for ratification

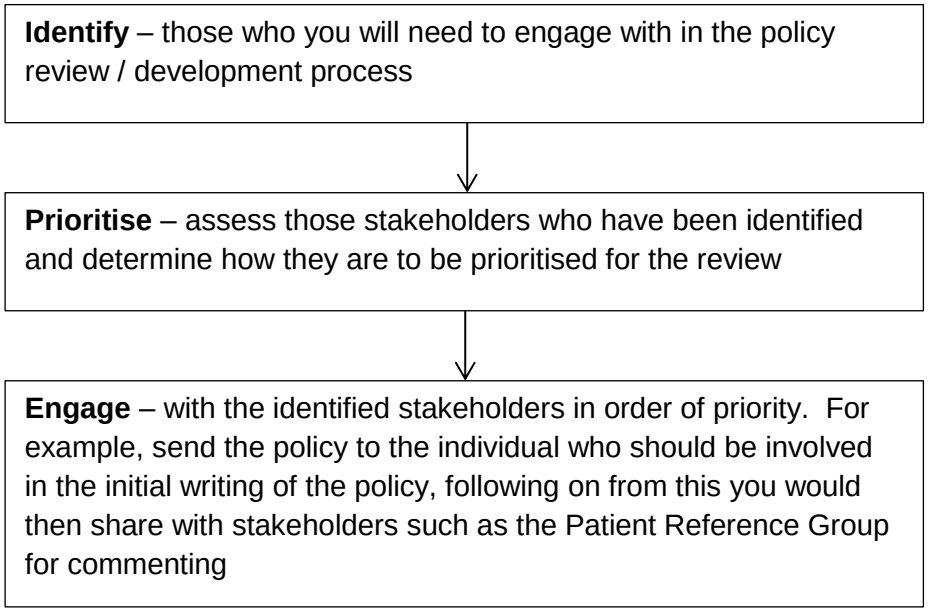
Policy area	Quality Committee	Executive Health and Care Commissioning Committee	Board
Safeguarding	For review and comments	For approval	On Policy Summary Report for ratification
Clinical	For review and comments	For approval	On Policy Summary Report for ratification
Quality	For review and comments	For approval	On Policy Summary Report for ratification

Where not listed, all other policies will be determined on a case by case basis.

Appendix B – Policy Governance Process



Appendix C - Stakeholder Mapping for Policies



Appendix D – Implementation and Training Plan

Policy name: *Policy owner:*

Actions identified for implementation	**Staff assigned to action**	**Target Completion date**	**Communication required?** *(external or internal)*	**Training required?**	**Communication scheduled dates**	**Communication details**	**Training scheduled dates**	**Training details**
(Example): Engagement with public on new policy	*Patient Engagement and Communications*	*10/17*	*Yes – external*	*No*	*September 2017*	*Onto website including period of one month on welcome page*	*N/A*	*N/A*

APPENDIX E – POLICY TEMPLATE

WECCG Policy Template.docx

APPENDIX F – POLICY AUDIT TEMPLATE

Policy Title:

Policy Owner:

Approving Sub-committee:

Group / Sub-committee responsible for ensuring actions are in place:

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements	Recommendations	Learning lessons