NHS
North Hampshire
Clinical Commissioning Group

# POLICY FOR THE DEVELOPMENT, REVIEW, APPROVAL AND IMPLEMENTATION OF POLICIES AND STANDARD OPERATING PROCEDURES

## COR/001/V1.12

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| **Subject and version number of document:** | Policy for the Development, Review, Approval and Implementation of Policies and Standard Operating Procedures |
| **Unique Reference Number:** | COR/001/Version 1.12 |
| **Operative date:** | 30 January 2015 |
| **Author:** | Richard Clarke, NH CCG Head of Business Development<br>Revision: Debbie Broughall, Business Development Manager (August & December 2014, January 2015) |
| **Review date:** | December 2017 |
| **For action by:** | All staff of the Clinical Commissioning Group (CCG) |
| **Policy statement:** | This document sets out the policy by which the policies and Standard Operating Procedures (including documents on procedures, protocols and guidelines) of the CCG will be prepared, approved, ratified, implemented and reviewed. This is a corporate policy. |
| **Target audience:** | All staff etc |
| **Responsibility for dissemination to new staff:** | NH CCG Business Development Manager |
| **Training Implications:** | Any CCG staff developing policies and SOPs need to be aware of this document. It will be posted on the CCG website. |
| **Further details and additional copies available from:** | Further details are available from the CCG Business Development Manager. Copies should be downloaded from the CCG's website. |
| **Equality Analysis Completed?** | This document includes a section about Equality Analysis (previously called Equality Impact Assessment), the aim being to encourage and support policy developers to demonstrate 'due regard' to the Equality Act 2010. |
| **Consultation Undertaken** | Initial approval:<br>Management Committees ie SMC, Clinical Cabinet, IGC<br>Governing body |
| **Approved & ratified by:** | North Hampshire CCG Governing Body |
| **Date approved:** | 27 February 2013 |

**Intranet and Website Upload:**

| | | |
|---|---|---|
| Website | CCG Website Policy webpages | January 2015 |
| Keywords: | Policy<br>Standard Operating Procedure<br>Management | |

**Amendments Summary:**

| Amend No | Issued | Page(s) | Subject | Action Date |
|---|---|---|---|---|
| 1 | Aug 2014 | 1 | Title – amended to describe full remit of policy | August 2014 |
| 2 | Aug 2014 | 5 | 2.2 Definitions – amended explanation | August 2014 |
| 3 | Aug 2014 | 7 | 3.2.1 Statutory Compliance references increased | August 2014 |
| 4 | Aug 2014 | 11 | 3.8.2 Approval – clarification of committees | August 2014 |
| 5 | Aug 2014 | 11 | 3.8.6 & Appendix 8 - Approval checklist removed | August 2014 |
| 6 | Aug 2014 | 12 | 3.11.1 & Appendix 5 - Implementation impact assessment removed | August 2014 |
| 7 | Aug 2014 | 14 | 3.14.13 Policy control – details policy version control | August 2014 |
| 8 | Aug 2014 | 14 | 4 Roles & Responsibilities – updated and clarified | August 2014 |
| 9 | Aug 2014 | 15 | 7.2 & Appendix 9 – Audit standard removed | August 2014 |
| 10 | Aug 2014 | 17 | Appendices – Reviewed and re-ordered | August 2014 |
| 11 | Dec 2014 | 13 | 3.12.1 Suggestions with regard to how compliance with policies can be tested | Dec 2014 |
| 12 | Dec 2014 | 14 | 3.14.3 Clarification as to when policies should be re-approved and when they can be changed by the Business Development Manager without re-approval | Dec 2014 |
| 13 | Jan 2015 | 31 | Appendix 5 – Equality Impact Analysis tool updated | Jan 2015 |
| 14 | Aug 2015 | 9 | Section 3.3 updated to show the need for Quality Impact Assessments and Privacy Impact Assessments to be undertaken if necessary. | Aug 2015 |
| 15 | Aug 2015 | 48 & 52 | App 7 Quality Impact Assessment added<br>App 8 Privacy Impact Assessment added | Aug 2015 |

**Review Log:**

Include details of when the document was last reviewed:

| Version Number | Review Date | Name of Reviewer | Ratification Process | Notes |
|---|---|---|---|---|
| V1.10 | August 2014 | D Broughall | None | Technical changes only |
| | December 2014 | R Clarke | None | Technical changes only |
| | January 2015 | D Broughall | EIA tool approved by CCG Integrated Governance Committee January 2015 | Technical changes only |
| V1.12 | September 2015 | R Clarke | Nil required | Technical changes only |

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# POLICY FOR THE DEVELOPMENT, REVIEW, APPROVAL AND IMPLEMENTATION OF POLICIES AND STANDARD OPERATING PROCEDURES

## CONTENTS

## SECTION

# POLICY FOR THE DEVELOPMENT, REVIEW, APPROVAL AND IMPLEMENTATION OF POLICIES AND STANDARD OPERATING PROCEDURES

## 1. INTRODUCTION & PURPOSE

1.1 Organisational documentation is an essential tool of governance, which helps to achieve the strategic objectives, operational requirements and brings consistency to everyday activity. A standard format and approved structure for such documents helps to ensure that policies and procedures are up to date and reflect the organisational approach.

1.2 All documents must undergo a rigorous process of development and be approved and monitored by the appropriate committee or subcommittee, who in turn provide assurance to the CCG Governing Body on relevant legal and statutory requirements, NHS policy and guidance.

1.3 The purpose of this document is to create a standardised approach to the development, review, approval and implementation process of policies and standard operating procedures (SOPs) in accordance with the NHS Litigation Authority (NHSLA) Risk Management Standards 2012-2013.

## 2. SCOPE & DEFINITIONS

2.1 SCOPE

2.1.1 This policy applies to all directly and indirectly employed staff and other persons working within the CCG.

2.1.2 For the purpose of this policy, the word 'policy' refers to policies, procedures, protocols, guidelines, Integrated Care Pathways and Patient Group Directions. This policy does not cover the guidelines and directions issued by NICE or NHS England, or the resultant policy recommendations from the SHIP Priorities Committee (see *Policy for the Adoption and Implementation of NICE Guidance and Policy Recommendations* CLI-006).

2.1.3 It is important that any members of staff who find it difficult or impossible to comply with a particular document or any aspect of it inform their manager at the earliest opportunity so that the document can be revised or action taken locally to make compliance possible. Where the policy is reviewed or revised as a result of a compliance issue, the Document Author must update the front cover and follow the process as outlined in section 3.12.

## 2.2 DEFINITIONS

| | |
|---|---|
| **Strategy**: | An overall plan to achieve longer-term objective |
| **Policy**: | A statement of intent which members of all CCG staff/consultants are expected to follow and should be regarded as mandatory by all. Failure to follow a CCG policy could result in disciplinary action being taken, up to and including dismissal. |
| **Standard Operating Procedures (SOPs):** | Documents that describe specific procedures, protocols and guidelines |
| **Procedure**: | The established form of conducting or performing an activity as a defined series of steps or actions to meet the requirements of a policy |
| **Protocol**: | The rules of behaviour |
| **Guidelines**: | Advisory or good practice principles put forward to set standards or determine a course of action. Clinical guidelines do not replace professional judgement and discretion. |
| **Integrated Care Pathways**: | Make explicit the most appropriate care for a patient group based upon the evidence available and a consensus of best practice. |
| **Patient Group Directions:** | *'Written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.'* Source MHRA. |
| **Standard**: | Specification of a required level of performance. |
| **Code of Practice**: | Specification of standards which must be met within a legal framework. |
| **Code of Conduct:** | Specification of standards which must be met by members of that profession. |
| **Document Author:** | For the purpose of this document the term Document Author will mean the original author and any subsequent person who is responsible for reviewing or revising the document. |
| **Stakeholder:** | A person, group, or organisation that has direct or indirect input in an organisation because it can affect or be affected by the organisation's actions, objectives and policies. |

## 3. PROCESS/REQUIREMENTS

3.1 A brief summary for the policy development, approval and ratification process has been provided in **Appendix 1**.

3.2 STATUTORY COMPLIANCE

3.2.1 All policies, protocols, guidelines and procedures will comply with the relevant statutory requirements, any subsidiary legislation and subsequent amendments, including but not limited to the following Acts:

- Health & Safety at Work Act 1974
- Health and Social Care Act 20018 (Regulated Activities), Regulations 2010
- Health Act 2009
- Care Quality Commission (Registration), Regulations 2009.
- Equality Act 2010, Equality Act 2010 (Specific Duties) Regulations 2011
- Human Rights Act 1998
- Promoting Equality and Human Rights in the NHS: a guide for Non-Executive Directors of NHS Boards (2005) Department of Health
- Mental Health Act 2007
- Mental Capacity Act 2005
- Civil Contingencies Act 2005
- Finance Act 2011
- Freedom of Information Act 2000
- Re-use of Public Sector Information Regulations 2005
- Data Protection Act 1998
- Environmental Information Regulations 2004
- Corporate Manslaughter & Corporate Homicide Act 2007
- Rehabilitation of Offenders Act 1974
- Trade Union and Labour Relations Act 1992
- Part time workers (Prevention of Less Favourable Treatment) Regulations 2000
- Working Time Regulations 1998

3.2.2 All policies should take into consideration the requirements of the Care Quality Commission (CQC) and the NHSLA Risk Management Standards 2012-2013: NHSLA Acute, Community, Mental Health & Learning Disability and Non-NHS providers of NHS Care. The NHSLA standards are essentially about the reduction of incidents that give rise to high value claims (or their defensibility). For more information:

- CQC homepage: http://www.cqc.org.uk
- NHSLA homepage: http://www.nhsla.com/Pages/Home.aspx

## 3.3 IMPACT ASSESSMENTS

3.3.1 Equality Impact Assessments

*"The public sector Equality Duty (section 149 of the Equality Act 2010) came into force on 5 April 2011. The Equality Duty applies to public bodies and others carrying out public functions. It supports good decision-making by ensuring public bodies consider how different people will be affected by their activities, helping them to deliver policies and services which are efficient and effective; accessible to all; and which meet different people's needs. The Equality Duty is supported by specific duties, set out in regulations which came into force on 10 September 2011. The specific duties require public bodies to publish relevant, proportionate information demonstrating their compliance with the Equality Duty; and to set themselves specific, measurable equality objectives."* Source: The Advisory, Conciliation and Arbitration Service (ACAS).

3.3.2 In accordance with the CCG's commitment to Equality and Diversity, we aim to eliminate discrimination, harassment and victimisation, advance equality of opportunity, and promote good relations between groups. We need to do this for the 9 protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. **Appendix 5** provides the Equality Analysis Template and guidance which is designed to help you systematically analyse the needs and impact of your policy on each equality group or protected characteristic.

3.3.3 Document Authors are instructed to undertake an Equality Analysis for all new policies. Results of the assessment, consultation and monitoring process should be detailed under the section heading *'Equality, Diversity and Mental Capacity Act'* in the policy document. Existing policies should already have been Equality Impact Assessed and so only a review will be necessary where this is the case.

3.3.4 The completed Equality Analysis will need to be submitted as part of the policy approval process, and may be published to demonstrate compliance with the specific equality duty to publish equalities information

3.3.5 An Equality Statement should be included at the end of any policy.

3.3.6 Quality Impact Assessments

The NHS continues to experience financial challenges across all sectors. As organisations scrutinise their budgets, cost improvement initiatives are introduced to meet the financial challenges and reduce the prospect of organisational deficits. During this period, many organisations are faced with the identification of schemes which introduce constraints into the healthcare system. The potential risks that cost saving or service improvement schemes can have on the quality of services must be assessed.

3.3.7 NHCCG uses a standard Quality Impact Assessment tool and risks are assessed using the Quality Monitoring Tool. Although the production of strategies and subsequent service improvement plans may not involve the development of a policy/procedure per se, all schemes that are worked up in outline and have a potential impact on the quality of clinical services will undergo a Quality & Equality Impact Assessment (QIA). To do this effectively, the right information is needed in order to understand the potential risks to quality and plans must be put in place to ensure action is taken before quality of services is impacted. An impact assessment on quality will be completed in the scheme planning stage and schemes that are considered unrealistic or that pose a risk to quality will not be put forward for consideration to the PMO Delivery Group. n addition to doing this assessment at the planning stage, the CCG should also do this during delivery, at key milestones and post-implementation to ensure sustainability.

The process and tool appear at **Appendix 7** of this document.

3.3.8 Privacy Impact Assessments

Policies, procedures or projects that involve the processing or sharing personal information or commercially sensitive data give rise to privacy issues and concerns. To enable an organisation to address the privacy concerns a Privacy Impact Assessment (PIA) can be used to assess privacy risks to individuals in the collection, use, disclosure and disposal of information. The PIA can help identify privacy risks, foresee problems and bring forward solutions.

The assessment form to be used in such cases is shown **Appendix 8**.

3.4 POLICY INITIATION AND DEVELOPMENT

3.4.1 To avoid duplication, promote the involvement of all relevant stakeholders and to provide general support in the development of policies and SOPs a short checklist can be found at **Appendix 4**.

3.4.2 The intention to develop a policy must be registered with the CCG Business Development Manager who will maintain a central register of all policies. Registration of a policy can be achieved by completing parts 1 and 2 of the form shown in **Appendix 2.**

## 3.5 POLICY STYLE AND FORMAT

3.5.1 All policies and standard operating procedures should be presented in accordance with the policy standard template **(see Appendix 3).**

The basic style and format requirements are as follows;

- The policy title (on the cover page) should be written in black, capitals in font Arial Bold 14 or greater.
- The organisational logo should be at the top right corner of the title page. If the policy is a joint policy then the partner organisation logo should be on the top left side of the title page. It should be noted that joint policies will require ratification by all partner organisations concerned prior to implementation.
- The body text should be written using black Arial 12 font, with headings written in bold, capitalisation and/or underlined.
- The policy should be written in Plain English. Jargon should be avoided and abbreviations should be explained in their first use and subsequently where necessary. The policy should be easy to understand so that diverse service users and employees are aware of its existence and purpose.
- All sections of the document should be numbered sequentially, including paragraphs and appendices.
- All documents should include a footer (including the title of the document, page number and version number).
- The content of the policy should refer to other relevant documents.

## 3.6 POLICY CONSULTATION

3.6.1 It is the responsibility of the Document Author to agree and undertake the appropriate consultation on the policy document, prior to passing the document through for ratification. This can be done by individual consultation and/or the use of committee meetings. See **Appendix 6** for consultation guidance.

3.6.2 All documents should be reviewed by and commented on by the appropriate internal and external stakeholders prior to formal ratification by the CCG Governing Body - – good communication and consultation taking place at the development stage will help with understanding and engagement. .

3.6.3 Advice on groups/individuals to be consulted can be sought from the CCG Business Development Manager, Staff Side, Union Representatives, Staff groups. See **Appendix 6**.

3.6.4 Any groups/individuals consulted throughout the development of the policy should be listed in the reference table at the front of the policy.

3.6.5 Any reviews or amendments as a result of the consultations must be listed in the review log at the front of the policy and will also require ratification. The process outlined in section 3.13.3 will need to be completed.

3.6.6 It is good practice to give consultation periods of at least one month to ensure that staff on leave and/or staff with prioritising workloads are able to give the document appropriate attention. At the end of a consultation period, where some staff have not responded, a view should be taken as to whether an appropriate proportion of those consulted have responded (given the nature of the policy) and/or whether particular individuals expected to have a key opinion have responded.

3.6.7 A trial or pilot of a policy may be the most suitable method of testing. Trials may be limited to particular sites or services and for a set period of time. Document Authors should be aware that approval of the basic policy should be given before a trial, as the service will be required to act within the requirements of the new policy rather than any existing policy. The policy document will have increased legal standing and will be relevant for any investigations.

3.7 SPECIAL CIRCUMSTANCES

3.7.1 Local Authority, Local NHS, Local Area Team or Department of Health policies do not need to be rewritten into the CCG format if the CCG is intending to adopt them. A separate front sheet should be attached to the policy showing the title and CCG policy reference. Details of the consultation process and the standard document control requirements must also be given on this sheet with a nominated CCG Owner, rather than the Document Author, who would be responsible for reviews and CCG re-approval.

3.8 POLICY APPROVAL AND RATIFICATION

3.8.1 The policy should be presented to the appropriate CCG sub-committee for approval prior to final ratification by the CCG Governing Body. See **Appendix 6** for consultation guidance.

3.8.2 The CCG Governing Body may wish to delegate the role of the CCG policy approval to one of its sub-committees eg:

- Integrated Governance Committee - general governance policies
- Clinical Cabinet - clinical and commissioning related policies
- Senior Management Committee – HR or non-clinical policies
- Remuneration Committee – policies that may have a material impact on the terms and conditions of the employment of staff

This should also be reflected in the CCG Scheme of Delegation.

| Policy type | Approval | Final Ratification |
|---|---|---|
| **Clinical/Commissioning** | Clinical Cabinet | CCG Governing Body |
| **HR / Corporate** | Senior Management Committee | |
| **Finance** | Audit Committee | |
| **Workforce / Terms and Conditions** | Remuneration Committee | |
| **Governance** | Integrated Governance Committee | |

3.8.3 The CCG Governing Body is responsible for the final ratification of policies for use within the CCG. Final ratification will be made via the use of a list of those policies approved by the delegated committee which displays the:

- Policy name in full
- Unique Reference Number
- Approving Committee
- Date of approval
- Outstanding conditions to approval

Policies approved with outstanding conditions may be ratified by 'Chairs action' dependant on the type of condition. This request should be made of the Chair at the time of ratification.

3.8.4 There is a requirement placed on the CCG by external agencies such as the NHS Litigation Authority, that some policies are formally approved by the CCG Governing Body and this may not be delegated (for example Risk Management Policy). The CCG Governing Body will also be expected to approve policies with significant public interest or where enactment would require a significant change in the way the CCG operates. Policies presented to the CCG Governing Body for approval should previously have been considered and agreed at the appropriate sub-committee.

3.8.5 There is no requirement to formally agree Standard Operating Procedures (SOPs) although there may be some instances where SOPs require approval and ratification depending on the content, potential risk and impact. Further guidance can be obtained from the CCG Business Development Manager.

3.8.6 Ratification is the point at which the approved policy is presented to the CCG Governing Body as final and accepted as ready for publication, and is signed by the Chair of the CCG. CCG Governing Body minutes must reflect the ratification by Policy Name and Policy Reference Number.

3.9 POLICY DISSEMINATION & ACCESS

3.9.1 The Document author should consider how the policy or SOP will be communicated to staff and disseminated throughout the organisation. All approved policies and SOPs will be disseminated by means of shared computer drives and the CCG's public website at:

**http://www.northhampshireccg.com/info.aspx?p=5**

**NB. Policies published here represent the latest full and final version for reference by all concerned**.

Attention may also be drawn to new policies by newsletters, an intranet news section or via staff communication meetings.

3.9.2 Document authors should consider whether additional dissemination routes, for example to stakeholders or partner organisations, would be appropriate. This should be detailed in the policy itself.

3.10 POLICY ROLES & RESPONSIBILITIES

3.10.1 The roles and responsibilities section should be presented in accordance with the standard template **(see Appendix 3).**

3.11 POLICY IMPLEMENTATION/TRAINING/AWARENESS

3.11.1 It will be the responsibility of the document author to ensure that any policy introduced within the organisation includes consideration for the provision of training or guidance for managers and staff. This may be through the organisations training department which could offer advice and support on training issues, and where appropriate facilitate organisation wide training to accompany the implementation of policies. Alternatively, it may be considered more appropriate by the document author to visit departments or to meet individually with managers to offer general guidance or discuss specific aspects of the policy.

3.11.2 As part of the arrangements for the implementation of individual policies, the document author will need to detail the specific education and training requirements for the staff operating the policy/procedure, etc. including induction and mandatory training elements.

3.11.3 The Training section should be presented in accordance with the standard template **(see Appendix 3).**

3.12 POLICY SUCCESS CRITERIA / MONITORING THE EFFECTIVENESS OF THE POLICY

3.12.1 It is important to ensure that the policy document achieves its aims. The policy document must stipulate how implementation will be monitored / audited and evaluated giving timescales and/or frequency and detail what steps will be taken in response to the audit results.

3.12.2 Monitoring compliance (Auditing)

It is a requirement that all staff adhere to policies. To facilitate local managers' assessment of compliance within their department each policy should be subject to local audits on a regular basis. Document authors will be expected to take local remedial action in response to audit findings and report as appropriate to the CCG Business Development Manager by completing Part 1 and 3 of **Appendix 2.**

The scope of audit will vary in size and complexity dependant on the policy concerned. Document authors should aim to keep the audit as simple as possible to promote use and hence compliance. This will need to be undertaken at least once during the 3 years of the life of the policy before the review date and reported to the CCG Business Development Manager.

3.12.3 Monitoring compliance (Implementation)

The document author must consider monitoring arrangements to assess general implementation of the policy. The document author should determine when implementation will be reviewed, by whom, using what tool and, where applicable, what sample size. The document author must state where the results of this monitoring will be taken and how any resulting actions will be taken forward and themselves monitored.

3.12.4 Achievement of aims

The document author should, where possible, identify qualitative and quantitative outcome measures to identify whether the aims are being achieved by implementation of the policy. The document author should detail the method by which these measures are monitored, how often this will take place and where performance results will be taken. Examples of compliance audit techniques may include:

- informal discussions with staff
- testing during training and refresher days
- bespoke survey or inclusion of questions in larger staff surveys
- specified audit of a selection of staff and/or policy performance measures
- the development of performance indicators to measure the outcome of policy implementation

3.13 POLICY REVIEW & REVISING DOCUMENTS

3.13.1 Documents will usually be current initially for one year prior to review, and then for a maximum of three years unless agreed otherwise when the document is approved. There are exceptions to this where some documents must be reviewed on an annual basis.

3.13.2 Upon review Document Author should ensure that any references or links used within the document are still relevant and current.

3.13.3 The CCG Business Development Manager should be notified of all reviewed policies through completion of parts 1 and 3 of **Appendix 2.** All reviewed policies where there have been significant amendments to the content of the policy must be re-approved by the committee. After review and re-approval the policy version number will be advanced by the document author and a complete copy of the reviewed policy will be distributed acting as a 'refresher' to staff.

3.13.4 On occasion it may be necessary for a document to be reviewed earlier than the agreed review date, e.g. 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.

3.14 POLICY CONTROL & ARCHIVING

3.14.1 Record retention periods are defined in the Records Management: NHS Code of Practice. Document Authors are responsible for any subsequent revisions to a document and archiving of all previous versions of documents electronically and/or hard copy and to notify the CCG Business Development Manager.

3.14.2 Document Authors or other responsible person/s should ensure appropriate communication of any amended documents or revisions to the relevant service areas covered by the CCG.

3.14.3 As per section 3.13.3, after review and re-approval the policy version number will be advanced and a complete copy of the reviewed policy will be distributed acting as a 'refresher' to staff. The CCG Business Development Manager will also need to be notified to update the policy register.

Version advancement should be as follows:

XX/XXX/**V1.0** ⇨ XX/XXX/**V2.0**: indicates a significant review and update and may need to be re-approved by the original approving committee. This decision is made by the Business Development Manager.

XX/XXX/**V1.1** ⇨ XX/XXX/**V1.2**: indicates a technical review and update and is normally undertaken by the Business Development Manager without the need for re-approval.

## 4. ROLES & RESPONSIBILITIES FOR THIS POLICY

4.1 Chief Clinical Officer - has ultimate accountability for the strategic and operational management of the organisation, including ensuring all policies are adhered to.

4.2 CCG Governing Body – has the responsibility for ensuring that all policies in use in the organisation are ratified.

4.3 Approving Committees - the Scheme of Delegation identifies the committee that has been delegated responsibility for approval of policies by the CCG Governing Body. This is also confirmed in appropriate committee terms of reference and in section 3.8.2 of this policy.

4.3 Stakeholders – are responsible for ensuring the following:

- to review this policy and provide feedback
- ensure policy has been implemented

4.4 Business Development Manager - is responsible for:

- maintaining a central policy register
- contacting the Document Author when policy is nearing review date
- ensuring the registration, approval and ratification process is followed

4.5 Document Author – is responsible for ensuring the following:

- documents that they are responsible for (as determined by their role) are regularly reviewed and maintained
- that the CCG Business Development Manager has been notified of any new policies or reviewed policies using the registration form in Appendix 1 and the central register updated
- that documents are accessible on the intranet (where appropriate).
- policies that they are responsible for are formally ratified following the correct procedures
- that documents are cascaded appropriately
- that their local document index is maintained
- that all documents follow the corporate format
- that the effectiveness of the policy is monitored and evidenced
- that any issues identified through the standard audit are followed up and appropriate actions taken

## 5. TRAINING FOR THIS POLICY

5.1 Advice is available to support this policy. Any specific queries should be addressed to the CCG Business Development Manager.

5.2 All stakeholders involved in policy development should be aware of the contents and location of this 'Policy for the Management of Policies and Standard Operating Procedures' document.

## 6. EQUALITY ANALYSIS RELATING TO THIS POLICY

6.1 To be completed for this policy.

## 7. SUCCESS CRITERIA / MONITORING THE EFFECTIVENESS OF THIS POLICY

7.1 This policy will be monitored for compliance and effectiveness by the CCG Business Development Manager during its lifetime and from feedback of users. Any issues identified will be recorded and may lead to early review of the policy.

## 8. REVIEW OF THIS POLICY

8.1 This document may be reviewed at any time at the request of either staff side or management, but will automatically be reviewed after the first twelve months and thereafter on a 3 yearly basis.

## 9. REFERENCES AND LINKS TO OTHER DOCUMENTS FOR THIS POLICY

- The Medicines and Healthcare products Regulatory Agency (MHRA)
- Legislation.gov.uk
- Good Governance Institute
- The Advisory, Conciliation and Arbitration Service (ACAS)
- Reference should be made to the individual PCT policies which were used to assist in the development of this policy: Southampton City PCT *'Policy on Policies and Standing Operating Procedures 2010*', Hampshire PCT *'Policy for the Management of Policies'* 2010, Isle of Wight PCT *'Policy Management'* 2012 and Portsmouth PCT *'Policy on Corporate & Commissioner Policies'* 2012.
- NHS South West London *'A Framework for the Development and Management of Policy and Procedural Documents'*
- Records Management: NHS Code of Practice
- The Department of Health

**APPENDICIES**

## APPENDIX 1: POLICY DEVELOPMENT / APPROVAL / RATIFICATION PROCESS

This sheet can also be used as a checklist to aid policy development and ratification.

| Stage 1 | Action | Appendix | Date ✓ |
|---|---|---|---|
| **Development & Consultation** | 1. Complete *Policy Registration Form* - send to Business Development Manager for registration and reference number | Appendix 2 | |
| | 2. Draft Policy using standard *Policy Template* | Appendix 3 | |
| | 3. Complete *Policy and SOPs Pre-Approval Checklist* | Appendix 4 | |
| | 4. Complete *Equality Analysis* template | Appendix 5 | |
| | 5. Consultation | Appendix 6 | |
| | 6. Amend draft policy as appropriate following consultation with stakeholders | | |

| Stage 2 | Action | Appendix | Date ✓ |
|---|---|---|---|
| **Approval** | 1. Amended draft policy to Business Development Manager | | |
| | 2. BDM presents draft policy to appropriate GB committee with attachments for review | Policy Section 3.8 | |
| | 3. Committee reviews policy for pre-ratification approval – completes *Checklist for Review & Approval of Policy Documents* | Appendix 8 | |
| | 4. Amendments by author as required | | |

| Stage 3 | Action | Appendix | Date ✓ |
|---|---|---|---|
| **Ratification** | 1. BDM refers final draft to Governing Body for ratification | Policy Section 3.8 | |
| | 2. BDM finalises registration detail and publication to website | | |

| Stage 4 | Action | Appendix | Date ✓ |
|---|---|---|---|
| **Review / Monitoring** | 1. BDM notifies author when review due (after initial 12 months, and then 3 yearly) | | |
| | 2. Author completes parts 1 and 3 of *Policy Registration Form* and returns to BDM with amended policy | Appendix 2 | |
| | 3. Significant changes require Stage 2 Approval and Stage 3 Ratification | | |
| | 4. Author audits policy success 3 yearly – completed audit sent to BDM | | |

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## APPENDIX 2: POLICY REGISTRATION FORM

### 1. AUTHOR INFORMATION

| | |
|---|---|
| **Name** | |
| **Job Title** | |
| **Service/Dept** | |
| **Directorate** | |
| **Work Telephone No.** | |
| **Email Address** | |
| **Work Address** | |

### 2. NEW POLICY

| | |
|---|---|
| **Proposed Title** | |
| **Summary of Policy** | |
| **Link with other policies** | |
| **Target Audience** | |
| **Proposed Approving Committee** | |
| **Who will be involved / consulted during development of this policy?** | |

## APPENDIX 2: POLICY REGISTRATION FORM

### 3. REVIEW OF EXISITING POLICY

| | |
|---|---|
| **Previous version number** | |
| **New version number** | |
| **Review Date** | |
| **Actual Date Reviewed** | |
| **Have there been any significant amendments to the content of the policy? If yes, please complete the amendments summary below.** | **YES / NO** |

**Please list significant changes in the Amendments Summary:**

| Amend No | Issued | Page(s) | Subject | Action Date |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |

**PLEASE SEND YOUR COMPLETED FORM TO:**

**Business Development Manager**
**Email Address: Deborah.Broughall@nhs.net / NHCCG.Policies@nhs.net**

**APPENDIX 3**

North Hampshire Clinical Commissioning Group

**POLICY FOR THE DEVELOPMENT, APPROVAL, IMPLEMENTATION AND REVIEW OF POLICIES AND STANDARD OPERATING PROCEDURES**

**NORTH HAMPSHIRE CLINICAL COMMISSIONING GROUP**

# Policy
# [Policy Version]

**APPENDIX 3: POLICY TEMPLATE Cont.**

| | |
|---|---|
| **Subject and version number of document:** | *Insert document title and version number.* |
| **Unique Reference Number:** | *Insert your next sequential number.* |
| **Operative date:** | *Insert the date the document will be operational.* |
| **Author:** | *Insert the contact details of the document author. If the document is being reviewed by a different person, state the name of the reviewer/person taking responsibility for the revision (N.B. This may not be the same person as the original author).* |
| **Review date:** | *Insert the date the document will be reviewed (this is 1 year after the document is first written and then every 2 years thereafter unless the Document Manager stipulates a different timescale).* |
| **For action by:** | *State who the document applies to.* |
| **Policy statement:** | *Summarise the purpose of the document.* |
| **Responsibility for dissemination to new staff:** | *State who will responsible for informing new staff about this document.* |
| **Training Implications:** | *Insert who needs to be aware of the content of the policy and how they will be made aware.* |
| **Further details and additional copies available from:** | *Insert website address or the name and contact details of where/who to contact to obtain additional copies and information.* |
| **Equality Analysis Completed?** | This document includes a section about Equality Analysis (previously called Equality Impact Assessment), the aim being to encourage and support policy developers to demonstrate 'due regard' to the Equality Act 2010. This will be achieved if all new policies are assessed for equality impact at an early stage, and records kept of the equality analysis process and any actions identified. |
| **Consultation Process** | *Insert names of persons/committees consulted during the construction of this policy.* |
| **Approved by:** | *Insert name of group/committee that approved the policy.* |
| **Date approved:** | *Insert the date the policy was approved.* |

**APPENDIX 3: POLICY TEMPLATE Cont.**

## Intranet and Website Upload:

| | | |
|---|---|---|
| Intranet | Electronic Document Library Location: | *Insert the location of the document on the intranet* |
| Website | Location in FOI Publication Scheme | |
| Keywords: | *Insert helpful keywords (metadata) that will be used to search for this document on the intranet and website* | |

## Amendments Summary:

| Amend No | Issued | Page(s) | Subject | Action Date |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |

## Review Log:

Include details of when the document was last reviewed:

| Version Number | Review Date | Name of Reviewer | Ratification Process | Notes |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**APPENDIX 3: POLICY TEMPLATE Cont.**

*INSERT POLICY TITLE*

*It may be appropriate to insert a **Contents Table** to ease navigation through the document.*

## 1. INTRODUCTION & PURPOSE

*1.1 Insert text*

## 2. SCOPE & DEFINITIONS

*SCOPE*

*2.1 It is essential that the document explicitly states who it applies to.*

*DEFINITIONS*

*2.2 Insert any definitions for any terms used*

## 3. PROCESS/REQUIREMENTS

*3.1 There is no prescriptive way of detailing this section and the main body of the document will be unique depending on the subject matter. Include subsections as required.*

## 4. ROLES & RESPONSIBILITIES

*4.6 Outline here (subsections may be necessary) the different roles and responsibilities staff / users may have in relation to this document.*

## 5. TRAINING

*5.1 Outline here any training implications or issues as a result of this document. The Document Author must ensure that the Learning & Development Team have been engaged in the development of the document where any learning or training needs have been identified.*
*Attendance at any training session carried out as a consequence of the policy implementation must be formally recorded and documented.*

## 6. EQUALITY ANALYSIS

*6.1 Include a statement summarising the outcome of the Equality Analysis that was conducted in relation to this policy, making reference to the Equality Analysis form which must be appended to the policy.*

**APPENDIX 3: POLICY TEMPLATE Cont.**

## 7. SUCCESS CRITERIA / MONITORING THE EFFECTIVENESS OF THE POLICY

*7.1 The Document Author must be able to demonstrate the effectiveness of the policy at the point of review, for example by; carrying out audits, reviewing incidents that may have occurred related to the policy, discussing the policy at team meetings. Any subsequent issues/findings resulting from the review should be incorporated in the new version of the policy.*

*7.3 This section should include details of the following (in accordance with NHSLA best practice);*

- *Monitoring arrangements for compliance and effectiveness i.e. audit, review etc*
- *Responsibilities for conducting the monitoring/audit*
- *Methodology to be used for monitoring/audit*
- *Frequency of monitoring/audit, i.e. quarterly, on a rolling basis*
- *Process for reviewing result and ensuring improvements in performance occur.*

*7.3 In relation to policies that support the NHSLA Risk Management standards 2012-2013, Document Authors should ensure they have referred to the NHSLA guidance to ensure that all the criteria requirements have been met.*

## 8. REVIEW

*8.2 Include the standard statement: "This document may be reviewed at any time at the request of either staff side or management, but will automatically be reviewed after twelve months and thereafter on a bi-annual basis"*

## 9. REFERENCES AND LINKS TO OTHER DOCUMENTS

*9.1 Where applicable, the document must contain a section detailing the Research/Evidence/References that were used to assist with the development of the Policy. Some of this information may be included at the beginning of the document as way of an introduction but should be referenced in full at the back of the policy. The Harvard Referencing System should be used as standard.*

*9.2 Signpost the reader to other relevant and supporting policies / Standard Operating Procedures. (Ensure these are cross referenced within the main body of the policy where appropriate).*

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## APPENDIX 4: POLICY AND STANDARD OPERATING PROCEDURES (SOPS) PRE-APPROVAL CHECKLIST

| Checklist | | | |
|---|---|---|---|
| **1** | **Before Development** | **To prevent duplication – have you completed the policy registration form and sent it to the Business Development Support Officer?** | Yes / No |
| **2** | **Consultation** | **Have you involved the appropriate stakeholders?**<br>• Are other departments involved, communities or partnership agencies? | Yes / No |
| **3** | **Format** | **Has the corporate front cover been included and the appropriate sections of the reference table at the front of the document been completed?**<br>• Unique Reference Number / Operative date / Review date etc | Yes / No |
| | | **Does the document follow the organisations format?**<br>• The body text should be written using black Arial 12 font etc | Yes / No |
| | | **Are the standard sections included?**<br>• INTRODUCTION & PURPOSE<br>• SCOPE & DEFINITIONS<br>• PROCESS/REQUIREMENTS<br>• ROLES & RESPONSIBILITIES<br>• TRAINING<br>• EQUALITY ANALYSIS<br>• SUCCESS CRITERIA / MONITORING THE EFFECTIVENESS OF THE POLICY<br>• REVIEW<br>• REFERENCES AND LINKS TO OTHER DOCUMENTS | Yes / No |
| | | **Has a source been identified for queries?** | Yes / No |
| **4** | **Scope** | **Does the document state what staff groups and patient/client group(s) it relates to?** | Yes / No |
| **5** | **Training Implications** | **Have the training and educational implications of the document been considered and documented?** | Yes / No |
| **6** | **Impact Assessments** | **Has an Implementation Impact Assessment been completed?** | Yes / No |
| | | **Has an Equality Analysis template been completed?** | Yes / No |
| | | **Is a Quality Impact Assessment required?**<br>**If so has it been completed?** | Yes / No<br>Yes / No |
| | | **Is a Privacy Impact Assessment required?**<br>**If so has it been completed?** | Yes / No<br>Yes / No |
| **7** | **References** | **Is relevant national guidance/evidence present in the document?** | Yes / No |
| **8** | **Monitoring Effectiveness** | **Has the process and timescales for monitoring the document's implementation and its effectiveness been identified?** | Yes / No |
| **9** | **Archiving** | **If the document is a review/amendment of an existing document, have you retained the original copy and** | Yes / No |

| | | | |
|---|---|---|---|
| | | **informed the Business Development Support Officer?** | |
| **10** | **Intranet Uploading** | **Have you identified a staff member to upload the document to the intranet once ratified?** | Yes / No<br>Name: |

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## APPENDIX 5: EQUALITY IMPACT ANALYSIS TOOL

**NHS North Hampshire Clinical Commissioning Group**
**Equality Impact Analysis (EIA) Tool and Guidance**

**Guidance**
**What is the Equality Impact Analysis?**

- This Equality and Diversity Impact Assessment (EIA) Tool provides a way to assess the potential impact of policies or functions on people who might experience disadvantage in their dealings with NHS North Hampshire CCG (NHCCG) as patients, carers, members of the public or members of staff, ensuring that individuals and teams think carefully about the likely impact of their work on different communities or groups.

- This EIA intends to support the recognition of the rights of vulnerable or identified groups under current legislation, and under the developing NHCCG Equality and Diversity strategy; it explicitly considers the equality and diversity impact of ***all*** policy developments and service provision.

- This EIA involves anticipating the consequences of policies or functions on relevant groups and making sure that, as far as possible, any negative consequences are eliminated or minimisesd and opportunities for promoting equality are maximised by:

  - **Taking account of the needs, circumstances and experiences of those who are affected**
  - **Identifying actual and potential inequalities in outcomes, including lawful discrimination**
  - **Considering other ways of achieving the aims of a policy or function in order to minimise or remove any possible adverse impact**

**When should the Equality Impact Analysis be carried out?**

- This EIA should be used as early as possible in the development of:

  - ***All new*** **policies, procedures, strategies, services or functions**
  - ***Reviewing*** **existing policies, procedures, strategies, services or functions**

  Even if considered to have no specific impact it is **essential that the process is followed, and decisions evidenced.**
- **Failure to assess the likely impact of new or ongoing policies or work could lead to legal challenge, as well as potential delays in providing needed services.**

**What areas should the impact assessment cover?**

- The EIA uses focused questions to identify information that might not otherwise be identified by decision makers and **is not accomplished by asserting that the initiative or policy would treat everyone the same**.

- The EIA must cover the *'Protected Characteristics'* as set out in the Equality Act 2010 and other vulnerable groups listed here:

| | |
|---|---|
| **A** | **Race** - minority ethnic people, including gypsy/travellers, refugees and asylum seekers |
| **B** | **Sex** - women and men |
| **C** | **Sexual orientation** – whether being lesbian, gay, bisexual or heterosexual |
| **D** | **Disability** - disabled people, or because of something connected with their disability |
| **E** | **Religion or belief** - people in religious/belief/faith groups |
| **F** | **Gender reassignment** - being a transsexual person (transsexuality is where someone has changed, is changing or has proposed changing their sex – called 'gender reassignment' in law) |
| **G** | **Pregnancy and maternity** – having just had a baby, or being pregnant |
| **H** | **Marriage and civil partnerships** - (this applies only at work or if someone is being trained for work) |
| **I** | **Age** - older people, children and young people - (this applies only at work or if someone is being trained for work) |
| **J** | **Homeless** people |
| **K** | **Income** - People of low/high/uncertain income (people who live in poverty) |
| **L** | **Long term unemployed** |
| **M** | **Stigmatised positions** – ie women who work in prostitution |
| **N** | **Drug misuse** |
| **O** | **Limited family or social networks** |
| **P** | **Geographically isolated** |
| **Q** | **Mental health issues** |
| **R** | **Criminal justice system involvement** |

## Completing an Equality Impact Assessment

- The NHCCG EIA assessment is split into three sections:
  - **Part 1 - The Pre-Assessment Checklist**
  - **Part 2 – The Rapid Assessment Checklist and Initial Action Planning**
  - **Part 3 - The Full Equality and Diversity Impact Assessment Tool**
- Not all policies, procedures, strategies, services or functions will have a high impact and require a detailed assessment at Part 2 or Part 3.
- The flow chart on the following page sets out the process to follow to determine the level at which an EIA needs to be completed for new or review policies, procedures, strategies, services or functions.

**Impact**

Impact should be categorised in three ways for the purpose of this assessment:

**a) A negative or adverse impact** occurs when a policy etc disadvantages one or more of the 'protected' groups

**b) A positive impact** occurs when a policy etc may be intentionally exclusive ie cultural interpreting services; the assessment will enable testing for appropriateness and justification

**c) A neutral impact** occurs when a policy etc has a similar impact upon groups, whether they belong to a 'protected' group or not

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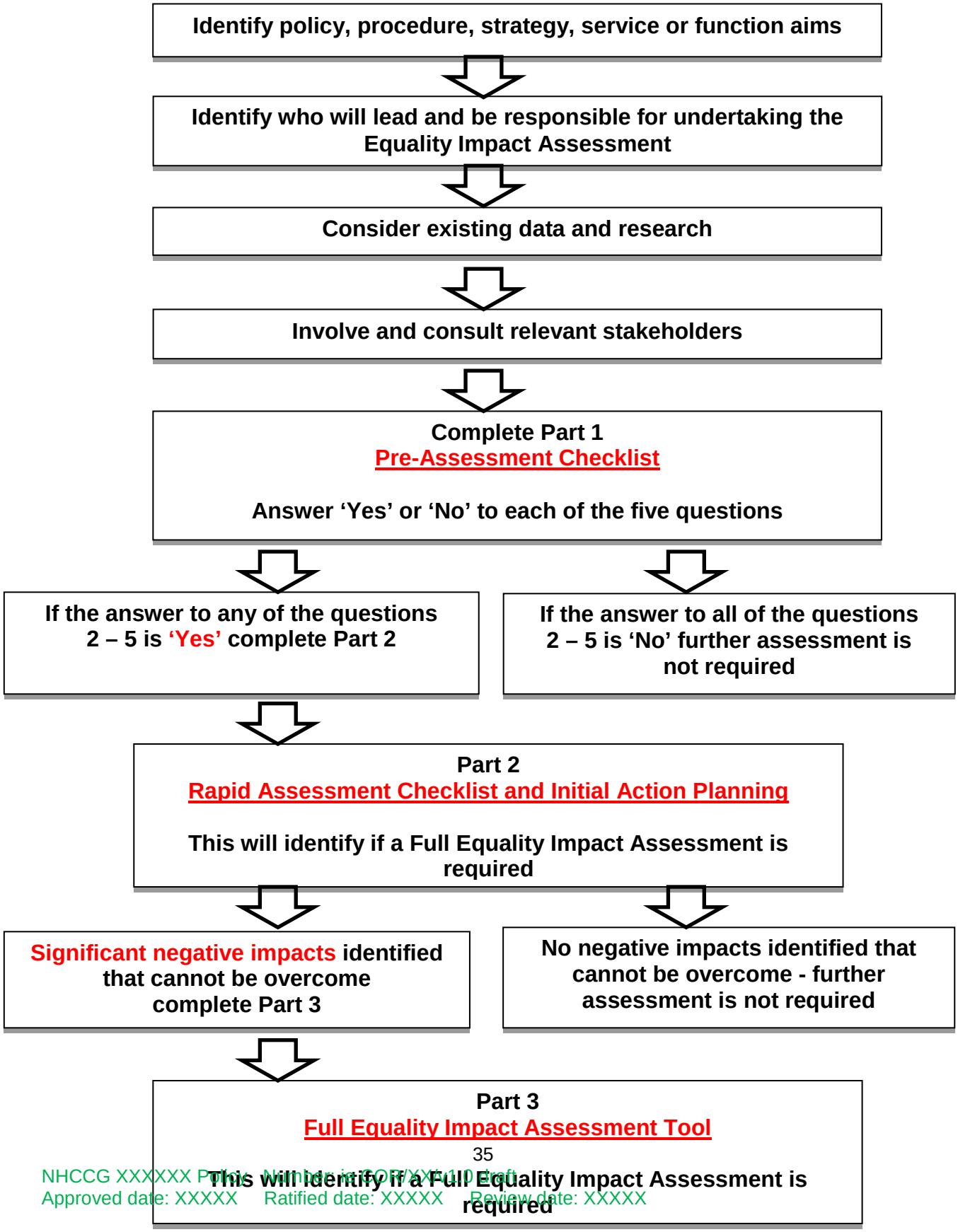
## Completing an Equality Impact Assessment



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**Part 1 - Pre-Assessment Checklist**

**You will need to complete this impact assessment for all new policies etc. You will only need to complete this assessment for policy reviews where the policy has been fundamentally changed or where an assessment has not been previously completed.**

The Equality Analysis is a written record that demonstrates that you have shown *due regard* to the need to **eliminate unlawful discrimination**, **advance equality of opportunity** and **foster good relations** with respect to the characteristics protected by the Equality Act 2010.

| | |
|---|---|
| **Policy/procedure/function** | |
| **Date of assessment:** | |
| **Name and job title of person completing the assessment:** | |
| **Department:** | |
| **Intended equality outcomes:** | |

| | |
|---|---|
| **Who was involved in the consultation of this document?** | |

**Please describe the positive and any potential negative impact of the policy on service users or staff. Please refer to section 4, item 3 of the guidance document.**

**In the case of negative impact, please indicate any measures planned to mitigate against this by completing stage 2.** Supporting Information can be found be following the link: www.legislation.gov.uk/ukpga/2010/15/contents

| Protected Characteristic | Positive impact | Negative impact |
|---|---|---|
| **Race** | | |
| **Sex** | | |

| | | |
|---|---|---|
| **Sexual Orientation** | | |
| **Disability** | | |
| **Religion or Belief** | | |
| **Gender Reassignment** | | |
| **Pregnancy & Maternity** | | |
| **Marriage & Civil Partnership** | | |
| **Age** | | |
| **Other** (see list Page 2) | | |

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**Part 2 – 'Rapid Assessment Checklist' and Initial Action Planning**

| | | |
|---|---|---|
| **1.** | **Title of policy / procedure / strategy / proposal / function being assessed:**<br><br>**Reference Number:** **Version:** **Version date:** | |
| **2.** | **a) Please state the aims and objectives of this work and the *intended equality outcomes*.**<br>**b) How is this proposal linked to the organisation's business plan and strategic equality objectives?** | |
| **3.** | **Which groups of staff or local population are likely to be affected by this proposed document? Use a ✓ to affirm.** | |
| ✓ | **A-R** | **Protected Characteristic** |
| | **A** | **Race** - minority ethnic people, including gypsy/travellers, refugees and asylum seekers |
| | **B** | **Sex** - women and men |
| | **C** | **Sexual orientation** – whether being lesbian, gay, bisexual or heterosexual |
| | **D** | **Disability** - disabled people, or because of something connected with their disability |
| | **E** | **Religion or belief** - people in religious/belief/faith groups |
| | **F** | **Gender reassignment** - being a transsexual person (transsexuality is where someone has changed, is changing or has |
| | **G** | **Pregnancy and maternity** – having just had a baby, or being pregnant |
| | **H** | **Marriage and civil partnerships** - (this applies only at work or if someone is being trained for work) |
| | **I** | **Age** - older people, children and young people - (this applies only at work or if someone is being trained for work) |
| | **J** | **Homeless** people |
| | **K** | **Income** - People of low/high/uncertain income (people who live in poverty) |
| | **L** | **Long term unemployed** |
| | **M** | **Stigmatised positions** – ie women who work in prostitution |

| | | |
|---|---|---|
| | **N** | **Drug misuse** |
| | **O** | **Limited family or social networks** |
| | **P** | **Geographically isolated** |
| | **Q** | **Mental health issues** |
| | **R** | **Criminal justice system involvement** |

**Identified affected groups:**

| **A-R** | **Protected Characteristic** |
|---|---|
| | |
| | |
| | |

**4. Using the groups ticked above, identify what the impacts might be:**

| Impact Category | Potential Impact | | | Action Plan |
|---|---|---|---|---|
| | **Group/s Affected (A-R)** | **Positive Impacts** | **Negative Impacts** | Detail the actions required to understand and overcome any undesired **impacts** within the **current scope** of this document |
| **4.1 What impact will the proposal have on lifestyles?** For example, will the changes affect:<br><br>• Diet and nutrition?<br>• Exercise and physical activity?<br>• Substance use: tobacco, alcohol or drugs?<br>• Risk taking behaviour?<br>• Education and learning, or skills? | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| **4.2 Will the proposal have any impact on the social environment?**<br>Things that might be affected include:<br>• Social status<br>• Employment (paid or unpaid)<br>• Social/family support<br>• Stress<br>• Income | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| **Impact Category** | **Group/s Affected (A-R)** | **Positive Impacts** | **Negative Impacts** | Detail the actions required to understand and overcome any undesired **impacts** within the **current** |

| | | | | |
|---|---|---|---|---|
| | | | | **scope** of this document |
| **4.3 Will the proposal have any impact on:**<br><br>• Discrimination?<br>• Equality of opportunity?<br>• Relations between groups? | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| **4.4 Will the proposal have an impact on the physical environment?** For example, will there be impacts on:<br>• Living conditions?<br>• Working conditions?<br>• Pollution or climate change?<br>• Accidental injuries or public safety?<br>• Transmission of infectious disease? | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| **4.5 Will the proposal affect access to and experience of services?** For example:<br>• Health care<br>• Transport<br>• Social services<br>• Housing services<br>• Education | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| **4.6 Are there any other groups that you have identified since you answered these questions? Please enter them above in the assessment.** | | | | |

**5. Is any additional information or evidence required to decide if a Part 3 – '*Full Equality Impact Assessment*' is required?**

☐ **No**

☐ **Yes - Please identify:**

**6. Name of person undertaking assessment: ……**

**Job / Role: ……**

**Date of assessment: ……..**

**7. Recommendations:**

**8. Manager's Assessment**

8.1 From the outcome of the Rapid Assessment Checklist, have any significant undesired impacts been identified that cannot be overcome within the current scope of the document? **Yes / No*** *please delete*

| | |
|---|---|
| 8.2 Has a full Equality Impact Assessment process been recommended? **Yes / No*** *please delete*<br><br>8.3 Why?: | |
| **Manager's name: ……..**<br><br>**Job / Role: ……**<br><br>**Manager's signature: ……** | **Date: ……** |

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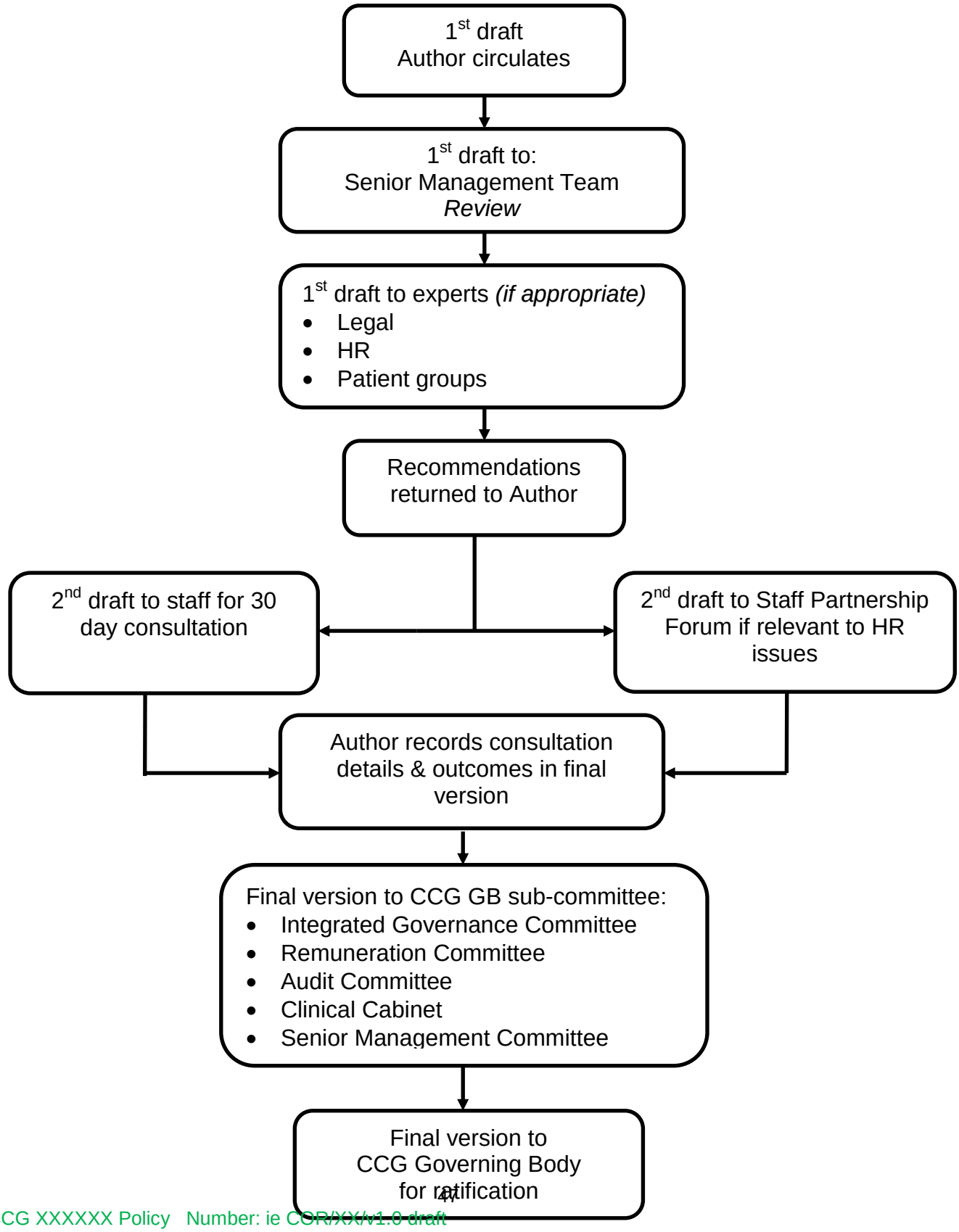
**APPENDIX 6: POLICY CONSULTATION PROCESS**

Consultation by all stakeholders should be sought and contribute to the development of the policy. Documents in draft should be circulated to relevant groups e.g. staff side, patient groups, CCG stakeholder groups for comment following the process outlined below:



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# APPENDIX 7 QUALITY IMPACT ASSESSMENT

The NHS continues to experience financial challenges across all sectors. As organisations scrutinise their budgets, cost improvement initiatives are introduced to meet the financial challenges and reduce the prospect of organisational deficits. During this period, many organisations are faced with the identification of schemes which introduce constraints into the healthcare system.

The ratified Quality Impact Assessment was developed by colleagues in NHS West Hampshire CCG and was adopted by the NHCCG in April 2015. The intention of the enhanced process is to remain aligned with West Hampshire CCG however to build on internal CCG governance processes.

The assessment template is certainly to be completed for cost improvement initiatives (CIP's), Quality Improvement, Productivity and Prevention (QIPP) schemes and/or other service improvement schemes to ensure these are scrutinised at the highest level within the CCG to assess the quality and equality impact on members of our population.

Where the word scheme is used in this document it refers to new indicative cost improvements, QIPP and service improvement schemes.

## The Process

The potential risks that cost saving or service improvement schemes can have on the quality of services must be assessed.

NHCCG uses a standard Quality Impact Assessment tool and risks are assessed using the Quality Monitoring Tool. All schemes that are worked up in outline and have an impact on clinical services will undergo a Quality & Equality Impact Assessment (QIA). To do this effectively, the right information is needed in order to understand the potential risks to quality and plans must be put in place to ensure action is taken before quality of services is impacted.

An impact assessment on quality will be completed in the scheme planning stage and schemes that are considered unrealistic or that pose a risk to quality will not be put forward for consideration to the PMO Delivery Group.

In challenging financial times it is increasingly likely that all service and cost improvement schemes will need some form of QIA.

In addition to doing this assessment at the planning stage, the CCG should also do this during delivery, at key milestones and post-implementation to ensure sustainability.

## Approving Schemes

NHCCG has further developed a robust system for approval of cost saving, QIPP schemes and service improvement schemes. This includes a process for reviewing schemes for Value for Money, Efficiency, Quality and Equality.

The flow chart below illustrates the approval process for new schemes:

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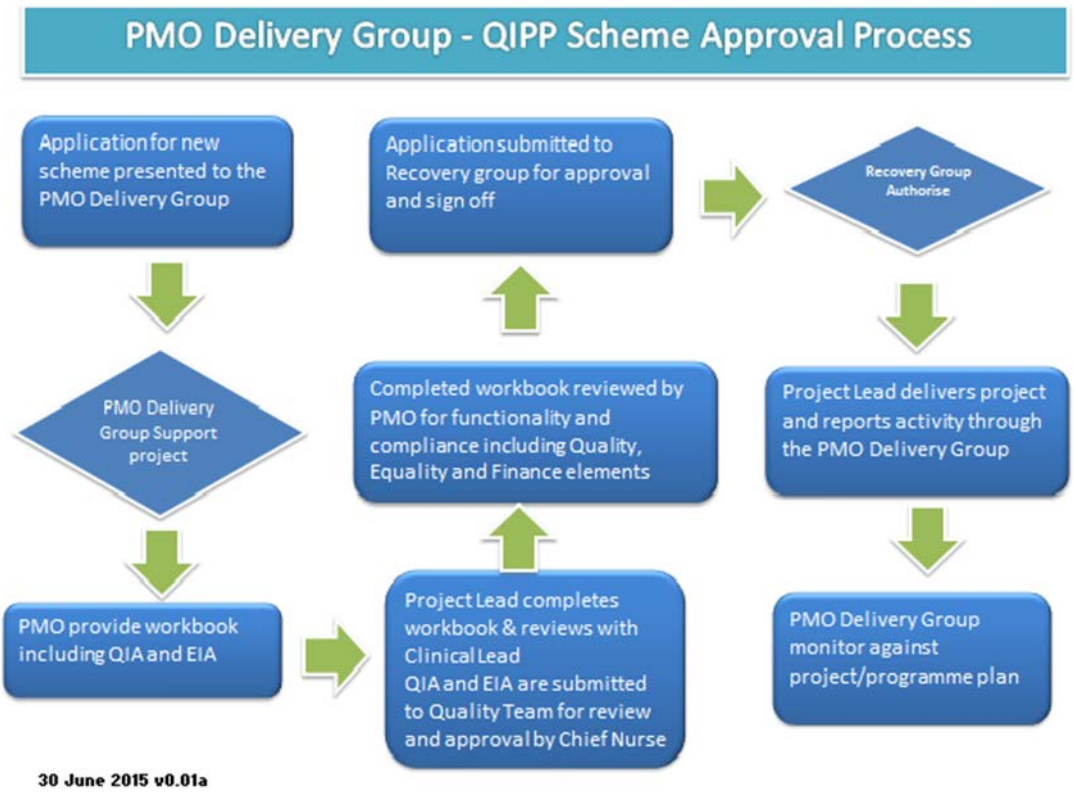


The scheme owner is required to include an outline of key objective(s), expected financial benefits and potential impact on quality prior to the document undergoing an initial review by the Quality Team. Where needed feedback is provided to the scheme owner prior to submission of the scheme outline proposal to the PMO Delivery Group.

If the scheme is approved, the PMO Delivery Group authorise the progression of the draft scheme to be developed further which will include a full Quality Impact Assessment, Equality Impact Assessment (EIA) and possibly a Privacy Impact Assessment (PIA). The Quality Team will review the completed scheme and undertake a full risk assessment using the NHCCG matrix.

The Quality Team assessment and recommendation is then forwarded to the Chief Nurse for consideration; in accordance with the Operating Framework 2015/16.

The reviewed QIA and EIA will be reviewed and signed-off by PMO Delivery Group, considering the recommendation from the Chief Nurse, ensuring that both the quality and operational impact of the scheme has been assessed, discussed and any risks mitigated

At any stage the Quality Team can request a meeting with the scheme owner to ensure all facts are understood.

The Quality Team, at any stage, can also request the scheme to be discussed at the NHCCG Clinical Quality Working Group (virtual or during a meeting, depending on timescales) to ensure a breath of expertise is included as part of the assessment process. The Clinical Quality Working Group will receive exception reporting on any schemes that have been identified to have an impact on Quality/Equality/Equality.

**Project Documentation**

NHCCG project plans follow an agreed standard which includes an agreed template for QIA and EIA. The templates are included in Appendix 1 and Appendix 2 of this document

**Monitoring and Reporting**

The projects leads will report to the PMO Delivery Group and the reports will summarise progress and work on the scheme and will include an exception report on QIA and EIA. Any exceptions identified for QIA and EIA are reported to the Clinical Quality Working Group as part of a standing agenda item.

Regular reassessment of the quality impact of the service and cost improvement must be an integral part of NHCCG monitoring arrangements, with clear escalation processes for when quality issues are identified and risk ratings worsen. This includes taking remedial action to manage risks to an acceptable level, which may involve tighter management or, if necessary, abandoning a scheme.

**Review of Quality & Equality Impact Assessment**

The Clinical Quality Working Group will review the assessment process and templates on an annual basis.

The CCG may also consider the use of Internal Audit to provide independent assurance on the development and process of the Quality & Equality Impact Assessment.

**Evaluation**

The CCG must evaluate how the projects have been delivered, including an assessment of the programme management and whether any lessons can be learned from each stage. The QIA and EIA are included in the evaluation on a corporate level.

**Key Performance Indicators**

Key Performance Indicators (KPIs) are:

- 100% of schemes have a QIA and EIA completed
- 100% of schemes have the QIA and EIA reviewed by the Quality Team
- 100% of the QIA and EIA's have been reviewed by the Chief nurse prior to submission to the PMO Delivery Group

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Quality and Fairness Impact Assessment Process
QFIA Form

| Quality and Fairnes Impact Assessment Process | Scheme numbe | PC7 |
|---|---|---|
| | Date of QRA: | 27-Mar-15 |

| | |
|---|---|
| Scheme Name | PLCV-non FJI |
| Scheme Description | To ensure that Procedures of limited clinical value are restricted in their use within a strict clinical framework. To reduce the numbers of individual funding requests particularly where they are not based on national guidance and practice. Embed use of PLCV policy in primary care. To faciltate a post providing adherence support for the above policy. |
| Benefits for patients | Patients will be clear about what is and what isnt available for treatment on the NHS . GPs will be fully aware of the process for obtaining prior approval if necessary. |
| Project Lead | KatherineCannon/AngusCarnegy |
| Directorate | System Reform - Planned Care |
| Quality Indicator(s) - consider PAF KPIs | Increased Complaints. Poor FFT results. Adverse reputational impact |

| | Risk Detail | Mitigation | Impact | Likelihood | Score |
|---|---|---|---|---|---|
| Risks to Patient Safety | Patients may not be referred for procedures when necessary. | Clear guidance will be provided in Primary care to assist with patient management and PLCV policy | 3 | 3 | 9 |
| Risks to Clinical Effectiveness | Poor outcomes if PLCV policy not strictly followed. | Clear guidance will be provided in Primary care to assist with patient management and PLCV policy | 3 | 2 | 6 |
| Risks to Patient Experience | Patients may be disappointed that their procedure has not been approved. | Clear explanation must be provided to the patient regarding what procedures are clinically appropriate. | 3 | 3 | 9 |
| Risks to fairness and reducing health inequalities | The policy is not applied fairly across the CCG. | Monitoring of policy use and number of prior approvals and IFR s. | 3 | 2 | 6 |

| | |
|---|---|
| Overall Risk Score (highest from above quality domains) | 9 |
| Date approved by | |
| Date approved by | |
| Date approved by | |

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## Appendix 8 Privacy Impact Assessment Template

Projects that involve processing or sharing personal information or commercially sensitive data give rise to privacy issues and concerns. To enable an organisation to address the privacy concerns a privacy impact assessment (PIA) can be used to assess privacy risks to individuals in the collection, use, disclosure and disposal of information. The PIA can help identify privacy risks, foresee problems and bring forward solutions.

| **Project Information** | |
|---|---|
| Project Name: | Date: |
| Organisation:<br><br>Sponsor (e.g. Project Board) | |
| Background:<br>Why is the new system/change in system/sharing of information required? | |
| Benefits: | |
| Constraints: | |
| Does the project involve multiple organisations? If yes – name them, and their project lead details: | |

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**This form is available as a MSWord version on request from Business Development Team**

## Work package details

| | | | |
|---|---|---|---|
| Project | | Point of contact for this work (name, role, phone, email) | |
| Specific area concerned | | | |
| Project summary | | | |
| Brief description of overall activity | | | |
| Has anything similar been undertaken before | | | |
| Is there a reason why an Impact Assessment is not required for this piece of work | | | |
| Stakeholder(s) / Organisation(s) involved | | | |
| Sponsor (e.g. Project Board) | | Activity period | |

## Information

| | | |
|---|---|---|
| What information will be collected – be specific (Person Identifiable Data (PID), Corporate, Sensitive etc) | | |
| Why is information being collected | | |
| How information is being collected | Verbal and | |
| | Other ☐→ | |
| How information is to be stored | Paper ☐ Electronic ☐ | |
| | Other ☐→ | |

| | |
|---|---|
| Where information will be stored (including back ups and copies) | |
| How information is to be edited or deleted | |
| How data is to be quality checked | |
| Who is responsible for the information | |
| What are the benefits to the individual and professional | |
| As part of this work is the use of Cloud technology being considered either by your own organisation or a 3rd party supplier?<br><br>If so please complete the questionnaire below | |
| | Cloud Screening Questions 08.01.14.c |

## Sharing and access

| | |
|---|---|
| What information is shared | |
| Who are you sharing with | |
| How information is to be transported | |
| Which roles will have access. Is there any restrictions based on different roles | |
| How is it accessed | |
| How access is to be monitored (audit, logs) | |
| What security measures will be in place | |

| | |
|---|---|
| What information sharing protocols and operational agreements will be in place | |
| What training is planned to support this piece of work | |
| What is the process for obtaining and recording consent/dissent (how, where, when, by whom) | |
| If consent has not been obtained, is there a legitimate reason to share? | |
| Will reports be generated from this information. If yes, will the information be identifiable or anonymous (will the reports be used for research) | |
| How can the individual access the information | |

## Retention

| | |
|---|---|
| How long data is to be retained | |
| What is the process for start-up and closing down this piece of work | |
| If the organisation/service ceases what will happen to the information | |

## Risks, issues and activities

| | |
|---|---|
| Any known risks or issues | |
| Any known activities that will have a direct affect on this piece of work | |

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| Outcome of Information Governance Team PIA Panel |
| --- |
| |

Signed on behalf of the Information Governance Team, [Enter organisation name]

Name: [Enter Name], Head of Information Governance (or equivalent)

Signature: ..... Date: .....

Signed on behalf of [Enter organisation name]

Name: ..... Caldicott Guardian

Signature: ..... Date: .....

**It is the responsibility of the Project Lead to notify the appropriate Information Asset Owner for inclusion on the Information Asset Register**