

Policy on the development and ratification of policies and similar documentation

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Document control sheet

Title of document:	Policy for the development and ratification of policies and similar documentation
Originating Directorate:	Chief Finance Officer
Originating team:	Corporate Governance
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Target audience:	All staff
Can this policy be released under FOI?	Yes
	Give reasons for exemption if no:
	N/A

Related policies:

Freedom of information policy
Equality and diversity policy

Version control (see section 8)

Version No	Revision date	Revision by	Nature of revisions
V1.0	September 2016	T Ancell	First issue
V1.1		B Gallagher	Review to streamline and reflect changes to organisational structure.
V1.2	February 2018	J James	Further revisions and streamlining
V1.3	September 2019	J James	Addition of equality and diversity considerations into pre-ratification checklist plus section on cross-referencing.
V2	June 2020	R Found	Reviewed and

			updated to reflect changes to management structure
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1. Introduction

The term “policies and similar documentation” in this document is used to refer to documentation such as policies, strategies and procedural documents that operate across the organisation.

These documents set out the way NHS Kernow Clinical Commissioning Group (NHS Kernow) conduct their business. This policy outlines the rules pertaining to the content, structure, approval and monitoring of these documents.

2. Purpose

To provide NHS Kernow staff with guidance on developing, reviewing and structuring corporate policies as well as how these should be taken through the appropriate approval process and implemented. It also outlines the processes in place to ensure these policies are available, accessible and remain up to date and compliant.

3. Definitions

Policies and similar documentation: Any document produced by NHS Kernow to provide formal guidance or instruction to staff across the organisation. Examples include policies, strategies and standard operating procedures:

Strategy: A high-level, long-term plan of action, usually covering three to five years to achieve a particular goal in relation to the strategic aims of the organisation.

Policy: A specific and enforceable set of principles or rules to define conduct by NHS Kernow members and employees, often outlining best practice or statutory requirements of the organisation.

Guidelines (including management guidance notes from human resources): Set out a preferred method of operation and are usually based on guidance published by national or external agencies using current evidence. They allow for informed decision making concerning the appropriate course of action to take. Other methods are not prohibited but a reason for deviation from guidance should be fully justifiable and line management agreement sought.

Protocols and procedures: Stipulate the practice required and the action to be taken to implement a policy. It is usually a set of detailed step by step instructions that describe the appropriate method for carrying out tasks or activities to achieve a stated

outcome to the highest possible standards and to ensure efficiency, consistency and safety.

Ratified documents: Those which have received formal approval by an authorised forum for use within the organisation. Section 13 outlines the appropriate level of approval for the different types of document.

Document Library: This is an electronic document storage system. NHS Kernow uses a document library centrally administered by the Royal Cornwall Hospitals NHS Trust as the formal repository of its corporate documentation. It forms the basis for NHS Kernow's Freedom of Information publication scheme and therefore discharges NHS Kernow's legal obligations in that respect.

External documents: Where a corporate document has been developed by an organisation other than NHS Kernow and is to be ratified for use by NHS Kernow – such as where a shared service provides a single policy, or a function is delivered on a joint basis under shared – NHS Kernow will be flexible regarding the format and structure of the document. However, such a document should not be ratified by NHS Kernow without:

- A satisfactory equality impact assessment (EIA)
- Being written in an easy to read format and plain English where possible
- Being presented to the ratifying forum with an NHS Kernow report frontispiece and supporting information completed

IRIS: This is the data warehouse used by NHS Kernow as a repository for various types of information including business intelligence as well as some policies, procedures and management guidance.

4. Responsibilities

The Workforce Committee (WC) is responsible for oversight of the policy schedule and policy management process. The committee will also be responsible for approving some policies and similar documentation, as set out in section 13, along with the other constitutional committees

Directors and line managers are responsible for ensuring that staff are made aware of, and are working to, all relevant new and revised policies and similar documentation.

The head of corporate governance is responsible for managing the process of implementation and evaluation of this policy and maintaining a register of policy documents.

The corporate governance team is responsible for:

- Ensuring that new or updated documents meet with corporate standard
- Managing the policy database
- Providing reports to relevant teams on the status of their policies to allow them to plan for reviews etc
- Providing reports to the relevant committee on the position of the management of policies and similar documentation as required

The author for each document is responsible for:

- Developing the policy or similar documentation in line with the information contained in this policy
- Using the policy template and ensuring it meets branding and policy guidelines
- Identifying and addressing resource and training implications
- Determining how compliance with the policy will be monitored
- Making staff aware of new or revised policies or similar documentation as required, for example through the staff bulletin
- Allocating a review period in line with statutory requirements if they apply and undertaking interim reviews to determine if the information in the document remains relevant
- Taking the policy through the appropriate ratification process in line with section 13, including an appropriate equality impact assessment (section 9)
- Informing the corporate governance team once a policy is reviewed and ratified.

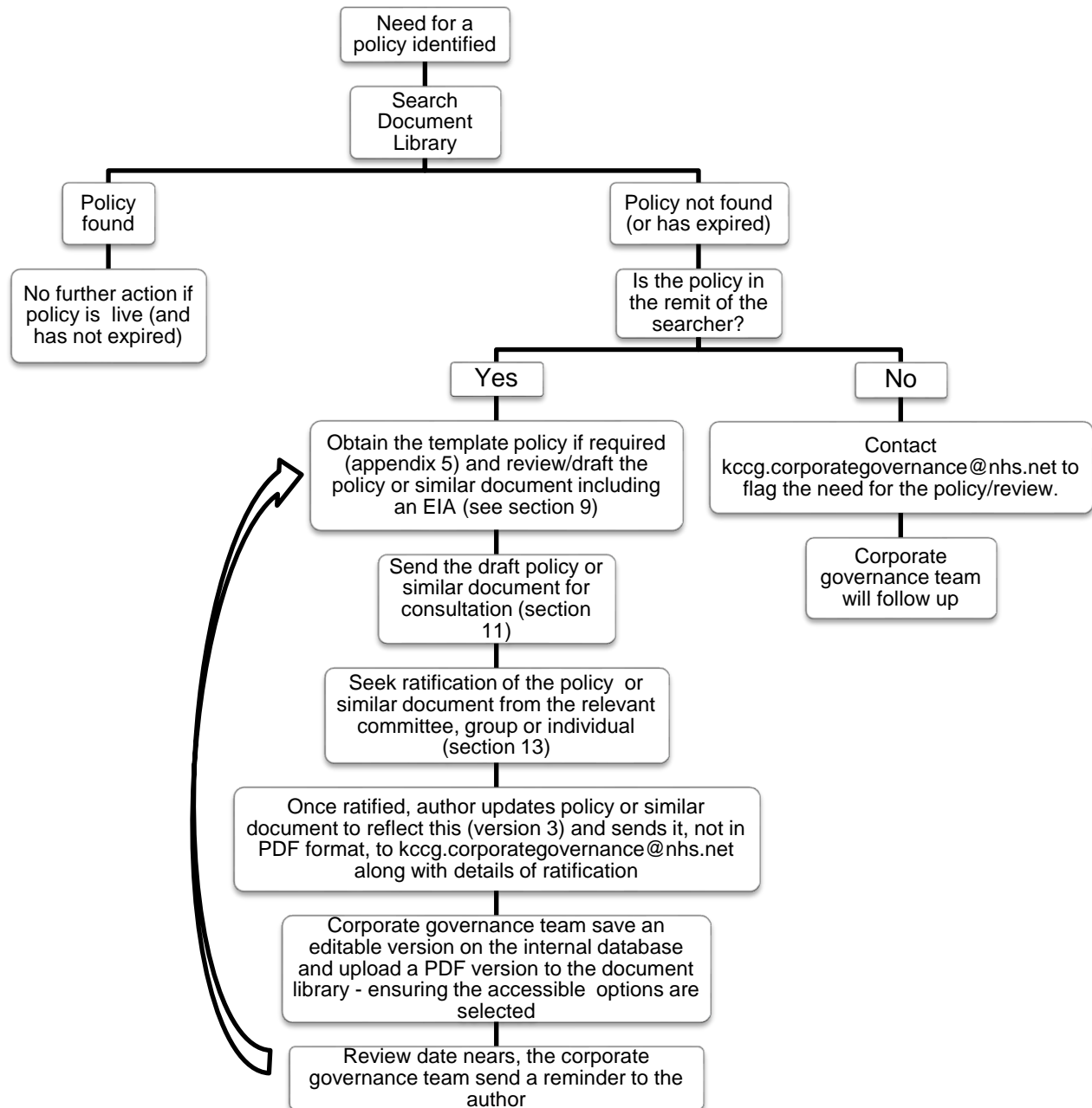
Consultees are responsible for reviewing policies and similar documents and providing feedback to the author.

Relevant committees, as set out in section 13, are responsible for ratifying policies and similar documents and formally recording this in the minutes. A checklist for ratification is provided at appendix two.

5. Policy lifecycle

The flowchart on the following page applies to all policies and similar documents.

Policy lifecycle:



If the review date passes and the policy or similar document has not been reviewed, it will remain on the document library, but be highlighted as overdue for review and this will be regularly followed up by the corporate governance team and highlighted in policy update reports to teams and if necessary relevant committees.

6. Content and structure

Policies and similar documents should be written in plain English as far as possible and structured to be easy to read and simple to use.

A policy template is provided at appendix one and also held in word format, and provides an expected layout and formatting for a policy for NHS Kernow, along with guidance on section headings and content. The [corporate style guide](#) should also be referred to by authors. The template is not exhaustive and authors may need to adapt and add to the 'skeleton' provided to meet their policy needs.

All new policies are expected to use this format. When existing policies are reviewed, it is expected that they will be re-formatted to align with this template.

7. Implementation plans and monitoring effectiveness

An implementation plan must be included within the document. This will advise how the content of the document will be introduced to individuals and implemented. It should include reference to any training required.

Authors will detail, in the monitoring section of the policy or similar document, how the organisation will measure the effectiveness of the policy.

In the case of this policy, the corporate governance team will conduct ongoing checks on the compliance of policies and similar documents submitted to the Document Library and will produce reports for relevant teams, directors and if necessary committees highlighting areas of concern.

8. Version control

Version numbers should be used by the author to keep track of whether a document is a working draft awaiting approval or ratified. Version numbers should be used as follows:

Version	Notes
V1.0 (and sequentially 1.1, 1.2, 1.3 etc)	<ul style="list-style-type: none"> Working draft. Sequential increases as draft is revised. Document must be clearly marked as 'draft'.
V2.0	<ul style="list-style-type: none"> Version control updated to V2 as document moves into

Version	Notes
(and sequentially 2.1, 2.2, 2.3 etc)	<p>sign off stage and becomes a final draft awaiting approval.</p> <ul style="list-style-type: none"> • Sequential increases if revisions are made following feedback from the ratifying body. • Document must be clearly marked as 'draft'.
V3.0	<ul style="list-style-type: none"> • Ratified and final version, ready for adding to Document Library. • When an existing policy is being reviewed, the version number resets to V1.

Printing of policies and similar documents increases the chances of referring to an out of date version. To reduce this risk, such documents must include a ratification date and also indicate how frequently they should be reviewed. If documents are printed it should be recognised that NHS Kernow considers the ratified version held on the Document Library to be the current version.

9. Equality impact assessment (EIA) and full impact assessment (FIA)

An EIA is used to establish how a policy or similar document may impact on individuals, communities or equality groups to identify and minimise or remove any disproportionate impact.

A FIA should be undertaken for policies, strategies, procedures or projects which will have an impact on patients.

Authors must ensure that an EIA or FIA is completed for all policies and similar documentation and is appended to the policy rather than being held as a separate document. This should be in place as part of the consultation process. The most recent version of the EIA and FIA is available from the Document Library.

Further guidance on completing an EIA or FIA is available in 'A practical guide to undertaking equality impact assessments' and in the Equality and Diversity policy, both available on the [Document Library](#).

Failure to include a completed EIA or FIA will mean that a policy or other document will not be added to a committee or other agenda for approval.

10. NHS Constitution

The rights and pledges of the NHS Constitution have been taken into account in the development of this policy to ensure that the values and principles of the NHS are upheld.

The NHS Constitution should be taken into account, and referenced as appropriate, in the development of all policies.

11. Consultation

Some policies and similar documents require a formal consultation, such as some HR policies. For other policies the views and input of colleagues may be valuable in identifying changes that are needed and assumptions that have been made.

The author will compile a comprehensive consultation list and arrange for the distribution of the draft policy or similar for consultation. Reasonable time should be given for consultees to review and feedback on the document. For formal consultations this should be at least 21 working days..

The author is responsible for collecting and acknowledging feedback, considering suggestions made and making any necessary/agreed changes needed. When submitting the document for approval the covering report should provide a summary of the consultation responses received (appendix four contains a template which could be used for this).

Specific consultation requirements include:

- **Clinical input** in any policy or similar document with potential to impact on patients, their care or safety.
- Consultation with the **joint partnership committee** (JPC) on any policies or similar documents which have an impact on employees working lives (usually but not restricted to HR policies). This is part of NHS Kernow's recognition and commitment to employee involvement. Such policies or similar documents are subject to consultation with the JPC for 21 working days, or the appropriate statutory period. The HR team will, on request, advise if consultation with employee representatives should be conducted.
- Policies and similar documents on finance, procurement and HR should be sent to the **local counter fraud specialist** (LCFS) for review prior to ratification. A judgement should be made in regard to relevance for LCFS of any other policies or similar documents.

12. Freedom of Information

NHS Kernow must comply with Freedom of Information (FOI) requests which support transparency, accessibility and public accountability of the NHS.

Under the Freedom of Information Act 2005, NHS Kernow has a legal obligation to have a Publication Scheme where all corporate documents can be easily found and accessed by the general public. To meet this obligation, policies and similar documents (such as strategies, procedures and guidelines) are made available via our website. If the document is not to be made available the relevant exemption, public interest test and any limitation in timescale that the exemption applies, should be detailed in the policy.

13. Ratification

Once the consultation has been completed, and appropriate amendments made, the document may proceed to the approval stage. It is the responsibility of the author, or their nominated representative, to take a policy or similar document through to ratification, including seeking director endorsement where required.

The table below sets out where the various documents should be taken for ratification.

Document type	Status	Ratification by
Impacting on working life of staff	New or pre-existing	Endorsement by joint partnership committee then ratification by workforce committee.
Policy (continues over)	Pre-existing – minor changes, such as to job titles or format. No notable changes to process or approach.	An Executive Directors Senior Manager Team (ED SMT) meeting or virtual sign off by the Executive Directors.

Document type	Status	Ratification by
Policy (cont'd)	Pre-existing – significant changes to content, process etc.	Responsible director endorsement followed by ratification by either the Joint Senior Leadership Team (JSLT) or the relevant constitutional committee (quality, , workforce, primary care commissioning or finance and performance). Some may require Governing Body approval (for example those relating to organisational governance) this may be determined by NHS Kernow's Constitution, including the incorporated standing orders, prime financial policies and the scheme of delegation; regulation, statute Department of Health guidance.
	New	JSLT, or its agreed alternative, endorsement followed by ratification by relevant constitutional committee (quality, workforce, primary care commissioning or finance and performance). Some may require Governing Body approval (for example those relating to organisational governance). In exceptional circumstances, JSLT may decide a policy does not require committee ratification and can be ratified by JSLT. In these circumstances, a clear rationale must be provided by JSLT.
Protocol / Procedure	New or existing	Accountable director to determine appropriate authorisation route following policy or standard operating procedure routes depending upon the complexity and/or importance of document.
Standard operating procedures and guidance	Organisation-wide	Accountable director ratification
	Team level	Head of service ratification
Strategy/ long term plan	New or revisions to pre-existing	Responsible director endorsement then JSLT and finally to Governing Body for ratification.

When a policy or similar document is presented for ratification it should include:

- A completed and signed EIA – see Appendix 5; and

- Ensure:
 - The pre-ratification checklist is considered – see Appendix 2, and
 - Appropriate consultation is undertaken – see Appendix 3 and 4

Those ratifying a policy or similar document are required to ensure that full strategic consideration of the document's implications and requirements has been carried out and to report any concerns, if identified, to the author.

14. Publication, the Document Library and management

Once ratified the author should update the policy to confirm its ratification status and date and send it to the corporate governance team in its original, editable format (e.g. word). The corporate governance team will enact a final check on the compliance of the document with this policy and once satisfied, convert it to PDF and upload it to the Document Library.

It is important that the Document Library, available via our website, contains a complete and up to date record of policies and similar documentation.

The corporate governance team will maintain a database of all policies, including previous versions. They are also responsible for maintaining and archiving old and obsolete files in accordance with the records management policy.

Authors are responsible for meeting the requirements of records retention schedules for the removal and destruction of old documents from their own record storage.

15. Updating and reviewing of policies and similar documents

All policies and similar documents must be dated when approved and a review date also included. This will usually be three years unless there is an indication to the contrary. It is the responsibility of the author (or nominated officer) to be aware of influencing factors and to initiate reviews promptly within the three years if appropriate. The EIA should also be subject to review.

The corporate governance team will send regular reminders to the author, and the executive lead. A report will be produced for teams, directors and where necessary committees of any policies or similar documents which have exceeded their review deadline. In some cases, the lack of an in date policy or similar document may require inclusion on the risk register.

Appendix 1: Policy template

This document is held separately in Word format.

Appendix 2: Pre-ratification checklist

This can be used by authors, reviewers and by ratifying bodies and can be attached to a policy or similar document when submitted to the appropriate committee/group/individual for consideration and ratification.

	Title of document being reviewed	Yes/No	Comments
1.	Title		
•	Is the title clear and unambiguous?	Choose an item.	
2.	Purpose		
•	Is the reason for the document stated?	Choose an item.	
3.	Development process		
•	Has a reasonable attempt been made to ensure relevant expertise has been included?	Choose an item.	
•	Is there evidence of consultation with stakeholders and users?	Choose an item.	
•	If appropriate, has there been clinical input?	Choose an item.	
•	If appropriate, has the Joint Partnership Committee been consulted?	Choose an item.	
•	If appropriate, has the Counter Fraud Specialist been consulted?	Choose an item.	
4.	Content		
•	Are the objectives and intended outcomes clear?	Choose an item.	
•	Is the target audience clear and unambiguous?	Choose an item.	
5.	Evidence base		
•	Are key references cited, if appropriate?	Choose an item.	
•	Are the references cited in full, if appropriate?	Choose an item.	
•	Are supporting documents cross referenced?	Choose	

	Title of document being reviewed	Yes/No	Comments
		an item.	
6	Equality and diversity		
•	Has an Equality Impact Assessment or Full Impact Assessment been completed and reviewed as required?	Choose an item.	
•	If appropriate, does the policy use gender neutral language, and is the policy explicitly inclusive of same-sex couples?	Choose an item.	
•	If appropriate, does the policy clearly state that the organisation will not tolerate discrimination against employees on the grounds of sexual orientation or gender identity and/or trans identity. These may be listed along with other protected characteristics?	Choose an item.	
•	If appropriate, does the policy include guidance on facilities and dress code for non-binary people?	Choose an item.	
7.	Ratification		
•	Does the document identify which committee will be asked to ratify it?	Choose an item.	
8.	Dissemination and implementation		
•	Is there an outline plan to identify how this will be done?	Choose an item.	
•	Does this include training/support to ensure compliance?	Choose an item.	
•	Is it clear whether the document can be published on the organisational website? If it cannot, is a clear, valid reason given for this?	Choose an item.	
9.	Process for review and monitoring compliance		
•	Is a review date identified?	Choose an item.	
•	Is the frequency of review identified? If so, is it reasonable?	Choose an item.	
•	Is there a plan to review or audit compliance with the document?	Choose an item.	
10.	Overall responsibility for the document		
•	Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?	Choose an item.	

Appendix 3: Consultation form

Please add any comments, sign on the last page and return this form. If you do not return this form, the assumption will be that you are satisfied with the content of the document.

This policy has been passed to the following people/groups for comment:

Name	Designation	Address

If you feel that this document should be passed to other colleagues/groups for their views then please write the names, job titles and contact addresses below. This could also include colleagues from outside NHS Kernow. **The author will arrange for a copy of the document to be sent to them.**

Name	Position	Address

Comments

Please specify page and paragraph numbers, or send back electronically with 'tracked changes' or comments.

Page/Para	Comment

Signed:

Appendix 4: Summary of consultation responses

Consultee	Response received (summary)	Changes made as result (or reason not made)

Appendix 5: Equality Impact Assessment

[Download the latest version here.](#)