Buckinghamshire Healthcare NHS Trust

Meeting the general equality duty

Title: Production, approval, registration and implementation of Trust wide strategies and policies

Which of the three aims is this information relevant to?

Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.

Advance equality of opportunity between people who share a protected characteristic and those who do not.

Foster good relations between people who share a protected characteristic and those who do not.

How does this information help us to show we are paying due regards to advancing equality?

Our process for policy and strategy development which takes into account the need for impact assessment demonstrates good governance. Our commitment is to try to make sure that we deliver services which are personal, fair and diverse and this process which includes the equality impact assessment process (EQIA) helps us to do this.

Buckinghamshire Healthcare NHS
NHS Trust

"Policy on Policies"

Production, Approval, Registration and Implementation of Trust-wide Strategies and Policies

Vs 5

Once printed off, this is an uncontrolled document. Please check the intranet for the most up to date copy

Version:	**5**
Consultation by:	Trust-wide Policy and Strategy Group
Date:	2nd October 2014
Ratified by:	Trust Management Committee
Date ratified:	21st November 2014
Review date:	**November 2017**
Name of originator/author:	Revisions June 2014 Gemma Richardson, Regulatory Compliance Manager Revisions March 2012 Catherine Brown, Board Assurance Facilitator
Lead Director	Chief Nurse and Director of Patient Care Standards
Name of responsible committee/individual:	Trust Management Committee
Document reference:	BHT Pol 075
Date Re-issued:	November 2014
Target audience:	All those writing Trust-wide policies/strategies
Equality Impact Assessment:	02.10.14
Location	**Swan Live Intranet**/Policies and Guidelines/Policies and Strategies

Document History

Version	Issue	Reason for change	Authorising body	Date
Version 1	0	NHSLA Risk Management requirement	Governance Committee	Oct 2007
Version 2	0	The documentation of Equality Impact Assessments	Governance Committee	May 2008
Version 3	0	Changes to Committee structure in 2008/09, and related functions and the creation of the Care Quality Commission	Governance Committee	Nov 2009
Version 3	1	Amended guidance, and reflection of merger with Community Health Bucks in April 2010.	Lead Director approval	07.07.10
Version 3	2	Minor amendments to the Trust name, logo and EIA.	Lead Director approval	21.03. 11
Version 4	0	Full review with revised guidance on approval process, EIAs and strategies.	Approved: Risk Monitoring Group	24.10.11
			Ratified: Healthcare Governance Committee	08.11.11
Version 4	1	Re-issued with mandatory sections for Document History and Associated Documents and associated text.	Lead Executive approval	08.05.12
Version 4	1	Re-issued with minor amendment. Reference to Race Relations Act 200- updated to Equality Act 2010	N/A	06.09.12
Version 5	0	Formal Review, with updated governance structures and reporting lines.	Ratified: Trust Management Committee	21.11.14

Associated documents

BHT Ref	Title	Location/Link BHT Intranet and Swan Live Intranet
206.8	Writing a Clinical Guideline	**Swan Live Intranet:** Policies and Guidelines/Clinical Guidelines/Other Information
BHT Pol 042	Freedom of Information Act 2000 Policy	**Swan Live Intranet:** Policies &Guidelines/Policies & Strategies/Freedom of Information & Records Management
BHT S018	Records Management Strategy	**Swan Live Intranet:** Policies &Guidelines/Policies & Strategies/Freedom of Information & Records Management
BHT Pol 125	Records Management Policy	**Swan Live Intranet:** Policies &Guidelines/Policies & Strategies/Freedom of Information & Records Management
BHT Pol 089	Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions	**Swan Live Intranet:** Policies & Guidelines/Policies & Strategies/Finance
N/A	The Trust's Good Communications Guide	**Swan Live Intranet:** http://swanlive/corporate-information/good-communications-guide
N/A	Care Quality Commission	http://www.cqc.org.uk/
N/A	Royal College of Physicians	http://www.rcplondon.ac.uk/Pages/index.aspx
N/A	Infection Control Manual	http://swanlive/policies-guidelines/infection-prevention-control-manual
N/A	Equality Act 2010	**Equality Act 2010: guidance - Detailed guidance - GOV.UK**

CONTENTS **Page**

APPENDICES

1. INTRODUCTION

1.1 This procedural document sets out the approval process at Buckinghamshire Healthcare NHS Trust for policies and strategies.

1.2 The document outlines the purpose of a policy approval process; defines policies and other related documents; provides guidance on the writing of a policy, and of a corporate strategy, including style and formatting; formalises the arrangements for policy approval; and clarifies the process of policy document management including version control and archiving.

1.3 This document has been set out in line with the requirements of the NHS Litigation Authority Risk Management Standards, and reflects the template they have developed, as well as providing Trust specific guidance.

1.4 To support compliance with statutory duties and the requirements of the Care Quality Commission, it clarifies the scope of **Equality Impact Assessments, which must be applied to all documents reflecting the functions and activities of the Trust.**

2 PURPOSE

2.1 Standardisation in production, approval, registration and implementation of Trust-wide strategies and policies is an important part of the Trust's corporate and clinical governance.

2.2 This document sets out the requirements for the production, approval, registration, implementation and dissemination of Trust-wide strategies and policies in Buckinghamshire Healthcare NHS Trust, to which the Trust is committed.

2.3 It does not provide comprehensive information on the production of clinical strategies, protocols, procedures or guidelines; however, the mandatory duty to carry out an Equality Impact Assessment on all the activities and functions of the Trust encompasses these types of document, as do the mechanisms for version control, and the Trust expects the principles and the spirit of this policy to apply to the production of all procedural documents. Significant examples of Trust guidance that would follow these principles are:

- Trust Clinical Guidelines (approved by the relevant committee for the subject area and published by the Clinical Audit and Effectiveness Department)
- Clinical Strategies such as the Clinical Strategy for the Prevention and Management of Pressure Ulcers
- Nursing and Midwifery Guidelines (approved by the Nursing, Midwifery and Therapies Professional Board)
- Obstetric and Gynaecology Guidelines (approved by the Divisional Board)
- The Infection Control Manual (approved by the Infection Prevention and Control Committee).

2.4 As part of good information governance, policy documents must be regularly reviewed and updated, and it must be clear at all times both on the document itself and in divisional or corporate records which is the latest version and issue. The guidance in this policy supports the maintenance of a corporate image, agreed good practice and the Trust's claims management process.

2.5 All **Trust-wide** strategies, policies, and guidance must be accessible to all staff at all times i.e. published on the Trust Intranet site (Swanlive/Policies and Guidelines).

2.6. This policy applies to all the committees shown on the Corporate governance structure (Appendix A) and to anyone tasked with drafting a Trust-wide policy or corporate strategy. It also contains helpful information for those writing a clinical strategy, protocol, procedure or guidance.

3 DUTIES AND RESPONSIBILITIES

Author

3.1 It is the duty of the author of the policy or strategy to ensure as far as possible that the policy or strategy is in line with Department of Health guidance, legal requirements and advice from clinical bodies.

3.2 The public sector equality duty (Equality Act (2010) places a statutory duty upon the Trust. Amongst other requirements, for eliminating unlawful discrimination, harassment and bullying, advancing equality of opportunity and fostering good relations, the Trust has to demonstrate how it assesses the positive or negative impact of any policy, strategy, guideline, or service and organisational change introduced. Currently, the Trust uses an equality impact assessment tool to do this and it should be applied to any of the functions listed above. In undertaking the equality impact assessment (EqIA) the Trust aims to minimise the risk of causing any adverse impact on any particular group and to provide services that are personal, fair and diverse for all. It is the duty of the author to complete an EqIA.

(See **Appendix C** for EqIA tool kit)

3.3 It is the duty of the author of the policy or strategy to identify and consult with the relevant stakeholders as part of the policy or strategy development

3.4 See Section 14.3 for Document Control responsibilities.

3.5 It is the duty of the author of the policy or strategy to ensure that the policy or strategy is developed, approved, ratified and disseminated in line with this policy.

Executive Lead

3.6 It is the duty of the Executive Director lead for the policy/strategy to endorse the document prior to submission to the relevant committee for approval or ratification.

Trust Board and Approving Committees

3.7 It is the duty of the appropriate sub-committee of the Board or the Trust Management Committee to ratify policies and inform the Trust Board of any new policies. They may delegate to appropriate committees but this must be clearly minuted.

3.8 It is the duty of the Trust Management Committee to exercise its delegated authority to ratify certain types of policies on behalf of the Board. The details of delegated authority are contained in Appendix D**.**

3.9 Following approval by the appropriate professional committee or advisory board, it is the duty of the Trust Management Committee to ratify Clinical Strategies, which reflect guidance on good clinical practice, and establish a Trust-wide approach, to which the Trust is committed.

3.8 Nothing in this policy affects the Board's right to determine those matters on which decisions are reserved to itself. These are set out in *Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions-BHT Pol 089- Section C "Decisions Reserved to the Board"*.

In accordance with these provisions, the Board reserves the right to ratify corporate strategies and some specified policies.

4 DEFINITIONS

4.1 **POLICY:** A policy is a statement of principles and a course of action that the Trust commits to and that influences the way it behaves.

- Trust-wide policies are binding and breach of them can lead to disciplinary action. The Equal Opportunities and Diversity Policy is an example.
- Many policies within the Trust are Departmental policies: these set out a course of action which is to be followed by specific members of staff, particularly those employed within the department to which the policy applies. Failure to apply departmental policy might result in disciplinary action.

4.2 **STRATEGY:** A strategy is a statement that sets out a planned series of actions for achieving an aim. The Peoples Strategy is an example. Although the Trust has different requirements for the content of corporate and clinical strategies, their purpose is the same.

This policy does not cover the detailed production or approval of:

4.3 **PROCEDURE:** A Procedure is a step-by-step written instructions about how a task is to be carried out, usually developed by a multidisciplinary team. An example of a procedure is the Child Protection Proforma for Nursing Staff (Clinical Guideline 263). A procedure usually requires wide consultation and must be approved by the most relevant Trust committee. A clinical procedure will be included in the Trust Clinical Guidelines system. Failure to apply a procedure when it reflects an agreed policy or includes the application of protocols, might result in disciplinary action.

4.4 **PROTOCOL:** A defined system of agreed rules and behaviour used in specified situations for performing defined activities/actions, usually developed by a multidisciplinary team. Protocols are prescriptive and do not allow for individual discretion. The protocol for the management of over-anticoagulation with Warfarin (Guideline 191.2) is an example. Deliberate breach of a protocol will lead to disciplinary action. Breach of an agreed Trust protocol must be recorded as an untoward incident. Protocols should be approved by the committee most relevant to the subject area. Clinical protocols should be included in the Trust Clinical Guidelines system.

4.5 **CLINICAL GUIDELINE:** A clinical guideline is a systematically developed statement to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances (*Royal College of Physicians).* Guidelines set standards that reference best practice; for example, the Trust Clinical Guidelines. This policy does not cover production or approval of guidelines, but as they reflect the activities and functions of the Trust, they are subject to Equality Impact Assessments. The Mental Capacity Act may also have a bearing on the application or use of a clinical guideline. Please refer to 'Writing a clinical Guideline BHT 206.6' on the Trust intranet, and contact the Clinical Audit and Effectiveness Department for further advice.

5 STYLE AND FORMAT

The style and format for Trust-wide Policy documents is set out in Appendix B1.

The style and format for corporate strategies is set out in Appendix B2.

6 THE DEVELOPMENT OF ORGANISATION-WIDE PROCEDURAL DOCUMENTS

6.1 Guidance

Guidance on writing a policy is in **Appendix B1** and on writing a strategy in **Appendix B2.** This section contains a number of general points that authors undertaking such a task must consider

6.2. Citation

The author must demonstrate an evidence base for procedural documents with up to date references. It is recommended that all references are cited in full using an agreed uniform approach to referencing.

Equality Act 2010: http://www.legislation.gov.uk/ukpga/2010/15/contents

6.3. Consultation

6.3.1 The consultation process should be planned in advance and agreed with the Lead Executive Director or authorising Committee. All departments/key individuals expected to implement the policy or strategy should have an opportunity to comment on the draft.

6.3.2. Always consider soliciting opinion from patients or patient representative groups when producing the document.

6.3.3. There must be consultation with the Joint Management and Staff Committee when the policy has implications for staff, or the Joint Consultation and Negotiation Committee when there are implications for medical staff specifically.

6.4. **Equality Impact Assessments**

- The Trust must assess the impact of its functions, policies and strategies on equal opportunities and equality groups. No Trust-wide policy will be approved or ratified without confirmation that an EqIA has been completed.

- This process should begin as soon as a new policy is being considered. It should be an integral part of policy making. The EqIA and guidance on how to complete the form is in **Appendix C.**

7. DOCUMENT APPROVAL AND RATIFICATION PROCESS FOR CORPORATE POLICIES AND STRATEGIES

7.1. **Strategies:** Any corporate Trust-wide strategy must be approved by the Trust Management Committee and ratified in public by the Trust Board. The process will be led by the appropriate Executive Director. A strategy should be shaped by wide consultation, including patients and the public, if relevant.

7.2. **Clinical Strategies** serve the same purpose but are usually approved by the appropriate professional or specialty committee and ratified by the Trust's Quality and Patient Safety Group. They will, however, be ratified by the Board if the Board requires that this is done.

7.3. **Policies:** All Trust-wide policies must be approved by an appropriate committee which takes responsibility for its implementation, and ratified by a Trust Board Committee (see below), or by the Trust Management Committee. Which Committee ratifies what will be determined by the content/source of the policy (**Appendix D** – Policy approval and ratification chart **Appendix D1**- Policy approval flow chart).

7.4. Board Committees (which ratify relevant policies):

- Trust Management Committee
- Remuneration and Appointments Committee
- Charitable Funds Committee

7.5. The Board committees may decide to delegate ratification of certain policies to their sub-committees, and subsequently endorse them through receipt of the minutes of that sub-committee. The decision to delegate this authority must be minuted.

7.6 The Chairman of the delegated sub-committee can reverse this decision if s/he considers a document must be debated by the Board committee.

8. RATIFICATION PROCEDURE

8.1 The author will submit the policy or strategy document to the relevant committee with a covering paper endorsed by the lead Executive Director. The covering paper

will outline the consultation and approval process, summarise the key points within the policy, including advice on the impact on risk reduction, corporate objectives and standards of care, and demonstrate how the policy will be disseminated across the organisation. The Committee will then review the policy and ratify accordingly.

8.2. The ratification of the policy or strategy must be recorded in the minutes of the Committee, including the version number, the corporate policy identification number and the departmental identification number (where applicable). Each Committee has standard templates for the submission of procedural documents, available on the Intranet.

9. PUBLICATION

The information in this section is primarily about the procedural steps required when the document has been written.

9.1 The author is responsible for ensuring that the approved document is published on the Trust intranet, and on the web site if appropriate, and for ensuring that it is kept up to date.

9.2 It is good practice to make procedural documents available to the public. The authorising Committee must minute the rationale and the decision if it decides that the final document should not be published on the Trust's web site, but very few documents are actually published on the website, due to lack of capacity. They are routinely provided in response to a specific request. When submitting a document to a Board Committee or the Trust Management Committee authors must take care to convey the correct position in regard to publication on the Trust intranet or web-site. An erroneous commitment to publish which is not carried out puts the Trust at risk.

9.3 The version number and issue number of a policy under discussion must be recorded in the minutes for audit purposes.

9.4 The author must retain an up-to-date Word version of the policy that can be enlarged for anyone with impaired sight.

9.5 Occasionally, the Trust may require a procedural document to be translated. The author must provide the up-to-date Word version for this purpose.

10. REFERENCING AND ASSOCIATED DOCUMENTS

10.1 Any reference to an external document or organisation, which is providing an evidence base for the policy or strategy, should be included in the References section (see Section 12), in a uniform manner, in its most up-to-date form, in full, with web links to the organisation or the actual document as appropriate

10.2 Internal documents associated with the policy or strategy or its development should be listed (see Section 12), as **Associated Documents in a table** at the start of the document with their links on the Trust's Intranet, for easy reference by all readers.

10.3 **Inclusion of an Associated Documents table is now mandatory**.

11. REVIEW AND REVISION ARRANGEMENTS INCLUDING VERSION CONTROL

11.1 Policy documents must be reviewed within a maximum of 3 years or more frequently if this is appropriate. The author of the document may make minor revisions to the published document between reviews to correct any information that might be misleading, and must ensure that the most up to date issue of the version is available on the intranet/website and that all relevant staff are aware of the changes.

11.2 The author must ensure that the Trust register of policies always contains the up-to-date version by contacting the and informing the Healthcare Governance Department. If the previous author has left the Trust or changed jobs, the relevant Executive /lead Director must identify who should take over this responsibility.

11.3 The date of the revision must be written on the front sheet of the document, and be included in the footer which appears on every page.

It is the responsibility of the author and lead director to initiate a review and to decide whether an update is minor or major. If a policy requires major updating before the time of its official review date, the review date should be brought forward.

It is good practice to review policies in the light of complaints, incidents, near misses, changes to practice or new evidence.

11.4 A version of a Trust policy/strategy, etc, is the definitive, approved document (e.g. Version 1). An update between formal reviews is called an "issue" and should be identified, for example, as "Version 1.2", or "1.3", etc, and dated. Once consultation has ended on the changes following a major review, the document should be numbered as the next version. In the above example this would be Version 2.

11.5 **Inclusion of a Document History table is now mandatory**. All versions and changes between should display a history of the progress of the document, in a **Document History table**, and each page should have a footer explaining which version and issue it is, with the date and reference number.

11.6. Several Trust-wide policies have associated annexes, which are published separately. An Annex must contain a footer which includes:

- the identification of the Policy to which it is an annex,
- its own identification (e.g. Annex 3) and version number
- date of issue

If the Annex does not have a contents page, the document must have appropriate numbering of sections and page numbering. (e.g. page 6 of 27)

11.7 LAPSED POLICY REVIEWS

When revising a lapsed policy the principles of version control remain the same;

- If the document requires minor or no changes then the Version number remains the same with only the Issue number changing.

- If the document requires a significant amount of change, reflects changes in legislation or changes in practice, then the document must change to a new Version number, with the issue number reverting to nought.

- Allowing a document to become lapsed should be avoided where possible. Quarterly alerts/ prompts are sent (by the Healthcare Governance department) in advance to authors and Executive leads for policies, notifying them of the date a policy will become lapsed. However, it is the responsibility of the author and Executive lead to ensure the formal policy review, and subsequent approvals, are completed before a document passes its review date.

- If a document has lapsed before it revised, it must be submitted through its full formal consultation, approval and ratification process.

12. EDUCATION AND TRAINING

12.1. Education and training appropriate for the particular policy should be identified in the document, in the form of a Training Needs Assessment (TNA) and be the subject of discussion with the Trust's Associate Director, Education, Learning and Development. A flow chart is attached as Appendix F. For example, if the contents of the policy are required for induction, the commitment can be identified from the TNA and built into the corporate and mandatory training framework of the Trust, or into the local induction check list.

12.2. All staff must be made aware of relevant departmental and Trust-wide policies as part of their individual departmental induction programme.

12.3. Line managers must ensure that systems are in place to enable all staff, including agency staff, to access relevant policies and to remain up to date with the content.

12.4. All staff have a responsibility to ensure they are aware of Trust policies relevant to their area of work and that they act in accordance with these at all times.

12.5. If paper copies of policies are held by departments, it is the departmental head's responsibility to ensure they are up to date and accessible to staff

13 DISSEMINATION AND IMPLEMENTATION

13.1 Key points of discussion and final approval or ratification of strategies or policies must be clearly recorded in the minutes of the committee considering the document. The minutes must also record the version number and date, and once approved, the date for review. This is an information governance requirement.

13.1 Once the document is ratified, the Regulatory Compliance Administrator, within the Healthcare Governance Department, will send a summary of the document, including the version number and date of approval, to the Associate Director of Healthcare Governance who will include this information in the next Healthcare Governance Quarterly Report.

13.2 The author must also send a full electronic copy of the document including completed details of the approval process to the Trust Board Secretary or the

Regulatory Compliance Administrator for registration. The Register is maintained by staff in the Healthcare Governance Team.

13.3 Ratification of procedural documents must be recorded in the relevant Board committee or TMC minutes. Approval will therefore be noted in public by the Board as minutes of the Board's Committees are public documents, or noted and endorsed in the Chief Executive's report to the Board.

13.4 The Trust Board Secretary will also report any procedural documents that the Board itself has approved to the Associate Director of Healthcare Governance, to include in the next Healthcare Governance Quarterly Report.

13.5 This policy, once approved and ratified, will be published on the Trust's intranet for staff to access. If stipulated by the author or Executive Lead, the policy can be sent to the Chairs and secretaries of each Division for implementation or circulated by email to all users with a covering explanation of the key points,

14 DOCUMENT CONTROL

14.1 The Associate Director of Healthcare Governance has nominated a member of staff (Regulatory Compliance Administrator), part of whose job it is to develop and maintain a Register of approved Trust wide policies and strategies. The Register is published on the intranet. It includes information on review dates which enables authors to be alert to impending review, and allows the Trust to track the progress and ownership of its Trust-wide Policies.

A separate database of Clinical Guidelines is held and maintained by the Clinical Audit and Effectiveness Department, some of these clinical guidelines are also Trust-wide policies. The department publishes information on out of date Clinical Guidelines to a dedicated section on the intranet and issues a monthly bulletin to all users. These enable divisions and authors to be alert to documents requiring review.

14.2 The Register of Trust-wide Policies and Strategies is published on the intranet on a monthly basis.

14.3 It is the responsibility of each author of the document and the lead executive director to ensure that:

- The document undergoes the appropriate consultation and process for approval
- The Associate Director of Healthcare Governance/ Regulatory Compliance Administrator is informed of progress.
- Once approved, staff are advised by appropriate means of its existence
- An up-to-date copy is maintained in the appropriate location on the Trust intranet and is cross referenced to any other appropriate location.
- An up to date copy is maintained in the appropriate location on the Trust website.
- Any references to the policy on the Trust Induction Programme or any other training programme are kept up to date and relevant.

- Procedures and protocols which reflect the policy are similarly maintained.

14.4 It is good practice for each Division or Directorate to maintain a register of the policies and other procedural documents it is responsible for producing, and to identify one person as the Local Record Manager or Document Controller. This is now a requirement of Trust Policy, described in the Records Management Policy (BHT Pol 125), to meet the relevant elements of Records Management: NHS Code of Practice. The Local Record Manager has an ongoing duty to liaise with the Trust officer responsible for the Trust Register of Policies and Strategies.

15 ARCHIVING ARRANGEMENTS

15.1. It is the responsibility of the author of the document, or in his or her absence, the lead Executive Director, to ensure that out of date documents are removed from the Trust intranet/website.

15.2 The appropriate Divisional or Directorate Local Record Manager is responsible for maintaining the local archive for out of date documents when the new version is approved. This archive will be maintained in accordance with Records Management: NHS Code of Practice, which requires that out-of-date policies are kept for ten years. The older version of a policy may be required for legal purposes.

15.3. If it is necessary to retrieve any archived policy, this request must be put in writing to the officer with responsibility for maintaining the Trust Register who will then respond accordingly, with the support of the Departmental, Divisional or Corporate Directorate Local Record Manager.

16 MONITORING COMPLIANCE WITH AND THE EFFECTIVENESS OF PROCEDURAL DOCUMENTS

16.1 All policies must include details of how compliance will be monitored. For example: this might be done through audits, surveys, performance management, and incident and complaints analysis. However, it is not sufficient to state that it will be subject to audit without a description of how that audit will be carried out. An audit is commonly only feasible on the basis of data gathered on a prospective rather than retrospective basis, and an undertaking to carry out audit must clarify how that will be done. **Appendix E** provides a list of possible Audit Methodologies, and advice can be obtained from the department of Clinical Audit and Effectiveness.

16.2 Monitoring of compliance is intended to demonstrate that the processes described in each individual policy are being monitored, and not simply the anticipated outcomes, such as the number of complaints in relation to the policy. Assurance of compliance is more usually achieved through pro-active performance or process management

16.3 Monitoring of compliance in any policy must include a clear description of how the responsible officer(s) and Committee will address gaps in compliance identified through the monitoring process.

17 MONITORING OF COMPLIANCE WITH THE PROCESSES DESCRIBED IN THIS POLICY

17.1 The manager responsible for keeping the Trust register up to date will undertake periodic surveys of a sample of 5 policies to review compliance with this policy - a minimum of once a year.

The survey will need to demonstrate that:

- Committee minutes reflect the policy approval, implementation and publication processes set out in this document
- The policies are registered and have a unique identification number
- There have been audits carried out of compliance
- The policy register is up-to-date with reference to the sample

The responsible officer is the Associate Director of Healthcare Governance, who will provide the Quality Committee with the survey report and an Action Plan for addressing any gaps in compliance identified in the survey.

17.2 The full register itself is reviewed annually to ensure that all entries are current and relevant policies have been reviewed. Gaps in compliance are initially the subject of action by the Regulatory Compliance Administrator. Any unresolved issues for review by the Quality Committee itself are included in the Quarterly Healthcare Governance Report.

17.3. Pro-active management of the process by the Regulatory Compliance Administrator consists of:

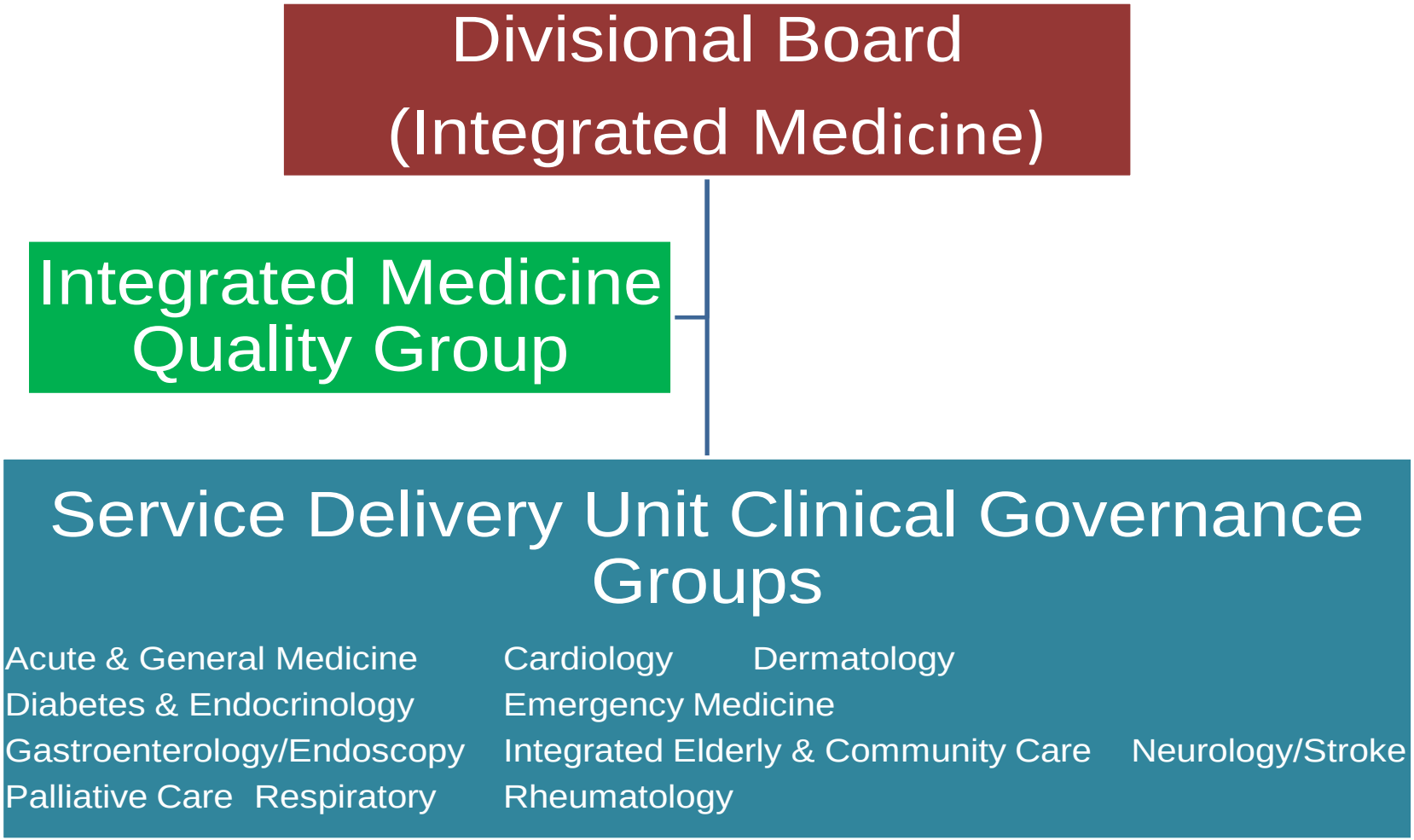
- A prompt sent to all Executive Directors and Authors, quarterly, notifying them of registered review dates for the following quarter, and the need for an EqIA for all new or reviewed approved Trust-wide documents
- Liaison on agenda management by nominated officers of each of the ratifying Committees to ensure due process in the content and compliance and appropriate recording of each decision.
- Approved and published processes for each type of approved document (see Section 2 above)
- Bi-annual review of compliance with the quarterly Prompts, reported to the Quality Committee within the Quarterly Healthcare Governance Report, with an appropriate Action Plan for consideration and approval.

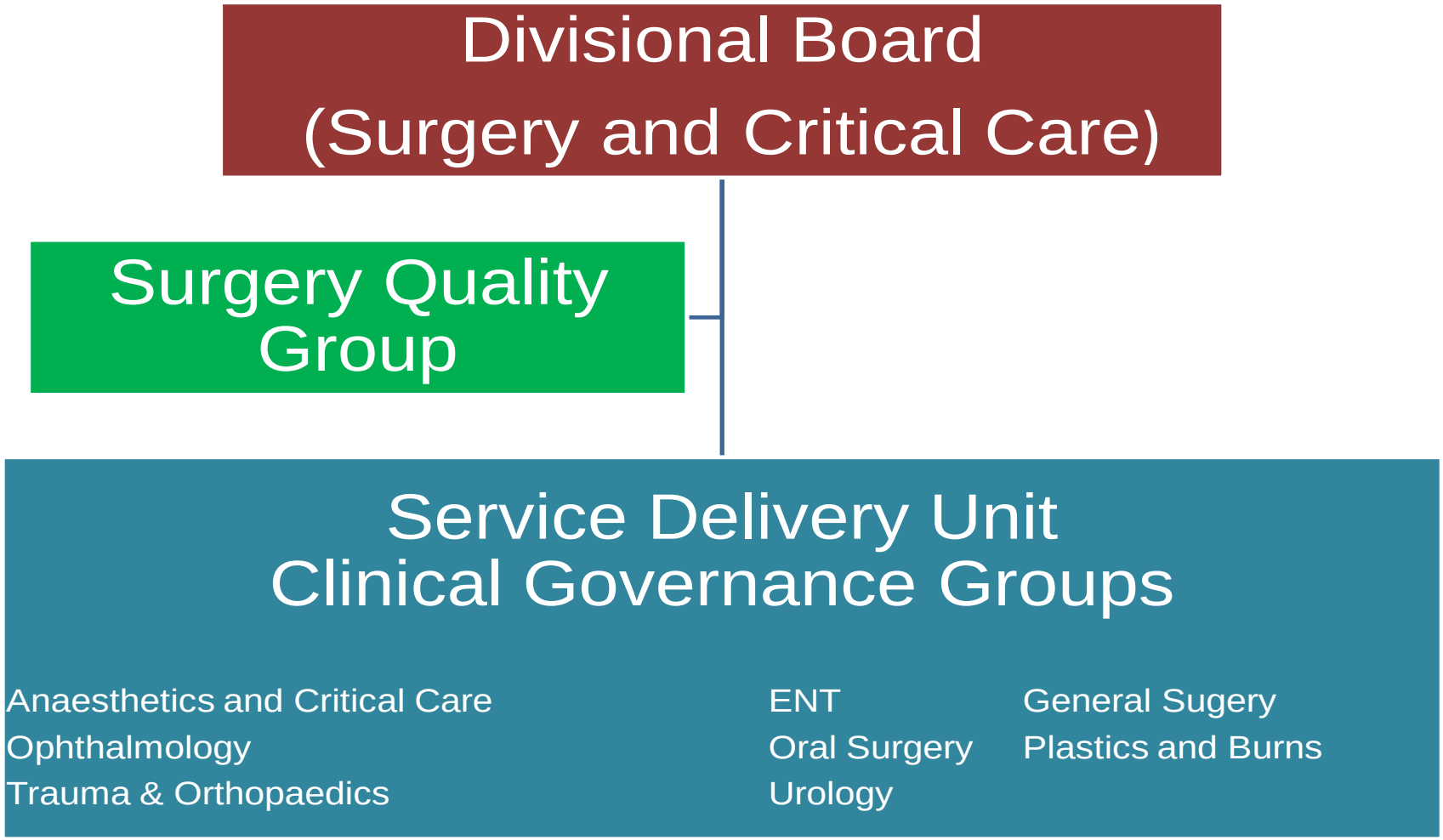
APPENDIX A: ***Governance Structure 2014***

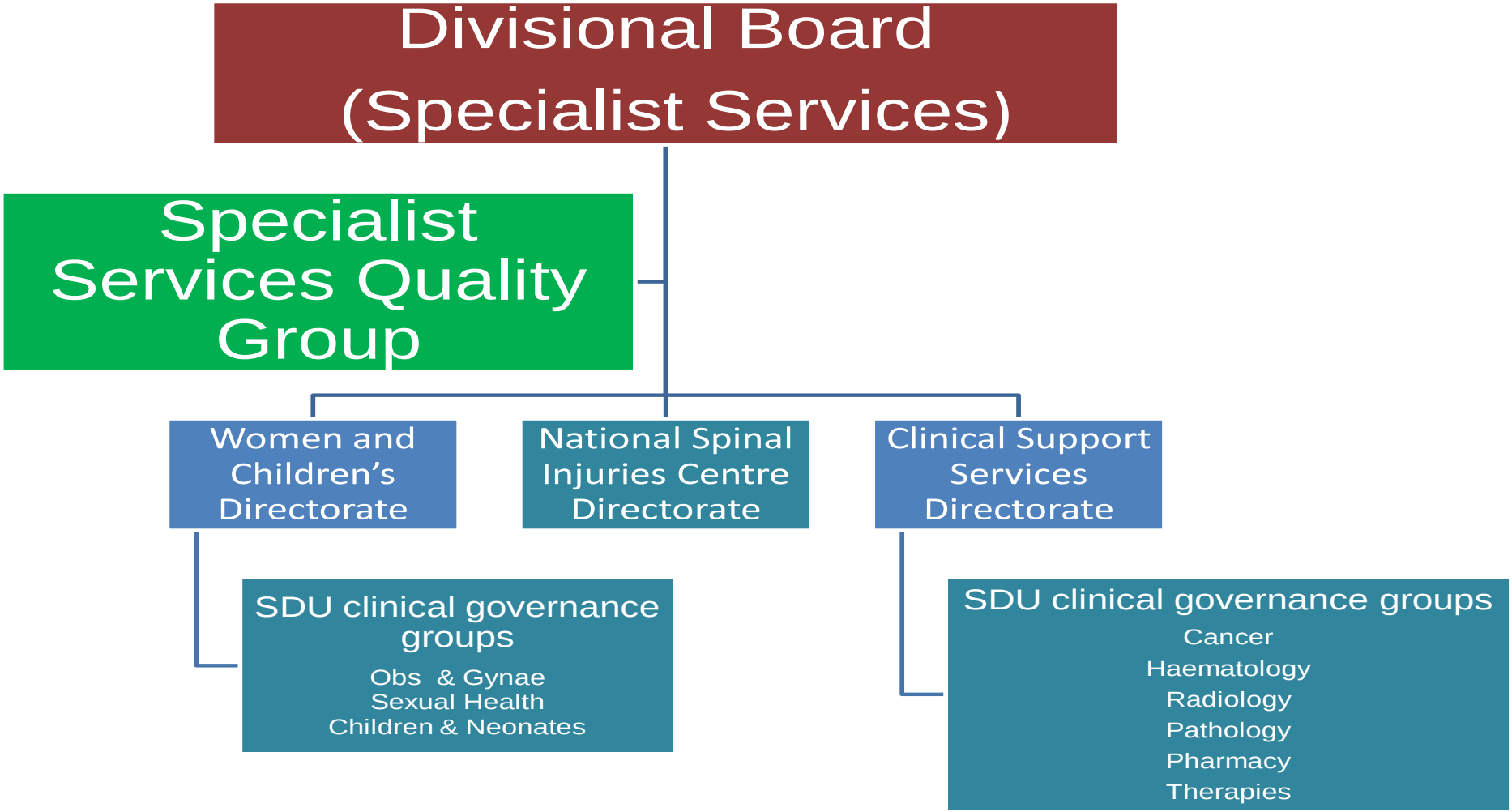
Trust Board and sub-committees

Quality Committee and sub-committees

Executive Committees


Divisional Board
(Integrated Medicine)
Integrated Medicine Quality Group
Service Delivery Unit Clinical Governance Groups
Acute & General Medicine
Cardiology
Dermatology
Diabetes & Endocrinology
Emergency Medicine
Gastroenterology/Endoscopy
Integrated Elderly & Community Care
Neurology/Stroke
Palliative Care
Respiratory
Rheumatology


Divisional Board
(Surgery and Critical Care)
Surgery Quality Group
Service Delivery Unit
Clinical Governance Groups
Anaesthetics and Critical Care
Ophthalmology
Trauma & Orthopaedics
ENT
Oral Surgery
Urology
General Sugery
Plastics and Burns


Divisional Board (Specialist Services)
Specialist Services Quality Group
Women and Children's Directorate
National Spinal Injuries Centre Directorate
Clinical Support Services Directorate
SDU clinical governance groups
Obs & Gynae
Sexual Health
Children & Neonates
SDU clinical governance groups
Cancer
Haematology
Radiology
Pathology
Pharmacy
Therapies

APPENDIX B1

GUIDANCE ON WRITING A POLICY

1. FRONT PAGE

The front page of all Trust-wide documents **must** contain the following information: (**See link to Front Sheet Template** or use the format of this policy as an example)

1.1 The following statement **must** be printed on the front of the document:

"Once printed off, this is an uncontrolled document. Please check the intranet for the most up to date copy".

1.2 The Trust logo in the top right hand corner.
1.3 A document title
1.4 The **version number** (e.g. Vs 1), and if relevant, the revision/issue number (e.g. Vs 1.2 – that is, the second issue of Vs 1)
1.5 The unique document reference number (Trust-wide and departmental if appropriate). Contact the Healthcare Governance Department for a **Trust-wide** reference number.
1.6 The date the version was approved.
1.7 The Committee that approved it.
1.8 The date the version was ratified.
1.9 The Committee that ratified it.
1.10 The next review date *or* revised review date.
1.11 Date of issue/publication.
1.12 The author – name is optional; title is essential
1.13 The responsible Committee/individual
1.14 The Lead Executive Director
1.15 Intended/Target audience.
1.16 The date its EqIA was approved.
1.17 Location (on the intranet).

The Document's History **must** be provided in a Version Control table separate from the Front Sheet (see page 2).

2. CONTENT OF THE DOCUMENT

Trust-wide policy documents must contain the following information:

2.1 Standard front page (see 1. above)
2.2 Version Control table, if preferred, for Document History
2.3 Associated Documents Table
2.4 Table of Contents
2.5 Introduction/Purpose of the document/who it is for, including any legal, regulatory or statutory framework.
2.6 An explanation of any terms used in the policy in a section on 'Definitions' (this includes words, terminology or abbreviations that could be misunderstood)

2.7 The policy
- the principles to which the Trust is committed
- the detail describing how these will be put into effect, in practice
- the outcomes on which achievement will be measured

2.8 The roles and responsibilities of management and staff in implementing the policy.

2.9 Consultation process used to inform the policy

2.10 Proposed dissemination, including publication

2.11 How compliance with the processes described in the policy will be monitored, and non-compliance acted upon

2.12 References and associated documents.

3. Use Arial font size 11 (as a minimum) for Trust-wide documents and ensure there is always a Word version available that can be enlarged for anyone with impaired sight.

4. Keep it short. Reference and append lengthy procedures to be followed.

5. The content must demonstrably comply with all relevant legal and statutory requirements, NHS guidance and policy in force at the time, and reflect evidence based best practice.

6. The needs of people from all equality groups, and general health and safety issues, must be considered. The process for doing so is an equality impact assessment. (Appendix C).

7. Advise the authorising committee of the impact of the policy/strategy on achievement of corporate objectives, achievement of healthcare standards and reduction of risk in the Trust.

8. Find out what already exists in the predecessor organisations in the Trust. Consider how the new policy links with other Trust policies and cross reference these where appropriate.

9. If your document contains any medicines content, you must ensure this is checked by the Clinical Guidelines Subgroup (CGS). The Clinical Guidelines Facilitator can advise further.

10. Any statistical or technical data must be referenced*.*

11. The consultation process should be planned in advance and agreed with the executive director or committee authorising the policy.

12. Solicit opinion from patients or patient representative groups, such as the Patient Experience Group

13. Consult the Joint Management and Staff Committee where a policy has implications for staff.

14. Remember that there will be open access to your document by the general public, if not on the website, then through any request.

APPENDIX B2

Template for a Trust Strategy document

Strategy: a three year vision, underpinned by an implementation plan containing key elements of resource allocation, risk management and accountability

The strategy should set out:

Aims: The overarching purpose

Objectives: How this will be achieved

Introduction: Why this is being done

What benefits will accrue

On what timescale

The evidence base for the approach taken

The principal drivers

Sections on: Summary of the resource allocation required

Identification of Business Plan needs

Education and Training Plan

How progress will be monitored

Summary conclusions

Recommendations

Implementation Plan attached as Appendix, for each of the 'milestones', project phases or concurrent activities. (CRS Project is an example)

Costs	Accountability	Timescale	Risk
££	**Individual & Committee**	**Yr 1 Yr 2 etc**	**What might prevent this being achieved What would happen if it were prevented etc**

Equality Impact Assessments (EqIA)

EqIA's assess the impact of policies and other Trust Documents on equality.

Any policy, strategy, guideline, service or organisational change should take into account the legal requirements for involvement and engagement of patients in line with the NHS Act (2012) and the NHS Constitution. Depending on the policy or service change etc this could be both from the perspective of developing the policy as well as the content, reflecting the need to encourage the patient and public voice to help shape what we do. Like equality and diversity, involvement of our patients is core to quality and safety and underpins our overall mission to provide safe and compassionate care every time. Please see the Trust patient involvement and participation strategy for further information or contact the Trust lead for involvement.

- The Trust must assess the impact of its functions, policies and strategies on equal opportunities and protected equality groups.
- No Trust-wide policy will be approved or ratified without confirmation that an EqIA has been completed.
- This process should begin as soon as a new policy is being considered. It should be an integral part of policy making.
- All submissions to Board committees must include advice on the impact on risk reduction, corporate objectives and standards of care.
- Policies for which it is appropriate may be subject to further scrutiny as part of the impact assessment process. It may also be appropriate to consult specifically with the Trust's Patient Experience Group. Authors of procedural documents must ensure that sufficient time is built into the timetable to do this.

Please use the following links on the intranet when completing an EqIA, or speak to the Trust's Equality and Diversity Manager.

Equality Impact Assessment Form:

- Swan Live Intranet/Corporate Information/Equality and Diversity

Guidance on Equality Impact Assessment's:

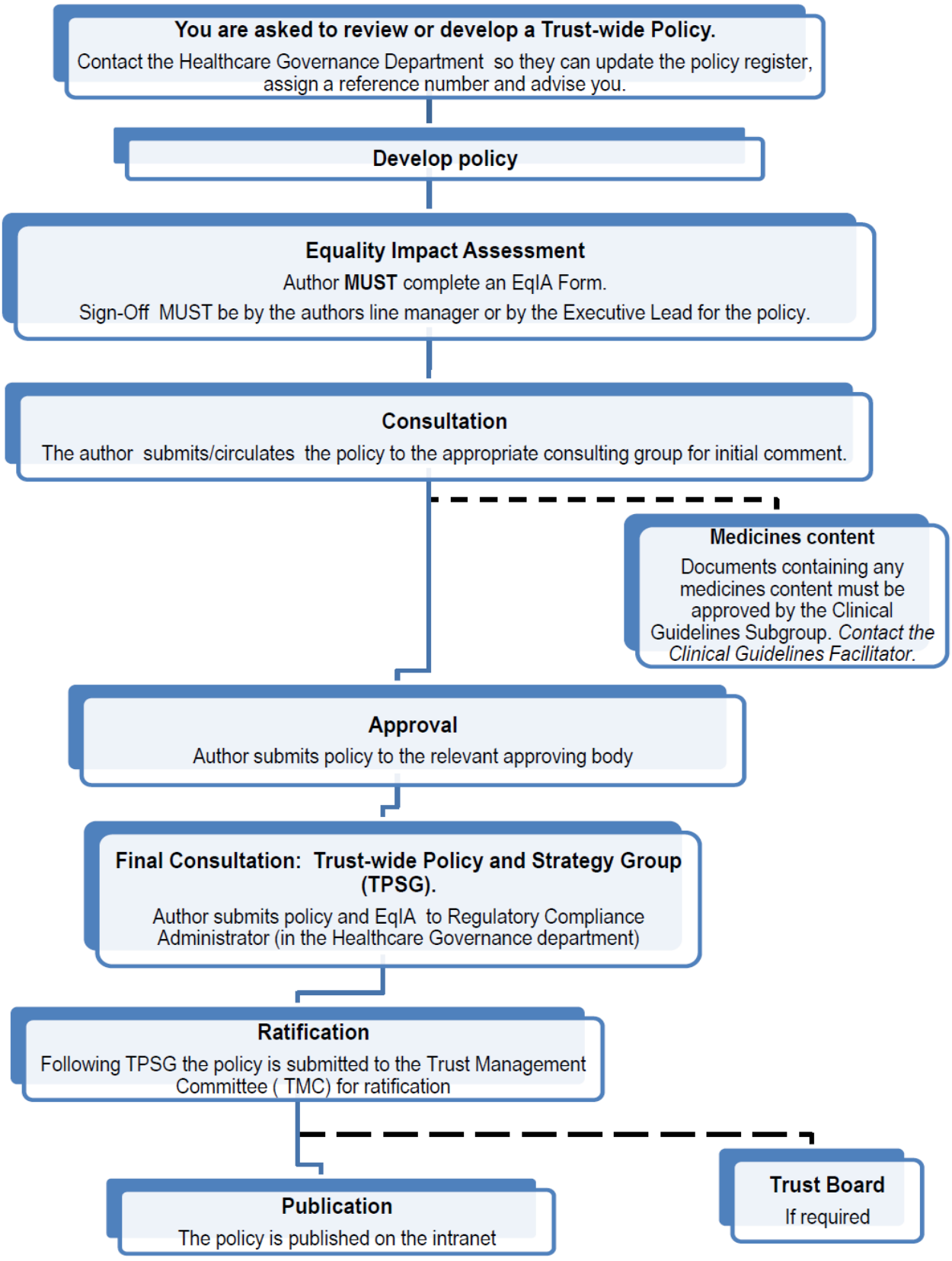
- Swan Live Intranet/Corporate Information/Equality and Diversity

APPENDIX D POLICY and STRATEGY APPROVAL AND RATIFICATION

Group name	Administrator & Chair	Frequency & *Submission sheet requirements*	Type of Documents (not exhaustive)
Trust Board	**Admin:** Elisabeth Ryder, Senior Board Admin **Chair:** Hattie Llewlyn- Davies	Bi-monthly *Submission sheet required.*	**RATIFIES:** Policies the Board decides to reserve to itself. All strategies. Assurance policies
Trust Management Committee (TMC)	**Admin:** Wendy Starodub, *PA to CEO* **Chair:**	Twice a month *Submission sheet required*	**RATIFIES:** All Trust-wide Policies & Strategies
Trust-wide Policy & Strategy Group (TPSG)	**Admin:** Gemma Richardson, *Regulatory Compliance Administrator* **Chair:** Elizabeth Hollman, Trust Board Secretary	Monthly *Submission sheet required.*	**FINAL CONSULTATIONS PRIOR to TMC:** All Trust-wide Policies & Strategies
Nursing & Midwifery Therapies Professional Board (NMTPB)	**Admin:** Geraldine Corbould, *Business Support Officer Chief Nurse* **Chair:** Carolyn Morrice, *Chief Nurse & Director of Patient Care Standards*	Monthly *Submission sheet required.*	**APPROVES:** Trust-wide documents regarding nursing, Patient involvement, Patient Information, Policies about patient access, Patient management, Child Protection Policies.
Drug and Therapeutics Committee (DTC)	**Admin:** Lesley O'Garro, *PA to Chief Pharmacist* **Chair:** Rachel Cox, *Associate Director Pharmacy*	Bi-Monthly *Submission sheet required.*	**APPROVES:** All medicines polices and guidelines.
Clinical Guidelines Subgroup (CGS)	**Admin:** Susan Felix, *Clinical Guidelines Facilitator* **Chair:** Maire Stapleton, *Formulary Manager Pharmacy*	Monthly *Submission sheet **not** required.*	**CONSULTATION:** Any document containing medicines content including Policies, Leaflets and Guidelines
Health & Safety Committee	**Admin:** Sarah Langan-Hart, *Healthcare Safety Team Administrator* **Chair:** Jackie Smith, *Patient Safety Manager*	Quarterly *Submission sheet required.*	**APPROVES:** • Risk Management policies • Health and Safety policies • Medical Devices Policies
Health Records Committee	**Admin:** **Chair:**		**APPROVES:** • Medical records policies. • Some Info Governance Policies
Infection Control Committee	**Admin: Karen McIntosh ,** Senior Med Sec & Lorraine Shaw, IPC Secretary **Chair: Jean O'driscoll,** Director IPC		**APPROVES:** • Infection Control Manual • Infection Control Policies and Strategy
Quality Committee	**Admin: Sheila Jalland, Exec** PA Healthcare Governance Team **Chair:** Non- Executive Director	Bi-monthly Submission sheet required	**NOTES/CONSULTS:** Some Trust wide policies as advised.

Quality and Patient Safety Group (Q&PSG)	**Admin: Geraldine Corbould,** Business Support Officer Chief Nurse **Chair: Carolyn Morrice,** Chief Nurse & Director of Patient Care Standards		**APPROVES:** Trust-wide documents regarding nursing, Patient involvement, Patient Information, Policies about patient access, Patient management, Child Protection Policies.
Quality Standards Monitoring Group (QSMG)	**Admin: Gemma Richardson,** Regulatory Compliance Admin **Chair:** Assoc. Director Healthcare Governance	N/A	N/A to policies and strategies
HR and Workforce Committee	**Admin: Vicky Adams,** PA to Director HR **Chair: Mark Warner,** Director HR		**APPROVES:** Human Resources Policies e.g. Grievance Policy; Whistleblowing Policy
Joint Management & Staff Committee (JMSC)	**Admin: Vicky Adams** **Minutes: Sue Fairman** **Chair: Mark Warner,** Director HR		**CONSULTATION:** Human Resources Policies e.g. Grievance Policy; Whistleblowing Policy
(JCNC)	**Admin:** **Chair:**		**CONSULTATION:** Human Resources Policies e.g. Grievance Policy; Whistleblowing Policy
Caldicott & Information Governance Committee	**Admin: Lorraine Pask,** Information Governance Manager **Chair: Giles Kidner,** Consultant Orthodontics	Quarterly Submission sheet not required.	**APPROVES:** Information Governance Policies. IT Policies Some Training Policies
Venous Thromboembolism Committee (VTEC)	**Admin: PA to Medical Director** **Chair: Graz Luzzi, Associate Medical Director**	Quarterly Submission sheet not required.	**CONSULTATION:**
Mortality Reduction Group	**Admin: PA to Medical Director** **Chair: Tina Kenny, Medical Director**	Monthly Submission sheet not required.	**N/A to policies & strategies**
Organ & Tissue Donation Committee	**Admin: PA to Medical Director** **Chair: Non Exec Director**	Quarterly Submission sheet not required.	
Medical Devices Committee (MDC)	**Admin: PA to Medical Director** **Chair: Graz Luzzi, Associate Medical Director**	Bi- monthly Submission sheet not required.	**APPROVES:** **Medical Devices Policies**
New Clinical Procedures Committee (NCP)	**Admin: PA to Medical Director** **Chair: Dr Kathy Cann, Associate Medical Director**	Quarterly Submission sheet not required.	**APPROVES:**
Antimicrobial Review Group (ARG)	**Admin: Claire Brandish, Phamacist** **Chair: Dr David Waghorn, Microbiology**	5 times per year (every 12 weeks) Submission sheet not required.	**N/A to policies & strategies**

Policy Approval Flow Chart



APPENDIX E- Audit Methodologies/ Tools

Methodology	Description
Prospective/Concurrent Audit	An audit with data collection taking place at the time of the event.
Retrospective Audit	An audit with data collection providing a picture of care provided during a given time period in the past.
Observational Audit	An audit where process are observed and recorded. eg Hand washing, IV care, use of Red Trays etc
Monitoring	On-going data collection to establish levels of performance.
Benchmarking	Use of monitoring information to compare practice across specialties etc.
Performance Indicators	Measuring practice against pre-defined criteria or targets.
Point Prevalence	An audit looking at a process/event on a given day for all wards/departments. This is useful to show trends.
Structural Audit	Auditing use of resources e.g. numbers of staff, skill mix, organisation, space and equipment.
Process Audit	Auditing the actions and decisions taken by clinicians. These may include communication, assessment, education, investigations, prescribing, surgical and other therapeutic interventions, evaluation and documentation.
Criterion Audit	Auditing against explicit and agreed criteria.
Adverse Events Audit	Auditing of poor care or outcomes; these can be identified from an Incident Reporting system.
Mortality Audit	Auditing of all deaths, often related to a specific condition.
Record Keeping Audit	This is an example of process audit of documentation.
Qualitative	This is data concerned with words rather than numbers.
Quantitative	This is audit concerned with numerical data.
Patient Experience	Survey/questionnaire to elicit patient views.
Focus Groups	Used to obtain patients'/staff views, can use semi-structured questions.
Structured Interviews	Structured interviews, one to one – time consuming. Face to face or telephone.

Integrated Care Pathways	These define expected timings and course of events in the care of a patient with a particular condition; it is then possible to audit variations in practice.
Standardised Scales	Daily living scales, SF 36 and SF12, anxiety and depression scales e.g. Hospital Anxiety and Depression Scale (HADS) etc. Can be used as outcome measures, if applied more than once.
Outcome Audit ***(Examples Below)***	**Auditing the measures of physical or behavioural responses to an intervention, reported health status, and level of knowledge and satisfaction.**
Goal Attainment Measure (GAM)	The Goal Attainment Measure (GAM) allows patients to identify 5 goals that they would like to achieve relating to aspects of their life affected by their condition and to weight each goal according to how much their condition has affected attaining the goal, when at their worst/lowest in the past month. Usually completed as a baseline, then again at following intervention.
Simplified Goal Attainment Measure	The simplified GAM requires the patient to identify their goals and later, following intervention, rate their level of attainment and satisfaction.
Patient Generated Index (PGI)	The Patient Generated Index (PGI) is an individualised quality of life (QoL) measure. Patients record the 5 most important areas of their life affected by their condition and weight these by how badly they were affected in each area when at their worst/lowest over the past month. Usually completed as a baseline, then again at end of therapy, treatment etc.
Physio scales and outcome measures (balance related)	• ConfBal (Confidence and balance – fear of falling) • Timed Get Up and Go (time taken to rise from a chair, walk 3 metres, turn round, return to the chair and sit down again) • Sharpen Romberg (feet in tandem heel to toe hands by their sides) timed with their eyes open/eyes closed without stepping out • Dizziness Handicap Inventory (DHI) used to determine the level of impairment felt by a patient with dizziness and incorporates measurements of the emotional, functional and physical impacts of dizziness on a person's life.
Likert Scale	A rating scale e.g. strongly agrees, agree, neither agree nor disagree, disagree, strongly disagree.
Visual Analogue Scale (VAS)	A rating scale utilising a line, that is only labelled at the ends, upon which the patient marks their perception or agreement – for example a pain scale labelled none and worst imaginable at either end. Requires accurate measurement to determine the patient's response.

APPENDIX F

Training Needs within a Policy

Training Activity/ Topic: (Please enter course name)	Response
Have you informed learning&development@buskchealthcare.nhs.uk that your policy includes a training section?	
Have you provided details to learning&development@buskchealthcare.nhs.uk of what the training will cover e.g. lesson plans, presentation slides and handouts	
Does the training need to be in the training matrix/prospectus, if not how ill staff be booked onto the training?	
Which staff need the training?	
How often do they need to be trained and/or assessed?	
Does your policy state how staff gain the knowledge and skills to be competent to practice i.e. within the workplace through supervised practice or through classroom learning/e-learning or a combination of all?	
Does your policy state if staff need to undertake a summative assessment by a qualified mentor who validates their competence to practice or is it they should receive training by an approved person	
Does the competencies/training need to be recorded?	
Have you forwarded registers to learning&development@buskchealthcare.nhs.uk for recording onto ESR for reporting and evidence purposes?	
Are these records audited and by whom?	