

## “Policy on Policies”

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

#### Vs 5.2

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<b>Lead Director</b>	Director for Governance
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## 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: Executive Management Committee	21.11.14
Version 5	1	Update to monitoring section. Appendix G added to support strengthening.	TPSG	04.06.15

Version 5	2	Update to bring into line with organisational changes	Executive Management Committee	October 2018
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## Associated documents

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

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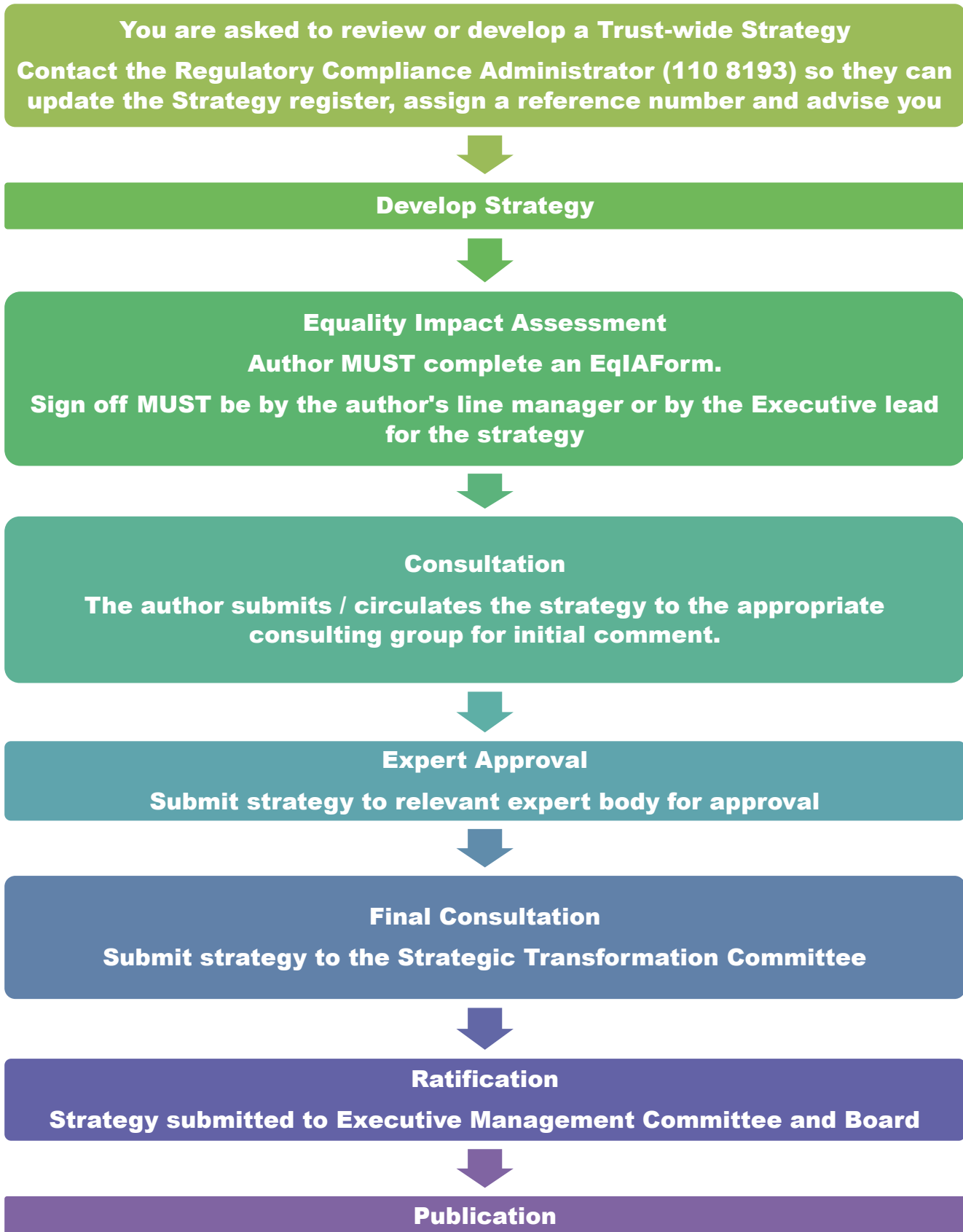
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## POLICY APPROVAL FLOW CHART



## STRATEGY APPROVAL FLOW CHART





## 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 Resolution 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
- 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 and Social Care 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 ensure that it is in alignment with the Trust strategy and the values of the organisation.
- 3.4 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
- 3.5 See [Section 14.3](#) for Document Control responsibilities.
- 3.6 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.
- 3.7 It is the duty of the author to ensure that the policy is monitored in line with the monitoring compliance section of the policy.

#### Executive Director Lead

- 3.8 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.
- 3.9 It is the duty of the Executive Director lead to ensure that the document is reviewed in a timely way and any lapses of review date are limited to 3 months.

It is the duty of the Executive Director lead to review the outputs of the policy monitoring and escalate for action as necessary.

## Trust Board and Approving Committees

- 3.10 It is the duty of the Executive Management Committee to ratify policies and inform the Trust Board of any new policies.
- 3.11 It is the duty of the Executive 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](#).
- 3.12 Following approval by the appropriate professional committee or advisory board such as the Strategic Transformation Committee, it is the duty of the Executive 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.
- 3.13 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 e.g. the risk management policy.

## 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.
  - Clinical policies are included within the definition.
- 4.2 **STRATEGY:** A method or plan chosen to bring about a desired future, such as achievement of a goal or solution to a problem over a period more than a year and typically between three and five years. The Workforce Strategy is an example.

Clinical strategies are included within this definition.

### **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. Standing Operating Procedures are included within this definition.

- 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](#)) 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](#)' 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 and clinical 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 EqlA 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 EqlA 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 Executive 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. Advice on the development of clinical and corporate strategies can be obtained from the Strategy and Business Development team.

7.2. **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 Executive 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).

### 8. **RATIFICATION PROCEDURE**

8.1 The author will submit the policy or strategy document to the relevant 'expert' committee/group for approval prior to submission to the Trust Policy sub-group (for policies) or the Strategic Transformation Committee (for strategies). Sometimes the policy or strategy will need to go to more than one 'expert' committee. For guidance on the appropriate committee or group please contact the Director for Governance. The Committee will then review the policy and ratify accordingly.

The author will submit any **policy** document to the Trust-wide Policy sub Group (TPSG) 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. TPSG will review each document to ensure it is in line with this policy and to comment in particular on style, format, readability, spelling, punctuation and Equality Impact Assessment. TPSG members are not experts in the subject matter for each policy and this is why the appropriateness of presentation of subject should be carried out by expert stakeholders before the

document comes to TPSG. TPSG will make a recommendation to the Executive Management Committee.

The author will submit any **strategy** document to the Strategic Transformation Committee (STC) 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 strategy, including advice on the impact on risk reduction, corporate objectives and standards of care, and demonstrate how the strategy will be disseminated across the organisation. The Strategic Transformation Committee will review each document to ensure it is in line with this policy and to comment in particular on style, format, readability, spelling, punctuation and Equality Impact Assessment. The Strategic Transformation Committee will make a recommendation to the Executive Management Committee.

- 8.2. The ratification of the policy or strategy must be recorded in the minutes of the Executive Management Committee, including the version number, the corporate policy identification number and the departmental identification number (where applicable).
- 8.3 The summary of policies/strategies approved by the Executive Management Committee will be included in the Chief Executive Officer's report to the Trust board in public on a bi-monthly basis.

## **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. The author should contact the Regulatory Compliance Administrator (110 8193) to upload the document once it has been ratified, and advise them if the document is amended for any reason.
- 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 Executive 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 author must retain an up-to-date Word version of the policy that can be enlarged for anyone with impaired sight.
- 9.4 Occasionally, the Trust may require a policy or strategy 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 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 Regulatory Compliance Administrator. 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 Regulatory Compliance Administrator) 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.
- 13.2 The author must also send a full electronic copy of the document including completed details of the approval process to the Director for Governance or the Regulatory Compliance Administrator for registration. The Register is maintained by the Regulatory Compliance Administrator.
- 13.3 Ratification of procedural documents must be recorded in the relevant Board committee or EMC 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 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 Director for 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 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 Regulatory Compliance Administrator who is 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.

[Appendix G](#) provides an example of the preferred tabulated monitoring and compliance tool with authors should use to document monitoring processes.

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 Director for Governance is responsible for keeping the Trust Register up to date and 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

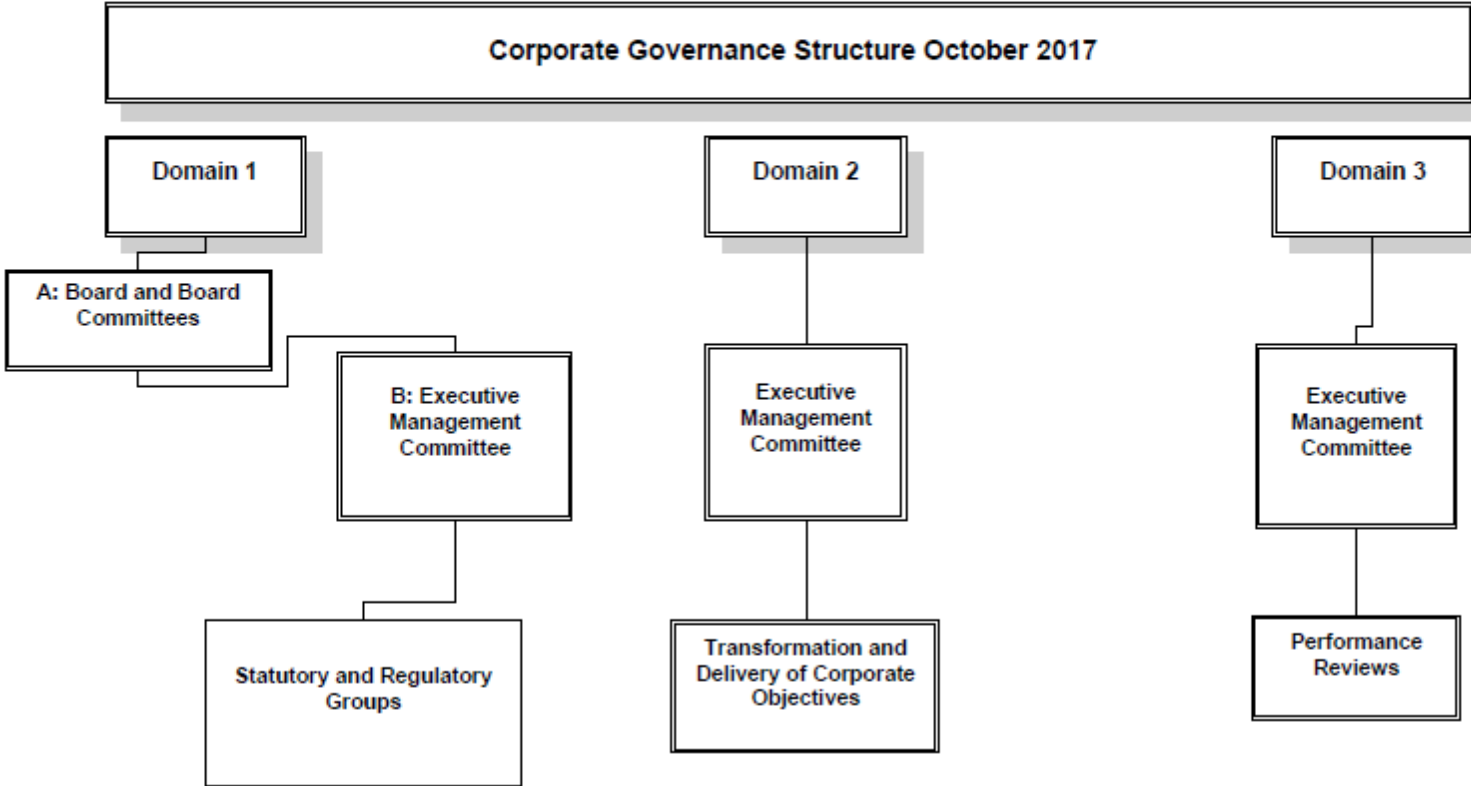
- 17.2 The full register itself is reviewed routinely (monthly) to ensure that all entries are current and relevant policies have been reviewed. Gaps in compliance are initially the subject of action by the Regulatory Compliance Administrator. Any unresolved issues for review will be reported to the Executive Management Committee on a quarterly basis.

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

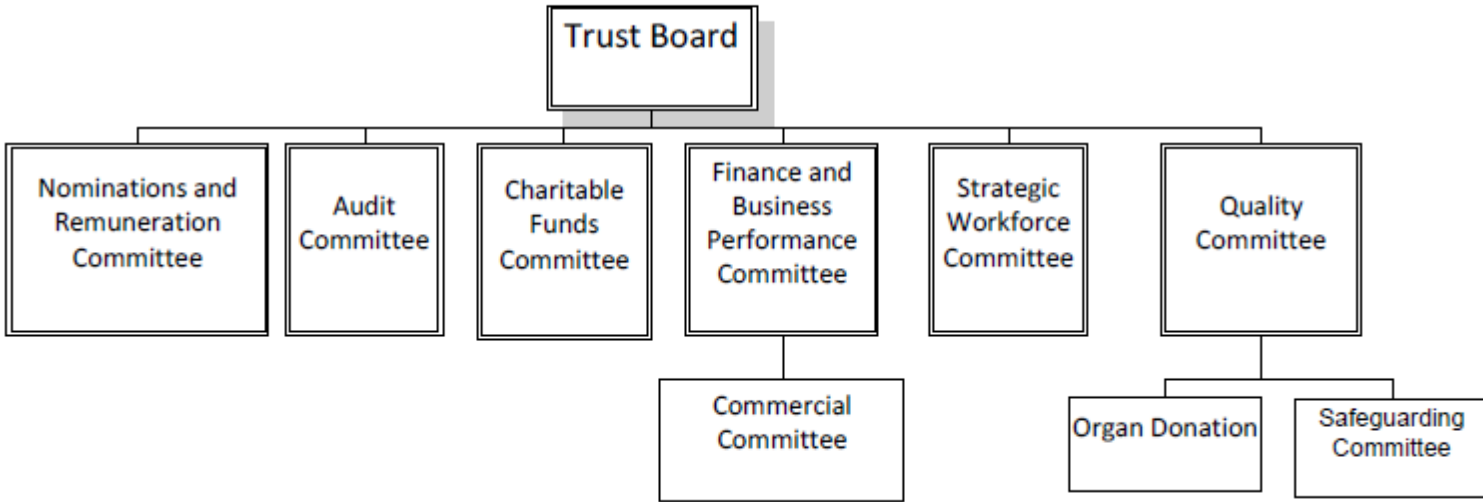
- A prompt sent to all Executive Directors and Authors, quarterly, notifying them of registered review dates for the following quarter, and the need for an EqlA for all new or reviewed approved Trust-wide documents
- Liaison on agenda management by nominated officers of each of the ratifying Committees 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 Executive Management Committee.

APPENDIX A: Governance Structure 2017

Safe & compassionate care,  
every time

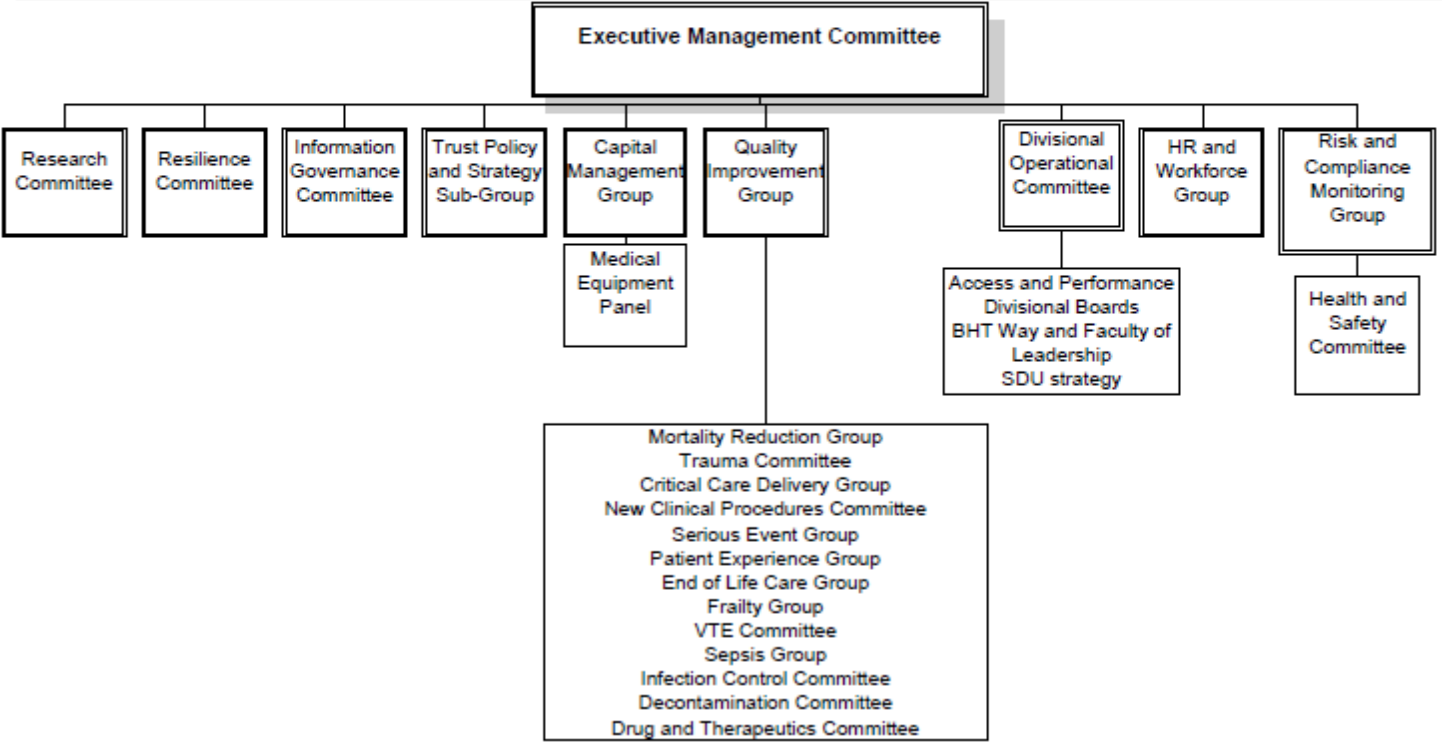


Corporate Governance Structure October 2017 Domain 1A

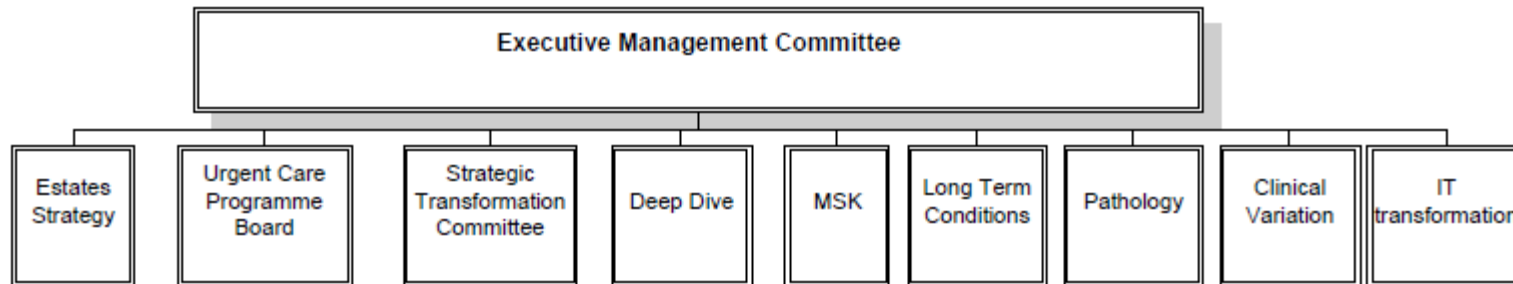


Board and Board Committees

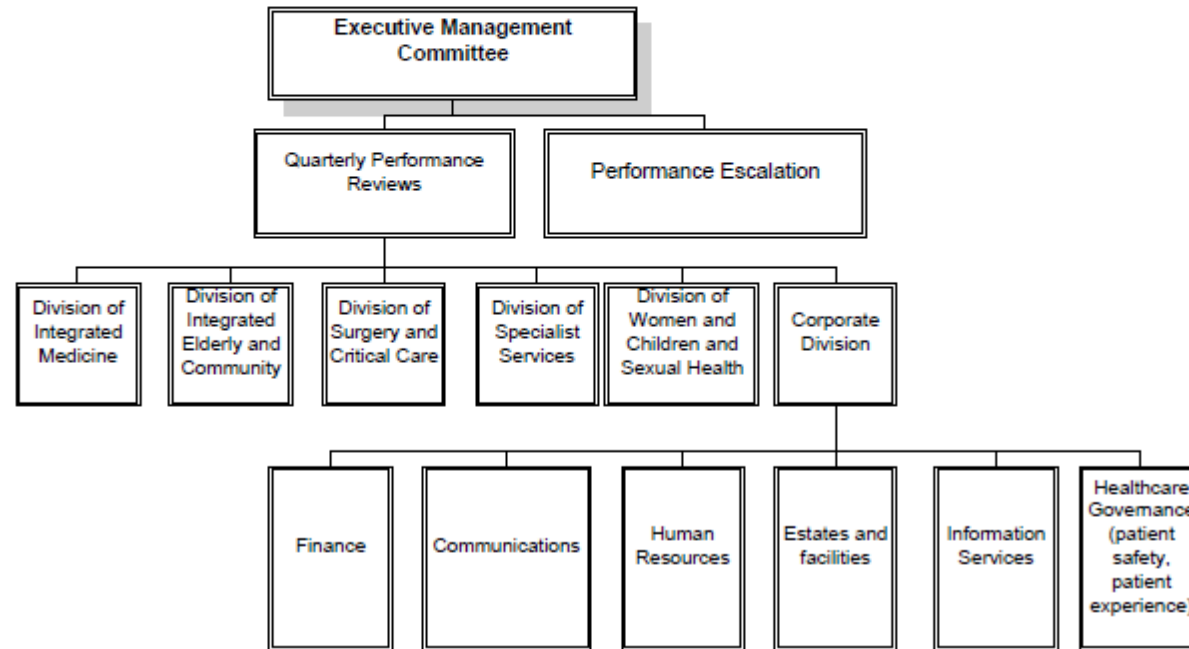
Corporate Governance Structure October 2017 Domain 1B



**Corporate Governance Structure October 2017 Domain 2: Transformation and Delivery**



Corporate Governance Structure October 2017 Domain 3: Performance Overview





## 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 to five 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)**

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

**APPENDIX C****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**
**Table 1 – approving/ratification groups**

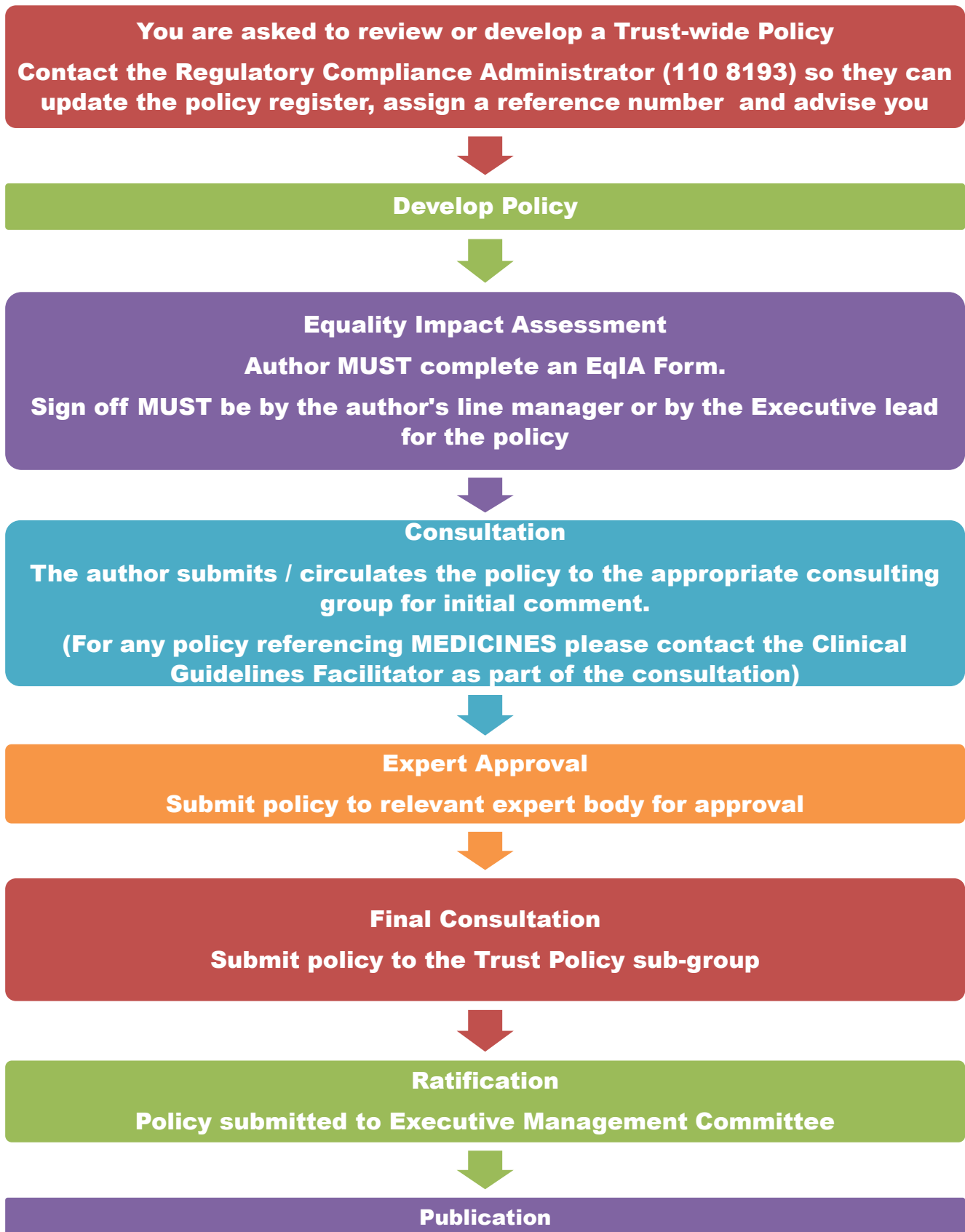
Group name	Administrator & Chair	Frequency & Submission sheet requirements	Type of Documents (not exhaustive)
<b>Trust Board</b>	<b>Admin:</b> Senior Board Administrator <b>Chair:</b> Trust Chair	Bi-monthly <i>Submission sheet required.</i>	<b>RATIFIES:</b> Policies the Board decides to reserve to itself. All strategies. Assurance policies
<b>Executive Management Committee (EMC)</b>	<b>Admin:</b> Senior Board Administrator <b>Chair:</b> Chief Executive	Twice a month <i>Submission sheet required</i>	<b>RATIFIES:</b> All Trust-wide Policies & Strategies
<b>Trust-wide Policy sub Group (TPSG)</b>	<b>Admin:</b> Regulatory Compliance Administrator <b>Chair:</b> Director for Governance	Monthly <i>Submission sheet required.</i>	<b>FINAL CONSULTATIONS PRIOR to EMC:</b> All Trust-wide Policies
<b>Strategic Transformation Committee</b>	<b>Admin:</b> p.a. to Director of Strategy <b>Chair:</b> Director of Strategy	Monthly <i>Submission sheet required.</i>	<b>FINAL CONSULTATIONS PRIOR to EMC:</b> All Trust-wide Strategies

**Table 2 – stakeholder groups**

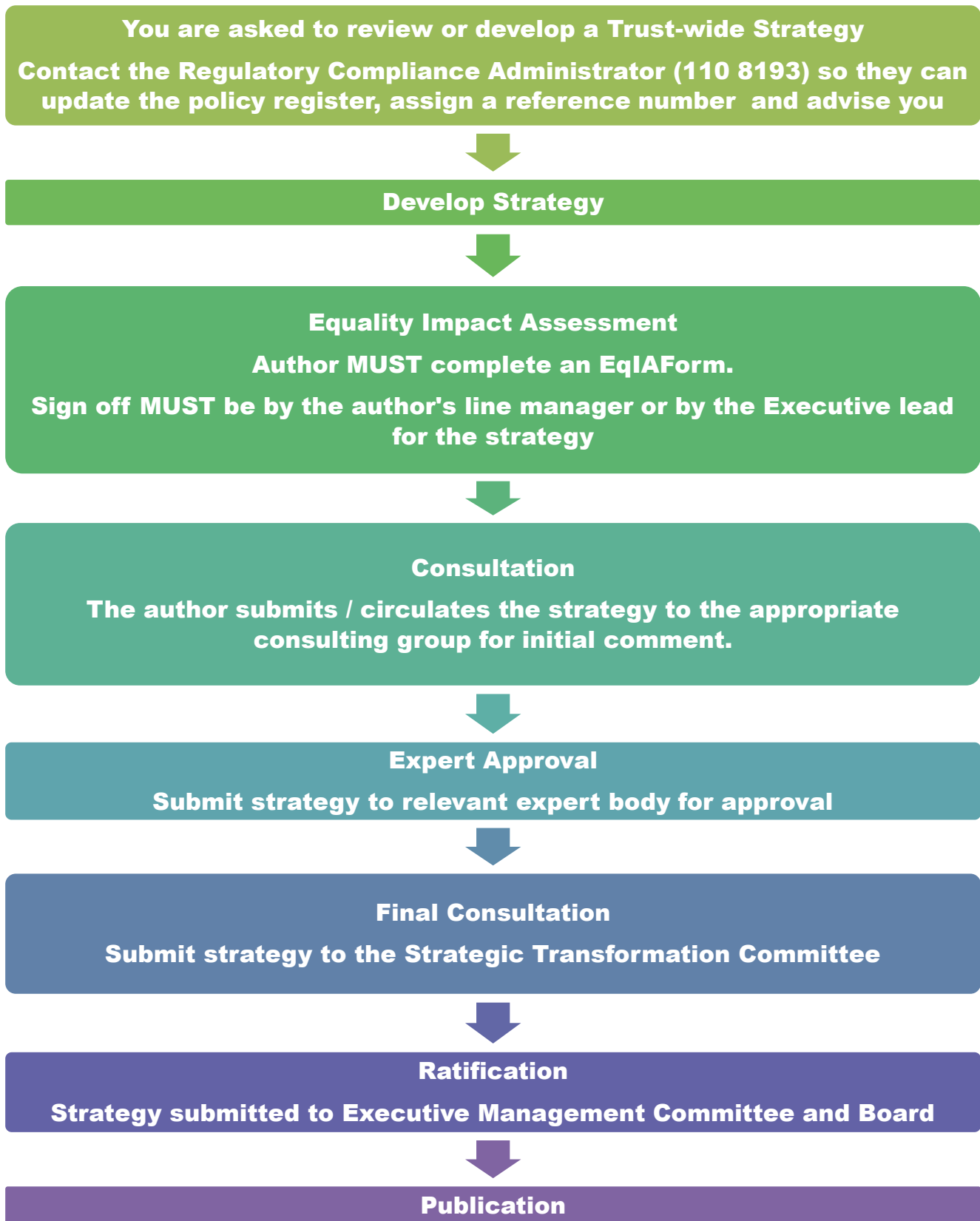
Group name	Administrator & Chair	Frequency & Submission sheet requirements	Type of Documents (not exhaustive)
<b>Nursing &amp; Midwifery Therapies Professional Board (NMTPB)</b>	<b>Admin:</b> Business Support Officer Chief Nurse <b>Chair:</b> Chief Nurse	Monthly <i>Submission sheet required.</i>	Trust-wide documents regarding nursing, Patient involvement, Patient Information, Policies about patient access, Patient management, Child Protection Policies.
<b>Drug and Therapeutics Committee (DTC)</b>	<b>Admin:</b> PA to Chief Pharmacist <b>Chair:</b> Associate Director Pharmacy	Bi-Monthly <i>Submission sheet required.</i>	All medicines polices and guidelines.
<b>Clinical Guidelines Subgroup ( CGS)</b>	<b>Admin:</b> Clinical Guidelines Facilitator <b>Chair:</b> Formulary Manager Pharmacy	Monthly <i>Submission sheet not required.</i>	Any document containing medicines content including Policies, Leaflets and Guidelines
<b>Health &amp; Safety Committee</b>	<b>Chair:</b> Property Services Risk Manager	Quarterly <i>Submission sheet required.</i>	<ul style="list-style-type: none"> <li>• Risk Management policies</li> <li>• Health and Safety policies</li> <li>• Medical Devices Policies</li> </ul>

<b>Health Records Committee</b>	<b>Admin:</b> <b>Chair:</b>		<ul style="list-style-type: none"> <li>• Medical records policies.</li> <li>• Some Info Governance Policies</li> </ul>
<b>Infection Prevention Control Committee</b>	<b>Admin:</b> , Senior Med Sec, IPC Secretary <b>Chair:</b> Director IPC		Infection Control Manual <ul style="list-style-type: none"> <li>• Infection Control Policies and Strategy</li> </ul>
<b>Quality and Patient Safety Group (Q&amp;PSG)</b>	<b>Admin:</b> Business Support Officer Chief Nurse <b>Chair:</b> Chief Nurse & Director of Patient Care Standards		Trust-wide documents regarding nursing, Patient involvement, Patient Information, Policies about patient access, Patient management, Child Protection Policies.
<b>HR and Workforce Committee</b>	<b>Admin:</b> PA to Director of Workforce and Organisational Development <b>Chair:</b> Director of Workforce and Organisational Development		Human Resources Policies e.g. Grievance Policy; Whistleblowing Policy
<b>Joint Management &amp; Staff Committee (JMSC)</b>	<b>Admin:</b> PA to Director of Workforce and Organisational Development <b>Minutes:</b> <b>Chair:</b> Director of Workforce and Organisational Development		<b>CONSULTATION:</b> Human Resources Policies e.g. Grievance Policy; Whistleblowing Policy
<b>Joint Consultation and Negotiation Committee (JCNC)</b>	<b>Admin:</b> <b>Chair:</b>		<b>CONSULTATION:</b> Human Resources Policies e.g. Grievance Policy; Whistleblowing Policy
<b>Caldicott &amp; Information Governance Committee</b>	<b>Admin:</b> Information Governance Manager <b>Chair:</b> Consultant Orthodontics	Quarterly Submission sheet not required.	Information Governance Policies. IT Policies Some Training Policies
<b>Venous Thromboembolism Group (VTEC)</b>	<b>Admin:</b> PA to Medical Director <b>Chair:</b> Associate Medical Director	Quarterly Submission sheet not required.	<b>CONSULTATION:</b>
<b>Medical Devices Committee (MDC)</b>	<b>Admin:</b> PA to Medical Director <b>Chair:</b> Associate Medical Director	Bi- monthly Submission sheet not required.	<b>APPROVES:</b> <b>Medical Devices Policies</b>
<b>New Clinical Procedures Committee (NCP)</b>	<b>Admin:</b> PA to Medical Director <b>Chair:</b> Associate Medical Director	Quarterly Submission sheet not required.	<b>APPROVES:</b>
<b>Antimicrobial Stewardship Committee (ASC)</b>	<b>Admin:</b> <b>Chair:</b>	5 times per year (every 12 weeks) Submission sheet not required.	<b>N/A to policies &amp; strategies</b>

**APPENDIX D1 POLICY APPROVAL FLOW CHART**



**APPENDIX D2 STRATEGY APPROVAL FLOW CHART**





**APPENDIX E- Audit Methodologies/ Tools**

<b>Methodology</b>	<b>Description</b>
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. E.g. 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.
<b>Outcome Audit (Examples Below)</b>	<b>Auditing the measures of physical or behavioural responses to an intervention, reported health status, and level of knowledge and satisfaction.</b>
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)	<ul style="list-style-type: none"> <li>• ConfBal (Confidence and balance – fear of falling)</li> <li>• 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)</li> <li>• Sharpen Romberg (feet in tandem heel to toe hands by their sides) timed with their eyes open/eyes closed without stepping out</li> <li>• 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.</li> </ul>
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 <a href="mailto:bht.practiceplacements@nhs.net">bht.practiceplacements@nhs.net</a> that your policy includes a training section?	
Have you provided details to <a href="mailto:bht.practiceplacements@nhs.net">bht.practiceplacements@nhs.net</a> 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 will 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 <a href="mailto:bht.practiceplacements@nhs.net">bht.practiceplacements@nhs.net</a> for recording onto ESR for reporting and evidence purposes?	
Are these records audited and by whom?	

**APPENDIX G**

**Monitoring & Compliance Table/Template**

**(Completed Example)**

What key element(s) need(s) monitoring as per local approved policy or guidance?	Who will lead on this aspect of monitoring?  Name the lead and what is the role of the multidisciplinary team or others be if any.	Which tool will be used to monitor/ check/ observe/ Assess/ inspect/ authenticate that everything is working according to this key element from the approved policy?	How often is the need to monitor each element?  How often is the need complete a report ?  How often is the need to share the report?	What committee will the completed report go to?
Element to be monitored	Lead	Tool	Frequency	Reporting arrangements
Organisational Risk Management Strategy and Structure detailing, committees/ sub committees groups which have some responsibility for risk	Assistant Director of Risk and Safety	DH Guidance  NHS Policy Frameworks	Annually	Board  Audit and Risk Committee  Executive Management Committee
Process for review of Corporate Risk Register TMG	Head of Risk and Patient Safety	Review of Risk Register against Risk Management Strategy	Monthly	Executive Management Committee
Process for Board Review of Corporate Risk Register	Assistant Director of Risk and Safety or Head of Risk and Patient Safety	Review of Risk Register against Risk Management Strategy	Quarterly	Board

Process for Audit and Risk Committee Review of Corporate Risk Register	Assistant Directors of Risk and Safety or Head of Risk and Patient Safety	Review of Risk Register against Risk Management Strategy	Each Meeting	Audit and Risk Committee
Process for Quality Committee review of Risk Registers in terms of Quality (Safety, Clinical Effectiveness, Patient Experience)	Divisional Risk Leads	Review of Risk Register against Risk Management Strategy	Each meeting reported through divisional risk reporting mechanisms	Quality Committee
Process for Divisional/Directorate Review of Risk Registers	Head of Risk and Patient Safety	Review of Risk Register against Risk Management Strategy	Monthly	Divisional Board or Quality meetings /Directorate Meetings/
Duties of the key individual(s) for risk management activities	Head of Risk and Patient Safety	Review of Duties undertaken against Risk Management Strategy	Annual	Board Audit Committee Executive Management Committee Quality Committee
Authority of all managers with regard to managing risk	Assistant Director of Risk and Safety or Corporate Governance and Risk	Review of authority against risk management process	On-going as part of Risk Register review. Annual Report	Board Audit Committee Executive Management

	Manager			Committee Quality Committee
Process for assessing all types of risk	Deputy Chief Executive	1. BAF Risk Agreed at Annual Risk/Objectives Seminar	Annually	Board
	Deputy Chief Executive	2. BAF Review	Every 2 months	Executive Management Committee
			Each Meeting	Audit Committee
			Quarterly	Board
Head of Risk and Patient Safety/Divisional Risk Leads	3. Corporate and Divisional Risk Registers reviewed on routine cycles.	Monthly	Executive Management Committee Divisional Boards /Quality Groups	
Process for ensuring a continual, systematic approach to risk assessments/risk identification is followed through the organisation	Internal Auditors/ Head of Risk and Patient Safety/ Assistant Director of Risk and Safety	Internal Auditors to review the risk management processes annually as part of the annual audit plan.  Risk Management Annual Risk Profile report will also review the risk management process and inform the DH Annual Governance Statement.	Annually	Audit Committee  EMC/Audit and Risk Committee and Trust Board

		<p>Risk will become a standing agenda item on all committees/team meetings.</p> <p>Risk assessments will be monitored through the Divisional/Directorate Structures and programmes.</p> <p>Aggregation of Incidents Complaints and Claims and the correlation between these and identified risk assessments/risks on Risk Registers.</p>	<p>On-going review sample checks.</p> <p>Quarterly</p> <p>Quarterly</p>	<p>Reported via all governance groups</p> <p>Quality themed Trust Operational Board Reporting</p> <p>Quality Committee</p>
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## APPENDIX H

### Approved: Vs3

Proposal and draft approval: EMC

Date: TBC

Approved by: TPSG

Date Approved: TBC

### Trust-wide Policy sub Group

#### Terms of Reference

#### Purpose

The purpose of the Trust-wide Policy sub Group (TPSG), as delegated by the Executive Management Committee, is to:

- facilitate Trust arrangements for policy production/review, consultation, approval and ratification;
- and to support authors in navigating the Trust formal processes for Trust-wide policy document management, from development to publication.

#### Membership

Membership of the Group will include

- Director for Governance (Chair)
- Executive Lead or delegate (by invitation, as appropriate for the policies submitted to the group)
- Regulatory Compliance Administrator (Document Controller and meeting administrator)
- Equality and Diversity Manager
- Head of Medical Quality and Development
- Authors of policies submitted to the group
- Governance Leads (as appropriate for the policies submitted to the group)
- Divisional representation as appropriate
- HR Policy Representative
- Clinical Audit representative (as appropriate for the policies submitted to the group)
- Communications Representative
- Information Technology representative
- Information Governance Representative
- Education team representative

#### Quorum

The Group is quorate when the Chair, Regulatory Compliance Administrator, Author, and one other are present for the meeting.

#### Frequency of Meetings

The Group will aim to meet monthly, for a duration no longer than two hours.

#### Administrative Support



The Document Controller/ Regulatory Compliance Administrator is responsible for administering the meeting, and inviting the relevant Leads/members to attend. Action notes from the meetings will be available to all group members.

### **Duties**

The Group will:

- Review new and revised Trust-wide Policies to ensure that that adequate review and consultation have taken place, and that the Trust standards for the development and ratification of policies have been followed. (Ref: Production, Approval, Registration and Implementation of Trust-wide Strategies and Policies Document- BHT Pol 075).
- Where the group is not assured of adequate review or consultation, it will advise the author of the necessary amendments to make, or the appropriate routes/frameworks to follow in order to ensure that there is wider consultation across the Trust.
- Provide oversight to make sure that policies submitted, meet the requirements placed upon us, under the public sector equality duty (Equality Act(2010)). This includes the need to demonstrate how it assesses policies for the impact on equality. Currently, the Trust uses an equality impact assessment toolkit.
- Ensure Policies are credible i.e. high quality and professionally produced within a common template, and include the Trust's mandatory requirements for formatting, document history, associated document's and version control.
- Ensure that Policies are readily available and communicated to those who need to access them.
- Ensure that the education and training requirements are identified as a consequence of introducing a new policy and that it is linked to the relevant training plan.
- Check that any Monitoring, Compliance and Auditing arrangements are identified in the policy

### **Accountability**

The Trust-wide Policy sub- Group will be accountable to Executive Management Committee. Documents ratified by the Group will be reported for noting at the meetings of the Executive Management Committee.