OUTSTANDING CARE
HEALTHY COMMUNITIES
AND A GREAT PLACE TO WORK

NHS
Buckinghamshire Healthcare
NHS Trust

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

Our process for policy development, which considers, 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.

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

Vs 6.0

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Version:	**6.0**
Consultation:	Nursing and Midwifery Board
Date:	28th January 2025
Ratified by:	Executive Management Committee
Date ratified:	6th May 2025
Review date:	May 2028
Name of originator/author:	Associate Chief Nurse - Director for Risk, Governance and Compliance
Executive Lead	Chief Nurse
Name of responsible committee/individual:	Executive Management Committee
Document reference:	BHT Pol 075
Date Re-issued:	May 2025
Target audience:	• All Trust staff. • Policy authors and reviewers. • Roles overseeing policy implementation and compliance. • Managers ensuring team awareness and adherence. • Executive Leads approving policies. • Regulatory Compliance Team. Stakeholders involved in consultation (e.g., clinical teams, HR, legal advisors).
Equality Impact Assessment:	Yes – January 2025
Location	CAKE – Policies/Governance

Consultation History

Date	Consulting Group	Discussion Outcome and Changes Made
14 February 2025	Care Group Operational Meeting	Advised to ensure clarity around Policy, SOP and Guidelines.
28 January 2025	Nursing and Midwifery Board	No amendments suggested.
28 January 2025	Clinical Effectiveness Board	Amendments suggested to the appendix of the document to reflect the changes which has been incorporated in the document.
TBC	JSMC	
25 February 2025	Trust-wide Policy Sub-Group	Following amendments suggested: updating the equality and diversity statement, ensuring consistent formatting, and clarifying references to the cake landing page, which has been incorporated in the document.

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

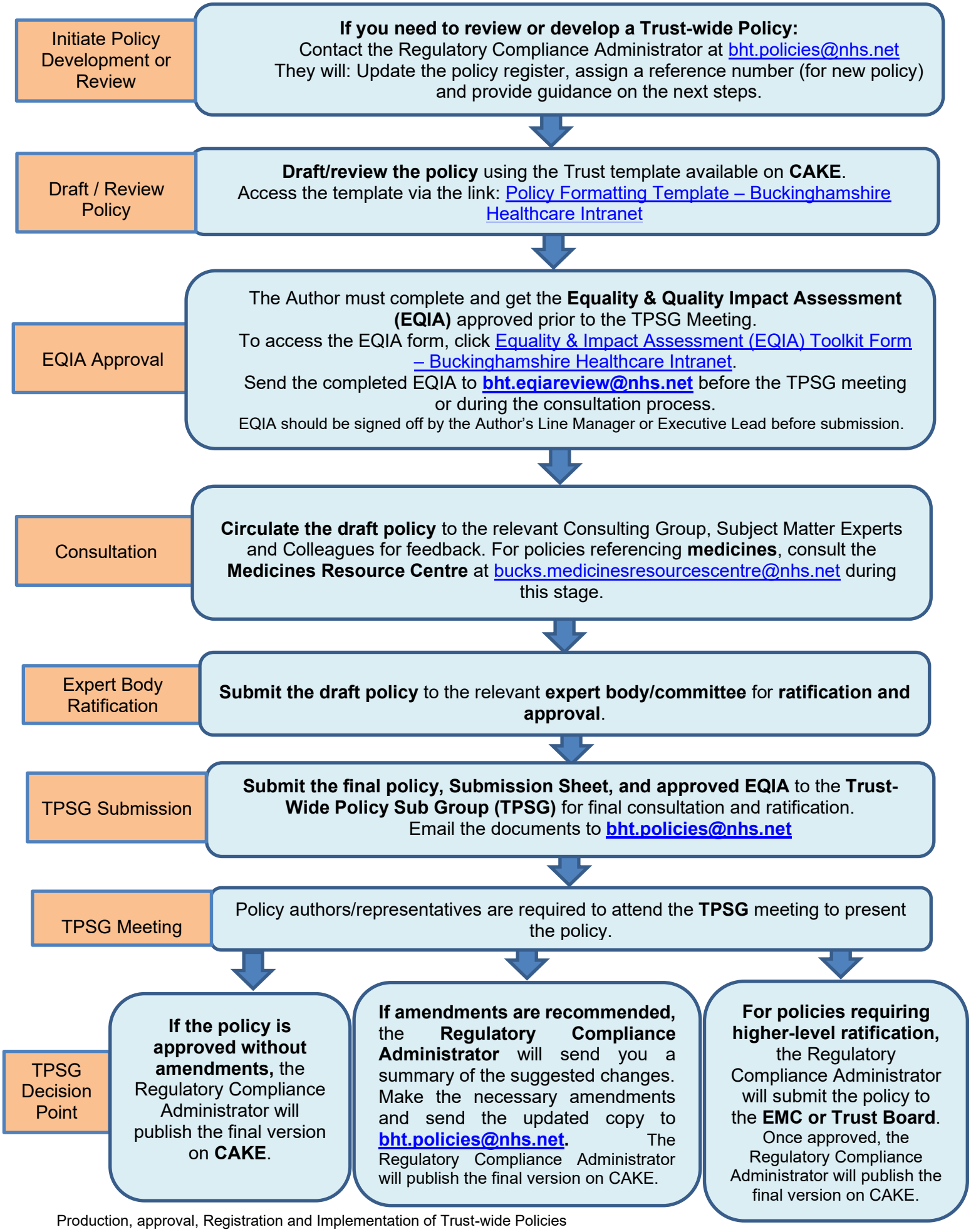
Version 4	1	Re-issued with mandatory sections for Document History and Associated Documents and associated text.	Lead Executive approval	08.05.12
Version 4	1	Re-issued with minor amendment. Reference to Race Relations Act 200- updated to Equality Act 2010	N/A	06.09.12
Version 5	0	Formal Review, with updated Governance structures and reporting lines.	Ratified: Executive Management Committee	21.11.14
Version 5	1	Update to monitoring section. Appendix F added to support strengthening.	TPSG	04.06.15
Version 5	2	Update to bring into line with organisational changes	Executive Management Committee	October 2018
Version 5	3	In formal Review and the removal of the out-of-date governance chart in Appendix A. Renumbering of Appendices	Executive Management Committee	November 2020
Version 6	0	Conducted a major rewrite to align with recent organisational changes. Introduced a 'Policy on a Page' for clarity. Refined roles and responsibilities. Removed the strategy section, as governance now follows a different process. Enhanced governance measures for policy ratification and approval.	Executive Management Committee	March 2025
Version 6	0	Additional Section (8) added to bring in line with use of artificial intelligence in policy development.	Executive Management Committee	May 2025

Associated documents

BHT Ref	Title	Location/Link BHT Intranet and CAKE
206.8	Writing a Clinical Guideline	Clinical Guidelines Policy BHT Pol 307
BHT Pol 042	Freedom of Information Act 2000 Policy	https://intranet.buckshealthcare.nhs.uk/documents/freedom-of-information-act-policy/
BHT S018	Records Management Strategy	https://intranet.buckshealthcare.nhs.uk/wp-content/uploads/2021/12/IG0080-Records-Management-Strategy-v8.pdf
BHT Pol 125	Records Management Policy	https://intranet.buckshealthcare.nhs.uk/documents/records-management-policy/
N/A	Corporate Governance Manual	https://intranet.buckshealthcare.nhs.uk/documents/standing-financial-instructions-policy/
N/A	'How to communicate professionally with colleagues, our patients and the public'	https://intranet.buckshealthcare.nhs.uk/brand-centre/
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	https://intranet.buckshealthcare.nhs.uk/document-library/policies/ - Infection Prevention & Control
N/A	Equality Act 2010	Equality Act 2010: guidance - Detailed guidance - GOV.UK

Contents

Trust-wide Policy Approval Process



1. INTRODUCTION

1.1 This document establishes the framework for developing, approving, and managing policies within Buckinghamshire Healthcare NHS Trust. It ensures that all policies adhere to national standards, regulatory requirements, and best practices, thereby promoting effective governance and enhancing safety for patients and colleagues.

1.2 Policies are a cornerstone of the Trust's governance and risk management frameworks. Consistent, appropriate, and effectively implemented policies are essential for delivering safe, high-quality care. To achieve this, the Trust mandates a rigorous process for the development, approval, and monitoring of all new or revised policies.

1.3 This document applies exclusively to policy development. Strategies, Protocols, Clinical Guidelines and Standard Operating Procedures (SOPs) are excluded from this framework and will continue to be managed at their respective governance frameworks. Guidance on reviewing these documents is provided in Section 5 of this policy.

1.4 To uphold statutory and regulatory responsibilities, the policy framework emphasises the mandatory completion of Equality and Quality Impact Assessments (EQIAs) for all new and revised policies. EQIAs ensure that all policies support equality, diversity, and inclusion across the Trust.

2. PURPOSE

The purpose of this policy is to:

2.1 Ensure consistency, clarity, and alignment across all policies to support the Trust's governance framework and strategic priorities.

2.2 Promote compliance with statutory and regulatory requirements, including those mandated by the Care Quality Commission (CQC) and NHS Resolution.

2.3 Minimise risks associated with policy inconsistencies, outdated documents, and non-compliance through robust processes for development, version control, and archiving.

2.4 Foster transparency and accessibility by ensuring policies are easily accessible to all staff, thereby enhancing understanding and accountability.

2.5 Integrate principles of equality, diversity, and inclusion into policy development by embedding Equality and Quality Impact Assessments (EQIA) as a mandatory component.

2.6 Support the delivery of safe, effective, and high-quality care by ensuring that policies reflect up-to-date best practices.

3. SCOPE

3.1 This policy applies to all individuals involved in drafting, reviewing, approving, and managing Trust policies, including all Trust staff, policy authors, reviewers, managers, Executive Leads, the Regulatory Compliance Team, and stakeholders such as clinical teams, HR, and legal advisors.

4. ROLES AND RESPONSIBILITIES

4.1 Author

The author is a key figure in policy development, responsible for ensuring that all policies meet the required standards and align with the Trust's objectives. The specific responsibilities of the author include:

- Ensure the policy aligns with the Department of Health and Social Care guidance, regulatory and legislative requirements, and any relevant standards.
- Complete an Equality Impact Assessment (EQIA) as described in Section 8 of this document.
- Ensure the policy aligns with the Trust's strategic objectives and core values while minimising adverse impacts on specific groups and promoting fairness, diversity, and inclusivity.
- Identify and consult with all relevant stakeholders during the policy development process to gather feedback and secure support.
- Oversee the development, approval, ratification, and dissemination processes for the policy as outlined in this document.
- Ensure that the policy undergoes document control measures, as described in Section 14.3.
- Ensure that the policy includes a clear monitoring and evaluation plan to measure its effectiveness and adherence, in line with the Monitoring Compliance section of this document.
- Attend the Trust-wide Policy Subgroup (TPSG) to present the policy or ensure a representative is sent in their place.

4.2 Executive Director Lead

The Executive Director Lead plays a crucial role in the governance and oversight of policy development and implementation. Their responsibilities include:

- Endorse the policy before its submission to the Trust Wide Policy Sub-Group for approval, ensuring it aligns with strategic objectives and compliance standards.
- Ensure that policies are reviewed on schedule, with delays in the review date limited to a maximum of six months.
- In cases where reviews are delayed, inform relevant stakeholders, outline interim measures to maintain policy relevance and compliance and provide updates on actions being taken to address delays in the future.
- Review the results of policy monitoring to assess effectiveness and compliance with the intended outcomes.
- Escalate identified issues or non-compliance promptly to relevant stakeholders, ensuring timely resolution and mitigation of risks.

4.3 Trust-wide Policy Subgroup (TPSG)

TPSG serves as the primary forum for overseeing, approving, and improving the Trust's approach to policy management. It reports monthly to the Executive Management Committee and plays a pivotal role in ensuring that all policies meet the Trust's strategic and operational needs.

- The TPSG scrutinises and challenges policies and policy extension requests to ensure they meet the following criteria:

- The policy is absolutely necessary.
- Is simple, clearly worded, and easily understood.
- Can be effectively disseminated to relevant staff.
- Is feasible for staff to adhere to and implement in practice.
- Includes clear mechanisms for evaluating both compliance and effectiveness.
- Conform to directives and strategic priorities set by the Trust Board.
- Policy is ratified by the appropriate committees and incorporates feedback from subject matter experts and key stakeholders before submission to the TPSG.

The Terms of Reference for TPSG is provided in Appendix G

4.4 Associate Chief Nurse for Governance, Risk, and Compliance

- The Associate Chief Nurse for Governance, Risk, and Compliance chairs the TPSG and acts as the primary agent for the Board in reviewing, improving, and adopting policies.

- The Associate Chief Nurse ensures that policies presented to the TPSG align with the Trust's governance and operational priorities while promoting robust scrutiny and quality assurance.

- Provides a monthly summary of policies approved at TPSG meetings, along with an updated status report of policies within the register to ensure transparency and effective tracking.

4.5 Regulatory Compliance Administrator

- The Regulatory Compliance Administrator oversees and manages the operations of TPSG, including:

    - Coordinating the submission of policies for review and approval.
    - Issuing meeting invitations to relevant stakeholders.
    - Documenting and distributing accurate minutes of TPSG meetings.
    - Providing feedback from the TPSG to policy authors to facilitate revisions or improvements.

- Guide and support policy authors throughout the drafting, review, and approval process, ensuring compliance with regulatory and organisational standards.

- Maintain an up-to-date and accurate policy register, tracking review dates, approval status, and version history.

- Ensures that all approved policies are published and accessible on the CAKE platform within defined timelines and standards.

- May periodically audit the organisation and usability of policies on CAKE to enhance accessibility.

- Monitors policies approaching their expiration date and escalates concerns about lapsed or soon-to-lapse policies to the Associate Chief Nurse to prompt timely action.

- Supports compliance by organising training sessions or disseminating resources for policy authors as needed.

- Provide regular updates to the TPSG on the status of the policy register, including detailed documentation and tracking of escalation outcomes to ensure timely resolution and accountability.

4.6 Executive Management Committees (EMC)

- The EMC is responsible for the approval of specific policies as defined in the Trust Standing Orders, outlined in Appendix C.
- The EMC acts as a key liaison to the Trust Board by:
    - Informing the Board of newly ratified policies to ensure transparency and governance alignment; and
    - Maintaining alignment with the Trust's strategic objectives through regular communication and reporting on policy decisions.
- The EMC has delegated authority from the Trust Board to ratify certain types of policies. Details of this delegation are provided in Appendix C and include specific operational and clinical policies that do not require Board-level oversight.

4.7 Trust Board

- This policy does not affect the Trust Board's authority to reserve decisions on specific matters. In accordance with The Corporate Governance Manual, Section D: 32 – Reservation of Matters to the Board, the Trust Board retains the right to ratify policies in critical areas, including:
    - Risk management policies;
    - Personnel policies related to staff appointments, removals, and remuneration; and
    - Policies requiring final approval as the Trustee of the BHT Charity, particularly Charity-related policies.

4.8 Ratification Committees (or Group)

Ratification Committees (or Groups) play a crucial role in the policy development process by ensuring that all policies are thoroughly reviewed, compliant with regulations, and operationally sound. Their responsibilities include:

- Ensuring that any policy drafted within their area of responsibility is consulted with subject matter experts and relevant stakeholders. This consultation ensures that the policy meets all applicable regulatory and operational requirements and incorporates expert insights.
- Approving the policy after a thorough review to confirm its clarity, feasibility, and alignment with the Trust's strategic objectives and regulatory and legislative responsibility prior to submission to TPSG.

- Ratification Committees serve as a critical checkpoint in the governance process, safeguarding the quality and compliance of all policies before they advance to the TPSG for final scrutiny and endorsement. Their work ensures policies are well-prepared, relevant, and actionable for implementation across the Trust.

4.9 Managers, Team Leads, and Heads of Service

Managers, Team Leads, and Heads of Service are responsible for ensuring the effective implementation, dissemination, and adherence to policies within their areas of responsibility. Their key responsibilities include:

- Distributing information about new policies and procedures in a timely manner across their Care Group or Service Decision Units to a pre-agreed distribution list developed with local managers to ensure effective communication.
- Ensuring all staff have access to up-to-date policies, either via the Trust website or other approved resources. If policy manuals are maintained locally, managers must allocate resources to ensure these are updated regularly.
- Maintaining a system for recording policies and procedures that have been distributed to and received by staff within the Department or Service. These records must be readily available for inspection and audit upon request.
- Ensuring that all policies, procedures, and SOPs are followed and understood by staff according to their roles and functions. This information must be provided to all new staff during induction and to staff returning from extended absences, such as maternity/paternity leave or long-term sickness leave. Local managers and team leaders must develop and implement a local induction program that includes an overview of relevant policies and procedures.
- Notifying staff promptly of any updates or changes to policies and briefing them on how these changes may impact their roles and responsibilities.
- Monitor staff compliance with policies and procedures and take corrective action when non-compliance is identified.

- Managers are critical to maintaining the Trust's governance and operational standards. By ensuring that policies are effectively disseminated, understood, and implemented, they play a pivotal role in fostering a culture of accountability, compliance, and continuous improvement within their teams.

4.10 All Staff

All staff, including temporary and seconded staff, have a responsibility to ensure they:

- Know where to locate policies and procedures when necessary and are familiar with how to access them, whether through the Trust website or other approved platforms.
- Adhere to all Trust policies in the course of their practice, ensuring compliance with specified requirements and standards.
- Understand how policies and procedures impact their roles and responsibilities, and are capable of following the specified requirements outlined within these documents.

- While senior staff hold overarching responsibilities, every staff member is accountable for their own compliance with policies, ensuring a culture of shared responsibility and professionalism.

- The Director of Human Resources and Organisational Development retains overarching responsibility for ensuring that draft policy documents are circulated

to staff-side representatives for comment, where appropriate, fostering collaboration and inclusivity in the policy development process.

5 DEFINITIONS

5.1 POLICY:

A policy is a formal statement of principles and a planned course of action that the Trust is committed to, guiding the behaviour and decisions of its staff.

- Trust-wide Policies: These policies apply across the entire Trust, establishing mandatory standards that must be adhered to by all employees. Breaches of Trust-wide policies may lead to disciplinary actions.
- Departmental Policies: These policies are specific to individual departments and outline the actions required from staff within those areas. Departmental policies must be followed by relevant employees, and failure to comply may result in disciplinary action.
- Clinical Policies: Clinical policies are specialised Trust-wide or departmental policies that focus on clinical practices and patient care. They are intended to ensure safety and high standards in clinical procedures and care delivery.

5.2 CAKE:

CAKE refers to the Trust's intranet platform, which serves as the central repository for policies and other important documents. It is accessible to all Trust staff and is used to ensure consistent communication and dissemination of information across the organisation.

5.3 STANDARD OPERATING PROCEDURES (SOP)

A Standard Operating Procedure (SOP) is a documented set of step-by-step instructions designed to help colleagues perform routine or complex tasks consistently and effectively. SOPs aim to enhance efficiency, ensure quality output, promote uniformity of performance, and reduce miscommunication. They also support compliance with regulations and standards, fostering accountability and reliability within services.

- Example: Safeguarding in the Emergency Department - SG SOP 4
- For more advice and information, please contact the relevant Clinical Governance Lead.

5.4 PROTOCOL:

A protocol is a prescriptive set of agreed rules and behaviours designed for specified situations, guiding the performance of specific activities or actions. Protocols are highly structured and do not permit individual discretion, ensuring standardised responses in clinical or operational scenarios.

- Example: Nutrition protocol for autologous stem cell transplant
- For more advice and information, please contact the relevant Clinical Governance Lead.

5.5 CLINICAL GUIDELINE:

A clinical guideline is a systematically developed statement aimed at guiding practitioner and patient decisions about suitable healthcare for specific clinical circumstances based on best practice standards (e.g., Royal College of Physicians).

- Examples can be found on Eolas: please see clinical guidelines page for more information
- For more advice and information, please refer to Clinical Guidelines Policy BHT Pol 307) or contact the Clinical Guidelines Team bht.guidelines@nhs.net

5.6 STRATEGIES

A strategy is a comprehensive plan or approach designed to achieve specific long-term goals or objectives. It outlines the direction and actions an organisation or individual will take to address challenges, leverage opportunities, and allocate resources effectively. Strategies are typically high-level, focused on overarching priorities, and serve as a framework for decision-making and operational planning.

- Example: Quality Strategy 2022-2025
- For more advice and information, please contact the Director of Strategic Delivery or Associate Director of Strategic Delivery.

6 POLICY OWNERSHIP

6.1 The author of the policy should be designated based on the role or position within the Trust, rather than the name of a specific individual. This ensures that the responsibility for the policy is clearly assigned and remains continuous, regardless of staff changes.

6.2 The designated role must have the authority, expertise, and accountability to oversee the development, implementation, and periodic review of the policy.

6.3 If the role associated with a policy changes, or becomes vacant, the department or line manager must ensure the responsibility is reassigned to an appropriate successor to maintain continuity and oversight of the policy.

7 POLICY DEVELOPMENT AND CONSULTATION

7.1 All policies should be drafted or reviewed by subject matter experts or policy authors to ensure technical accuracy and relevance.

7.2 Guidance on writing a policy, including the standard style and format, is provided in Appendix A. This section highlights key considerations for authors during policy development. Additionally, a process flowchart to assist with understanding the steps involved is provided on page 5 of this document.

7.3 Each policy should include a ‘Quick Guide’ or Flowchart immediately following the table of contents. This quick-reference guide provides an overview of the key steps and processes, helping readers understand and follow the main points at a glance.

7.4 Policies must be written in Plain English, avoiding acronyms, jargon, or unnecessarily complicated language to ensure clarity and accessibility for all readers. The focus should be on straightforward communication to enhance understanding and reduce ambiguity.

7.5 Authors must ensure that policies are evidence-based and supported by current and complete references. References should follow a consistent format, for example, Equality Act 2010: http://www.legislation.gov.uk/ukpga/2010/15/contents

7.6 Once drafted or reviewed, the policy must be sent to the Executive Lead for a final review to confirm adherence to Trust standards and governance requirements. It is not the responsibility of the Executive Lead to verify the technical details of the policy.

7.7 The consultation process should be planned in advance in agreement with the Executive Lead or authorising committee. Departments or individuals expected to implement the policy must have the opportunity to review and provide feedback on the draft.

7.8 Authors are encouraged to seek input from patients or patient representative groups where relevant to ensure the policy aligns with patient needs and perspectives.

7.9 If the policy impacts staff, the consultation process must include the Joint Management and Staff Committee. For policies specifically affecting medical staff, consultation must include the Joint Consultation and Negotiation Committee.

8 USE OF ARTIFICIAL INTELLIGENCE IN POLICY DEVELOPMENT

8.1 Artificial Intelligence (AI) may be used to support the development and review of policies within the organisation.

8.2 AI tools can assist policy authors by generating initial drafts, enhancing clarity and structure, and ensuring consistency in language, formatting, and tone. They can also support alignment with current legislation, regulatory standards (such as the Care Quality Commission, UK GDPR, and NICE guidance), and internal governance frameworks.

8.3 AI may be used to summarise complex policy content for different audiences, aiding in communication and implementation.

8.4 The use of AI does not replace the author’s professional judgement.

8.5 It is the responsibility of the policy author to ensure the accuracy, relevance, and appropriateness of the final content, and to verify that all information complies with applicable standards and organisational requirements.

8.6 It is the responsibility of all policy authors to ensure AI is used appropriately and correctly to guarantee it does not compromise personal data, business sensitive information, violate policies, or pose a risk to patient safety or our network integrity.

8.7 Under no circumstances should personal data or commercially sensitive/branding information be used in publicly available AI tools.

9 EQUALITY AND QUALITY IMPACT ASSESSMENT (EQIA)

9.1 The Equality and Quality Impact Assessment (EQIA) is a tool used to evaluate the impact of the proposed policy on quality, equality and related, connected or interdependent services.

9.2 The EQIA process must begin as soon as a policy is proposed and should be integrated into the policy development process from the outset.

9.3 Guidance on completing an EQIA is provided in Appendix B.

9.4 Key Requirements for EQIA:

- The policy author must complete Stage 1 of the Equality & Quality Impact Assessment (EQIA) workbook.
- To access the EQIA workbook, click on the Equality & Quality Impact Assessment (EQIA) Toolkit available on the Buckinghamshire Healthcare Intranet.
- The EQIA must be signed off by the Author's Line Manager or Executive Lead before submission to the EQIA panel.
- The signed EQIA should be sent to bht.eqiareview@nhs.net for review and approval prior to the TPSG meeting.
- The Regulatory Compliance Officer will submit the approved EQIA to the TPSG meeting.

9.5 No Trust-wide policy will be approved or ratified without an EQIA being submitted and approved by the EQIA Panel.

10 POLICY RATIFICATION AND APPROVAL

10.1 After completing the consultation process and incorporating feedback, the policy must be approved by the nominated responsible committee or group before submission to TPSG for final approval.

10.2 If the policy requires input from multiple committees or groups, the author should consult the Associate Chief Nurse-Director for Risk, Governance, and Compliance to determine the appropriate committee involvement. Each committee involved should review and, if appropriate, approve the policy. The committee responsible for the initial approval of each policy is determined based on the policy's content and origin.

10.3 After committee approval, the policy author must submit the policy document to TPSG with a cover paper endorsed by the lead Executive Director. The cover paper should include a summary of the consultation and approval process, key policy elements, the expected impact on risk management, corporate objectives, and standards of care, and the dissemination plan for implementing the policy across the Trust.

10.4 The policy author must clearly document the consultation dates, feedback Incorporated, and the approving committee/groups when submitting the policy to TPSG.

10.5 The policy author or a designated representative is required to attend the TPSG meeting to present the policy.

10.6 TPSG will review the policy to ensure compliance with the Trust's policy framework and may provide feedback on style, format, readability, and compliance with the Equality and Quality Impact Assessment (EQIA). TPSG will provide the following 3 decisions:

10.7 Policies related to risk management, governance, or strategic priorities may require additional approval by the Trust Board or a relevant Board Subcommittee. A detailed list of policies requiring EMC and Board-level approval is provided in Appendix C.

- If amendments are recommended by TPSG, the Regulatory Compliance Administrator will provide a summary of suggested changes. The policy author must make the necessary amendments and send the updated version to bht.policies@nhs.net. The Regulatory Compliance Administrator will review the amendments made and publish the policy on CAKE.

- If the policy is approved at TPSG, the Regulatory Compliance Administrator will publish the policy on CAKE.

- For policies requiring higher-level approval, the Regulatory Compliance Administrator will submit the policy to the EMC or Trust Board for consideration. Once ratified, the final version will be published on CAKE by the Regulatory Compliance Administrator, and the author will be informed.

10.7 Policies related to risk management, governance, or strategic priorities may require additional approval by the Trust Board or a relevant Board Subcommittee. A detailed list of policies requiring EMC and Board-level approval is provided in Appendix C.

11 GOVERNANCE FRAMEWORK

11.1 Key discussion points and final approval or ratification details for each policy must be consistently documented in the minutes of the approving committee at every stage of

the policy's path to approval. The minutes must include the policy's version number, approval date, and designated review date in alignment with information governance requirements.

11.2 Every month, TPSG will provide a report to EMC, listing all policies ratified during that period. This report will also include any approved requests for policy review extensions, allowing EMC to maintain oversight of policy approvals.

11.3 The Chief Executive Officer will include a summary of policies approved by EMC in a bi-monthly public report to the Trust Board, ensuring transparency and accountability.

12 EXTENSION REQUESTS

12.1 Authors may submit extension requests for policies that are due to lapse and cannot be reviewed or ratified within the set timeframe.

12.2 When submitting an extension request, the author must:

- Complete the Extension Request Form and the required Risk Assessment Form to evaluate the risks posed by allowing the policy to lapse.
- Clearly justify the reason for requesting the extension.

12.3 The completed Extension Request Form and Risk Assessment must be submitted to the Regulatory Compliance Officer by email at bht.policies@nhs.net

12.4 The extension request must be approved by the Executive Lead before submitting to TPSG and cannot exceed a maximum period of 6 months.

12.5 Only one extension request will be granted for any given policy.

13 POLICY DISSEMINATION AND PUBLICATION

13.1 The author is responsible for ensuring that the approved document is published on the Trust intranet and, if appropriate, on the public website. To facilitate this, the author should contact the Regulatory Compliance Administrator (bht.policies@nhs.net) to upload the document following ratification. The author must also inform the Regulatory Compliance Administrator if any amendments are made to the document to ensure it remains current.

13.2 Where feasible, procedural documents should be made accessible to the public. If the authorising committee decides not to publish a document on the Trust's public website, the decision and rationale must be recorded in the meeting minutes. Although few documents are published on the public website, they are routinely available upon request. When submitting documents to the Board or Executive Management Committee, authors must clarify the intended publication platform (intranet or website). Miscommunication regarding publication can place the Trust at reputational risk.

13.3 At the end of every month, the Regulatory Compliance Officer will ensure that the Communication Team is informed of all policies uploaded to CAKE so that they can be disseminated to all Trust users through established communication channels.

13.4 Once approved and ratified, the policy will be published on CAKE for staff access. If requested by the author or Executive Lead, the policy can also be distributed directly

to Care Group Chairs and secretaries for implementation or circulated by email to relevant staff, with a summary of key points included.

13.5 It is the responsibility of managers to ensure that their staff are aware of the policies that have been reviewed and understand any changes applicable to their roles.

13.6 The author must retain an up-to-date Word version of the policy that can be modified to accommodate users with impaired sight.

13.7 If the Trust requires a policy document to be translated, the author must provide the current Word version for this purpose.

14 REFERENCING AND ASSOCIATED DOCUMENTS

14.1 An Associated Documents table is required in all policies. This table ensures that:

- Relevant supporting documents are readily accessible.
- The policy is contextualised within the broader Trust Framework.

14.2 Internal documents relevant to the policy must be listed in the Associated Documents table, positioned at the start of the policy document (see Section 7).These documents should be directed to the CAKE **'Landing Page'** to ensure easy navigation and accessibility for readers. The PDF documents should not be embedded in the policy document.

14.3 If external document or work from other organisations is used to support the policy's evidence base, it must be included in the References section (see Section 7). Each reference should:

- Follow a consistent format.
- Be up-to-date.
- Include the full document title and, if applicable, a web link to the organisation or document.

15 REVIEW AND REVISION ARRANGEMENTS INCLUDING VERSION CONTROL

15.1 Policy documents must be reviewed at least every three years, or more frequently if necessary. The author may make minor revisions between formal reviews to correct any potentially misleading information. It is the author's responsibility to ensure that the latest version is available on the intranet or website and that relevant staff are informed of any updates.

15.2 The author must ensure that the Trust's policy register is updated with the latest version by contacting the Regulatory Compliance Administrator.

15.3 Each revision date must be recorded on the front page of the document and included in the footer on each page. The author and Executive Lead Director are jointly responsible for initiating reviews and determining if an update is minor or major. For significant updates before the next scheduled review, the review date should be adjusted accordingly. Policies should also be reviewed in response to complaints, incidents, near misses, changes in practice, or new evidence.

15.4 Each policy's version reflects the current, approved document (e.g., Version 1). Minor updates between major reviews are identified as "issues" and should be labelled incrementally (e.g., Version 1.1, 1.2, etc.). After consulting on significant changes

from a major review, the document should be reissued as the next version (e.g., Version 2).

15.5 Including a Document History Table is mandatory. This table should chronologically display all versions and changes, with each page footer indicating the version, issue, date, and reference number for transparency and tracking.

15.6 Certain Trust-wide policies may include annexes that are published separately. Each annexe must include a footer specifying:

- The associated policy's identification,
- Its own unique identifier (e.g., Annex 3) and version number,
- Date of issue.

If an annexe does not have a contents page, sections and pages should be numbered clearly (e.g., "page 6 of 27") to maintain document integrity.

16 LAPSED POLICY REVIEWS

It is crucial to ensure that all policies remain current and do not lapse. Outdated or lapsed policies can compromise compliance, risk management, and the Trust's operational effectiveness. Allowing a policy to lapse should be avoided whenever possible.

To assist with this, the Regulatory Compliance Administrator sends quarterly alerts to authors and Executive Leads, reminding them of upcoming review deadlines. However, it is ultimately the responsibility of the designated policy owner or author (assigned by role) and the Executive Lead to ensure that formal policy review and subsequent approvals or extension requests are completed before policy lapses.

Managers are accountable for supporting policy owners in meeting deadlines and addressing any barriers to timely reviews. This includes providing the necessary resources, removing obstacles, and ensuring that policy-related responsibilities are prioritised within their teams.

When revising a lapsed policy, strict adherence to version control principles is required:

- If the document requires only minor updates or no changes, the version number remains the same, and only the issue number is updated (e.g., from Version 1.1 to Version 1.2).
- If the document requires significant updates—such as those resulting from new legislation or updated practices—the version number must be incremented to reflect a new version (e.g., from Version 1 to Version 2), and the issue number resets to zero.
- If a policy has lapsed before being revised, it must go through the full formal consultation, approval, and ratification process prior to issuance.

17 EDUCATION AND TRAINING

17.1 The policy document must outline any specific education and training required, using a Training Needs Assessment (TNA). The TNA should be discussed with the Trust's Associate Director of Education, Learning, and Development to ensure alignment

with corporate training initiatives. A flowchart for this process is included in Appendix E. For instance, if the policy's content is necessary for induction, the TNA can designate it for inclusion in the Trust's corporate and mandatory training framework or local induction checklist.

17.2 Departments should encourage staff to regularly use the CAKE platform to access policies. CAKE includes an accessibility tool to assist users with visual or other accessibility needs.

18 DOCUMENT CONTROL

18.1 The Regulatory Compliance Administrator is responsible for developing and maintaining a comprehensive register of all approved Trust-wide policies. This register, published on the intranet, includes review dates to alert authors to impending reviews and assists the Trust in tracking policy progress and ownership.

18.2 The Trust-wide Policy Register is updated and published on CAKE monthly to provide an up-to-date record for all staff.

18.3 Each Care Group or Directorate is encouraged to maintain its own register of policies and procedural documents it produces. A designated Local Record Manager or Document Controller should be appointed within each Care Group. This is now a Trust policy requirement, as outlined in the Records Management Policy (BHT Pol 125), and supports compliance with the NHS Code of Practice for Records Management. The Local Record Manager is also responsible for coordinating with the Regulatory Compliance Administrator on policy updates.

19 ARCHIVING ARRANGEMENTS

19.1 It is the responsibility of the document author, or in their absence, the Lead Executive Director, to ensure that outdated versions of documents are removed from the Trust's intranet and/or website to prevent confusion and maintain currency. This can be done by emailing bht.policies@nhs.net.

19.2 The Regulatory Compliance Administrator is responsible for maintaining a local archive of all historic documents once a new version is approved. This archive is managed in accordance with the Records Management: NHS Code of Practice, which mandates that archived policies are retained for a minimum of ten years. Archived versions are preserved for potential legal or reference purposes.

19.3. If an archived policy needs to be retrieved, a formal written request should be submitted to the Regulatory Compliance Administrator, who manages the Trust Register. The Regulatory Compliance Administrator will coordinate with the relevant Departmental, Care Group, or Corporate Directorate Local Record Manager to facilitate the retrieval process.

20 MONITORING COMPLIANCE WITH AND THE EFFECTIVENESS OF POLICY

20.1 Each policy must specify how compliance will be monitored, detailing specific methods such as audits, surveys, performance management, and analysis of incidents and complaints. A mere statement that the policy is "subject to audit" is insufficient; the policy must include a clear description of the audit process, including how and when data will be collected. Prospective data collection is often required for effective auditing. Appendix D offers a range of potential Audit Methodologies.

Alternatively, you can contact the Department of Clinical Effectiveness by email (bht.cae@nhs.net), who is available for guidance.

Appendix F provides an example of the preferred tabulated monitoring and compliance tool that authors should use to document the policy's monitoring processes.

20.2 The purpose of compliance monitoring is to assess adherence to the processes outlined in each policy rather than simply measuring outcomes (e.g., the number of complaints). Assurance of compliance is typically best achieved through proactive performance or process management to confirm that each step in the policy is followed.

20.3 Each policy's compliance monitoring must include a clear plan detailing how the responsible officer(s) and the designated committee will address any gaps in compliance identified during the monitoring process. This includes defining corrective actions and follow-up measures to ensure continuous improvement and adherence.

21 MONITORING OF COMPLIANCE WITH THE PROCESSES DESCRIBED IN THIS POLICY

Minimum Requirement to be Monitored	Process for Monitoring (e.g., audit)	Responsible Individuals for Monitoring and Report Production	Frequency of Monitoring/Audit	Responsible Individuals for Receiving the Report and Developing the Action Plan	Responsible Committee for Reviewing the Action Plan	Responsible Committee for Monitoring Actions and Ensuring Satisfactory Conclusions
Assess adherence to this policy standards.	Conduct an audit of a sample of five policies approved in the previous year to assess adherence to policy standards: • Committee minutes accurately reflect the policy approval, implementation, and publication processes outlined in this document. • Each policy is registered with a unique identification number. • Compliance audits have been conducted as required.	Regulatory Compliance Officer	Annually	TPSG	Executive Management Committee (EMC)	Executive Management Committee (EMC)

Minimum Requirement to be Monitored	Process for Monitoring (e.g., audit)	Responsible Individuals for Monitoring and Report Production	Frequency of Monitoring/Audit	Responsible Individuals for Receiving the Report and Developing the Action Plan	Responsible Committee for Reviewing the Action Plan	Responsible Committee for Monitoring Actions and Ensuring Satisfactory Conclusions
	• The policy register for the sampled policies is up to date. • The policy follows the right style and format. • The policy has gone through an appropriate consultation process.					
Accuracy of Trust policy register.	Audit	Regulatory Compliance Administrator	Monthly	Chair of TPSG	Executive Management Committee (EMC)	Executive Management Committee (EMC)

APPENDIX A: 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 current 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. Underlined and italic text should be avoided.

4. Policies must be written in Plain English, avoiding acronyms, jargon, or unnecessarily complicated language to ensure clarity and accessibility for all readers. The focus should be on straightforward communication to enhance understanding and reduce ambiguity.

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

6. 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.

7. 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 B).

8. 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.

9. 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.

10. If your document contains any medicines content, you must ensure this is checked by the Medicines Resource Centre (bucks.medicinesresourcecentre@nhs.net).

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

12. The consultation process should be planned in advance and agreed with the Executive Director or committee authorising the policy.

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

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

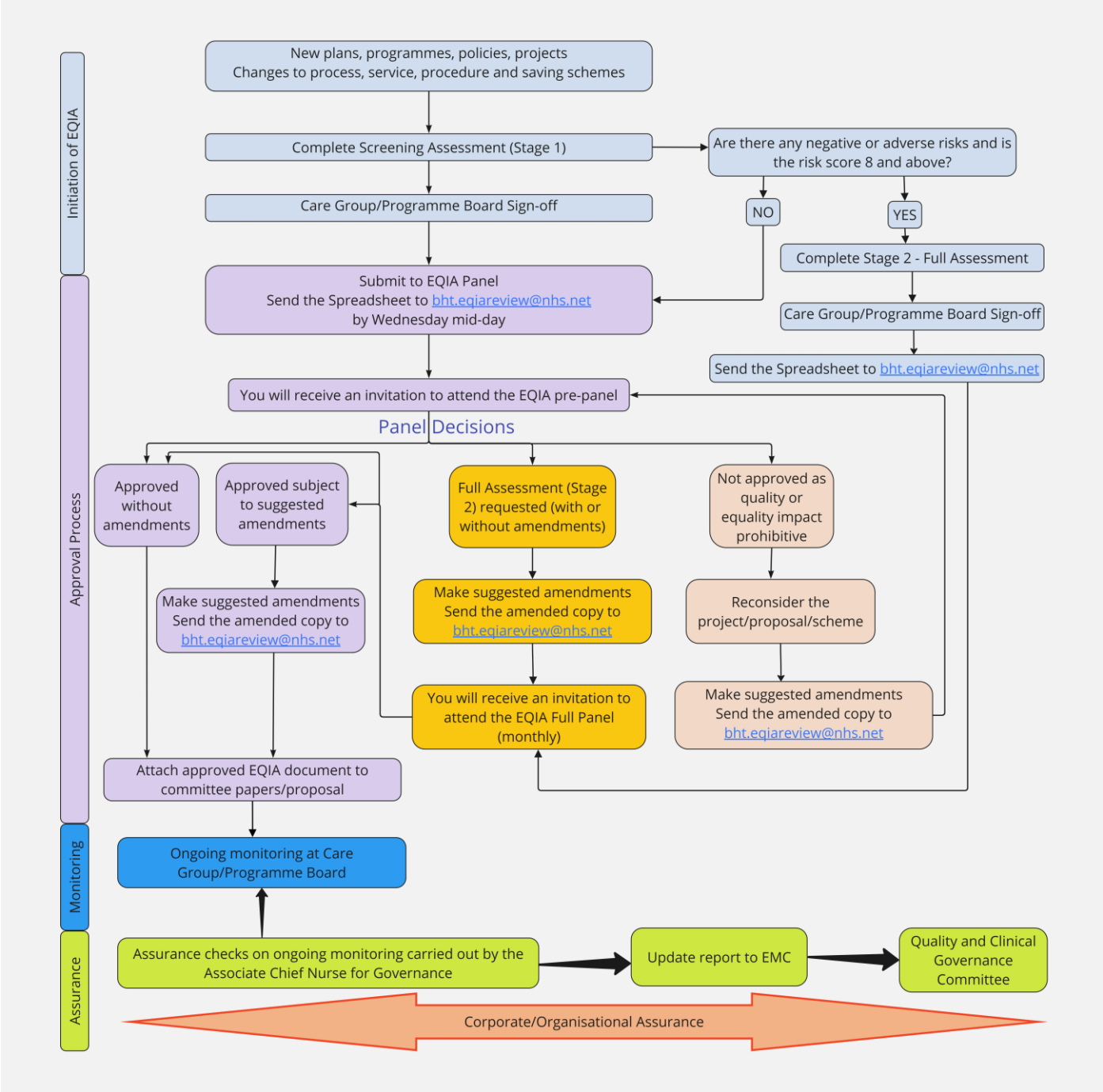
15. Remember that there will be open access to your document by the general public, if not on the website, then through any request.

APPENDIX B: EQUALITY AND QUALITY IMPACT ASSESSMENT (EQIA)

All public bodies have a statutory duty under The Equality Act 2010 (Statutory Duties) Regulations 2011 to provide “evidence of analysis it undertook to establish whether its policies and practices would further, or had furthered, the aims set out in section 149(1) of the [Equality Act 2010]; in effect to undertake Equality Impact Assessment (EIA) on all procedural documents and practices.

The EQIA uses an approach which tests the impact of a proposed policy on the following areas: effectiveness of quality in patient care, patient safety and patient experience along with the impact of the change of other parts of the health and social care system. It seeks to ensure that fairness and accessibility are underpinning planning and provision by ensuring the Policy Lead considers the likely impact of the policy on different communities/groups.

EQIA Process Flowchart



When completing an Equality Impact Assessment (EQIA), please use the following resources available on the intranet or contact the Trust EQIA Panel for further assistance at bht.eqiareview@nhs.net.

Equality Impact Assessment Form:

- https://bucks-intranet.wehp.co.uk/documents/equality-impact-assessment-eqia-toolkit-form-for-policies/

Guidance on Equality Impact Assessments:

- https://intranet.buckshealthcare.nhs.uk/documents/eqia-guidelines/

APPENDIX C: POLICY APPROVAL AND RATIFICATION

Table 1 – approving/ratification groups

Group name	Administrator & Chair	Frequency & *Submission sheet requirements*	Type of Documents (not exhaustive)
Trust Board	**Admin:** Senior Board Administrator **Chair:** Trust Chair	Monthly *Submission sheet required.*	**RATIFIES:** Policies the Board decides to reserve to itself. Assurance policies
Executive Management Committee (EMC)	**Admin:** Senior Board Administrator **Chair:** Chief Executive	Three a month *Submission sheet required*	**RATIFIES:** All Trust-wide Strategies. All Policies requiring Board or Committee approval
Trust-wide Policy sub Group (TPSG)	**Admin:** Regulatory Compliance Administrator **Chair:** Associate Chief Nurse-Risk, Governance and Compliance	Monthly *Submission sheet required.*	**FINAL CONSULTATIONS:** All Trust-wide Policies

Table 2 – stakeholder groups

Group name	Administrator & Chair	Frequency & Submission sheet requirements	Type of Documents (not exhaustive)
Nursing & Midwifery Allied Health Professional Board (NMAHPB)	**Admin:** Executive Assistant for Chief Nurse **Chair:** Chief Nurse	Monthly *Submission sheet required.*	Trust-wide documents regarding nursing, Patient involvement, Patient Information, Policies about patient access, Patient management, Child Protection Policies.
ICS Medicines, Safety and Quality Group	**Admin:** PA to Chief Pharmacist *(Currently at CCG)* **Chair:** Associate Medical Director - Pharmacy	Bi-Monthly *Submission sheet required.*	All medicines policies and guidelines.
Clinical Effectiveness Group	**Admin:** Clinical Guidelines Facilitator **Chair:** Head of Medical Quality	Monthly *Submission sheet **not** required.*	Monitors Trust Clinical Guideline activity. with or without Medical content. It does not approve Clinical Guidelines, policies or leaflets.
Health & Safety Committee	**Chair:** Property Services Risk Manager	Quarterly *Submission sheet required.*	• Risk Management policies • Health and Safety policies • Medical Devices Policies
Health Records Committee	**Admin:** Head of Medical Records **Chair:** Associate Medical Director - Pharmacy		• Medical records policies. • Some Info Governance Policies

Group name	Administrator & Chair	Frequency & Submission sheet requirements	Type of Documents (not exhaustive)
Infection Prevention Control Committee	**Admin:** IPC Administrator **Chair:** Director IPC	Every 3rd Quarter. *Submission sheet **not** required*	Infection Control Manual • Infection Control Policies and Strategy • IPC Clinical Guidelines
Patient Safety Board (PSB)	**Admin:** Quality Governance Officer, Patient Safety Team **Chair:** Chief Nurse/Deputy Chief Nurse	Monthly *Submission sheet **not** required.*	Trust-wide documents regarding patient safety. Policies and guidelines about patient access and management.
HR and Workforce Committee	**Admin:** PA to Chief People Officer **Chair:** Chief People Officer	Monthly	**Review:** risk register, policy register - proposed major changes, audits, HR metrics, CQC and legislative change, consultations, actions arising from key meetings/steering groups.
Joint Management & Staff Committee (JMSC)	**Admin:** PA to Chief People Officer **Chair:** Chief People Officer (or nominated representative)	Monthly	Consultation and communication meeting: management and staff-side, also the policy approval committee (Trust-wide and AfC policies).
Joint Consultation and Negotiation Committee (JCNC)	**Admin:** Medical HR Coordinator **Chair:** Alternates between Chief People Officer and LNC Lead (or nominated representative)	Bi-Monthly	Medical & Dental consultation and communication meeting: management and staff-side, also the policy approval committee (Medical and Dental policies).
Caldicott & Information Governance Committee	**Admin:** Information Governance Manager **Chair:** Consultant Orthodontics	Quarterly Submission sheet not required.	Information Governance Policies. IT Policies Some Training Policies
Venous Thromboembolism Group (VTEC)	**Admin:** No Admin Support **Chair:** Head of Medical Quality	Quarterly Submission sheet not required.	**CONSULTATION:**
Medical Devices Committee (MDC) **New Clinical Procedures Committee (NCP)**	**These meetings have been incorporated into the 'Safety of Medicines and Medical Devices and New Clinical Procedures (SMDP) Group'** **Admin:** PA to CMO Office **Chair:** Deputy Chief Medical Officer	Bi- monthly No submission sheet required	**APPROVES:** • Medical Devices Policies • New Clinical Procedures • Medicine Policies • Patient Group Directions (PGD) • Patient Specific Directions (PSD)
Antimicrobial Stewardship Group (ASG)	**Admin:** Antimicrobial Stewardship Support/PA **Chair:** Consultant Medical Microbiologist	5 times per year (every 12 weeks) Submission sheet not required.	Approves relevant policies and Clinical Guidelines

APPENDIX D: 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. 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	A process audit evaluates the steps taken in a particular process, focusing on how tasks are carried out, rather than on whether they meet a specific standard.
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 a criterion audit.
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.

Methodology	Description
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.
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.

APPENDIX E: TRAINING NEEDS WITHIN A POLICY

When planning the training, ensure that any training required is accessible to all attendees and that reasonable adjustments are made in advance and on the day of the training to accommodate individual needs.

Training Activity/ Topic: (Please enter course name)	**Response**
Have you informed bht.learning.development@nhs.net that your policy includes a training section?	
Have you provided details to bht.learning.development@nhs.net 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 bht.learning.development@nhs.net for recording onto ESR for reporting and evidence purposes?	
Are these records audited and by whom?	

APPENDIX F: Monitoring and Compliance Table/Template

(Completed Example)

Minimum requirement to be monitored	Process for monitoring e.g. audit	Responsible Individuals to undertake monitoring and production of a report.	Frequency of monitoring / audit	Responsible individuals receiving the monitoring report and for development of action plan.	Responsible committee for review of action plan	Responsible committee for Monitoring of action and audit to ensure satisfactory conclusions.
Timely completion of incident reporting	Review of incident reporting logs against defined timeframes	Risk Management Team	Monthly	Risk Manager	Risk Management Committee	Governance Committee
Equipment maintenance compliance	Review of maintenance logs and records of scheduled servicing	Facilities Manager	Annually	Head of Estates and Facilities	Health and Safety Committee	Health and Safety Committee
Fire safety compliance	Audit of fire drills, equipment checks, and staff training records	Fire Safety Officer	Biannually	Fire Safety Manager	Health and Safety Committee	Health and Safety Committee
Timely review, approval, and publication of Trust policies	Quarterly audit of the policy register to check for lapsed or overdue policies and adherence to review schedules	Regulatory Compliance Administrator	Quarterly	Associate Chief Nurse - Director for Risk, Governance, and Compliance	Executive Management Committee (EMC)	Executive Management Committee (EMC)

APPENDIX G TERMS OF REFERENCE

TO BE ATTACHED ONCE APPROVED