NHS
Mid Essex
Clinical Commissioning Group

Policy Development, Management and Review Policy
ME CCG Policy Reference:
MECCG13

THIS POLICY WILL BE APPROVED BY THE CCG BOARD, AND WILL HAVE EFFECT AS IF INCORPORATED INTO THE CONSTITUTION AS PART OF THE SCHEME OF DELEGATION.

Target Audience	Board members, sub-committee members and all staff working for, or on behalf of, the ME CCG
Brief Description (max 50 words)	This policy sets out the principles by which the Mid Essex Clinical Commissioning Group will develop, manage and review all policies and associated documentation.
Action Required	Once the policy has been approved it will be made available to all staff via the Intranet.

Document Information

Version	2.1
Accountable Executive	Chief Operating Officer
Responsible Post holder/Policy Owner	Director of Nursing and Quality
Date Approved	11th March 2014
Approved By	Quality and Governance Committee and then approved by the Mid Essex CCG Board on 27th March 2014
Review Date	March 2022 (Agreed at Audit Committee 23 Feb 2021 to extend the review date for this policy to March 2022)
Stakeholders engaged in development/review	Risk Manager/ Business Manager Rep/ Admin Officer rep/ Performance Lead/ Corporate Business Manager /Clinical Quality Lead/ Authorisation Lead/ Operational Executive Committee
Equality Impact Assessment	**EQUALITY IMPACT ASSESSMENT** This document has been assessed for equality impact on the protected groups, as set out in the Equality Act 2010. This Policy is applicable to the Board, every member of staff within the CCG irrespective of their age, disability, sex, gender reassignment, pregnancy, maternity, race (which includes colour, nationality and ethnic or national origins), sexual orientation, religion or belief, marriage or civil partnership, and those who work on behalf of the CCG

Amendment History

Version	Date	Reviewer Name(s)	Comments
1.0	July 2013	Governance and Corporate Team, CE CSU	Escalation process updated within Policy Statement 4 (Item 7 page 10)
1.1	February 2014	Governance and Corporate Team, CE CSU on behalf of the Director of Nursing	Policy updated in line with planned review to produce version 2.
2.0	April 2014	Governance and Corporate Team, CE CSU on behalf of the Director of Nursing	Policy amended to incorporate comments from the Quality and Governance Committee. Version number changed to 2.1

This policy progresses the following Authorisation Domains and Equality Delivery System (tick all relevant boxes).

Clear and Credible Plan		Collaborative Arrangements	
Clinical Focus and Added Value		Engagement with Patients/Communities	
Commissioning processes	**x**	Leadership Capacity and Capability	**x**
Equality Delivery System	**x**	NHS Constitution ref	

Glossary

Term	Definition
Accountable Executive	CCG Executive accountable for development, implementation and review of the policy
Policy Owner	Post holder responsible for the development, implementation and review of the policy
Document definitions	These are provided in Section 1

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Policy Overview:

1. ME CCG Board will develop a range of policies to enable it to deliver the functions and duties of the organisation and will clearly define the requirements of policies and other documents.
2. ME CCG Board will identify those policies which require governing body approval and establish a scheme of delegation for development and approval of policies.
3. Board sub-committees will establish arrangements for allocation, review, management and approval of policies that have been delegated.
4. All policies will have a designated owner within the ME CCG.
5. Policies will have a clear target audience and will be developed in conjunction with the relevant stakeholders, including patient groups and third party organisations if appropriate.
6. Policies will be incorporated into the core business of the ME CCG.
7. CCG policies will be accessible to all interested parties and only held in one place.
8. Procedures for the delivery of the policy will be clearly identified as such and either signposted within the body of the policy or attached as an appendix or hyperlink.
9. Policies will have a clear and costed implementation plan attached as an appendix together with an appendix detailing the proposed audit arrangements.
10. Policies will be drafted in a standardised format.

**POLICY STATEMENT 1:
THE BOARD WILL DEVELOP A RANGE OF POLICIES TO ENABLE IT TO DELIVER THE FUNCTIONS AND DUTIES OF THE ORGANISATION AND WILL CLEARLY DEFINE THE REQUIREMENTS OF POLICIES AND OTHER DOCUMENTS**

1. The Mid Essex Clinical Commissioning Group (ME CCG) has defined its high level functions in the Constitution that it has adopted. Section 5.1 of the Constitution (version 2.7) states

   The Board will from time to time agree and approve Policy statements/ procedures which will apply to all or specific groups of staff employed by the group. The decisions to approve such policies and procedures will be recorded in an appropriate Board minute and will be deemed where appropriate to be an integral part of the group's Standing Orders and Standing Financial Instructions.

2. In developing policies the ME CCG Board will take into account

   - Primary legislation – Health and Social Care Act 2012; The Equality Act 2010
   - Secondary guidance – The Functions of Commissioning Groups *(DH, Gateway ref 17005, June 2012);* and
   - Formal guidance – not applicable for this policy

3. New or fully revised policies will be commissioned either by the ME CCG Board or by the relevant ME CCG Sub-committee, as set out in the schedule of delegation within this policy at Section 2 and must be submitted for approval by the ME CCG Board.

4. The ME CCG Board and employees will adopt the standard definitions of documents across the organisation

   - **A 'policy'** is a comprehensive statement that sets out the ME CCG position and governing principles with regard to a specific area of work. A 'policy' must be followed by all staff, and is enforceable by management. It may include instructions that must be followed, or prohibit certain behaviour. No member is authorised to deviate from Trust policy in all but the most extreme circumstances. Deviation from a particular procedure within a policy can occur and such circumstances are described in the paragraph below.

   - **A 'procedure'** is a recommended way of working for staff to follow, usually based on evidence of good practice. Procedures are contained within policy documents, usually as an appendix. A member of staff may depart from a 'procedure' only where they; 1) feel it is an inappropriate procedure to follow in the particular and usually extraordinary circumstances they face AND 2) can

provide and record documentary evidence to show that the procedure is not appropriate, or that an alternative approach should be taken AND 3) have authority to depart from that procedure by management approval through a formal variation request to the Accountable Executive.

- **A 'strategy'** sets out a plan of action to meet specific goals. Strategies will usually be developed to support and implement long term or organisational goals, and will be approved by the ME CCG Board

- A **'guideline'** is a document which details rules or principals that provides guidance for practitioners and others in their clinical or managerial decision making. It allows choices to be made about how standards are achieved and about appropriate actions or behaviour in a given circumstance. Documentation to support the reasons for variance from the guideline would need to be completed and supported by evidence.

5. This glossary of terminology is not universal and other agencies may use different terminologies. For example, the word "protocol" is in wide use within the NHS, both in terms of clinical procedure & inter-agency agreement. Similarly, the word "policy" has been widely used within NHS organisations and often applied to matters that are (within this terminology) "procedures".

   For the purposes of ME CCG policy development, management & review, a protocol will be regarded as a type of procedure.

POLICY STATEMENT 2:
THE ME CCG BOARD WILL IDENTIFY THOSE POLICIES WHICH REQUIRE GOVERNING BODY APPROVAL AND ESTABLISH A SCHEME OF DELEGATION FOR DEVELOPMENT AND APPROVAL OF POLICIES

1. Prime Financial Policies will be approved :
   - by the Board and
   - and have effect as if incorporated into the Constitution

2. Policies relating to procurement will:
   - Be commissioned by the Finance and Performance Committee.
   - Be reviewed by the Audit Committee and
   - approved by the Board and
   - Have effect as if incorporated into the CCG Constitution.

3. Financial procedures and any subsequent amendments will be:
   - commissioned by the Finance and Performance Committee and
   - reviewed and approved by the Audit Committee

4. Policies relating to Risk Management will be:
   - commissioned by the Operational Executive and
   - reviewed by the Transformation and Delivery Committee and
   - approved by the Board

5. Human Resource Policies applying to all groups of staff will be:
   - commissioned by the Operational Executive and
   - approved by the Board,

6. Policies which involved substantial external consultation or which are likely to attract media attention will be approved by the Board

7. The responsibility for policy review will be delegated to a ME CCG Board Sub-committee as in the schedule below. The Sub-committee will have the delegated power to review and make recommendations to the Board for adoption the policy. During the transition period and first year of operation of the ME CCG, that recommendation should determine whether the approval of any further revision of the policy can be delegated to the sub-committee.

Sub-committee	Policy Area delegated (Abbreviations shown for referencing)
Operational Executive	All policies associated with: Human Resources (HR); Emergency Planning (EP); Risk Management (RM); Communications (Comm) (including media and website) Corporate Governance (CG) (including Business Continuity and Legal Framework)
Quality	All policies associated with: Safeguarding (SG);

	Information Governance (IG); Health and Safety and associated secondary legislation (H&S); Complaints and PALS; Patient Safety (PS) (including incident reporting)
Audit	All policies associated with: Financial transactions or accounting processes; (FIN) Procurement (inc Competition Disputes) (Proc) Claims Policy; Standards of Business Conduct;
Transformation and Delivery	Clinical Priorities Policy (including Service Restrictions); Patient Engagement Strategy and Policy; Sustainable Development Policy;

8. In discharging its responsibilities, the ME CCG Operational Executive Committee will adopt a "portfolio" approach in which individual executives lead on and are accountable for policy areas. In terms of policy development, management & review these portfolios are summarised below:

Executive	**Policy area for which they are accountable**
Accountable Officer	Health & Safety
Chief Operating Officer	Policy Development and Review Corporate Governance Emergency Planning & Business Continuity Sustainable Development Human Resources IM&T and Information Governance
Chief Financial Officer	Financial Management & Accounting Risk Management Security Management Procurement Provider Performance
Assistant Director of Clinical Quality/ Executive Nurse	Safeguarding (children & vulnerable adults) Patient Safety (including Incident Reporting) Patient Experience (including PPE, PALS and Complaints) Clinical Quality
Medical Director	Caldicott Guardianship Research & Development (RD) Education & Training (ET) Clinical Engagement

9. A schedule of policies and allocation /review dates will be maintained by the CE CSU Governance and Corporate Team.

POLICY STATEMENT 3:
BOARD SUB-COMMITTEES WILL ESTABLISH ARRANGEMENTS FOR ALLOCATION, REVIEW, MANAGEMENT AND APPROVAL OF POLICIES THAT HAVE BEEN DELEGATED

1. The Board Sub-committee chair will maintain a standing agenda item for “Policy Review and Updates”, and with the assistance of the Corporate Business Manager, plan agendas to ensure that all policies associated with that committee are reviewed in a timely manner.

2. The Accountable Executive will identify an appropriate person as the policy owner. The policy owner will be responsible for the development, implementation and review of the policy and will possess the appropriate competence, experience and authority in order to achieve this.

3. The Board Sub-committee will recommend to the Board the review period for each policy associated with that committee.

4. The Accountable Executive will advise the policy owner of the appropriate approval process and ensure that the policy is discussed and recorded at a full meeting of the Sub-committee in the presence of the policy owner.

5. The Chair of the Board Sub-committee will report the key points of the discussion and recommendations (in an appropriate level of detail) to the ME CCG Board in Part 1.

6. The Sub-committee secretary will ensure that the latest approved version of a policy is provided in the required format to the Corporate Business Manager and recorded in the ME CCG central register, under configuration control.

7. The Corporate Business Manager will ensure that the document is fully compliant with the ME CCG requirements before being placed on the website.

8. Where the policy owner is unable to complete the work of review prior to the expiry date, they will notify both the Chair of the relevant Sub-committee and their line manager (if different.)

9. The Accountable Executive will be responsible for reporting this delay to the Operational Executive and the Corporate Business Manager, and proposing to the Sub-committee chair any interim extension to the policy if required.

10. Where the policy is delegated to the Operational Executive, then any delay in the review process and the proposal for interim extension must be notified to the Chair of the Board, together with the proposal for managing the delay.

POLICY STATEMENT 4:

ALL POLICIES WILL HAVE A DESIGNATED OWNER WITHIN THE CCG

1. The policy owner will be responsible for the drafting and review of the policy, in collaboration with appropriate and knowledgeable members of the ME CCG, ensuring that it is compliant with the law, regulation, guidance or best practice in place from time to time, and accurate and fit for purpose,

2. The policy owner will also identify any requirement for change as the result of emerging guidance, policy or legislation.

3. The policy owner will identify the target audience for a policy and the stakeholders, including patients, carers and partner organisations that need to be involved in development or review of the policy.

4. The policy owner will complete an Equality Impact Assessment and discuss any issues arising with the Accountable Executive and Sub-committee chair before submitting as part of the draft policy for approval

5. The policy owner will complete the Policy Approval Checklist and submit with the draft policy for approval;

6. The policy owner will complete an Implementation and Training Plan to identify actions that need to be taken, and by whom, to ensure proper awareness and application of the policy. This may include a range of issues such as:

   - the requirement to incorporate into mandatory training, or team training
   - the revision of contracts
   - Changes to current ME CCG practice.

7. Two months before a policy is due to be reviewed, the Governance and Corporate Team from the Commissioning Support Unit (CSU) will send a reminder to the Policy Owner that the policy is due for review.

   Reminders will be sent out at two weekly intervals and Policy Owners should advise the Governance and Corporate Team of their progress during this two month period. If, three weeks before the policy review date expires, no contact has been made by the Policy Owner, the Governance and Corporate Team will escalate to the Policy Owner's Line Manager, if no response after 7 days from the Line Manager, escalation to the relevant Director, and if no response after a further 7 days from the Director, escalation to the Chief Operating Officer.
   If a progress update has been received by the policy owner but the policy owner is unable to commit to their policy being reviewed by the deadline, their Line Manager will be made away of the status of the policy. The policy owner

must give the Governance and Corporate Team a clear indication of the progress made and when the policy will be reviewed by.

Any policy which has not been reviewed by the due date **will be removed from the Intranet** and the relevant Director and Policy Owner informed. The ME CCGs policies and procedures form the basis of corporate governance and therefore it is essential that they are up to date and meet certain minimum standards. There are both legal and patient safety implications to individuals and the ME CCG if policies and procedures are out of date. It is essential to have up to date and effective policies and procedures, which incorporate current guidelines and best practice.

8. Where minor amendments to policy are required, the policy owner will amend the document and notify the Accountable Executive and Sub-committee chair, which may choose to ratify the amendment to the policy. A maximum of three amendments can be made within the life of the policy without a formal review.

9. The policy owner will notify the Corporate Business Manager all those whose work is affected by any minor revisions to the policy of the nature of that revision

10. Where a policy owner's post is vacant at the point of the review being due, the Accountable Executive will inform the Sub-committee chair and Operational Executive and agree the most appropriate course of action.

POLICY STATEMENT 5:

POLICIES WILL HAVE A CLEAR TARGET AUDIENCE AND WILL BE DEVELOPED IN CONJUNCTION WITH THE RELEVANT STAKEHOLDERS, INCLUDING PATIENT GROUPS AND THIRD PARTY ORGANISATIONS IF APPROPRIATE

1. The Accountable Executive and policy owner will identify the requirement for the policy to be maintained, developed or revised by linking it to the relevant primary and secondary legislation and guidance.

2. As a minimum, each policy must be reviewed at least once every three years. New policies will be reviewed after one year.

3. The policy owner will define the stakeholder map for each policy, and consider the implications of the proposed policy under the Equality Act to ensure that those people or organisations which need to take account of the policy are included in the development or review process. This may include representatives from

    a. Patients and service users, including carers and those defined as having protected characteristics
    b. Member practices
    c. Commissioning Support Unit staff
    d. Any Providers where applicable.

4. The policy owner and will ensure that each individual participant within the review has fully considered whether they have a conflict of interest that must be declared, in accordance with the ME CCG Standards of Business Conduct policy. In the event of any doubt or concern, the policy owner will inform the Accountable Executive of the facts of the matter. Substantive or potential matters of concern will be reported to the Sub-committee when it considers the policy.

5. The role of patient and/or carer representatives in the review of policy will be clearly defined, and support given to ensure the views of vulnerable groups are adequately represented.

POLICY STATEMENT 6:

POLICIES WILL BE INCORPORATED INTO THE CORE BUSINESS OF THE CCG

1. The policy owner will liaise with the relevant ME CCG members and staff, the Commissioning Support Unit or other relevant organisations to incorporate the policy into contracts where applicable and agree the relevant monitoring or audit plan

2. The ME CCG Board will agree a core suite of policies that must be incorporated into the specification for any clinical procurement, and the Operational Executive Committee will agree a standardised means of evaluating the tender responses against those requirements

3. The Commissioner lead on any procurement project will identify any additional policy or legislation that affects a specific planned procurement, and the evaluation of that requirement.

POLICY STATEMENT 7:

MECCG POLICIES WILL BE ACCESSIBLE TO ALL INTERESTED PARTIES AND ONLY HELD IN ONE PLACE

1. All relevant policies lodged in the central register will be published on the ME CCG website and be available to the public.

2. The Corporate Business Manager, in conjunction with the policy owner, will contact all staff and Board Members to advise of the publication of a new or revised policy, and to remind each individual of their responsibility to familiarise themselves with the policy.

3. If a policy has passed its review date, and the Operational Executive has not agreed an extension date, will be removed from public display on the website.

4. The CE CSU Governance and Corporate Team (or nominated deputy in their absence) can publish or remove policies on the website in accordance with the content of this policy

5. Once a policy has been replaced or been made redundant, it will be placed in an electronic archive maintained in accordance with DH Retention of Records standards by the CE CSU Governance and Corporate Team or nominated deputy.

POLICY STATEMENT 8:

PROCEDURES FOR THE DELIVERY OF THE POLICY WILL BE CLEARLY IDENTIFIED AS SUCH AND EITHER SIGNPOSTED WITHIN THE BODY OF THE POLICY OR ATTACHED AS AN APPENDIX

1. In general, detailed procedures that are subsidiary to ME CCG policies should **not** be incorporated within the policy documents, nor created as separate policy documents.

2. Where the policy owner and approving Sub-committee believe it is in the public interest to publish a procedure that is in place to enable the policy to be delivered, this should not be included in the main body of the document, except in summary form, but included either as
   - an appendix to the policy
   - a hyperlink to another website (eg Essex Safeguarding procedures)

3. Where the procedure is for a specific departmental task, then it should be referred to within the policy as a Standard Operating Procedure (SOP) and the SOP maintained and updated within the department concerned. (eg a financial accounting procedure)

4. Where the procedure for applying the policy is expected to be applied across multiple organisations, then those organisations will be required to include both the policy and procedure in the appropriate section or schedule of any contract, multi-agency agreement or "transfer of funding" document.

POLICY STATEMENT 9:

POLICIES WILL HAVE A CLEAR AND COSTED IMPLEMENTATION PLAN ATTACHED AS AN APPENDIX, TOGETHER WITH AN APPENDIX DETAILING THE PROPOSED AUDIT ARRANGEMENTS

1. The policy owner will consider with stakeholders the most appropriate implementation plan for any new or substantially revised policy. In doing this they will identify who will be responsible for any action within or across organisations, and agree with them a reasonable timescale.

2. The policy owner will identify the associated resources necessary to achieve effective implementation – whether that be time or money or specialist resource (such as facilitators for workshops or legal advice) – and validate these with the Finance Department

3. The policy owner will agree with the relevant approving committee a dissemination and training plan where there has been substantial change to the policy, or where the application of the policy is seen through audit or observation to be deficient.

4. The Accountable Executive will identify with the Operational Executive any resources required to implement a policy.

5. The policy owner will be required to monitor or audit the implementation plan at an agreed date and provide feedback to the Accountable Executive.

6. The Accountable Executive and policy owner will be required to attend and report to the relevant Sub-committee the outcome of any audit of the policy.

POLICY STATEMENT 10:

POLICIES WILL BE DRAFTED IN A STANDARDISED FORMAT

1. Each ME CCG Policy will be allocated a unique identifier, using the conventions set out below:

   MECCG /unique policy number

2. Policy documents will be produced in Arial font size 12 and have a paginated index

3. All pages will be numbered, and contain a footer in font size 10 showing the Policy reference/ version number and date approved/date for review

4. Abbreviations may be used, but full details must be given in the first instance followed by the abbreviation in brackets. The abbreviation and full detail should be included in the glossary.

5. The glossary will be included at the front of the policy as part of the Document Information Summary

6. The front sheet for all policies will be as set out in Appendix A to this policy *(see this front sheet for example)*

7. The format for the Policy Approval Checklist for policies is included as Appendix B to this policy

8. The format for the Implementation and Training plan is set out as Appendix C to this policy

9. All policies will be informed by an Equality Impact Analysis which will consider the effect of the policy on the organisation and population that it serves.

APPENDIX A – POLICY FRONT SHEET

Title of Policy
MECCG Policy Reference:
MECCG (Reference number allocated)

Brief Description (max 50 words)	
Target Audience	
Action Required	

Document Information

Version Number	
Accountable Officer	
Responsible Officer/ Policy Owner	
Date Approved	
Approved By	
Review Date	
Stakeholders engaged in development or review	
Equality Impact Assessment	**EQUALITY IMPACT ASSESSMENT** This document has been assessed for equality impact on the protected groups, as set out in the Equality Act 2010. This Policy is applicable to the Board, every member of staff within the CCG irrespective of their age, disability, sex, gender reassignment, pregnancy, maternity, race (which includes colour, nationality and ethnic or national origins), sexual orientation, religion or belief, marriage or civil partnership, and those who work on behalf of the CCG

Amendment History

Version	Date	Reviewer Name(s)	Comments

This policy progresses the following Authorisation Domains and Equality Delivery System (tick all relevant boxes).

Clear and Credible Plan		Collaborative Arrangements	
Clinical Focus and Added Value		Engagement with Patients/Communities	
Commissioning processes		Leadership Capacity and Capability	
Equality Delivery System		NHS Constitution ref	

Associated Policy Documents

Reference	Title

Glossary

Term	Definition

Appendix B
Checklist for Approval of Policy – (To be removed in Finalised Version)

To be completed by Policy Owner and attached to any document which guides practice or organisational approach when submitted to the appropriate committee for consideration and approval.

	Title of document being reviewed:	**Yes/No/ Unsure**	**Comments**
1.	**Title**		
	Is the title clear and unambiguous?	Y	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Y	
2.	**Rationale**		
	Are reasons for development of the document stated?	Y	
3.	**Development Process**		
	Are people involved in the development identified?	Y	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Y	
	Is there evidence of consultation with stakeholders and users?	Y	
4.	**Content**		
	Is the objective of the document clear?	Y	
	Is the target population clear and unambiguous?	Y	
	Are the intended outcomes described?	Y	
	Are the statements clear and unambiguous?		
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Y	
	Are key references cited?	Y	
	Are the references cited in full?	Y	
	Are supporting documents referenced?	Y	
6.	**Approval**		
	Does the document identify which CCG committee/group will approve it?		
	If appropriate have third party organisations approved the document? (ie Staff Side bodies for HR matters/ partners for joint documents)	N/A	
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Y	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	Does the plan include the necessary training/support to ensure compliance?	N/A	
8.	**Document Control**		
	Does the document identify where it will be held?	Y	
	Have archiving arrangements for superseded documents been addressed?	Y	
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	N/A	
	Is there a plan to review or audit compliance with the document?	Y	
10.	**Review Date**		
	Is the review date identified?	Y	
	Is the frequency of review identified? If so is it acceptable?	Y	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the documentation?	Y	
12	**Equality Impact Assessment (EIA)**		
	Has an equality analysis been undertaken in preparation for this policy?	Y	
	Has the Accountable Executive undertaken a review, and signed off any mitigating actions to reduce any impact on protected groups?	N/A	

Accountable Executive Approval			
If you are happy to approve this document, please sign and date it and forward to the chair of the committee/group where it will receive final approval.			
Name		Date	
Signature			
Sub-Committee /Board Chair Approval			
If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.			
Name		Date	
Signature			

Appendix C – Implementation and Training Plan

Target Group for initial awareness or training *(add rows if required)*	Training Method	Individual/ Team responsible for training	Target date for commence ment	Target date for completion	Resources Required	Method of Updating awareness during life of policy

Appendix D Monitoring Statement

Aspect of the policy to be monitored	Monitoring Method	Individual/ Team responsible for the monitoring	Frequency	Group/ Committee that will receive the findings/monitor ing report	Actions taken by the Group/ Committee