MANAGEMENT OF POLICIES, PROCEDURES AND OTHER WRITTEN CONTROL DOCUMENTS

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To ensure that you are always using the latest version please refer to the online issue.

Disclaimer

Powys Teaching Health Board is the operational name of Powys Teaching Local Health Board

Version Control:

Version	Summary of Changes/Amendments	Issue Date
1	Initial Issue	Oct 2003
2	Reviewed following change from Trust to Local Health Board	Jan 2004
3	Reviewed and updated following Organisational changes	Jun 2009
4	Reviewed and further minor updates made following departmental changes	Aug 2010
5	Interim adjustments pending confirmation of organisation restructure	Aug 2013
6	Full review and update undertaken to meet Internal Audit recommendations and organisational restructure. Clarification of responsibilities and approval routes.	Dec 2014
7	Recoded CGP 004 (Previously CP 012)	Dec 2017
8	Full review and update	Nov 2022

Contents	**Page**

Engagement & Consultation

Key Individuals/Groups Involved in developing this document

Role / Designation
Corporate Governance Officer
Head of Governance

Circulated to the following for consultation

Date	Role / Designation
15/11/22	Executive Team

Evidence Base
Please list any National Guidelines, Legislation or Standards for Health Services in Wales relating to this subject area? This Policy has taken into consideration all national guidance and legislation. This Policy takes account of the Standards for Health Services in Wales and underpins Standard 1 Governance and Accountability.

Impact Assessment Summary

Equality Impact Assessment Summary

	No impact	Adverse	Differential	Positive
Age	X			
Disability	X			
Gender	X			
Race	X			
Religion/ Belief	X			
Sexual Orientation	X			
Welsh Language		X		
Human Rights	X			

Statement

This document been developed to support PtHB employees in the development and implementation of policies, procedures and other written control documents. It has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, gender, sexual orientation, race, religion / belief or human rights.

PtHB does not routinely translate all its policies and other written control documents into Welsh, there is therefore an impact on staff for whom, Welsh is the first language.

A redacted version will be uploaded to the internet in Welsh and English. The procedural sections apply to staff not the general public.

Risk Assessment Summary

Have you identified any risks arising from the implementation of this policy / procedure / written control document?

No. This policy and procedure have been developed to reduce / manage risks to the organisation, by ensuring that there is a robust system in place for Powys teaching Health Board to deliver its aims, objectives, responsibilities and legal requirements transparently and consistently. Developing and describing its “ways of working” in policies, procedures, guidelines and other written control documents

Have you identified any Information Governance issues arising from the implementation of this policy / procedure / written control document?

No information governance issues have been identified from the implementation of this policy and procedure.

Have you identified any training and / or resource implications as a result of implementing this?

No specific staff training is required to implement this procedure. Advice and support with the process is provided within the supporting Toolkit and via the Corporate Governance Department.

Increased involvement of the Corporate Governance Department for central management, overview, support/advice, database maintenance and the publication of documents to the health board’s intranet and internet.

Increased involvement of health board Professional / Service Groups and Committees in the consultation and/or approval of policies, procedures and other written control documents.

Management of Policies, Procedures and other Written Control Documents

1. Policy Statement

To ensure Powys teaching Health Board (the health board) delivers its aims, objectives, responsibilities and legal requirements transparently and consistently. The health board will develop and describe its "ways of working" in policies, procedures, guidelines and other written control documents.

Our documents will be written in plain language so that all staff, stakeholders and where appropriate, our patients and the people we serve are clear about what is expected. Our documents will be aligned to the values and behaviours of the organisation, contribute to staff engagement and meet the characteristics of being a teaching health board.

It will be possible to find these documents easily on our internal SharePoint site or Internet sites.

2. Scope

This policy applies to all staff employed by the health board who have the responsibility for the development or review, approval, dissemination and management of policy documents and describes the processes to be followed.

3. Aim

The aim of this policy is to provide a structure and process for the development or review, approval, dissemination and management of policies ensuring that they are in line with current legislation, guidance and evidence.

4. Objective

To ensure consistency in the format, consultation, approval, dissemination and application of the organisation's written control documents so that they are:

- aligned with the values and behaviours of the health board and contribute to promoting staff engagement;
- aligned with the characteristics of being a teaching Health Board;
- developed and reviewed when required and in a timely manner;
- owned – each document will have an Owner - a Senior Manager or Lead, who has responsibility for making sure that it is regularly reviewed and kept up to date;
- written in plain language so that they can be understood and people are clear on what is expected;
- subject to Equality and Health Impact Assessments where required;

- recorded, stored and archived in accordance with the health board policy and procedure (*IG 005 Policy and Procedure for the Destruction of Records*);
- appropriately consulted on and co-produced where required;
- considered and approved by the appropriate Forum/Senior Officer with delegated powers;
- shared with staff and stakeholders as needed;
- supported by appropriate learning, education and development where required; and
- available to the public in line with Freedom of Information Act requirements and our Publication Scheme

5. Definitions

5.1 Written Control Documents.

This is a group name used in reference to any of the document types defined below.

5.1.1 Guidelines

Give general advice and recommendations for dealing with specific circumstances. They differ from procedures and protocols by giving options of how something might be carried out. They are used in conjunction with the knowledge and expertise of the individual using them.

Guidelines are not prescriptive. However, whilst guidelines are not mandatory, it could prove difficult to defend a case where agreed guidelines had not been followed and the rationale for this has not been justified.

5.1.2 National Clinical Guidelines

The National Institute for Health and Clinical Excellence (NICE) defines guidelines as:

“Systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances. Research has shown that if properly developed, disseminated and implemented, guidelines can lead to improved patient care” (NICE 1999).

5.1.3 Policy

A written statement of intent, describing the broad approach or course of action that the health board is taking with a particular issue. Policies may be underpinned by evidence-based procedures and guidelines and are mandatory.

The formulation of policies allows the heath board to produce formal agreements, which clearly define the commitment of the Organisation and the obligations of individual staff to meet the Organisation's strategic goals.

5.1.4 Procedure

A standardised method of performing clinical or non-clinical tasks by providing series of actions to be conducted in an agreed and consistent way, to achieve a safe, effective outcome.

This will ensure all concerned undertake the task in an agreed and consistent way. Procedures are often the documents detailing how a policy is to be achieved. Procedures are considered mandatory in the health board.

5.1.5 Protocol

Protocols are different from policies as they lack the mandatory element and, by allowing professional judgement, individual cases and competency play a role. They are flexible working documents.

Within a protocol it must be clear by whose authority it is being implemented and what the scope of the protocol is. If a protocol is not to be followed, it is necessary to record the alternative action that is to be taken and the rationale for this.

In the case of clinical protocols, clinicians must be advised in every document that it is for their guidance only and that the advice should not supersede their own clinical judgement.

5.1.6 Standards

The Royal College of Nursing definition is:

".. to provide a record of service or representation of care which people are entitled to experience, either as a basic minimum or for use as a measure of excellence"

Standard Statements are accompanied by a description of the structure and process needed to attain specified observable outcomes.

Standards are not generally prescriptive however it could prove difficult to defend a case if a standard is not adhered to.

5.1.7 Strategy

A long-term plan designed to achieve particular goals or objectives.

A strategy is often a broad statement of an approach to accomplishing these desired goals or objectives and can be supported by policies and procedures.

The above definitions are taken from a range of sources. There is no single legal definition and the terms can mean different things to different organisations.

5.2 Classification of Written Control Documents

5.2.1 Clinical

Clinical policies relate to the care and treatment of patients and offer an evidence-based approach to making a series of clinical decisions for patients.

5.2.2 Corporate

Corporate policies relate to the management of the organisation and formulation of a response to known situations and circumstances.

5.2.3 Employment

Employment policies relate specifically to the management of employees (however defined) within the organisation and are a written source of guidance on how a wide range of issues should be handled within an employing organisation, incorporating a description of principles, rights and responsibilities for managers and employees.

6. Roles and Responsibilities

In addition to the responsibilities detailed below, all health board employees have a responsibility for making sure that they meet the requirements of their role profiles and any other responsibilities delegated to them.

6.1 Chief Executive

The Chief Executive, as Accountable Officer, has overall responsibility for ensuring the health board has appropriate policies in place to ensure the organisation works to best practice and complies with all relevant legislation.

6.2 Board Secretary

The Board Secretary is responsible for the effective management of, and compliance with, this policy. This includes ensuring that:

- a database of policies and procedures is maintained;
- policies are approved as part of the Governance Framework at the appropriate level in the organisation;
- the documents are accessible to all relevant staff;
- documents are cascaded appropriately across the organization; and
- all policies are reviewed in a timely manner.

6.3 Executive Directors

The Executive Directors are responsible for the effective management of and compliance with this policy. They are responsible for ensuring that all policies within their remit are maintained and updated by liaising with the appropriate policy leads. They are responsible for ensuring that the appropriate advice and assistance is provided to authors and that consideration is given to any training and resources implications that are defined. Each Director will appoint a Policy Lead for their Directorate. Specifically, each Director is responsible for:

- ensuring each Service / Department under their portfolio has an identified Document Owner;
- ensuring the Corporate Governance Department is notified of Document Owner changes; and
- ensuring / agreeing transfer of policies or other written control document ownership when changes occur to Director's portfolios or when there are questions raised regarding ownership.

6.4 Document Owners *(Service Leads / Department Heads / Responsible Managers)*

A Document Owner (Owner) is responsible for:

- ensuring the service or department has the appropriate policies, procedures, guidelines or other written control documents in place and for the ongoing management of those documents;
- maintaining a list of the departmental/service policies, procedures, guidelines and other written control documents and making sure that these documents are up to date and reviewed in line with the review date or as a result of changes to practice, organisational restructure or legislation;
- ensuring their staff have read, understood and implement all policies, procedures, guidelines and other written control documents applicable to their roles;
- undertaking, or identifying a document author, to develop, review or update the departmental documents when needed (including re-allocating responsibility if the author leaves or moves to another role);
- confirming that consultation has taken place and equality/risk/health impact assessments have been undertaken where necessary;
- making sure that any training requirements specific to the document have been referenced;
- making sure that where a process of audit &/or review has been agreed that this is maintained and reported on;
- checking the final document for accuracy of content / referenced material prior to approval submission;
- making sure there are arrangements in place to capture, respond to and review documents when external organisations such as the Health and Safety Executive, Royal Colleges and so forth publish new and updated information which requires action by the health board;

- ensuring development and review of departmental written control documents is a standing agenda item in Team / Professional groups or committees;

If an Owner leaves the health board or takes up another post, the responsibilities are taken up by their replacement. Where no direct role replacement is appointed, the responsibility for assigning a new Owner reverts to the Director.

6.5 Document Authors

Authors are employees who have been given the task of writing or reviewing the department / services' written control documents or requested to co-produce a multi organisation/ joint service document for the health board.

Authors are responsible for:

- ensuring compliance with this Policy and with the organisational style when developing and/or reviewing written control documents;
- undertaking and documenting any necessary equality, health and/or risk assessments during development, liaising with the Document Owner and making sure appropriate action has been taken in response;
- liaising with the Document Owner to ensure that appropriate engagement and consultation takes place with the relevant individuals or groups and that feedback is incorporated / actioned;
- identifying any learning, education or development needs and resource implications which must be considered before approval can take place;
- proof reading the document in liaison with the Document Owner prior to approval submission;
- presenting the final document to the approving Committee; and
- ensuring, in liaison with the Document Owner, that policies and written control documents are implemented appropriately and where necessary, that compliance with these documents is formally audited.

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Note: Employment written control documents should always have at least 2 authors i.e. a management representative and a staff representative.

6.6 Corporate Governance Department

The Corporate Governance Department has responsibility for:

- ensuring up to date guidance and documentation regarding the policy process is accessible;
- managing the maintenance of the health board's central policy tracker and database (including a record of equality impact assessments);
- facilitation of the health board internal policy group;
- ensuring an appropriate "toolkit" is available to support the Document Owners / Authors in the development, review and management of said documents;

- Final Quality Check and confirmation of approval pathway
- Maintenance of the health board's website policy pages including publication of approved documents to the health board's SharePoint and internet sites as required and in line with the Publication Scheme and removal of expired written control documents; and
- notifying Document Owners of pending review dates.

6.7 Line Managers

Are responsible for:

- ensuring that new members of staff that join the health board are made aware of the policy control system at local induction, and how to access health board wide and local policy documents specific to their area;
- understanding the policy process and their role in supporting best practice;
- working with staff without access to the intranet to ensure they have access to relevant documentation;
- ensuring that local arrangements are established to monitor the receipt and understanding of all relevant health board documents; thus reducing the risk of misuse of misinterpretation; and
- ensuring that the staff for whom they are responsible are aware of and adhere to this document.

This includes ensuring that:

- copies of health board policies are readily available and accessible to all staff;
- information is disseminated on a regular basis, to ensure staff have read and understood the relevant documents and are aware of any new guidance or revisions;
- the identification of specific staff training needs on the implementation of new or updated documents; and
- systems exist to enable the review, audit and compliance testing of all relevant departmental policies as required.

6.8 All staff

Are responsible for ensuring that:

- they comply with the provision of this policy and where requested to demonstrate such compliance. Failure to comply will be dealt with under the health board's disciplinary processes as appropriate;
- information regarding failure to comply with the policy, for example, lack of training, inadequate equipment, is reported to their line manager and that the incident reporting system is used where appropriate;
- their practice is in line with policies in use across the health board and specific to their area of work; and

- information regarding any changes in practice, organisational structure or legislation that would require an urgent review of documents is immediately reported to their line manager.

7. Policy Register

A central Policy database is in place within the health board which includes details of all policies which have been approved and published or are currently in the process of development or review.

All policies will be subject to version control as well as issued with a unique policy identification number.

Where a policy has been superseded, the archived copy will be held on file by the Corporate Governance Team but will no longer be available via the internet. Each Directorate that develops or reviews policies shall set up their own system to ensure ownership and responsibility for their delegated areas. This shall hold all current and out of date policies. All out of date policies must be kept for a period of 30 years in line with the WHC (2000) 071 For the Record. These will be audited annually, and cross referenced with the main health board Policy Register to ensure consistency.

All policies shall include a specific reference to records retention as detailed above with mention of the health board Records Management policy.

8. Process for Developing/Reviewing a Policy

The full process for developing or reviewing a policy shall apply to any policy which has never been considered by the Policy Group or Workforce Policy Review Group and to all policies which require ***significant*** changes since the last review. A flowchart describing this process is detailed in Appendix 1 and should be referred to prior to commencement of the process.

The process for reviewing policies which have previously been considered by the Policy Group or Workforce Policy Review Group and only require ***reasonable*** or ***minor*** changes since the last review is set out in paragraph 12.1.

8.1 Identifying the Need for Developing/Reviewing a Policy

Drivers for reviewing or developing new policies include:

- Legislation
- National guidance
- External reviews
- Audits
- Improving working practice
- Mitigating an identified risk
- Adopting an all-Wales policy

8.2 Responsibilities and Partnership Working

Managers, staff or functions are responsible for recognising when a policy is required to minimise risk to patients, staff or the organisation. Once the need for a policy has been identified, the responsible Executive Director will identify a Policy Lead to work with an identified Trade Union Lead to review or develop the document. The Policy Lead shall contact the Trade Union Chair or Secretary to request a nominated Trade Union Lead to work with. The Policy Lead shall liaise with the TU Lead to agree the process for drafting the Policy.

8.3 Central Policy Register

The Policy Lead should contact the Corporate Governance Team in the first instance to check the policy database to ensure that there is not a policy already in existence on the same or similar subject, thus avoiding duplication of effort.

8.4 Policy Registration Form

The first step in the development or review of a policy is the completion of the Policy Registration Form (PRF).

The PRF shall also be completed for all Wales or jointly developed policies. A department only document which is a local procedure or guideline, setting out the requirements for staff in a discrete department or professional group, and one which does not have wider implications outside of this, will not require a PRF. Further clarity can be sought from the Corporate Governance Team.

The overarching rationale for completion of the PRF is to aid the Policy Group or Workforce Policy Review Group in being clear about the reason for the policy, the potential impacts of it as well as the support required to facilitate implementation of it. It is best practice to consider these prior to developing or reviewing all policies.

The PRF specifically aims to ensure that:-

- the right type of document is developed (see Definitions in section 5);
- that a policy is developed/reviewed within the context of existing policies;
- there is a plan for appropriate involvement of the Policy Group or Workforce Policy Review Group as well as interested parties who will be essential to the implementation of the policy; and
- consideration is given to the possible wider implications of the policy within the health board.

Consideration of the above at the outset will help to ensure that the development/review process is robust and efficient and will also enable the Corporate Governance Team to keep track of all policies which are under development or review.

The completed PRF shall be signed off by the Executive Director who owns the policy and forwarded to the Corporate Governance Team for processing in order to ensure that the document is entered into the health board's database and is submitted to either the Policy Group or Workforce Policy Review Group for support and guidance through the whole process.

8.5 Policy Group and Workforce Policy Review Group

The Policy Group is responsible for all Clinical and Corporate policies and the Employment Sub-group is responsible for all Employment policies.

Both groups are responsible for providing guidance and support to each of the nominated Policy/Clinical Leads and Trade Union Leads to undertake the process of reviewing existing or developing new policies and ensuring that the process outlined in this policy is adhered to.

The groups will:

- ensure that the development/review is undertaken in a timely manner;
- ensure that the relevant knowledge and expertise is accessible within the group's membership and co-opted members specific to the review or development of each policy;
- ensure that the developmental process has been robust and in line with this policy;
- ensure that the language is consistent and the policy content is described in a concise and succinct manner;
- ensure that the final version of the policy is in line with current legislation, guidance and evidence and can be implemented;
- ensure that appropriate engagement with all relevant and interested parties is undertaken dependent on the scope of the document and that they have an opportunity to agree their contribution to the development or review; and
- ensure that the final draft document along with supporting SBAR is submitted to the relevant groups for consideration and to the approving body for formal adoption and publication.

In the event of any queries raised which are addressed to Policy Group members please contact the Corporate Governance Team in the first instance or the Workforce Lead for any queries for direction to the Workforce Policy Review Group members.

8.6 Fast Track Process

An exceptional route is available for a policy to progress through the system should an urgent situation arise. The Policy Group will consider each fast track request on a case by case basis and make a decision based on specific criteria. It may be necessary to convene a separate meeting dependent upon the

urgency and the Health & Safety Lead should be in attendance. The policy must be accompanied by a Risk Assessment including the reasons for the fast track request.

8.7 Impact Assessments

Policies will not be approved without an Equality Impact Assessment (EqIA) or a Welsh Language Impact Assessment being considered and completed as appropriate as this process has been developed to help promote fair and equal treatment in the delivery of services. It is the responsibility of the Policy Lead to ensure that relevant impact assessments are undertaken during development or review of a policy.

8.7.1 Equality Impact Assessment

In accordance with the Equality Act 2010, all policies shall be subject to an EqIA. This enables resources to be targeted effectively and can help to reduce inequalities. The EqIA is process to find out whether a policy will affect people differently on the basis of their 'protected characteristics': age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion, sex or sexual orientation and if it will affect their human rights.

Evidence gathered at the initial stages, by undertaking an initial screening, will determine the relevance of policies and how they affect people as service users, members of the public and as employees of the health board and indicate whether or not a full EqIA is required.

Where a procedure or other written control document has been developed in support of a policy it may not be necessary to undertake a further EqIA.

Support and advice for undertaking an EqIA is available via The Service Improvement Manager: Welsh Language & Equality, the health board intranet site and within *PtHB/HR 075 Equality Impact Assessment Policy*. Completed EqIAs are submitted to the Service Improvement Manager: Welsh Language & Equalities and are available to staff for reference.

A summary of your findings must be recorded within the document.

Equality Impact Assessment forms and procedures for completion as part of policy development are available on the health board's intranet Policy page. Further information on the development and value of EqIAs can be found on the health board's Intranet site and via the following link:
www.eiapractice.wales.nhs.uk/home.

All finalised policies shall include reference to the EqIA which has been undertaken.

8.7.2 Welsh Language Impact Assessment

The health board is required under the The Welsh Language (Wales) Measure 2011, when formulating new policies or reviewing or revising existing policies, to assess what effect a policy decision would have on opportunities for persons to use the Welsh language and on treating the Welsh language no less favourably than the English language.

8.7.3 Environmental Standards and Impact Assessment

All policies shall be considered as to whether they have any environmental impact during the review/development process. For those policies that are deemed to have no environmental impact it will be sufficient to include the following paragraph:

This policy will put the relevant requirements in place (such as waste management plan, reduction of CO_2 emissions & reduction of carbon footprint) in order to ensure that the health board's ongoing commitment to reduce its impact on the environment is maintained and to become a more sustainable organisation.

However, the Policy Group or Workforce Policy Review Group will ensure that the Estates Team have had an opportunity to consider all policies within the process in order to establish whether an impact assessment, waste management plan, or CO_2 Reduction Plan is required.

8.8 Task and Finish Groups

Whilst accepting that it is not always appropriate, it is strongly recommended that, a Task and Finish group is established to help develop the policy in partnership involving relevant staff groups, services and departments.

8.9 Interested Parties

Interested parties are expected to contribute to the content of the policy and give explicit approval of the relevant sections by which they are affected or responsible for. Interested parties are also required to identify any barriers which could inhibit the implementation of and/or compliance with the policy once approved. These barriers must be resolved prior to the policy being presented for approval ensuring that it is fit for purpose and can be implemented and complied with by all the relevant interested parties.

In addition, members of the health board's Virtual Policy Group will review each policy in accordance with their area of expertise, for example; training, counter fraud, information governance, health and safety and records management etc.

8.9.1 Counter Fraud

All policies shall be reviewed by the health board's Counter Fraud team during the development/review process to ensure that the policy contains the correct counter fraud advice to deter fraud. For the majority of policies it will be acceptable to include the following paragraph; however, the Policy Group or Workforce Policy Review Group will ensure that the Counter Fraud Team have had an opportunity to consider all policies within the process.

Anti-Fraud and Corruption Concerns

Powys teaching Health Board is committed to taking all necessary steps to counter fraud, bribery and corruption within the health board. Staff should report suspected incidents of fraud and corruption to the health board Local Counter Fraud Specialist, who will be happy to discuss any issues or concerns. Alternatively, staff may contact the confidential NHS Counter Fraud Authority, Fraud and Corruption Reporting line on 0800 028 40 60; or the on-line reporting facility https://cfa.nhs.uk/reportfraud Fraud investigations may lead to disciplinary action and / or prosecution and civil recovery procedures.

8.9.2 Records Management

Policy Leads are asked to consider whether the policy being developed or reviewed requires the inclusion of the standard statement described below or a more in-depth statement as to how the records relating to the policy will be managed. Please refer to the health board's Records Management Policy as a guide.

The health board recognises the importance of sound records management arrangements for both clinical and corporate records. The health board's records are its corporate memory, providing evidence of actions and decisions and representing a vital asset to support daily functions and operations. Records support policy formation and managerial decision-making, protect the interests of the health board and the rights of patients, staff and members of the public.

8.9.3 Information Governance

Policy Leads shall consider information governance when developing or reviewing policies and establish whether inclusion of the paragraph below will suffice or whether a more in-depth statement is required as to how this will be addressed by the policy. Please refer to the health board's Information Governance Policy as a guide.

Information Governance (IG) is an overarching term used to describe all aspects of information management. The health board and its staff shall ensure that they provide satisfactory assurance to stakeholders as to how the organisation fulfils its statutory and organisational responsibilities in relation to the management of information. It will enable management and staff to make correct decisions, work

effectively and comply with relevant legislation and the organisations aims and objectives.

8.9.4 Training

All policies shall be considered as to whether they have any education or training requirements during the review/development process. For those policies that are deemed to have no education or training impact it will be sufficient to include the following paragraph:

Powys teaching Health Board is committed to providing high quality evidence based education to an engaged and skilled workforce operating within an organisational culture and framework that enables colleagues to work to the top of their skill set to deliver high quality care and services with competence and confidence.

Any policy specific training would need to be devised by the Policy Lead and subject matter expert.

9. Document Format

The correct template must be used when reviewing or developing a policy to ensure that the minimum information required is contained within it. Policies not following this format will not go out for consultation or proceed to the approval stage.

A Corporate Governance Document Toolkit (the Toolkit) has been developed, containing templates, forms, flowcharts and information to support the development, review and approval of health board policies and other written control documents.

The toolkit is available here: Written Control Document Toolkit (sharepoint.com)

All documentation must be in the agreed corporate format/style which is demonstrated within the Toolkit.

Where a document consists of, for example, a single flowchart, an alternative format is acceptable but the minimum principles listed below must still be followed:

- the document must have a clear heading;
- the scope and objective must be defined;
- the status/type of document must be defined e.g. guidance/mandatory requirement;
- instructions/guidance must be logically recorded;
- approval information noted (approved by & when);
- the review date noted;
- author (job title/department);

- page and number of total pages in the footer (e.g. page 1 of 2);
- forms should not be embedded within documents. Forms should be either automated or created and saved within a directorate's own communication site and a link to that communication site embedded within the document. Both options will enable the form to be available in an editable format.

Use plain language, short sentences and where possible, avoid technical terms. If technical terms are used they should be explained using a glossary or footnotes. Policies must be factual, evidence-based and concisely written; keeping content to brief and to the point.

The table below explains the terminology that shall be used in all policies.

Term	***Meaning/Application***
SHALL	*This term is used to state a **Mandatory** requirement of the policy*
SHOULD	*This term is used to state a **Recommended** requirement of the policy*
MAY	*This term is used to state an **Optional** requirement of the policy*

Policies, procedures and other written control documents are not routinely translated into other languages. Where the author / owner is aware that this may cause difficulty for staff, patients or their families, they will ensure that the content is explained by an interpreter or arrange written translation.

Policies that are to be published on the health board website have to be provided in English and Welsh. Translation of the policy can be arranged via the Service Improvement Manager: Welsh Language & Equalities.

In accordance with the requirements of the Data Protection Act 1998, the names of individuals will not be contained within policies and written control documents. Individuals with particular responsibilities will be identified by their job title only.

If the health board is adopting an externally approved document it will not require reformatting providing it meets the standards set above. These documents will be given a reference number, recorded and uploaded as if they were a Powys teaching Health Board document. Once adopted the responsibility for review falls to the Department/Service Lead (the Owner) if the original authors do not provide an update within the standard 3-year period.

10. Engagement and Consultation

Engagement and consultation on all new health board policies, procedures, guidelines and other written control documents should take place with the target audience including appropriate stakeholder, service user/carer, managerial, clinical and staff representation.

Where appropriate, documents should be co-produced with that target audience.

The Toolkit contains a consultation feedback form that can be used during this stage. The completed feedback forms should be retained by the author until the document has been approved.

When a final draft has been developed the formal consultation can start. The recommended consultation period should be a minimum of **14 days** including weekends but excluding bank holidays. This may be shortened in exceptional circumstances by agreement with the Policy Group or Workforce Policy Review Group.

The Document Author / Owner must provide assurance to the approving Committee/Group that consultation has been conducted thoroughly and that comments have been incorporated into the policy or written control document. The groups/individuals consulted must be recorded in the Engagement and Consultation section of the final document.

11. Approval Submission

The Board has overall responsibility for the approval of all strategy and policy documents. However, this responsibility will be delegated to an appropriate Committee for approval in accordance with the Scheme of Delegation and Standing Orders. This includes all policies written on an All-Wales basis, for formal adoption by the health board.

Each policy document requiring approval will be submitted to Trade Union Partners prior to recommendation for approval. The document will then be submitted to the Executive Director who will take the final document to Executive Committee for consideration. The policy can then be submitted to the approving body.

The final version of the document should be sent to the Corporate Governance Department who will undertake a quality check prior to publication.

A submission approval form is provided within the Toolkit and must accompany the document through these last steps (*Form reference CGD 005*).

11.1 Approval Routes

A map has been provided within the Toolkit (*Form reference CGD 006*) indicating the appropriate approving groups or committees. The group/committee will depend on the nature of the document and will be confirmed by the Corporate Governance Department as required.

It is recommended that the Document Owner or Author presents the document to the approving Committee where possible.

Policies, Plans and Strategic Frameworks. Executive Lead or Document Owner to take to Powys teaching Health Board or delegated Committee.

Procedures, Guidelines, Protocols & Standards. Document Author or Owner to present the written control document to the appropriate professional group / committee for approval.

All Wales Policies / Procedures / Guidelines. All Wales documents whether adopted or adapted for use by the health board must follow the approval routes indicated above.

Other Organisation or other Health Boards' Written Control Documents. Documents from other organisations or health boards may be adapted for use by the health board providing that:

- permission is granted, in writing, by the organisation to use or adapt for use;
- the source is clearly recorded in the reference section; and
- it follows the format, consultation and approval path as per Powys teaching Health Board documents.

The Committee or Group will contact the Corporate Governance Team within 5 working days of the meeting date to confirm the approval status. If approved the document will then be uploaded to the intranet and / or internet as indicated on the approval submission form.

12. Review of Existing Documents

The standard maximum review period for all health board policies and other written control documents is 3 years from the issue date. Some documents are routinely reviewed earlier. However, if changes occur that affect the document content e.g. new legislation, recommended best practice, change in equipment used etc. the document should be updated at the earliest opportunity (whether a review is due or not).

The Corporate Governance Department will notify the Document Owner that a review is due three months prior to the review date, which equates to four months prior to the document expiry date.

Document Owners are responsible for undertaking or arranging the review of their departmental / service documents.

If a review is incomplete by the document expiry date, the Document Owner must notify the Corporate Governance Department via email and a three month extension will be applied. If the review has still not been completed by the end of the extension period the appropriate Executive Director will be notified.

12.1 Approval of Reviewed Documents

- **If no changes are required** the document can be signed off by the Document Owner, using the submission and approval form provided in the Toolkit and the document will be validated for a further 3 years. Send the form to the Corporate Governance Department.

- **If minor changes are required** (e.g. Re-formatting to current corporate style) the document can be signed off by the Document Owner. Send the updated copy, with the submission and approval form, to the Corporate Governance Department.

- **If reasonable content changes are required** to bring the policy up to date then the Policy Lead is required to obtain approval from the Policy Group or Workforce Policy Review Group.

- **If significant content changes are required,** the reviewed document must follow the approval route as if it were a new document. The changes must be summarised / noted in the version control table within the document.

13. Archive and destruction

If a document is no longer needed, the Document Owner must notify the Corporate Governance Department via email and the central database can be updated. The document will then be removed and archived in electronic version as per health board IGP 005 Policy and Procedure for the destruction of records.

After the retention period the document will be permanently deleted.

14. Publication and Dissemination

The Corporate Governance Department will publish specified written control documents, in PDF format. They will notify Service / Department Leads when the upload is complete. The Service/Department Leads are then responsible for cascading the information to their staff (see section 6).

Policies, Plans and Strategic Frameworks. To be published on both the health board SharePoint and internet. The approval submission form includes a section

regarding publication to the internet as some documents may require redaction before internet publication.

It is the responsibility of the Policy Lead to ensure that a link established from the health board's central policy page to the Directorate pages and maintained to ensure that only the current and correct version of the policy is published online. Under no circumstances must any policies be directly uploaded onto any pages of the intranet.

In accordance with Freedom of Information legislation, all new and amended policies will be published on the health board's intranet site to ensure that staff can access the most up to date versions in one place.

Once a policy has been entered onto the database, approved and published on the internet, this should be regarded as the only official health board version for dissemination to and use by employees.

Procedures, Guidelines, Protocols & Standards. To be published on the health board's intranet site. The Corporate Governance Department will liaise with Service / Department Leads to confirm when upload is complete. The Service/Department Leads are then responsible for cascading the information to their staff.

15. Monitoring Compliance, Audit & Review

No policy, procedure, guideline or other written control document can be approved unless the processes set out in this Policy have been followed. All approved written control documents will be recorded in a Central Database maintained by the Corporate Governance Department.

Approved policies, plans and strategic frameworks can only be published to the internet / intranet by the Corporate Governance Department. If services wish to include guidelines, procedures or standards on their own pages this may only be done in consultation with the Corporate Governance Department in order to ensure each instance is appropriate and the Central Database is kept up to date.

Internal audit will assess the effectiveness of and compliance with this policy and of all health board policies on a periodic basis.

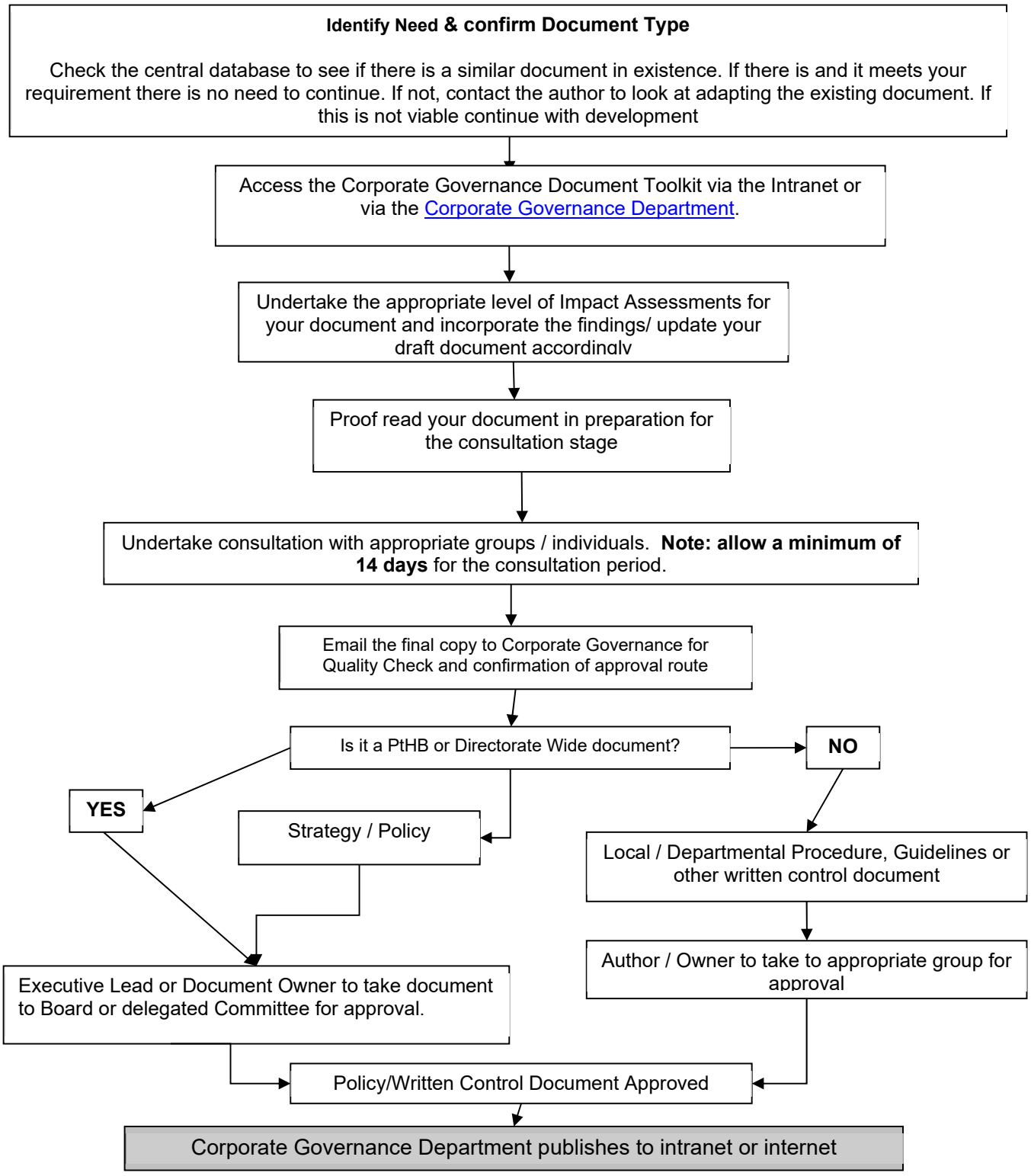
This document will be reviewed every three years or earlier should audit results or changes to legislation / practice within the health board indicate otherwise.

16. References

- The Equalities Act 2010
- Welsh Language Standards
- PtHB Publication Scheme
- Doing Well, Doing Better – Healthcare Standards for Wales
- PtHB / CGP 009 Equality Impact Assessment Policy 2021
- PtHB / IGP 005 Policy and Procedure for the Destruction of Records
- PtHB / IGP 012 NHS Wales Information Governance Policy
- PtHB / IGP 008 Records Management Policy 2018
- PtHB / IGP 014 Records Management Framework
- WAST Policy for the Development, Review and Approval of Policies 2019

Appendix A

FLOWCHART



Appendix B

Corporate Governance Written Control Document (WCD) Toolkit

The documents listed below are all contained in the Toolkit. Use of all of these documents is not mandatory with the exception of the formatting documents (CGD 003/003a or 003b) and the approval submission form (CGD 005) that are highlighted in green.

The remaining documents have been included for support or advice purposes.

Toolkit Contents

CGD 001	Process flowchart
CGD 002	PtHB Written control document definitions
CGD 003	PtHB Corporate style and format details
CGD 003a	PtHB Corporate skeleton document for policies and strategies
CGD 003b	PtHB Corporate skeleton document for procedures, protocols and guidelines
CGD 004	Consultation feedback record
CGD 005	Approval submission form
CGD 006	Approving committee structure – *this document may undergo further amendments following any structural change or if a Committee is stood down*
CGD 007	Staff sign off record – confirming they have read and understood a particular document
CGD 008	Author/ reviewer checklist
CGD 009	Useful contacts
CGD 010	Health Impact Assessment Tool from the Department of Health