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Written Control Documents - Development and Approval Procedure

Introduction and Aim

To ensure that Cardiff and Vale University Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will develop and describe our "ways of working" in policies, procedures and other written control documents. In this regard, the Management of Policies, Procedures and Other Written Control Documents Policy (UHB 001) has been produced.

This procedure translates the principles from that policy into more detailed guidance, including individual responsibilities for developing and reviewing written control documents. This is summarised at Table 1: Steps Involved in Document Creation/Amendment (page 8).

Unless otherwise stated, the phrase *'key documents'* will be used in this procedure when a point is equally relevant to a range of control documents whether they be strategies, policies, procedures, guidelines etc.

Objectives

This procedure ensures consistency in the format, compilation, approval and dissemination of all control documents, so that they are:

- Developed and reviewed when required;
- "Owned" – each document will have an owner 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 of what is expected.
- Subject to Equality and Health Impact Assessments (EHIA) where required;
- Recorded, stored and archived in accordance with the UHB Records Management Retention and Destruction Protocol;
- Appropriately co-produced and consulted on;
- Considered and approved by the appropriate forum/senior officer (with delegated powers);
- Shared with staff and stakeholders where required;
- 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.

Scope

This procedure applies to all of our staff in all locations including those with honorary contracts.

In addition to the responsibilities detailed within the procedure, staff also have a responsibility for making sure that they meet the requirements of their role profiles and any other responsibilities delegated to them.

Equality and Health Impact Assessment	The procedure relies on the generic EHIA for Administrative-type policies.
Documents to read alongside this Procedure	UHB 001: Management of Policies, Procedures and Other Written Control Documents Policy.
	UHB 142: Records Management Policy.
	UHB 183: Records Retention and Destruction Protocol.
	UHB 202: Safety Notices and Important Documents Management Policy.
	UHB 228: Producing Written Information for Patients Guidance.
	UHB 246: Information Governance Policy.
Approved by	Audit and Assurance Committee

Accountable Executive or Clinical Board Director	Director of Corporate Governance
Author(s)	Corporate Archivist and Records Management Manger

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
1	18/09/2014	24/09/2014	Content previously included within Management of Policies, Procedures and Other Written Control Documents Policy. The revised policy is in the new shorter format and this procedure has been written in support of the new policy.
1.1	10/12/2015	16/12/2015	Title of Appendix 2 corrected

2	30/11/2017	05/12/2017	Revised Procedure. Titles amended Reference to new EHIA that replaced EQIA Changes in Committee structure and inclusion of R&D
3	05/07/2022	09/08/2022	Revised to reflect change to UHB 001: Management of Policies, Procedures and Other Written Control Documents Policy. Definitions moved from appendix to main body. Document Approval process revised. Committee titles updated.
4	03/09/2024	11/11/2024	Full review of policy, amendments throughout, review of approval committees in line with current Health Board structure. Including additional appendices for clarity

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Appendices

1. Definition of Terms

1.1 **Note**. These definitions are adapted from a range of sources. There are no single legal definitions and the terms can mean different things to different organisations.

1.2 **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. A strategy may be supported

by policies and procedures. Strategies always require an Equality & Health Impact Assessment (EHIA).

1.3 **Policy.** A formal written statement of intent, describing the broad approach or course of action that the Health Board is taking with a particular issue. The formulation of policies allows the Health Board to produce formal agreements, which clearly define the commitment of the organisation and the obligations of individual staff. An Operational Policy is a statement outlining the objectives, principal functions and modes of operation of an entire hospital or a department, particular service or activity.

Policies are usually underpinned by evidenced based procedures and guidelines. Policies are mandatory and usually require an EHIA.

1.4 **Procedure.** A standardised method of performing clinical or non-clinical tasks by providing a series of actions to be conducted in an agreed and consistent way to achieve a safe, effective outcome. Procedures set out the operational processes to be followed to meet objectives, usually the objectives required by a strategy or policy. They must include reference to any evidence used. Procedures are considered mandatory. The equality impact of a procedure that supports a policy may be covered by that policy's EHIA but consideration should always be given to the need for a specific EHIA.

1.5 **Protocols.** Protocols are an agreed framework that provides step by step guidance. They are different from policies and procedures as they lack the 'mandatory' element and by allowing for professional judgement, individual cases and competencies can play a role as they are flexible working documents.

Within a protocol it must be clear by whose authority is it 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. Protocols may have potential to impact on people with protected characteristics and therefore consideration should be given to conducting an EHIA.

1.6 **Guidelines.** 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 recorded or justified.

1.7 **Standard**. A standard is a statement, reached through consensus, which clearly identifies the desired outcome. A standard is usually used within audit as a measure of success. Standards may be published as a standalone document or may be incorporated into a strategy or policy.

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.

2. Responsibilities

2.1 Executive and Clinical Board Directors

2.1.1 The delegated responsibilities of Executive and Clinical Board Directors are set out in the Scheme of Delegation. They have responsibility for:

a. Verifying that there is a need for a new written control document and ensuring that there is no duplication or conflict with other written control documents within their sphere of influence.

b. Ensuring that appropriate written control documents are produced and kept up to date by identifying a document author (including reallocating responsibility if the author leaves or moves to another role).

c. Personally checking for accuracy of content prior to submission to a committee/group for approval.

d. Maintaining a list of up to date policies and written control documents, supported by the Head of Corporate Governance.

e. Ensuring that there are arrangements in place to capture, respond to and review documents when external organisations (e.g. Health and Safety Executive, Royal Colleges) publish new and updated information which require action by the Health Board.

f. Ensuring that consultation has taken place and impact assessments, including the equality and health impact assessment, have been completed where necessary. Where these have not been undertaken a reason for this will be provided.

g. Ensuring that any training requirements specific to the document have been referenced.

h. Establishing an appropriate date for review of the key document.

i. Ensuring that, where a process of audit and/or review has been agreed, this is maintained and reported on.

2.2 Document Authors

2.2.1 Authors are employees who have been given the task of writing or reviewing a key document. Employment documents should always have at least two authors i.e. a management representative and a staff representative.

2.2.2 Authors are responsible for the review of their documents. If an author leaves the Health Board or takes up a non-related post, the responsibility for the ongoing maintenance of the document is taken on by their replacement. Where no direct role replacement is appointed, responsibility reverts to the post holder's line manager. The Executive Director and Clinical Board Director will be informed of the situation to allow them to identify a replacement author if it is not appropriate for the responsibility to stay within that department.

2.2.3 Authors must:

a. Liaise with Executive or Clinical Board Directors to make sure policies and written control documents are implemented appropriately and, where necessary, compliance with these documents is formally audited.

b. Make sure that documents are reviewed in line with the review date or amended as a result of changes to practice, organisational structure or legislation.

c. Work with the Executive/Clinical Board Director and the Head of Corporate Governance to ensure appropriate engagement and consultation with relevant individuals and groups.

d. Inform the Executive or Clinical Board Director of any learning, education, development or resource issues needing to be addressed prior to the granting of approval.

e. Undertake the necessary impact assessments, including EHIA.

f. Consider the findings and make sure that appropriate action has been taken in response to EHIAs.

g. Send the approved document to the Head of Corporate Governance for publication within **five working days** of approval by Board or Committee.

h. Following review ensure Audit tracking dates and actions on Audit Tracking software (AMaT) have been updated.

2.4 Corporate Governance

2.4.1 The Director of Corporate Governance is responsible for ensuring that the Health Board has arrangements in place to ensure effective development and management of key documents.

2.4.2 The Head of Corporate Governance is part of the Director of Corporate Governance's team. They undertake the function of organisation wide "Policy Process Manager" and can provide advice and assistance on any aspect of document development and review. The Corporate Governance Team can be contacted via governanceteam.cav@wales.nhs.uk.

2.4.3 The Corporate Governance Team maintains a register of all documents which are centrally recorded and will be able to advise if a document already exists. All of these documents are both published on the UHB Website and SharePoint site.

2.4.4 The Corporate Governance Team will arrange for draft documents to go for consultation, this will include posting across platforms and sharing directly with partner/working groups (to include Stakeholder reference group, Llais and Local Partnership Forums). The policy will then be posted online and shared for a 28-day consultation period, during this time comments are to be sent to the document author.

2.4.5 Following consultation period Corporate Governance team will remove the documented from the consultation pages and await the final version to be resubmitted following final approval being received from the relevant committee.

3. Process for Drafting or Revising Key Documents

3.1 Each pan-Health Board policy and written control document will be sponsored by a lead Executive Director. At Clinical Board/Directorate level written control documents will be sponsored by the appropriate Director or Clinical Board Director (see Appendix 2).

3.2 In accordance with the Equality Act 2010 (as may be amended), all strategies and policies will be subject to an EHIA (see Paragraph 6).

3.3 In the case of **employment policies**, (excluding those enforced from Welsh Government following national negotiations and other "All Wales policies"), staff representatives and management will jointly negotiate a draft policy for submission to the People and Culture Committee (or another appropriate Committee if this is superseded) for approval. If there are any

issues that cannot be resolved at Committee level, the Policy will be brought to the Board for final consideration and approval.

3.4 All Wales Policies are to be accompanied by a CAV UHB Policy Cover sheet which must include the appropriate Exec lead and Responsible individual to conduct future reviews to ensure the policy remains adequate to the Health Board. This will allow All Wales Policies to be controlled locally and not rely on National reviews to be conducted, demonstrating assurance to our employees that the policy is still relevant to our Health Board.

3.4 The development of policies and written control documents will be based on sound evidence, and take account of current legislation, mandatory requirements and national/professional guidance.

3.5 Sources of information used should be appropriately referenced or acknowledged.

Table 1: Steps Involved in Document Creation/Amendment

Stages	Lead	Action	Additional Information
Step 1	Policy Author	**Identify the need for a new (or revised version of an existing) Policy or Key Document)** by completing the Key Document Approval Form at Appendix 1.	Approval obtained from the Corporate Governance Team following submission of the Approval Form
Step 2	Policy Author	**Carry out an Equality & Health Impact Assessment (EHIA)** The purpose of an EHIA is to identify and eliminate any negative effect that the key document may have upon groups, individuals or communities as a consequence of their race, gender, disability, religion or belief, sexual orientation, age, Welsh language, gender reassignment, pregnancy or maternity, marital or civil partnership status or human rights. EHIA should start at the beginning of key document making or review. This enables equality considerations to be considered throughout the design or review. Responsible officers must therefore carry out the EIA process and start by screening the document for relevance to equality. The EHIA Process should	Support available from the Equality and Welsh Language Teams. See 'Definition of Terms' for guidance on the EHIA requirements for each Key Document type

		be used to carry out the screening (see Appendix 2). Responsibility for completing the EHIA lies with the officer(s) responsible for the key document, however the Equality & Welsh Language Teams are able to support as required.	
Step 3	Policy Author	**Understand Key Document Format and Template Requirements** The drafted Key Document needs to comply with: • The Document Format at Paragraph 5. • The Template requirements at Paragraph 5. • As required the EHIA Format at Paragraph 6.	Advice available from the Corporate Governance Team
Step 4	Policy Author	**Draft the Key Document**	Advice available from the Corporate Governance Team
Step 5	Policy Author	**Engagement and Consultation** Engagement and consultation on all policies and 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.	See Paragraph 7. Allow at least 28 working days
Step 6	Executive Lead/Author	**Obtain Approval** Lead Executive to discuss with Head of Corporate Governance the process to be adopted for draft document approval by Board, committee or other appropriate group.	See Appendix 2.
Step 7	Executive Lead/Author	**Approval** Following approval, the author of the document is responsible for submitting the final document to the Corporate Governance Team for publication via the Internet and adding to Audit tracking database. In accordance with the Welsh Language Standards, some policies need to be made available in Welsh. This should take place once the final version is approved.	See Paragraph 4 for specific requirement
Step 8	Corporate Governance Team	**Publication** When the policy has been received from the Policy Author the Corporate Governance Team will update the repository and upload to the internet as required.	

Step 9	Executive Lead/Author	**Review** Executive Leads/Authors are responsible for reviewing the key document in accordance with the review date set when published and/or changed circumstances requiring more immediate review. The Corporate Governance Team operate Audit tracking software which will automate due date reminder notifications 3 months prior to required date. Major updates will require resubmitting to committee/board, minor updates can be approved by Exec lead for submission to sub committee	See Paragraph 8 for specific requirement.

4. Approval for Key Documents

4.1 Some “All Wales” policies are developed by the Welsh Government or by Health Boards and Trusts working together. The Health Board is often mandated to adopt these documents. Where this is the case they will be reported to the Board or a Board Committee so that there is a record of their adoption.

4.2 Where policies relate to equitable access to safe and sustainable, high quality specialised and tertiary services (Relevant Services), the Board will delegate approval to the Joint Commissioning Committee.

4.3 All other strategies and policies will be approved in accordance with the guidance provided at Appendix 2. In accordance with Standing Orders the Health Board's top-level organisation structure and corporate policies require Board approval; Lead Executives/Authors who feel that their draft policy requires deviation from the guidance in Appendix 2 should discuss with the Head of Corporate Governance.

4.4 Where a document requires only a small amendment which is not material to the aims or objectives of the document, e.g. to reflect a change in working practice, content of supporting documents etc., an interim review may be undertaken. This will be agreed in advance with the Corporate Governance Directorate to ensure that the completion of an interim review does not expose the Health Board to an increased level of risk. The Board will periodically receive an update on all controlled documents approved by committee or other appropriate group.

4.5 Once approved, documents will be published on the UHB Internet and SharePoint sites. Under limited circumstances it may be necessary to redact information from a document prior to publication on the Internet e.g. direct dial telephone numbers within the Major Incident Plan. The Committee/Group approving the document will determine if redaction is required. Where this has been agreed the reason and extent of redaction will be explained in the published document.

5. Document Format

5.1 Document templates have been developed which contain the mandatory sections for inclusion in policies and written control documents (See Appendix 3).

5.2 This Template must be used for all Health Board wide, Clinical Board or multi-departmental documents. Where a document is only applicable within a single Department or, for example consists of a flow chart, an alternative format is acceptable and a “basic template” is also shown in Appendix 3. As a minimum the following principles must be followed:

- Document must have a clear heading.
- The scope and objectives must be defined.
- The status of the document must be clear e.g. guidance/mandatory requirement.
- Instructions/guidance must be logically recorded.
- Date of approval shown.
- Date for next review shown.
- Date of last review shown.
- Job title of Lead Exec supporting, demonstrating department ownership
- Author's details.
- Pages numbered.

5.3 The language used for all documents should be plain English, using short sentences and where possible avoiding technical terms. If technical terms are used, they should be explained using a glossary or footnotes.

5.4 Policies, procedures and other written control documents will not be routinely translated into other languages. However, where staff are aware that this may cause difficulty for patients or their families they will ensure that the content is explained to them by an interpreter, translated if necessary or available in accessible formats (e.g. e-readers for the visually impaired).

5.5 In accordance with the requirements of the Data Protection Act 2018 (as may be amended), 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.

5.6 Certain key documents may require the collection and processing of personal data as defined and regulated by personal data legislation as applies in Wales and /or the UK (including, without limitation, the Data Protection Act 2018 and the UK General Data Protection Regulation (UK GDPR)). Authors and sponsoring Executive Directors must ensure that the proposed key documents complies with these requirements, liaising with The Digital and Information Technology Directorate as required.

5.7 If the Health Board is adopting an externally approved document (such an All-Wales Policy) it will not need reformatting providing it meets the standards set above. These documents will be provided a CAV policy cover sheet, given a reference number, dated, recorded and uploaded as if they were a Health Board authored document.

6. Equality and Health Impact Assessments

6.1 The Equality Act 2010 requires the undertaking of Equality and Health Impact Assessments and all Health Board policies will require the completion of such **before** the policy is consulted upon.

6.2 These assessments determine 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. It also takes account of Welsh Language issues. It is designed to ensure that Cardiff and Vale University Health Board take into consideration the needs of all individuals who work for us and/or access our services.

6.3 Health Impact Assessment (HIA) is a process that considers how the health and well-being of a population may be affected by a proposed action, be it a policy, programme, plan, project or a change to the organisation or delivery of a particular public service. Some impacts of policies on health may be direct, obvious and/or intentional, whilst others may be indirect, difficult to identify and unintentional. HIA is a systematic, objective, flexible and practical way of assessing both the potential positive and negative impacts of a proposal on health and well-being and suggests ways in which opportunities for health gain can be maximised and risks to health minimised. HIA looks at health in its broadest sense, using the wider determinants of health as a framework.

6.4 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 EHIA. If an EHIA has not been completed the reason for this will be explained at the beginning of the document. Where an EHIA has been completed the impact will be included in the document.

6.5 EHIAs will be published as part of the consultation process and they will be available on our internet and intranet sites alongside the relevant policy or written control document. A generic EHIA for Administrative-Type Policies has also been produced and formally agreed and can be used in support of the review and development of such policy types. This is available on the Policies page of the Intranet.

7. Engagement and Consultation

7.1 Written control documents must not be written in isolation. Engagement and consultation on all key documents occur 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.

7.2 The Health Board is developing a range of mechanisms to involve patients, carers and members of the public in its work. This will strengthen the stakeholder involvement with the Health Board, demonstrate our commitment to working with the local community, and develop our services and policies jointly. If required, authors should contact the Assistant Director

of Patient Experience and the Assistant Director of Planning for advice and assistance in identifying the appropriate groups/individuals for co-production and consultation.

7.3 When a final draft has been developed the formal consultation can start. The consultation period should be a minimum of **28 working days.**

7.4 The policy author should send the document and equality and health impact assessment (if applicable) to the Corporate Governance Team who will arrange for the documents to be uploaded onto the Health Board's Written Control Documents Consultation Page on the Intranet and SharePoint and directly submit to partner/working groups (to include if appropriate, Stakeholder reference group, Llais and Local Partnership Forums).

8. Key Document Review

8.1 When drafting or reviewing a document the author should consult with the sponsoring executive to determine the most appropriate date for the key document to be reviewed.

8.2 Such consideration should be cognisant of any specific requirements imposed by statutory, regulatory or professional bodies, and the likelihood of a rapidly changing context or background to the key document.

8.3 The maximum 'life' of a key document before review will be three years from the date of publication.

See appendix 5b for process flow.

Appendix 1

Key Document Approval Form

This form should be completed by the document author and sent to the Corporate Governance Department for approval before production of the document.

1. Key Document Category:	New	☐	Existing	☐
2. Key Document Type:	Choose an item.			
3. What is the reason for developing a new key document?				
• Improve or standardise organisational procedures				☐
• In response to learning from a complaint, incident or claim				☐
• In response to alerts, safety notifications, Welsh Health Circulars etc				☐
• Re-organisation of a service/department				☐
• New or amended legislation				☐
• Other (please specify)	Click here to enter text.			
4. What is the reason for amending an existing key document?				
• Routine review				☐
• Improve or standardise organisational procedures				☐
• In response to learning from a complaint, incident or claim				☐
• In response to alerts, safety notifications, Welsh Health Circulars etc				☐
• Re-organisation of a service/department				☐
• New or amended legislation				☐
• Other (please specify)	Click here to enter text.			
What Key Document need replacement/update?	Click here to enter text.			
Review type required:	Full Review	☐	Interim Review	☐
5. What will be/is the title of the key document?	Click here to enter text.			
6. What will be/is the aim of the document?	Click here to enter text.			
7. Which other key documents will be/are relevant to the document?	Click here to enter text.			
8. Please indicate which of the following will need to be considered/consulted when developing/reviewing this document:				
• Consent				☐
• Deprivation of Liberty Safeguards (DOLS)				☐
• Mental Capacity Act				☐
• Mental Health Act				☐
• Data Protection/GDPR				☐
• Safeguarding				☐
• Equality and Diversity				☐

• Welsh Language				☐
• Patient Safety and Concerns				☐
• Health and Safety				☐
• Risk and Regulation				☐
• Workforce and Development				☐
• Information Governance				☐
• Financial				☐
• Business Continuity/Emergency Planning/Major Incident				☐
• Other:		Click here to enter text.		
9. Who will be/is the sponsoring Executive Lead for this key document?		Click here to enter text.		
10. Lead Author Details:				
Name:	Click here to enter text.	Job Title:	Click here to enter text.	
Email Address	Click here to enter text.			

For Use by Corporate Governance:					
a. Date Received by Corporate Governance			Click here to enter a date.		
b. Permission to develop key document given?	Yes	☐	No	☐	
c. Full or Interim Review approved:	Choose an item.				
d. If **NOT** permitted why? What actions must author take to gain permission?	Click here to enter text.				
e. Approved title and reference number for **NEW** Key Document	Click here to enter text.				
f. Identify any other external or UHB Key Documents to be signposted/referenced in the new/reviewed key document	Click here to enter text.				
g. General Advice and follow up actions:	Click here to enter text.				
Name of Approver:	Click here to enter text.				
Job Role:	Click here to enter text.	Date Approved:	Click here to enter a date.		
Date that Approval Form Returned to Author:			Click here to enter a date.		

Appendix 2: Example of approving Committee/ Group

Example Subject Area	Approving Body	Sub groups / committees
Financial Governance Capital	Finance and Performance Committee	
Corporate Governance Counter Fraud	Audit & Assurance Committee	Digital Health & Intelligence IMT Capital groups
Respect & Resolution Employee Wellbeing and Stress Environmental Management Food Safety and Hygiene	People & Culture Committee	Health & Safety Sub-Committee Policy sub group LPF
Clinical Governance / Patient Experience / Quality and Safety Consent to Examination or Treatment Nutrition and Catering Patient and Public Information Mental Health Policies	Quality, Safety and Experience Committee	Mental Health Future Hospitals Clinical Boards (QSE Groups)
Standing Orders Major Incident Plan Equality, Diversity and Human Rights Fire & Disaster Planning Fundraising and Investment Policies	The Board	

Appendix 3

TEMPLATES FOR DOCUMENTS

The template is designed for use when developing policies, procedures and other written control documents. It may not be suitable for all documents but any deviation will be agreed with the Head of Corporate Risk and Governance. Documents should be formatted in line with Corporate Style as follows:

Electronic format	Development - Microsoft Word Publishing - PDF Read only (this will be arranged by the Head of Corporate Risk and Governance after the Policy reference number has been added.
Document Style	Corporate Policy Template Corporate Procedure Template Employment Policy Template Employment Procedure Template
Audit trail	Record information regarding consultation during development.
Body text	Arial 12
Headings	Arial 12 (Lower Case)
Tables and charts	Arial (size as appropriate)
Flow charts	Use Standard Flow Chart Symbols where possible
Use of bold	Headings only or to emphasise text
Alignment	Left Justified
Line spacing	Paragraphs – Single
Paragraph spacing	One line between paragraphs and section headings
Underlining	None
Contents page Contents page if >3 pages	As template Use judgement - help reader to find relevant information more easily
Staff Names	Use titles only. No names
Logo	Use UHB logo as incorporated in corporate template
Headers and footers	Arial 9

Margins	Top and bottom of page 2.54 cm, sides 3.17cm
Document Title	To be included in the header on every page after first page
Page numbering	To be included in the header on every page after first page. It will include the page number and total number of pages (page x of x)
Bullets	• Use standard bullets only, as they do not always format across different systems
Abbreviations	State in full in first usage with abbreviation in brackets
Printing	A4 / double sided
Hyperlinks	Hyperlinks should be considered for use in key documents when this will reduce the volume of a document or in any other way improve the reader's experience and understanding. However, consideration should be given to the anticipated longevity of a link to a site external to C&V UHB. If it is assessed that a link has reasonable potential to change it should not be used. All hyperlinks should be preceded or superseded with a full reference to the external information source to enable access if the hyperlink fails. **Hyperlinks in Approved Documents**: Authors are responsible for ensuring the accuracy of hyperlinks to external sites when submitting approved documents to Corporate Governance for publishing. If hyperlinks to existing C&V UHB published key documents are required these will be inserted by the Corporate Governance Team prior to publishing; authors should clearly indicate which key documents require this action.
Referencing	All reference material should be listed in full at the end of every document in Harvard style.
Glossary of terms	All documents need to be user friendly. They will be read by staff and members of the public. Therefore all necessary abbreviations, technical terms, jargon and

	specific wording must be clearly explained to the reader. Where possible always use plain English. Information to help with this is available on the Plain English Campaign web site.
Version Control	Reference Number will be provided by the Corporate Governance Department. Documents to state 'Draft' as watermark whilst in development together with version number of draft e.g. Draft 1.

APPENDIX 4

Audit and Tracking of Policies

About AMaT

AMaT is an innovative system designed to make auditing easier, faster, and more effective. Auditing is a vital part of healthcare, helping to improve patient care, manage risk, and comply with reporting requirements. But it is also time-consuming, labour-intensive, and often slow to deliver results and actions.

AMaT was created with NHS clinical audit teams to give you more control over your audit activity and to provide real-time insight and reporting for clinicians, wards, audit departments and healthcare trusts.

AMaT is easy to implement, and simple to use. Data can be input and accessed in real time on a smartphone, tablet, laptop or desktop computer, giving healthcare staff increased flexibility and mobility - and more time to spend with patients.

AMaT is intuitive and perfectly aligned with our processes whilst being designed around a dashboard system, which means the results of your audit and improvement data can be seen at a glance in easy-to-read graphical presentations.

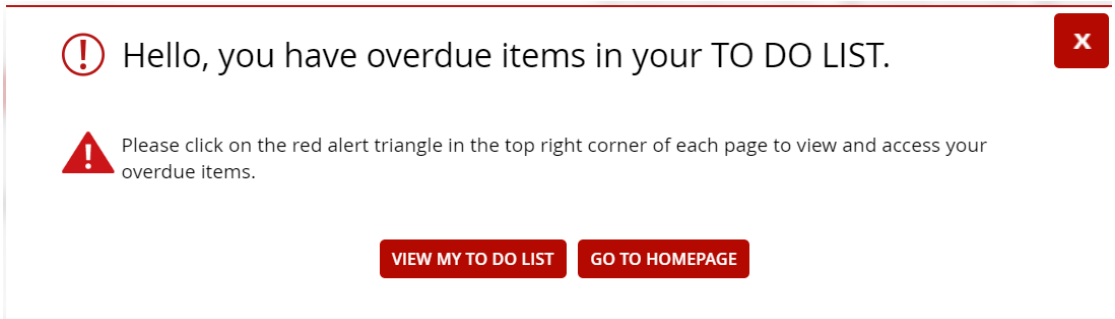
Whether you need to share audit results trust-wide, or tailor them for specific specialities and divisions, AMaT will help you increase awareness and education throughout your organisation.

The dashboards provide clear visuals for your audit data, giving you real-time insight into how well you're performing, and providing the ability to react swiftly to implement change and improvements where necessary.

AMaT is intuitive and simple to use, it works seamlessly with all elements of your audit process: upload files from other sources; create pro formas and questionnaires; send instant email notifications to co-workers for their input; submit reports to managers, and generate completion certificates - from your desktop or mobile device.

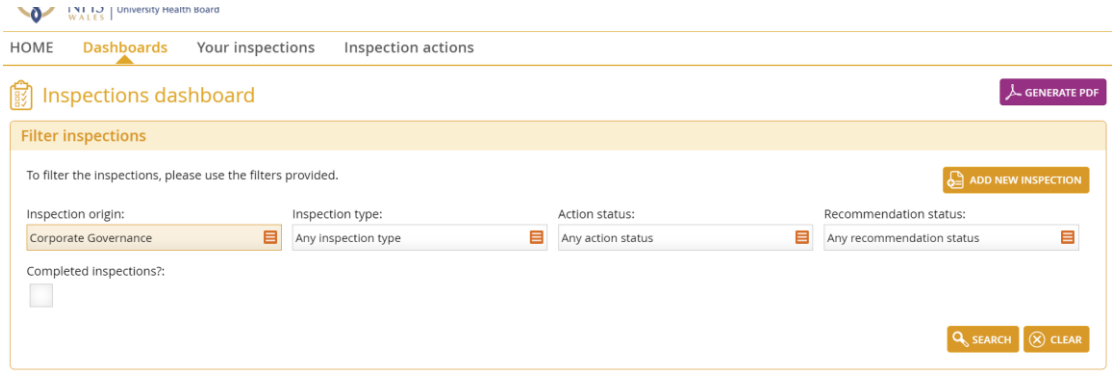
The AMaT Module that policies are stored under is Inspections Recommendations and Actions

On signing in to AMaT you will always be greeted by your own ‘To Do List’

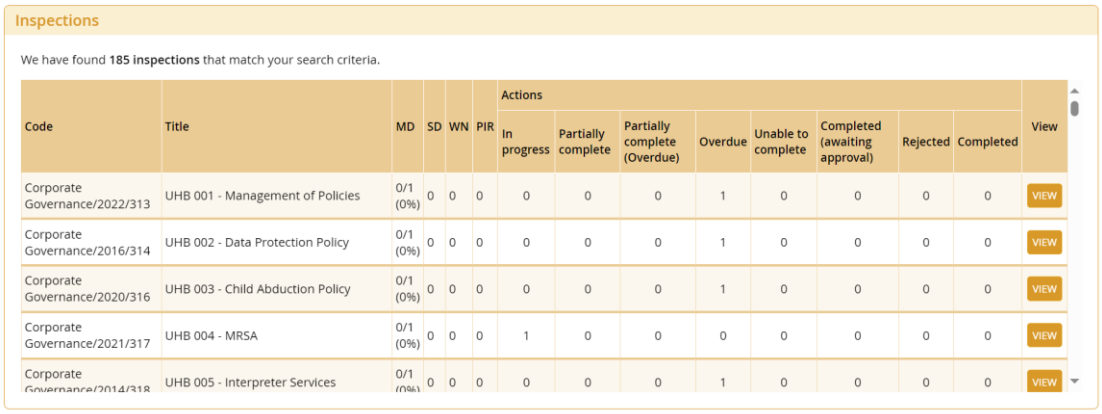


From here you can either view listing or close to access the AMaT System

Centrally held Policies are located under Inspections Recommendations and Actions, with a sub filter on Origin by Corporate Governance



Once Origin has been selected, click search to view all Policies, these are stored in order of policy reference i.e. UHB001



Each policy will have 1 Recommendation and 1 Action assigned to it

Recommendation

Policy must be reviewed 3 months before expiry date

Action

1) Download the policy version and share with the Exec lead and Authors for review
2) Provide an update to the relevant Committee / Board
3) Once the policy is approved, upload the new policy onto AMAT and amend the action dates to carry any recommendations/actions forward

The policies on AMaT are saved as Word documents for ease of review and update

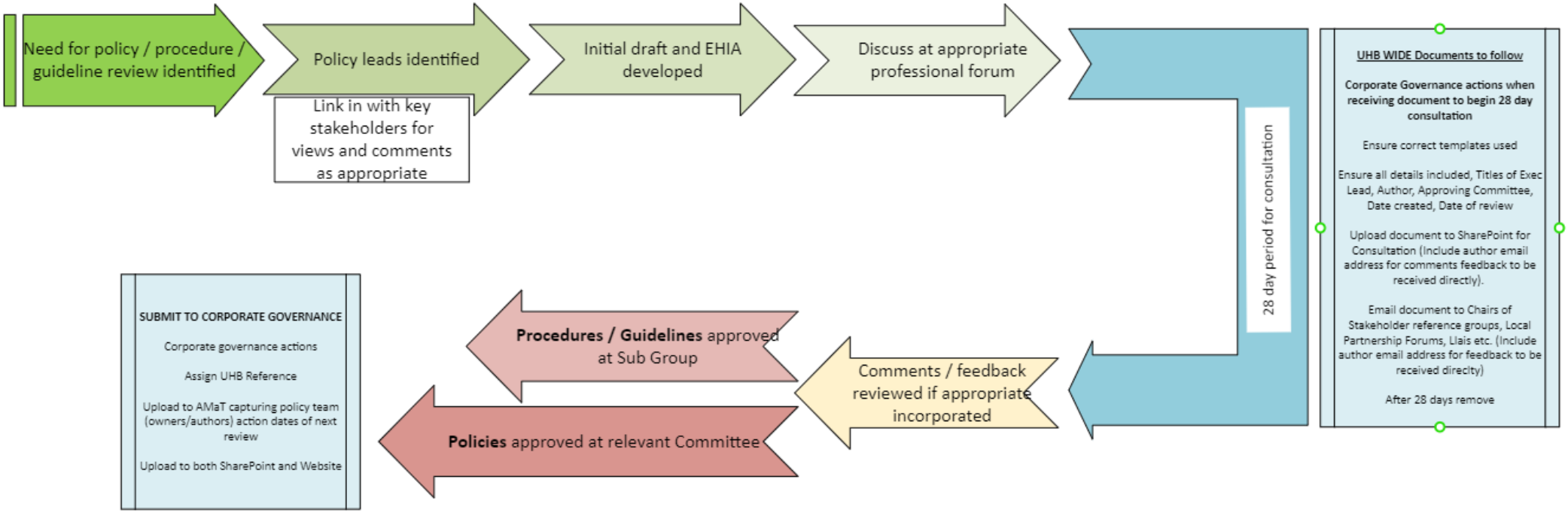
There is a Notes section within AMaT that can track all actions conducted for each Policy. All Policy correspondence is to be conducted within AMaT this will save the history of movement and reviews whilst notifying the Inspection Team members that Actions are being conducted/completed

Benefits

1. Increased transparency
2. Ownership retained by Author and/or Executive Lead
3. Each policy will have an Inspection Team consisting of Author/s Executive Assistant Corporate Governance officers and where appropriate Clinical Directors, Executives etc. there is no restriction to volume of users who can be assigned to manage the life of a policy
4. The Inspection Team will receive Automated Notifications when a policy is due for renew, these are set 3 months prior to review date
5. Should the ‘Author’ have left the Health Board when a review is required the remaining Inspection Team members will add additional members to assist the inspection team and ensure the review is conducted in a timely manner
6. A wider team action removes the onus from an individual and shared responsibility to ensure no policies are forgotten

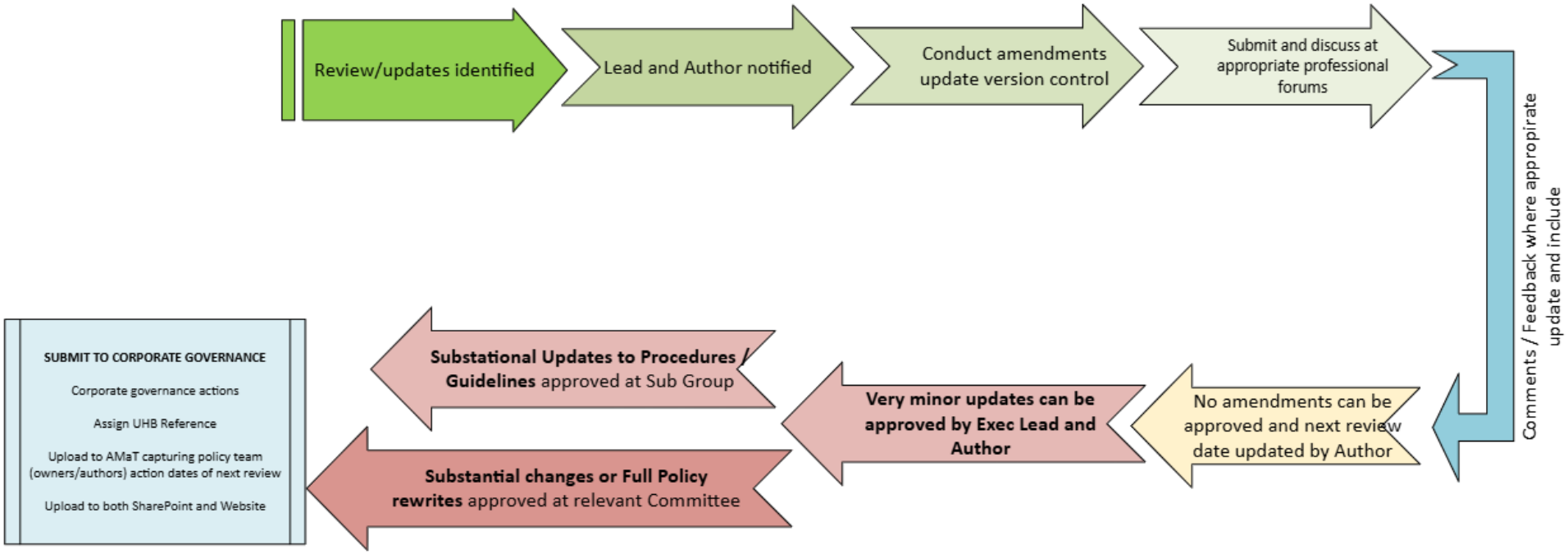
Appendix 5a

Example flowchart of document creation (See table 1, page 9 for detailed guidance on creation of new document)



Appendix 5b

Example flowchart of document creation (See table 1, page 9 for detailed guidance on reviews and amendments)


Review/updates identified
Lead and Author notified
Conduct amendments update version control
Submit and discuss at appropriate professional forums
Comments / Feedback where appropirate update and include
No amendments can be approved and next review date updated by Author
Very minor updates can be approved by Exec Lead and Author
Substational Updates to Procedures / Guidelines approved at Sub Group
Substantial changes or Full Policy rewrites approved at relevant Committee
SUBMIT TO CORPORATE GOVERNANCE
Corporate governance actions
Assign UHB Reference
Upload to AMaT capturing policy team (owners/authors) action dates of next review
Upload to both SharePoint and Website