POLICY FOR THE DEVELOPMENT, REVIEW AND APPROVAL OF ORGANISATIONAL WIDE POLICIES

Policy Details:

Ref:	GC02
Policy Author:	Assistant Director of Governance & Risk
Executive Sponsor:	Director of Corporate Governance / Board Secretary
Approval / Effective Date:	
Review Date:	
Version:	1 – Draft 6.8.2020

Target Audience:

People who need to know this document in detail	Authors and owners of policies, procedures and written control documents
People who need to have a broad understanding of this document	Board Members, Management Board. Senior Leaders. Board Committees.
People who need to know that this document exists	All staff involved in the development of Health Board Policies.

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	**Date:**
	Outcome:
Welsh Language Standard 82	
Date of approval by Equality Team:	Equality Team engaged in the review of this Policy.
Aligns to the following Wellbeing of Future Generation Act Objective	Provide high quality, evidence based, and accessible care

Policy Approval Route:

Where	When	Why
Management Board	December 2020	Endorsed for Approval
Health Board	28th January 2021	Approval

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Disclaimer:

If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or CTM_Corporate_Governance@wales.nhs.uk

CONTENTS

Introduction

The Cwm Taf Morgannwg University Health Board, subsequently referred to in this policy as the CTMUHB, has a statutory duty to ensure that appropriate policies are in place. Policies ensure Health board compliance to legislative and mandatory requirements. Policies outline the overarching principles for staff to perform their roles safely and competently.

A robust and clear governance framework for the management of policies is essential to minimise risk to patients, employees and the organisation itself; therefore, the Health Board has developed a system to support the development or review, approval, dissemination and management of polices.

All CTMUHB policies must be drafted in line with and incorporating the Health Board's organisational values and behaviours available via the following link: http://ctuhb-intranet/dir/AtOurBest/SitePages/Home.aspx

1. POLICY STATEMENT

1.1 This policy outlines the process for development, consultation, approval, dissemination, and review of key organisational documents such as policies, strategies, procedures, guidelines and protocols.

2. SCOPE OF POLICY

2.1 This policy applies to all staff and any particular areas of responsibility are listed in section setting out responsibilities.

2.2 Unless otherwise stated, the phrase 'key documents' will be the term used when a point is equally relevant to a range of documents whether they be strategies, policies, procedures, protocols, guidelines etc.

2.3 This policy relates to **organisation wide non clinical** documents however its principles equally apply to any local and/or clinical policy documents that are developed which are specific to a defined department to ensure that they are appropriately authenticated and regularly updated to form a reliable and valid source of good practice for staff.

3. AIMS AND OBJECTIVES

3.1 The purpose of this policy is to ensure that:

- All written key documents comply in terms of their format and content.
- The organisational values and behaviours are demonstrated by all through use of the policy
- There are systems in place for:
  - maintenance of a comprehensive index of all key documents
  - systems for consultation and approval of organisation wide key documents
  - comprehensive arrangements for dissemination of organisation wide policies, procedures, protocols, and guidelines across the organisation
  - systems for review of such documents within an appropriate timescale.

4. DEFINITIONS

4.1 **Strategy** - is a long term plan designed to achieve particular goals or objectives which is supported by policies and or procedures. They require an Equality Impact Assessment (EIA – refer to 5.4)

4.2 **Policy** - a written statement of intent, setting out the way in which an issue is to be managed by the Health Board. They are underpinned with evidence based procedures and guidelines and are mandatory, binding staff to follow them. They require an Equality Impact Assessment (EIA – refer to 5.4)

4.3 **Procedures / Standard Operating Procedures** - set out a series of actions which, when taken in a required order, will achieve a desired outcome. Procedures set out the operational processes to be followed to meet the objectives of the policy. They must include reference of any researched evidence used;

4.4 **Protocols** - provide step by step guidance. Within a protocol it must be clear by whose authority it is being implemented, what the scope of the protocol is and what should be done if practice is to be outside the protocol and reasons must be documented. Protocols are not mandatory, however they are generally prescriptive;

4.5 **Guidelines** - give general advice and recommendations for dealing with specific circumstances. They give options of how something might be carried out. Clinical guidelines are an aid to helping health care professionals and patients make the right decision about health care (NICE, 2001). Guidelines are not prescriptive and neither are they mandatory.

4.6 **Values** – are the principles that help you to decide what is right and wrong and how to act in various situations

4.7 **Behaviours** – are the way in which a person acts or conducts themselves especially towards others

5. IDENTIFYING THE NEED FOR A DOCUMENT

5.1 The diverse nature of health care means there will be a large number of policies, procedures, guidelines and protocols in place. Some will apply across the organisation and be relevant to all staff, and others will be specific to certain areas or activities. It is important that documents are assigned the correct definition as set out in point 4.

5.2 Documents that apply across the organisation must be sponsored by a lead Executive Director and therefore the author proposing the development of a policy document will need to discuss any proposal to create a new policy document with the relevant sponsor before proceeding. The author of the document should identify themselves by job title as the contact point on the front of the document. The authors cannot be named as more than one person and therefore if there is a group acting as the author a decision will need to made as to who the contact will be.

5.3 All documents must be compliant with the CTMUHB organisational values and behaviours which must be referenced and feature throughout the policy document

5.4 When the need for a key document arises, the Corporate Governance Team should be informed before preparation commences to ensure there is not a document already in existence on the same or a similar subject. Authors should complete the Initial Approval Form checklist (Appendix 1).

5.5 The Workforce and Organisational function has a well-established Workforce Policy Review Group (WPRG), which meets monthly. The purpose of the group is to work in partnership with CTMUHB trade union and professional organisation colleagues, to harmonise, develop and review the Health Board's corporate workforce related policies and associated procedures. The WPRG is accountable to the Local Partnership Forum, which is responsible for reviewing policies and procedures and where appropriate endorse them following the consultation process, to be ratified by the Management Board and People and Culture Committee as appropriate. The WPRG policy review process requires the partnership group to determine whether the policy / procedure is still required or requires updating due to legislation changes, being superseded by another policy etc. As the WPRG is a formal Heath Board group, whose remit it is to review and develop corporate policies and procedures that a decision is made that they are not

required to complete Appendix 1 for policies that are due for renewal. The WPRG would complete this form where it is identified that a new policy should be developed.

5.6 The Initial Approval Form checklist will be endorsed by the Management Board following consideration by the Corporate Governance Team.

5.7 Rather than drafting a completely new key document in some instances there may be an existing document that simply requires updating or expanding within its three year life.

5.8 In accordance with the Equality Act 2010, if the document is assigned the status of being a 'policy' it will be require an Equality Impact Assessment (EIA). The document author must carry this out and a notice to this effect must appear on the front of the document confirming the outcome. (See Appendix 4 for further information). Also in accordance with the Welsh Language (Wales) Measure 2011, when a policy is being formulated or revised, consideration of the effects, if any, of a policy on (a) opportunities for persons to use the Welsh Language, and (b) treating the Welsh language no less favourably than the English language must be considered and views sought. This has been incorporated into the EIA process.

5.9 The process for formulation and production and approval must follow the steps outlined in this document under sections 5-8.

5.10 The language used within a key document should be plain English avoiding technical terms wherever possible. If technical terms are necessary, or abbreviations desirable, they must be explained using a glossary / footnotes.

5.11 In accordance with the requirements of General Data Protection Regulations, names of individual staff must not be contained within key documents however job titles can be used. This will prevent a document being out of date should staff members leave their posts.

5.12 All documents must comply with current legislation, national and professional guidance. Policies must be based on sound evidence and be appropriately referenced.

5.13 Where a document requires that records are to be kept, the requirements of such documentation should be clearly set out in the document.

5.14 Where training is required to be able to implement a document, this must be clearly defined.

5.15 Any cost implications arising from a key document must be defined in the covering report circulated at the time of consultation/approval.

5.16 The sponsor is responsible for ensuring that the final version of the key document is fit for purpose and that it has followed a robust consultation process prior to it being presented for final approval (see Section 7 for information on the consultation/approval process).

6. RESPONSIBILITIES

6.1 **Staff** are responsible for the documents they use and create. Furthermore staff are responsible for ensuring that they are aware of the key documents relevant to their area of work, and that they act in accordance with these.

6.2 **Integrated Locality Groups, Clinical Service Groups, System Groups and Corporate Functions/Departments** are responsible for implementing systems to ensure that their staff within their area are promptly made aware of new or replacement documents and that they have a means of accessing live documents via the intranet site.

6.3 The **Corporate Governance Department** will act as a central point of contact for all organisation-wide non-clinical policy queries and will manage the organisation's non-clinical policy publication and archive system. They will:

- Ensure that policy authors have considered the Health Boards values and behaviours in the policy development. See Appendix 7.
- undertake a pre-publication check to validate compliance with the 'Policy on Policies' and those not meeting the requirements will not be published.
- ensure strict version control for organisation wide non clinical documents;
- ensure newly approved organisation-wide documents are notified to operational management units by email (a copy of the relevant email will be added to the final page of the document for reference purposes);
- advise and assist responsible officers as necessary with document queries;
- maintain a library of current documents which sets out date of approval and date of review;
- maintain a library of archived documents.

The Corporate Governance Department is located at Health Board Headquarters in Abercynon and can be contacted by email at: CTM_Corporate_Governance@wales.nhs.uk

6.4 The Organisational Wide **Clinical Policies** are managed by (TBC) and can be contacted on via (TBC).

6.5 Whether clinical or non-clinical, organisation-wide or locally applicable, document authors are responsible for:

- Identifying themselves as the contact point on the front of the document. Any documents not identifying the author will not be published.
- the appropriate production, consultation and timely review of key documents
- carrying out an Equality Impact Assessment as an integral part of policy development. Any policy not containing a reference to the outcome of the EIA on its front page will not be published. The EIA should be readily available upon request. An EIA must be signed off by a member of the Equality team
- ensuring that support measures are in place to provide training and advice, where required, by key document users
- ensuring that existing policy documents are flagged to the appropriate custodian (Corporate Governance or Clinical Policy Team) in order that documents under review are accordingly marked.
- at the point when a revised version of an existing key document is approved submit to the Corporate Governance Team to enable both archiving and also to ensure that the newly approved document is published on the intranet and internet as appropriate.

7. CONSULTATION / APPROVAL PROCESS

7.1 All new or significantly revised key documents must be developed in consultation with the relevant target audience involving appropriate managerial, professional, clinical and staff representation as necessary. The period of consultation must be adequate to allow robust consultation i.e. not less than 1 week but possibly as long as eight weeks. The consultation must be led by the author and completed prior to the document beginning the approval process.

7.2 Once consultation has been completed and content finalised the author is responsible for producing a covering report setting out the extent of the consultation process followed and details of any significant differences of opinion/ risks identified as part of this. This must be channelled through the executive sponsor to the relevant Board, Committee, Group or Forum who will be asked to approve the document. If the terms of reference of a Board level committee or Board level Group/Forum confirm it has delegated the approval process then the approval still requires formal reporting upwards and notifying by the author to the relevant committee. If there is no

covering report (see Appendix 6) summarising the process followed for consultation the document will not be published.

7.3 Standing Orders set out a Scheme of Delegation for CTMUHB and for organisation-wide documents. Strategies are a matter on which Health Board approval is required. Certain key policies also require approval by the Health Board (see section 7.6) whilst others are delegated to the appropriate Committee, Forum or Executive based Group (see section 7.7). Any delegated approvals must also be submitted through the relevant Executive Sponsor to the Corporate Governance Team to enable the document to be published on SharePoint and the internet. Documents that have not gained the required approval will not be published.

7.4 Where documents are written on an all-Wales basis or jointly with local authorities for formal adoption by CTMUHB, the Board will delegate adoption of the document to the relevant Committee, Forum or Group. The equality impact assessment will still require completion in these circumstances.

7.5 Local documents requiring approval will be subject to a documented process set out at operational level. These will be documents that are only applicable to a particular department or service clinical site rather than the organisation as a whole.

7.6 **Documents reserved for approval by the Health Board and or one of its Board Committees, Groups or Forums.**

APPROVING BODY	DOCUMENT EXECUTIVE SPONSOR	THEMES
Health Board *Endorsement for approval should be sought from the Management Board or Audit & Risk Committee (Standing Orders) prior to submission to the Board*	Chief Executive Director of Corporate Governance	Statutory/Legislative e.g. Standing Orders, Standing Financial Instructions etc.
Audit & Risk Committee	Director of Corporate Governance Executive Director of Finance & Procurement	Financial Management (Financial Control Procedures FCP's), Corporate Governance, Counter fraud. Risk Management
Charitable Funds Committee	Executive Director of Finance & Procurement	Investments, Fundraising, Bequests, Donations

Digital & Data Committee	Executive Director of Planning & Performance	Information Security Information Governance Information Communication & Technology Digital
Mental Health Act Monitoring Committee	Executive Director of Operations	Compliance with the Mental Health Act, Powers of Discharge
People & Culture Committee	Executive Director of Workforce & OD	Workforce matters
Planning, Performance & Finance Committee	Executive Director of Planning & Performance	Planning, Performance and Financial arrangements.
Primary Care and Population Health Committee	Executive Director of Operations	Primary Care & Population Health arrangements
Quality & Safety Committee	Medical Director Executive Nurse Director	Clinical Governance Patient Care related documents Complaints, Concerns and Claims Incidents Health & Safety
Local Partnership Forum *To endorse prior to approval to the People & Culture Committee*	Executive Director of Workforce & OD	Workforce matters
Management Board	Executive Director dependent on applicable portfolio	Organisational wide procedures.

7.7 Documents must be produced using the document template provided in Appendix 2 to this policy and will not be published unless they meet the requirements set out in this document. Appendix 2 contains the standard front cover which is to be applied to key documents along with supplementary guidance in Appendix 3. The only exception to this is for documents that are issued on an all-Wales basis.

7.8 Where changes are found to be necessary to a document between the date of approval and review, the nature of the changes will need to be considered by the relevant Executive Sponsor. Where changes are not considered material they can authorise an amendment and the document will then need to be relayed by email for publication to the Corporate Governance Team confirming a summary of the updates made and when this took place.

7.9 Where changes are significant, the document will need to be subject to consultation and reconsidered by the committee, forum or group who originally approved the document. Subsequent approval will need to be notified via the author to Corporate Governance Team. Urgent approvals can be sought as necessary and advice can be sought from the Corporate Governance Team on how to proceed with an urgent request.

7.10 If a document has come to the end of its three year life and the necessary amendments are not felt significant it will not require further consultation and can be sent to approval to the relevant body providing a summary of the changes in an accompanying cover paper.

7.11 The Corporate Governance Team will maintain records of all organisation-wide documents reported to them in accordance with this policy.

7.12 A mechanism to involve patients and members of the public in consultation (also known as citizen engagement) will be used where this is appropriate, demonstrating the organisation's commitment to working with the local community. Further information on this process can be accessed from the Planning function as appropriate. All consultation will be led by the author and must be completed prior to the document approval process.

8. PUBLICATION AND DISSEMINATION

8.1 The Corporate Governance Team are responsible for:

- Publishing notices regarding newly approved organisation-wide non- clinical documents.
- Publishing the approved organisation-wide non-clinical document on SharePoint and the Internet.

8.2 Operational Management Teams are responsible for:

- Notifying staff of the publication of the document and ensuring they have a means of accessing such documents so that they can be implemented as necessary by staff in their day-to-day role.

8.3 Policy authors should refer to Welsh Language Standards Policy Making Standards 69-77, Standard 82 and others as some policies need to be made available in Welsh. Furthermore, Welsh Language Standards, 78 and 110, require the health board to produce specific policies in Welsh, relating to the Welsh language in Primary Care and to Conducting a Clinical Consultation in Welsh. Other policies may also need to be made available in Welsh if they relate to the language. Advice can be sought from the Welsh Language Manager on this area of policy development.

8.4 If a document exists in both Welsh and English versions, both versions are considered to be authoritative health board documents, and you should not treat the Welsh language version less favourably than the English. It is acceptable to gain final approval of a draft policy in one language prior to translation to the other, but translation should take place as soon as possible to ensure both versions are published at the same time.

9. REVIEW PROCESS

9.1 A small number of documents need to be reviewed annually (and this requirement will be identified in individual documents by their authors), with the majority requiring review and re-approval in three years. Sometimes however a document which was subject to a three-year cycle will also need to be reviewed earlier in the light of changing practice, legislation or Welsh Government guidance/ policy changes etc. The author of the individual document is responsible for ensuring this takes place.

9.2 Any review of a document should include a review of related documents, such as Equality Impact Assessments, to ensure they reflect the content of the most recent version of the document.

9.3 If a document which exists in both Welsh and English versions is reviewed, you must ensure both versions are updated to reflect any changes as soon as possible after the approval of the changes.

9.4 In the event a notification is not received from the author by the Corporate Governance Team, the document will remain extant, authors must therefore ensure that they take steps to ensure that they either arrange for a document to be reviewed and reapproved prior to the three year anniversary or for it to be identified for archive.

9.5 Any documents beyond their three-year lifespan will be archived so that out-of- date documents are not in use.

9.6 Organisational change can lead to more than one version of a document on a given subject area existing. In such instances the author will take steps to develop a single version of the document. Should this not be achieved prior to the document reaching three years post approval it will be archived.

9.7 To assist Executives to maintaining an oversight of the documents approaching three years post-approval a twice yearly report will be sent to the Management Board from the Corporate Governance Team providing a summary of the position.

10. REVIEW PROCESS

10.1 Any advice required on implementation of this policy should be obtained via the Executive Sponsor the Corporate Governance Team.

10.2 The Corporate Governance Team will undertake periodic sampling to verify compliance with the requirements of this policy.

10.3 Where documents are submitted for publication but do not meet the pre-publication requirements they will be not be published. Such documents will be returned to the Executive Sponsor for action.

11. ACKNOWLEDGEMENTS

11.1 This policy is based on one developed by Swansea Bay University Health Board.

APPENDICES

The following appendices are held separately to the policy for ease of use.

Appendix 1 Policy / Key Document Approval Form / Checklist

Appendix 2 Policy / Key Document Template & Components

Appendix 3 Characteristics of Policies and Key Documents

Appendix 4 Equality Impact Assessment Tool & Guidance (including Welsh Language compliance)

Appendix 5 Steps involved in the creation of a Policy / Key Document

Appendix 6 Policy Approval Cover Report

Appendix 7 Values and Behaviours Inclusion in Health Board Policies

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

APPENDIX 1 POLICY / KEY DOCUMENT APPROVAL FORM/CHECKLIST

This form should be completed and approval obtained before you start producing your document. The Equality Impact Assessment should also have been started and any Welsh Language requirements considered. **To be completed by document author.**

1. **Proposed/existing title of document**

2. **'Owning group' - which group/committee will own the document?**

Name of group		**Chair of group**	
Please indicate (further details may be requested if applicable)			

3. **What type of document are you proposing/adopting/reviewing?**

4.

Policy		Procedure		Guideline		Protocol	
New		Existing					

5. **Which category will it be/is it?**

Clinical		Corporate	

If this is a corporate document will/does it impact on patient care?

Yes		No	

6. **What is the reason for developing/adopting/reviewing this document?**
Please tick the box that is most relevant. If there are no relevant boxes please tick other and ensure that you specify the reason in the box

7.

Improve/standardise clinical care/organisational procedures	
In response to complaint, incident or claim	
In response to alerts, safety notifications, WHCs etc.	
Re-organisation of service/department	
New/amended legislation	
All Wales documents / national guidance documents to be adopted for use	
Replacing/updating existing written control documents. If so, which ones (Please include policy reference and full name)	
Other (please specify)	

8. **What will be/is the aim of the document? What risks are being mitigated?**

9. **Which other written control documents will be/are relevant to the document?**

Document Number	**Document Name** List all document names and numbers that are relevant to this document

10. **What will be/is the scope of this document?**
What service area is covered by the document? Who does it affect? What patient groups? What professional groups or individuals does it affect? What competence is required by staff to use this procedure, e.g. completion of specific training, e-learning, formal qualification, competency framework, is required from users of the procedure?

11. **Have you considered how our values and behaviours feature throughout this policy?**

12. **Collaboration with Key stakeholders - What staff groups/professional groups/clinical specialities/services will be/are responsible for implementing/complying with this document?** These key stakeholders' will need to be involved in the development/adoption/review of the document to eliminate any barriers to its implementation prior to approval (see policy for guidance)

13. **Collaboration with others**
Involvement is an essential component of developing/adopting/reviewing the document. Please indicate which of the following need to be considered when developing/reviewing this document

Compliance with legislation/regulation/alert	**Please tick ☐**
Consent	
Deprivation of Liberty Safeguards (DOLS)	
Mental Capacity Act (MCA)	
Mental Health Act	
Safeguarding	
Data Protection/Records Management and Information Governance	

Welsh Language	
Counter Fraud	
Equality & Diversity	
National Safety Standards for Invasive Procedures (NatSSIPs)	
Alert/NCEPOD	
Interested parties	
NICE Guidance	
Patient Information	
Training/Learning & Development	
Legal	
Financial	
Workforce	
Medicines Management	
Medical Devices	
Maternity	
Infection Prevention & Control	
Business Continuity/Emergency Planning/Major Incident	

14. **Who will be/is the sponsoring Executive Lead and date they agreed to own this document?**

15. **Who will be/is the lead author/main contact for this document?** An individual's name and details will need to be provided as a contact for this document for any queries arise both during development and after approval.

Name	
Job Title	
Email Address	

Date of completion		**Name of person completing this form:**	
Chair of the owning group		**Signature of the Chair of the owning Group:**	

Please send completed form to the Corporate Governance Team:


GIG
CYMRU
NHS
WALES
Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

(DOCUMENT TITLE)

Document Type:	Choose an item.
Ref:	(For Non-Clinical References – Contact: CTM_Corporate_Governance@wales.nhs.uk For Clinical References – Contact: CTM_ClinicalPolicies@wales.nhs.uk
Author:	(Name and Title of Document Author)
Executive Sponsor:	Choose an item.
Approved By:	Choose an item.
Approval / Effective Date:	(00/00/0000)
Review Date:	(00/00/0000)
Version:	

Target Audience:

People who need to know about this document in detail	(*For example:* Authors and owners of policies, procedures and written control documents)
People who need to have a broad understanding of this document	(*For example:* Board Members, Management Board. Senior Leaders. Board Committees.)
People who need to know that this document exists	(*For example:* All staff involved in the development of Health Board Policies.)

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	**Date:** **Outcome:**
Welsh Language Standard	Choose an item.
Date of approval by Equality Team:	(00/00/0000)
Aligns to the following Wellbeing of Future Generation Act Objective	Choose an item.

Disclaimer:
If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or CTM_Corporate_Governance@wales.nhs.uk

COMPONENTS:

A policy must contain the following components and must also be written to include the values and behaviours of the organisation wherever relevant:

It is accepted that for Clinical Policies and or other Written Control Documents (Procedures, Guidance etc.) the policy components below may not all be relevant.

For guidance on Clinical Policy Development please contact:

CTM_ClinicalPolicies@wales.nhs.uk

For guidance on Non Clinical Policy Development please contact:

CTM_Corporate_Governance@wales.nhs.uk

Or visit the Policy Author Page on SharePoint:

CONTENTS PAGE

To create an interactive contents page that updates as you edit your document please follow the steps in the following guidance:
https://support.microsoft.com/en-us/office/insert-a-table-of-contents-882e8564-0edb-435e-84b5-1d8552ccf0c0

INTRODUCTION

1. POLICY STATEMENT

A concise statement of the rationale for the policy, including where necessary reference to external regulations or other relevant guidance. This should also reference the organisational values and behaviours.

2. SCOPE OF POLICY

Exactly who the policy applies to and the consequences for non-compliance where appropriate.

3. AIMS AND OBJECTIVES

This should be a statement of the desired outcome the organisation is seeking to achieve through the policy and how this aligns with corporate objectives and values and behaviours.

4. RESPONSIBILITIES

Describes the responsibilities and duties of both management and employees. It should include any particular functions that a particular post or department may have, relevant to the policy or its implementation

5. DEFINITIONS

Definition of terms where required

6. IMPLEMENTATION/POLICY COMPLIANCE

Reference to how the policy is to be implemented. This will be the main part of the policy, generally divided into sections and describe in detail what has to be done in order to comply with the policy, and achieve the policy statement. The document needs to set out how compliance with the policy is to be measured and reported.

7. EQUALITY IMPACT ASSESSMENT STATEMENT

A summary of the outcome of the EIA must be present on the front cover of the document.

Either

This policy has been screened for relevance to Equality. No potential negative impact has been identified.

Or

This policy has been subject to a full equality impact assessment and some issues have been identified and highlighted to ensure that due regard and weight is given to them in carrying out this policy.

Either statement needs to be approved by a member of the Equality team (CTM_Equality@wales.nhs.uk), and the date this was done noted.

Under Welsh Language Standard 82 policies which cover the following areas need to be made available in Welsh:

(a) a policy relating to behaviour in the workplace;
(b) a policy relating to health and well-being at work;
(c) a policy relating to salaries or workplace benefits;
(d) a policy relating to performance management;
(e) a policy relating to absence from work;
(f) a policy relating to working conditions;
(g) a policy relating to work patterns.

If one or more of the above apply, this should be indicated on the template and the policy (once approved) should be made available in Welsh. A Welsh version of a health board policy has equal status and authority to any English version. It should be published at the same time and it is vital that any changes made to either version are reflected immediately in the other.

Translations can be sent to ctt_welsh_translation@wales.nhs.uk.

8. REFERENCES

Policies must be based on sound evidence and be appropriately referenced.

9. GETTING HELP

Details of the specific office or department to contact for interpretations, resolution of problems and other special situations

A policy may also need to contain the following additional components:

10. RELATED POLICIES

Where other policies are relevant these should be listed.

11. INFORMATION, INSTRUCTION AND TRAINING

This section is relevant where instruction, training and supervision is necessary for to meet the policy requirements. It should detail when, how often and by whom the action will be taken and any requirement for keeping training records should be indicated.

12. MAIN RELEVANT LEGISLATION

A list of the relevant statutory provisions which influence the organisation's operation in relation to the policy.

APPENDIX 3 CHARACTERISTICS OF POLICIES, PROCEDURES AND GUIDELINES

The overall goal is for the design to be simple, consistent and easy to use.

Writing Style:

- Factual - accuracy should be double checked
- Should not provide information that may be quickly outdated
- If an acronym is used, it should be in full initially
- Not excessively technical, must be simple enough to be understood by a new member of staff

Policies should:

- Be written in clear, concise and simple language wherever possible
- Incorporate our organisational values and behaviours
- Identify the rule rather than how to implement the rule
- Be based on sound evidence and be appropriately referenced.
- Be readily available and their authority should be clear.
- Indicate designated "experts" who can interpret documents and resolve problems
- Represent a consistent, logical framework for action

Procedures/Guidelines should:

- Be clear in terms of how the procedure helps the organisation achieve its aims and objectives.
- Incorporate our organisational values and behaviours
- Be developed with the client/patient/relative/carer/objective in mind. Well developed and thought-out procedures provide benefits to the procedure user.
- Involve users in their development where appropriate to engender a sense of ownership

Design and Layout of Policy and Procedure Documents

- Use Verdana font 11 text
- Number paragraphs and pages
- Generous use of white space
- Structure the presentation so that the reader can quickly focus on the aspect of policy relevant to the decision in hand
- Headings need to be consistent, e.g. location on each page, type size, bold etc.
- Footer should contain: the reference, title and page number
- Abbreviations should be stated in full first use with abbreviation in brackets
- Logo – use the Health Board Logo
- Electronic format is Microsoft Word
- Front cover as the template document
- Underlining – avoid where possible.

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Equality Impact Assessment - Policies

This section must be completed at the beginning of a policy or service review, this includes changed or withdrawn services in order to the assess the impact on different protected groups under the Equality Act 2010. For advice on its completion please contact the Equality Team on CTM_Equality@wales.nhs.uk. For examples of completed EIAs please see the Equality site on Sharepoint.

Section 1 – Preparation		
1.	**Title of Policy/service**	
	Is this a new policy/service or an existing one?	Choose an item.
2.	**Policy/Service Aims and Brief Description**	*What is the policy/service for? Give a brief description of the policy/service – no more than 4-5 lines.*
3.	**Who Owns/Defines the Policy/Service?** -	*Who is responsible for the policy/service/work? i.e. the department.*
4.	**Who is Involved in undertaking this EqIA?**	*Who are the key contributors and what are their roles in the process?* *Please note this should be completed by the author but the views of other team members, service users etc should be sought.*
5.	**Other Policies and Services** -	*Describe where this policy/service/work fits in a wider context. Is it related to any other policies/activities that could be included in this EqIA? Is it relevant to the Integrated Medium Term Plan (IMTP)?*

Section 1 – Preparation		
7.	**What might help/hinder the success of the policy/service?**	*These could be internal or external factors. E.g. training, awareness raising.*
8.	Is the policy/service relevant to "eliminating discrimination and eliminating harassment?"	*Eliminating discrimination refers to the removal of barriers that disproportionately affect some groups more than others. Any policy/service which specifically relates to a particular kind of person will likely relate to eliminating discrimination.* *Eliminating harassment refers to the prevention of bullying or other unwanted behaviour based on an individual's protected characteristics.*
9.	Is the policy/service relevant to "promoting equality of opportunity?"	*Promoting Equality of Opportunity means that all people have the same chance to access a service or other opportunity. This may mean treating some groups differently to others to ensure they have the same chance.*
10.	Is the policy/service relevant to "promoting good relationships and positive attitudes?"	*Does the policy/service encourage people to treat one another fairly, irrespective of any protected characteristics?*

Section 2. Impact

Please answer the following.
Consider and refer to the information you have gathered from census data, relevant organisations and groups, staff groups, individuals etc. Please indicate the likelihood and risk associated with the issues raised. Some examples have been given against each category but this is not exhaustive and you may identify other issues.

PLEASE INCLUDE RELEVANT DATA FOR EACH GROUP *E.G. IF YOU ARE AWARE OF YOUR POLICY OR SERVICE BEING RELEVANT TO PARTICULAR GROUPS E.G. IF IT IMPACTS ON OR IS LIKELY TO BE USED OR RELEVANT TO OLDER PEOPLE, ADD STATISTICS IN RELATION TO STAFF AND OR LOCAL POPULATION. USE NATIONAL STATISTICS WHERE RELEVANT.*

Do you think that the policy/service impacts on people because of their age? (This includes people of any age but typically focusing on children and young people up to 18 and older people over 60)

Issues to consider might include things like retirement, public transport access. Old age often intersects with disability e.g. sensory loss (particularly hearing), mobility problems.

Do you think that the policy/service impacts on people because of their disability? (This includes sensory loss, physical disability, learning disability, some mental health problems, and some other long term conditions such as Cancer or HIV)

Consider how people with a range of disabilities will be differently affected. This could include mobility in terms of access to different sites, people with sight loss or learning disabilities being able to negotiate new surroundings, people with hearing or communication difficulties being able to access telephone based services or intercom systems.

Does the policy impact on people because of their caring responsibilities?

Do you think that the policy/service impacts on people because of their caring responsibilities? I.e. would it affect their ability to care for somebody who is primarily dependant on them? This could include family members but not necessarily. E.g. if a children's service is relocated, how would that impact on the parents' ability to care for other family members.
Do you think that the policy/service impacts on people because of Gender reassignment? (This includes all people included under trans* e.g. transgender, non-binary, gender fluid etc.) *If the policy/service treats men and women differently how will you ensure Trans*individuals are included? Does the policy/service ensure that Trans* individuals maintain privacy and the right to gender expression? Is language gender neutral and are specific provisions made for their needs.*
Do you think that the policy/service impacts on people because of their being married or in a civil partnership? *Impacts in this area are rare, but it can intersect with gender discrimination. Whether an individual is married or not should not impact any aspect of the way they are treated.*
Do you think that the policy/service impacts on people because of their being pregnant or having recently had a baby? (This applies to anyone who is pregnant or on maternity leave, but not parents of older children) *For example, e.g. would an individual miss an opportunity due to being on Maternity Leave? How will you ensure those absent on maternity leave have the same access to those at work?*
Do you think that the policy/service impacts on people because of their race? (This includes colour, nationality and citizenship or ethnic or national origin such as Gypsy and Traveller Communities, Welsh/English etc.) *For example people might be affected as they are marginalised within communities or because of language barriers*
Do you think that the policy/service impacts on people because of their religion, belief or non-belief? (Religious groups cover a wide range including Buddhist, Christians, Hindus, Jews, Muslims, and Sikhs as well as atheists and other non-religious groups)

Could they be impacted because of their cultural beliefs and observations e.g. sensitivities regarding being treated by staff of a particular gender, prayer and dietary issues etc.
Do you think that the policy/service impacts on men and women in different ways? *Do men and women have different needs and commitments that need to be considered. Are their respective roles fully considered in work-life balance policies etc.*
Do you think that the policy/service impacts on people because of their sexual orientation? (This includes Gay men, heterosexual, lesbian and bisexual people) *Do policies take account of same sex relationships in terms of work-life balance policies, visitors and relationship status etc.*
Do you think that the policy/service impacts on people because of their Welsh language? (e.g. the active offer to receive services in Welsh, bilingual information etc). *Does the policy take account of the Welsh Language Standards e.g. is information translated, do patients have the opportunity to communicate in Welsh, are staff available for this purpose*
The Welsh government is introducing **a new Socio-economic duty which will be effective from April 2021. It will ask us to consider the impact of our decisions on inequality experienced by people at socio-economic disadvantage.** *We know that we provide services to some of the most economically disadvantaged groups in Wales, please take account of how this policy/service could impact on them (from 1.4.21.). e.g. when services move, it can be difficult to travel for those relying on public transport.*

Section 3 Outcome	
Summary of Assessment: **Please summarise Equality issues of concern and changes that will be made to the service development accordingly.**	
Please indicate whether these changes have been made.	
Please indicate where issues have been raised but the service development has not been changed and indicate reasons and alternative action (mitigation) taken where appropriate.	
Who will monitor this EIA and ensure mitigation is undertaken	
Approved by Equality Team **To be held on Equality /Covid 19 Site**	**Yes/No** **Signed .....** **(Equality Manager / Officer)** **Date.....** **Actioned Yes/No**

APPENDIX 6 - STEPS INVOLVED IN DOCUMENT CREATION

Stages	Lead	Action	Additional Information
Step 1	Policy Owner / Author	**Validate the need for a new (or revised version of an existing) Policy or Key Document** by completing the Policy / Key Document Approval Form Checklist	Support available from Corporate Governance Team
Step 2	Policy Owner / Author	**Carry out an Equality Impact Assessment** The purpose of carrying out an assessment is to enable the organisation to identify and eliminate any negative effect that 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. Equality impact assessment should start at the beginning of key document making or review. This will enable equality considerations to be taken into account throughout the design or review. Responsible officers must therefore carry out the equality impact assessment process and start by screening the document for relevance to equality. The Equality Impact Assessment Process should be used to carry out the screening (see Appendix 5). Responsibility for completing the Equality Impact Assessment lies with the officer(s) responsible for the policy, however the Equality & Welsh Language Team are able to support as required. A member of the team should sign off a completed EIA.	Support available from the Equality & Welsh Language Team
Step 3	Policy Owner / Author	**Include Values and Behaviours in your Policy - refer to the organisational values and behaviours document** We want to bring our values and behaviours to life, in every way we can. Our organisational policies is certainly one of them. There will be opportunities for you to demonstrate our values and behaviours throughout your policy. This consideration should be made as you are drafting or reviewing your document. Not only should our values and behaviours be referenced at the beginning of the policy, they need to be woven through the content at every opportunity.	Support available from the Values & Behaviours project team
Step 4	Policy Owner / Author	**Document Components and Format Requirements** Reference the following items needs to be made: • Policy Key Document Template & Components (Appendix 2) • Characteristics of Policies & Key Documents (Appendix 3) • Equality Impact Assessment (Appendix 5)	Support available from Corporate Governance Team
Step 5	Policy Owner / Author	**Document drafted**	Support available from Corporate Governance Team
Step 6	Policy Owner / Author	**Engagement with Target Audiences / Identified Interested Parties** Formal response from engagement to be captured and incorporated into the invitation for Organisational Wide Consultation.	Liaise with the Executive Sponsors
Step 7	Policy Owner / Author	**Engagement with Local Partnership Forum** Formal response from engagement to be captured and incorporated into the invitation for Consultation.	Liaise with the Assistant Director of Workforce initiate this stage.

Step 8	Policy Owner / Author	**Consultation** Authors must ensure they consult widely with all interested parties ensuring an adequate period for receipt of comments of between 1-6 weeks. If the key document is relevant to patient / donor care it may be appropriate to seek views from patient / donor focus groups, equality groups or similar and in this circumstance the need to produce the document in other formats (in terms of language and format) may apply. Advice can be obtained from the Patient Experience Departments. Any documents created for patients/public must be produced bilingually in line with the organisation's commitment to the Welsh Language. Advice can be obtained from the Welsh Language Officer.	Support available from Corporate Governance Team
Step 9	Policy Owner / Author	**Preparing for Validation and Approval** The author will need to identify the appropriate committee/group to approve the document. A covering report will need to set out the consultation process followed and the Executive Sponsor will submit to the relevant Board/Committee for approval. The Board will receive updates on approved policies for endorsement as appropriate.	Support available from Corporate Governance Team
Step 10	Policy Owner / Author	**Following Approval** Following approval the author of the document is responsible for submitting the final document to the Corporate Governance Team for publication via SharePoint and the Internet. In accordance with the Welsh Language Standards, some policies need to be made available in Welsh. These policies can be translated internally and this should take place once the final version is approved.	Support available from Corporate Governance Team Support available from Welsh Language Team
Step 11	Corporate Governance Team	**Publication** When the policy has been received from the Policy Owner / Author the Corporate Governance Team will update the master policy library and send to the Communications Team to upload to SharePoint and the internet as appropriate.	

AGENDA ITEM
(INSERT NUMBER)

Choose an item.

(INSERT POLICY TITLE)

Date of meeting	(DD/MM/YYYY)
FOI Status	Choose an item.
If closed please indicate reason	Choose an item.
Prepared by	(Please Include Name and Title)
Presented by	(Please Include Name and Title)
Approving Executive Sponsor	Choose an item.
Report purpose	FOR APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 (Include the brief purpose of the policy and its scope).

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 Engagement on this Policy and Procedure has taken place with:

Name Title	***Date Consulted/Completed***
Equality Impact Assessment	
Informal Consultation with interested parties	
Formal Consultation	
Committee – For approval	

2.2 The policy has been reviewed and is consistent with the approach across NHS Wales / legislation.

2.3 ?? have been engaged in the consultation

2.4 Organisational values and behaviours have been reflected within the policy.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 In response to the consultation the following amendments have been made:

Or

Only minor typographical amendments were made as a result of the various consultation stages.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Choose an item.
Related Health and Care standard(s)	Choose an item.
	If more than one Healthcare Standard applies please list below:
Equality impact assessment completed	Choose an item.
Legal implications / impact	Choose an item.
Resource (Capital/Revenue £/Workforce) implications / Impact	Choose an item.
Link to Strategic Well-being Objectives	Choose an item.

5. RECOMMENDATION

*5.1 The (Meeting Name) are asked **APPROVE** the (Policy Name)*

5.2 Once approval is sought the author will share the Policy with the Corporate Governance Team for publication on SharePoint and the Health Board Internet Site.

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Appendix 7

Values and Behaviours Inclusion – Policies

This document is designed to support you in incorporating our values & behaviours into your policy document or review. To create the culture we all desire within Cwm Taf Morgannwg, our values and behaviours must be woven into everything that we do and our organisational policies are an important example. Please consider where you can incorporate our values and behaviours in every section of your policy. Our values and behaviours are listed below. For advice on its completion please contact the Values and Behaviours project team at CTM.atourbest@wales.nhs.uk

An example of how the values can be applied to a policy is included on the Policy Author page on SharePoint using the Raising Concerns Policy.

For each of our 3 values and associated behaviours below, consider how each can appropriately feature throughout your policy document:

Please put a tick in the box ☐☐ to indicate you have incorporated the values and behaviours below:

Incorporating our values and behaviours

We Listen, Learn & Improve ☐☐

- We take time to ask and listen carefully to people's worries, views and ideas — then actively do something to make a difference. ☐☐
- We make it safe and easy for people to speak up - as well as being open to giving and receiving feedback as a chance to learn. ☐☐
- We welcome change, bring a positive, 'will do' attitude and find ways to actively improve the way we do things. ☐☐

We Treat Everyone With Respect ☐☐

- We take time to ask and listen carefully to people's worries, views and ideas — then actively do something to make a difference. ☐☐
- We make it safe and easy for people to speak up - as well as being open to giving and receiving feedback as a chance to learn. ☐☐
- We welcome change, bring a positive, 'will do' attitude and find ways to actively improve the way we do things. ☐☐

We All Work Together As One Team ☐☐

- We bring people together and build strong, trusting relationships by including others in decisions and activities. ☐☐
- We look out for people's wellbeing and safety — both physical and psychological — and support them if these are at risk. ☐☐
- We are open, clear and honest in the way we communicate, and — if we need to — change the way we explain something to help people understand. ☐☐
- When we learn something useful and inspiring, we share it with others. ☐☐

Values and Behaviours Review	
Please indicate if you have not included one of our values– provide a brief explanation	
On a scale of 1-5, how easy or difficult was it to incorporate our values? **5 - very easy** **4 – easy** **3 – not very easy** **2 – fairly difficult** **1 – very difficult** **Please provide any feedback as necessary**	