Meeting Date	**25th May 2023**	**Agenda Item**	**5.2**
Report Title	**Corporate Governance Report**		
Report Author	Georgia Pennells, Corporate Governance Officer		
Report Sponsor	Hazel Lloyd, Director of Corporate Governance		
Presented by	Hazel Lloyd, Director of Corporate Governance		
Freedom of Information	Open		
Purpose of the Report	To report on corporate governance matters arising since the previous meeting.		
Key Issues	There are a number of corporate governance matters which have to be reported to the board as a regular item in-line with standing orders. This report encompasses all such issues as one agenda item. The Board is asked to receive the updates in relation to : • Matters considered In-Committee; • Welsh Health Circulars; • Business Cycle; • Common Seal Register. • Annual General Meeting (AGM)		
Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☒	☐	☐	☒
Recommendations	Members are asked to: • **NOTE** the Matters considered In-Committee including Chair's Actions; Welsh Health Circulars, Business Cycle, the Common Seal Register • **APPROVE** the policy for the management of Health Board wide policies, procedures and other written control documents • **APPROVE** a temporary change to standing orders for the AGM to take place no later than 28th September 2023 rather than 31st July 2023 and; • **APPROVE** the changes to the WHSSC standing orders		

CORPORATE GOVERNANCE REPORT

1. INTRODUCTION
To report on corporate governance matters arising since the previous meeting.

2. BACKGROUND
There are a number of corporate governance matters, which have to be reported to the board as a regular item in-line with standing orders. This report encompasses all such issues as one agenda item.

3. GOVERNANCE AND RISK ISSUES

(i) Matters Considered In-Committee
In accordance with standing orders, the health board is required to report any decisions made in private session, to the next available public meeting of the board.

The following items were discussed during the in-committee board session in January 2023:

- **Key Issues Report from In-Committee Board Committee meetings** - a report on key issues discussed at recent committee meetings was received for assurance.
- **Operational Matters –** a verbal update was provided by Mark Hackett, Chief Executive.
- **Industrial Action** – a verbal update was provided by Debbie Eyitayo, Director of Workforce and OD.
- **Risk Register** – a report outlining the in-committee section of the risk register was receive.
- **nVCC financial and commercial case** – a report outlining the commercially sensitive aspects of the nVCC financial and commercial case was received.
- **The self-assessment against the Auditor General's board effectiveness review of Betsi Cadwaladr University Health Board Chair's Actions** - a report on the findings was considered.
- **Chairs actions** The following chairs actions were ratified:
  - The final lease exit payment to the landlord of the Bay Studios Site
  - The payment of an invoice over £750k to Neath Port Talbot County Borough Council in respect of Regional Investment Fund Funding

(ii) Welsh Health Circulars (WHCs)
Welsh Government issues WHCs around specific topics. The WHCs set out in **appendix 1** have been received since the last meeting and are available via the Welsh Government website, where further details as to the risks and governance issues are available.

(iii) Board Business Cycle
At each meeting, the board receives copy of its business cycle, which outlines the business planned for each meeting. This is set out in **appendix 2.**

(iv) Common Seal Register

In-line with standing orders, a routine report on documents to which the common seal has been affixed is required. Attached at **appendix 3** are details taken from the seal register.

(v) Policy for the management of Health Board wide policies, procedures and other written control documents

The attached policy (appendix 4) has been reviewed and was submitted for approval to Management Board on 19th April 2023. The purpose of the document is to provide guidance on the production of all written key documents with regard to their format and content and to ensure systems are in place for consultation, approval and dissemination of policies, procedures and Written Control Documents (WCDs). The document has been updated, with only some minor changes around the EQIA process, contact details for the Library & Knowledge Service, changes from Executive Board to Management Board, removal of H&S Committee and the archiving process for policies. The board is now asked to approve the policy as it is a responsibility of the board to approve and ratify the overarching policy on the management and approval process for health board policies.

(vi) Annual General Meeting

The revised timetable for Audit Wales to submit Final Annual Reports and Accounts to HSSG Finance has impacted on organisations ability to hold an Annual General Meeting (AGM) (referred to as Public Meetings in the Financial Reporting Manual) by 31 July, the date specified within the Health Boards Model Standing Orders as referred to in Welsh Health Circular (2021) 010.

Welsh Government has written to organisations to formally confirm and acknowledge, as referred to within the recently revised Chapter 3 of the Financial Reporting Manual (extract below), that the AGM can take place no later than 28 September and not 31 July in 2023 as specified within the Model Standing Orders issued in 2021.

A temporary amendment is to be made the standing orders for 2023.to recognise that the AGM will be held no later than 28 September 2023. This was supported by the Management Board and Audit Committee for board approval.

(vii) WHSSC Standing Orders

In accordance with the WHSSC Regulations 2009, each Local Health Board (LHB) in Wales must agree Standing Orders (SOs) for the regulation of the Joint Committee proceedings and business. These Joint Committee standing orders form a schedule to each LHB's own standing orders, and have effect as if incorporated within them. Together with the adoption of the Scheme of Decisions.

4. FINANCIAL IMPLICATIONS

There are no financial implications arising within this report.

5. RECOMMENDATIONS

Members are asked to:

- **NOTE** the Matters considered In-Committee including Chair's Actions; Welsh Health Circulars, Business Cycle, the Common Seal Register and;
- **APPROVE** the policy for the management of Health Board wide policies, procedures and other written control documents.
- **APPROVE** a temporary change to standing orders for the AGM to take place no later than 28th September 2023 rather than 31st July 2023
- **APPROVE** the changes to the WHSSC standing orders

Governance and Assurance		
Link to Enabling Objectives *(please choose)*	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☒
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☐
	Partnerships for Care	☒
	Excellent Staff	☐
	Digitally Enabled Care	☐
	Outstanding Research, Innovation, Education and Learning	☐
Health and Care Standards		
(please choose)	Staying Healthy	☐
	Safe Care	☐
	Effective Care	☐
	Dignified Care	☐
	Timely Care	☐
	Individual Care	☐
	Staff and Resources	☒
Quality, Safety and Patient Experience		
Welsh health circulars provide advice, guidance and information relating to changes in process or services which work to enhance services.		
Financial Implications		
There are no financial implications associated with this report.		
Legal Implications (including equality and diversity assessment)		
Any legal implications relating to Welsh health circulars would be identified in the individual documents.		
Staffing Implications		
There are no staffing implications contained within this report.		
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)		
Welsh health circulars provide advice, guidance and information relating to changes in process or services which work to enhance the way in which NHS Wales		

organisations function and would therefore potentially have individual long-term impacts.	
Report History	This report is a standard item on the board's business cycle.
Appendices	Appendix 1 - Welsh Health Circulars; Appendix 2 - Board business cycle; Appendix 3 – Common seal register Appendix 4 – Policy on Policies Resources – WHSSC Standing Orders

Appendix 1

WELSH HEALTH CIRCULARS LOG

WHC Number and Title	Date Received by Email	Recipients Taking Action
WHC 2022 032 Further extending the use of Blueteq in secondary care	21/03/23	Medical Directors, Finance Directors, Chief Pharmacists, Local Health Boards and NHS Trusts
WHC/2023/07 Patient Testing Framework – Updated guidance	31/03/23	All Health Boards, NHS Trusts
WHC/2023/06 Commencement of the Health and Social Care (Quality and Engagement) (Wales) Act 2020	05/04/23	Medical Directors, Nurse Executive Directors, Directors of Primary and Community Care, Directors of Therapies and Health Sciences (DoTHS), Local Health Boards, NHS Trusts, Strategic Health Authorities, WHSSC, NHS Blood and Transport (in relation to Welsh functions), GP practices, community pharmacies, optometrists and dental practices.
WHC/2023/03 Guideline for the Investigation of Moderate or Severe early developmental impairment or intellectual disability (EDI/ID)	05/04/23	All Health Boards
WHC/2023/09 COVID-19 vaccination of children aged 6 months to 4 years in a clinical risk group	06/04/23	Chief Executives, Health Boards/Trusts Immunisation Leads, Health Boards/Trusts Immunisation Coordinators, Health Boards COVID-19 Vaccination Leads, Health Boards/Trusts Medical Directors, Health Boards/Trusts Directors of Primary Care, Health Boards/Trusts Nurse Executive Directors, Health Boards/Trusts Chief Pharmacists, Health Boards/Trusts Directors of Public Health, Health Boards/Trusts Executive Director of Public Health, Public Health Wales Head Vaccine Preventable Disease Programme, Public Health Wales Director of Planning, NHS Wales Delivery Unit, Community Pharmacy Wales, General Practitioner Council, Wales General practitioners, Community pharmacists

Appendix 3

COMMON SEAL REGISTER

Document Number	Date Signed	Document Details
16/23	22.03.23	NEC4 engineering and construction short contract In relation to DYFED and Tempest ward works Morriston Hospital
17/23	22.03.23	Lease room 3.2.8, 3rd Floor Civic Centre Oystermouth road Swansea
18/23	22.03.23	Gamma Camera Morriston Hospital (Spect CT)
19/23	22.03.23	Morriston Hospital Cath Lab Suite A
20/23	22.03.23	SARC - Architect and Principal Designer Services
21/23	22.03.23	NEC4 engineering and construction short contract in relation to supply and fit fence at Meadow Court
22/23	22.03.23	SARC Quantity Surveying Services
23/23	22.03.23	Dyfed Road Health Centre Boiler House
24/23	22.03.23	NEC4 engineering and construction short contract in relation to Emergency Department Waiting Area improvements at Morriston Hospital
25/23	22.03.23	NEC4 engineering and Construction Short contract in relation to Cimla Digital Solutions Suite
26/23	22.03.23	Mammography 2nd room Singleton hospital
27/23	22.03.23	Ty'r Felin Surgery Gorseinon
28/23	22.03.23	Refit project phase 4 – Extension of the existing Brynwhilach Solar Farm to 5MWp and the inclusion of 2 MWh of Battery Storage
29/23	22.03.23	Morriston Hospital Cath Lab Suite A
30/23	22.03.23	Ward 5 Relocation to Ward 18 Singleton Hospital
31/23	22.03.23	Clinical space lower ground floor at the former Rhondda Magistrates Court Tonypandy
32/23	31.03.23	Integrated Care Fund Main Capital Programme
33/23	19.04.23	Remedial Repair Works Roof Level Flank Wall & Engineering Compound 2 Morriston Hospital
34/23	19.04.23	NEC4 Engineering + Construction Short Contract In relation to Oncology: Lin 5 Improvement Works

35/23	19.04.23	NEC4 Engineering + Construction Short Contract In relation to Security Works at Cefn Coed Hospital

Health Board Work Programme

Topic	Lead	May	June	July	September	November	January	March
Preliminary Matters								
Patient Story	Director of Nursing and Patient Experience							
Minutes of the Previous Meeting	Director of Corporate Governance							
Action Log	Director of Corporate Governance							
Chair's Report	Chair (verbal)							
Chief Executive's Report	Director of Corporate Governance							
Quality, Safety and Performance								
Committee Key Issue Reports	Director of Corporate Governance							
HIW Annual Report	Director of Nursing and Patient Experience							
Risk Register	Director of Corporate Governance							
Board Assurance Framework	Director of Corporate Governance							
Annual Report and Governance Statement	Director of Corporate Governance							
Annual Accounts and ISA260	Director of Finance							
Strategic Items								
Discretionary Capital Plan	Director of Strategy							
Budget and Financial Allocations	Director of Finance							
Major Incident Plan	Director of Strategy							
Winter Plan	Chief Operating Officer							
People								
Quarterly workforce resilience report	Director of Workforce and OD							
Governance								
Corporate Governance Issues	Director of Corporate Governance							
Welsh Language Standards	Director of Corporate Governance							
Review of Standing Orders	Director of Corporate Governance							
Organisational Annual Report	Director of Corporate Governance							
Accountability Report	Director of Corporate Governance							
Advisory Group Key Issues	Director of Corporate Governance							
Structured Assessment and Audit Letter	Director of Corporate Governance							
Items Already Considered by Committees								
Financial Position	Director of Finance							
Peformance Report	Director of Finance							
Nurse Staffing Levels (Wales) Act 2016	Director of Nursing and Patient Experience							
Progress Against the IMTP	Director of Strategy							
Items for Noting								
NHS Wales Partnerships	Director of Strategy							
External Partnerships	Director of Strategy							

POLICY FOR THE MANAGEMENT OF HEALTH BOARD WIDE POLICIES, PROCEDURES AND OTHER WRITTEN CONTROL DOCUMENTS (WCD)

This policy has been screened for relevance to equality. No potential negative impact has been identified so a full equality impact assessment is not required.

Amendment: April 2023 – changes to EQIA process, contact details COIN, committee structure, minor changes to review process and removal of EQIA guidance document

Document Author:	***Director of Corporate Governance***
Approved by:	***Health Board***
Approval Date:	***April 2023***
Review Date:	***April 2026***
Document No:	***HB76***

CONTENTS **Page**

1. POLICY STATEMENT

1.1 This document 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** documents however its principles equally apply to any local policy documents that are developed which are specific to defined department as they also need to be appropriately authenticated and regularly updated so that they 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:

3.1.1 all written key documents comply in terms of their format and content.

3.1.2 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.

3.1.3 to provide a template for local policy documents to follow.

3.2 This policy aligns with the Health Boards corporate objectives in terms of providing systems to ensure effective governance of key organisational documents.

4. DEFINITIONS

– **Strategy -** is a long term plan designed to achieve particular goals or objectives which is supported by policies and or procedures;

– **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 Analysis (EIA – refer to 5.5)

- **Procedure -** 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;
- **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;
- **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.

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 sponsor/author of the document should identify themselves by job title as the contact point on the front of the document..

5.3 When the need for a new policy or WCD arises, the Corporate Services Department 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).

5.4 Rather than drafting a completely new key document in some instances there may be an existing version that that simply needs updating within its three year life. In such instances depending on whether the document is clinical or non-clinical this will need to be flagged by email to the relevant team details of which are under point 6.3 & 6.4.

5.5 In accordance with the Equality Act 2010, the document will 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 of this assessment. Please contact the Director of Insight, Communications and Engagement Directorate for further information on the EqIA process.(appendix 6 – EQIA assessment tool). 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. If advice on this area, is required please contact the Health Board's Welsh Language Officer.

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

5.7 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.

5.8 In accordance with the requirements of GDPR, 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.

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

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

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

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

5.13 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. Further more 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 Delivery Units and Corporate 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 Services Department will act as a central point of contact for all organisation-wide non-clinical document queries and will manage the organisation's non-clinical policy publication and archive system. They will:

- 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 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 Services Department is located at Health Board Headquarters, One Talbot Gateway, Port Talbot, SA12 7BR and can be contacted by email at sbu.inquiries@wales.nhs.uk.

6.4 The organisation wide clinical document directory 'Clinical Online Information Network' (COIN) is managed by the Library & Knowledge Service based at Cefn Coed Hospital Library. The contact extensions numbers are ext 36606/36454 and the email address is SBU.COINAdministration@wales.nhs.uk.

They will:

- advise and assist responsible officers on queries with clinical documents;
- ensure a regular report is generated on organisation wide clinical documents ratified/validated;
- keep a record of organisation wide clinical documents that are due for renewal and expedite out of date clinical documents to the COEG Committee
- maintain a repository of archived organisation wide clinical documents.
- Develop, manage and maintain the Clinical Online Information Network directory sharepoint site.

Detailed information on the approval/publication process for clinical documents can be found on the COIN homepage or via the following link: https://nhswales365.sharepoint.com/sites/SBUClinicalPathways/SitePages/How-to-Publish-on-COIN.aspx

- 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 assessment on its front page will **not be published**
- 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 Services or COIN Team) in order that documents under review are accordingly marked.
- at the point when a revised version of an existing key document is approved, flagging the relevant pre-existing version with the appropriate custodian to enable both archiving and also to ensure that the newly approved document is published by the appropriate custodian team.

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 2) summarizing the process followed for consultation the document will **not be published**.

7.3 Standing Orders set out a Scheme of Delegation for the UHB 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 either Corporate Services in the case of non-clinical policy documents or the COIN team for clinical policy documents to enable the document to be published on the intranet. A copy of the relevant minute confirming the approval will be required by corporate services. Documents that have not gained the required approval will **not be published**.

7.4 Where documents are written on an all-Wales basis for formal adoption by the UHB, the Board will delegate adoption of the document to the relevant Committee, Forum or Group.

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 hospital site rather than the organisation as a whole.

7.6 **Documents Reserved for Approval by the Health Board and or one of its Committees or Groups or Forums**

Approving Body	Document Sponsor	Themes
Health Board (require approval of the document by the Management Board prior to consideration by the Health Board)	Chief Executive/ Chief Operating Officer	Statutory/Legislative e.g. Standing Orders, Standing Financial Instructions etc ,
Audit Committee	Director of Finance	Financial Management , Corporate Governance, counter fraud.
Quality & Safety Governance Group	Medical Director / Director of Nursing & Patient Experience	Clinical Governance, risk management, patient care related documents and Health & safety
Partnership Forum	Director of Workforce & OD	Workforce matters (including all-Wales human resource policies on behalf of the Board).
Performance & Finance Committee	Director of Finance	Performance & Finance Arrangements
Mental Health & Learning Disabilities Legislative Committee	Chief Operating Officer	Compliance with the Mental Health Act, Powers of Discharge
Charitable Funds Committee (in conjunction with Charitable Fund Trustees)	Director of Finance	Investments, Fundraising, Bequests, Donations
WHSSC Joint Committee	Director of Strategy	All WHSSC related policies
Management Board (policy assurance sub-group –see appendix 7 TOR)	Chief Executive/ Chief Operating Officer	Any other matters including organisation-wide clinical and non-clinical policies i.e. Information Governance
Service Delivery Units	Service Director	Departmental clinical or non-clinical documents that are not organisation-wide – 'local' documents.

7.7 Documents must be produced using the document template provided in appendix 4 to this policy and will **not be published** unless they meet the requirements set out in this document. Appendix 3 contains the standard front cover which is to be applied to Health Board policies and other WCD along with supplementary guidance in appendix 5. 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 (either Corporate Services in the case of non-clinical policy documents or the COIN Team for clinical policy documents) confirming on the front cover summarizing the updates made and when this took place. 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 Services (non-clinical documents) to the COIN team (clinical documents). Urgent approvals can be sought from the Executive Board/Senior Leadership Team as necessary.

7.9 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 on its front cover.

7.10 Corporate Services will maintain records of all organisation-wide documents reported to the Executive Board (or its successor) which sets out whether the item was approved or otherwise.

7.11 Service Delivery Units are responsible for publishing and maintaining an up-to-date record of any local documents that have been approved and for ensuring that documents are appropriately archived when they are overtaken and that documents are reviewed within a three-year timescale.

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 Directorate. All consultation will be led by the author and must be completed prior to the document approval process.

8. PUBLICATION / DISSEMINATION OF ORGANISATION WIDE DOCUMENTS

8.1 The Corporate Services Department are responsible for:

- Publishing email notices to operational management teams regarding newly approved organisation-wide non- clinical documents.

- Publishing the approved organisation-wide non-clinical document on the Intranet Document Database.

8.2 The COIN team are responsible for:
- Publishing email notices to operational management teams and clinical directors regarding newly approved/reviewed organisation-wide clinical documents.
- Publishing the approved organisation-wide clinical document on the COIN directory.

8.3 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.

9. REVIEW PROCESS

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

9.2 Any corporate wide documents beyond their three-year lifespan will remain extant until reviewed. The author (executive lead sponsor) 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.

9.3 Clinical document authors will contacted at regular intervals before their document expiry date by the Library & Knowledge Service. Any clinical documents which are out of date and not reviewed by the author during the designated timeframe will be expedited to the COEG Committee for escalation.

9.4 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.

9.5 To assist Executives to maintaining an oversight of the documents approaching three years post-approval a twice yearly report will be submitted to the Management Board by the Director of Corporate Governanceoviding a summary of the position.

10. IMPLEMENTATION AND POLICY COMPLIANCE

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

10.2 Corporate Services 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.

APPENDIX 1
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)	Internal Swansea Bay HB group ☐ Multi-agency group ☐ Regional Group ☐		

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

Policy		Procedure		Guideline		Protocol	
New		Existing					

4. Which category will it be/is it?

Clinical		Corporate	

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

Yes		No	

5. 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

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)	

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

7. 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

8. **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, eg completion of specific training, e-learning, formal qualification, competency framework, is required from users of the procedure?

9. **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)

10. 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	

11. Policy documents only: Who will be/is the sponsoring Executive Lead and date they agreed to own this document?

Name:	Date:

12. 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 Services Department.

APPENDIX 2

POLICY/ WRITTEN CONTROL DOCUMENT – SUMMARY APPROVAL REPORT **Name of Committee/Group**

DATE OF MEETING:	
TITLE OF POLICY/ WRITTEN CONTROL DOCUMENT:	
EXECUTIVE LEAD (POLICY ONLY)	
REPORTING OFFICER: (CHAIR OF OWNING GROUP)	

REPORT
Situation The insert name of group/committee is asked to approve insert name and number of the policy/written control document This report provides the required assurance that the Policy on Policies has been adhered to in the adoption of the written control document (WCD) and that therefore the WCD is in line with legislation/regulations, available evidence base and can be implemented within the health board.
Background 1.Brief summary of the WCD: Copy from front page of WCD 2. Reason for developing/adopting/reviewing (delete as appropriate) the WCD: Copy from Document Approval Form
Assurance 1. Equality Impact Assessment: Explain whether a screening or full assessment was undertaken and the issues identified. Comment on how the identified issues have been addressed within the WCD or will be addressed. 2. Compliance with Legislation/Regulations/alerts Confirmation that the document is compliant with the identified legislation, regulation or alert. 3. Interested Parties: A record of involvement of all interested parties: Include for each interested party:

- Who or which committee/group has been contacted and whether they have given explicit approval of the relevant sections of the WCD which they are affected by or responsible for.
- Whether any barriers for implementation/adherence which were identified have been resolved.

6. Patient Information:

Confirmation that if the document requires patient information whether it is available on the patient information library

8. Dissemination:

To be published on the intranet and will be notified to delivery units and corporate departments by email from Corporate Services.

9. Implementation:

Comment on how, and by who and by when the WCD will be implemented. If a specific dissemination plan is required, attach to the report.

10 Monitoring:

Comment on how, by who and when the compliance with the WCD will be monitored, including how any identified issues of non-compliance will be addressed.

Recommendation

For the insert name of committee/group to approve the name of WCD.

Governance and Assurance

Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☐
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☐
	Partnerships for Care	☐
	Excellent Staff	☐
	Digitally Enabled Care	☐
	Outstanding Research, Innovation, Education and Learning	☐
Health and Care Standards		
(please choose)	Staying Healthy	☐
	Safe Care	☐
	Effective Care	☐
	Dignified Care	☐
	Timely Care	☐
	Individual Care	☐
	Staff and Resources	☐

Long Term Implications (including the impact of the Well-being of Future

Generations (Wales) Act 2015)
Briefly identify how the policy will have an impact of the "The Well-being of Future Generations (Wales) Act 2015, 5 ways of working. **Long Term** - The importance of balancing short-term needs with the need to safeguard the ability to also meet long-term needs. **Prevention** - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives. **Integration -** Considering how the public body's well-being objectives may impact upon each of the well-being goals, on their other objectives, or on the objectives of other public bodies. **Collaboration -** Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives. **Involvement -** The importance of involving people with an interest in achieving the well-being goals, and ensuring that those people reflect the diversity of the area which the body serves.

Further Information:	

APPENDIX 3

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Bae Abertawe

Swansea Bay University Health Board

Name
(of Policy/Procedure/Guideline/ Strategy/ Protocol)

For policies – add the outcome of the EIA

Document Author: ***e.g. Director of Corporate Governance***

Approved by: ***e.g. Quality & Safety Committee***

Approval Date: this information can only be added once a document has received approval

Review Date: Enter a date (1- 3years – 3 years being the norm)

Document No: (this will be allocated by the document custodian i.e. Corporate Services or COIN Team)

APPENDIX 4

COMPONENTS OF A POLICY

A policy must contain the following components:

1. **Policy Statement**
   A concise statement of the rationale for the policy, including where necessary reference to external regulations or other relevant guidance.

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.

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**
   Policies require these. 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 so a full equality impact assessment is not required.

   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 (see attached action plan).

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 5

SUPPLEMENTARY GUIDANCE

Document should be formatted in line with the Corporate Style as follows:

Electronic format	Microsoft Word
Front Cover	Corporate Template
Body Text	Arial 12
Headings	Arial 12 UPPER CASE
Use of Bold	Headings only
Alignment	Left aligned
Line spacing	Body text single
Paragraph spacing	One line between paragraphs. Two lines between main sections
Underlining	None
Staff names	Use titles rather than names
Logo	Use Health Board Logo
Headers and Footers	Arial 9
Document Title	To be included in the header on every page
Page numbering	To be included in the footer
Bullets	• Use standard bullets only
Abbreviations	State in full in first useage with abbreviation in brackets
Referencing	All reference material should be listed in full at the end of every document

APPENDIX 6

Equality Impact Assessments (EqIA)
Screening Tool to decide if an EqIA is needed

1. What is your Service Area and Directorate?

Service area: Name of Initiative:

Directorate:

2. What initiative are you screening for relevance to equality?

New Service	☐		
Service Review		☐	
Service change		☐	
Strategy	☐		
Policy	☐		
Project		☐	
Care pathway		☐	
Financial decision/ Efficiency saving	☐		

Other *Please write in:*

3. Please give a brief description of the initiative including the aims, objectives, who will be affected and what you are trying to achieve

Please write in

4. What does the initiative mainly relate to?

Direct frontline service delivery e.g. face to face contact with service users ☐

Please explain why

Indirect front line service delivery e.g. support service provided at a distance ☐

Please explain why

Indirect back room service delivery e.g. support service with no patient contact ☐

Please explain why

5. Would this initiative be delivered in partnership with other public sector partner organisations or contractors?

Yes ☐ No ☐

6. What is the potential impact on the following groups of people including patients or the wider community?

Group	High Negative	Medium Negative	Low negative	Neutral	Positive	Unknown
Different racial groups	☐	☐	☐	☐	☐	☐
	Please describe what existing evidence you have for your assessment					
Different age groups	☐	☐	☐	☐	☐	☐
	Please describe what existing evidence you have for your assessment					
Children	☐	☐	☐	☐	☐	☐

Group	High Negative	Medium Negative	Low negative	Neutral	Positive	Unknown
	Please describe what existing evidence you have for your assessment					
Men, women	☐	☐	☐	☐	☐	☐
	Please describe what existing evidence you have for your assessment					
People with disabilities	☐	☐	☐	☐	☐	☐
	Please describe what existing evidence you have for your assessment					
Different religions or beliefs	☐	☐	☐	☐	☐	☐
	Please describe what existing evidence you have for your assessment					
Different sexual orientations	☐	☐	☐	☐	☐	☐
	Please describe what existing evidence you have for your assessment					
Gender reassignment	☐	☐	☐	☐	☐	☐
	Please describe what existing evidence you have for your assessment					
Welsh language speakers	☐		☐	☐	☐	☐
	Please describe what existing evidence you have for your assessment					
Pregnant women/women who have recently given birth to children	☐	☐	☐	☐	☐	☐
	Please describe what existing evidence you have for your assessment					
Marital or civil partnership status	☐	☐	☐	☐	☐	☐
	Please describe what existing evidence you have for your assessment					
Carers	☐	☐	☐	☐	☐	☐
	Please describe what existing evidence you have for your assessment					

Group	High Negative	Medium Negative	Low negative	Neutral	Positive	Unknown
Different socio-economic groups	☐	☐	☐	☐	☐	☐
	Please describe what existing evidence you have for your assessment					

7. What is the potential impact on staff?

Staff Group	High Negative	Medium Negative	Low negative	Neutral	Positive	Unknown
	☐	☐	☐	☐	☐	☐
	Please describe what existing evidence you have for your assessment					

8. What is the potential impact on the Human Rights of individuals and in particular to the principles of:

Principle	High Negative	Medium Negative	Low negative	Neutral	Positive	Unknown
Dignity	☐	☐	☐	☐	☐	☐
	Please describe what existing evidence you have for your assessment					
Respect	☐	☐	☐	☐	☐	☐
	Please describe what existing evidence you have for your assessment					
Fairness	☐	☐	☐	☐	☐	☐
	Please describe what existing evidence you have for your assessment					
Independence	☐	☐	☐	☐	☐	☐
	Please describe what existing evidence you have for your assessment					

9. How visible is this initiative to the general public?

High visibility to general public ☐
Medium visibility to general public ☐
Low visibility to general public ☐

10. Does this proposal identify potential negative impacts?

Yes ☐ No ☐ Unable to decide ☐

If yes

Please explain why. Have you fully mitigated these in your plans? If there are residual issues, you will need to proceed to a full EqIA

If no

*Please explain why and attach an action plan, **if necessary**, indicating how you will ensure that you will have enough information to review this decision in the future.*

If unable to decide

Please explain why and indicate what steps you are going to take to be able to reach a conclusion either way.

11. Decision

Full EqIA required ☐ Full EqIA not required ☐

12. Sign off

Assessment team

a.
b.
c.
d.

Lead for the initiative:

Signature:

Date:

Appendix 7

POLICY ASSURANCE GROUP
(sub group of Management Board)
TERMS OF REFERENCE

Purpose of the Group:

The Policy Assurance Group will review, endorse and approve Health Board wide corporate policies prior to their final ratification by the Management Board.

The purpose of the review is to limit the administrative burden on the Management Board and provide assurance that the relevant policy or procedure complies with the Health Boards 'Policy for Policies' and follows appropriate governance practice. It is not to assess the technical competency of policies.

Membership of the Group:

- Director of Corporate Governance (Chair)
- Corporate Services Manager
- 1 representative from each Corporate area i.e. finance, corporate nursing etc
- 1 representative from each service unit

Author or nominated lead of the relevant policy may be invited to present the policy/procedure.

Role and Responsibilities:

1. The policy assurance group will only review Health Board wide policies and procedures (non-clinical).
2. To identify needs and gaps in policies and procedures and action to resolve
3. Ensure all policies and procedures are subject to an equality impact assessment
4. The policy review group has delegated authority to approve policies with minor changes on behalf of the Management Board i.e. where changes are not considered material for example changing a reference within the policy.
5. To approve policies/procedures subject to final ratification to Management Board. Final ratification will be in the form of a report to Management Board from this Group summarising the policies that have been approved and highlighting any necessary changes.

Meeting Arrangements:

The group will meet on a bi monthly basis or on as and when required basis.

Quorate:

The group will be quorate when the Chair/Vice Chair and 3 other members are present.

Administrative Support:

Administrative support to this group will be provided by the Corporate Services team.