Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

Ref: GCO1

POLICY AND PROCEDURE FOR THE MANAGEMENT OF TRUST WIDE POLICIES AND OTHER TRUST WIDE WRITTEN CONTROL DOCUMENTS

Executive Sponsor & Function	Director of Corporate Governance Governance & Communications Function
Document Author:	Head of Corporate Governance
Approved by:	Quality, Safety & Performance Committee
Approval Date:	11 September 2025
Date of Equality Impact Assessment:	July 2025
Equality Impact Assessment Outcome:	No negative impact identified
Review Date:	September 2028
Version:	Version 3

1. INTRODUCTION AND AIM

1.1 Velindre University NHS Trust, subsequently referred to in this policy as the 'Trust', has a statutory duty to ensure that appropriate policies and supporting strategies procedures, protocols, or guidelines (referred to collectively as other Written Control Documents) are in place. Policies and other Written Control Documents help ensure that the Trust complies with legislation, meets mandatory requirements, and provides services that are evidenced-based, safe and sustainable, enabling all staff to fulfil their roles safely and competently to provide effective and appropriate care and services for patients, donors and their colleagues.

1.2 Policies describe the Trust's guiding principles that underpin its decisions, behaviours and actions for everything it does. A Policy statement is a public commitment of our intent. Other written control documents translate these principles into more detailed instructions or guidance including individual responsibilities

1.3 Policies and other Written Control Documents provide the Trust with a clear governance framework to operate within and provide a process of internal control. They define what the organisation does and how it is done, support effective decision making and delegation and provide guidance for staff to follow.

1.4 To ensure the Trust delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, it will develop and describe its "ways of working" in Policies and other Written Control Documents. In this regard, the Trust has approved the Policy and Procedure for the Management of Trust Wide Policies and other Trust Wide Written Control Documents (GC01), commonly referred to as the "*Policy on Policies"*.

1.5 Through this Policy the Trust ensures that there is a process whereby all policy documentation is consistent in format, compilation and dissemination. In addition, there is an effective process for managing and reviewing policies and any other written control documents on a regularised basis, to ensure that documentation remains legally compliant and actions are undertaken in a safe and efficient manner.

1.6 The principles of the policy management process including individual responsibilities for developing and reviewing policies and other written control documents, is summarised in the flow chart on page 7.

2. OBJECTIVES

2.1 This Policy ensures consistency in the format, compilation, approval and dissemination of all Policies and other Written Control Documents, so that they are:

- Developed and reviewed when required;
- "Owned" – each document will have an owner who has responsibility for making sure that it is regularly reviewed and kept up to date;
- Written in plain language so that they can be understood, and people are clear of what is expected;
- Subject to an Impact Assessments where required;

- Recorded, stored and archived in accordance with the Trust's Records Management Policy;
- Appropriately co-produced and consulted on;
- Considered and approved at the appropriate level within the Trust by the appropriate advisory group, forum, sub-committee or committee (with delegated powers and authority to do so);
- Shared with staff and stakeholders where required;
- Supported by appropriate learning, education and development where required; and,
- Available to the public, in line with Freedom of Information Act requirements and the Trust's Publication Scheme.

3. SCOPE

3.1 This Policy is applicable across the whole of the Trust in all locations. It applies to all Employees and Independent Board Members. The term "Employees" includes all those who have a contract of employment or honorary contract with the Trust.

3.2 Any reference in this Policy to the Trust should also be applied to any services or programmes that the Trust hosts such as the NHS Wales Shared Services Partnership (NWSSP), Health Technology Wales (HTW) and Advancing Therapies Wales (ATW).

3.3 This policy applies to all Trust wide Policies and other Trust wide Written Control Documents which fall within the definitions contained in this policy, both clinical and non-clinical.

3.4 Where written control documents relate to a single Directorate or Division and there is no wider impact on the Trust, they may be approved by the relevant Senior Management/Leadership Management Team.

3.5 In addition to the responsibilities detailed within the Policy, staff also have a responsibility for making sure that they meet the requirements of their role profiles and any other responsibilities delegated to them, which includes the development, review, publication and implementation of Policies and other Written Control Documents within their role.

4. POLICIES AND OTHER WRITTEN CONTROL DOCUMENT PROCESS AND FLOWCHART

4.1 The reason to develop a new or review an existing Policy or Written Control document can come from a variety of sources, i.e. legislation, national guidance, external reviews, audits, to clarify/improve working practice, to mitigate an identified risk or to adopt an all Wales Policy or other Written Control Document. It is up to managers of a service, staff or function to recognise when a Policy or other Written Control Document is required to minimise risk to patients, donors, staff and the organisation. An example is, as a result of an investigation following incident reporting, which recommends additional system controls to prevent the risk of reoccurrence of a similar incident. This can equally apply to action required following the investigation of a complaint and claims management.

4.2 The first step in the development/review of a Policy or other Written Control Document is the completion of the Document Approval Checklist. The Document Approval Checklist must be completed when the Policy or other Written Control Document is multi-disciplinary and/or multi-agency in nature. The Document Approval Checklist must also be completed for all Wales or jointly developed Policies and other Written Control Documents.

4.3 Any local Written Control Document, which is a local/divisional procedure or guideline which sets out the requirements for staff in a discrete department or professional group and does not have wider implications across the Trust, may not require a Document Approval Checklist. Further clarity can be sought from the Corporate Governance Team.

4.4 The overarching rationale for completion of the Document Approval Checklist is to aid the responsible document author (see section 10) in being clear about the reason for the document, the potential impacts of the document and the support required to facilitate the implementation of the document. It is best practice to consider these prior to developing or reviewing all Policies or Written Control Documents.

4.5 Whilst most Policies and other Written Controls Documents are developed internally for internal use within the Trust, there will be occasions when a Policy or other Written Control Document requires to be developed jointly with another organisation, for example, a Local Authority or other partner agencies. These must follow the process as Trust only Policies and Written Control Documents (page 7).

4.6 Some Policies and other Written Control Documents are issued on an all Wales basis with the expectation of local adoption. These documents must also be subject to formal adoption for use in the Trust (refer to section 6).

4.7 When the requirement for a developing a new or reviewing an existing Policy or other Written Control Document arises, it is recommended that contact is made with the Corporate Governance Team via VUNHST.PoliciesManagement@wales.nhs.uk who will able to provide advice and support about each stage of the Policy and other Written Control Document development/review process.

4.8 The most important thing to note is that the development of a new or review of an existing Policy and other Written Control Document must not be undertaken in isolation and that it must be owned and overseen by the appropriate advisory group, forum, sub-committee or committee. Policies and other Written Control Documents are best developed/reviewed in collaboration with others to ensure that the final document is one that is in line with current legislation, guidance and evidence and can be implemented seamlessly within the organisation.

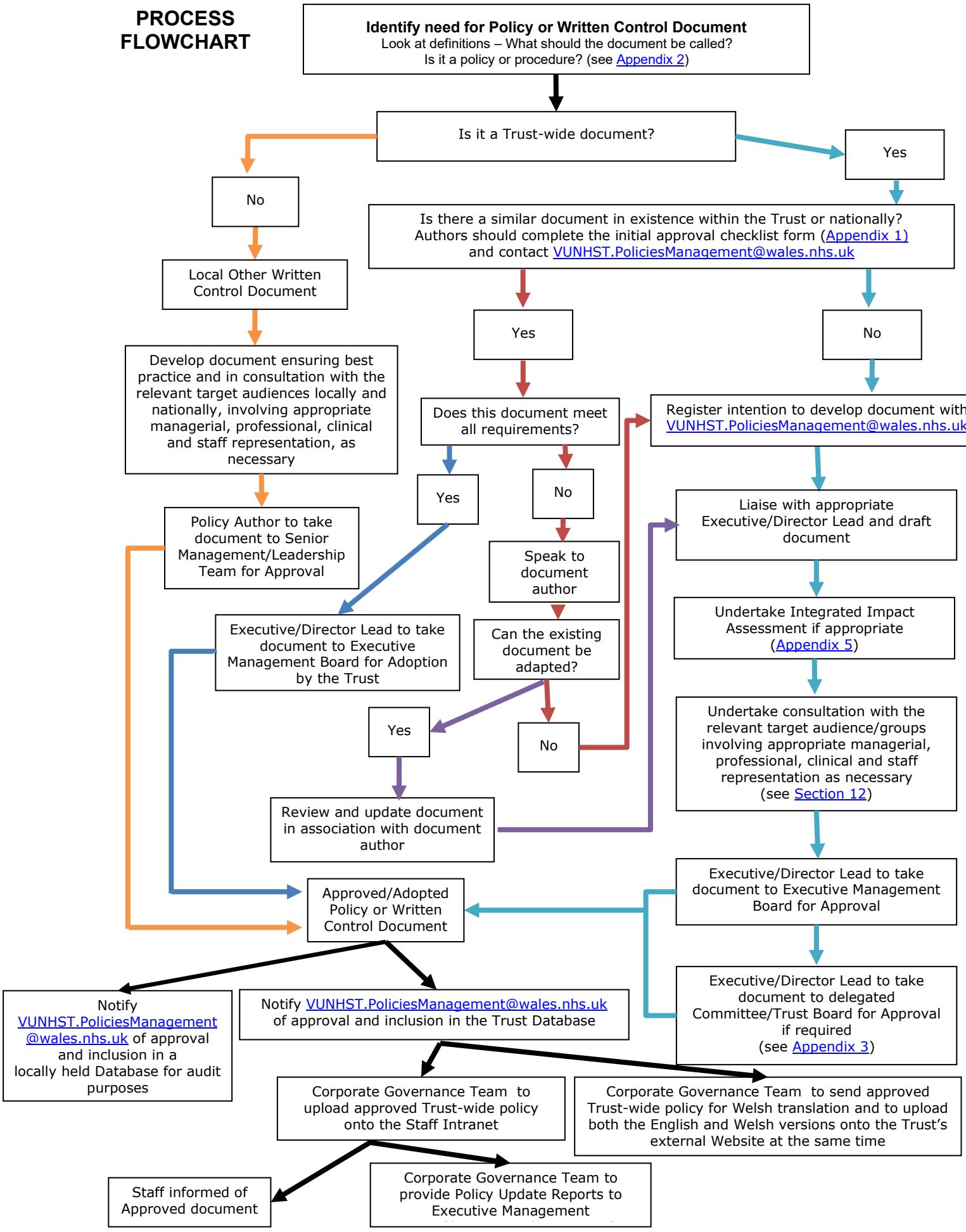
4.9 In addition, Strategies and Policies only must be sponsored by an Executive/ Director. If not already identified, the advisory group, forum, sub-committee or committee must nominate an author who will be responsible for ensuring that the process outlined in this policy is adhered to, starting with the completion of the Document Approval Checklist (Appendix 1).

4.10 All policies will be subject to and Equality Impact Assessment and a Quality Impact Assessment.

4.11 The flow chart on the following page explain the steps to be taken when considering the development of a Policy or Written Control Document. It is important that appropriate engagement and consultation takes place. In the case of employment policies, (excluding those enforced from Welsh Government following national negotiations and other “All Wales policies”), staff representatives and management will jointly negotiate a draft policy for submission to the appropriate Committee for approval. If there are any issues that cannot be resolved at Committee level, the Policy will be brought to the Trust Board for final consideration and approval.

4.12 The development of Policies and other Written Control Documents must not be undertaken in isolation and will be based on sound evidence, and take account of current legislation, mandatory requirements and national/professional guidance. Sources of information used should be appropriately referenced.

PROCESS FLOWCHART



5. DEFINITIONS

5.1 Policies and other Written Control Documents are essential in the delivery of a high quality and safe health services and to ensure the Trust operates within the law. They form an integral element of the governance and assurance framework by which the Trust regulates its activities to achieve its goals and are used as reference points to assist staff in their day to day working.

5.2 Terminology across the range of documentation can often be confusing for both those that develop the documents and to those that use them. Clear definitions for these terms, highlighting the differences and similarities and the appropriate use of each is provided Appendix 2.

6. WHO CAN APPROVE THESE DOCUMENTS AND WHERE ARE THEY PUBLISHED?

6.1 The Standing Orders set out a Scheme of Delegation for the Trust and for organisation-wide documents. Strategies are a matter on which Trust Board approval is required. Certain key policies also require approval by the Trust Board (see Appendix 3) whilst others are delegated to the appropriate advisory group, forum, sub-committee or committee or Executive based Group (see Appendix 3). Any delegated approvals must also be submitted through the relevant Executive Sponsor to the Corporate Governance Team. A copy of the relevant minute confirming the approval may be required. Documents that have not gained the required approval **will not be published.**

6.2 **Directorate and Division Specific Documents:** Where written control documents relate to a single Directorate or Division and there is no wider impact on the Trust, they may be approved by the relevant Senior Management/Leadership Management Team. Such documents will still need to be recorded in a suitable database at a local level and subjected to strict version control, issued with a unique reference number and meet the standards set within this policy. There must also be a clearly documented audit trail to indicate where and by whom the document has been considered.

6.3 Some “All Wales” policies are developed by the Welsh Government or by Health Boards and Trusts working together. For some of these documents the Trust must adopt them. Where this is the case, they will be reported to the appropriate advisory group, forum, sub-committee or committee or Trust Board so that there is a record of their adoption.

6.5 Once approved, centrally recorded documents are published on the Trust Intranet and Internet sites by the Corporate Governance Team. Under limited circumstances it may be necessary to redact [remove or hide] information from a document prior to publication on the website e.g. direct dial telephone numbers within the Business Continuity Policy. The advisory group, forum, sub-committee or committee approving the document will determine if it is necessary to redact information prior to publication. Where this has been agreed it will be made clear within the body of the text on the document made available.

6.6 The diverse nature of health care means there will be a large number of policies and other Written Control Documents in place. Some will apply across the Trust and be relevant to all staff, and others will be specific to certain areas or activities.

6.7 For ease of reference, all policy documentation will be listed and numbered under a series of headings. An index of Policies and other Written Control Documents will be maintained as part of the on-line database that is in place and maintained to manage the review process. The database will become the central register for all Policies and other Written Control Documents in the Trust.

7. WHO CAN PROVIDE ADVICE ON WHAT TO DO AND HOW DO WE KNOW WHAT DOCUMENTS HAVE ALREADY BEEN DEVELOPED?

7.1 The Director of Corporate Governance is responsible for making sure that the Trust has arrangements in place to ensure effective development and management of Policies and other Written Control Documents.

7.2 The Corporate Governance Team can provide advice and assistance on any aspect of document development and review. They can be contacted via the generic Policy email account VUNHST.PoliciesManagement@wales.nhs.uk

7.3 The Corporate Governance Team maintains a register of all documents that are centrally recorded and will be able to advise if a document already exists. All of these documents are also published on the Trust's Intranet and can be found through either the A-Z Listing or by searching on key words. Most documents are also published on the Trust's website.

7.4 The Corporate Governance Team will arrange for approved documents and the accompanying Equality Integrated Impact Assessment (if applicable) to be published on the intranet/internet as appropriate within ten working days of receipt from the policy author or advisory group, forum, sub-committee or committee Secretariat.

7.5 Where an approved document is a Trust-wide policy, the Corporate Governance Team will arrange for the Welsh translation of the policy prior to publishing the English and Welsh versions on the website in line with the requirements of the Welsh language standards.

8. WHAT ARE THE ROLES AND RESPONSIBILITIES OF EXECUTIVE/DIRECTOR LEADS

8.1 The Chief Executive, as Accountable Officer, has overall responsibility for ensuring the Trust has appropriate Policies and other Written Control Documents in place to ensure the Trust works to best practice and complies with all relevant legislation.

8.2 The delegated responsibilities of Executive/Director Leads are set out in the Scheme of Delegation. They have responsibility for:

- making sure that appropriate Policies and Written Control Documents are produced and kept up to date by identifying a document author (including reallocating responsibility if the author leaves or moves to another role);

- personally checking for accuracy of content prior to submission to an advisory group, forum, sub-committee or committee for approval;
- maintaining a list of these Policies and Written Control Documents, supported by the Corporate Governance Team and making sure that these documents are up to date;
- making sure that there are arrangements in place to capture as appropriate, respond to and review documents when external organisations, e.g. Health and Safety Executive, Royal Colleges, publish new and updated information which require action by the Trust;
- making sure that consultation has taken place and an Integrated Impact Assessment, which includes the equality and health impact assessments, have been completed where necessary. Where these have not been undertaken a reason for this will be provided;
- making sure that any training requirements specific to the document have been referenced; and,
- making sure that where a process of audit and/or review has been agreed this is maintained and reported on.

9. WHAT ARE THE RESPONSIBILITIES OF DOCUMENT AUTHORS?

9.1 Authors are employees who have been given the task of writing or reviewing Policies and Written Control Documents. Employment documents should always have at least two authors i.e. a management representative and a staff representative. Authors must:

- liaise with Executive/Director Leads to make sure Policies and Written Control Documents are implemented appropriately and, where necessary, compliance with these documents is formally audited;
- make sure that documents are reviewed in line with the review date or as a result of changes to practice, organisational structure or legislation;
- work with the Executive/Director Lead and the Corporate Governance Team to make sure that appropriate engagement and consultation has taken place with the relevant individuals and groups;
- inform the Executive/Director Lead of any learning, education or development needs and resource implications which must be considered before approval can take place;
- undertake the necessary impact assessments, including equality and health impact assessments, in consultation with the Equality, Diversity and OD Manager and Equality Integrated Impact Assessment (EQIA) Group, as required (Appendix 5);
- consider the findings and make sure that appropriate action has been taken in response to equality and health impact assessments.
- send the approved document to the Corporate Governance Team for publication within ten working days of approval.

9.2 Authors are responsible for the review of their documents. If an author leaves the Trust or takes up another post, the responsibility for the ongoing maintenance of the document is taken on by their replacement. Where no direct role replacement is appointed, responsibility reverts to the post holder's line manager. The Executive/Director Lead will be informed of the situation to allow them to identify a

replacement author if it is not appropriate for the responsibility to stay within that department.

10. POLICY DEVELOPMENT

10.1 Each Trust-wide policy will be sponsored by a lead Executive. At Directorate/ Departmental level, Policies and other Written Control Documents will be sponsored by the appropriate Director/Head of Department. The Director of Corporate Governance will ensure that all Policies and Other Written Control documents are reviewed and appropriately monitored.

10.2 The development of new Policies and other Written Control Documents, or the amendment of existing documentation, will be overseen by the appropriate lead Executive/Director. They will be responsible for ensuring that content and scope are fit for purpose before being presented for approval.

10.3 When the need for a new policy document arises, the Corporate Governance Team should be informed before preparation commences to ensure there is not a Policy or other Written Control Document already in existence locally or nationally on the same or similar subject, thus avoiding duplication of effort. Authors should complete the initial Document Approval Checklist (Appendix 1) and send to the generic Policy email account VUNHST.PoliciesManagement@wales.nhs.uk

10.4 Once the need and type of Policy or other Written Control Document is identified, the process for production and approval must follow that contained within this Policy. A flowchart depicting this process is set out on page 7.

10.5 The language used should be plain English, using short sentences and where possible avoiding technical terms. If technical terms are used, they should be explained using a glossary or footnotes. In accordance with the requirements of the Data Protection Act 2018, the names of individuals will not be contained within policies and other written control documents. Individuals with particular responsibilities will be identified by their job title only.

10.6 All Policy and Written Control Document development should be undertaken in line with current legislation, national and professional guidance. Documentation should also be based on sound evidence and be appropriately referenced.

10.7 **Quality Impact Assessment and Health Care Standards**
All new Policies require a Quality Impact Assessment. All Policies and other Written Control Documents should outline how they contribute to compliance with the Health and Care Standards and should also indicate to which Standards this area of activity is linked.

10.8 **Well-being of Future Generations (Wales) Act 2015**
The Well-being of Future Generations (Wales) Act 2015 is about improving the social, economic, environmental and cultural well-being of Wales. As a listed body, we are mandated to assess our long-term impact, work better with people and communities and each other, look to prevent problems and take a more joined-up approach. This will help us to create a Wales that we all want to live in, now and in

the future. To make sure we are all working towards the same vision, the Act puts in place seven well-being goals:

- A Prosperous Wales
- A Resilient Wales
- A Healthier Wales
- A More Equal Wales
- A Wales of Cohesive Communities
- A Wales of Vibrant Culture and Thriving Welsh Language
- A Globally Responsible Wales

The Act also lists the 5 Ways of Working:

- Long Term
- Collaboration
- Prevention
- Involvement
- Integration

All Policies and other Written Control Documents must consider provisions and demonstrate that all key goals were considered in the development of the document.

Each Well-being Goal and the 5 Ways of Working are incorporated into the Integrated Impact Assessment, refer to Appendix 5 for further detail. All documentation is required to highlight how it contributes to at least one Well-being Goal and assesses the whether the documentation adheres to the 5 Ways of Working.

10.9 **Equality Integrated Impact Assessment**

The Equality Act 2010 requires the undertaking of various impact assessments and all Trust Policies and other Written Control Documents will require the completion of these before the document is consulted upon. The impact assessments are a process to find out whether a ‘policy’ will affect people differently on the basis of their 'protected characteristics': age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion, sex or sexual orientation and if it will affect their human rights. It also takes account of Welsh Language issues. It is designed to ensure that the Trust is taking into consideration the needs of all individuals who work for it and/or access its services.

The Trust has adopted an integrated approach to impact assessment, which combines the equality and health assessment alongside environmental impacts, Welsh Language whilst assessing the document against the requirements within the Well-being of Future Generations (Wales) Act 2015 and the Socio-Economic Duty.

A health impact assessment is a process that considers how the health and well-being of a population may be affected by a proposed action, be it a policy, programme, plan, project or a change to the organisation or delivery of a particular public service. Some impacts of policies on health may be direct, obvious and/or intentional, whilst others may be indirect, difficult to identify and unintentional. A health impact assessment is a systematic, objective, flexible and practical way of assessing both the potential positive and negative impacts of a proposal on health

and well-being and suggests ways in which opportunities for health gain can be maximised and risks to health minimised. Health impact assessment looks at health in its broadest sense, using the wider determinants of health as a framework.

Where another Written Control Document has been developed in support of a policy it may not be necessary to undertake a further Integrated Impact Assessment. If an Integrated Impact Assessment has not been completed the reason for this will be explained at the beginning of the document. Where an Integrated Impact Assessment has been completed the impact will be included in the document.

10.10 **Environmental Management**

The Trust is accredited to the Environmental Management System (EMS) ISO 14001:2015 which is the internationally recognised standard for managing the environment. The EMS provides a framework for managing environmental impacts associated with the Trust's activities.

The system applies to both the public and private sectors and demonstrates that the organisation has a formal system in place for managing the environment.

The system is based on the principle of continual improvement and requires the Trust to demonstrate this by the use of Key Performance Indicators and progress towards environmental objectives and targets. This framework allows an organisation to understand, describe and control its significant impacts on the environment, reduce the risk of potentially costly pollution incidents, ensure compliance with environmental legislation and continually improve its business operations.

An environmental impact assessment is undertaken as part of the Integrated Impact Assessment process and is an assessment of the possible positive or negative impact that a proposed project may have on the environment, together consisting of the natural, social and economic aspects.

The purpose of the assessment is to ensure that decision makers consider the ensuing environmental impacts when deciding whether to proceed with a project. Advice on areas that require an environmental impact assessment can be obtained from the Trust's Environmental Development Officer.

11. DOCUMENT FORMAT

11.1 A document template has been developed to provide guidance on what information should be contained in which policy/other written control document along with some standard clauses that can be used as appropriate (Appendix 4) and indicates fields that are mandatory. It also contains the standard front cover which is to be applied to Trust Policies and other Written Control Documents, together with some specific points regarding formatting. See Appendix 4 and the Policies Intranet page.

11.2 This Template must be used for all Trust-wide, Divisional or multi-departmental documents. Where a document is only applicable within a single Department or, for example consists of a flow chart, an alternative format is acceptable and a "basic template" is also shown below. As a minimum the principles listed below must still be followed:

- Document must have a clear heading.
- The scope and objectives must be defined.
- The status of the document must be clear e.g. guidance/mandatory requirement.
- Instructions/guidance must be logically recorded.
- Date of approval shown.
- Date of review shown.
- Author's details.
- Pages numbered.

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

11.4 Policies and other written control documents will not be routinely translated into other languages. However, where staff are aware that this may cause difficulty for patients, donors or their families, they will ensure that the content is explained to them by an interpreter or translated if necessary.

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

11.6 If the Trust is adopting an externally approved document it will not need reformatting providing it meets the standards set above. These documents will be given a reference number, recorded and uploaded as if they were a Trust document.

12. ENGAGEMENT AND CONSULTATION

12.1 Policies and other Written Control Documents must not be written in isolation.

12.2 Engagement and consultation on all Policies and other Written Control Documents should take place with the target audience including appropriate stakeholder, service user/carer, managerial, clinical and staff representation. Where appropriate, documents should be co-produced with that target audience.

12.3 The Trust has a range of mechanisms to involve patients, carers, donors and members of the public in its work. This will strengthen the stakeholder involvement with the Trust and demonstrate our commitment to working with the local community and develop our services and policies jointly. Where appropriate, the relevant patient and donor Engagement Leads should be contacted.

12.4 When a final draft has been developed the formal consultation can start. The consultation period should allow enough time to enable the key stakeholders to have had an opportunity to consider and input into the consultation. If necessary, the Corporate Governance Team can provide advice.

12.5 The policy author should send the document and Integrated Impact Assessment (if applicable) to the Corporate Governance Team via VUHNST.PoliciesManagement@wales.nhs.uk who will arrange for the documents

to be shared for consultation. They will also make sure that they are brought to the attention of appropriate stakeholders in a timely manner (to include Llais and Local Partnership Forum) in accordance with mutually agreed principles.

12.6 The author, in association with the appropriate Executive/Director lead, must document the consultation arrangements and provide assurance to the approving advisory group, forum, sub-committee or committee that this has been conducted thoroughly and that comments have been incorporated into the policy or written control document where appropriate. The groups/individuals consulted will be clearly identified in the report presented to the approving advisory group, forum, sub-committee or committee.

13. REVIEW PROCESS

13.1 The Policy or other Written Control Document Author who owns the Policy or Written Control Document is responsible for ensuring it remains in line with current legislation, guidance and evidence and therefore is required to review the Policy or other Written Control Document in light of new or updated legislation and/or guidance (NICE, Professional bodies) as it is published.

13.2 All Policies and Written Control Documents should be reviewed on a minimum cycle of three years. With the exception that a small number of documents need to be reviewed annually (and this requirement will be identified in individual documents by their authors). Sometimes, a document which was subject to a three-year cycle will also need to be reviewed earlier in the light of changing practice or Welsh Government guidance/ policy changes / legislation / evidence, etc. However, if no revisions have occurred in the preceding three years, it must be subject to the full Policy or other Written Control Document process. The author of the individual document is responsible for ensuring this takes place.

13.3 Nine months prior to the review date, the Corporate Governance Team will contact the document author who owns the Policy or other Written Control Document to notify them that their document is due for reviewing. The author, in conjunction with the Executive/Director lead who owns the Policy or other Written Control Document, is responsible for ensuring that the document is reviewed by the review by date. If it is foreseen that the review date will not be met, the approving advisory group, forum, sub-committee or committee must receive assurance that the current version of the Policy or other Written Control Document is still fit for purpose and agree an extension of up to a maximum of six months. Any material or significant changes to an existing Policy or Written Control Document will require it to be re-approved by the approving advisory group, forum, sub-committee or committee following the Policy and other Written Control Document process.

13.4 Until a document is reviewed, it will remain the extant policy document of the Trust until replaced. It is the responsibility of the policy author to ensure that documents are reviewed in line with their review dates.

13.5 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.

13.6 To assist Executive/Director leads to maintain an oversight of the documents approaching three years post-approval, a bi-annual report will be sent to the Executive Management Board and relevant advisory group, forum, sub-committee or committee by the Corporate Governance Team providing a summary of the position.

13.7 **Interim Policy Review:** Where a document requires only a small amendment which is not material to the aims or objectives of the document, e.g. to reflect a change in working practice, content of supporting documents etc, an interim review may be undertaken. This will be agreed in advance with the Corporate Governance Team to ensure that the completion of an interim review does not expose the Trust to an increased level of risk. The change will be reported to the next available meeting of the Approving Body.

13.8 **Extending Review Dates:** The Policy Author will be contacted to let them know their document is due for review nine months before the review date. The Policy Author, in conjunction with the Executive/Director lead who owns the Policy or other Written Control Document, is responsible for ensuring that the document is reviewed before the expiry date. If the expiry date will pass, the Approving Body (Appendix 3) must receive assurance that the current version of the Policy is still fit for purpose. The Approving Body must then agree an extension of up to a maximum of six months. Any significant changes to an existing Policy will require it to be re-approved by the Approving Body by following the Policy process.

13.9 **Minor Changes to an Existing Policy:** If the amendments are minor, then a 'tracked-change' Word version of the Policy will need to be submitted for approval to the Approving Body. The Equality Integrated Impact Assessment must be checked to see if it requires updating in line with the changes.

Global consultation is not required if there are minimal changes; however, assurance must be given that the Policy Author has consulted with applicable colleagues.

13.10 **Change from Policy to another type of Written Control Document:** If during the review process it is identified that a Policy can be changed to another type of Written Control Document, i.e. Procedure, Protocol, Guidelines, etc. the Policy Author, in conjunction with the Executive/Director lead who owns the Policy or other Written Control Document, will need to provide evidence / justification for such a change to the Approving Body by following the Policy process. Once the Approving Body has approved the change, the new Written Control Document Approving Body will be amended to reflect the document status.

14. PUBLICATION, DISSEMINATION AND DISTRIBUTION

14.1 The Policies and other Written Control Documents which are approved through the Scheme of Delegation for the Trust are centrally managed through the Corporate Governance Department. A Trust Policy database is in place and once a document has been entered onto the database, approved and published on the internet, this should be regarded as the only official Trust version for dissemination to and use by Trust employees.

14.2 Where a Policy or Written Control Document has been superseded, the archived copy will be held on file by the Corporate Governance Team but will no longer be available via the internet. The Trust is required to keep a record of all archived, out of date Policies and other Written Control Documents, in line with WHC (2000) 071 for the Record and Records Management Policies.

14.3 Each department/service which develops/reviews Policies and other Written Control Documents must set up their own local document management system. This must hold all current and out of date Policies and other Written Control Documents. All out of date documents must be kept for **a period of 30 years in line with the WHC (2000) 071 For the Record.**

14.4 All policies and other written control documents that have been ratified appropriately must be forwarded to the Corporate Governance Team via VUNHST.PoliciesManagement@wales.nhs.uk within ten working days of approval. They will then ensure that the document is:

- Added/updated on the Trust Policy database;
- Cascaded in line with the Trust's communications system;
- Included within the Executive Management Board and Trust Board regular reporting;
- Uploaded onto the intranet;
- Included in the Freedom of Information Publication Scheme.

14.5 The Trust's intranet site will be the primary location for all Policies and other Written Control Documents to ensure that staff can access the most up to date versions. Where hard copies need to be circulated, these should be downloaded from the intranet site by the appropriate Line Manager.

14.6 All documents will be subject to version control and archived in line with legal requirements. Once revised Policies and other Written Control Documents are approved, the Corporate Governance Team will e-mail the author/policy lead to inform them in order that they can ensure appropriate dissemination to their staff.

14.7 Once issued, individual Line Managers will be responsible for ensuring that all staff are aware of the revisions and that any out of date versions are taken out of local circulation. Each Directorate/Department will put in place a robust controlled documentation system to ensure that records of distribution of policies and other written control documents are maintained.

14.8 Information on new and revised policies will be cascaded in line with the Trust's communications system. Where appropriate other communication channels may be used to inform staff of policy development (for example, inclusion with payslips).

14.9 It is the responsibility of the author of a Policy or Written Control Document to ensure that when a document is revised, a copy of the original is forwarded to the Corporate Governance Team via VUNHST.PoliciesManagement@wales.nhs.uk for audit purposes.

14.10 The Director of Corporate Governance will ensure that the register of all Policies and other Written Control Documents is reported bi-annually to the Executive Management Board, relevant advisory group, forum, sub-committee or committee and Trust Board.

15. TRAINING

15.1 All Executive/Director leads will work with the Executive Director of Organisational Development and Workforce to ensure that there is an ongoing training programme for all staff that incorporates the implementation of Policies and other Written Control Documents. Key subject areas will be included at local induction and as part of staff development processes.

15.2 Line Managers must ensure that new starters are aware of this policy, induction arrangements and of their individual departmental processes.

15.3 It is the responsibility of individual Line Managers to inform the Executive Director of Organisational Development and Workforce of the requirement where specific staff training needs are identified, particularly in relation to the implementation of new or updated documents.

15.4 Executive/Director leads will ensure that responsibilities for policy development are clearly outlined in each individual Job Description, in accordance with their role.

16. IMPLEMENTATION AND POLICY COMPLIANCE

16.1 Any advice required on implementation of this policy should be obtained from the Corporate Governance Team via VUNHST.PoliciesManagement@wales.nhs.uk .

16.2 All policies should be part of the Trust and/or Directorate/Department auditing process to ensure that they:

- have been implemented effectively;
- are fit for purpose; and
- are being complied with.

16.3 Information regarding the frequency of the monitoring arrangements should be included within the main policy document. If appropriate, questionnaires can be used for staff feedback to evaluate any policy and supporting written control documentation.

16.4 It will be necessary to ensure that all documents are being produced, vetted, approved and disseminated in accordance with this policy. Periodical ‘spot checks’ will be carried out in all areas to ensure that all policies and other written control documents comply with this policy.

16.5 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.

17. REVIEW PERIOD

17.1 This policy will be reviewed every three years, or sooner should the author or legal requirements deem it to be relevant or required.

18. ACKNOWLEDGEMENTS

18.1 This policy has been developed following benchmarking with the following:

Aneurin Bevan University Health Board, (ABUHB001) Policy and Procedure for the Management of Policies, Procedures and other Written Control Documents

Cardiff and Vale University Health Board, (UHB 001) Management of Policies, Procedures and Other Written Control Documents Policy

Hywel Dda University Health Board, (190) Written Control Documentation Policy and Procedures

Public Health Wales, (PHW47/TP01) Policies, Procedures and Other Written Control Documents Management Procedure

Swansea Bay University Health Board, (HB76) Policy for the Management of Health Board Wide Policies, Procedures and Other Written Control Documents (WCD)

APPENDIX 1

DOCUMENT FOR APPROVAL CHECKLIST

This form should be completed and approval to proceed obtained before you start producing your document. The Equality and Health Impact Assessment, known as the Equality Integrated 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 advisory group, forum, sub-committee or committee will own the document?

Name of Group		**Chair of Group**		
Please indicate (further details may be requested if applicable)	**Internal Trust Group**		**Yes**	**No**
	Multi-Agency Group		**Yes**	**No**
	Regional Group		**Yes**	**No**

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

Policy		**Strategy**		**Procedure**		**Guideline**	
Protocol		**Other**	**Please describe**				

New		**Existing**	

4. Which category will it be/is it?

Clinical		**Corporate**	

If it is a corporate document will/does it impact on patient/donor 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

	Insert tick for most relevant
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, e.g. 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 and Inclusion	
Socio Economic Duty	
National Safety Standards for Invasive Procedures (NatSSIPs)	
Alert/NCEPOD	
Interested Parties	
NICE Guidance	
Patient/Donor Information	
Training / Learning and Development	
Legal	
Financial	
Workforce	
Medicines Management	
Medical Devices	
Infection Prevention & Control	
Business Continuity / Emergency Planning / Major Incident	
Health and Social Care (Quality and Engagement) (Wales) Act 2020	

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

Job Title	
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 CHECKLIST FORM TO

VUNHST.PoliciesManagement@wales.nhs.uk

APPENDIX 2

TYPES OF WRITTEN CONTROL DOCUMENTS (DEFINITIONS)

Written Control Document – Is a supporting strategy, procedure, protocol, guideline or standard referred to collectively as other Written Control Documents within this Policy.

Strategy - A strategy is a broad statement of an approach designed to accomplish the desired objectives or goals and can be supported by other Written Control Documents. Strategies are always organisational wide and required to be approved by the Board via the Scheme of Delegation.

Policy – A written statement of intent, describing the broad approach or course of action that the Trust is taking with a particular issue. Policies are underpinned by evidenced based procedures and guidelines and are mandatory. Policy documents may be used to support the Trust during legal action.

The formulation of policies allows the Trust to produce formal agreements, which clearly defines the commitment of the organisation and the obligations of individual staff.

Procedure - A standardised method of performing clinical or non-clinical tasks by providing a series of actions to be conducted in an agreed and consistent way to achieve a safe, effective outcome. This will ensure all concerned undertake the task in an agreed and consistent way. These are often the documents detailing how a policy is to be achieved.

Procedures can be written as part of a policy document (in which case they are mandatory) or as ‘stand-alone’ documents (in which case they are discretionary).

Where procedures are formulated utilising evidence-based knowledge and best practice guidelines, they must include reference of any researched evidence used.

‘Stand-alone’ procedures give the user the means to carry out specific tasks. This may be within the overall control framework of the organisation or to regulate activities to achieve a quality outcome. ‘Stand-alone’ procedures do not have the same status in law as a policy; however, failure to follow a specific procedure may prejudice the successful defence of a claim against the organisation.

Protocol - A written code of practice, including recommendations, roles and standards to be followed, which can also include details of competencies and delegation of authority.

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

Within a protocol it must be clear by whose authority is it being implemented, what the scope of the protocol is and what procedure is to be followed if practice is to be outside of the protocol.

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

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

Guidelines are not prescriptive. However, whilst guidelines are not mandatory, it could prove difficult to defend a case where agreed guidelines had not been followed.

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

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

Standards - The Royal College of Nursing definition is:

> *"to provide a record of service or representation of care which people are entitled to experience, either as a basic minimum or for use as a measure of excellence" (RCN 1997)*

> The Health and Care Standards define standards as:
> *"Standards are a means of describing the level of quality health care organisations are expected to meet or to aspire to. The performance of organisations can be assessed against this level of quality" (Welsh Government 2015).*

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

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

CLASSIFICATION OF DOCUMENTS

Clinical – Clinical Written Control Documents relate to the care and treatment of patients within the organisation and offer an evidence-based approach to making a series of clinical decisions for patients with a given condition.

Corporate – Corporate Written Control Documents relate to the management of the organisation and formulate the organisation's response to known situations and circumstances.

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

APPENDIX 3

DOCUMENTS RESERVED FOR APPROVAL BY THE TRUST BOARD AND OR ONE OF ITS COMMITTEES, GROUPS OR FORUMS

AREAS COVERED	DOCUMENT SPONSOR	ENDORSING GROUP	ENDORSING BODY	APPROVING BODY
Standing Orders	**Director of Corporate Governance**	**Executive Management Board**	**Audit Committee**	**Trust Board**
Risk Management Board Assurance Framework	**Director of Corporate Governance**	**Executive Management Board**	**Audit Committee**	**Trust Board**
Citizen Engagement & Involvement Partner & Stakeholder Engagement Corporate Governance	**Director of Corporate Governance**	**Executive Management Board**	**Quality, Safety & Performance Committee**	**Trust Board**
Policy and procedure for the management of Trust wide policies and other Trust wide written control documents	**Director of Corporate Governance**	**Executive Management Board**	**-**	**Quality, Safety & Performance Committee**
Standing Financial Instructions Financial Procedures Financial Management Financial Governance Commissioning Arrangements	**Executive Director of Finance**	**Executive Management Board**	**Audit Committee**	**Audit Committee**
Information Governance Health Records	**Executive Director of Finance**	**Executive Management Board**	**-**	**Quality, Safety & Performance Committee**
All aspects of Workforce and Organisational Development including Wellbeing, Equality, Diversity & Human Rights (including all-Wales workforce policies on behalf of the Trust Board). Welsh Language	**Executive Director of Organisational Development and Workforce**	**Executive Management Board**	**Local Partnership Forum** **Quality, Safety & Performance Committee**	**Trust Board**
Clinical Audit & Effectiveness Inquests Clinical Strategy	**Medical Director**	**Executive Management Board**	**-**	**Quality, Safety & Performance Committee**

AREAS COVERED	DOCUMENT SPONSOR	ENDORSING GROUP	ENDORSING BODY	APPROVING BODY
Research & Development Innovation Intellectual Property	**Medical Director**	**Executive Management Board**	**-**	**Research, Development & Innovation Sub Committee**
Medicines Management Civil Contingency/Emergency Planning Arrangements	**Chief Operating Officer**	**-**	**-**	**Executive Management Board**
Major Incident Plan/Business Continuity	**Chief Operating Officer**	**Executive Management Board**	**Strategic Development Committee**	**Trust Board**
Quality, Safety and Performance of patient and service user centred healthcare Patient Experience including Complaints, Incidents & Litigation Safeguarding Human Tissue Act	**Executive Director of Nursing, Allied Health Professionals & Health Sciences**	**Executive Management Board**	**-**	**Quality, Safety & Performance Committee**
Infection Prevention & Control	**Executive Director of Nursing, Allied Health Professionals & Health Sciences**	**Infection Prevention & Control Management Group**	**Executive Management Board**	**Quality, Safety & Performance Committee**
Nursing Services Nutrition Allied Health Professional Services Health Sciences	**Executive Director of Nursing, Allied Health Professionals & Health Sciences**	**-**	**-**	**Executive Management Board**
Integrated Medium Term Plan Performance Management Framework	**Director of Strategic Transformation, Planning & Digital**	**Executive Management Board**	**Strategic Development Committee**	**Trust Board**
Digital Infrastructure and Digital Delivery Health & Safety Performance Arrangements Estate Plans	**Director of Strategic Transformation, Planning & Digital**	**Executive Management Board**	**-**	**Quality, Safety & Performance Committee**

AREAS COVERED	DOCUMENT SPONSOR	ENDORSING GROUP	ENDORSING BODY	APPROVING BODY
Strategy Planning Sustainability/Environment Management	**Director of Strategic Transformation, Planning & Digital**	**Executive Management Board**	**-**	**Strategic Development Committee**
Investments Fundraising Bequests Donations	**Executive Director of Finance**	**Executive Management Board**	**-**	**Charitable Funds Committee (in conjunction with Charitable Fund Trustees)**

APPENDIX 4

POLICY OR WRITTEN CONTROL DOCUMENT TEMPLATE

Ref: ( )

(DOCUMENT TITLE)

Executive Sponsor & Function

Document Author:

Approved by:

Approval Date:

Date of Quality Impact Assessment:

Date of Equality Impact Assessment:

Equality Impact Assessment Outcome:

Review Date:

Version:

TEMPLATES FOR DOCUMENTS

The template and control sheet should be used by anyone wishing to formulate any written control system. Documents should be formatted in line with Corporate Style as follows:

Electronic format	Microsoft Word - PDF Read only
Front cover	Corporate template
Audit trail	Use Policy process
Body text	Arial 12
Headings	Arial 12 (UPPER CASE)
Tables and charts	Arial (size as appropriate)
Use of bold	Headings only
Alignment	Justified
Line spacing	Body text single
Paragraph spacing	One line between paragraphs. Two lines between main sections.
Underlining	None
Contents page Contents page if >3 pages	As template Use judgement - help reader to find relevant information more easily.
Staff Names	Use titles rather than names.
Logo	Use Trust logo.
Headers and footers	Arial 9
Margins	Top and bottom of page 2.5cm, sides 2.5cm.
Document Title	To be included in the header on every page
Page numbering	To be included in the footer (e.g. page x of x)
Bullets	• Use standard bullets only, as they do not always format across different systems.
Abbreviations	State in full in first usage with abbreviation in brackets.
Printing	A4/double sided.
Referencing	All reference material should be listed in full at the end of every document in Harvard style.
Glossary of terms	As all policy documents are subject to the Freedom of Information Act, they need to be user friendly as they are documents that can be held up to public scrutiny. Therefore, all abbreviations, jargon and specific wording must be clearly explained to the reader.
Version Control	Reference Number provided by the Corporate Governance Manager. Documents to state 'Draft' whilst in development.

COMPONENTS OF A POLICY

All Policies must include the following headings as a minimum

Introduction/Aim	What is the purpose of the document? What is it about? Why is it needed? This should include where necessary reference to external regulations or other relevant guidance. This may require information relating to audit, risk management, quality and safety.
Objectives	What will the document achieve?
Scope/Area of Application	Exactly who the policy applies to and the consequences for non-compliance where appropriate: • All staff? • Directorate/Clinical Department/Corporate Department specific?
Roles and Responsibilities	• Who is responsible for implementation? • Which groups of staff are able to carry out the procedures required? • What action points does the document raise? • Who is responsible for ensuring action points are undertaken? • Who is accountable if the responsibilities are not followed?
Main Body	Show how the document aims and objectives will be achieved. Reference evidence appropriately.
Resources	Are there any resource issues in order for the document to be implemented? Financial/Time/Training – these must be identified as if there are no resources the document will not be achievable.
Training	• Are there any training issues and if so, who is responsible for the training programme? • Who will keep a record of those members of staff who have been trained? • Will there be update training? How often? If the document compliance is not carried out for any length of time at what stage will the person cease to be authorised to carry out that policy? Where appropriate, specify the grade and required education and training of staff implementing the document.

Implementation and Policy Compliance	How will the document be implemented? • Action Plan? • Timescales? • What level of training should they have? 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 objective. The document needs to set out how compliance with the policy is to be measured and reported.
References	Policies must be based on sound evidence and be appropriately referenced. Name any recognised relevant professional body, for example the source of your evidence base. Where appropriate, specify what is required to be documented in patients' notes. Clinical policies should also include a review of the evidence used and a reference list of that evidence.
Health and Care Standards	This section should outline how the policy or written control document contributes to compliance with the Health and Care Standards and should also indicate to which Standards this area of activity is linked.
Integrated Impact Assessment	Has an equality and health impact assessment been carried out? If 'no' the reason for this will be explained at the beginning of the document. If 'yes' the impact will be included in the document and appended. Explain how the document promotes equality of opportunity and/or good relations between different groups. For further information contact the Equality, Diversity and OD Manager
Environmental Impact	Does an Environmental Impact Assessment need to be carried out? For further information contact the Trust's Environmental Development Officer.
Audit	This is required to ensure that the document is appropriate and achievable and that there is compliance with the document by staff. An audit tool must therefore be built into the policy document.
Review	Generally, 3 years unless legislation requires differently – check with Corporate Governance Manager.

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	**Related Policies and/or written control documents** Where other policies are relevant these should be listed. **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. **Main Relevant Legislation** A list of the relevant statutory provisions which influence the organisation's operation in relation to the policy.

CHARACTERISTICS OF POLICIES AND WRITTEN CONTROL DOCUMENTS

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
- 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

Written Control Documents should:

- Be clear in terms of how the procedure helps the organisation achieve its aims and objectives.
- 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 Written Control Documents

- Use Arial 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 page number

APPENDIX 5

Equality Impact Assessment Process and Form

The Equality Act 2010 requires the undertaking of equality and health impact assessments and all Trust policies will require the completion of such before the policy is consulted upon. This is a process to find out whether a 'policy' will affect people differently on the basis of their 'protected characteristics': age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion, sex or sexual orientation and if it will affect their human rights. It also takes account of Welsh Language issues. It is designed to ensure that we are taking into consideration the needs of all individuals who work for us and/or access our services.

The Integrated Impact Assessment (IIA) is a process that considers how the health and well-being of a population may be affected by a proposed action, be it a policy, programme, plan, project or a change to the organisation or delivery of a particular public service. Some impacts of policies on health may be direct, obvious and/or intentional, whilst others may be indirect, difficult to identify and unintentional. The IIA is a systematic, objective, flexible and practical way of assessing both the potential positive and negative impacts of a proposal on health and well-being and suggests ways in which opportunities for health gain can be maximised and risks to health minimised. HIA looks at health in its broadest sense, using the wider determinants of health as a framework. This will ensure that any negative or indirect discrimination which could be an outcome of the policy, etc. is identified and risk assessed, linking to the Trust Risk Management Policy and Strategy. All final policies must include reference to the Integrated Impact Assessment that has been undertaken.

Where a procedure or other written control document has been developed in support of a policy it may not be necessary to undertake a further Integrated Impact Assessment. If an IIA has not been completed the reason for this will be explained at the beginning of the document. Where an IIA has been completed, the impact will be included in the document.

IIAs will be published as part of the consultation process and they will be available on our internet and intranet sites alongside the relevant policy or written control document.

One of the key requirements is the need to involve stakeholders in the process, whether internal or external. This ensures that any potential areas for discrimination are identified and solutions are sought to prevent discrimination.

In addition, the Trust's IIA process also includes the Welsh language and carers as well as adopting a human rights-based approach, ensuring dignity and respect are also evaluated in the process.

An Equality Impact Assessment form must be completed as part of the assessment process. Prior to attending the EQIA Group meeting the policy author/lead will be required to complete and forward the first page of the Integrated Impact Assessment form to the Equality, Diversity and OD Manager.

To arrange for your policy or written control document to be assessed please contact the Trust's Equality, Diversity and OD Manager VUNHST.Equality&Diversity@wales.nhs.uk