INFORMATION GOVERNANCE SUB-COMMITTEE COMMITTEE UPDATE REPORT

Date of last meeting: 28 January 2025

Quoracy: Met

Report by: Anthony Tracey, Digital Director, Chair

KEY DISCUSSION POINTS AND MATTERS TO BE ESCALATED FROM THE DISCUSSION AT THE MEETING:

Alert (may require discussion)

Information Governance Sub-Committee wish to **alert** members of the Sustainable Resource Committee that:

- **Unauthorised Access to Patient Records Procedure** – the Sub-Committee approved the updates changes to the procedure.
- **Written Control Documentation Policy** – the Sub-Committee approved the changes.

Clinical Coding Update

The Sub-Committee were notified that the Health Board did not meet the clinical coding target for October 2024. The Health Board has ranked 4th out of the 8 Health Boards for October performance (85%). Only 2 Health Boards, Powys and Velindre achieved the 95% target for June 2024 activity. The Health Board despite not achieving the target is still well above the all-Wales average of 70.0%. As performance has declined over the last 12 months, NHS Executive have asked to see a planned trajectory for meeting the ministerial target. The Health Board will be back to achieving the target in November 2025 (for September 2025 activity) as the new trainee coders will have been in post for 18 months.

Advise (to monitor)

Information Governance Sub-Committee had no matters that they wish to **advise** members of the Sustainable Resource Committee that:

Assure (to note)

Information Governance Sub-Committee wish to **assure** members of the Sustainable Resource Committee that:

- **Corporate and Medical Records Storage Assurance Report** – The Sub-Committee received an update report on the storage of records within external facilities. The Sub-Committee were pleased to note the number of records that have been moved back to the internal records facilities reducing our reliance on external suppliers.

Review of Risks

The Sub-Committee reviewed the two risks which are aligned to Group. As part of its review, the Sub-Committee considered the status of each risk, and the current score was deemed in tolerance. However, the Sub-Committee did recognise the work that had been done by the Information Governance and Health Records Teams in reducing the risk of inappropriate storage facilities.

Sharing of learning

The Information Governance Sub-Committee had no matters to alert the Group on this occasion.

Recommendation

The Committee is asked:

- **NOTE** the report and **TAKE ASSURANCE** from the actions and oversight of the Sub-Committee.
- **APPROVE** an update of Procedure 773 Unauthorised Access to Patient Records – Reporting and Escalation Procedure
- **APPROVE** an update of Policy 190 Written Control Documentation Policy

UNAUTHORISED ACCESS TO PATIENT RECORDS - REPORTING AND ESCALATION PROCEDURE

Procedure information

Procedure number: Enter procedure number (policy team) 773

Classification:
Corporate

Supersedes:
N/A

Clinical documents only:
Local Safety Standard for Invasive Procedures (LOCSSIP) reference:
List the LOCSSIP reference if applicable, if not state not applicable

National Safety Standards for Invasive Procedures (NatSSIPs) standards:
List the NatSSIP reference if applicable, if not state not applicable

Version number:
1

Date of Equality Impact Assessment:
12/07/2022

Approval information

Approved by:

Date of approval:
Enter approval date

Date made active:
Enter date made active (completion by policy team)

Review date:
Enter review date (normally three years from approval date)

Summary of document:
This document includes the correct procedure for the use of the National Integrated Intelligence Audit Solution (NIIAS) to identify potentially inappropriate access to clinical records and how to escalate this through an agreed process.

Scope:
All staff with access to electronic clinical systems will be affected by the introduction of NIIAS. Staff within the Health Board have been fully briefed as to what this system will deliver through a robust communications plan, Information Governance training sessions and discussions at the relevant forums (including Staff Partnership Forum). Communication reminders are sent to staff on a regular basis to remind them of their responsibilities in relation to accessing patient records and respecting patient privacy and confidentiality.

To be read in conjunction with:
320 – Acceptable Use of IT Policy
172 – Confidentiality Policy
836 – All Wales Information Governance Policy
837 – All Wales Information Security Policy
995 - All Wales Respect and Resolution Policy
201 - All Wales Disciplinary Policy and Procedure
435 - All Wales NHS Staff to Raise Concerns Procedure (Whistleblowing)
488 - All Wales Upholding Professional Standards in Wales (Medical & Dental Staff) Policy

Patient information:
Include links to Patient Information Library

Owning group:
Information Governance Sub Committee
Date signed off by owning group

Executive Director job title:
Huw Thomas , Director of Finance

Reviews and updates:
1.0 New Procedure

Keywords
NIIAS, Audit, Information Governance, Unauthorised Access

Glossary of terms

Term	Definition
Caldicott Guardian	A Caldicott Guardian is a senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly.
Data Protection Legislation	Data protection legislation is about the rights and freedoms of living individuals and in particular

	their right to privacy in respect of their personal data. It stipulates that those who record and use any personal data must be open, clear and transparent about why personal data is being collected, and how the data is going to be used, stored and shared.
NIIAS	National Integrated Intelligent Audit Solution
Personal Data	Personal Data is information which relates to a living individual who can be identified from the information itself or by linking it with other information – for example a person's name and address, an online profile, a member of staff's HR record or records relating to individual's such as patients or service users.
Personal Data Breach	A personal data breach means a breach of security leading to the accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to, personal data. This includes breaches that are the result of both accidental and deliberate causes.
Senior Information Risk Owner (SIRO)	An Executive Director or member of the Senior Management Board with overall responsibility for information risk across the Health Board.
Special Category Data	Special category data means personal data consisting of information as to: - Genetic and biometric data - Political opinions - Religious or other beliefs - Trade union membership - Physical or mental health/condition - Sexual life And although not specifically described as special category data, this information requires the same treatment: - The commission or alleged commission of any offence - Any proceedings for any offence committed/alleged to have been committed, the disposal of such proceedings or the sentence of such proceedings
Unauthorised Access	Access to information that is not part of your work duties. Access to a patients record where the patient is not under your care.

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Scope

All staff with access to electronic clinical systems will be affected by the introduction of NIIAS. Staff within the Health Board have been fully briefed as to what this system will deliver through a robust communications plan, Information Governance training sessions and discussions at the relevant forums (including Staff Partnership Forum). Communication reminders are sent to staff on a regular basis to remind them of their responsibilities in relation to accessing patient records and respecting patient privacy and confidentiality.

Aim

The aim of this document is to:

- ensure appropriate and relevant access to Patient Identifiable Information (PII).
- ensure that all staff understand their responsibilities when accessing patient records.
- educate staff on the process Information Governance will take on any identified inappropriate access to information.
- ensure the Health Board has taken all steps possible to educate staff to prevent any future breaches of confidentiality.

Objectives

The aim of this document will be achieved by the following objectives:

- Identify any potential inappropriate access to PII in line with the principles of the current Data Protection Legislation and confidentiality and privacy laws to ensure that patient information is handled by staff members fully respecting the privacy rights of each individual patient.
- Escalate any potential Personal Data Beaches to the Information Governance team so that action can be taken.
- Where a case has to be answered, inform the Workforce Department to follow the processes outlined within this procedure and which may result in action being taken in line with the Health Board's Disciplinary Policy and Procedure.

Main body (Free typing add titles etc)

1. INTRODUCTION

The National Intelligent Integrated Audit Solution (NIIAS) will take the audit trail from electronic clinical systems, e.g. Welsh Patient Administration System (WPAS), Laboratory Information Management System (LIMS), the Welsh Clinical Portal (WCP) and cross match against both an employee record in the Electronic Staff Record (ESR) and HDUHB's national directory (Cymru). NIIAS will then report on any unauthorised access to person identifiable information (PII) against the domains outlined in section 2.1.

2. PROCEDURE

The Procedures follow several steps to identify and escalate potential personal data breaches:

2.1 Definition of the 8 domains

Breaches have been defined on a National level and fall into the following 8 domains.

Term	Definition	Comment
Own Care Record	A user has accessed their own patient records.	Identification of Patient IDs for the staff member through ESR-MPI triangulation.
Family Care Record	A User has accessed the record of a Patient who has the same surname and postcode as the User.	Family classified as matching same surname + postcode through ESR-MPI triangulation.
Staff Member Record	A User has accessed the record of a Patient who has a matching employee record in ESR.	
Living in the Same Vicinity	A User has accessed the record of a Patient who lives very close to the User. In rural areas this distance is 0.5 miles, in urban areas this distance is 0.1 miles.	Identification of distance between User and Patient postcodes through ESR-MPI triangulation.
Person of Interest	A User has accessed the record of a Patient who has been flagged by the HBs as being a "person of interest".	This Patient is flagged locally using their NHS number.
Patients with the Same Surname	A User has accessed three Patients in the space of 1 day who share the same surname.	The 15 most common surnames in Wales have been excluded (Davies, Edwards, Evans, Griffiths, Hughes, James, Jenkins, Jones, Lewis, Morgan, Rees, Roberts, Smith, Thomas, and Williams).
Historic Record	A User has accessed patient records that are older than 1 year without first accessing a more recent record for that same Patient within the last 45 days.	Users with Clinical Job Roles assigned in ESR are excluded.
Deceased Patient	A User has accessed the records of a deceased Patient who has been deceased for more than 60 days.	Identification of deceased patient through MPI.

The Health Board is currently enforcing the following domains:

- Access to Own Record;
- Access to Family Record;
- Access to persons living in the Same Vicinity;
- Access to Persons of Interest;
- Access to Deceased patient's records; and
- Access to Staff Members Records.

2.2 Process for managing Access to Own Record: First time accessed by staff member (See Appendix 1 for flow chart)

The Information Governance team will produce a daily report that will identify any staff accesses to own record. Any staff member identified through the report will be sent an e-mail with an attached letter from the Information Governance Team outlining the details of the access. The attached letter will advise staff that they need to share a copy of the letter with their line manager within 5 working days, and attend one of the Information Governance Awareness Training sessions. Individuals are advised that attendance at the training session will be recorded on their ESR record.

Line Managers are then requested to confirm receipt of the letter to the Information Governance Team within 10 working days by completing the attached FORM 1 and confirming which of the Information Governance Awareness training sessions the individual will attend.

Staff will then book via ESR or directly with IG onto a virtual training session of their choosing.

Following completion of the training, any further attempts by a staff member to access their Own Record within a two-year period will be dealt with formally through the NIIAS procedure for further access to own record (see point 2.3 below).

NB: If at any point during the analysis of the NIIAS report the Information Governance Team, Executive Lead or Manager suspects there has been serious malpractice carried out by an employee a full investigation can be undertaken.

If a member of staff fails to respond to the Information Governance team, manager details are requested via Workforce.

2.3 Process for managing Access to Own Record: Further access by staff member (See Appendix 2 for flow chart)

The line manager for the staff in question will be contacted and asked to complete an 'Initial Assessment of Facts Form'. This will be returned to the Information Governance Team within 10 working days.

If it is not possible to identify the line manager for the staff member in question, the process outlined in 2.2 will be followed to make initial contact with the staff member and to request details of their line manager.

The Information Governance Team will review the returned 'Initial Assessment of Facts Form'. If the access is deemed as appropriate by the line manager (i.e. there is a legitimate work reason for the staff member accessing the record) and this is confirmed and agreed by the Information Governance team, the case will be closed on the NIIAS tracker and no further action taken.

If the access was inappropriate, the Information Governance Team will send details of the access and the outcome of the returned 'Initial Assessments of Facts Form' and investigation through to the identified link in the Workforce team to initiate the procedure as detailed in the All Wales Disciplinary Policy and Procedure document (201).

The Workforce team will liaise with the line manager to agree any further action required in relation to the staff member.

The Information Governance Team will provide any appropriate NIIAS reports as requested by the Workforce team.

2.4 Process for managing access to Family Record, Staff Record, Same Vicinity, Persons of Interest and Deceased patient's records. (See Appendix 3 for flow chart)

The Information Governance team will produce a report daily that will identify any staff accesses to the records above.

The individual staff member will be sent an e-mail with an attached basic letter advising them they have been identified through the NIIAS system as potentially having accessed a record without authorisation to do so. Staff will be asked to enter details of their line manager onto the contact letter and return this to the Information Governance team within 5 working days.

The Information Governance team will then contact the line manager directly with full details of the breach and ask that they complete an 'Initial Assessment of Facts Form' to identify whether the access is appropriate or not in relation to their staff member. This form will then be returned to the Information Governance team within 10 working days.

2.4.1 Appropriate access to records of Family Member, Staff Record, Same Vicinity, Persons of Interest and Deceased patient's records.

If the breach is deemed as appropriate by the line manager (i.e. there is a legitimate work reason for the staff member accessing the record) and this is confirmed and agreed by the Information Governance team, the case will be closed on the NIIAS tracker and no further action taken.

2.4.2 Inappropriate access to record of Family Member, Staff Record, Same Vicinity, Persons of Interest and Deceased patient's records.

The line manager will be required to conduct a formal meeting with the staff member to advise them that their access to the record is not appropriate, remind them of the NIIAS procedure and the Health Board's Confidentiality Policy. The line manager may wish to link in with their HR advisor within the Workforce team to assist with this process if further support is required.

The IG Team will run a full NIIAS check report against the individual to ensure there are no wider concerns about the individual's access to patient records.

The staff member will be required to attend an Information Governance training session within three months. The NIIAS tracker will be updated once the staff member has completed their IG training and the IG Team have completed their report. If no further inappropriate access to records takes place and no wider concerns are identified, then no further action will be taken and the case will be considered for closure.

If the access relates to more than a single record access or, if there are wider concerns confirmed or noticed about the individual's access to records, the Information Governance Team will commence the procedure for Managing Information Governance Incidents. This will be run alongside any on-going disciplinary/Workforce investigation. The Information Governance and Workforce teams will share information from their on-going investigations where it is felt appropriate to do so.

As part of the Managing Information Governance Incidents Procedure, the Information Governance Team will report the breach to the Caldicott Guardian and Senior Information Risk Owner who may decide to immediately suspend the staff member's access to patient records whilst the investigation is on-going. The Information Governance team will also need to determine if the breach is reportable to the Information Commissioner Office, this is in accordance with the Health Boards statutory obligations to report personal data breaches.

Once the investigation has concluded the Information Governance team will be informed by the Workforce link

NB: If at any point during the analysis of the NIIAS report the Information Governance team, Executive Lead or Manager suspect there has been serious malpractice carried out by an employee i.e. evidence that a large number of records have been accessed or multiple family members etc, this should be reported immediately to the Head of Information Governance and the Director of Digital Services.

2.5 Escalation process for all non-responses from staff and managers

If an individual member or line manager do not respond to requests for information from the Information Governance team within the agreed time-scales at any stage of the NIIAS process, the following action will be taken:

- An initial chaser e-mail will be sent by the Information Governance Team requesting a response within 5 working days.
- If no response, then the Workforce will be contacted for the employees managers details. If the manager fails to respond their line manager will be contacted.
- If no response received details will be sent to the relevant Executive Director who will contact the line manager requesting a response within 10 working days be sent to the Information Governance team.

2.6 Escalation process for not attending a booked Information Governance training session (without giving prior notice to the IG Team)

- An e-mail will be sent to the individual's line manager advising their staff member did not attend the IG training session. The line manager will be requested to remind the individual to book onto another IG training session and to respond within 5 working days.
- If no response then a second chaser e-mail will be sent requesting a response within a further 5 working days.
- If the individual does not attend the re-booked IG training session that their line manager has confirmed, they will be referred to their Executive Director with a request that they attend the next training session available, and their line manager will be copied into this e-mail.
- If the line manager does not respond to any requests to re-book their staff member onto a future session by the IG team then they will be referred to their Executive Director and a response will formally be requested.

2.7 Choose Pharmacy Application

The Choose Pharmacy application supports the delivery of a number of NHS community pharmacy services and enables access to NHS patient record systems including the Welsh Demographic Service and the Welsh GP Record.

The Health Board will be responsible for monitoring community pharmacy staff's access to patient data through the above application via the NIIAS monitoring tool.

The NIIAS system provides a report of potential breaches, this is then analysed by the Information Governance team on a twice weekly basis.

The Information Governance Team will then e-mail a report of any potential breaches to the Primary Care Manager (Community Pharmacy).

The Primary Care Manager will then contact the relevant pharmacy and ask that the following process is completed:

2.7.1 Pharmacy staff accessing their own record on one occasion (See Appendix 4 for flow chart)

The Pharmacist must issue a warning email for staff members accessing their own record on the first occasion. They must confirm that this action has been completed to the Primary Care Manager. The Primary Care Manager will then inform the Information Governance Team that this action has been taken.

Where the access has been made by the pharmacy superintendent/pharmacy owner, the Primary Care Manager will send the warning email.

2.7.2 Pharmacy staff accessing their own record on more than one occasion or potentially accessing another person's record inappropriately (See Appendix 5 for flow chart)

The Primary Care Manager will request that the Pharmacist undertake an initial assessment using the Potential Access Breach – Initial Assessment Form to establish whether there is a legitimate clinical or

administrative reason for the staff member to have accessed the record(s) for second access to own record or all other potential breaches.

The potential breach will be communicated to the superintendent pharmacist for the community pharmacy at which the breach occurred. The superintendent will provide the Primary Care Manager with the name of the person who will undertake the initial assessment within 5 days.

The initial assessment must be undertaken within 10 working days from a date agreed between the superintendent/owner and the Health Board.

The outcome of the initial assessment should be communicated to the Primary Care Manager via the Potential Access Breach – Initial Assessment Form.

Where the assessment concludes that no further action is necessary the Primary Care Manager will confirm they are satisfied with this decision. The Primary Care Manager will inform the Information Governance Team that no further action is required.

Where the assessment indicates the need for a full investigation – this should be completed in line with the pharmacy Information Governance policy for the management of Information Governance incidents. Access to the Choose Pharmacy application may be removed for the duration of the investigation. The outcome of the investigation will be reported to the Primary Care Manager who will inform the Information Governance Team that the record can be closed.

Any further general learning or training identified following the investigation will be agreed between the Primary Care Manager and the Information Governance team and progress monitored through the Information Governance tracker.

If the inappropriate access is carried out by the Pharmacy Owner/superintendent pharmacist then the Primary Care Manager will appoint an appropriate individual within the HDUHB to carry out a full investigation.

3 TRAINING

All staff will be required to have appropriate Information Governance training, additional training can be requested by individuals or line managers. Training will be provided in several formats to accommodate all learning styles and the requirements of staff and The Health Board.

4 IMPLEMENTATION

Extensive communications exercises have been undertaken to ensure all staff groups are aware of NIIAS and the implications of any breaches identified. This will be further supported through Information Governance communications via Globals / Newsletters / IG Awareness on Intranet.

5 REVIEW

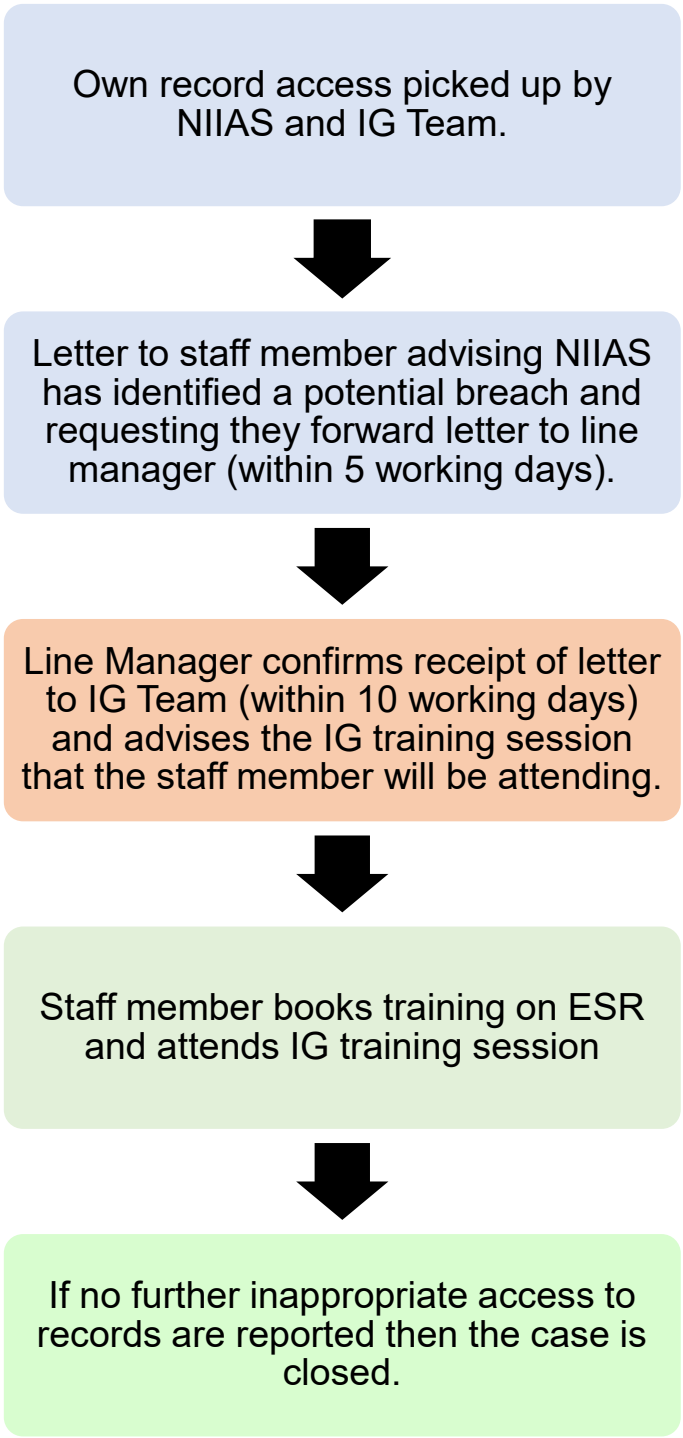
This Procedure will be reviewed in line with the further roll out and enforcement of the policy rules, or sooner, as required.

References

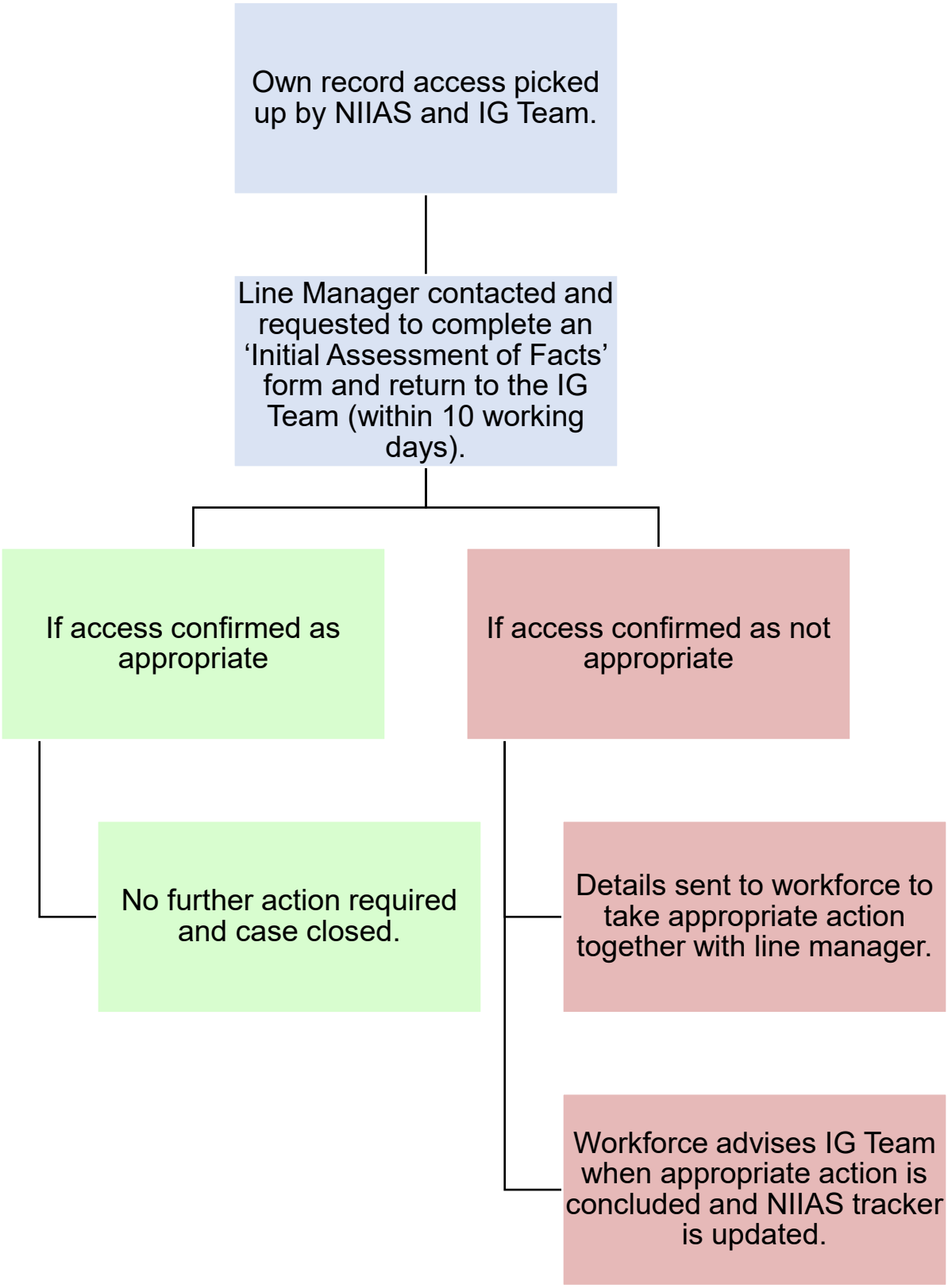
Information Commissioner Office https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/personal-data-breaches/

6 APPENDICES

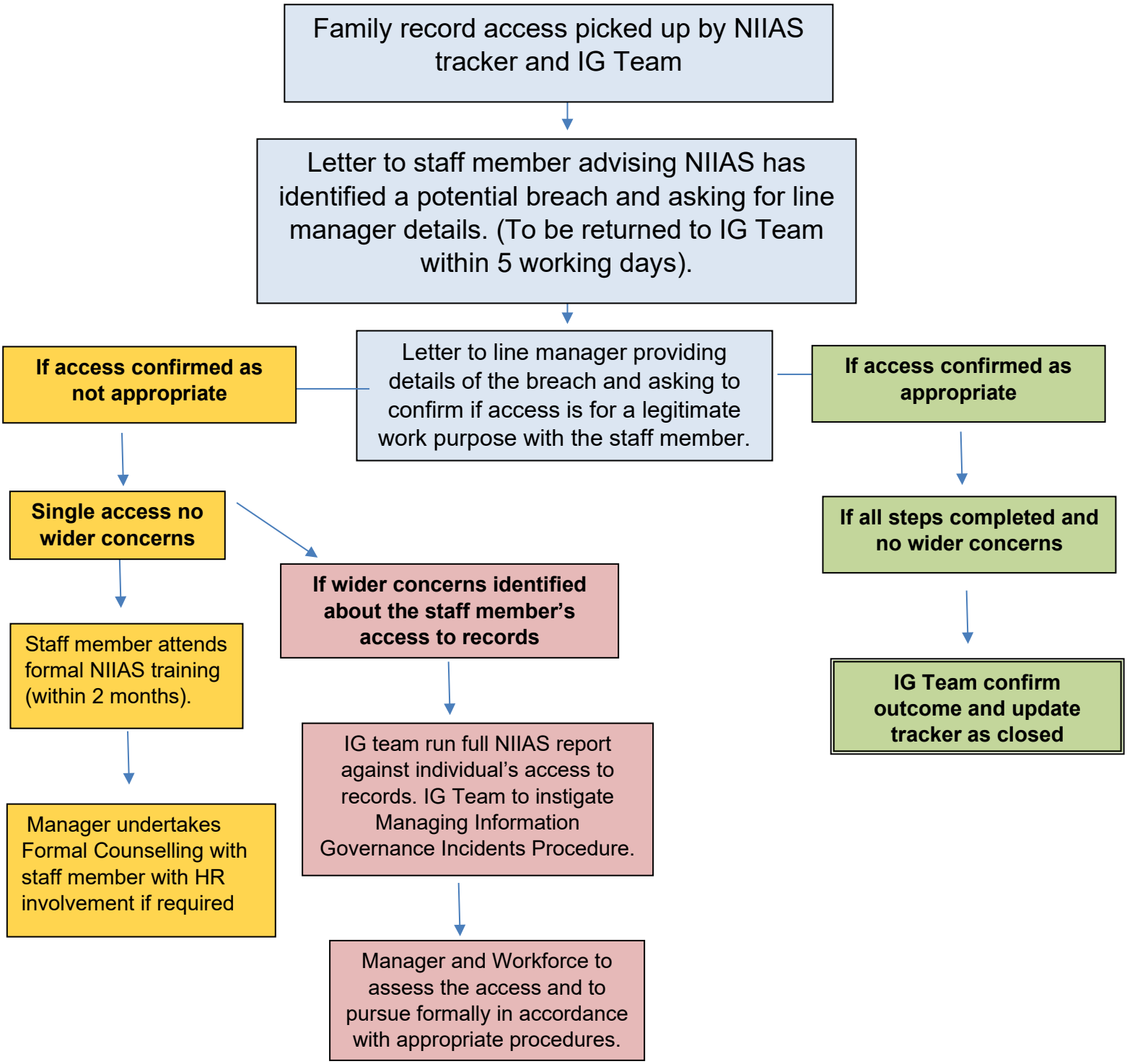
Appendix 1 – Process for managing Access to Own Record: First access by staff member



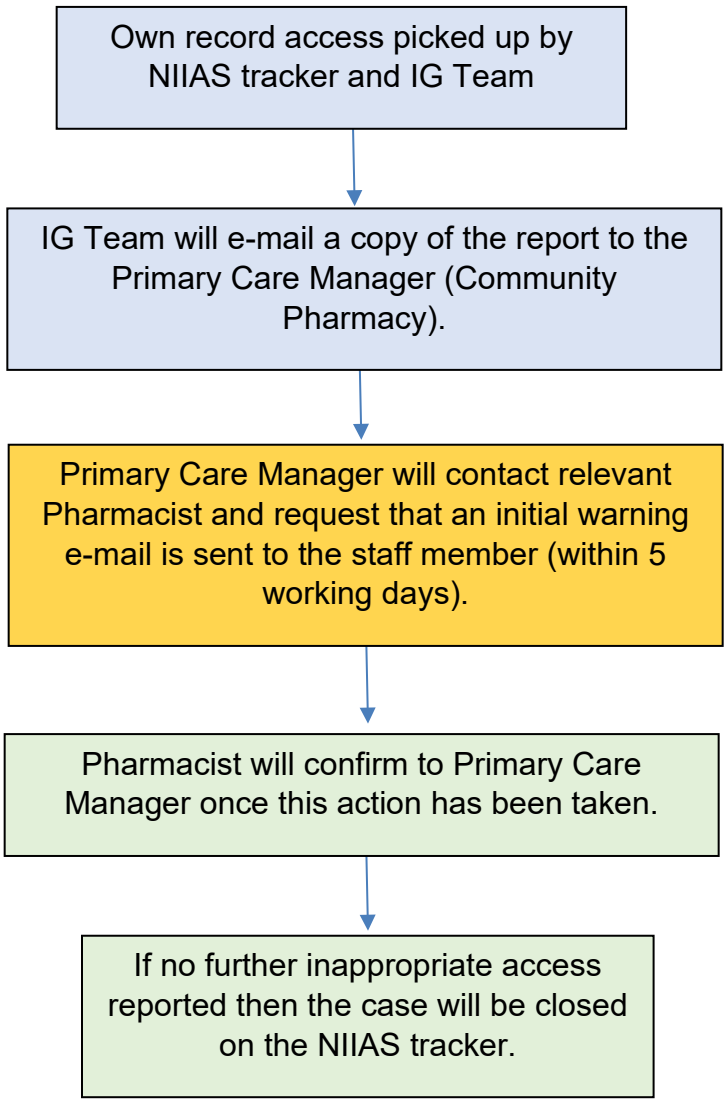
Appendix 2 – Process for managing Access to Own Record: Further access by staff member



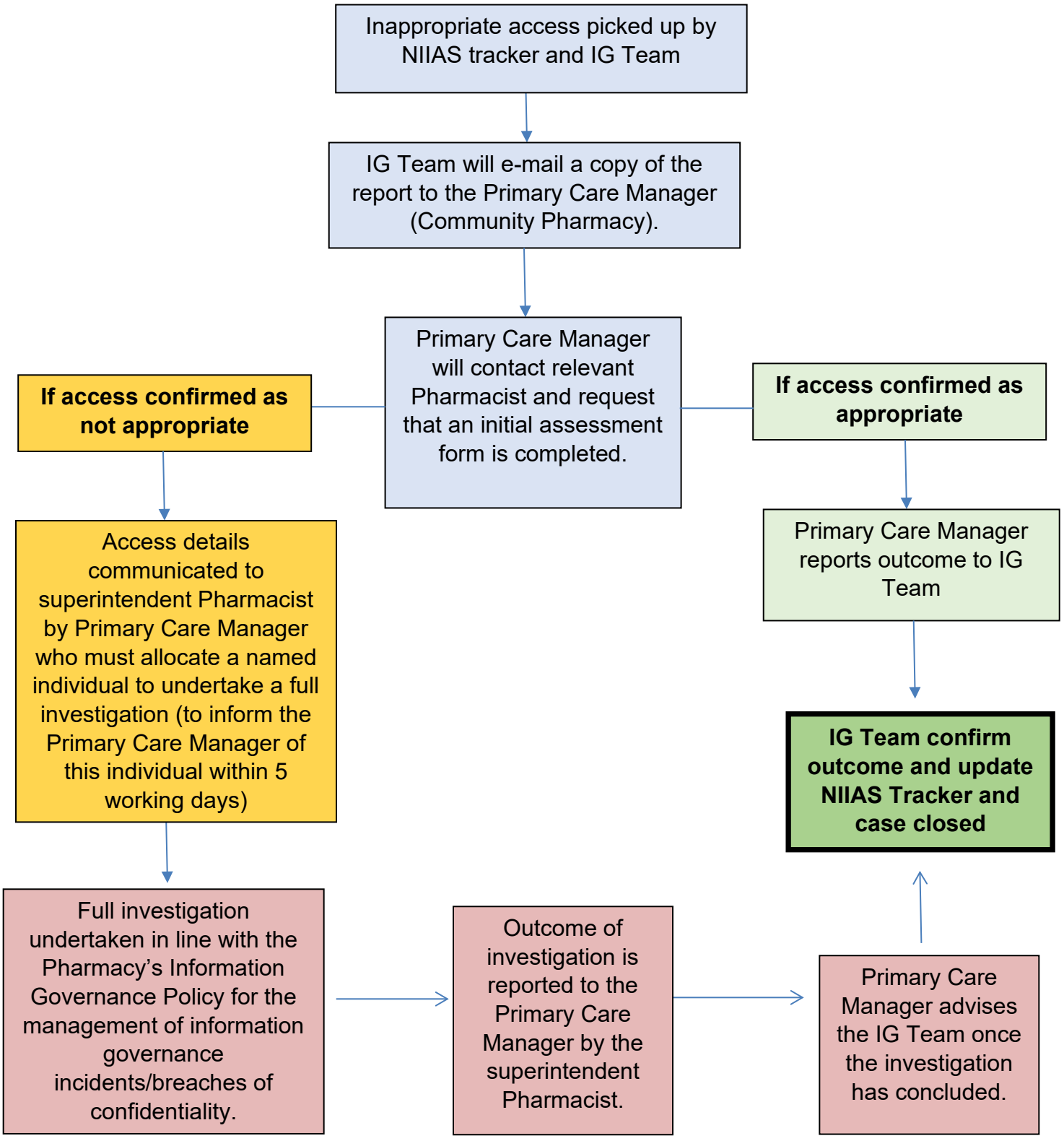
Appendix 3 - *Process for* managing access to Family Record, Staff Record, Same Vicinity, Persons of Interest and Deceased patient's records.



Appendix 4: Pharmacy staff accessing their own record on one occasion



Appendix 5: Pharmacy staff accessing their own record on more than one occasion or potentially accessing another person's record inappropriately



Written Control Documentation Policy

Policy information

Policy number: 190
Classification: Corporate
Supersedes: All previous versions
Local Safety Standard for Invasive Procedures (LOCSSIP) reference: NA
National Safety Standards for Invasive Procedures (NatSSIPs) standards: NA
Version number: **5**
Date of Equality Impact Assessment: 10.12.2024

Approval information

Approved by: Sustainable Resource Committee SRC
Date of approval:
Date made active:
Review date:

Summary of document:
This policy describes the process for the development, adoption, review, approval, publication and implementation of all written control documents (WCD-s). This policy ensures the organisations WCDs are in line with current legislation, guidance and evidence. WCDs can include policies, procedures, guidelines and strategies.

Scope:
This policy applies to all staff employed by the Health Board who are involved with the written control documentation development and review process.

To be read in conjunction with:
153 – Equality Impact Policy and Procedure (opens in new tab)
173 – Freedom Of Information Policy (opens in new tab)
193 – Retention and Destruction of Records Policy (including Health Records) Version 2 (opens in new tab)
307 - Production of Patient and Carer Information Policy (opens in new tab)

Patient information:
Not applicable

Owning group:
Written Control Document Review Task and Finish Group/IGSC

Executive Director job title:
Director of Corporate Governance/Board Secretary

Reviews and updates:
Version 1 – New policy approved on 10th May 2011.

Version 2 - Revised policy to reflect new process for written control documentation approved on 24th May 2016.
Version 3 - Slight amendments – Data Protection Act, approved on 26th June 2018.
Version 4 – Full review
Version 5 – Full review

Keywords
Policy, procedure, guideline, protocol, Standard Operating Procedure (SOP), Written control documents (WCD), summary approval report, Document Approval Form (DAF), Equality Impact Assessment (EqIA)

Glossary of terms
- WCD - Written Control Document
- A collective word for all policies, procedures, guidelines and strategies that the Health Board have put in place to ensure that the organisation is run effectively.
- DAF - Document Approval Form
- SBAR - Situation, Background, Assessment, Recommendations (Report)
- EqIA – Equality Impact Assessment
- CWCDG - Clinical Written Control Documentation Group
- Owner Group - The committee, sub-committee, group or department that has ownership and responsibility for each
- NWJJC - NHS Wales Joint Commissioning Committee
- WHC - Welsh Health Circular. These are health guidance issued to health boards by the Welsh Government

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Introduction

Hywel Dda University Health Board (Health Board) has a legal duty to ensure that the policies, procedures, and guidelines are in place. Written Control Documents are also known as WCDs. WCDs help ensure that the Health Board follows legislation, meets mandatory requirements, and provides services that are evidenced-based, safe and sustainable.

Having relevant, up to date and easy to follow WCDs minimises risk to patients, employees and the organisation. With this policy, the Health Board provides a robust and clear WCD management system. This policy includes the arrangements that support the development, review, approval, publication and implementation of WCDs. This policy helps to achieve compliance with corporate and clinical governance standards.

Policy statement

This policy sets out what the organisation does to manage WCDs and how that is done. This policy supports the effective decision making and delegation process and provides a step-by-step process for staff to follow.

Scope

This policy applies to all staff who have the responsibility for the development and/or review, publication and implementation of WCDs within their role. This policy applies to all Health Board WCDs, both clinical and non-clinical.

Aim

This policy aims to describe the WCD process, ensuring they are in line with current legal requirements and relevant to the service.

Objectives

To achieve this aim, the policy sets out the procedures for:

- The development and review of WCDs.
- The standard approach to WCDs, including corporate style and templates.
- Completion of equality impact assessments to enable the identification and elimination of inequality.
- Approval of WCDs following the correct approval processes.
- The publication of approved WCDs, including the WCD system.

Types of written control documents

Definitions of the WCDs in use within the Health Board are:

Strategy

A strategy is defined as a long plan designed to achieve goals or objectives. A strategy is often a broad statement of an approach to achieving these desired goals or objectives and can be supported by written control documents.

Policy

A policy is a written directive from the Board, which may be driven by statute or law, describing the broad approach or course of action that the Health Board is taking with an issue. Policies define the commitment of the Health Board and the obligations of individual staff. A policy is underpinned by evidenced based procedures and guidelines that must be adhered to.

A policy is Health Board wide and approved on behalf of the Board via the correct approval process.

Procedures
A procedure is a standardised method of performing tasks by providing a series of step-by-step actions on how to achieve a safe and effective outcome.

A procedure often sets out how a policy is to be achieved; however, procedures can also be a stand-alone document and must be adhered to.

Clinical procedures must be underpinned by evidence-based guidance from recognised bodies.

Guidelines
A guideline gives general advice and recommendations for dealing with a specific circumstance.

A guideline must be used in conjunction with your existing knowledge and expertise to ensure you take the right action in a specific situation.

A guideline often sets out how a policy is to be achieved however guidelines can also be standalone documents.

A clinical guideline is underpinned by evidence-based guidance from recognised bodies. Clinical guidelines should be followed to protect yourself and the organisation if an issue occurs.

Protocol
The Health Board considers this document as the same status as a procedure and should be referred to as a procedure.

Pathway
The Health Board considers this document as the same status as a guideline and should be referred to as a guideline.

Standard Operating Procedure
A standard operating procedure is either a procedure or a guideline and the appropriate template should be used.

Service specification
Service specifications do not fall under the remit of the 190 – Written Control Documentation Policy and therefore the process and document, EqIA and SBAR must be scrutinised and approved by the relevant operational business group/committee who has this responsibility within their terms of reference.
Service specifications must not contain guidelines or procedures – these must be separate documents, which have been through the 190 – Written Control Documentation Policy process and can be hyperlinked in.
For ease of access, service specifications can be housed on the Health Board policy intranet pages.

Prescribing information
Prescribing Information is approved and managed directly by the Medicines Management Operational Group (MMOG). All Prescribing Information, Guidelines and Procedures must be approved by MMOG prior to uploading onto an electronic resource (e.g. app).

Classification of Documents

Clinical

Clinical WCDs relate to the care and treatment of patients and offer an evidence-based approach to clinical decisions for patients with a given condition.

Corporate

Corporate WCDs relate to the management of the organisation and formulate the organisation's response to known situations and circumstances.

Employment

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

Financial

Financial WCDs relate specifically to the financial controls within the organisation. They are a written source of guidance and incorporate a description of controls, processes and responsibilities for all managers and employees. These need to align to the Health Board's standing orders and Standing Financial Instructions. The governance of financial WCD is overseen by the Health Board's Finance committee. Financial WCD do not require a DAF or to go through the global consultation process.

Identifying the need for developing, adopting or reviewing a WCD

The reason to develop a new, adopt or review an existing WCD can come from a variety of sources including:

- changes to legislation or national guidance,
- external reviews,
- audits,
- standardisation,
- clarify or improve working practices,
- to lessen an identified risk,
- to reduce the risk of fraud, bribery and corruption,
- to adopt an all Wales WCD.

The managers and staff of a service are often best placed to recognise when a WCD is needed. One example is the development of a WCD following an investigation into an incident, which includes recommendations on other controls to prevent a reoccurrence. This can also be because of an investigation into a complaint, litigation or external investigation, counter fraud review/investigation, audit or report.

Most WCDs are developed internally for use within the organisation; occasionally, a WCD needs to be developed jointly with another organisation. See joint policy example 395 – Section 136 – Mental Health Act, 1983 Mentally Disordered Persons found in public places (opens in new tab). This document brings together the Local Authorities, Police, Ambulance and other partner organisations. The WCD must go through the other organisation's processes and be approved.

Some WCDs are issued on an All Wales basis with the expectation of local adoption. These documents must also be subject to formal approval for use in the Health Board. Although the content of these

documents cannot be amended it is for us to confirm how they will be implemented and monitored. If more specific local information and guidance is required to implement the All Wales document, this will be contained in a local written control document.

Before developing a new or reviewing an existing WCD, the Policy Coordination Officer should be contacted. The Policy Coordination Officer will be able to provide advice and support about each stage of the process. You can contact the Policy Co-ordination officer via email at policies.hdd@wales.nhs.uk

You cannot develop or amend a document on your own; the document must be owned and overseen by the correct committee, sub-committee, task and finish group or department (known as owner group). This group must contain the expertise to advise on current legislation, guidance and evidence that affects the WCD. They must nominate a lead author who will handle ensuring that the process outlined in this policy is followed. WCDs should always be developed and reviewed in collaboration with others to ensure that the final document is in line with current legislation, guidance and evidence. If not, this may delay the approval of the document.

Strategies and policies must be sponsored by the Executive Director who has responsibility for the relevant service or area the document relates to.

All Wales and joint WCDs must be overseen by the right committee, group or department, who will nominate a lead to complete the approval process.

Steps in the development and approval process

Step 1 – Document Initial Assessment Form (DAF)

The first step in the WCD process is the completion of the Document Approval Form (DAF).

The DAF must be completed with the WCD for all documents except:

- Financial procedures, as these are structured documents which link into our standing financial instructions.
- A department only or single profession WCD, which sets out the requirements for a specific department or professional group and does not have wider implications. For further advice contact the Policy Co-Ordination Officer.

The content of All Wales documentation cannot be changed; however, the form needs to be completed to look at how the content can be implemented.

The DAF is to aid the responsible person to be clear about the reasons for the document, and the potential impacts of it. It is best practice to consider these prior to developing or reviewing all WCDs.

The DAF specifically aims to ensure that: -

- The right type of document is developed.
- The WCD is developed, adopted or reviewed within the context of existing WCDs.
- There is a plan of involvement with interested parties who will be essential to the implementation of the WCD.
- Consideration is given to the possible wider implications of the WCD.

Using this form from the start will ensure that the development or review process is robust, efficient and prompt. This form also enables the Policy Co-ordination Officer to track all WCDs that are under development or review.

Following sign off by the committee, group or department who owns the WCD, the DAF should be sent to the Policy Co-ordination Officer.

For all clinical policies, the DAF must be reviewed by the Clinical Written Control Documentation Group (CWCDG) to ensure it is right for the purpose and everyone will be consulted, and a mentor from CWCDG will be appointed.

For clinical procedures/guidelines, the DAF can be signed off by the appropriate owning group to ensure it is right for the purpose/consultation is ticked appropriately and an appropriate mentor from the group will be appointed. A summary of any DAFs approved by other groups/committees will be reported into CWCDG.

Financial WCD – The process of completing a DAF is not required.

Step 2 - Format of your document

The development and review of a WCD requires proper planning and time for collaboration with others. This will ensure that the WCD is robust and meets the requirements of current legislation, guidance and evidence. It will also ensure that enough time to undertake the development process is allocated. A minimum of 6 months should be allowed from the completion of the DAF to final publication.

Once the type of document has been agreed, the correct template must be used to ensure that the information needed is contained within the document.

The templates and guidance on how to complete them are included as appendices to this policy. Using the template correctly will ensure the document is as digitally accessible as possible, and that it can progress to consultation stage. WCDs not following this format will not go on further in the process and will be returned to the author for correction.

The new digitally accessible templates can be found here on the developing a written control document page (opens in new tab)

All WCDs must follow the Digital Accessibility Standards, which came into force for all public sector bodies in the United Kingdom on 23rd September 2018. The templates have been designed to comply with this; you must follow the guidance document when completing the template.

It is important that all WCDs are written so that they can be understood by all staff; to do this, the document must be written with a reading age of between 8-12 years. All WCDs must be factual, evidence-based and concise.

Step 3 - Assessing for impact

Equality Impact Assessment (EqIA)

The impact of the WCD must be considered before starting its development or at the first stages of its review. Undertaking an equality impact assessment enables resources to be targeted effectively and can help to reduce health inequalities.

A first screening will need to be undertaken for all WCDs as this will show whether a full equality impact assessment is needed.

The EqIA process involves looking at the likely effects of this document on those with a protected characteristic both while it is being developed and while it is being implemented. Impact assessments apply to existing as well as new and proposed WCDs.

Equality Impact Assessments must be undertaken on relevant WCDs to ensure they follow the Equality Act 2010 and the Data Protection Act, General Data Protection Regulations 2016 and any later legislation.

The WCD author will need time to assess the document and make any required changes once the EqIA has been completed. The EqIA needs to be signed off by the Equality & Diversity Team prior to the WCD approval. Refer to section: Approval of urgent documentation without an equality impact assessment having been finalised.

The Equality Impact Assessment will be published along with the approved WCD.
Further information, guidance and support on EqIA completion is available here on the Equality, Diversity and Inclusion intranet page (opens in new tab).
You can also contact the team via email on Inclusion.hdd@wales.nhs.uk.

Privacy Impact Assessment

Privacy Impact Assessments (PIAs) look at the privacy and data protection issues that may arise by the implementation of a WCD. This assessment ensures that the WCD does not breach the Data Protection Act, UK General Data Protection Regulations 2016 or any other related laws and guidance.

Ensuring WCDs are developed or reviewed with privacy in mind at the outset can lead to benefits which include:

- Potential problems are found at an early stage; this means addressing them early will often be simpler and less costly.
- Increased awareness of privacy and data protection across our organisation.
- Organisations are more likely to meet their legal obligations and less likely to breach regulations
- Actions are less likely to be privacy intrusive and have a negative impact on individuals.

A PIA can reduce the risks of harm to individuals through the misuse of their personal information. It can also help to design a more efficient and effective process for handling personal data. A first screening tool will need to be completed on all WCDs as this will show whether a full assessment is needed.

The Information Governance Team is available to help and recommend that staff complete the document and to answer any queries about the process. You can contact the team via email Information.Governance.hdd@wales.nhs.uk

Further information on PIAs can also be viewed here on the Information Commissioners Office (ICO) website (opens in new tab)

Step 4 – Collaboration with others

Compliance with legislation and regulations

All WCDs must follow legislative frameworks such as Consent, Deprivation of Liberties, Mental Capacity, Child and Adult Safeguarding, Data Protection, Welsh Language, Digital Accessibility, Equality and Fraud. To do this, the lead author must seek assurance from the relevant Health Board

leads that the WCD adheres to the relevant legislation. Evidence of this assurance must be included in the SBAR that goes with the final draft WCD when presented to the Approving Committee, Sub-Committee or Group.

Interested Parties Involvement

WCDs must not be developed in isolation. At the start of the development, adoption or review process all interested parties named in the DAF, must be approached by the lead author. The early involvement of all interested parties ensures the WCD is fit for purpose and can be implemented and followed by all involved.

Interested parties can contribute to the content of the WCD and give approval of the sections which they handle or that will affect them. Interested parties must find any barriers which could obstruct the implementation of/or compliance with the WCD. Any identified barriers must be resolved prior to the WCD being presented for approval.

For clinical WCDs, the lead author should wherever appropriate contact the Clinical Effectiveness Co-ordinator who will help with the identification of all relevant National Institute of Clinical Excellence (NICE) and Royal College Guidance. This guidance must inform and be referenced within the WCD.

The Library and Knowledge Services Manager is available to undertake a literature search and provide guidance on referencing.

Most clinical WCDs must include patient information leaflets as appendices when approved. Eido Healthcare or Welsh Risk Pool (WRP) approved alternative patient information leaflets must be used wherever possible. For more information you can click here to visit the Patient Experience intranet page (opens in new tab)

Information on developing patient leaflets can be found here in 307 - Production of Patient and Carer Information Policy (opens in new tab)

If you would like further information on patient leaflets you can email patient.experience.HDD@wales.nhs.uk

Comments and feedback received from interested parties must be collated and a record kept of the action taken; for example, if the comments were incorporated or not. This information must be included in the SBAR when the WCD is presented for approval.

Step 5 - Consultation

This is the final stage in the development, adoption or review process. This provides a further opportunity to interested parties who have already contributed and those who might have been inadvertently missed, to comment.

Any written control document that has an impact on staff (ie failure to comply resulting in disciplinary action) must be submitted to Staff Partnership Forum/Trade Union for comments.

Any clinical written control document that has an impact on staff (ie failure to comply) must be submitted to the LNC for information and comment. The Policy team will assist with this process.

Consultation must be undertaken for all organisational strategies, policies, procedures and guidelines, which are multi-disciplinary or multi-agency. You can contact the Policy Co-ordination Officer for advice on this.

Consultation involves the WCD being placed onto the Health Board's intranet site for a minimum of two weeks. The draft document is then circulated on the global emails where all members of staff are invited to comment on the WCD via the on-line form. The completed comment form is sent direct to the lead author for consideration and action.

All Wales and other relevant guidance documentation that is being adopted by the Health Board must go out for formal global consultation. Although the content of the document cannot be amended, it is for assurance that it can be implemented and monitored within the Health Board.

Comments and feedback received from the consultation must be collated and a record kept of the action taken. This must be included in the SBAR which will go with the WCD when it is presented for approval.

Step 6 – Preparing your document for approval.

Before you are ready to send your WCD for approval you must ensure you have all the accompanying information completed.

1. Equality Impact Assessment (EqIA).
2. Privacy Impact Assessment (PIA).
3. Interested parties' comments or approval.
4. If required, a full implementation plan.
5. SBAR which refers to all the above.

SBAR

All WCDs presented for approval must be accompanied by a SBAR, which will provide assurance that the development or review of the WCD has been undertaken in line with this policy.

The SBAR needs to: -

- Prove the development process has been robust and in line with this policy.
- Prove the last version of the WCD is in line with current legislation, guidelines and evidence and can be implemented.
- Include an assessment of the impact of the WCD, the EqIA and PIA.
- List the interested parties who have been involved in the development of the WCD and evidence their approval of the final WCD.
- Supply evidence that a wider consultation has taken place and include the record of comments received and actions taken.
- Supply details on how, and by whom, the WCD is issued and how you will ensure that this happens.
- Supply details on how, by whom and when the WCD will be implemented and whether a detailed separate implementation plan is needed. If it is, this must go with the SBAR.
- Prove that there are processes in place to check the compliance with the WCD and show how they will be addressed as soon as possible.

Step 7 – Approval of your WCD

Approval of single department or profession WCDs

These WCDs relate to a single department, profession or staff group and there is no wider impact on the Health Board. Final approval of these documents can be provided by the department or service manager. These documents do not need to be recorded on the central database, but records must be kept at a local level. This is to ensure that there is a full history and document archive in line with the 193 – Retention and Destruction of Records Policy (opens in new tab)

Approval of all other WCDs

The Board has delegated approval of WCDs to its committee structure. WCD approval is included within the individual committee, sub-committee and group's terms of reference. All WCDs must be sent to the right approving committee, sub-committee or group for approval. You can find out more about which committees, sub-committees or groups approve which document by contacting the Policy Co-ordination Officer.

If an approved WCD needs to be amended or updated prior to the full formal 3-year review, contact the Policy Co-ordination officer for instructions.

Approval of urgent documentation without an equality impact assessment having been finalised.

In exceptional circumstances only, a WCD without an EqIA can be approved. This must be for a short interim period of 1-3 months only. This brief period is to give the author time to complete the equality process.

Once this urgent document has been approved, an email must be sent to the lead author and copied to the line manager and executive lead. This email will confirm the short approval and make it clear that the document will be removed after that date. The WCD and all supporting documentation must go for approval to the next relevant group or committee meeting.

Publication of the WCD

Following approval, the last version of the WCD, plus its impact assessment documentation, must be sent to the Policy Co-ordinator within 5 working days.

The Policy Co-ordination Officer will then:

- Upload the WCD and Equality Impact Assessment documentation on the intranet or internet site as appropriate within the next 5 working days.
- Include the WCD in the daily global email sent out by the Communications Team.
- Include the WCD in the Freedom of Information Publication Scheme.

The intranet or internet page will be the primary location for all WCDs. This ensures that staff have access to the most up to date version. Staff should not upload duplicated versions of the approved WCDs but should link to the newest online version. All approved WCDs will be listed on the approved WCD page on the intranet or internet site as appropriate.

The lead author can arrange for a link to the document to be published within relevant newsletters and/ or other relevant sections of the intranet. Make sure that it is the link that is published and not a downloaded version of the WCD.

Dissemination of the WCD

The owner group is responsible for agreeing how, and by whom, the WCD is issued. They must also ensure that this is undertaken. As a minimum, the WCD must be issued to the relevant operational leads to implement the WCD locally.

In addition to the dissemination found within the scope, all WCDs are also issued, as relevant to Assistant Directors, Associate Medical Directors, and operational senior management. They will then act as appropriate.

Monitoring of the WCD

The owner group is responsible for ensuring that they check compliance with the WCD. They must ensure that any issues that are found are addressed as appropriate. This might result in the updating of the WCD. Correct monitoring will help ensure that the WCD stays in line with current legislation, guidance and evidence.

Reviewing the WCD

All WCDs must be reviewed every three years unless it has been reviewed within this time scale.

The owner group is responsible for ensuring the document is reviewed and stays in line with current legislation, guidance and evidence. They must review the WCD considering new or updated legislation and/ or guidance as they are published.

Extending review dates of the WCD

The Policy Co-ordination Officer will contact the owner group to let them know their document is due for review 9 months before the review date. The lead author, in conjunction with the owner group, is responsible for ensuring that the document is reviewed before the expiry date. If the expiry date will pass, the owner group must receive assurance that the current version of the WCD is still fit for purpose. The owner group must then agree an extension of up to a maximum of six months.
Any significant changes to an existing WCD will require it to be re-approved by the approving owner group by following the WCD process.

Minor changes to an existing WCD

If the amendments are minor, then a SBAR/version control document must be completed and attached to a tracked-change Word version of the WCD. The version control document must be fully completed and approved by the owner group. The equality 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 lead author/owning group have consulted with applicable colleagues.

Documentation must be submitted for approval as per step 7

Documentation should be forwarded to the Policy Co-ordination Officer for uploading.

Significant changes to an existing WCD

Significant changes to an existing WCD must be undertaken in conjunction with key individuals and the owner group identified in the original SBAR. Amendments should be undertaken using tracked changes in Word for record keeping purposes.

The equality impact assessment must also be reviewed. The amended WCD must go out for global consultation as in the initial process.

A new SBAR should be completed prior to approval.

People included in the WCD approval process

Sub-committee, group or department who owns the WCD (known as the owner group)

The owner group is responsible for approving procedures and guidelines and recommending policies for approval to the approving committee, sub-committee or group.

The owner group is responsible for: -

- Ensuring the development or review of the WCD is undertaken within the timescale.
- Ensuring that it has the relevant knowledge and expertise within its membership to develop or review a WCD.
- Nominating and providing support to the lead author. The support person will be responsible for ensuring that the process outlined in this policy is adhered to.
- Signing off the DAF.
- Providing assurance to the approving committee, sub-committee or group via a SBAR that the following has been undertaken:
    - The developmental process has been in line with the WCD Policy.
    - The final version of the WCD complies with current legislation, guidance and evidence and can be implemented.
    - Agreement on how, and by whom, the document is disseminated and ensuring that this is undertaken.
    - Agreement on how, by whom, and when the WCD will be implemented and whether a detailed separate implementation plan is required.
    - There are mechanisms in place to monitor the compliance with the WCD and ensuring that any identified issues are addressed as soon as possible.
    - Ensuring that the WCD remains in line with current legislation, guidance and evidence throughout its lifetime.

Lead author

The lead author will be identified by the owner group and will act as the nominated lead during the development or review of the WCD. The lead author should have the right level of knowledge, and experience to lead on the development of WCDs on behalf of the owner group. In particular, the lead author will be responsible for ensuring that each step of the WCD procedures has been followed.

The lead author, in conjunction with the owner group, is responsible for:

- Contacting the Policy Co-ordination Officer at the start for advice and support throughout each stage of the WCD development or review process.
- Identifying the scope and purpose of the document and completing the DAF before starting the development or review of the document.
- Identifying the interested parties, dependent upon the scope of the document and expertise required. These may include other specialist groups and committees, specialties, professional groups or services.
- Identifying and following the approval procedure for the WCD being developed or reviewed.

- Providing assurance to the approving committee, sub-committee or group that all relevant interested parties have contributed and given approval of the WCD.
- Where any issues cannot be resolved, the most senior appropriate individual must be notified before recommending the WCD for approval.
- Ensuring that the WCD is produced in line with current legislation, guidance and evidence.
- Ensuring that any potential negative impacts are considered throughout the development or review process. As a minimum, a screening for equality impact must be completed in line with this policy.
- Ensuring that privacy and data protection principles are considered by completing a Privacy Impact Assessment (PIA).
- Producing the SBAR, which must accompany the final draft of the WCD.
- Developing or reviewing documents within the 6-month timeframe.

WCD approving committee

This will be the most appropriate committee with delegated authority from the Board and its sub committees.

All Wales or jointly developed policies must be formally adopted by the Health Board, via the appropriate approval committee, before being implemented in the organisation. These may require additional procedures to be developed to support implementation within the Health Board.

The approving committee through the SBAR must assure themselves that the following has been completed: -

- The development or review process has been robust and in line with the WCD Policy. The final version of the WCD is in line with current legislation, guidance and evidence and can be implemented.
- An assessment of the impact of the WCD including the EqIA and PIA.
- The SBAR lists the interested parties involved in the development of the WCD and their comments and approval of the final WCD have been considered.
- Evidence that wider consultation has taken place and records the comments received, and action taken.
- Agreement on how, and by whom, the document is disseminated and ensuring that this is undertaken.
- Agreement on how, by whom, and when the WCD will be implemented and whether a detailed separate implementation plan is required.
- There are mechanisms in place to monitor the compliance with the WCD and ensure that any identified issues are addressed when identified.

Policy Co-ordination Officer

The Policy Co-ordination Officer will provide advice and support to authors throughout the WCD process.

The Policy Co-ordination Officer is responsible for:

- Managing the written control document system in line with statutory requirements outlined within the Public Records Act 1958.
- Providing secretarial support for the Clinical Written Control Documentation Group.
- Ensuring that this policy and process is followed and acting as the operational gatekeeper for all WCDs.

- Publishing WCDs on the staff intranet and internet sites as appropriate.
- Ensuring up to date guidance and documentation on the WCD process is accessible.

Written control document system

The WCDs that are approved within the Health Board are centrally managed through the Corporate Governance department. A WCD database is in place.

Once a WCD has been entered onto the database, approved and published on the intranet or internet, then this should be regarded as the only official Health Board version by staff.

Where to find the approved WCDs

A central written control documentation intranet page has been developed for staff to house hyperlinks to all Health Board written control documentation: Central WCD page (opens in a new tab)

Intranet Pages:

Clinical WCDs can be found here on the Clinical Written Control Documents intranet page (opens in new tab)
Financial WCDs can be found here on the financial written control documentation intranet page (opens in new tab)

Internet page

Corporate and Employment WCDs can be found her on the written control document page of our website (opens in new tab)

ARCHIVING OF WRITTEN CONTROL DOCUMENTATION

The owner group is responsible for identifying when/if a document is deemed as no longer required or fit for purpose and needs to be archived. The owner group will recommend to the approving group/committee that the document is withdrawn and archived as appropriate.

Once approval to archive has been received, the Policy Co-ordination Officer will remove the policy from the central policy page and update the database.

Where a WCD has been replaced or archived, the archived copy will be held by the Policy Co-ordination Officer but will no longer be available online. The Health Board is required to keep a record of all previously approved WCDs, for 30 years in line with WHC (2000) 071 for the Record and Records Management Policies

Each department or service that develops or reviews WCDs must set up their own WCD system. This must hold all current and out of date WCDs. All out of date WCDs must be kept for a period of 30 years.

Responsibilities

Chief Executive

As Accountable Officer, the Chief Executive has overall responsibility for ensuring the Health Board has appropriate WCDs in place. These WCDs must comply with legislation, meet mandatory requirements, and provide services that are safe, evidenced-based and sustainable.

Nominated Director – Director of Corporate Governance/Board Secretary

The Board Secretary is responsible for providing a robust and clear governance framework for the effective management of all WCDs, and compliance with this policy. Specifically ensuring that:

- A consistent approach and process for the development, approval, publication, implementation and management of WCDs meets statutory requirements is in place.
- There is an appropriate scheme of delegation in place for the approval of WCDs.
- There is a WCD management system in place.
- WCDs are available to the public to improve transparency and in accordance with the requirements of the Freedom of Information Act.

Senior Management

Senior management are responsible for:

- Ensuring that the WCD policy is adhered to by staff within their area of responsibility.
- Ensuring all staff have access to WCDs.
- Ensuring that all newly approved WCDs are distributed appropriately within their area of responsibility.

Department, service or ward management

Department, service or ward managers, through their supervisory structure, are responsible for:

- Ensuring that the WCD Policy is adhered to by staff within their area of responsibility.
- Contributing to the development of WCDs that may impact their area of responsibility
- Ensuring there is a robust documentation control system in place locally to ensure WCDs are readily available and accessible to staff.
- Ensuring that staff are working to the most up to date WCD.
- Ensuring that staff are aware of any new or reviewed WCDs and a process is in place to demonstrate that staff have read and understood the WCD.
- Ensuring that any new members of staff are made aware of the local WCD system at local induction. This must include how to access relevant WCDs and demonstrate that they have read and understood them.
- Ensuring their staff are competent to implement this WCD Policy.

All Staff

All staff are responsible for:

- Complying with this policy.
- Ensuring their practice is in line with all WCDs relevant to their area of work.
- Identifying any barriers to compliance with any WCD, and report this up through the appropriate structure, for example, competence or equipment.
- Identifying any changes in practice, guidance or legislation that require a review of any WCD and report this up through the appropriate structure.

NHS Wales Joint Commissioning Committee Website (NWJJC)

(Formerly knowns as Welsh Health Specialised Services Committee (WHSCC)
Publications relating to written control documentation received by the corporate team from NWJJC are disseminated to relevant clinical leads in collaboration with the Clinical Effectiveness team. The Clinical Effectiveness Team is responsible for bringing to the Clinical Written Control Documentation any publications that have queries or that should be noted.

References

- Cardiff and Vale University Health Board (2011) Management of Policies, Procedures and Other Written Control Documents Policy.
- Public Records Act 1958
- WHC (2000) 071 For the record and records management policies.