

Guidance on Developing, Formatting and Accessibility for Policy Documentation

V2.0

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1. Accessibility and Web Content Accessibility Guidelines (WCAG)

- 1.1. Accessibility Legislation that came into effect in September 2020 requires the Trust by law to ensure that all material published on its websites or Document Library, regardless of format, is Accessibility compliant to the WCAG 2.2 (Level AA) for perceivable, operable, understandable and robust content. This means that the way staff handle content to be uploaded for the Internet and Intranet has changed.
 - 1.1.1. Further reading: [Understanding WCAG 2.2 \(gov.uk\)](#) and [Understanding accessibility requirements for public sector bodies \(gov.uk\)](#)
 - 1.1.2. The **Accessibility Guidelines: Working Group** agreed in July 2021 that all documents approved at Policy Review Group (PRG) must be compliant with all 'errors' identified via the word accessibility checker before these can be uploaded following PRG approval.

1.2. What is Web Content Accessibility Guidelines (WCAG)

The WCAG covers a wide range of recommendations for making web content more accessible. Web content includes documents published to webpages. Following these guidelines will make content more accessible to a wider range of people with disabilities, including accommodations for blindness and low vision, deafness and hearing loss, limited movement, speech disabilities, photosensitivity, and combinations of these, and some accommodation for learning disabilities and cognitive limitations; but will not address every user need for people with these disabilities. These guidelines address accessibility of web content on desktops, laptops, tablets, and mobile devices. Following these guidelines will also often make Web content more usable to users in general.

1.3. What does WCAG mean for Document Manager Users

For anyone uploading content via Document Manager this means that it is essential that the content must be compliant with this standard.

1.4. Training and Support

- 1.4.1. **Accessibility guides:** There are accessibility tools available on the CITS portal to support accessibility of documents in MS office which can be accessed using the link [Accessibility Guides \(cornwall.nhs.uk\)](#)
- 1.4.2. **Accessibility Training:** The Trust provides foundation level accessibility training, which can be booked onto via the CITS training portal.
- 1.4.3. **Accessibility Toolkit:** The Accessibility toolkit supports requirements by providing a colour contrast analyser to check the use of colour in documents meets WCAG requirements and the Non-Visual Desktop Access (NVDA) screen reader provides a check tool to understand how the text may be read by a screen reader.

Download the toolkit from the Application Catalogue by searching for 'Accessibility' and selecting 'install'. This will then download two programmes to your desktop for:

- Colour Contrast Analyser (CCA).
- NVDA screen reader.

Further information: For more information about accessibility and the Trust on the Trust website, please see [this accessibility guidance](#) page on our intranet.

1.5. **Advice on Clinical Needs in Documents:**

Where there is a demonstratable clinical need for formatting and structure in a document which is not fully accessible, then this may be applied. For example, including a label in non-accessible colours to be consistent with how the label is presented in the clinical setting. This does not apply to formatting proposed as a result of clinical preference rather than need.

2. **Applying Accessibility and Branding to Trust Documents**

The RCHT Accessibility and Branding checklist provides an essential guide to the requirements of Accessibility and NHS Branding to be applied to all documents. This is provided below and can also be accessed via the Document Library here:

[Accessibility and Branding Checklist](#)

Accessibility checklist



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NHS Trust

Structure



- ☐ Has correct template been used, text left-aligned, Arial 12 and in single line spacing?
- ☐ Are the title and headings marked using styles menu? Remove bold from body text.
- ☐ Are there any blank headings (check in view > navigation)?
- ☐ Are headings in the correct order (h1, h2)?
- ☐ Has the document been saved with a title as well as a file name?

Colour and contrast



- ☐ All graphs and charts are labelled correctly and do not rely on colour alone.
- ☐ Tables do not have columns or rows that rely on colour alone.
- ☐ Is there any text relying on colour? For example, 'click the green button' or 'fill in pink box to confirm'. If so, please amend.
- ☐ Run the Microsoft Office accessibility checker to check for colour and contrast issues.

Use of images



- ☐ No clip art has been used.
- ☐ Images are clear and sized correctly.
- ☐ Images are left aligned and do not have text wrapped around them.
- ☐ All images have descriptive alt text (check what the author has written).
- ☐ Run the Microsoft Office accessibility checker to check for alt text issues.

Links (hyperlinks)



- ☐ Text describes links clearly and easily identifies what the link is about.
- ☐ Remove links such as click here, find out more and change to descriptive link.
- ☐ For digital documents, do not include full url web addresses.
- ☐ Check web addresses aren't repeated.
- ☐ Check bookmarks have been used if referencing sections or headings.

Plain English



- ☐ Check that acronyms are only used if well known (spell out in full when first used).
- ☐ Remove jargon and abbreviations, for example PC (primary care).
- ☐ Bullet point lists are left aligned, there are no more than 10 items in each list.
- ☐ Numbers are written as numbers and date and time formats correct (see branding).
- ☐ Check Flesch reading age score is above 60 using spell checker.

Tables



- ☐ Tables have a heading row (table properties > row > repeat as heading row).
- ☐ Table rows do not break across pages (table properties > uncheck allow row to break).
- ☐ Heading row text is bold and row shaded light grey (rest of table is not shaded).
- ☐ There are no merged or split cells.
- ☐ There are no blank rows or columns.

Branding checklist



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NHS Trust

It is important all our publications are produced in a consistent style and use the same format to present information. All external publications should be designed in-house, [email our design team](#) to submit a design request. [Read our accessibility and supply guidelines](#).

& and percent

- ☐ Have ampersands been removed? Do not use &, it's and.
- ☐ Check use of % is consistent. Write % rather than per cent or percent.

Capital letters

- ☐ Have capital letters that aren't needed been removed?
- Keep capitals to a minimum. Use sentence case when writing titles, headings, and job titles.

Dates and times

- ☐ Have dates been written correctly? We use this format: 1 April 2013. Do not use th, st, or rd.
- ☐ Have times been written correctly? We use this format: 8am, 5.30pm, midnight or midday.

Fonts

- ☐ Has Arial been used throughout the document?
 - ☐ Is the minimum font size 12pt?
- The approved NHS desktop font is Arial. No other fonts should be used.

Images

- ☐ Have you checked the copyright of the image?
 - ☐ If graphics included, do they meet NHS brand guidelines?
- Contact the [RCHT Communications Team](#) for guidance.

Logo

- ☐ Are you using the correct logo? The comms team can supply the correct logo.
- ☐ Is the logo placed in the header of the document on the right-hand side?

Styles

- ☐ Have italics been removed?
- ☐ Has text that is centred and justified been changed to left aligned?
- ☐ Unless it's a link, has underlining been removed?

Organisation name

- ☐ Write Royal Cornwall Hospitals NHS Trust and RCHT thereafter.
- Do not use any other variation.

Stationery

- ☐ Are you using the correct corporate stationery?
- Templates including a Power Point presentation pack are available on the [intranet](#)

3. Which Trust template to use?

- 3.1. Trust templates assist colleagues to complete their documents in a way which is open, transparent, safe, legal, and consistent. The templates ensure essential information is provided in the appropriate document type and that the document meets required legislation for accessibility.
- 3.2. It is a requirement in the Trust Development and Management of Knowledge Procedural and Web Documents Policy that all governed documents are completed on a Trust template and meet the structure and formatting as set out in the template.
- 3.3. The different templates which must be used for documents being uploaded to the Document Library are:
 - **Policy/Procedure Template**: A policy is a specific and enforceable set of principles or rules which have been formally agreed and which are used as a basis for decision-making. They set out the overall aims and objectives in a particular area and explain 'what we will do' and 'how we will do it'. A procedure stipulates the practice required and the action to be taken to implement a policy. It is usually a set of detailed step-by-step instructions that describe the appropriate method for carrying out tasks or activities to achieve a stated outcome to the highest possible standards and to ensure efficiency, consistency, and safety.
 - **Clinical Guideline**: Includes management guidance notes and documents setting out a preferred method of operation. Usually based on guidance published by national or external agencies using current evidence. A guideline allows for informed decision making concerning the appropriate course of action to take. Other methods are not prohibited but a reason for deviation from guidance should be fully justifiable and approval by line management sought.
 - **Standard Operating Procedures (SOP) / Local Procedure**: A SOP is designed to provide accurate and detailed instructions on how to perform a defined process or procedure to ensure consistency and standardisation.
 - **Strategy**: A strategy is a high-level, long-term plan of action, usually covering three to five years to achieve a particular goal in relation to the strategic aims of the Trust.
There is no Trust **Strategy Template**. Please contact the Strategy Team on rcht.strategy@nhs.net for advice if updating or developing a Strategy.
 - **Joint RCHT and CFT Policy And Procedure Template**
 - **Joint RCHT and CFT Clinical Guideline Template**

4. Style and Format

All procedural and web documents should be written in a style which is concise and clear, using unambiguous terms and language, allowing for the use of medical language where the document is clinical in nature.

All Trust templates are available via the [Document Library](#) and must be accessed as appropriate to maintain corporate consistency. Web documents do not have a template, so the author has more scope to style the document as they deem most appropriate.

4.1. Template Structure:

- Display the Trust logo in the top right-hand corner of the first page.
- Have a footer displaying the name of the document and page number in the same format as this policy, i.e. Page X of XX in Arial size 10 font, with alignment and spacing as shown in the Trust template.
- All margins are to be set at two cm.

4.2. Content:

- Clearly indicate relevant legislation or directives.
- Include references to Trust procedural documents from which they derive.
- Dates should be written - day, month, year and may be included in abbreviated characters such as using DD/MM/YYYY and must be consistent through the document.
- Years should be written in full, e.g. 2023/24.
- The numbers 'zero' to 'nine' should be written in words; '10' and after should be written in numbers; but if you are starting a sentence with a figure over 10 it should be in words, e.g. 'Forty-seven people agreed.' This is the required approach by NHS Digital and is a sensible approach to ensuring the readability of texts that refer to numbers and figures frequently.
- Names of boards, working groups, committees and project boards should have initial capitals, e.g. The Trust Board or The Patient Experience Group and when referring to 'the Trust' or to 'the Hospital', it is singular.
- All abbreviations and acronyms must be written in full the first time that they are used in a document, e.g. after writing '... the Information Governance Group (IGG) ...' the abbreviation IGG may be used again without further explanation.
- Refer to a person's job title rather than personal names wherever possible unless the inclusion of a personal name is necessary to add meaning. Patient identifiable information must never be included under any circumstances.
- Use consistent terminology and style if putting together a long document or compiling a document with more than one author.

4.3. Font size and Scale

Be written in 'Arial' font, with main body text being font size 12. As per [NHS digital service manual](#).

4.4. **Aligning Text Paragraph**

Left-align text in English. Some people with cognitive differences have difficulty with blocks of text that are justified. Also people who use screen magnifiers may miss text that is not left-aligned. Alignment of text to be aligned to the right-hand side of the subnumber and sit directly under subtitle text.

4.5. **Paragraph and Sub Paragraph numbering, sub numbering and indenting:**

Use paragraph numbering in the following style:

4.6. Main Paragraph.

4.6.1. First Sub-Paragraph.

4.6.2. Second Sub-Paragraph.

4.6.2.1. First Sub-Paragraph of Second Sub-Paragraph.

- Each sub-paragraph is to be indented by one cm from the previous paragraph level.
- Where a section of the document that starts with a paragraph heading has only one paragraph then only the paragraph heading will be numbered.

4.7. **Bold Text**

Use bold sparingly – too much bold makes it difficult for users to know which parts of your content they need to pay most attention to. Do not use bold to emphasise text. To emphasise words or phrases, you can:

- Front-load sentences.
- Use headings.
- Use bullets.

4.8. **Use of Italics**

WCAG states: “Do not use italics or bold on long sections of text”, however, italics can be used sparingly highlight important content.

4.9. **Emphasising/Underlining text:**

Do not use underlining to emphasise text. Instead consider the following alternative options:

- **Use bold for the writing.**
- Make the font larger.
- **Consider using a different colour (which meets accessibility requirements).**

4.10. Use of Colour:

Ensure that all uses of colour in the document, such as in graphs, charts and tables are labelled correctly and do not rely on colour alone. For example 'click the green button' or 'fill in pink box to confirm'. If so, please amend to clearly state the action required without the need to identify the colour.

By using the accessibility checker to check for issues and warning, this will identify any colour or contrast issues in your document.

4.11. Line Spacing

Lines are required to be well spaced for visual accessibility. The use of the 'enter' key to provide line spacing creates the word 'blank' on screen readers, so it is important to avoid using this in documents. Instead line spacing in documents needs to be created using the Paragraph Tab for:

- **Line Spacing:** Single.
- **Spacing:** Before 6 points and Below 12 points.

4.12. Font Scale

It is important to ensure the scale of the document is set to Scale: 100% and Character Spacing: Normal. This can be checked and adjusted in the Font Tab under 'Advanced'.

4.13. Capitalisation

The use of block capitals is not allowed. This is because capitals are difficult for people to read. Please refer to section 4.9 for alternative ways to emphasise text. Always use sentence case, including page titles. The exception is proper nouns and examples in the GOV.UK style guide capitalisation list and abbreviations.

4.14. Bullets and Lists

Use lists to make text easier to read. Bulleted lists should be short and snappy.

The use of capitals letters at the start of a bullet list must be consistent or if using lowercase then this must be consistent throughout the bulleted lists of the document.

For accessibility requirements, full stops must be used at the end of each bullet or alternatively semi-colons with a full stop for the last bullet, and this must be consistent throughout the document. This allows screen readers to identify the end of each bullet.

For bulleting symbols 'o' bullets must not be used as screen readers will pick these up as a letter.

- Use these style bullets ones for the initial bullet lists.
 - Then use an alternative style bullet for sub bulleted lists.

Do not include more than one sentence at each bullet point. If possible, avoid ending a bullet point with "and" and "or".

4.15. Alternative Text

If you're using images or charts, think about how you'll make the content accessible. Alt text is used to provide an alternative description of the image for those people who are unable to view it. This may include people with visual impairments who use screen readers as well as people using text only browsers. Alt text is also useful if the image fails to load properly.

You must add alt text to objects, such as pictures, clip art, charts, shapes, SmartArt, embedded objects, and audio or video objects.

Adding alt text is really easy: In Word or PowerPoint right click on the image and select 'edit alt text' from the drop down menu and then add your description in the box provided.

4.16. Accessibility Check:

All documents must have an accessibility check applied using the MS word accessibility checker and this can be accessed in two ways, as shown below:

- Select File > Info > Check For Issues > Check Accessibility.

Or,

- Select Review > Check Accessibility > Check Accessibility tool.

This then produces a report with results on the right-hand side of the screen and when selecting an error, the steps to correct it will appear at the bottom of the right-hand side of the screen.

5. Mandatory elements of a procedural or web document

High-level documents that affect the direction of the Trust must contain the following information to ensure a corporate approach for their development, implementation, and management.

The table below indicates which sections are mandatory for documents dependent upon their applicability as defined below.

Table 1. Mandatory Elements for Procedural Documents (NB: Where 'No' is used, this indicates that this section is not mandatory but can be included if desired).

Type of Document	Trust-wide Policies and Procedures	Clinical Guidelines	Systemwide	Local	Web Documents and Patient Information Leaflets
Document Title Page	Yes	Yes	No	No	No

Type of Document	Trust-wide Policies and Procedures	Clinical Guidelines	Systemwide	Local	Web Documents and Patient Information Leaflets
Version Control Table	Yes	Yes	No	No	No
Contents Page	Yes	No	No	No	No
Introduction	Yes	No	Yes	Yes	No
Purpose	Yes	Yes	Yes	Yes	No
Scope	Yes	Yes	No	No	No
Definitions / Glossary	No	No	No	No	No
Responsibilities	Yes	No	Yes	Yes	No
Standards and Practice	Yes	No	Yes	Yes	No
Dissemination / Implementation	Yes	No	Yes	Yes	No
Monitoring compliance and effectiveness	Yes	Yes	Yes	Yes	No
Updating and Review	Yes	No	Yes	Yes	Yes
Equality and Diversity	Yes	Yes	Yes	Yes	No
Governance Information	Yes	Yes	Yes	No	No
Equality Impact Assessment	Yes	Yes	Yes	Yes	No

6. Information and Guidance on How to Complete a Trust Template

6.1. Document Title Page

All Trust-wide procedural documents published via the Document Library must have a title page with core information consisting of Trust logo, Title, Date (reflecting the month and year that version has been uploaded to the Document library), and the Version number.

6.2. Contents Page

This should contain the main levels of corporate documents like policies, procedures, strategies, and business plans; non-policy procedural documents like guidelines may not require a contents page although this is always good practice for large documents.

6.3. Introduction

This section should provide an overview of the importance and role of the subject covered by the document. If the document is created in support of a parent procedural document, then this should be referenced.

6.4. Purpose

This should provide an explanation of the intent/purpose of the document and the rationale for its development. Where appropriate, reference should be made to statutory or legal requirements or to evidence-based good practice. An outline of the objectives and intended outcomes should be provided for the process or system being described.

6.5. Scope

It should clearly state who is expected to comply with the document.

6.6. Definitions / Glossary

A list and description of the meaning of the terms used in the context of the procedural document should be provided if it is considered necessary.

6.7. Responsibilities

This section should give a detailed overview of the strategic and operational roles responsible for the development, management, and implementation of the procedural document. It should include details of the groups or committees, as well as individuals.

6.8. Standards and Practice

This section may use more relevant wording and is used to provide details and information describing the practices, systems, and processes staff are expected to follow to comply with the procedural document.

6.9. Dissemination and Implementation

6.9.1. A summary on how the document will be disseminated should be included, together with details of any special arrangements that may be required or help in aiding retrieval. If the document replaces a previous version the summary should refer to archiving arrangements and any process in place ensuring staff are aware of the new version.

- 6.9.2. This section should also describe the arrangements for implementing the procedural document, such as the provision of training and support for staff, dissemination through a series of roadshows or briefing sessions.

6.10. Monitoring compliance and effectiveness

- 6.10.1. This part must provide information on the processes and methodology for monitoring compliance with, and effectiveness of, the procedural document. It may include any reporting requirements or responsibilities, as well as refer to a set of Key Performance Indicators (KPIs).
- 6.10.2. All procedural documents must include a section which outlines how compliance with the document will be audited. Specifically, authors must complete the table below:

Table 2. Mandatory Elements of Monitoring Compliance and Effectiveness Section

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	What part of the process do you intend to monitor (you may intend or need to monitor all of it).
Lead	Who will lead on this aspect of monitoring? Please include name and job role here.
Tool	What tool will be used to monitor / check / observe / asses / inspect / authenticate that everything is working according to this key element from the approved policy? This is the name/location of a Word/Excel/Access/Database template specific to the topic.
Frequency	How often is the need to monitor each element? How often is the need to complete a report? How often is the need to share the report? Individualise the timeframe(s).
Reporting arrangements	Who or what committees will the completed report be sent to. How will each report be interrogated to identify the required actions and how thoroughly should this be documented in e.g. meeting minutes. The lead or committee is expected to read and interrogate the report to identify deficiencies in the system and act upon them. Consider stating this responsibility in committee terms of reference.

Information Category	Detail of process and methodology for monitoring compliance
Acting on recommendations and Lead(s)	Which committee, department or lead will undertake subsequent recommendations and action planning for any or all deficiencies and recommendations within reasonable timeframes? Required actions will be identified and completed in a specified timeframe. Consider stating this responsibility in committee terms of reference.
Change in practice and lessons to be shared	How will system or practice changes be implemented the lessons learned, and how will these be shared. Possible wording to use for this column. Required changes to practice will be identified and actioned within ... (state a specific time frame). A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

6.11. Updating and Review

This section covers information regarding the review process. All procedural documents should be reviewed no less than every three years. Where appropriate, the author may set a shorter review date.

6.12. Equality and Diversity Statement

- 6.12.1. All new and revised documents (excluding Human Resource documents) must acknowledge adherence to the Trust agreed equality and diversity statement by inclusion of the following:
- 6.12.2. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the [Equality, Diversity and Human Rights Policy](#) or the [Equality and Diversity](#) website.

6.13. All Human Resources policies must include, or refer to, the following employment statement with the Equality and Diversity Statement

Royal Cornwall Hospitals NHS Trust is committed to a Policy of Equal Opportunities in employment. The aim of this policy is to ensure that no job applicant or employee receives less favourable treatment because of their race, colour, nationality, ethnic or national origin, or on the grounds of their age, gender, gender reassignment, marital status, domestic circumstances, disability, HIV status, sexual orientation, religion, belief, political affiliation or trade union membership, social or employment status or is disadvantaged by conditions or requirements which are not justified by the job to be done. This policy concerns all aspects of employment for existing staff and potential employees.

6.14. Governance Information:

The Governance Information must each section completed in full and given updated information as below:

- **Document Title:** Ensure the title matches that as shown on the front sheet and contains the latest version number.
- **This document replaces (exact title of previous version):** Include the title and version number of the document this is replaces exactly at appeared on the Document Library (noting the new document title may be different) or if this is a V1.0 then include 'New Document.
- **Date Issued/Approved:** This is the date signed off by the Committee/group responsible for ratification.
- **Date Valid From:** Month and Year document is uploaded to Document Library.
- **Date Valid To: Month and Year** - No more than Three years from Date Valid From.
- **Directorate / Department responsible (author/owner):** Name of author and Job Title.
- **Contact details:** Number in full, not extension only. **Do not** include personal emails, only generic work emails. If possible do not use switchboard number.
- **Brief summary of contents:** Provide a brief description of the document, which aids document retrieval. This will appear on the Document Library under the title of the document.
- **Suggested Keywords:** Use this section to provide keywords to be added by the uploader to aid document retrieval on the Document Library.
- **Target Audience:** Select the Trust Audience that this document applies to.
- **Executive Director responsible for Policy:** Provide the title of the Executive, name is not to be included.
- **Approval route for consultation and ratification:** Include the name(s) of committees/groups where the document has had governance approval. e.g. Divisions Governance Meeting, Medicine Practice Committee, Information Governance Group.
- **General Manager confirming approval processes:** Ensure this is the most up to date name of General Manager for the relevant Divisions / Speciality.
- **Name of Governance Lead confirming approval by specialty and Divisions management meetings:** Ensure this is the most up to date name of General Manager for the relevant Divisions / Speciality.

- **Links to key external standards:** Include links to external guidance such as National Institute for Health and Care Excellence (NICE) or if there is none include 'none required' here.
- **Related Documents:** Include RCHT related documents or include 'none required' here if there is not any. Up-to-date references should be listed using this section to enhance effective document retrieval by the reader. Details of supporting or associated Trust or Cornwall Health Community documents should also be included.
- **Training Need Identified?** State Yes / No – If stating “Yes’ then details for where staff can access the training must be included.
- **Publication Location (refer to Policy on Policies – Approvals and Ratification):** All Trust documents must be made available on the internet and Intranet, except for there is a risk to staff or public by doing so.
- **Document Library Folder/Sub Folder:** This should include the parent folder and sub folder, where the document will be uploaded to on Document Manager. You can also see the folder path in the hyperlink of the document when searching for it on the Document Library browser.

6.15. Version Control Table

6.15.1. The version control table enables appropriate control of document configuration to be maintained. Normally a draft document will have version V0.1, V0.2, etc. during its development until it is finally published as V1.0.

6.15.2. Non-Trust-wide procedural documents do not require a version control table but, if a version control table is not included, the document must be annotated with author/owner of the document, the version number, and date for review in the document footer example as shown below:

Author/Owner: Document Library Manager – **Version:** V2.0 - **Review Due:** May 2024
Page 1 of 2

6.15.3. In the case where there are minor changes to a document during its current lifespan, documents should increase in version numbers in part such as V1.2, V1.3 etc. When carrying out a full review prior to the expiry date, the version control should increase in full e.g. V2.0, V3.0 etc.

6.15.4. However, where there has been a change in legislation or best practice then a full review and full version increase should take place.

6.15.5. The formatting style of previous details in a Version Control Table may be amended for consistency and to meet accessibility requirements, such as font type and size, alignment and spacing. However, changes to the content such the changing the date, the author name/role or changing the wording of the changes made at each version updated is not permitted.

6.16. Freedom of Information (FOI) Statement

There is a standard FOI statement which appears under the version control table, and this must be included in its entirety as shown on the Trust templates, and no amendments or further information is to be included here.

6.17. Equality Impact Assessment (EIA)

The Governance Information must each section completed in full and given updated information as below:

- **Name of the strategy / policy / proposal / service function to be assessed:** Ensure the title matches that as shown on the front sheet and contains the latest version number.
- **Directorate and service area:** This is to include the speciality and then the Divisions of speciality group.
- **Is this a new or existing Policy?** To include answer as 'New' or 'Existing'.
- **Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):** Name of staff member completing the EIA and their Job Title.
- **Contact details:** Number in full, not extension only. **Do not** include personal emails, only generic work emails. If possible do not use switchboard number.
- **1.Policy Aim - Who is the Policy aimed at?** If unsure, this can be found in the section two of the document.
- **2.Policy Objectives** If unsure, this can be found in the section two of the document.
- **3.Policy Intended Outcomes** If unsure, this can be found in the Monitoring Compliance and Effectiveness.
- **4.How will you measure each outcome?** If unsure, this can be found in the Monitoring Compliance and Effectiveness.
- **5.Who is intended to benefit from the policy?** If unsure, this can be found in the Monitoring Compliance and Effectiveness.
- **6a. Who did you consult with?** Select Yes or No for each category.
- **6b. Please list the individuals/groups who have been consulted about this policy.** This is also included in the Governance Information as 'Approval route for consultation and ratification'.
- **6c. What was the outcome of the consultation?** Provide assurance that the document has been 'approved' or 'agreed' here.
- **6d. Have you used any of the following to assist your assessment?**

- **7. The Impact:** Select 'Yes' or 'No' for each protected characteristic. For any characteristics where answering 'yes' then please note that a rationale is required for each one. Where a negative impact is identified without rationale, the key groups will need to be consulted again.
- **Name of person confirming result of initial impact assessment:** Name of staff member completing the EIA and their Job Title.

6.18. Appendixes: Patient Information and Forms To Print:

- 6.18.1. When including details for Trust forms and / or Trust Patient Information Leaflets, where the form/leaflet is available on the Trust intranet then this must have the hyperlink to the form/leaflet in the title.
- 6.18.2. Some forms/leaflet are only available via Unit 4 ordering, so these will not have a hyperlink as this is not available on the intranet.
- 6.18.3. Ensure it is clearly stated that the form/leaflet is not to be printed directly from the document by advising where the staff member can access the form.
- 6.18.4. Consider applying word art across the form to ensure staff to this is not printed directly from the document.

7. Hyperlinks

Hyperlinks to documents should be carefully considered before being included as links will break if the document/webpage linked to is updated which can cause frustration to the reader. Hyperlinks may be included if it is considered necessary and helpful to the document. It is the author's responsibility to ensure that all hyperlinks in their document work correctly.

When including hyperlinks ensure the text to be displayed is concise and directly reflects the information being linked to and avoid using the full URL address as the link. Do not just use the word 'Link' as the hyperlink text.

8. Copyright

- 8.1. There is a potential copyright issue if we do not own the graphics on a sheet and/or appendix in a document.
- 8.2. Before using an image anywhere in a document which is going to be published onto the RCHT websites/Document Library it is important to consider:
 1. Where did you (the author) get the images from?
 2. Have you (the author) received written permission from the people who own the original document to repurpose it?
 3. If so, what is the licence agreement regarding any imagery they used?

4. Specifically, if they purchased the images or had permission from someone else themselves, then that license/permission will mostly likely be for their use only and not give them the right to allow you to then use it, in which case you would need to seek written permission from the owner of the original images themselves or purchase a suitable license.
5. It must be the person who authors the image/guidance who gives permission not the company they work for.
- 8.3. An option if this is not possible is to remove the images from the document (if it can work without them, it can be easier to do this) or if there are required then to create your own in their place.
- 8.4. **How do I acknowledge the guidelines from another organisation/website?**
You need to check with the originator for terms of use. This means:
 1. Looking at the website or company where it came from.
 2. Checking their terms and conditions, which usually provide usage information.
 3. Then if required by that information, contact them to request permission.
 4. This permission is then copy and pasted under the file which has been lifted/copy from another website.

9. Authorising and Uploading of Documents via Policy Review Group (PRG)

- 9.1. **Document Manager**: Document Manger is the software required to publish documents on the Trust Documents Library. Access to Document Manager can be arranged by contacting the Document Library Manager or CITS.
- 9.2. All procedural documents published onto the Document Library, barring any identified and agreed exceptions like Patient Information Leaflets, shall have a governance information appendix with the name of an executive who holds delegated powers. Authorisation of nursing and medical documents may be delegated to Divisions Directors and/or Divisions Governance Leads.
- 9.3. The key individuals and committees included in the consultation should be noted in the governance information appendix.
- 9.4. Please ensure when using Document Manager (DM) to upload the document that the title on the DM uploading page directly reflects the title of the document on its front page and does not contain the version number. This is especially important on the first version as it makes it easier to ensure the trail of updated versions all have the correct title too.
- 9.5. When updating a title on a later version, please let the Document Library Manager know you have done this so that the filename of the document (stored in Document Manager and only shows on the URL link for the document) can be updated to correct it as well.

***Always ensure the version number is not included on the title on DM uploading page.**

- 9.6. If there is no one available in your department to upload the document onto Document Manager, the Document Library Manager can assist by doing this. Please send the approved/finalised copy with completed amendments to the Document Library Manager and it then be uploaded and approved from there.
- 9.7. If you are an uploader and there is no one available to authorise the document onto the DL, please let the Document Library Manager know as it can be authorised here also.
- 9.8. It is important to never upload a document on someone's behalf or share user login details. When uploading a document this creates an audit trail with the uploader as the responsible person for any issues that may arise and will need to take responsibility for this document being uploaded to the Trust document Library and making it widely available for Staff/patients and the public to access.
- 9.9. If you require any help or advice in the management of your documents please do not hesitate to ask, we can be contacted via:
rch-tr.PolicyReviewGroup@nhs.net

10. Applying Extensions to a Trust Governed Document

- 10.1. **Watermark:** A watermark must be applied to the document stating '**Under Review**' which will appear across each page of the document in transparent text.

To apply a watermark:

Select 'Design' from the toolbar.

Select the Tab marked 'Watermark' on the far-right side of the toolbar.

Scroll down to the bottom of the watermarks and select **Custom Watermark**.

Select **Text watermark** and type the text **UNDER REVIEW** in the **Text** box (this shows the text as ASAP until you type over it).

Click 'APPLY'.

- 10.2. **Coversheet:** The coversheet is a copy of the Governance Information, to be copied and pasted to the front of the document. The information must match the information as reflected from the Appendix 1 of the document being updated. The only areas of the coversheet information to be updated are

- Valid To Date.
- Title of Executive responsible for the document (if this has changed since the document was last updated).
- Name of the Manager (if this has changed since the document was last updated).

- Name of the Governance Lead (if this has changed since the document was last updated).

- 10.3. There is no requirement for documents having extensions applied to be reviewed at Policy review Group. An e-mail containing the policy with the extension cover sheet and confirmation that the author has said it is fit for purpose to remain on the document library is sent to the PRG e-mail so there is a record that this has been approved to have the extension applied appropriately.
- 10.4. For any queries or if any support is required, please email the Policy Review Group on rch-tr.policyreviewgroup@nhs.net
- 10.5. If the document has still not been republished during the 6-month extension it will expire from the Document Library, no further extensions beyond this period will be permitted under any circumstances unless specifically authorised by the appropriate Executive Lead.
- 10.6. Where a document has not been reviewed and falls outside of its review/expiry date it will still appear on the Document Library.

11. Guidance on Producing Mobile Summary Guidelines (Mobile Guidelines)

- 11.1. The aim of the RCHT 'Mobile Guidelines' is to provide Trust guidance in an easily digestible form that can be accessed by all staff via their mobile device (i.e. any Internet capable phone or tablet).
- 11.2. To achieve this all documents submitted for publication as a 'Mobile Guidelines' must adhere to the following standards:
1. All summary guidance must be published as an appendix to an existing Trust governed document. This avoids the need for the summary to be subject to the full governance process in its own right.
 2. The summary guidance and main guidance documents must contain hyperlinks linking both documents together.
 3. Whilst the summary guidance can be included as an appendix in the main governed document, it is not a duplication, as the main guidance document provides a more detailed version with supporting information as laid out in the Trust Governed templates.
 4. All processes must be described in flow chart form.
 5. Flow charts must be constructed using standard flow chart terminology.
 6. The font used must be Arial with a minimum size of 16.
 7. Supporting text must be kept to the minimum necessary to safely carry out the process described.
 8. The title and footer of the summary document must be the same as the main guidance document with the addition of the phrase 'Appendix 3'.

Guideline Summary' (or whichever appendix number it is) at the end of the title.

9. Margin widths must be minimised so that the document is displayed at full screen width on a mobile phone screen.
10. Hyperlinks to other existing guidance documents or scoring systems are encouraged.

11.3. [Guidance on Producing Mobile Summary Guidelines \(Mobile Guidelines\)](#)

12. Local Documents – Shared Drive Documents

In the context of this policy a 'Local Document' is defined as a procedural document that is only applicable to a discrete element of the Trust (for example the Information Governance Department) and therefore, there is no requirement for wider dissemination of the document. In this case the document can be published on local network servers (shared drives) under the approval and control of the manager of that element for example, if the document applies to a division, then the Divisions director must approve the document as being fit for use. The approving manager then becomes responsible for managing the lifecycle (including version control, dissemination, and disposal) of that document in accordance with the Trust's existing policies. Document production and control may be subject to the requirements of external accreditation bodies that will, in this instance, take precedence over the Trust's requirements.

13. Web Documents

- 13.1. Web documents can be uploaded following approval by the Web Team after creation or modification by the author and approval by the relevant Service Manager. The Trust Internet and Intranet home pages contain an A-Z list of services which defines the responsible Service Manager for each service. The flowchart at [Appendix 1](#) is to be used to guide the manager's decision as to whether the information is to be published on the Internet and Intranet, the Intranet only or retained on the network server/shared drive.
- 13.2. Web pages must not contain procedural documents (i.e. documents that tells us how to perform tasks) as these must be subject to the rigour of the governance arrangements implemented in the Document Library. However, web pages can contain information that enhances service efficiency such as staff rotas, reports, audit and training schedules and contact information.

13.3. Web Documents: Governance Information

Web documents may contain information that enhances service efficiency such as staff rotas, reports, audit and training schedules and contact information, and these are included on the relevant service web pages.

Web documents must not contain clinical guidance and/or procedural information which must be followed by staff (i.e. documents that tell staff how to perform tasks) as these must be subject to the rigour of the governance arrangements implemented in the Document Library as governed documents.

Web documents are required to include details of the document's control processes. As web documents are not required to have the full Appendix 1 Governance Information then the minimum information that must be included in the footer is:

- The author/owner's name and post title.
- The Version number.
- The Review Due Date.
- And in the Header, the Trust logo.

13.4. Process for Uploading Web Documents

- 13.4.1. **Document Development.** When developing Intranet web content the author is to take note of the contents of this policy, paying particular attention to the sections on suitable and unsuitable content. See guidance (include hyperlink).
- 13.4.2. **Authorisation.** Intranet web content can be developed by anyone in the Trust however, as the content of Intranet web pages is organised according to the A-Z of Services, responsibility for authorising the publication of web content to the Intranet rests with the Service Delivery Manager of the relevant service. The contact details for this post holder are to be listed on the home page for the service. Authorisation for the publication of web content and the responsibility for web content uploaded to their website cannot be delegated by the Service Delivery Manager.
- 13.4.3. **Uploading.** The task of uploading requires specific authorisation and training and so this role will be limited to a small group of people needing such access. If Uploader/Authoriser training has not been provided to a department then documents for publication should be sent to the Web Team.
- 13.4.4. **Review.** Responsibility for the content of web pages rests with the relevant service delivery manager and so they must ensure that the content of their web pages is regularly reviewed to ensure that the content remains valid and relevant. The Uploader may assist with this task by informing the Service Delivery Manager when web content is due to be reviewed.
- 13.4.5. **Retention and Disposal.** Some content published on Intranet web pages may need to be retained and subsequently disposed of under the arrangements described in the Trust policies detailed in the 'Related Documents' section of the governance information appendix. Identification and management of web content that needs to be subject to such retention and disposal arrangements rests with the relevant service delivery manager.

13.5. Suitable Content for Web Publication

- 13.5.1. If the document is not a procedural document (e.g. general information, posters, reports, etc.) then it can be published on a Trust website, but each document must contain the following: version control information, the author's name and job title or department details and a review due date.
- 13.5.2. When submitting documents for uploading to a web page the file name must not contain version numbers (these must be on the document itself) or any non-specific terms such as 'copy of', 'merged', 'draft', etc. If it is necessary to identify a document as 'draft' then this should be done in the document header. Dates may be included in the file name of a document if the document is date sensitive and will never be subject to a review, such as with Board Minutes.
- 13.5.3. Further clarification can be obtained from either the Document Library Manager or the CITS Web Team.

13.6. Unsuitable Content for Web Publication

13.6.1. Personal Identifiable Information

It is not permissible to publish any information that enables the identity of an individual to be identified unless their permission has been granted. In such cases, where an individual has given their permission for their personal information to be published, evidence of this permission must be retained by the Service Delivery Manager.

It is expected, however, that the work contact details of key personnel (for example, Service Delivery Managers) and the names of authors providing documents for web publication will be published unless they have explicitly stated that this information is to be withheld.

13.6.2. Procedural documents

A procedural document is defined as a document that contains instructions irrespective of whether it is called a guideline, strategy, policy, presentation, or anything else. If the document is a procedural document and it needs to be accessed outside of the immediate department that produced it, then the document must be published on the Document Library. If it is a procedural document and does not need to be accessed outside the immediate department then it should be retained on the shared drive and managed locally. This means that the authoring department will be responsible for version control, review, dissemination, retention (in accordance with the NHS Code of Practice), eventual disposal and recording the document as an information asset using the Trust's Information Asset Register.

Procedural documents will not be published on other websites as they need to have appropriate governance arrangements in place that cannot be reliably achieved on individual websites.

13.6.3. Patient Information Leaflets

Patient Information Leaflets will all be published on the Document Library and so will not be published on other Trust Internet or Intranet web pages. However, it will be possible for Service Delivery Managers to provide links from their web pages to documents in the Document Library.

13.6.4. Documents Accessible Externally

If the document is available elsewhere on the Internet, then it will not be republished on a Trust webpage. Instead a link should be provided to the source document.

13.6.5. Copyright Protected Documents

If the document has been provided by an external source and it has been protected by copyright, it cannot be published on a Trust web page unless the Trust has received explicit permission to publish the document from the copyright holder. Evidence of such permission must be retained by the Service Delivery Manager responsible for the web page on which the copyrighted document is published.

13.6.6. Excessively Large Documents

Documents that are excessive in size must not be uploaded to web pages unless this is essential. Therefore, to reduce the overall size of the document only Adobe Reader (pdf) documents should be uploaded unless the documents need to be editable (such as a form or template) or is a spreadsheet. Presentations, which often contain many graphics, must always be uploaded in pdf format to reduce the file size.

13.6.7. Vanity Publishing

The use of Trust resources to publish material simply to enhance the standing or reputation of an individual is not permitted. Material must only be published if it is deemed necessary to the efficient delivery of the service concerned. Similarly Trust resources must not be used to develop or administer external websites.

14. Process Following Inappropriate Publication of Web Documents

- 14.1. The ultimate authority, and hence also the person holding responsibility, for all material published on behalf of the Trust is the Chief Executive. To aid the efficient delivery of patient care this authority has been delegated through the Head of Communications to Service Delivery Managers.
- 14.2. Inappropriate material is defined as a governed document which has not been through the appropriate ratification and approval processes or a web document which has not been given the necessary governance, approval and accessibility checks before uploading.

14.3. It is essential that inappropriate material is not published either internally on the Intranet or to the public on the Internet and therefore, the web content management system has been configured to provide an audit trail so that the person responsible for authorising web content can be identified. This system is reliant upon being able to identify an individual through their system login name therefore, it is imperative that login names and passwords are never shared.

14.4. If it is found that inappropriate material has been published to the Internet or Intranet the following escalation process will be enforced:

- The person responsible for authorising the publication of inappropriate material will be asked to attend an interview with the individual's line manager, assisted as necessary by the Divisions people partner as regards any action deemed necessary, to discuss why the published material is unsuitable for publication.
- During this interview, the responsible person will be asked to ensure that the material deemed inappropriate is removed from publication. This can be achieved by either requesting that the document is archived (via the Document Library Manager or by uploading a blank document with the same file name and title.
- The individual's line manager will ensure that a note is made on the responsible person's personal file to record the action resulting from the interview.

14.5. If there are repeated infringements of this policy (defined as three separate instances of publishing inappropriate material) then the individual's line manager will invoke disciplinary proceedings in accordance with the Trust's extant policies.

14.6. If required, please revert to the Head of Communication for advice.

15. Links from External Websites

Trust staff are not to set up external websites that have automatic redirection to RCHT websites as this results in the external website effectively masquerading as the RCHT.

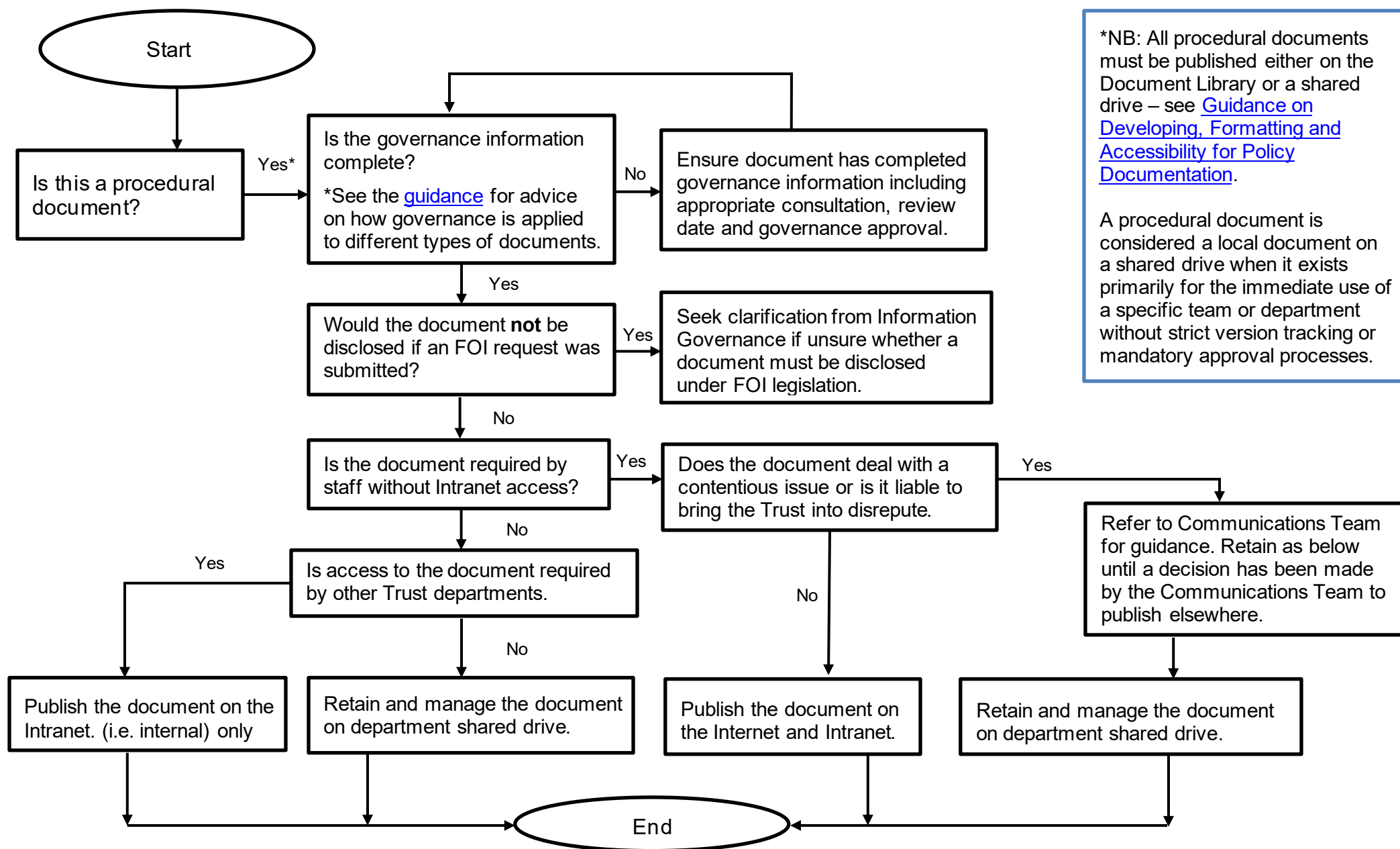
16. Patient Information Leaflets

The publication of Patient Information Leaflets follows their own approval process which can be found by contacting rch-tr.patientinformation@nhs.net where the information will be authorised for publication by the Patient Information Group with the assigned appropriate design, publication and review date and will then be published on the Document Library for ease of access.

17. Forms to Print

All forms which will contain patient identifiable information must be sent to the Forms Review Group (FRG) on the generic email rcht.formsreviewgroup@nhs.net where the form will be allocated a CHA (Cornwall Health Authority) number, and then will be sent to publications to be put into Trust format. Once the form has been put into Trust format by publications, FRG will be in touch with the final version for you to check before it is either uploaded to the 'Form to Print' intranet page (small usage forms) or added to Unit 4.

Appendix 1. Flow Chart for Deciding Where to Publish Governed Documents



Summary - Flowchart to Guide Authors on the Development and Approval Process for Procedural Documents

