

The Policy on Policies

(Development and Management of Knowledge, Procedural and Web Documents Policy)

V9.0

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

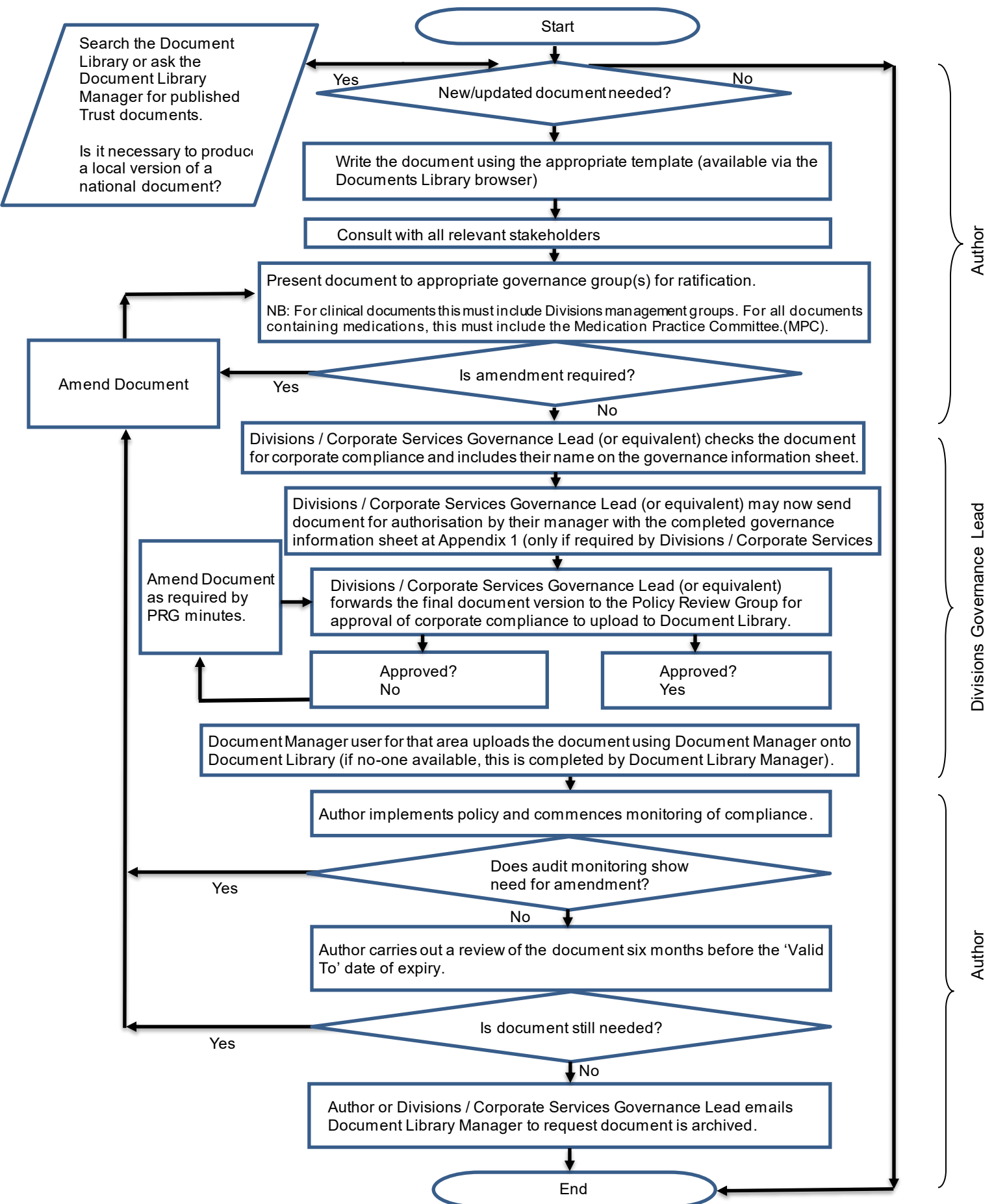


Table of Contents

Summary - Flowchart to Guide Authors on the Development and Approval Process for Procedural Documents	2
1. Introduction.....	5
2. Purpose of this Policy/Procedure.....	5
3. Scope	6
4. Definitions / Glossary	6
5. Ownership and Responsibilities.....	8
5.1. Matters Reserved for the Trust's Board of Directors	8
5.2. Role of the Author/Owner	9
5.3. Role of the Executive Director/Leads	9
5.4. Role of the Trust's Company Secretary	10
5.5. Role of the Document Library Manager (DLM)	10
5.6. Role of the Division / Corporate Services	11
5.7. Role of the Division / Corporate Services Governance Leads	11
5.8. Role of the Policy Review Group (PRG)	12
5.9. Role of the Uploader / Authoriser	12
5.10. Role of the Managers	13
5.11. Role of Individual Staff	13
6. Standards and Practice	13
6.1. Developing a procedural document	13
6.2. Accessibility and Web Content Accessibility Guidelines (WCAG)	14
6.3. Consultation, Approvals, and Ratification	15
6.4. Equality Impact Assessment	16
6.5. County Wide Documents and Joint Trust Documents	17
6.6. Approval and Uploading of Documents via Policy Review Group (PRG)	17
6.7. Review and Version Control	17
6.8. Deletion and Archival of Documents	18
6.9. Extension of Document Validity	19
7. Dissemination and Implementation	19
7.3. Training and Education	19
8. Monitoring compliance and effectiveness	20
9. Updating and Review.....	21
10. Equality and Diversity	21
Appendix 1. Governance Information	22
Appendix 2. Quality and Equality Impact Assessment (QEIA) Form	28
Appendix 3. Flow Chart for Deciding Where to Publish Governed Documents	29

Data Protection Act 2018 (UK General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team

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1. Introduction

- 1.1. This policy sets out the framework for the development and management of all Trust procedural documents, i.e. policies, procedures, protocols, standing operating procedures, plans and clinical guidelines and non-procedural documents that are published via the Trust's Internet or Intranet.
- 1.2. Standards outlined in this procedural document should be applied to all policy, procedure and guidance documentation produced by the Trust. The guidance on a corporate design, to ensure a consistent approach across the whole organisation, is provided in the [Guidance on Developing, Formatting and Accessibility for Policy Documentation](#).
- 1.3. The quality and content of Trust documents and web pages must be robustly managed to ensure that patients and staff are provided with valid and relevant documentation to help keep them safe and informed. Therefore, it is essential that any staff member who has responsibility for uploading or authorising the publication of documents complies with a Trust-wide policy to ensure that corporate standards are maintained.
- 1.4. This version supersedes any previous versions of this document.

2. Purpose of this Policy/Procedure

- 2.1. The purpose of this policy is to ensure the Trust meets best practice for the development and management of its procedural and web documents.
- 2.2. Implementation of this policy will help to ensure that:
 - There is a process whereby procedural documents are consistent in format, compilation, and dissemination.
 - These documents are agreed via a clear and relevant formal route and process.
 - Development of procedural documents follows a clear system of consultation and ratification.
 - Equality impact assessments are undertaken on all procedural documents to meet the organisation's statutory duties.
 - Documents are reviewed at regular intervals to ensure they remain up to date.
 - There is an effective system for the control of documents including version control and archiving arrangements.
 - Documents are made accessible according to the document's content.
 - Processes for monitoring the compliance and effectiveness of Trust procedural documents are established.

3. Scope

- 3.1. This policy applies to all Trust staff involved in the development and use of procedural documents and all documents published via the Trust's Internet or Intranet.
- 3.2. This policy excludes:
- All patient Medical Record forms (that are part of a paper or electronic patient record).
 - Documents maintained and managed locally (although some guidance is provided in the section 'Approval and Ratification').
 - Patient Information Leaflets.

4. Definitions / Glossary

- 4.1. **Authoriser:** The person with responsibility for ensuring that a document submitted for publication meets the requirements of this policy, with regard to the consultation process.
- 4.2. **Document Library (DL):** The online repository for all procedural documents that need to be accessed outside the originating department.
- 4.3. **Forms:** Ensure specific information is captured and displayed to a certain standard using a prescribed layout. Forms can be published on the Document Library once having gone through appropriate approvals.
- 4.4. **Clinical forms:** Clinical forms are any form which will have patient identifiable data (PID) included on it and/or a form which will be filed in the patient health record. All forms that contain PID and / or are filed in the patient health records must be approved by the Forms Review Group (FRG) prior to use to ensure that appropriate control measures have been implemented.
- 4.5. **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.
- 4.6. **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 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.

- 4.7. **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.
- 4.8. **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.
- 4.9. **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.

At the time of updating this policy, there is no Trust Strategy Template. Please contact the Strategy Team on richt.strategy@nhs.net for advice if updating or developing a Strategy.

- 4.10. **Non-procedural documents**: These must only contain information and not instructions.
- 4.11. **Service Manager**: Each service listed on the Trust's A-Z services will have an associated Service Manager whose contact details will be provided on the home page for that service. The Service Manager is usually the 'authoriser' for that service's web documents.
- 4.12. **Templates**: A template is a master version of a form or model.
- 4.13. **Uniform Resource Locator (URL)**: The unique web address that identifies a single web page.
- 4.14. **Uploader**: The person with responsibility for adding a document submitted for publication to the Document Library through the Document Manager application.
- 4.15. **Vanity Publishing**: The publication of material to fulfil the wishes of an individual, normally designed to enhance the reputation or standing of the author.
- 4.16. **Web Content**: Any material that is published via the Intranet or Internet.
- 4.17. **Web Document**: A document that has been published via an Internet or Intranet web page; in contrast to a Trust-wide procedural document that has been published via the Document Library.
- 4.18. **Web Page**: A single page (and hence having only one URL) of material published on either the Intranet or Internet.
- 4.19. **Web Site**: A collection of web pages (and hence having many associated and interlinked URLs) of material published on either the Intranet or Internet.

4.20. **PRG:** Policy Review Group. The group which signs off the corporate compliance of the document with the Policy on Policies and gives the final authorisation to upload to the document library. PRG does not approve the content of documentation; that is the responsibility of the relevant approving bodies of the Trust.

4.21. **CITS:** Cornwall and Isles of Scilly Information and Technology Services. CITS is a service providing a wide range of services for information systems and technology.

5. Ownership and Responsibilities

Initial approval of a Trust-wide procedural document should be given at the most appropriate governance Board, Committee or Group. In order to be owned by the Trust all relevant documents are to be acknowledged by a combination of:

- The Trust Board or a sub-committee of the Trust Board.
- An Executive or senior management meeting/group with delegated powers.
- An Executive Director with delegated powers.

There are specific roles and responsibilities regarding the support and maintenance of the electronic Document Library referred to in more detail under the [Guidance on Developing, Formatting and Accessibility for Policy Documentation](#).

5.1. Matters Reserved for the Trust's Board of Directors

The Trust Board reserves the right to approve the below documents as set out in the Trust's Standing Orders and as amended. The list below is correct as of January 2026 however the Trust's [Standing Orders](#) should always be referred to ensure the most up-to-date list:

- [Complaints Policy](#)
- [Confidentiality Code of Conduct Policy](#)
- [Disciplinary Policy](#)
- [Equality, Diversity, and Inclusion Policy](#)
- [Freedom to Speak Up – Raising Concerns Policy](#)
- [Gifts, Hospitality, Sponsorship and Declaration of Interest Policy](#)
- [Health and Safety General Policy HSP 001](#)
- [Patient Property Policy](#)
- [Risk Assessment and Management Strategy and Policy](#)
- [The Policy on Policies \(Development and Management of Knowledge Procedural and Web Documents Policy\)](#)

- Clinical Governance policies including:
 - [Clinical Audit and NICE Guidance Policy](#)
 - [Learning from Deaths Policy](#).
 - [Patient Safety Incident Response Policy](#).

5.2. Role of the Author/Owner

The author/owner is responsible for:

- Ensuring the document is required and does not duplicate other local work, and for confirming the need with relevant line management or working group.
- Ensuring that key stakeholders are consulted with and involved in the development of the document.
- Ensure that the content of the procedural document is aligned with the requirements of the Care Quality Commission (CQC) and other external regulation, see [Related Documents](#).
- Undertaking an Equality Impact Assessment each time the document is reviewed.
- Following the agreed approval and ratification processes. Ensuring the document is appropriately disseminated and communicated.
- Describing how the procedural document will be monitored for compliance and effectiveness.
- Reviewing the document at the agreed interval.
- Deciding whether to restrict publication to the Trust's Intranet only, noting that as all procedural documents should be published via the Internet, any reason for restricting publication is prominently recorded on the document's version control table.
- Embedding robust arrangements to ensure staff appropriately follow the contents of the Trust's procedural documents.
- To consider the impact to public safety/welfare by uploading the document to the Internet.

5.3. Role of the Executive Director/Leads

The Executive Director/Leads are responsible for:

- Ensuring all procedural documents have had appropriate consultation, engagement, and approval.
- Acting as the Trust's delegated Authoriser by including the Executive Title in the governance information appendix.

5.4. Role of the Trust's Company Secretary

As Trust lead for the Policy on Policies, the Company Secretary has delegated responsibility from the Chief Executive Officer to ensure there is a process in place for the development and management of a Trust wide policy and effective management of the document library.

The Company Secretary delegates day-to-day responsibility to the Document Library Manager for ensuring that the processes for the development and management of procedural documents are effective. This includes, but is not limited to:

- Ensuring the development and management of procedural documents has been undertaken in accordance with this policy.
- Ensuring document control for procedural documents is maintained and that there is a robust archiving system in place.
- Ensuring information regarding new, reviewed, or revised procedural documents is disseminated throughout the Trust.
- Providing advice to authors and departments regarding the development and management, including archiving arrangements of procedural documents.
- Monitoring and reporting on the performance, development and management of the Policy on Policies, and the documents within the Document Library.

5.5. Role of the Document Library Manager (DLM)

The Document Library Manager:

- Supports the delivery of Trust documents by ensuring the Trust Document Library and its contents meet the highest standards.
- Ensures the consistency of style and structure as set out in the Trust's policy by reviewing documents in the Policy Review Group prior to uploading. Providing advice as required regarding style and format.
- Provides advice and recommendations to authors and Division / Corporate Services Governance Leads regarding the development and management of their procedural documents.
- Provides support to policy authors in ensuring policies are created and maintained in line with the Policy on Policies.
- Manages the content of the Document Library and provides secretariat support to the Policy Review Group (PRG).
- Communicates with the Governance Leads and administrators.
- Provides training and support where needed to Document Manager user in uploading documents to the Trust Documents Library.

- Monitors compliance with the Policy on Policies through regular audits of the agreed monitoring requirements and ensure the Policy is updated.

5.6. Role of the Division / Corporate Services

Divisions / Corporate Services or Boards, in both clinical and corporate functions, are responsible for:

- Providing initial approval or endorsement of relevant procedural documents as part of the document's pathway through to final approval at the relevant governance body.
- Ensuring that all procedural documents submitted for approval comply with the Policy on Policies.
- Ensuring that responsibility for developing a procedural document for a Division / Corporate Services or area is assigned to the most appropriate person or team.
- Ensuring local systems and processes adopt all approved corporate documents where relevant.
- Providing assurance to the relevant Executive Director that each document presented for authorisation has been scrutinised by the appropriate specialty and Division / Corporate Services management meetings.
- Ensuring that any resource implications of policy/guidance implementation have been addressed; this must include personnel, documentation, equipment (purchase and maintenance), finance and training.
- Activating publication of the document via the Document Library once the authorisation has been received from the Policy Review Group.

5.7. Role of the Division / Corporate Services Governance Leads

- Ensuring that all formatting, corporate compliance, and any copyright acknowledgement is included in the document and the document is fit for submission to the PRG.
- Responsible for submitting the final document to the PRG for approval and responsible for liaising with the author on any amendments that may be needed following review by the PRG.
- If holding the ability to upload, publish the document once it has been authorised by the Policy Review Group (PRG). See section 5.9 for uploader responsibilities.
- Advising the Document Library Manager when a document is no longer required to be used for reference and there is not an updated version of the same content or subject matter, so that the document may be archived from the Document Library.

- To consider the impact to public safety/welfare by uploading the document to the Internet.

5.8. Role of the Policy Review Group (PRG)

5.8.1. The purpose of the Group is to review all aspects of the management of all Trust documentation on the Document Library.

5.8.2. The Group:

- Provides assurance to the Information Governance Group that documents held on the Trust's document library are managed in a governed way.
- Provides advice and recommendations regarding compliance with procedural standards.
- Supports the development and validation of policies in order to enhance Trust compliance with legal, national, and regional guidance and Trust local requirements.
- Champions accessibility standards and ensure Trust documents meet such standards prior to upload to the document library.
- Reviews the overall status of the Trust's Document Library and managing out of date documentation.
- Ensures all documents are compliant with the structure and formatting of the appropriate Trust template.

5.8.3. The PRG has the authority to challenge and prevent any ungoverned documents being uploaded to the document library in accordance with the standards required in the Policy on Policies and its related Guidance.

5.9. Role of the Uploader / Authoriser

The Uploader is the staff member uploading the document to Document Manager, and the authoriser is the staff member authorising the document on Document Manager, thus making the document available on the Trust Document library.

The uploader and/or authoriser is responsible for:

- Quality control of documents presented for publication and the accurate entry of data to the Document Manager application, as shown in the Governance Information of the most recent version being uploaded.
- Informing the Document Library Manager should the file path of a document not match the title of the document.
- Ensuring that once the document has been uploaded, the author is informed that it has been published.

5.10. Role of the Managers

Line managers are responsible for:

- Ensuring staff are aware of, and act upon, the Trust's procedural documents.
- Implementing the procedural documents for the areas in which they apply.
- Notifying all new and existing staff on how to access both current and archived Trust procedural documents.
- Ensuring that all staff members have access to the Trust Intranet site to enable access to published documents.
- Ensuring that all staff members are aware of their responsibility in maintaining compliance with Trust documents.

5.11. Role of Individual Staff

All staff members are responsible for:

- Participating in the development and consultation process where appropriate.
- Making themselves aware of the procedural documents that relate to their role and responsibilities.
- Complying with agreed Trust procedural documents where they apply.
- Raising any queries about implementation of Trust documents with their line manager.
- Alerting their line manager of any non-compliance with procedural documents where it is noted and represents an actual risk to the Trust, its staff, patients, or the public.

6. Standards and Practice

6.1. Developing a procedural document

- 6.1.1. A [Flowchart to Guide Authors on the Development and Approval Process](#) for procedural documents is provided in the summary. To ensure a comprehensive and consistent approach, it is recommended that all authors refer to this framework before they commence writing.
- 6.1.2. All documents are to be compliant with relevant legislative requirements and should aim to adopt any recommended national best practice or standards within that area of expertise. Where no national guidance exists, the document should reflect agreed local or regional practice and where possible be evidence based and bench marked.
- 6.1.3. It is the responsibility of the author/s to ensure that no similar document currently exists before starting development to avoid duplication of effort across the Trust.

- 6.1.4. The different templates which must be used for documents being uploaded to the trust library are:
- [Policy/Procedure Template](#)
 - [Clinical Guideline](#)
 - [Standard Operating Procedures \(SOP\) / Local Procedure](#).
 - **Strategy** - At the time of updating this policy, there is no Trust Strategy Template. Please contact the Strategy Team on rcht.strategy@nhs.net for advice if updating or developing a Strategy.
- 6.1.5. The publication process is summarised in the flow chart at [Appendix 3](#).

6.2. Accessibility and Web Content Accessibility Guidelines (WCAG)

- 6.2.1. 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.

Further reading: [Understanding WCAG 2.2 \(gov.uk\)](#) and [Understanding accessibility requirements for public sector bodies \(gov.uk\)](#)

6.2.2. What is Web Content Accessibility Guidelines (WCAG)

The WCAG covers a wide range of recommendations for making web content more accessible. 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.

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

6.2.4. Applying Accessibility and Branding to Trust Documents

There is a RCHT Accessibility and Branding checklist which provides an essential guide to the requirements of Accessibility and NHS Branding to be applied to all documents. This can be accessed via the Document Library and is linked to here:

[Accessibility and Branding Checklist](#)

6.3. Consultation, Approvals, and Ratification

When it is decided that a document needs to be produced or reviewed, appropriate or affected disciplines/professionals should be included or consulted. This should also include users of the service, especially where they may be impacted due to changes in practice.

This information is supported by using the [Guidance on Developing, Formatting and Accessibility for Policy Documentation](#) which provides information on the required governance.

Further supporting information for documents which need to be produced or reviewed can be found under the Corporate Records tab on the [Records Management](#) webpage.

6.3.1. Identifying stakeholders

Stakeholders are those people who are affected by the contents of a document, and they may be internal or external to the Trust. For example, NHS staff; patients; service users; commissioners of services; partners in service provision; or local or health community groups.

For all clinical documents published via the Document Library the stakeholder group must include specialty and Division / Corporate Services management groups.

6.3.2. Consultation Process

Where appropriate:

- Patient/public representatives must be involved in the consultation.
- The Joint Consulting and Negotiating Committee (JCNC) must be allowed to consider documents which refer to working arrangements and terms and conditions for Trust staff.
- The Health and Safety Committee should be allowed to consider documents that may affect the health, safety or well-being of patients or staff.
- The Medicines Practice Committee (MPC) must be involved in the consultation of all documents that have medicines included them unless the document has had a pharmacist involved in the review of the document.
- The Guidelines and Alerts Steering Process (GASP) Working Group is to be consulted on documents that fall within their terms of reference in respect of clinical guidance.
- At the discretion of the Lead Executive Director and/or guided by the relevant Terms of Reference or Trust Standing Orders, the Executive Leadership Group and Trust Board should consider any procedural document that may have significant corporate impact.

- Any additional body or group at the discretion of the authorising Executive.

This list is not limited to the above consultation processes, and these will be further defined by each speciality group / directorate.

6.3.3. **Approval and Ratification Process for Documents**

Following initial approval or feedback from the specialty committee or group, the document is then presented or re-submitted to Division / Corporate Services management for approval.

The Division / Corporate Services management group will ensure that the document conforms to the relevant Trust standard and that it has had appropriate consultation and approval.

For all clinical documents published via the Document Library the document must have been approved by the relevant specialty and Division / Corporate Services management meetings. The flow chart at [Appendix 3](#) describes the publication process.

All Trust-wide procedural documents should be published to the Internet by default; however, the approving Executive Director may decide to restrict publication to the Trust's Intranet after following the guidance contained in [Appendix 3](#). If such a restriction is applied the Executive Director is responsible for ensuring that the reasons for restricting publication are documented either on the title page of the document itself or in the version control table.

Approval of a document must be recorded in the relevant committee's or group's minutes and the name of the committee/group must be included on the Governance Information.

Once Division / Corporate Services Manager, Governance Lead, or appropriate role, is content that the document can be published on the Document Library their name will be included on the Governance Information.

Following ratification of the content of the document by the appropriate governance committee, the document should be sent to the Policy Review Group (PRG) for final approval to upload the document into the Trust's document library.

6.4. **Equality Impact Assessment**

All public bodies have a statutory obligation to undertake Equality Impact Assessments on all procedural documents. This must be undertaken by the author using the agreed Equality Impact Assessment Template. The completed assessment is to be added to the end of the procedural document as an appendix prior to it being ratified.

6.5. County Wide Documents and Joint Trust Documents

6.5.1. County wide documents are those documents that are produced within the Trust for county wide distribution. Approval for the publication of documents with county wide applicability on the Document Library must come from the chairperson of the relevant group, for example the Prescribing Committee.

6.5.2. Joint documents:

The Trust and CFT have developed a joint Trust template for these combined Trust procedural documents and a mechanism to review and approve for uploading onto the Trust and CFT Document Libraries. Please contact the Document Library Manager for advice if creating or updating a joint RCHT and CFT Trust document.

6.6. Approval and Uploading of Documents via Policy Review Group (PRG)

6.6.1. Before any document can be uploaded to the Trust Library, it must be authorised at the Policy Review Group (PRG).

6.6.2. When requesting documents to be reviewed:

The document(s) for review at PRG are to be sent to the PRG e-mail address at rch-tr.PolicyReviewGroup@nhs.net

6.6.3. Once a document has been reviewed at PRG this is then confirmed with the governance lead and/or author of the document together with any formatting amendments which the Document Library Manager have completed, as agreed at PRG, and any amendment/further information which is required before the document can be uploaded to the Document Library.

6.6.4. 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

6.7. Review and Version Control

6.7.1. All procedural documents should be reviewed no less than every three years. Where appropriate, the author may set a shorter review date.

6.7.2. Revisions can be made ahead of the review date when the procedural document requires updating, e.g. to reflect changes in national guidance or policy.

6.7.3. Where the revisions are significant or large sections of the policy is changed, the author should ensure the revised document is taken through the standard consultation, approval, and dissemination processes.

- 6.7.4. Where the revisions are minor, e.g. amended job titles, telephone numbers or formatting/grammar changes, then approval can be sought from the Executive Director responsible for the document and then this can be published as partial version update without having gone through the full consultation and ratification process.'
- 6.7.5. Any revision activity is to be recorded in the version control table as part of the document control process.
- 6.7.6. Version numbers reflect the approved update to the document as it is uploaded to the document library

6.8. Deletion and Archival of Documents

6.8.1. Deletion

When a document is deleted from the system the document and all records of the document's existence will also be deleted and hence there will be no audit trail.

Only the CITS Web Team, Company Secretary and Document Library Manager, as System Administrators, have the access rights to delete published documents. If requiring a document to be deleted, the criteria for deletion must apply. The criteria for deletion is:

- A document has become corrupted.
- A document has been uploaded to the Document Manager but not authorised. At this stage uploaders are also able to delete the document from the system.

6.8.2. Archival

When a document is archived, it is removed from the web page and the document management system. However, the audit trail of the document is retained and if necessary, the document can be retrieved and re-published by submitting a request via the Document Library Manager to re-instate a previous version.

The Document Library Manager can archive documents, and this will only be done when:

- Inappropriate content has been uploaded. This 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.
- The document is deemed to be no longer required, and the Document Library Manager has received a written request to archive the document with the reason why the document is no longer required. For example, the document has been superseded by National Advice, or the document has been amalgamated into another Trust document.

- The document has been uploaded in error and a duplicate version exists.

6.8.3. Retrieval of Archived Documents

Master copies of all archived documents will be retained in the Documents Library although they are removed from view once archived. Copies of archived documents can be retrieved by submitting an email request to the Document Library Manager.

6.8.4. Removal from Publication

Once a document has reached its 'Valid To' date it will be automatically appear as out of date, but it will not be removed from publication without request (as advised above in Section 6.8.2). Whilst a document will be marked as out of date, it will still be accessible on the Document Library and links on webpages.

6.9. Extension of Document Validity

- 6.9.1. Occasions may arise where it is necessary to extend the life of a document beyond the validity date.
- 6.9.2. Before an extension may be applied the author/owner of the document must confirm the document as fit for purpose to remain on the Document Library whilst under review.
- 6.9.3. The content of the extended document must not be altered in any way except that it must be clearly marked with a watermark to state 'Under Review' and a Coversheet applied at that part of the document.
- 6.9.4. Details on how to request an extension are included in the [Guidance on Developing, Formatting and Accessibility for Policy Documentation](#).

7. Dissemination and Implementation

- 7.1. This document is available on the document library. Significant updates will be communicated via Trust wide email.
- 7.2. Implementation of the policy will be via Trust wide communication and supported by appropriate training for the relevant members of staff.

7.3. Training and Education

- 7.3.1. Those staff members assigned IT permissions within the Document Library are provided training to ensure adequate understanding of the roles and responsibilities of acting as a Document Library 'Authoriser' or 'Uploader'.
- 7.3.2. For a Document Manager account to be set up, the user must first complete the [Web and Document Library Manager Access Request Form](#) and have this signed off by the Service Manager or the Document Library Manager before it is sent to CITS-RA Business Team.

- 7.3.3. Document Library 'Authoriser' or 'Uploader' training is provided by the CITS training portal and supported by the Document Library Manager where required. There is web document 'Authoriser' or 'Uploader' training provided by the CITS Training department online. The account request process is described in the [Document Manager User Guide RCHT](#) (available via the Document Library browser).
- 7.3.4. End-user guidance and help screens are provided within the Document Library system for all staff accessing the Document Library to locate a procedural document; additional help is available by contacting the CITS Service Desk on 01209 88 1717.

8. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Successful implementation of the processes described in this policy culminates in a properly approved and formatted document. Only approved documents are published via the Document Library and so the quality of documents on the Document Library will be monitored as a check of the overall process for Trust wide documentation. Web documents will be monitored on an ad-hoc basis.
Lead	Document Library Manager.
Tool	1. Policy Review Group (PRG) report containing the details of all documents which have been reviewed at PRG on a weekly basis, stored on an Excel Spreadsheet. 2. Bimonthly PRG Assurance Report to Information Governance Group. 3. Annual information provided via graphs to reflect the number of documents reviewed, approved, and rejected by Divisions and Corporate Services in the Status Report.
Frequency	1. PRG report: Weekly. 2. IGG Assurance Report: Bimonthly. 3. Status Report: Annually.
Reporting arrangements	A summary of considerations will be reported to the Company Secretary for sign off before being submitted to the Information Governance Group (IGG) on a bi-monthly basis. Information Governance Group (IGG) – each IGG meeting will receive an update on Document Library performance. Governance support – CITS to ensure that the access permissions document is kept up to date.

Information Category	Detail of process and methodology for monitoring compliance
	Governance support – CITS to provide data on archived documents on request. Any actions resulting from the above reports will be recorded in the relevant meeting minutes. The lead or committee is expected to read and interrogate the report to identify deficiencies in the system and act upon them.
Acting on recommendations and Lead(s)	Document Library Manager will undertake subsequent recommendations and action planning for any or all deficiencies and recommendations within an agreed timeframe dependent upon the complexity of the task.
Change in practice and lessons to be shared	Where non-compliance is identified, support and advice will be provided to improve practice. However, responsibility for compliance with a published document ultimately rests with the approving executive. Where changes in practice have been identified these will be communicated to either the Document Library Manager or CITS Training team for inclusion in their training material. Required changes to practice will be identified and actioned within six months. 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.

9. Updating and Review

- 9.1. The document review process is managed via the document library. Document review will be every three years unless best practice dictates otherwise. The author remains responsible for the policy document review. Should they no longer work in the organisation or in the relevant practice area then an appropriate practitioner will be nominated to undertake the document review by the designed director.
- 9.2. Revision activity will be recorded in the version control table to ensure robust document control measures are maintained.

10. Equality and Diversity

- 10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the [Equality Diversity And Inclusion Policy](#) or the [Equality and Diversity website](#).
- 10.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	The Policy on Policies V9.0
This document replaces (exact title of previous version):	The Policy on Policies V8.1
Date Issued/Approved:	7 May 2026
Date Valid From:	May 2026
Date Valid To:	May 2029
Directorate / Department responsible (author/owner):	Demi Louise Kent, Document Library Manager
Contact details:	01872 25 4622
Brief summary of contents:	Defines Trust Knowledge documents and outlines the governance requirements for developing, approving, and publishing such documents.
Suggested Keywords:	Policy, Policy Appraisal, Policy Control, Policy Development, Policy Formulation, Policy Making, Procedural Documents, Procedures, Publishing, Publications, Corporate Governance, Corporate Identity, Corporate Image, Corporate Records, Knowledge Management, Documentation, Websites.
Target Audience:	RCHT: Yes CFT: No CIOS ICB: No
Executive Director responsible for Policy:	Chief Executive
Approval route for consultation and ratification:	Information Governance Group (IGG). Audit and Risk Assurance Committee. Trust Board.
General Manager confirming approval processes:	Lynsey Neave, Company Secretary
Name of Governance Lead confirming approval by specialty and Division management meetings:	Demi Louise Kent, Document Library Manager

Information Category	Detailed Information
Links to key external standards:	CQC Regulation 17 IG Toolkit.
Related Documents:	NHSLA Risk Management Standards for Acute Trusts Care Quality Commission – Guidance about compliance RCHT Document Library: Management of Information, Records and Data Quality Policy. Policy and Procedure Template Standard Operating Procedure Template Clinical Guideline Template Joint RCHT and CFT Policy And Procedure Template. Joint RCHT and CFT Clinical Guideline Template. RCHT Website: Guidance on Developing, Formatting and Accessibility for Policy Documentation Web and Document Library Manager Access Request Form Document Manager Access Control Protocol RCH Document Manager User Guide RCHT
Training Need Identified?	No
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Chief Executive / Corporate Governance

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
December 2007	V1.0	Final amendments approved and EIA completed	Debby Blease Deputy Director of Nursing

Date	Version Number	Summary of Changes	Changes Made by
July 2008	V1.1	NHSLA review	Karen Waite (Acting) Head of Corporate Governance
February 2009	V2.0	Changes to job titles to reflect changes to organisational structure.	Debby Blease Deputy Director of Nursing
January 2010	V2.1	Updated to reflect release of the new Document Library 2 system and changes to the PoP/DL2 process and governance arrangements.	Karen Waite Document Library Manager
August 2010	V3.0	Reduction of content to aid clarity and readability. Process details moved to separate document.	Andrew Rogers Corporate Records Manager
May 2011	V4.0	Amendment to the wording of approval for local documents. Addition of document expiry extension process. Addition of Clinical Guidelines template and requirement for paragraph numbering.	Andrew Rogers Corporate Records Manager
January 2012	V4.1	Amendment to the requirements for approval of local procedural documents that are managed within an ISO9000 QMS.	Andrew Rogers Corporate Records Manager
April 2013	V5.0	Management of hyperlinks amended. Changes to approval to reflect establishment of Policy Review Group. Addition of publication process flow chart.	Andrew Rogers Corporate Records Manager
September 2013	V5.1	Updated Section 8 'Mandatory Elements'. Removed extra box in flow chart at App 1.	Andrew Rogers Corporate Records Manager
January 2014	V6.0	Web Document Management Policy incorporated into this policy. Division/Directorate governance leads to do Upload task.	Andrew Rogers Corporate Records Manager
December 2014	V6.1	Para 6.47 (and other references) arrangements for delegated authorisation of procedural documents. Para 5.8 Policy Review Group removed. Summary flow chart moved to front of policy.	Andrew Rogers Corporate Records Manager
November 2016	V6.2	Director of HI and ICT Services to replace Company Secretary to authorise extensions beyond six months.	Kim Bellis Records Services, PAS and Data

Date	Version Number	Summary of Changes	Changes Made by
		Records Services, PAS and Data Quality Manager is the new Author. Replacing Document Library Manager with Deputy Service Manager (Records Management). Equality Impact Assessment statement and table has been updated.	Quality Manager
November 2016	V6.2g	Director of HI and ICT Services to replace Company Secretary to authorise extensions beyond six months. Records Services, PAS and Data Quality Manager is the new Author. Replacing Document Library Manager with Deputy Service Manager (Records Management). Equality Impact Assessment statement and table has been updated.	Kim Bellis Records Services, PAS and Data Quality Manager
March 2017	V6.2h	Replacing Company Secretary with Director of Corporate Affairs. Director of Corporate Affairs to replace Director of HI and ICT to authorise extensions beyond six months. Paragraph 6.90 Insert authority to archive document to Division Governance Leads in addition to the Deputy Service Manager (Records Management). Addition of EIA Prompt sheet at front of Document. Addition of Division Governance Leads role Addition of Cornwall Health Library role.	Elise James, Deputy Service Manager, Records Management
May 2018	V6.3	Addition of boxes to summary flow chart Addition of sections 4.15. Amendment to section 5.5 Role of the Author, Amendments to section 5.9 Role of the Division Governance Leads (DGL's). Addition of section 5.10 Role of the Policy Review Group. Amendment to section 6.12 Version Control Addition of section 6.53. Addition of section 10 General Data Protection Regulations.	Elise James, Deputy Service Manager, Records Management

Date	Version Number	Summary of Changes	Changes Made by
		Move Appendix 1 to become Appendix 3	
June 2019	V7.0	Policy moved to latest Trust template with formatting updated including updated sub numbering in section 6. Updated title and changed all references from Deputy Services Manager to Document Library Manager.	Demi Louise Scott-Ward, Corporate Records Manager
28 May 2020	V7.1	Formatting and structural changes to all sections. Additional responsibility added to section 5.5 and 5.9.	Demi Louise Kent, Corporate Records Manager
April 2023	V8.0	Formatting and structural changes to all sections to match accessible Trust template. Summary: Flowchart updated terms. Section 1: Reference to guidance included. Section 4: Definitions and glossary updated. Section 5: Updates to roles and responsibilities Section 6: Updates throughout Section 7: Updates to definitions and actions required. Section 8: Updates to definitions and actions required. Appendix 3. Flowchart updated Separate supporting document developed for: Guidance on Developing, Formatting and Accessibility for Policy Documentation .	Demi Louise Kent, Document Library Manager
February 2024	V8.1	Section 5.1: Hyperlinks added to Trust policies on the Document Library. Section 6.1.1. and Section 6.3: Hyperlinks updated and paragraph updated to reflect location of summary. Section 6.8.4: Reference to Section 6.8.2 corrected.	Demi Louise Kent, Document Library Manager
February 2026	V9.0	Formatting updated to match latest Trust template. Updates to reference of 'Divisions' instead of 'Care Groups'. Hyperlinks reviewed and updated where needed Policy Supporting guidance updated to reflect latest accessibility guidance and formatting.	Demi Louise Kent, Document Library Manager

All or part of this document can be released under the Freedom of Information Act 2000

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document

This document has been created following the Royal Cornwall Hospitals NHS Trust [The Policy on Policies \(Development and Management of Knowledge Procedural and Web Documents Policy\)](#). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Quality and Equality Impact Assessment (QEIA) Form

The QEIA process allows RCHT to monitor the impact of changes to its policies and services, ensuring that nobody is unduly disadvantaged.

Please ensure you have completed a Quality and Equality Impact Assessment (QEIA) using this link to complete the form:

[E11 QEIA Policy](#).

For guidance, please see the [QEIA Essentials – Quick Reference Guide](#) or contact as required below:

Equality, Diversity and Inclusion guidance, please contact: rcht.inclusion@nhs.net.

Quality Governance guidance, please contact Jillian Tozer: jillian.tozer3@nhs.net

Appendix 3. Flow Chart for Deciding Where to Publish Governed Documents

