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Royal Cornwall Hospitals NHS Trust

Development and Management of Knowledge, Procedural and Web Documents Policy

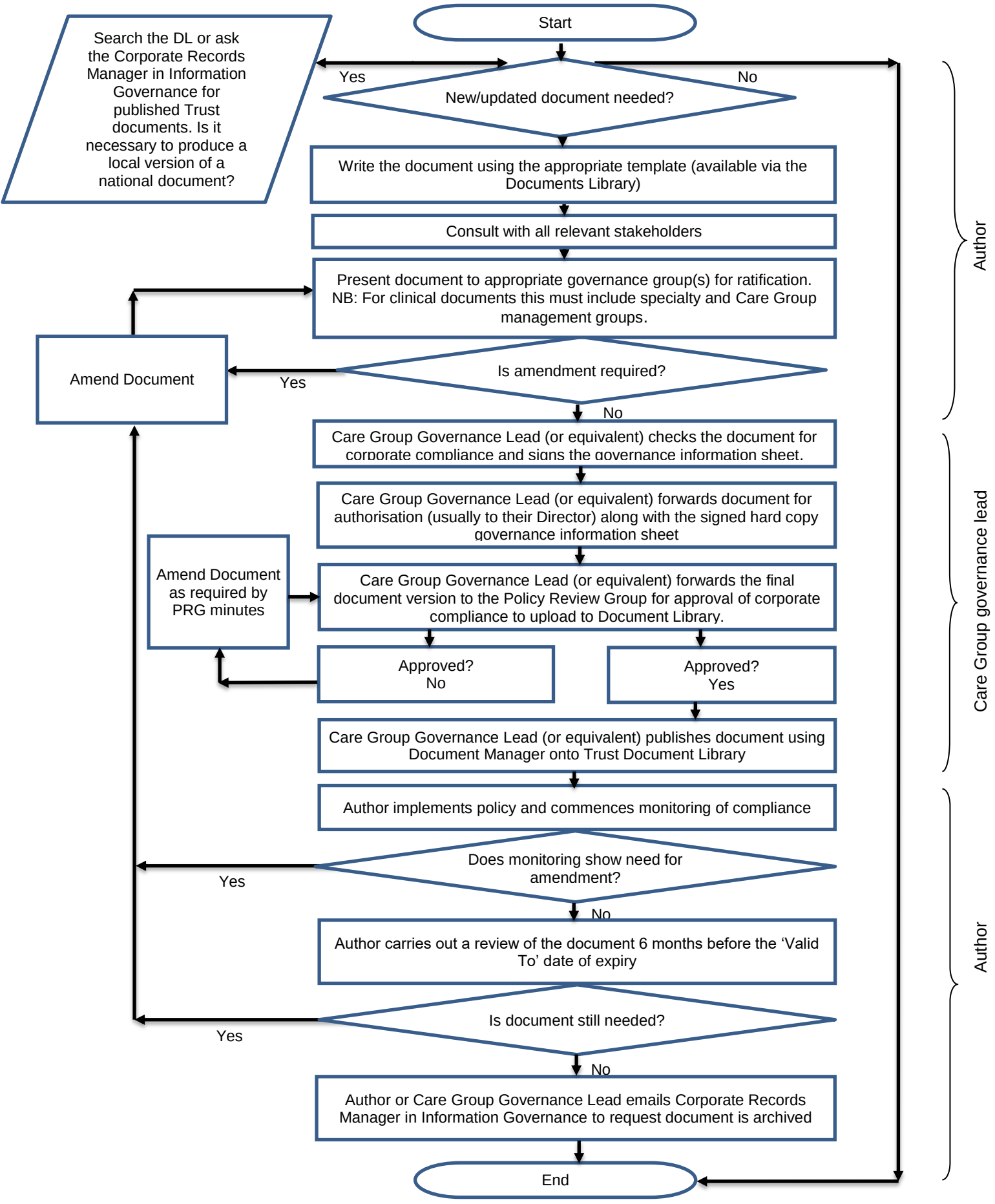
(The Policy on Policies)

V7.1

June 2020

Summary

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



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

The Trust has a duty under the DPA18 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.

DPA18 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the DPA18 please see the *Information Use Framework Policy* or contact the Information Governance Team rch-tr.infogov@nhs.net

1. Introduction

1.1. This policy sets out the framework for the development and management of Trust procedural documents, i.e. policies, procedures, protocols, and guidelines and also non-procedural documents that are published via the Trust's Internet or Intranet. It provides guidance on a corporate design to ensure a consistent approach across the whole organisation.

1.2. 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 information. 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.

1.3. 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 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 in order to meet the organisation's statutory duties.
- Documents are reviewed at regular intervals.
- There is an effective system for the control of documents including version control and archiving arrangements.
- Documents are made accessible as deemed appropriate 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 particular regard to the consultation process.

4.2. Document Library: 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: must be approved by the Forms Review Group prior to use to ensure that appropriate control measures have been implemented.

4.5. Procedural Document: Procedural documents are any documents that provide instructions on how to carry out certain tasks and can be strategies, protocols, policies, guidelines, procedures or Standard Operating Procedures (SOPs). Non-procedural documents only contain information and not instructions.

4.6. Service Delivery Manager: Each service listed on the Trust's A-Z services will have an associated Service Delivery Manager whose contact details will be provide on the home page for that service. The Service Delivery Manager is usually the Authoriser for that service's web documents.

4.7. Templates: A template is a master version of a form or model.

4.8. Uniform Resource Locator (URL): The unique web address that identifies a single web page.

4.9. Uploader: The person with responsibility for adding a document submitted for publication to the Document Library through the Document Manager application.

4.10. Vanity Publishing: The publication of material to fulfil the wishes of an individual, normally designed to enhance the reputation or standing of the author.

4.11. Web Content: Any material that is published via the Intranet or Internet.

4.12. 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.

4.13. Web Page: A single page (and hence having only one URL) of material published on either the Intranet or Internet.

4.14. Web Site: A collection of web pages (and hence having many associated and interlinked URLs) of material published on either the Intranet or Internet.

4.15. PRG: Policy Review Group. The group which signs off the corporate compliance of the document and gives the final approval to upload to the document library.

4.16. 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

5.1. Initial approval of a Trust-wide procedural document should be given at the most appropriate group or committee. 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
- A senior management committee with delegated powers
- An Executive Director with delegated powers.

5.2. 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 Care Group Directors and/or Care Group Governance Leads, see paragraph 6.26.1.1 for details.

5.3. The key individuals and committees included in the consultation should be noted in the governance information appendix.

5.4. There are specific roles and responsibilities regarding the support and maintenance of the electronic Document Library referred to in more detail under the Document Library section of this policy.

5.5. *Role of the Author/Owner*

The author/owner is responsible for:

- Ensuring that 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 extant 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.
- Where appropriate, ensuring implementation is carried out and retains evidence of the implementation.
- Reviewing the document at the agreed interval.
- Ensuring that their documents comply with extant RCHT policies.
- Ensuring that where images have been used that these comply with

copyright regulations and that the appropriate permission to use the image is sought from the publisher in writing. An acknowledgement (which may be specified by the publisher) should be included underneath the image.

- Ensuring that the governance information appendix is complete and up-to-date. In cases where there is more than one author, all contributors should be recorded on the governance information appendix.
- 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 front page.
- 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 this document to the Internet.

5.6. *Role of the Executive Director/Leads (Document Library Document Authorisers)*

The Executive Director/Leads are responsible for:

- Ensuring all procedural documents have had appropriate consultation, and where identified as required, presented to the Trust Board.
- Acting as the Trust's delegated Authoriser by signing the governance information appendix in hardcopy.
    - All Trust-wide procedural documents must be recorded as accepted on behalf of the Trust and in signing approval the Executive Director is accepting the document on behalf of the Trust. However, where the Executive Director feels that the document is of such significance they may present it to the full Trust Board prior to giving signed approval.
- Approving electronic publication of the document onto the Trust's Document Library thus confirming that they are satisfied the document has undergone the development and governance processes appropriate for the document in question.
    - Electronic approval is the step that releases the document for publication. This task will be carried out by Care Group/Directorate governance leads who publish the document once it has been authorised in hard copy by the relevant Executive Director see section 5.9 for details.
    - NB: Authorisation of nursing and medical documents may be delegated to Care Group Directors and/or Care Group Governance Leads, see para 6.26.1.1. for details.

NB: Approval of non-policy procedural documents relating to a department, service, team or professional group should be agreed locally rather than at the Board, e.g. at the appropriate departmental or team meeting, as appropriate.

5.7. *Role of the Trust's Director of Integrated Governance*

As Trust lead for the Policy on Policies the Director of Integrated Governance delegates responsibility to the Corporate Records Manager and is responsible 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.
  - Assisting with identifying exceptions regarding use of the Document Library for publication of procedural documents.
  - Monitoring and reporting on the performance, development and management of the Policy on Policies, and the documents within the Document Library.
  - Liaising with the Trust's Knowledge and IT experts regarding the support, availability and access to procedural documents.

5.8. *Role of the Care Group/Directorate Groups*

Care Group Groups 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 sub-committee, executive management team or Trust Board. Approval is to be completed on the governance coversheet prior to the document being submitted to an Executive Director (or Care Group Directors / Care Group Governance Leads as appropriate, see para 6.26.1.1. for details) for authorisation.
- 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 or area is assigned to the most appropriate person or team.
- Ensuring local systems and processes adopt all approved corporate documents where relevant.
- Providing a source of expertise and advice for staff developing Trust procedural documents.
- Providing assurance to the relevant Executive Director that each document presented for authorisation has been scrutinised by the appropriate specialty and Care Group 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 signature has been received in hard copy from the relevant Executive Director.

5.9. *Role of the Care Group Governance Leads*

- If holding the ability to upload, publish the document once it has been authorised in hard copy by the relevant Executive Director. See section 5.11 for Uploader responsibilities.
- Ensuring that a replacement main contact is identified should the original author be re-deployed or leave the organisation.
- Supporting the implementation of robust arrangements to ensure staff appropriately follow the contents of the Trust's procedural documents.
- Checking that the new or updated procedural document supports the requirements of the Care Quality Commission (see Related Documents for more detail).
- Ensuring that all formatting, corporate compliance and any Copyright acknowledgement is included in the document and the document is fit for submission to the Policy Review Group (PRG).
- Responsible for submitting the final document to the PRG for approval to upload.
- Responsible for liaising with the author on any amendments that may be needed following review by the PRG.
- Archiving of documents when the document is no longer required to be used for reference and there is not an updated version of the same content or subject matter.
- To consider the impact to public safety/welfare by uploading this document to the Internet.

5.10. *Role of the Corporate Records Manager (CRM)*

- To support the delivery of Trust documents to ensure the Trusts Document Library and its contents meet the highest standards.
- To ensure 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.
- To provide advice and recommendations to authors and Care Group Governance Leads regarding their documents.
- Provide support to policy authors in ensuring policies are created and maintained in line with the Policy on Policies.
- To manage the content of the Document Library.
- To lead on the Policy Review Group, ensuring the meetings are arranged to take place on a regular basis and shared with attendees.
- Following review, communicating with the Care Group Governance Leads any amendments to the documents before an upload can take place or to advise the document has been approved for upload.
- To continue to develop the Policies on Policies to ensure it is in line with national and local requirements.
- To ensure reports are created to support the management of documents which are presented to senior management.
- To monitor compliance with the Policy on Policies through regular audits of the agreed monitoring requirements.

5.11. *Role of the Policy Review Group (PRG)*

- To provide assurance to the Information Governance Group that documents held on the Trust's document library are managed in a governed way.
- To ensure that all policy/procedure/guideline/protocol/strategy documents are reviewed regularly.
- Providing advice and recommendations to authors and Care Group Governance Leads regarding corporate compliance.
- Responsible for checking documents against Trust templates to ensure compliance prior to any upload to the document library.
- Following review, communicating with the Care Group Governance Leads any amendments to the documents before an upload can take place or to advise the document has been approved for upload.
- Contribute to the development of the Policy for the Development and Management of Knowledge, Procedural and Web Documents (The Policy on Policies).
- The PRG has the authority to challenge and prevent any ungoverned documents being uploaded to the document library.

5.12. *Role of the Service Delivery Managers (Web Page Editors and Web Document Uploaders/Authorisers)*

Service Delivery Managers are responsible for:

- Deciding whether web content provided to them for publication on the Internet or Intranet meets the following criteria:
  - It is suitable for publication;
  - It is necessary for the efficient delivery of the service concerned;
  - It is correctly formatted;
  - It contains the Trust logo, version control, review due date and author details.
- Deciding whether web content can be published on the Internet and Intranet or only on the Intranet and ensuring that the Uploader receives clear instructions on the publication location. The default publication location for web documents is the Intranet only whereas the default publication location for all Document Library documents is the Intranet and Internet. If it is necessary to publish a web document via the Internet the Service Delivery Manager will need to contact the Web Team.
- Reviewing all published documents at the agreed interval.
- Ensuring that published documents comply with extant RCHT policies.
- Regularly checking that documents waiting for authorisation are duly processed in accordance with this policy.

5.13. *Role of the Uploader*

The Uploader is responsible for:

- Quality control of documents presented for publication and the accurate entry of data to the Document Manager application.

- Ensuring that the relevant Executive Director, Care Group Directors / Care Group Governance Leads or Service Delivery Manager (as appropriate) is aware of any urgent documents waiting for authorisation.
- Regularly checking that documents waiting to be uploaded are duly processed in accordance with this policy.
- Ensuring that once the document has been uploaded, the author is informed that it has been published.

5.14. *Role of the CITS Web Team*

The CITS Web Team is responsible for:

- Acting as a centre of excellence for web design, including acting as systems architects;
- Providing advice and technical assistance as required especially regarding the style and formatting of web pages and navigation systems;
- Developing solutions to meet end-user requirements;
- Deciding on the feasibility and efficacy of solutions within the constraints of system functionality and team resources;
- Publishing web content for those departments that have not received training in the use of the Contensis Web Content Management system.
- Providing Contensis training to the CITS Training Team.
- Designing and maintaining system webpage templates.
- Assigning archive and un-publish rights via specific request which only apply where the user already has authorisation rights.

5.15. *Role of the CITS Training Team*

- The CITS Training Team are responsible for providing Contensis Page Editing training to those personnel nominated as Editors/Authorisers.
- Providing training in Web Document uploading/authorising via the Document Manager application.

5.16. *Role of the Cornwall Health Library*

- The Cornwall Health are responsible for providing training and support in Policy uploading/authorising via the Document Manager application.

5.17. *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.
- Nominating a member of staff to be responsible for ensuring that all hard copies of documents are removed and destroyed when an updated procedural document has been published.

5.18. *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.
- Contacting the CITS Service Desk (01209 881717) if experiencing difficulties accessing the electronic Document Library.
- Ensuring that any anomalies or omissions with Internet or Intranet web content are highlighted to the relevant service delivery manager.
- Ensuring that they remain fully conversant with published documents necessary for the performance of their duties.

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 as a separate document available via the Intranet Document Library webpage. In order 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. In-date procedural documents can be found by searching RCHT's online Document Library. If a current version is not published, but an earlier version is known to exist, a formal request to Cornwall IT Services (CITS) Service Desk (01209 88 1717) can be submitted to access the knowledge archive to retrieve a non-publishable copy of the document.

6.1.4. The publication process is summarised in the flow chart at Appendix 3.

6.2. *Shared Services or Health Community Documents*

Where a procedural document is developed by other health community partners, e.g. Cornwall IT Services, documents are to be badged 'RCHT' for corporate identity and tailored to accommodate any local specifics. These documents are normally approved by RCHT and require Executive Director authorisation and signature before use and adoption in the Trust. They may however, be approved by the Chair of the group provided that all organisations are represented.

6.3. *Style and Format*

6.3.1. All procedural and web documents should be written in a style which is concise and clear, using unambiguous terms and language.

6.3.2. Procedural documents must be formatted as set out either in the Policy and Procedure Template or Clinical Guidelines Template, that are available via the Document Library, 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.

6.3.3. Therefore, all documents should:

- Display the Trust logo in the top right hand corner of the first page.
- Be written in 'Arial' font, with main body text being font size 12.
- Clearly indicate relevant legislation or directives.
- Include references to Trust procedural documents from which they derive.
- 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
- Documents in the process of development or approval must be clearly marked "DRAFT" as a header.
- Dates should be written - day, month, year
- Years should be written, e.g. 2003/04.
- Double quotes should only be used for reported speech. Only use single quotes 'for emphasis' or to indicate a quote.
- 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.'
- Use italics for the titles of documents, books, strategies, papers and laws.
- Names of boards, working groups, committees and project boards should have initial capitals, e.g. The Trust Board or The Charities Committee and when referring to 'the Trust' or to 'the Hospital', it is singular.
- All abbreviations 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.
- All margins are to be set at 2cm.
- Use paragraph numbering in the following style:

6.3. Main Paragraph

6.3.1. First Sub-Paragraph

6.3.2. Second Sub-Paragraph

6.3.2.1. First Sub-Paragraph of Second Sub-Paragraph

- Each sub-paragraph is to be indented by 1cm 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.

6.4. *Mandatory elements of a procedural or web document*

High-level documents that affect the direction of the Trust must contain the following information in order 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: An '□' indicates that this section is not mandatory but can be included if desired).

	Trust-wide Policies & Procedures	**Clinical Guidelines**	**County-Wide**	**Local**	**Web Documents & Patient Information Leaflets**
Document Title Page	□	□	□	□	□
Version Control Table	□	□	□	□	□
Contents Page	□	□	□	□	□
Introduction	□	□	□	□	□
Purpose	□	□	□	□	□
Scope	□	□	□	□	□
Definitions / Glossary	□	□	□	□	□
Responsibilities	□	□	□	□	□

Standards & Practice					
Dissemination/ Implementation					
Monitoring compliance & effectiveness					
Updating & Review					
Equality & Diversity					
Governance Information					
Equality Impact Assessment					

6.5. *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, and Version number.

6.6. *Version Control Table*

6.6.1. 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.

6.6.2. 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 the title, version number, date and author in the document footer example as shown below:

Checklist for the Review and Approval of a Document V1.0
Review Due: May 2017
Author: Corporate Records Manager
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6.6.3. In the case where there are minor changes to a document during its current life-span, documents should increase in version numbers in part such as V1.2, V1.3 etc. When carrying out a full review at the expiry date, the version control should increase in full e.g. V2.0, V3.0 etc.

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

6.7. *Contents Page*

This should contain the main levels of corporate documents like policies, 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.

6.8. *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.

6.9. *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.

6.10. *Scope*

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

6.11. *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.

6.12. *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.

6.13. *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 in order to comply with the procedural document.

6.14. *Dissemination and Implementation*

6.14.1. A brief 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.

6.14.2. 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.

6.15. *Monitoring compliance and effectiveness*

6.15.1. 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).

6.15.2. 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 Section.

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?
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? Attach the tool to the policy or no one will know what you are monitoring.
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 committee 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
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

6.16. *Updating and Review*

6.16.1. 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.

6.16.2. Revisions can be made ahead of the review date when the procedural document requires updating. Where the revisions are significant and the overall policy is changed, the author should ensure the revised document is taken through the standard consultation, approval and dissemination processes.

6.16.3. Where the revisions are minor, e.g. amended job titles or changes in the organisational structure, approval can be sought from the Executive Director responsible for signatory approval, and can be re-published accordingly without having gone through the full consultation and ratification process.

6.16.4. Any revision activity is to be recorded in the version control table as part of the document control process.

6.17. *Equality and Diversity Statement*

6.17.1. 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:

6.17.2. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality, Diversity & Human Rights Policy or the Equality and Diversity website.

6.18. *All Human Resources policies must include, or refer to, the following employment 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.

6.19. *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.

6.20. *References and Associated Trust Documents*

Up-to-date references should be listed using the reference document title in the 'Related Documents' row of the Governance Information Appendix to enhance effective document retrieval by the reader. Details of supporting or associated Trust or Cornwall Health Community documents should also be included.

6.21. *Web Documents - Governance Information*

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 Trust logo.
- The author/owner's name.
- The author/owner's post title.
- The Version number.
- The Review Due Date.

6.22. *Hyperlinks*

Hyperlinks to documents should be avoided as they often break and cause frustration to the reader however, they may be included at the author's discretion if it is considered necessary. It is the author's responsibility to ensure that all hyperlinks in their document work correctly.

6.23. *Consultation, Approvals, and Ratification*

6.23.1. 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.

6.23.2. This information is supported by using the *Checklist for New Documents, Partial or Full Updates of Documents for the Trust Document Library* (available via the Intranet Document Library website) which provides information on the required governance over a procedural document and can be used to support procedural documents when submitted to the appropriate committee for consideration and approval.

6.23.3. Further supporting information for documents which need to produced or reviewed can be found under the Corporate Records tab on the Records Management webpage.

6.24. *Identifying stakeholders*

6.24.1. 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.

6.24.2. For all clinical documents published via the Document Library the stakeholder group must include specialty and Care Group management groups.

6.25. *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 Guidelines & 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, the Trust Management Committee 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.

6.26. *Approval and Ratification Process for Documents*

6.26.1. **Trust-Wide Documents**

A 'Trust-wide document' is defined as any document that needs to be accessed outside the department where it originated. Initial approval should be sought from the relevant specialty committee or steering group. Where there is no obvious committee, the lead Executive Director must decide if it should be submitted to the Trust Management Committee for comment or elsewhere. Following initial approval or feedback from the specialty committee or group, the document is then presented or re-submitted to Care Group/directorate management group for approval.

6.26.1.1. The Care Group/directorate management group will ensure that the document conforms to the relevant Trust standard and that it has had appropriate consultation and approval before forwarding to the relevant Executive Director for final approval of publication on the Document Library. Authorisation of nursing and medical documents may be delegated to Care Group Directors and/or Care Group Governance Leads but only for documents that are clinical guidelines. Listed below are examples of documents that are not considered to be either clinical or guidelines and so these documents and other similar documents must still be authorised by an Executive Director:

- RCHT Dementia Care Policy.

- Prevention of Pressure Ulcers Policy.
- Clinical Decision Unit Standard Operating Policy.
- Blood and Blood Product Refusal Policy.
- Pregnancy Testing – Clinical Guideline.

6.26.1.2. For all clinical documents published via the Document Library the document must have been approved by the relevant specialty and Care Group management meetings. The flow chart at Appendix 3 describes the publication process.

6.26.1.3. 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 1. If such a restriction is applied the Executive Director is responsible for ensuring that the reasons for restricting publication are documented on the title page of the document itself.

6.26.1.4. A checklist is available via the Document Library and the Records Management webpage (under the Corporate Records tab) to assist authors to ensure that each stage of the approval and ratification process has been recorded. Alternatively, approval of a document may be recorded in the relevant committee's or group's minutes, and summarized by holding relevant signature/s on the Governance Coversheet.

6.26.1.5. Executive Directors hold final responsibility for ensuring that the process of development and production is consistent with the governance arrangements set out within this policy.

6.26.1.6. Once the appropriate Executive Director (or Care Group Directors / Care Group Governance Leads as appropriate, see para 6.26.1.1.) is content that the document can be published on the Document Library he will sign the Governance Coversheet. In order to protect the original signature the signed Governance Coversheet must not be uploaded to the Document Library and must retain the hard copy Governance Coversheet containing the original signature for future reference.

6.26.1.7. Following ratification of the content of the document by the appropriate governance committee, the document should be passed via the Governance Lead to the PRG for final approval to upload the document into the Trust's document library.

6.26.2. **Local Documents**

6.26.2.1. 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 Health Records Disclosure Office) 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 Care Group 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 extant 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.

6.26.2.2. Where a local procedural document forms part of a Quality Management System (QMS) that has received external accreditation to the ISO9000:xxxx standard it may be published on the relevant department's Intranet page. The ISO9000:xxxx accreditation certificate should be published alongside the documents and all published documents must comply with the requirements of this policy. Approval of QMS documents will be as described for other local procedural documents above.

6.26.3. **County-Wide Documents**

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.

6.26.4. **Web Documents**

6.26.4.1. Web documents can be uploaded by the Web Team following 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 3. 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.

6.26.4.2. 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.

6.26.5. **Patient Information Leaflets**

The publication of Patient Information Leaflets follows their own approval process that is documented in the Trust policy on this subject. However, they must be authorised for publication by the appropriate Care Group Manager, be assigned an appropriate review

date and will then be published on the Document Library for ease of access.

6.27. *Extension of Document Validity*

6.27.1. Occasions may arise where it is necessary to extend the life of a document beyond the validity date appended to the document as the 'Date Valid To' in the Governance Information Appendix when it was originally published, for example where a longer than expected consultation period is necessary. In such cases the document may be extended by a period of 6 months from the original 'Date Valid To'. The extended document must not be altered in any way except that it must be clearly marked as 'Under Review' and the following statement must be added at the top of the new Coversheet:

POLICY UNDER REVIEW

Please note that this policy is under review. It does, however, remain current Trust policy subject to any recent legislative changes, national policy instruction (NHS or Department of Health), or Trust Board decision. For guidance, please contact the Author/Owner.

6.27.2. If the document has still not been republished during the 6 month extension it will be removed from the Document Library, no further extensions beyond this period will be permitted under any circumstances unless specifically authorised by the appropriate Executive Lead.

6.27.3. Where a document has not been reviewed and falls outside of its review/expiry date it will still appear on the Document Library.

6.28. *Process for Uploading Web Documents*

6.28.1. 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.

6.28.2. 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.

6.28.3. 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.

6.28.4. 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.

6.28.5. 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.

6.29. *Suitable Content for Web Publication*

6.29.1. 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.

6.29.2. 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.

6.29.3. Further clarification can be obtained from either the Corporate records Manager or the CITS Web Team.

6.29.4. Rosters. Many departments find it particularly useful to publish staff rosters on the Intranet as this enables efficient use of staff resources in a rapidly changing environment through the provision of an easily accessible roster. The Trust is implementing an eRostering solution that may obviate the need for staff rosters to be published on the Trust Intranet however, until such time as this system is fully implemented staff rosters for some departments will continue to be published on the Intranet.

6.29.5. Due to the unique demands of publishing staff rosters, and the need to dynamically upload frequently amended rosters, special arrangements have been put in place for those few departments needing this facility. This facility can be enabled via the Corporate Records Manager (Records Management).

6.30. *Unsuitable Content for Web Publication*

6.30.1. Person Identifiable Information

6.30.1.1. 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.

6.30.1.2. 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.

6.30.2. Procedural documents

6.30.2.1. 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.

6.30.2.2. 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.

6.30.3. 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.

6.30.4. 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.

6.30.5. 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.

6.30.6. Excessively Large Documents

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

6.30.7. 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.

6.31. *Process Following Inappropriate Publication of Web Documents*

6.31.1. 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.

6.31.2. It is essential that inappropriate material is not published either internally on the Intranet or to the general 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.

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

6.31.4. The person responsible for authorising the publication of inappropriate material will be asked to attend an interview with the Head of Communications to discuss why the published material is unsuitable for publication.

6.31.5. 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 Corporate Records Manager (Records Management)) or by uploading a blank document with the same file name and title.

6.31.6. The Head of Communications will ensure that a note is made on the responsible person’s personal file to record the action resulting from the interview.

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

6.32. *Deletion and Archival of Documents*

6.32.1. **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, as System Administrators, have the access rights to delete published documents and this facility is only exercised when a document has become corrupted. Where a document has been uploaded to the Document Manager but never authorised Uploaders are also able to delete the document from the system.

6.32.2. **Archival**

6.32.2.1. When a document is archived it is removed from the web page and the document management system however, the audit trail is retained and, if necessary, the document could be retrieved and re-published by submitting a request via the Corporate Records Manager (Records Management) to re-instate a previous version. The Corporate Records Manager (Records Management) or appropriate Care Group Governance Lead (Authoriser) can archive documents and this will only be done when:

- Inappropriate content has been uploaded.
- Requested by the Service Delivery Manager or higher level management.
- The document is deemed to be no longer required and the Corporate Records Manager (Records Management) has received a written request to archive the document.
- The document has been uploaded in error and a duplicate version exists.

6.32.2.2. The authorising Executive Director, the associated Uploader or the document author/owner can request that a document be archived by sending a request by email to the Corporate Records Manager (Records Management). The Corporate Records Manager (Records Management) will then:

- Archive the document as requested and;
- Maintain a record of all archived documents.

6.32.3. **Removal from Publication**

Once a document has reached its 'Valid To' date it will be automatically removed from publication. This means that the document will not be accessible to anyone except Uploaders and Authorisers within the document management system, thus expired documents can still be reviewed and republished if necessary.

6.32.4. **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 Corporate Records Manager (Records Management).

6.33. *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.

7. Dissemination and Implementation

7.1. All procedural documents shall be stored electronically on the Trust's Document Library. The process for publishing these documents is electronic and devolved locally to the individual Executive Director and their administration. Once a document has been approved and its coversheet signed, the document is uploaded into the system and remains unseen until the lead Executive Director electronically authorizes its release.

7.2. Although the Uploader role is usually undertaken by the respective Executive Director's Executive Assistant this role may be shared amongst other staff members after having received training and authorization. However, the number of authorised Uploaders must be restricted to maintain quality standards. Uploaders are responsible for ensuring that the Governance Information Appendix has been completed, that appropriate keywords have been added and that the document replaces previous versions where they exist.

7.3. The Corporate Records Manager (Records Management) will produce monthly reports to notify staff of additions to the Document Library. The Trust's Librarian will assist in disseminating awareness of all newly approved procedural documents by releasing to the Trust a monthly list of all procedural documents recently published onto the Document Library via an All Users communication.

7.4. *Training and Education*

7.4.1. 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'.

7.4.2. Document Library 'Authoriser' or 'Uploader' training is provided by the Trust Librarians and web document 'Authoriser' or 'Uploader' training is provided by the CITS Training department. The account request process is described in the DL And Web Account Request Flowchart (available via the Document Library, 'Help Documents' page).

7.4.3. 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

Element to be monitored	Successful implementation of the processes described in this policy culminates in a properly approved and formatted document. Only documents approved by an Executive Director 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. Site visits will be conducted by the Corporate Records Manager (Records Management) to assess the compliance of local procedural documents. Web documents will be monitored on an ad-hoc basis.
Lead	Corporate Records Manager (Records Management).
Tool	Spot checks through sampling 10% of uploaded documents from each directorate to assess compliance with: • Style and format. • Explanation of terms. • Consultation process. • Ratification process. • Review process. • Archiving process. • Associated and reference documents. With adherence to this policy monitored as part of the ongoing audit process on a Word or Excel template specific to the topic.
Frequency	Annual cycle however, the intention is to carry out sampling quarterly to ensure that Executive Directors and authors receive timely feedback on any errors.
Reporting arrangements	Executive Management Team – will receive reports on a monthly basis stating which procedural documents have been removed from the Document Library and have yet to be replaced due to expired review dates. 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. Governance support – CITS to provide data on archived documents on request. Web Content Management Group – will receive routine updates on the rate of support calls and compliance with this policy. 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)	Corporate Records Manager (Information Governance) 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 Library Services 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

This policy will normally be reviewed no less than every three years by the Trust's Corporate Records Manager (Records Management) unless an earlier review is required.

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, Inclusion & Human Rights 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

Document Title	Development and Management of Knowledge, Procedural and Web Documents Policy V7.1		
This document replaces (exact title of previous version):	Policy for the Development and Management of Knowledge, Procedural and Web Documents (The Policy on Policies) V7.0		
Date Issued/Approved:	28th May 2020		
Date Valid From:	15th June 2020		
Date Valid To:	12th July 2022		
Directorate / Department responsible (author/owner):	Demi Louise Kent, Corporate Records 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	CFT	KCCG
	✓		
Executive Director responsible for Policy:	Director of Integrated Governance		
Approval route for consultation and ratification:	28th May 2020		
General Manager confirming approval processes	Mark Scallan, Head of Information Governance		
Name of Governance Lead confirming approval by specialty and care group management meetings	Demi Louise Kent, Corporate Records Manager		
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:** Policy to Manage Information and Records Patient Information Policy. Policy and Procedure Template.		

	Clinical Guidelines Template. **RCHT Website:** Checklist for Document Review and Approval. Flowchart for the Development and Approval of Procedural Documents. Guidance for Publishing onto the Document Library. Document Library Roles and Responsibilities. Document Library Access Request Form. Document Library Access Control Protocol RCH.			
Training Need Identified?	No			
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet & Intranet	✓	Intranet Only	
Document Library Folder/Sub Folder	Health Informatics/Corporate and Health Records			

Version Control Table

Date	Version No	Summary of Changes	Changes Made by *(Name and Job Title)*
Dec 07	V1	Final amendments approved and EIA completed	Debby Blease Deputy Director of Nursing
Jul 08	V1.1	NHSLA review	Karen Waite (Acting) Head of Corporate Governance
Feb 09	V2	Changes to job titles to reflect changes to organisational structure.	Debby Blease Deputy Director of Nursing
Jan 10	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 Corporate Records Manager
Aug 10	V3.0	Reduction of content to aid clarity and readability. Process details moved to separate document.	Andrew Rogers Corporate Records Manager
May 11	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
Jan 12	V4.1	Amendment to the requirements for approval of local procedural documents that are managed within an ISO9000 QMS.	Andrew Rogers Corporate Records Manager
Apr 13	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

Sep 13	V5.1	Updated Section 8 'Mandatory Elements'. Removed extra box in flow chart at App 1.	Andrew Rogers Corporate Records Manager
Jan 14	V6.0	Web Document Management Policy incorporated into this policy. Care Group/Directorate governance leads to do Upload task.	Andrew Rogers Corporate Records Manager
Dec 14	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
Nov 16	V6.2	Director of HI&ICT Services to replace Company Secretary to authorise extensions beyond six months Records Services, PAS & Data Quality Manager is the new Author Replacing Corporate Records Manager with Deputy Service Manager (Records Management) Equality Impact Assessment statement and table has been updated	Kim Bellis Records Services, PAS & Data Quality Manager
Nov 16	V6.2g	Director of HI&ICT Services to replace Company Secretary to authorise extensions beyond six months Records Services, PAS & Data Quality Manager is the new Author Replacing Corporate Records Manager with Deputy Service Manager (Records Management) Equality Impact Assessment statement and table has been updated	Kim Bellis Records Services, PAS & Data Quality Manager
Mar 17	V6.2h	Replacing Company Secretary with Director of Corporate Affairs Director of Corporate Affairs to replace Director of HI &ICT to authorise extensions beyond six months Paragraph 6.90 Insert authority to archive document to Care Group Governance Leads in addition to the Deputy Service Manager (Records Management) Addition of EIA Prompt sheet at front of Document Addition of Care Group Governance Leads role Addition of Cornwall Health Library role	Elise James, Deputy Service Manager, Records Management

May 18	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 Care Group 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 Move Appendix 1 to become Appendix 3	Elise James, Deputy Service Manager, Records Management
June 19	V7	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 Corporate Records Manager.	Demi Louise Scott-Ward, Corporate Records Manager
28th 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

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

This document is to be retained for 10 years from the date of expiry.
This document is only valid on the day of printing

Controlled Document

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

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Appendix 2. Equality Impact Assessment

<table>
<tr><th colspan="6">Section 1: Equality Impact Assessment Form</th></tr>
<tr><td colspan="6">Name of the strategy / policy /proposal / service function to be assessed
Development and Management of Knowledge, Procedural and Web Documents Policy V7.1</td></tr>
<tr><td colspan="3">Directorate and service area:
Health Informatics</td><td colspan="3">Is this a new or existing Policy?
Existing</td></tr>
<tr><td colspan="3">Name of individual/group completing EIA
Demi Louise Kent</td><td colspan="3">Contact details:
01872 254622</td></tr>
<tr><td>1. Policy Aim
Who is the strategy / policy / proposal / service function aimed at?</td><td colspan="5">To ensure that the Trust meets best practice for the development and management of its policy documents</td></tr>
<tr><td>2. Policy Objectives</td><td colspan="5">To ensure that there is a process whereby procedural documents are consistent in format, compilation and dissemination and that these documents are agreed via a formal route and process including a clear system of consultation and ratification</td></tr>
<tr><td>3. Policy Intended Outcomes</td><td colspan="5">Effective control of documents including version control and archiving arrangements. Documents accessible via the Trust’s ‘knowledge’ tool,
i.e. the Document Library</td></tr>
<tr><td>4. How will you measure the outcome?</td><td colspan="5">A percentage audit of documents uploaded to the Document Library.</td></tr>
<tr><td>5. Who is intended to benefit from the policy?</td><td colspan="5">All staff and patients.</td></tr>
<tr><td rowspan="3">6a). Who did you consult with?

b). Please list any groups who have been consulted about this procedure.</td><td>Workforce</td><td>Patients</td><td>Local groups</td><td>External organisations</td><td>Other</td></tr>
<tr><td>X</td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="5">Please record specific names of groups:
Information Governance Group</td></tr>
<tr><td>c). What was the outcome of the consultation?</td><td colspan="5">Agreed</td></tr>
</table>

7. The Impact

Please complete the following table. If you are unsure/don't know if there is a negative impact you need to repeat the consultation step.

Are there concerns that the policy **could** have a positive/negative impact on:

Protected Characteristic	Yes	No	Unsure	Rationale for Assessment / Existing Evidence
Age		X		
Sex (male, female non-binary, asexual etc.)		X		
Gender reassignment		X		
Race/ethnic communities /groups		X		
Disability (learning disability, physical disability, sensory impairment, mental health problems and some long term health conditions)		X		
Religion/ other beliefs		X		
Marriage and civil partnership		X		
Pregnancy and maternity		X		
Sexual orientation (bisexual, gay, heterosexual, lesbian)		X		

If all characteristics are ticked 'no', and this is not a major working or service change, you can end the assessment here as long as you have a robust rationale in place.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment:	**Demi Louise Kent**

If you have ticked 'yes' to any characteristic above OR this is a major working or service change, you will need to complete section 2 of the EIA form available here: Section 2. Full Equality Analysis

For guidance please refer to the Equality Impact Assessments Policy (available from the document library) or contact the Human Rights, Equality and Inclusion Lead debby.lewis@nhs.net

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