University Hospitals of Derby and Burton NHS Foundation Trust

TRUST POLICY FOR THE DEVELOPMENT AND MANAGEMENT OF PROCEDURAL DOCUMENTS

Reference Number: POL-COR/171/ 07	**Version:** 8		**Status:** Draft	**Author(s):** Deb Price/ Amy Brinklow **Job Title**: Associate Director - Medical Directors Office / Corporate Governance Officer
Version / Amendment History	**Version**	**Date**	**Author**	**Reason**
	7.1	June 2020	Deb Price/ Laura Reekie	Inclusion of ligature patient safety alerts and changes in practices due to restoration and recovery
	7.2	September 2020	Deb Price/ Laura Reekie	Significant amendments to definition of documents
	7.3	June 2021	Laura Reekie/ Dr Jothi Srinivasan	Inclusion of Local Safety Standards for Invasive Procedures (LocSSIPs)
	7.4	November 2022	Deb Price/ Amy Brinklow	Review – minor changes
	8	November 2022	Amy Brinklow	Removal of reference to LocSIPPS as new stand-alone policy has been created.
Intended Recipients: All staff with responsibility for generating Procedural Documentation.				
Training and Dissemination: Launched through Intranet.				
To be read in conjunction with: Trust's Records Management Policy, Expansion & Implementation of Developing Scope of Professional Practice Policy				
In consultation with and Date: Clinical Guidelines Group 2021; Clinical Compliance Group 2021, Trust Delivery Group November 2022,				

EIRA stage one Completed Stage two Completed	Yes No – Not Applicable
Approving Body	19 February 2024 Trust Delivery Group
Date Approved	19 December 2022
Review Date and Frequency	January 2026 (then every 3 years)
Contact for Review	Corporate Governance Officer
Lead Executive Director Signature	 Executive Director of Corporate Development

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TRUST POLICY FOR THE DEVELOPMENT AND MANAGEMENT OF PROCEDURAL DOCUMENTS

1. Introduction

Procedural Documents are necessary to ensure that the Trust's intentions and methodologies are clearly understood by all stakeholders. The management of these is a key element of the controls which enable the Trust to manage those risks which threaten the achievement of its objectives and the strategies that define them.

2. Purpose and Outcomes

The purpose of this Policy is:

- To describe the approach to the development and approval of Procedural Documents;
- To provide a standard outline for the content of Procedural Documents;
- To ensure that there are arrangements for dissemination so that staff are aware of their responsibilities in relation to the Procedural Documents;
- To describe arrangements for ensuring such Procedural Documents are regularly reviewed to reflect current guidance;
- To describe the process for version control to ensure staff have access to – and are operating to - the most current version;
- To ensure arrangements are in place for archiving Procedural Documents in line with records management requirements.

3. Definitions of Procedural Documents Held on Koha

3.1 A **STRATEGY** is a corporate statement which sets out a plan of action designed to achieve a long term or overall plan. These Procedural Documents tend to be high level and for a period of three to five years. They will link with Policies to ensure there is clear guidance to ensure effective delivery.

3.2 A **FRAMEWORK** is an overarching document that outlines the interlinked items which support a particular approach to a specific objective.

3.3 A **POLICY** is a high-level statement. Each Policy should specify its purpose and may also include a procedure setting out how the Policy will be achieved. A Policy enables management and staff to make correct decisions, deal effectively and comply with legislation, Trust processes and good working practices.

3.4 A **CLINICAL GUIDELINE** is a document to guide diagnosis, management, or treatment of a specific condition. Clinical Guidelines are systematically developed recommendations to assist practitioners to make decisions about appropriate health care, including diagnosis, management, and treatment for staff with specific diseases and conditions. They are based on the best available evidence for the care and services that are suitable for most staff with a specific condition or need (NICE article [PMG20] Oct 2014) but do not replace the clinician's knowledge, skills, or professional judgement.

3.5 Clinical Guidelines aim to improve the quality of patient care in order to improve patient outcomes and pursue the most effective use of resources. They may be used in the education and training of health professionals. Any Clinical Guideline may be changed as a result of learning from experience or from changes in knowledge or practice e.g. in response to new or revised NICE Guidance.

3.6 A **SCOPE NOTE** applies to any significant expansion to the Scope of Professional Practice of an individual, excluding Medical staff, and applies to all registered and non-registered staff at the Trust including both temporary and permanent staff. For the purpose of this policy significant expansion is deemed to be any change that has an impact on an individual's training needs or resources. Please refer to the Expansion & Implementation of Developing Scope of Professional Practice Policy for further details.

Held on Net-I - ***these documents are the responsibility of the individual Business Units***

3.7 A **PROCEDURE or STANDARD OPERATING PROCEDURE (SOP) or GUIDELINE (non-clinical) or FORM** may be incorporated into a Policy as an appendix but really should be a stand-alone document that can be amended without the need for the Policy to be altered. They are the practical way in which a Policy is translated into action. They explicitly outline how to accomplish a task or activity, giving detailed instructions. They often allocate specific roles that specific individuals must undertake. If they are directly linked to a Policy, then it needs to be held on Koha as a separate document but linked to its "parent" Policy. However, if it has no direct link to any Policy then it will be held in a designated section of the Divisions intranet site.

3.8 **OTHER DOCUMENTS** such as referral forms/ pathways, patient information leaflets will be held in a designated section of the Divisions intranet site.

4. Managing the Development and Management of Procedural Documents

4.1 Style and Format

All Procedural Documents should be written in a style that is clear, concise and unambiguous. Titles should be kept simple and accurate to the subject to assist easy identification of the document.

All Procedural Documents need to be concise and not over-long to ensure they can be understood and are able to be easily used.

Strategies and Frameworks may follow a different layout but should still follow the corporate style requirement such as Arial 12 point and clarity.

The standard font is Arial 12 point. Uppercase and underlining should be avoided except in headings. Page numbers must be used.

4.1.1 Clinical Guidelines will be documented in the same format to standardise documentation across all sites.

1. Summary Clinical Guideline
   This must be one or a maximum of two pages long. The aim is to direct the management of patients within a busy clinical setting. This can take the form of a checklist, algorithm or flow chart where possible.

2. Full Clinical Guideline
   All charts / diagrams will be in portrait format where possible. All guidelines can be printed off for use in the clinical setting; however, staff must be aware that printed copies are not document controlled.

Please see Appendices A to G for template and content guidance.

4.2 Glossary

Acronyms and technical language, where necessary must be explained and included in a glossary.

4.3 Justification

The identification of need for each Procedural Document must link with the business of the Trust and could arise for a number of reasons, for example:

- National initiatives and local priorities
- Legislation
- New Regulations
- National guidance
- The outcome of Audit assessment
- The results of a risk assessment process
- Findings of investigation into an incident, complaint or litigation.

4.4 New Document Development

Where a need for a new document is identified, an appropriate sponsor should be identified, and a responsible officer designated. The Responsible Officer will:

- Ensure the identified need is not already covered/part covered by an existing document;
- Draft a document, using an appropriate template, in consultation with relevant officers;
- Distribute the draft document for comment and feedback;
- Ensure the sign off section is fully completed, bases on the final draft;
- Agree the appropriate Committee/meeting to approve the document;
- Ensure gateway clearance is obtained;
- Present the draft document to the approving Committee/meeting;
- Ensure the approved document is made available on Koha and advertised to all staff.

4.5 Approval of Procedural Documents

The approval pathways for Procedural Documents are detailed in Appendices B to F.

The Responsible Officer will present the new/revised document highlighting the reason why a new document is required or the changes since the previous approved version.

The Committee/Meeting will:

- Consider and confirm (of not) the need for a new document;
- Ensure the document is fit for purpose and meets the identified need;
- Complies with this policy and the appropriate template;
- Has completed all the steps necessary to obtain approval;
- Approve, approve subject to specified corrections, request resubmission after correction for reconsideration, or reject (giving reasons for not approving) the document presented.

4.6 Review of a Procedural Document

At the time of approval, all Procedural Documents should have a clearly defined review date. If the review date is listed as a month and year, the document should be reviewed by the end of the specified month. This may be brought forward if earlier review is required, for example because of an identified risk or change in national Policy.

Strategies and Frameworks are typically reviewed every three to five years, all Policies, and Clinical Guidelines must be reviewed at least every three years. As good practice Procedures, SOP, Guidelines (non-clinical) or Forms should be reviewed at least annually.

For Trust Policies – The Corporate Governance Team will send a reminder to the author/policy contact three months prior to the policy review date. When policies are within one month of their review date a further reminder email will be sent to the policy author and lead Executive Director to inform them the policy is approaching its review date.

When a policy is identified as being out of date, this will be escalated to the Lead Executive Director for corrective action.

Prior to the designated review date, the Responsible Officer should:

- Distribute the document seeking comment and feedback;
- Ensure the sign off section is fully completed , based on the final draft;
- Agree the appropriate Committee/meeting to review and approve the document;
- Ensure gateway clearance is obtained;
- Present the review draft document to the approving Committee/meeting
- Ensure the approved document is made available via Koha and

advertised to all staff.

4.7 Dissemination and Training

The author is responsible for the development of an Implementation Plan. This could include raising awareness via presentations at Trust meetings, Intranet news, , e-mail communication, newsletters or training.

4.8 Stakeholders

The involvement of key stakeholders within the Trust is integral to this process and all Procedural Documents being developed or reviewed should be able to evidence their process for engaging stakeholders.

4.9 Equality Impact Risk Assessment (EIRA)

No Procedural Document will be approved by the Trust without evidence of stage one EIRA. If a full EIRA (stage 2) is indicated this must be completed alongside the draft Policy development.

4.10 Version Control

All Procedural Documents must have the version number, date of issue and the review date clearly marked on the front cover and as a footnote.

This is based on the following system:

1.0 Initial document
1.1 All Lead Executive Director approval changes
2.0 Fully revised document

4.11 Register / Library of Procedural Documents

It is the responsibility of the Library and Knowledge Service to ensure that the Procedural Documents detailed in sections 3.1 – 3.6, once approved, will be converted to PDF format and published on Koha.

Maintaining the library of Procedural Documents is the responsibility of the Library and Knowledge Service, within the requirements of the Trust's Records Management Policy.

It is the responsibility of the author for Procedural Documents detailed in sections 3.7 – 3.8 to send to the Digital Communications Team who will upload to the stipulated section of Net-i. It is not the responsibility of the Digital Communications Team to maintain an audit trail or version control.

4.12 Archiving Arrangements

Formal archiving of the Procedural Documents detailed in sections 3.1 – 3.6 is the responsibility of the Library and Knowledge Service. Archiving will be undertaken within the requirements of the Trust's Records Management Policy.

All requests to archive a Policy will require approval from the Trust Delivery Group.

The documents detailed in sections 3.7 – 3.8 have no review date and there is no formal governance procedure in place regarding uploading or archiving. The Digital Communications Team upload whatever documents are sent to them; it is the responsibility of the Divisional area/ Business Unit that is requesting the upload to ensure that there is a robust process in place and back copies of documents should be kept where appropriate.

4.13 Freedom of Information (FOI)

Trust Policies and Clinical Guidelines must be made available on the internet as part of the Freedom of Information Publication Scheme. As the Policies will be uploaded onto Koha, the library management system, they will be automatically available both internally and externally, whilst ensuring version control is managed.

4.14 Patient Safety

A National Patient Safety Alert around ligatures and ligature point risk assessment tools and policies was issued to the Trust. As part of the alert, the Trust is required to ensure that the content of local publication procedures uploaded to public facing websites does not risk the safety of patients or the public. Prior to approval, all authors have a responsibility to ensure this has been considered.

4.15 Restoration and Recovery

Where changes in practices occur as a result of the restoration and recovery phase, the relevant Lead should review the associated policies and amend in accordance with the normal procedure.

5. Monitoring Compliance and Effectiveness

The key requirements of this Policy will be monitored in a composite report presented on the Trust's Monitoring Report Template:

Monitoring Requirement:	To demonstrate that, the Trust is monitoring compliance with the process for the development of organisation-wide Procedural Documents, in relation to the ratification process and control of Procedural Documents, including archiving arrangements.
Monitoring Method:	The Trust Delivery Group will receive a monthly report on out of date policies.
Monitoring Report presented to:	Trust Delivery Group and Audit Committee
Frequency of report	Monthly for Trust Delivery Group

6. Key Responsibilities / Duties

6.1 Trust Board

Trust Board has overall responsibility for approving Strategies, Frameworks and Policies which are of major strategic significance or are required by legislation.

Policies requiring approval by the Trust Board may be approved by a Board Committee subject to appropriate delegated authority being granted through the Terms of Reference and Scheme of Delegation.

A full list of these policies can be obtained from the Trust Secretary.

6.2 Trust Delivery Group (TDG)

The TDG will review, then approve, all policies that cannot be approved by the Lead Executive Director due to the level of change in the Policy. The TDG will be responsible for monitoring that the Policy documents are kept up to date and have been disseminated and implemented as required.

6.3 Lead Executive Director

Each Procedural Document detailed in sections 3.1 – 3.3 will have an appointed **Lead Executive Director**. The **Lead Executive Director** will be responsible for:-

- Engaging relevant stakeholders in the development of the Procedural Document
- Ensuring appropriate arrangements are in place for managing any resource implications, including dissemination and training
- Ensuring the most current version is in use and obsolete versions have been withdrawn from circulation.

Lead Executive Directors have authority to approve policies where it is appropriate; these will then be passed to the TDG for ratification.

6.4 Trust Secretary

The Trust Secretary is the lead person for corporate governance within the Trust. They are responsible for working with the Library and Knowledge Service to ensure that all new Procedural Documents:

- Meet the agreed format and criteria.
- Meet the required approval process.

6.5 Library and Knowledge Service

All Policies detailed in section 3.3, once approved, will be submitted to the Library and Knowledge Service Manager who will issue new policies with their own unique identifier.

6.6 Specialist Groups / Committees

Specialist Groups / Committees are responsible for reviewing the documents detailed in sections 3.4 – 3.6 as part of the consultation process. The duties of the Specialist Groups / Committee will be defined by their Terms of Reference and will include ensuring that the Trust has Policies and Procedures in place to meet national and clinical requirement.

6.7 Divisions

The Divisions are responsible for reviewing the documents details in sections 3.7 – 3.8.

6.8 Staff

All staff need to be aware of the Trust's Procedural Documents and how they impact on their work. All approved new Procedural Documents are communicated through the staff briefing and via the intranet with staff having an individual responsibility to seek out this information.

7. References

Information Governance Standards

CQC Standards

Equality Impact and Risk Assessment (EIRA)

Retention and Destruction Schedule

APPENDIX A

CONTENT GUIDANCE FOR PROCEDURAL DOCUMENTS

All sections to be numbered and indexed to facilitate rapid access to relevant information. Font is Calibri 12, with headings to be in bold and underlined:

1. Introduction

Overview of the background and importance of the subject of the document.

2. Purpose and Outcomes

Purpose of the document including rationale for development plus expected outcomes.

3. Key Responsibilities / Duties

An overview of the individual, departmental and committee responsibilities.

4. Definitions Used

List of the terms used and their meaning within the context of the document to clarify interpretation.

5. Monitoring Compliance and Effectiveness

Identify how the key requirements will be monitored including how you are going to identify deficiencies and develop and produce action plans to implement changes accordingly.

6. References

This should refer to procedures, manuals, external publications, regulations, law etc. And indicate where these can be obtained from (web site details).

7. Appendices

These must be numbered and added to the top right hand corner of the page Procedures and forms are part of the appendices.

APPENDIX B

STRATEGY DOCUMENT TEMPLATE

NHS
University Hospitals of Derby and Burton
NHS Foundation Trust

EXCEPTIONAL Care Together

Our XXX Strategy (Working Draft) 20XX to 20XX

Purpose

Context and Background

Our 5 year strategic objectives

Strategic aim

[description]

HOW we will do this:

-
-

WHAT we will do:

-
-

Outcome: How we will measure success and impact:

We will measure this through:

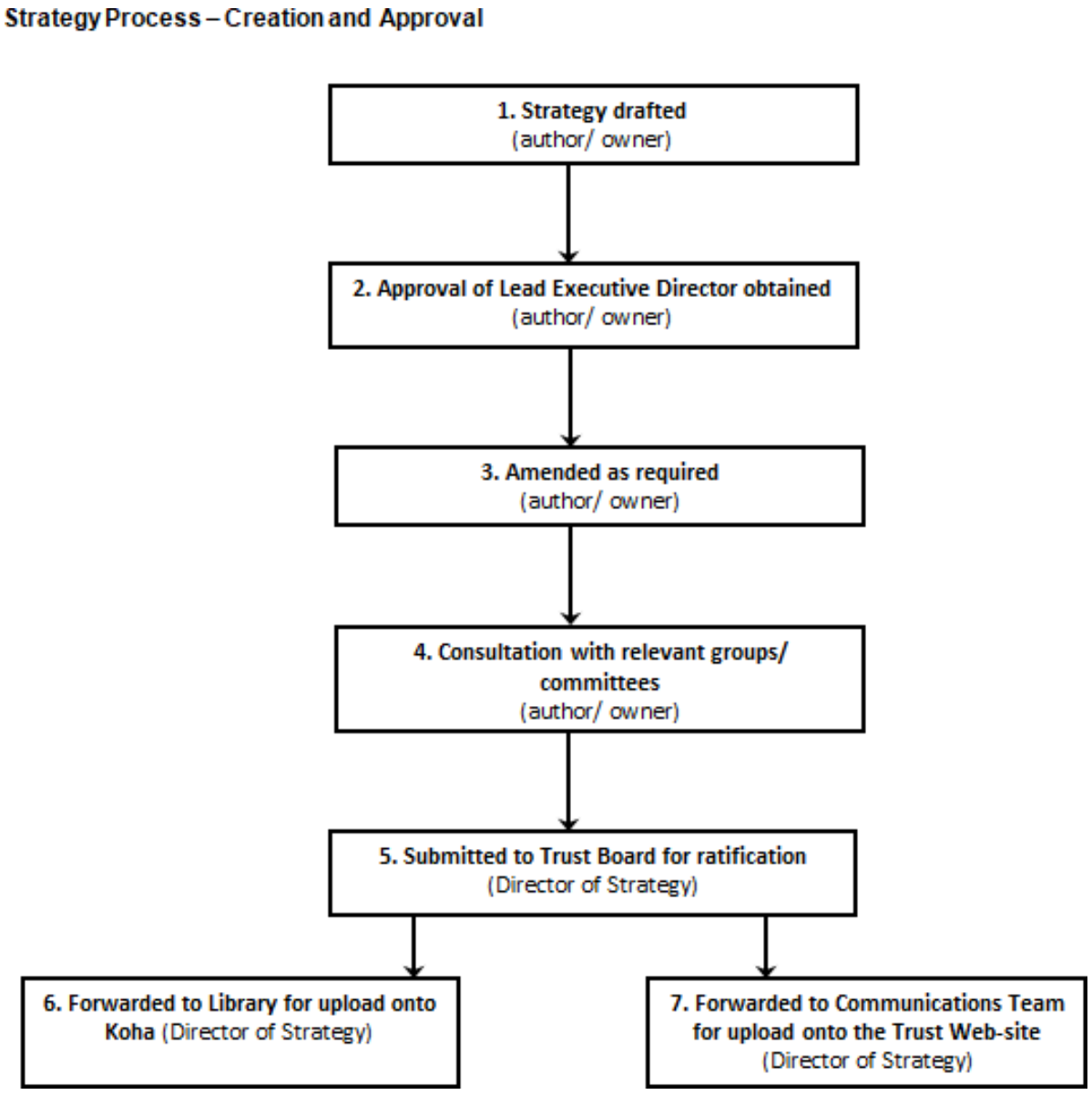
-

Appendix

Our Priorities	PRIDE Ambition/Performance measures	20/21	21/22	22/23	23/24	24/25

APPENDIX B1

STRATEGY PROCESS – CREATION AND APPROVAL



APPROVAL OF STRATEGIES

Strategies will be presented to the Trust Board for approval.

APPENDIX C

FRAMEWORK DOCUMENT TEMPLATE

NHS
University Hospitals of Derby and Burton
NHS Foundation Trust

xxxx Framework

20xx-20xx

Introduction

In this framework, we set out our **Why?** our **How?** and our **What?**

1. OUR WHY?

2. Our HOW?

3. Our WHAT?

Priorities for the next three years -

20xx -20xx

-

20xx -20xx

-

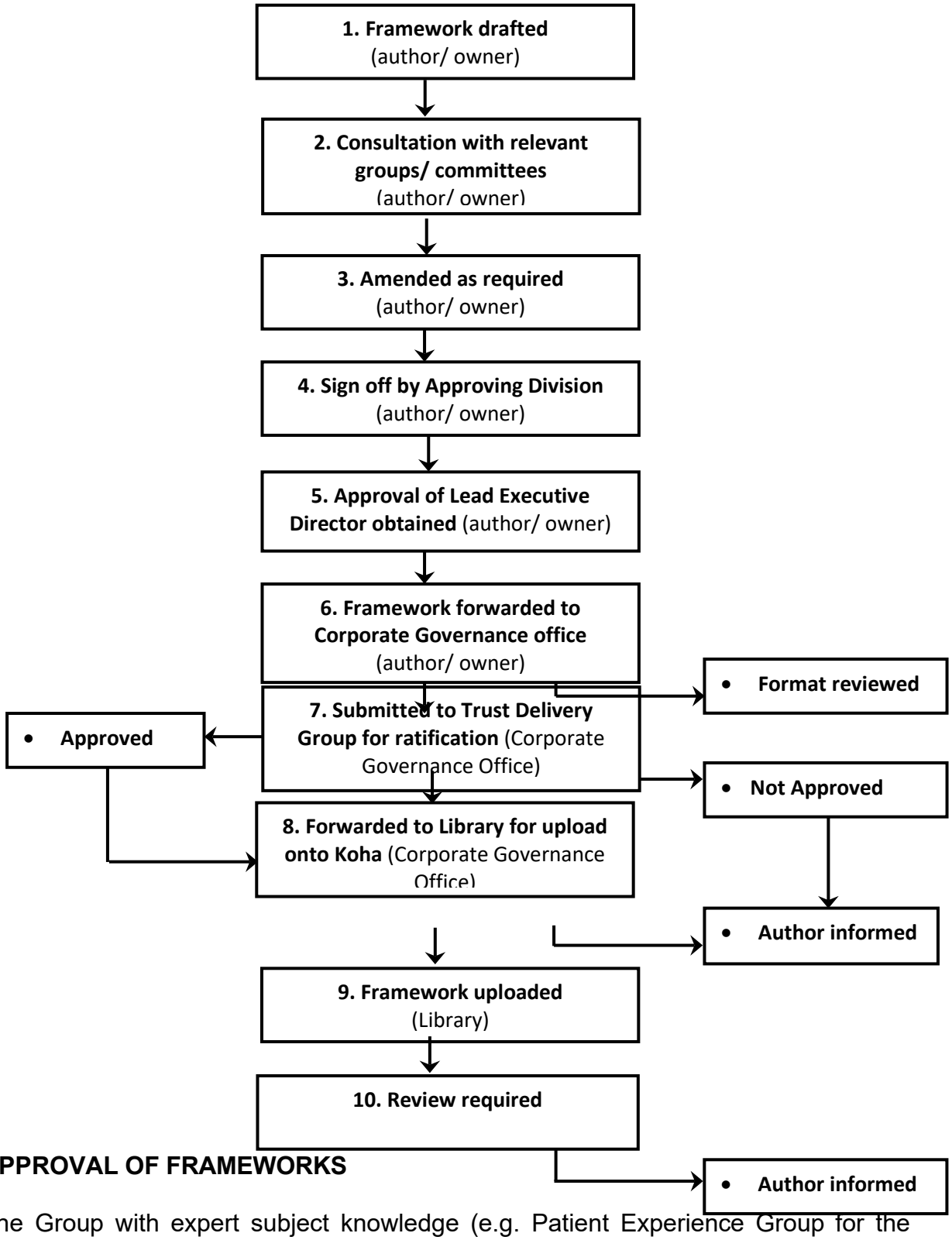
20xx -20xx

-

Appendices:

APPENDIX C1

FRAMEWORK PROCESS – CREATION AND APPROVAL



APPROVAL OF FRAMEWORKS

The Group with expert subject knowledge (e.g. Patient Experience Group for the Patient and Experience Framework) is responsible for developing and approving specialist content; then recommending final approval of new Procedural Documents.

APPENDIX D

POLICY DOCUMENT TEMPLATE

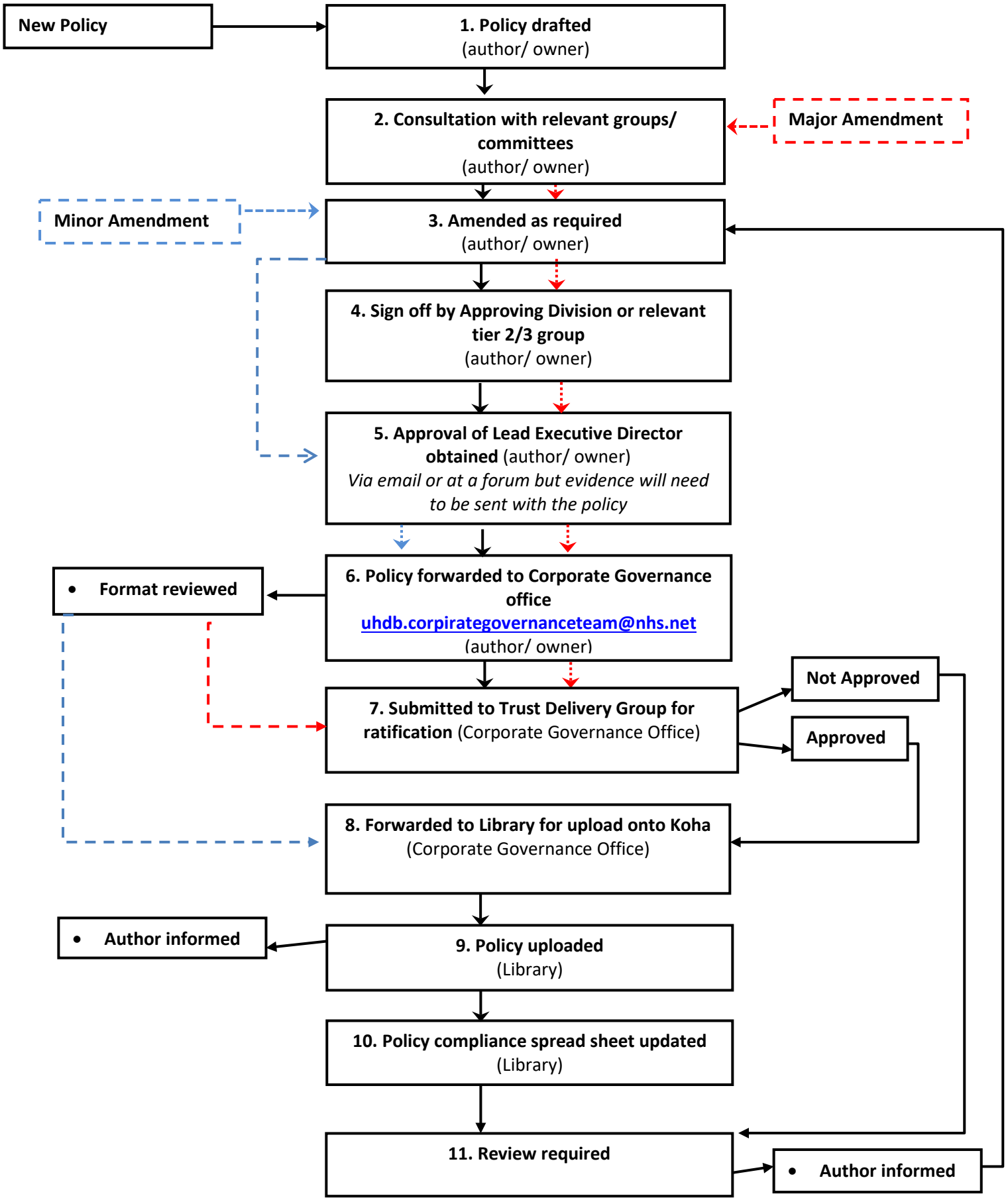
University Hospitals of Derby and Burton NHS Foundation Trust

TRUST POLICY FOR ……..

Reference Number From Library and Knowledge Service Manager	**Version:**		**Status**	**Author:** **Job Title**
Version / Amendment History	Version	Date	Author	Reason
				Brief reference / description as to why an amendment has been made
Intended Recipients: State who the policy is aimed at – staff groups etc				
Training and Dissemination: How will you implement the policy, cascade the information and address training				
To be read in conjunction with: State the name(s) of any other relevant policies: / procedure				
In consultation with and Date: State which groups you have consulted with and when. Give names in full followed by abbreviations e.g. Medical Advisory Committee (MAC)				
EIRA stage One Completed Yes / No *Delete as appropriate* stage Two Completed Yes / No *Delete as appropriate*				
Approving Body and Date Approved			Date and Full Name of Approving Body followed by abbreviations	
Date of Issue			Month and Year	
Review Date and Frequency			Year and Frequency e.g. 2008 every 3 years	
Contact for Review			This should match the author of the policy if different please state who the contact is by Job Title	
Executive Lead Signature				

APPENDIX D1

POLICY PROCESS – CREATION AND APPROVAL



Approval of Policies

The Group with expert subject knowledge (e.g. Health and Safety Group for Health and Safety Policies) is responsible for developing and approving specialist content; then recommending final approval. Where there is a new Policy or significant changes made to an existing Policy, following approval of the Policy by the relevant committee with expert subject knowledge, the Lead Executive Director for the Policy will approve the Policy and then submit to the TDG for final sign off.

Where there are no or minor changes the approval will be by the Lead Executive Director.

Policies will not be presented in full at the TDG meeting, but as a list of policies for approval / ratification. The Policies requiring approval will be circulated to the TDG members via email prior to the meeting so that the Executive Team have the ability to review/comment on each Policy electronically.

Extension requests for Trust Policies will require the approval of the Lead Executive Director and will be noted at the following Trust Delivery Group meeting. Please note that only one extension will be granted.

When a Trust Policy is changed to a Guideline, authorisation from the Lead Executive Director must be sought and reported to the Trust Delivery Group for information and archiving of old policy.

APPENDIX E

CLINICAL GUIDELINES TEMPLATE

University Hospitals of Derby and Burton NHS Foundation Trust

TRUST CLINICAL GUIDELINE FOR ……..

Reference Number From Library andKnowledge Service Manager	**Version:**		**Status** Draft or Final	**Author:** **Job Title:**
Version / Amendment History	Version	Date	Author	Reason
				Brief reference / description as to why an amendment has been made
Intended Recipients: State who the Clinical Guideline is aimed at – staff groups etc.				
Training and Dissemination: How will you implement the Clinical Guideline, cascade the information and address training				
Linked Documents: State the name(s) of any other relevant documents				
Keywords:				
Business Unit Sign Off			**Group : Date:**	
Divisional Sign Off			**Group : Date:**	
EIRA Stage One Completed Yes / No *Delete as appropriate* Stage Two Completed Yes / No *Delete as appropriate*				
Date of Approval			Month and Year	
Review Date and Frequency			Year and Frequency e.g. 2008 every 3 years	
Contact for Review			This should match the author if different please state who the contact is by Job Title	
Lead Executive Director Signature				

APPENDIX E1

FULL CLINICAL GUIDELINE

Reference no.:

1. **Introduction**

   [Cover succinct introduction to the guideline and why it is required.]

2. **Aim and Purpose**

   [What does this document aim to achieve?]

3. **Definitions, Keywords**

   [Any definitions that give the reader a better understanding of the subject matter. Include acronyms or abbreviations in a glossary, as necessary.] Add keywords you think would help to find the document more easily.

4. **Main Body of Guidelines – [feel free to change title here to suit the guidance]**

   [Lay out the guidance you would like to be followed here.]

5. **References (including any links to NICE Guidance etc.)**

6. **Appendices**

APPENDIX E2

SUMMARY CLINICAL GUIDELINE

Reference No:

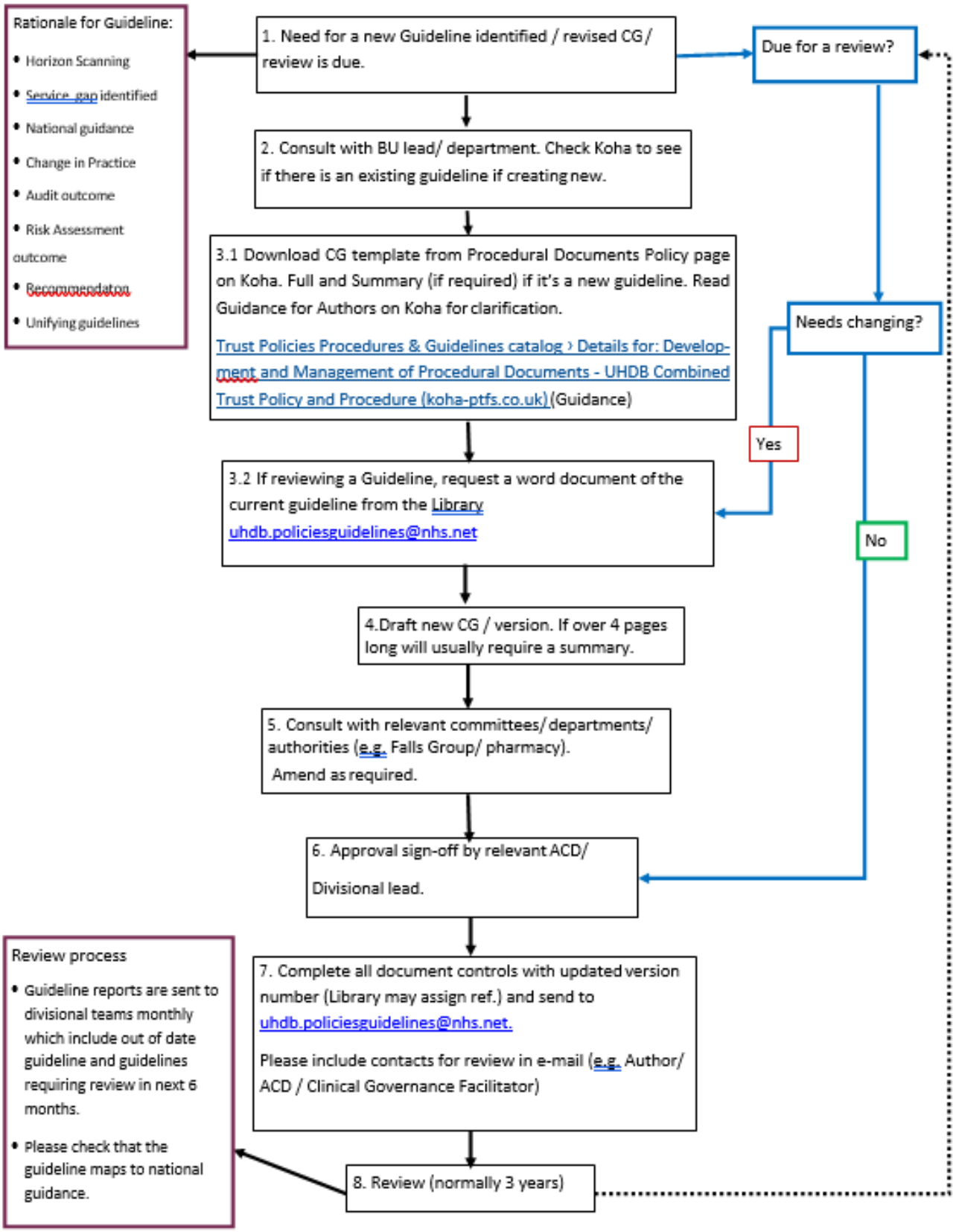
Summary guideline

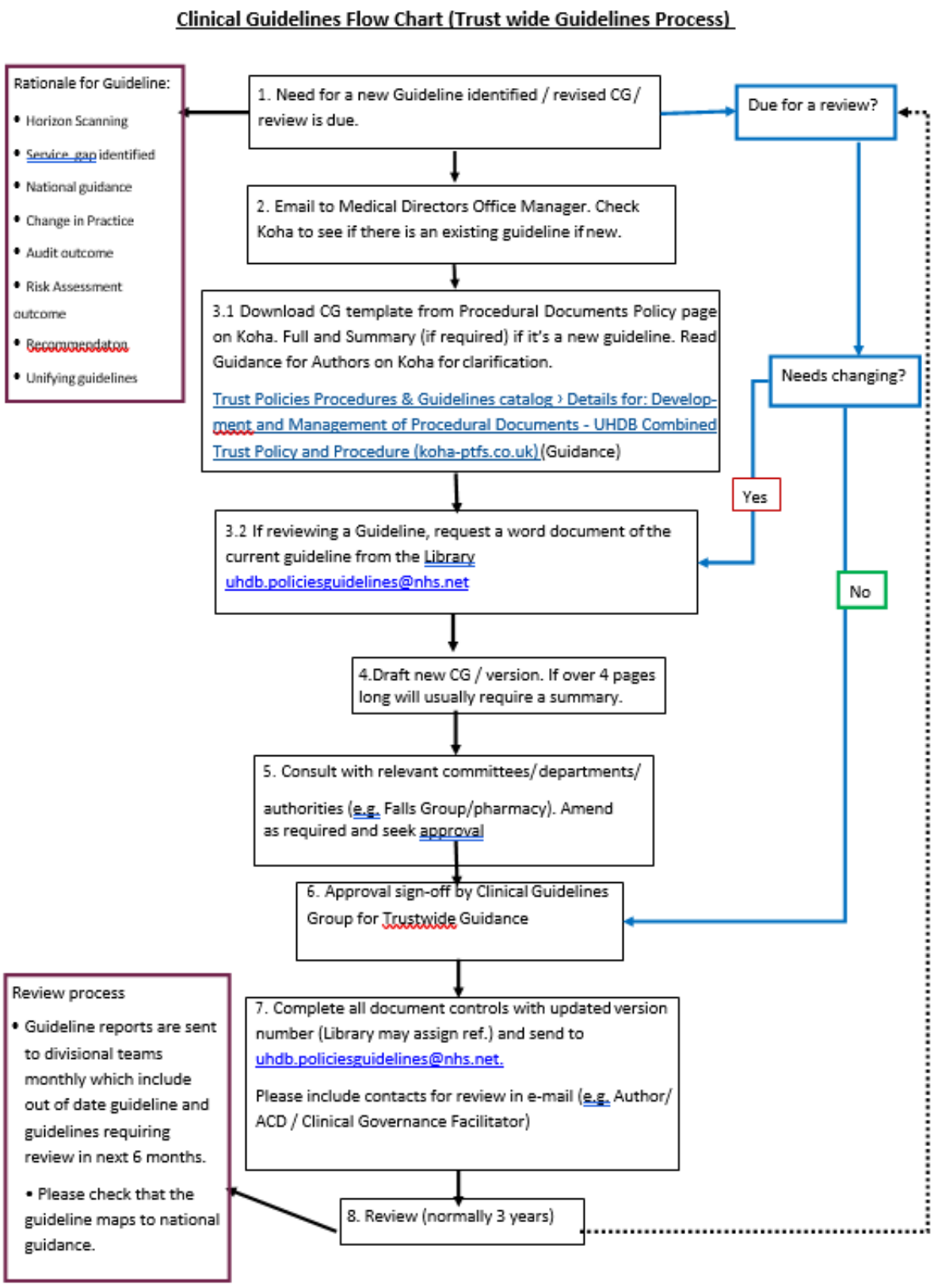
[For summary guideline – include flow chart / algorithm / checklist here / care bundle detail.] [Please ensure body text is Arial pt 11.]

APPENDIX E3

CLINICAL GUIDELINE PROCESS - CREATION AND APPROVAL

Clinical Guidelines Flow Chart (Divisional Guidelines Process)





Approval of Clinical Guidelines

Clinical Guidelines will be submitted to the relevant Divisional Clinical Governance Group (CGG), Specialist Forum or equivalent for approval. Authors should be aware that they need to check that there is no duplication of current Clinical Guidelines. Once approved, these can be added to the relevant section on the database by the Clinical Guidelines Group.

All clinical guidelines that mention antibiotics also require approval by the Antimicrobial Stewardship Group uhdb.antimicrobialstewardship2@nhs.net.

Clinical Guidelines will require approval by specialties as required by the CGG and the relevant Division. The approved guidelines are reviewed by the CGG before uploading onto the Trust intranet and appropriate databases.

When new guidance is approved and added to the database any previous versions will be removed and archived by the Library and Knowledge Service.

Evidence of consultation and approval should be provided in electronic, as opposed to paper, format.

NHS
University Hospitals of Derby and Burton
NHS Foundation Trust

INSERT TITLE

<table>
<tr><td>Reference Number</td><td colspan="2">Version:

V1</td><td>Status

Draft</td><td>Authors:</td></tr>
<tr><td rowspan="2">Version / Amendment History</td><td>Version</td><td>Date</td><td>Author</td><td>Reason</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="5">Intended Recipients: This LocSSIP is aimed at</td></tr>
<tr><td colspan="5">Training and Dissemination:</td></tr>
<tr><td colspan="5">To be read in conjunction with:</td></tr>
<tr><td colspan="5">In consultation with and Date:</td></tr>
<tr><td colspan="3">Approving Body and Date Approved</td><td colspan="2">Date and Full Name of Approving Body followed by abbreviations</td></tr>
<tr><td colspan="3">Date of Issue</td><td colspan="2">Month and Year</td></tr>
<tr><td colspan="3">Review Date and Frequency</td><td colspan="2">Year and Frequency e.g. 2008 every 3 years</td></tr>
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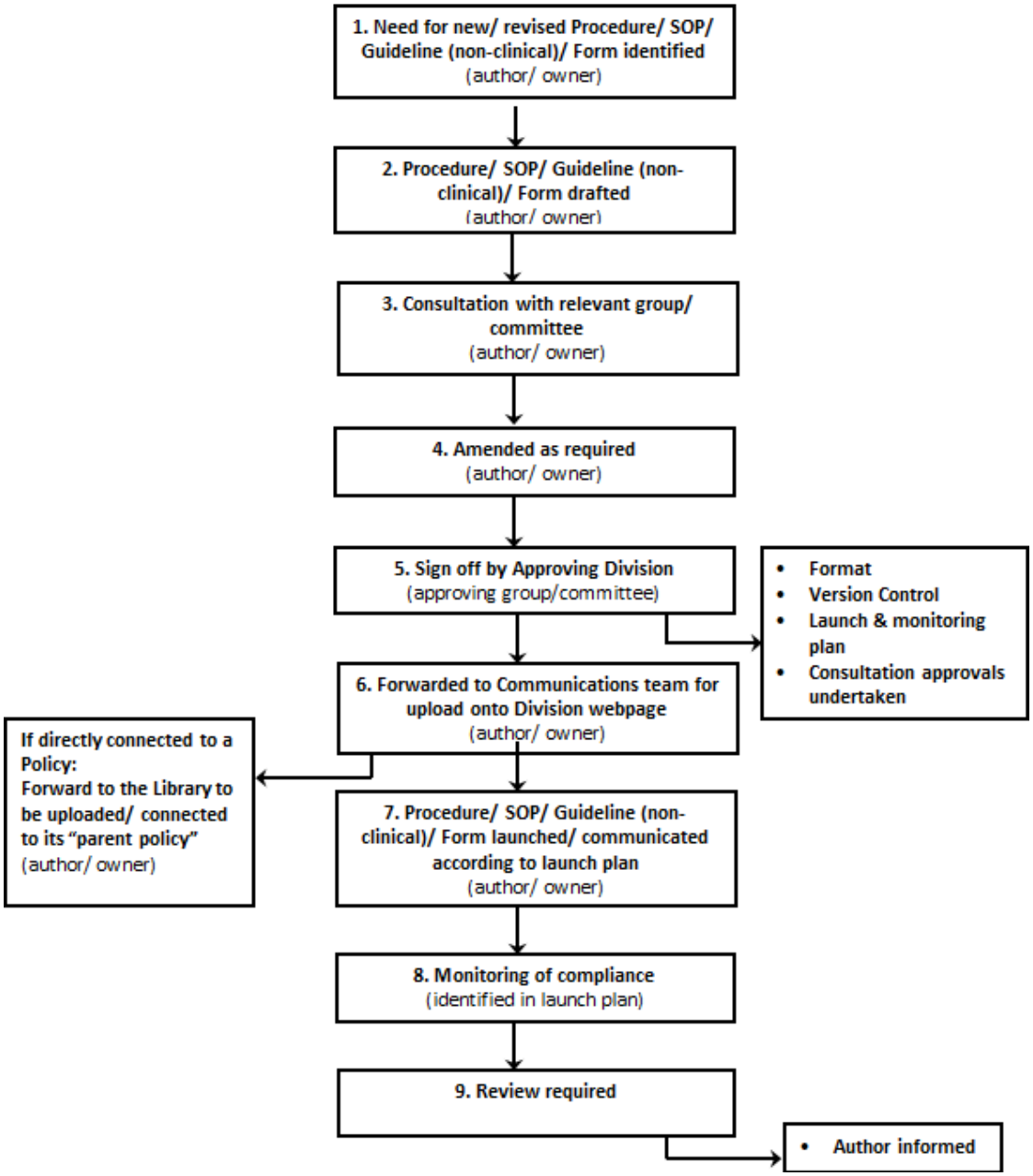
APPENDIX F

PROCEDURE/SOP/GUIDELINE (NON-CLINICAL)/ FORM PROCESS - CREATION AND APPROVAL



Approval of Procedure or SOP or Guideline (Non-Clinical) or Form

Procedures or SOP's or Guidelines (non-clinical) will be submitted to the relevant Divisional Governance Group, Specialist Forum or equivalent for approval. Authors should be aware that they need to check that there is no duplication of current Procedures or SOPs or Guidelines (non-clinical). Once approved (if it has a direct link to a Policy) it can be forwarded to the Library and Knowledge Service Team to be uploaded onto Koha. If there is no direct link to a Policy it should forwarded to the Communications Team to be uploaded to the designated section of each Division's intranet site.

APPENDIX G

STANDARD OPERATING PROCEDURE (SOP) TEMPLATE

{Topic} Standard Operating Procedure

The operating procedure set out below must comply with the Data Quality Standards set out within Trust Data Quality Policy

1. Overview

Describe here the purpose of the procedure/ routine covered by the SOP.

2. SOP Governance

Department:	**No of pages**:	**Version & Date**:
Author:	**Authorised by**:	**Review date**:

Frequency and Time frame: *eg Annual, Quarterly, Monthly, Weekly. Return due by XX date/ Nth day of month*

3. Key indicators, output or purpose from this procedure

Eg, National indicator description(s), Ref within IPR, to inform annual survey of XYZ etc

4. Data Source(s)

Describe and provide hyperlinks where appropriate to shared drive or internet/ intranet sites

5. Process

1.	Set out instructions of **what** to do, similar to current process. Where detailed guidance of *how to do it* is appropriate, use hyperlink to supporting instructions in section 10	☑
ⓘ 2.	Where there are checks, decision points or potential sign-off/ stage boundaries, indicate so that these are distinct from other steps within the process	☑
3.	*etc*	☑

6. Validation Checks

These might be included within the process in (5) above, but validation of data is absolutely critical, so suggest that there should be a description of validation checks required that recaps checks within the process above, and might also add further checks to be completed on the final data set

7. Sign off (separation, supervision, authorisation)

Stage/ purpose	Name and role	Date (how/ where evidenced)
Peer review:	XXX	XXX
Supervisor/ Lead review:	XXX	XXX
Information Asset Owner/ Trust Lead:	XXX	XXX

8. Information Governance

Record details of any IG considerations and approvals – for example, are data flows identified and documented, are information sharing agreements in place where applicable, is there a need for DPO advice, is the purpose and legal basis for processing and sharing clear?

9. Export/ use of data

Detail where/ how the information is to be used/ shared/ uploaded or exported. Include any specific considerations such as the format and whether there is a need for password protection

10. Detailed Instructions

ⓘ 1 – How to xxx

Set out detail

ⓘ 2 – How to xxx

Set out detail