

Risk Management Policy

NHS Devon



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Equality, Diversity, and Inclusion Statement

NHS Devon is committed to the promotion of equal opportunities, addressing health inequalities, and fostering of good relations between people protected under the terms of the Equality Act 2010, the Health and Social Care Act 2012 and Human Rights legislation. We are equally committed to the elimination of unlawful discrimination, harassment, and victimisation. To demonstrate this commitment, we develop, promote, and maintain policies, strategies, and operating procedures. Every effort is made to ensure that patients, employees, contractors, or visitors do not experience discrimination; either directly or indirectly, because of their vulnerability; disadvantage; age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion and belief; sex (gender) or sexual orientation.

All staff must comply with this policy. Compliance must reflect our organisational commitment to and policy on, equality, diversity, and inclusion. In addition, each manager and member of staff involved in implementing this policy must give due regard to the needs of those protected under law.

If you, or any other groups, believe you are discriminated against under the terms of the Equality Act, the Health and Social Care Act 2012 or Human Rights legislation by anything contained in this document; or you need this document in an alternative format, for example, large print, Braille, Easy read, or other languages; please contact our Patient Advice and Complaints Team (PACT):

Tel: 0300 123 1672
Email: pals.devon@nhs.net

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** All appendices to this policy are procedural documents*

1. Introduction

- 1.1 Risk management plays a critical role in helping NHS Devon understand and manage risks to the achievement of its priorities. It helps us to determine an appropriate control environment and balance of strategies to address risk, so that we use resources both efficiently and effectively. It involves making decisions and establishing governance systems that embed and support effective risk processes, as well as building an organisational culture that supports integrity, accountability, honesty, openness, and responsiveness to change.
- 1.2 This policy sets out the key principles that guide risk management within NHS Devon.
- 1.3 Further advice and guidance is available from the Corporate Governance team by emailing d-icb.governance@nhs.net.

2. Purpose and Objectives

- 2.1. Risks will always occur. Many risks are manageable, but others pose a more serious possibility of impact on the organisation, staff, patients and / or the general public. Once identified, risks must be assessed, recorded, managed according to severity, reported and scrutinised.
- 2.2. NHS Devon is required by statute and by guidance from the Department of Health and Social Care (DHSC), to systematically identify and control all significant strategic and operational risks. These arise across the organisation and include clinical and corporate services.
- 2.3. The Board is required to ensure that robust risk management processes exist and assured that there are systems in place to control and manage risk and that these systems are working effectively. This involves the proactive identification and management of risks that may threaten achievement of NHS Devon's objectives, its statutory or regulatory duties and the response to adverse events or learning from audits and other independent reviews.
- 2.4. The Chief Executive Officer (CEO) is required to sign an Annual Governance Statement (as part of the Annual Report and Accounts) to provide reasonable assurance that NHS Devon has been properly informed about the totality of its risks and can evidence they have identified NHS Devon's strategic and corporate objectives, and managed the principal risks to achieving them. This includes all measures and practices that are used to control and manage risks. The system operates at all levels within NHS Devon and is continuously monitored for effectiveness on behalf of, and by, the Board.

2.5. This policy will:

- Establish a framework for risk management and board assurance which embraces organisational, financial, clinical, and non-clinical risks and in which all parts of the organisation are involved.
- Provide an environment for proactive decision making.
- Empower all staff to manage risk within delegated limits.
- Provide a proactive early warning system and enable a comprehensive response to mitigate risk where indicated.
- Establish a platform for managing risks within partnership working.
- Ensure the integration of risk management with NHS Devon's strategies and objectives and with local (directorate / team) objectives that these support.

2.6. This policy also helps to reduce the risk of fraud and bribery by providing a robust system of internal control for risk management. It supports and complements NHS Devon's Counter Fraud, Bribery and Corruption Policy and has been reviewed by the organisation's Local Counter Fraud Specialist. Fraud and bribery risks will be included in NHS Devon's risk register and its performance against standards will be assessed annually via completion of the NHS Counter Fraud Authority (CFA) Counter Fraud Functional Standard Return.

2.7. The NHS Devon Board recognises that risk management is an integral part of good management practice and an effective corporate governance framework and, to be most effective, it must become part of the organisation's culture. The Board is therefore committed to ensuring that risk management forms a part of the NHS Devon philosophy, practice, and planning, rather than being viewed or practised as a separate programme, and that responsibility for implementation is accepted at all levels of the organisation.

2.8. The Board acknowledges that the provision of appropriate training is central to the achievement of this aim.

2.9. A critical role of any Board is to focus on the risks that may compromise the achievement of the organisation's strategic and corporate objectives its statutory or regulatory duties. In order to be confident that the systems of internal control are robust, the NHS Devon Board must be able to provide evidence that it has systematically identified its strategic objectives and managed the principal risks to achieving them.

2.10. The NHS Devon Board is committed to the following key principles:

- **A Just Culture** – Staff reporting or directly involved in incidents are assured that any investigation will be carried out fairly, openly, transparently, without prejudice and with the aim of identifying learning and correcting underlying causes of the incident to prevent recurrence.
- **Freedom to Speak Up (Whistleblowing)** – All staff should be familiar with NHS Devon's Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy, available on the staff intranet, which sets out

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procedures and guidance to staff on raising concerns. NHS Devon has Freedom to Speak Up Guardians to whom staff may raise concerns; their details can be found on the staff intranet.

3. Definitions

- 3.1. For a full glossary of terms used within this policy document and in risk management in general, please refer to **Appendix A**.

Risk

- 3.2. Risk is defined as:

“An uncertain event or set of events, that should it occur, will have an effect on the achievement of objectives. A risk is measured by the combination of the probability of perceived threat or opportunity occurring and the magnitude of its perceived impact on objectives”.

(Management of Risk: Guidance for Practitioners, Officer of Government Commerce, 2010)

- 3.3. For example, the potential occurrence of an event that may either cause harm or have an impact on patients, visitors, partner organisations, strategic objectives, assets and / or reputation.

- 3.4. In particular:

- Any element which has the potential to damage or threaten the achievement of the statutory or regulatory duties, strategic and corporate objectives, programmes, or service delivery of NHS Devon.
- Anything that could damage the reputation of NHS Devon and undermine the public's confidence in NHS Devon.
- Failure to guard against impropriety, malpractice, waste and / or poor value for money.
- Non-compliance with regulations and / or legislation such as those covering health and safety, safeguarding and the environment.
- An inability to respond to, or manage, changed circumstances in a way that prevents or minimises adverse effects on the delivery of NHS Devon's statutory or regulatory duties, strategic and corporate objectives.

- 3.5. NHS Devon distinguishes between **inherent risks** and **residual risks**. An inherent risk is one that is unmitigated whilst a residual risk is the risk that remains once the inherent risk has been mitigated or managed. **Appendix B** provides an illustration of the difference between these two types of risk.

Issues

- 3.6. An issue is an event that has happened or is happening. It is a 'known' as opposed to an 'unknown' quantity. The outcome of the actions and events is no longer subject to uncertainty as in the case of a risk. The consequences may be observed and measured. However, that is not to say that new risks will not emerge as the 'issue' continues.

In simplistic terms, the difference comes down to whether the event has the **potential to occur** (i.e. it is a risk), or **has already occurred** and the impact / consequence is now present (i.e. it is an issue).

Appendix C provides more detailed information in relation to the key differences between risks and issues. **This policy does not mandate the recording of issues; it is for teams / directorates to decide whether to do so. Where this is the case, the level of detail and the related action plans to address an issue should be proportionate to the nature of the issue that has arisen.**

Risk Management Principles

- 3.7. Risk management within NHS Devon will be carried out in accordance with the principles set out in **Appendix D**. Examples include alignment with objectives, fits the context, promotes, guides, and supports a clear and consistent approach, informs decision-making, facilitates continual improvement, and achieves measurable value.

4. Risk Management Activities and Processes

- 4.1. Risk management involves the following activities (see **Appendix E**):
- 4.1.1. **Identify the risk:** Consider how and why the successful achievement of a goal / objective might be prevented. Hazards, barriers, and challenges to achievement of objectives, at strategic and operational level, can be identified from a variety of internal and external sources such as staff resource issues, workforce recruitment problems, incompatibility of IT systems, a lack of assurance on areas of quality and performance data or information from staff and / or patients etc.
 - 4.1.2. **Assess the risk:** Describe the risk and give it a succinct title which clearly identifies the risk, the area to which it relates and, where appropriate, the financial year to which it relates. Consider how the risk could occur, who or what might be involved, what the effect(s) would be if the risk were to materialise and how this could be reduced or minimised. Describe the risk clearly and concisely; think in terms of the "if", "then", "resulting in" statement e.g. **if** (the cause – why the risk is happening) -, **then** (the risk event, that if it happened, could

have an impact on objectives) **resulting in** (the effect or impact of the risk – what will happen if the risk realises).

- 4.1.3. **Analyse, evaluate and score the risk:** Assess the likelihood of the risk materialising, and the level of its impact should it occur; it informs the risk score matrix. See **Appendix F** to assess whether the risk scores highly enough to take action. The total risk score will also determine whether the risk is managed at a team / directorate level or via the NHS Devon Corporate Risk Register (CRR).
- 4.1.4. **Treat the risk:** Determine which of the following actions will be required:

Treatment	Treatment Description
Treat	Draw up a specific action plan (which includes consideration of funding / associated costs) to reduce the impact or likelihood scores to an acceptable level, as articulated in the 'risk appetite' agreed by the NHS Devon Board, in order to gain further control.
Tolerate	It is not always possible to identify and then fully implement actions that eliminate or minimise the risk. Where this is the case, it is essential that the significance of the risk that remains (the residual risk) is understood and the organisation, in accordance with the level of authority for risk management, confirms that it is prepared to accept that level of risk.
Transfer	Transfer the risk to another organisation (this is rare).
Terminate	Close the risk (subject to approval) – for example, decide to no longer do the activity that is causing the risk.

- 4.1.5. **Report the risk:** All identified risks should be recorded on a risk register; the risk score determines where it is reported:

- 4.1.5.1. **All team / directorate risks** (generally scoring 10 or below) are reported and managed locally via a team / directorate risk register. The risk register should be reviewed monthly and escalated to the relevant Chief Officer as required.

A quarterly review of all team / directorate risk registers should be undertaken by the Corporate Governance team to ensure oversight of any risks that may need to be escalated.

All teams / directorates should maintain their own risk registers.

If a risk is deemed to be a risk to the achievement of NHS Devon's statutory or regulatory duties, corporate objectives or statutory purposes, and not just those of the team / directorate, and scores 12 or above, then it can be escalated for inclusion on the NHS Devon Corporate Risk Register (CRR).

4.1.5.2. **All project / programme risks** (any score) are reported and managed locally via a project / programme risk register. The risk register should be reviewed regularly by the Project / Programme Manager. Where there is a significant risk to the non-achievement of the project / programme objective which may then pose a further risk to the achievement of an organisational statutory or regulatory duty, objective, operational or strategic, the Project / Programme Manager will discuss with the most senior officer with portfolio responsibility for the risk and seek advice and guidance from the central Corporate Governance team as appropriate.

4.1.5.3. **All operational risks** (generally scoring 12 and above) are added to the NHS Devon Corporate Risk Register (CRR); this is done in conjunction with a member of the Corporate Governance team. Operational risks are reviewed on a monthly basis. The review is overseen by a member of the Corporate Governance team.

Operational risks scoring 15 and above are reported alongside the Board Assurance Framework (BAF) to the Executive Committee.

4.1.5.4. **All strategic risks** (generally scoring 15 and above) are included on the Board Assurance Framework (BAF) and are reviewed regularly and reported alongside operational risks (scoring 15 and above) to the Executive Committee, the NHS Devon Board, and where appropriate, its associated Assurance Committees.

Refer to **Appendix G** for a summary of risk action and reporting requirements.

4.1.6. **Monitor / review the risk:** Monitor the risk impact and review the effectiveness of action / actions taken. It is important to consider whether the risk score / risk priority has changed as a result.

4.1.7. **Communicate with and consult those impacted by the risk:** It is important to identify who is affected by the risk and who needs to know about it e.g. internally and / or externally.

5. Strategic and Operational Risks

- 5.1. Risk related activity within NHS Devon is derived from two directions
- **Bottom up:** Individuals, teams, directorates, Chief Officers, the Executive Committee, and Board Assurance Committees can identify a risk and this risk would then be recorded and managed accordingly in accordance with the details laid out in this policy document. These risks are operational risks. Those risks scoring 10 or below are included on team / directorate risk registers and those scoring 12 or above form the NHS Devon Corporate Risk Register (CRR).
 - **Top down:** The NHS Devon Board discusses and agrees those strategic risks that it considers the organisation faces in the achievement of its statutory or regulatory duties, agreed corporate objectives or other statutory functions. These form the strategic risks of NHS Devon and are recorded in its Board Assurance Framework (BAF).
- 5.2. Both operational and strategic risks should be aligned to NHS Devon's statutory or regulatory duties and objectives (as articulated in the Integrated Care Strategy and Joint Forward Plan (JFP)). In the absence of corporate objectives at any point, operational and strategic risks should be expressed and recorded against
- either** one of the four statutory purposes of Integrated Care Boards:
- Improve outcomes in population health and healthcare.
 - Reduce health inequalities in outcomes, experience, and access.
 - Enhance productivity and Value for Money (VfM).
 - Support broader social and economic development.
- or** one of the six themes of the NHS Oversight Framework:
- Quality of care, access & outcomes.
 - Preventing ill-health and reducing inequalities.
 - Finance and use of resources.
 - People.
 - Leadership & capability.
 - Local strategic priorities.
- 5.3. **Risk Scores** are calculated in accordance with the National Patient Safety Agency (NPSA) Model Risk Matrix and are the product of the impact / consequence and the likelihood of the risk arising (see **Appendix F**).
- 5.4. NHS Devon adheres to the Nolan Principles of openness and accountability, however occasionally there is the requirement to make a risk **confidential** which means that it is not reported within the public domain. A risk can be classified as confidential, with the approval of the Corporate Governance team and Chief Officer, if it contains clinically or commercially sensitive information. The classification of a risk as being confidential due to clinically sensitive

information also requires the approval of either the Chief Medical Officer (CMO) or the Chief Nursing Officer (CNO).

6. Corporate Risk Register (CRR)

- 6.1. **Risk escalation to the NHS Devon Corporate Risk Register (CRR)** - All teams / directorates should maintain their own risk registers. If a risk is deemed to be a risk to the achievement of NHS Devon's statutory or regulatory duties or corporate objectives, and not just those of the team or directorate, and score 12 or above, then it can be escalated for inclusion on the NHS Devon Corporate Risk Register (CRR). The Corporate Governance team reviews any such risk with the risk assessor and owner to establish whether this is appropriate, and the scoring is proportionate. If the risk is deemed appropriate for inclusion, it is added to the NHS Devon Corporate Risk Register (CRR).
- 6.2. **Risk Management System** – All managers have a responsibility to record identified corporate risks on NHS Devon's risk management system. This ensures risks at all levels are held in a central location which is fully auditable (please contact the Corporate Governance team for access to and training on how to use the risk management system if required). The use of the risk management system enables staff to add new risks or make updates to existing risks at any time. Corporate risks must be reviewed and updated every month by the named assessor. Following this review the update will be agreed by the risk owner and reported as appropriate.
- 6.3. Regular reviews are undertaken across NHS Devon to ensure that:
 - New risks are identified and assessed.
 - A careful watch is maintained on cumulative risk across NHS Devon to ensure that this is identified and properly escalated.
 - Existing risks and their mitigating actions are tracked and kept up to date.
 - A summary of all incidents within teams / directorates is reviewed and this information is disseminated to ensure that appropriate learning takes place to reduce future risks.
 - Risks that are no longer being faced by NHS Devon are closed.
- 6.4. The full process for the identification, scoring, management and reporting of risks is detailed within the Standard Operating Procedures (SOPs) that support this policy document.

7. Board Assurance Framework (BAF)

- 7.1. The Board Assurance Framework (BAF) provides a structure and process that enables NHS Devon to focus on the risks that might compromise achieving its most important goals and objectives, to map the controls that should be in place to manage those objectives, and to confirm that the Board has sufficient

assurance regarding the effectiveness of those controls. The Board Assurance Framework (BAF) also identifies any gaps in control and / or assurance and articulates action plans in place to address them.

- 7.2. In advance of each financial year, the NHS Devon Board should agree overarching corporate goals for that year. These goals have a number of underpinning corporate objectives. The Board Assurance Framework (BAF) captures these corporate goals and the strategic risks applicable to them. Each goal and the strategic risks associated with this goal will be assigned to a Board Assurance Committee for scrutiny, monitoring, and testing of whether evidence provided to substantiate the levels of control applied. In the absence of corporate objectives at any point, operational and strategic risks are expressed and recorded against

either one of the four Statutory Purposes for Integrated Care Boards, those being:

- Improve outcomes in population health and healthcare.
- Reduce health inequalities in outcomes, experience, and access.
- Enhance productivity and Value for Money (VfM).
- Support broader social and economic development.

or one of the six themes of the NHS Oversight Framework:

- Quality of care, access & outcomes.
- Preventing ill-health and reducing inequalities.
- Finance and use of resources.
- People.
- Leadership & capability.
- Local strategic priorities.

- 7.3. Any Board Assurance Committee responsible for scrutinising an area of risk can escalate a risk onto the Board Assurance Framework (BAF) when one or more of the following criteria are met:

- The current score is significantly in excess of the target score;
- It is a long-standing risk that shows little or no reduction in current risk score; or
- The Committee has not received sufficient assurance that the risk is being appropriately and effectively managed.

- 7.4. The Board Assurance Framework (BAF) is updated by Chief Officers in conjunction with the Corporate Governance team, on a bi-monthly basis, and reported to the Executive Committee for recommendation to the NHS Devon Board. The Board Assurance Framework (BAF) will set out the controls, assurances, gaps and associated mitigating actions relating to each gap. The details in relation to mitigating actions will also require an 'action owner', the 'action status' and 'planned implementation date' to be recorded; this is so that progress against plan can be monitored, and corrective action taken where there is deviation from plan.

- 7.5. The Board Assurance Framework (BAF) will be used as a tool for setting the agendas of Board meetings and development sessions (as well as Board Assurance Committee agendas). It will be presented at each formal meeting. To be an effective tool, it should be possible to map items identified in the Board Assurance Framework (BAF) to papers presented to the meeting which address those items. This may be through specific papers, or within standing agenda items such as finance, quality, or performance report.

8. Risk Appetite

- 8.1. NHS Devon's **Risk Appetite Statement** documents the delegation of risk taking from the Board to senior management. It specifies the overall risk levels that the Board is willing to accept whilst operating in full compliance with regulatory and legal requirements.
- 8.2. **Risk appetite** is defined as “the amount and type of risk that an organisation is prepared to pursue, retain or take in pursuit of its strategic aims and objectives” and is key to achieving effective risk management. It can be influenced by personal experience, political factors, and external events.
- 8.3. It represents a balance between the potential benefits of innovation and the threats that change, and improvement inevitably bring. It should be at the heart of the systems and processes in place to manage risk within NHS Devon, as well as how decisions are taken.
- 8.4. The NHS Devon Board should articulate, as part of the annual risk cycle, its appetite in relation to each of the statutory or regulatory duties or corporate objectives, expressed using the following Corporate Governance Institute (CGI) Framework:

Risk Appetite Level	Risk Appetite Level - Description
Avoid	The avoidance of risk and uncertainty is a key organisational objective
Minimal	(ALARP – As Little As Reasonably Possible): The preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential
Cautious	The preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
Open	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward and Value for Money (VfM)
Seek	Eager to be innovative and to choose options offering potentially

Risk Appetite Level	Risk Appetite Level - Description
	higher business rewards despite greater inherent risk
Mature	Confident in setting higher levels of risk appetite because controls, forward scanning and responsiveness systems are robust

- 8.5. Based on risk appetite, a 'target' risk score is set for individual risks, this is the level to which the risk is managed to. The benefits of this approach include:
- Management focus on risks that can be managed / reduced;
 - Identification of targeted actions to reduce risks to 'target';
 - Timely reduction of risks;
 - Identification of static risks / ineffective actions; and
 - Management focus on risks that are not reducing.
- 8.6. The process for setting and reviewing risk appetite (including 'target' risk scores) is detailed in **Appendix H** together with the current risk appetite statement agreed by the NHS Devon Board.

9. Accountabilities, Duties and Responsibilities

- 9.1. The **NHS Devon Board** is ultimately responsible for the organisation's systems of internal control (financial, organisational, clinical, and non-clinical) and risk management arrangements, and for demonstrating leadership, active involvement, and support for risk management across the organisation. It is supported in the discharge of its responsibilities by the Audit & Risk Committee (ARC), other Assurance Committees, and the Executive Committee.

The Board receives assurance as to whether operational and strategic risks are being effectively managed. It reviews and approves the Board Assurance Framework (BAF) on a regular basis to monitor the actions and assurances against the strategic risks and assesses the overall impact on delivery of the NHS Devon statutory/regulatory duties or corporate objectives.

In addition to the above, it is also responsible for determining the risk appetite of NHS Devon and for approving the organisation's Risk Management Policy.

- 9.2. The **Audit & Risk Committee** (ARC) provides an objective view on internal control and risk management systems to the NHS Devon Board that is independent of the executive. The Audit & Risk Committee (ARC) also:
- Reviews the adequacy and effectiveness of the system of integrated governance and risk management and internal control across the whole of the NHS Devon activities that support the achievement of its objectives, and to highlight any areas of weakness to the NHS Devon Board.

- Reviews the adequacy and effectiveness of the assurance processes that indicate the degree of achievement of NHS Devon's statutory/regulatory duties or objectives, the effectiveness of the management of principal risks.
- Maintains oversight of organisational and system risks where they relate to the achievement of NHS Devon's statutory or regulatory duties or objectives; the Board maintains overall responsibility for risk management.
- Seeks reports and assurance from directors and managers as appropriate, concentrating on the systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.
- Reviews the outcome of the annual internal audit of governance and risk management arrangements which, along with other assurances received, will enable the committee to recommend the Annual Governance Statement is signed off by the Chief Executive Officer (CEO) at the end of each financial year.
- Identifies opportunities to improve governance, risk management and internal control processes across NHS Devon.

The Chair of the Audit & Risk Committee (ARC) will provide a summary to the NHS Devon Board of its assurances and where necessary, request deep dives to be undertaken in areas of risk where further assurances are required.

- 9.3. The **Head of Internal Audit** (HoIA) is responsible for implementing a programme of verification to ensure that the risk management systems and controls NHS Devon has in place are sufficient and will enable the provision of an audit assurance opinion to the Chief Executive Officer (CEO) and the Audit & Risk Committee (ARC).
- 9.4. The **NHS Devon Board Assurance Committees** have specific roles in relation to the statutory/regulatory duties or strategic risks assigned to them and as set out in their Terms of Reference.
- 9.5. The Executive Committee provides oversight and delivery of risk management arrangements. It regularly has oversight of the NHS Devon Corporate Risk Register (CRR) to review whether individual operational risks are being effectively managed and whether the action plans are sufficient and having the desired effect within the agreed timescales. In addition, it regularly has oversight of the Board Assurance Framework (BAF) to monitor the actions and assurance against the strategic risks and to assess the overall impact on delivery of NHS Devon's statutory/regulatory duties or corporate objectives, and approves its submission to the NHS Devon Board.
- 9.6. The **Chief Executive Officer** (CEO) has overall responsibility for ensuring that an effective risk management system is in place. They are also responsible for ensuring that there is an adequate system of internal control in place. The work of ensuring that this system is in place is delegated to the Company Secretary in practice, who is also responsible for overseeing the management and maintenance of the Board Assurance Framework (BAF) and ensuring the Board follows due process with regards to the overall

management of risk. The Company Secretary is accountable to the Chief Communications and Partnerships Officer and is responsible for ensuring (and reporting to the Board and to the Audit & Risk Committee (ARC)) that systems and structures are in place for the effective management of financial risk and organisational controls.

The Chief Executive Officer (CEO) is responsible for the preparation of an Annual Governance Statement setting out how these responsibilities have been discharged.

- 9.7. The **Chief Nursing Officer** (CNO) is accountable to the Chief Executive Officer (CEO) and is responsible for ensuring (and reporting to the Board or appropriately established committees) that systems and structures are in place for the effective management of clinical quality and safety. As the **Caldicott Guardian** they ensure that the Caldicott principles for managing information and ensuring its security and integrity are adhered to by staff within NHS Devon.
- 9.8. The **Chief Medical Officer** (CMO) provides Clinical Leadership for NHS Devon and is accountable to the Chief Executive Officer (CEO) and is responsible for providing strategic and operational leadership and management of the clinical risk within NHS Devon and organisational assurance on all matters of clinical risk and clinical outcomes to the NHS Devon Board.
- 9.9. The **Corporate Governance team** is responsible for overseeing the day-to-day management and co-ordination of the risk management system.
- 9.10. The **Risk Manager** is responsible for providing support and advice on risk management issues across NHS Devon. In addition, they will work closely with specialist advisers within NHS Devon who provide advice on specific areas of risk management, for example, Health and Safety; Fire; Infection Control; Manual Handling; Security; Fraud and Information Governance. The Risk Manager will provide information about corporate and strategic risks for the Executive Committee, Board Assurance Committees, and the NHS Devon Board. This forms the basis of 'bottom up' population of the risk register and will be used to inform the Corporate Risk Register (CRR) and the Board Assurance Framework (BAF). They are responsible for the ongoing development, implementation, and evaluation of risk management systems. These systems will align with the requirements of related regulatory bodies such as NHS England and the Care Quality Commission (CQC).
- 9.11. The **Senior Information Risk Owner** (SIRO) is accountable to the Chief Executive Officer (CEO) and is responsible for managing information assets and risks across the organisations. The role of the Senior Information Officer (SIRO) for NHS Devon is undertaken by the Chief Communications and Partnerships Officer.
- 9.12. The **Company Secretary** reports to the Chief Communications and Partnerships Officer and is responsible for ensuring the development and

implementation of Risk Management Policy across NHS Devon, ensuring that risk management processes are effectively coordinated, implemented, and monitored. This responsibility includes:

- Maintenance of the Board Assurance Framework (BAF) and the NHS Devon Corporate Risk Register (CRR) as active documents with clear monitoring of mitigation and action plans.
- Supporting the implementation of NHS Devon's Risk Management Policy (including the provision of advice and training).
- Overseeing and reporting on risk management compliance requirements.

9.13. All **Chief Officers***, **Senior Leadership Team** members and **Managers** are responsible for:

- Implementing the Risk Management Policy and procedures within their scope of responsibility.
- Ensuring that NHS Devon's risk management processes, including risk assessments, monitoring and escalation of cumulative risks and regular reviews are embedded in their team / programme management functions, included as a standing item on the monthly team meeting agenda and ensuring risk discussions are minuted or included in an action log.
- Ensuring that NHS Devon's risk management processes, including risk assessments, are in place within their scope of responsibility.
- Ensuring that relevant risks are identified, assessed, reviewed, and appropriately managed.
- Ensuring that they discuss risks with relevant senior managers and directors as appropriate.
- Implementing and monitoring any risk management actions within their designated area. Where local actions are considered to be inadequate, senior managers are responsible for escalating these risks through the agreed committee or management structure if local resolution has not been satisfactorily achieved.
- Reviewing a summary of all incidents within their teams or their scope of responsibility on a regular basis and disseminating this information to ensure that appropriate learning takes place in order to reduce risks.
- Ensuring that all staff are given the necessary information and training to enable them to be aware of the risks to their local objectives, those in their work environment and of their personal responsibilities and responsibilities towards working safely.
- Ensuring that staff undertake all relevant mandatory training.
- Ensuring staff compliance with this document.

** It should be noted that a Chief Officer can delegate any of the responsibilities outlined above to their deputy but delegation below this level is not permitted.*

Where delegation is granted, this should be communicated by the Chief Officer in writing to the Corporate Governance team (and specifically the Risk Manager).

- 9.14. All **Staff** have a responsibility to co-operate with managers and they are encouraged to identify risks and advise their line managers accordingly. Risk management is the responsibility of all employees. Key responsibilities include:

- Being familiar, and complying with, the Risk Management Policy and supporting procedures and with all other relevant policies and procedures.
- Reporting incidents, accidents and “near misses” following procedures set out in the Incident Reporting Policy and supporting procedures.
- Being aware of their duty under legislation to take reasonable care for personal safety and the safety of all others who may be affected by the business of NHS Devon.
- Complying with NHS Devon rules, regulations, and instructions to protect the health, safety, and welfare of anyone affected by the business of NHS Devon.

10. Monitoring Compliance and Effectiveness

Training

- 10.1. Knowledge of how to manage risk is essential in embedding and maintaining an efficient risk management system. To this end, the Corporate Governance team will work in conjunction with Human Resources (HR) to conduct a Training Needs Analysis (TNA) to ensure that the necessary training and education needs, and methods needed to implement this policy and any supporting procedure(s) are identified and resourced as required. This may include identification of external training providers and / or development of an internal training process. Once the TNA has been undertaken, the Risk Management Training Schedule will be appended to this policy document at **Appendix I**.
- 10.2. The TNA and Risk Management Training Schedule will be reviewed and updated periodically so that it reflects the changing needs of the organisation and / or when there are significant changes in risk management arrangements (including changes to this policy or any of its related processes).

Implementation

- 10.3. NHS Devon Managers, or their designated representatives, will implement this policy by:
- Notifying all staff of its existence. New staff will be informed of this policy as part of their induction.
 - Destroying all superseded paper-based versions of the policy and electronic versions retained in their area.

- Having adequate knowledge of, and / or access to, all relevant legislation in order to ensure that compliance with such legislation is maintained.
- Discussing with staff as part of their regular one-to-ones how they seek to achieve their individual objectives around policy review and maintenance.

Review

- 10.4. NHS Devon will review its performance on risk management through a specific annual internal audit on Risk and Assurance Processes. This annual audit is submitted to the Audit & Risk Committee (ARC) and is reflected in the Head of Internal Audit Opinion (HIAO) on the organisational arrangements for risk management and internal control.
- 10.5. The Chief Executive Officer (CEO) will review compliance with, and effectiveness of, the risk management system of internal control annually in preparing the Annual Governance Statement.
- 10.6. The Audit & Risk Committee (ARC) will review risk through information submitted to it throughout the year. In addition to this, risk reports will be submitted to the NHS Devon Board Assurance Committees as appropriate. These Committees can request information on specific risks to seek further assurance and details of actions being taken to address the risk.
- 10.7. The NHS Devon Risk Appetite will be reviewed annually by the NHS Devon Board.
- 10.8. Any trends resulting from possible policy non-compliance will be raised with staff through appropriate management routes.
- 10.9. Delivery and records of attendance at risk management awareness training will be reviewed annually by the Corporate Governance team.

11. References

Other related policy documents

- 11.1 Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy
- 11.2 Internal Incident Policy
- 11.3 Serious Incidents Policy

Legislation and statutory requirements

- 11.4 Equality Act 2010:
www.legislation.gov.uk/ukpga/2010/15/contents
- 11.5 Freedom of Information Act 2000:
www.legislation.gov.uk/ukpga/2000/36/contents
ico.org.uk/for-organisations/guide-to-freedom-of-information/what-is-the-foi-act/
- 11.6 Health and Safety at Work Act 1974:
www.hse.gov.uk/legislation/hswa.htm

- 11.7 Human Rights Act 1998:
www.legislation.gov.uk/ukpga/1998/42/contents
- 11.8 Management of Health and Safety at Work Regulations 1999:
www.legislation.gov.uk/uksi/1999/3242/contents/made
www.hse.gov.uk/pubns/hsc13.pdf

Best practice recommendations and other key guidance

- 11.9 Caldicott Principles:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942217/Eight_Caldicott_Principles_08.12.20.pdf
- 11.10 Department of Health and Social Care Group Accounting Manual 2021/2022:
www.gov.uk/government/publications/dhsc-group-accounting-manual-2020-to-2021
- 11.11 Good Governance Institute 'The New Good Governance Handbook 2016':
www.good-governance.org.uk/wp-content/uploads/2017/04/The-new-Integrated-Governance-Handbook-2016.pdf
- 11.12 Federation of European Risk Management Associations (FERMA):
www.ferma.eu/about/about-ferma
- 11.13 Financial Reporting Council 'UK Corporate Governance Code 2018':
www.frc.org.uk/directors/corporate-governance-and-stewardship/uk-corporate-governance-code
- 11.14 Health and Safety Executive 'Managing for Health and Safety 2013':
www.hse.gov.uk/pubns/books/hsg65.htm
- 11.15 The Institute of Risk Management 'A Risk Management Standard 2002':
www.theirm.org/media/4709/arms_2002_irm.pdf
- 11.16 International Organisation for Standardisation (ISO) Guide '73:2009 Risk Management' (Revised 2016):
www.iso.org/standard/44651.html
- 11.17 NHS England - Learning from patient safety events:
<https://www.england.nhs.uk/patient-safety/patient-safety-insight/learning-from-patient-safety-events/>
- 11.18 NHS Resolution:
resolution.nhs.uk/
- 11.19 NHS Leadership Academy – The Healthy NHS Board 2013:
www.leadershipacademy.nhs.uk/wp-content/uploads/2013/06/NHSLeadership-HealthyNHSBoard-2013.pdf
- 11.20 HM Government: The Orange Book – Management of Risk – Principles and Concepts:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1154709/HMT_Orange_Book_May_2023.pdf

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APPENDIX A: Glossary of Terms

Terms	Definition
Acceptance	Informed decision to take a particular risk.
Avoidance	Informed decision not to be involved in, or to withdraw from, an activity in order not to be exposed to a particular risk.
Consequence	Outcome of an event affecting objectives.
Control	Measure that is modifying risk. Control include any process, policy, device, practice, or other actions which may modify risk.
Governance	Is a system by which organisations are directed and controlled. It defines accountabilities, relationships and the distribution of rights and responsibilities among those who work with and in the organisation, determines the rules and procedures through which the organisation's objectives are set, and provides the means of attaining those objectives and monitoring performance. This includes the establishing, supporting, and overseeing the risk management framework.
Likelihood	Chance of something happening.
Monitoring	Continual checking, supervising, critically observing, or determining the status in order to identify change from the performance level or expected. Monitoring can be applied to a risk management framework, risk management process, risk, or control.
Residual Risk	Risk remaining after risk treatment.
Resilience	Capacity of an organisation to adapt in a complex and changing environment.
Risk	Is the effect of uncertainty on objectives. Risk is usually expressed in terms of causes, potential events, and their consequences.
Risk Appetite	Amount and type of risk that an organisation is willing to pursue or retain.
Risk Assessment	Overall process of risk identification, risk analysis and risk evaluation.
Risk Management	Is the co-ordinated activities designed and operated to manage risk and exercise internal control within an organisation.
Risk Management Process	Systematic application of management policies, procedures, and practices to the activities of communicating, consulting, establishing context, and identifying, analysing, evaluating, treating, monitoring, and reviewing risk.

Terms	Definition
Risk Matrix	Tool for ranking and displaying risks by defining ranges for likelihood and impact.
Risk Owner	Person with the accountability and to make a decision regarding the management of a risk.
Risk Profile	Description of any set of risks.
Risk Register	Record of information about identified risks. The term 'risk log' is sometimes used instead of 'risk register'.
Risk Reporting	Form of communication intended to inform particular internal or external stakeholders by providing information regarding the current state of risk and its management.
Risk Source	Element(s) which alone or in combination has the intrinsic potential to give rise to risk.
Stakeholder	Person or organisation that can affect, be affected by, or perceive themselves to be affected by a decision or activity.
Treatment	Process to modify risk. Risk treatment can involve: ▪ Avoiding the risk by deciding not to start or continue with the activity that gives rise to the risk; ▪ Taking or increasing the risk in order to pursue an opportunity; ▪ Removing the risk source; ▪ Changing the likelihood; ▪ Changing the impact; ▪ Sharing the risk with another party or parties (including contracts); and ▪ Retaining the risk by informed decision. Risk treatments that deal with negative consequences are sometimes referred to as "risk mitigation", "risk elimination", "risk prevention" and "risk reduction".

APPENDIX B: Inherent and Residual Risk

NB: This is a procedural document separate to the Risk Management Policy and may be amended without requiring the amendment of the policy.

Event	Inherent Risk
Event: Getting into the driving seat of a car, turning on the engine and moving off	Inherent Risk: Damage to vehicles and injury to driver, other road users and pedestrians
<i>Risk Management Action</i>	<i>Residual Risk</i>
Instructions to check mirrors and use indicators appropriately before moving off and to wear a seat belt	Reduced possibility of damage to vehicles and injury to driver, other road users and pedestrians
<i>Further Risk Management Action</i>	<i>Residual Risk</i>
Driver must obtain permission to move off from passenger who will ensure that mirrors are checked, indicator used appropriately, and seat belt is properly worn	Further reduced of the possibility of damage to vehicles and injury to driver, other road users and pedestrians
<i>Further Risk Management Action</i>	<i>Residual Risk</i>
In addition to the two measures above the car is immobilised, that is mechanically unable to move, until such a time as the passenger is satisfied that all safety precautions have been undertaken. The passenger will then flick a switch which will disengage the immobiliser	Even less possibility of damage to vehicles and injury to driver, other road users and pedestrians

APPENDIX C: Risks and Issues

NB: This is a procedural document separate to the Risk Management Policy and may be amended without requiring the amendment of the policy.

The table below summarises the key differences between 'risks' and 'issues':

RISK	ISSUE
An event that may occur	An event that is currently happening or has happened
Described in the future tense	Described in the present tense
Has a material impact on objectives ¹	Has a material impact on objectives ¹
Can be beneficial or harmful / positive or negative	Issue itself is always negative <i>(however, the outcome of solving an issue may still be beneficial, albeit it may take more time and effort)</i>
Can be mitigated against to prevent the risk from becoming an issue	Prevention is not possible ; action is needed to mitigate its impact or to resolve the issue
<u>Management Techniques:</u> Reduce risk; transfer the risk; manage the risk; contingency plan; accept risk or terminate risk	<u>Management Techniques:</u> Problem solving; decision-making

¹ *Material Impact on Objectives – this can be in terms of programme / project objectives, team objectives, directorate objectives, corporate objectives, or strategic objectives.*

APPENDIX D: Risk Management Principles

NB: This is a procedural document separate to the Risk Management Policy and may be amended without requiring the amendment of the policy.

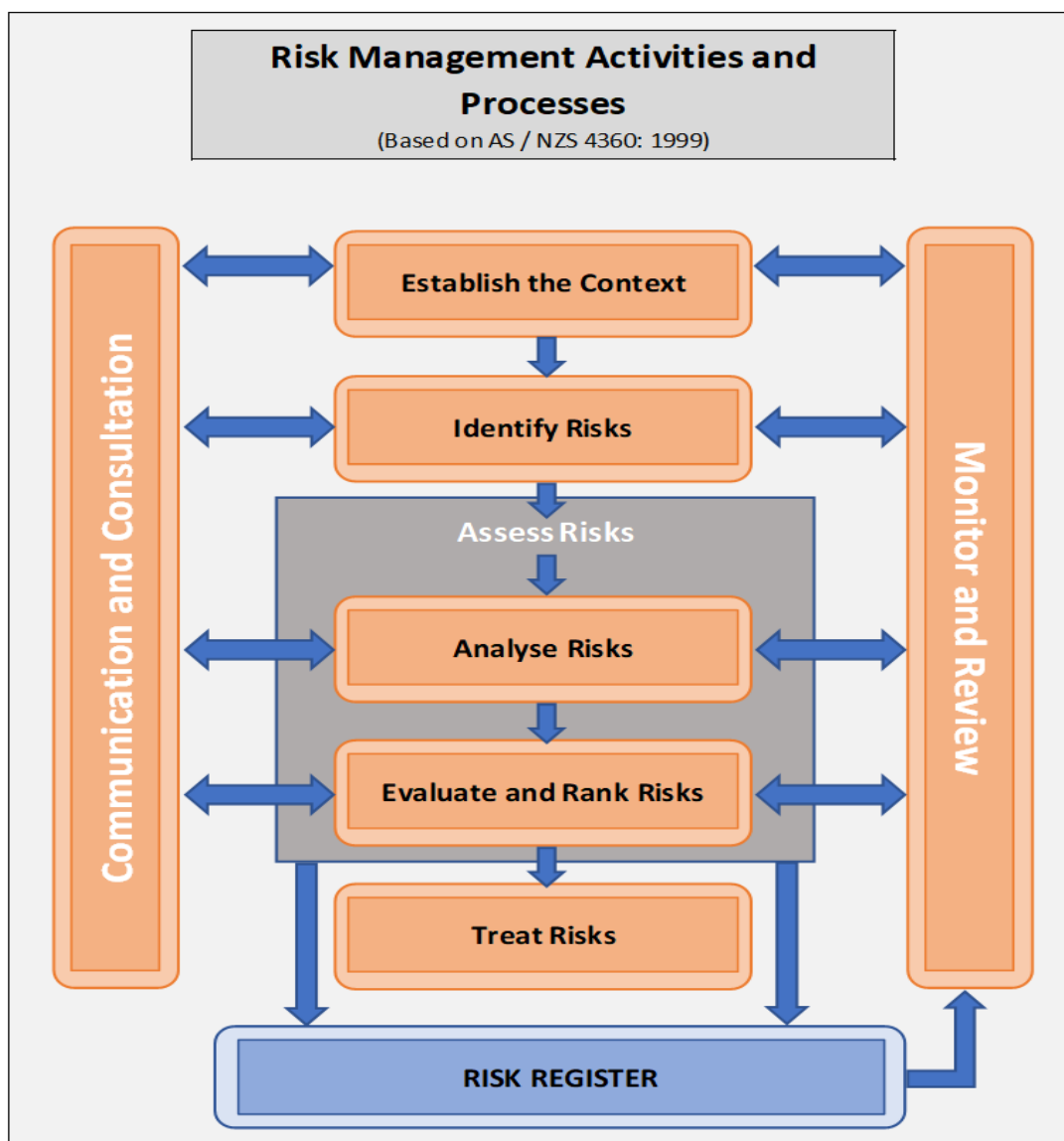
Principle	Principle Description
Proactive	Risk management will be used proactively to manage key risks and used as an active management tool. This helps to ensure that risks are considered, and future actions planned in a visible, consistent, and controlled manner. Risk management will form part of plans with work on risk management being front loaded.
Aligns with Objectives	Risk management will be focused on the key uncertainties which may impact on the achievement of one or more objectives. Risks will be identified and given the appropriate priority for action.
Fits the Context	The risk management approach will be designed to fit the internal and external environment in which NHS Devon operates and so that time, effort, resources, and energy will be used in the appropriate way.
Engages Partners and Stakeholders	Risk management will engage with the right partners and stakeholders in the Integrated Care System (ICS) and deal with different perceptions of risk. Appropriate risks will be identified early and dealt with at the right level.
Promotes, Guides and Supports a Clear and Consistent Approach	Risk management will provide clear and coherent guidance to staff and key stakeholders so everyone can see how NHS Devon identifies, assesses, and controls key risks, and is consistent across the organisation. This enables people to compare results with plans and enable better decision making about how resources will be deployed. It also provides clear guidance on roles within risk management and explains responsibilities and accountabilities.
Informs Decision Making	Risk management will be linked to and inform decision making across the organisation. This enables important decisions to be made with explicit consideration of the impact of risks and the status of risk management. This also helps to safeguard the decision making process to allow for good decision making.
Facilitates Continual Improvement	Risk management will be used to help NHS Devon to improve by proactively managing risks and increasing organisational risk maturity. The organisation will use its experience of risk management to continually improve through 'lessons learned' and best use of the resources available.
Creates a Supportive Culture	NHS Devon will create a culture that recognises uncertainty and supports considered risk taking. The organisation recognises that zero risk taking is neither possible nor desirable.
Achieves Measurable Value	Risk management will help to achieve measurable value through the effective identification and management of key risks. In general, it costs less to anticipate and manage a risk

than it does to recover from an issue.

APPENDIX E: Risk Activities and Processes

NB: This is a procedural document separate to the Risk Management Policy and may be amended without requiring the amendment of the policy.

The following diagram sets out NHS Devon's approach to risk management:



APPENDIX F – Model Risk Matrix

NB: This is a procedural document separate to the Risk Management Policy and may be amended without requiring the amendment of the policy.

Instructions for use:

1. Define the risk(s) explicitly in terms of the adverse impact(s) that might arise from the risk.
2. Use **Table 1** to determine the impact score (I) for the potential adverse outcome(s) relevant to the risk being evaluated. Choose the most appropriate domain for the identified risk from the left hand side of the table then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.
3. Use **Table 2** to determine the likelihood score (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability, then use the probability descriptions to determine the most appropriate score.
4. Calculate the risk score by multiplying the impact by the likelihood: $I \text{ (impact)} \times L \text{ (Likelihood)} = R \text{ (risk score)}$ - **See Table 3**.
5. Identify the level at which the risk will be managed in the organisation, assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings, the risk ratings and the organisations' risk management system. Include the risk in the organisations' risk register at the appropriate level.

Table 1 – Impact (Consequences) - Scores

Impact (Consequence) Score (Severity Levels) and Examples of Descriptors					
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Impact on the Safety of Patients, Staff or Public (Physical / Psychological Harm)	Minimal injury requiring no / minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR / agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity / disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients

Impact (Consequence) Score (Severity Levels) and Examples of Descriptors					
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Quality of Service	Peripheral element of treatment or service suboptimal Informal complaint	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints / independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment / service Gross failure of patient safety if findings not acted on Inquest / ombudsman inquiry Gross failure to meet national standards
Human Resources / Organisational Development / Staffing / Competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective / service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory / key training	Uncertain delivery of key objective / service due to lack of staff. Unsafe staffing level or competence (>5 days). Loss of key staff. Very low staff morale. No staff attending mandatory / key training	Non-delivery of key objective / service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training / key training on an ongoing basis

Impact (Consequence) Score (Severity Levels) and Examples of Descriptors					
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Statutory Duty / Inspections	No or minimal impact or breach of guidance / statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations / improvement notice	Enforcement action. Multiple breaches in statutory duty. Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty. Prosecution Complete systems change required. Zero performance rating. Severely critical report
Adverse Publicity / Reputation	Rumours Potential for public concern	Local media coverage – short- term reduction in public confidence	Local media coverage –long-term reduction in public confidence	National media coverage with service well below reasonable public expectation <3 days	National media coverage with service well below reasonable public expectation >3 days MPs concerned (questions in the House).
Business Objectives / Projects	Insignificant cost increase / schedule slippage	Elements of public expectation not being met. <5 per cent over project budget Schedule slippage <5 per cent	5–10 per cent over project budget Schedule slippage 5–10 per cent over	11–25 per cent over project budget Schedule slippage 11–25 per cent over Key objectives not met	Incident leading to >25 per cent over project budget Schedule slippage >25 per cent over Key objectives not met

Impact (Consequence) Score (Severity Levels) and Examples of Descriptors					
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Finance, Including Claims Service / Business Interruption Environmental Impact	Small loss Risk of claim remote Business loss / interruption of >1 hour Minimal or no impact on the environment	Loss of 0.1 – 0.25 per cent of budget Claim less than £10,000 Business loss / interruption of >8 hours Minor impact on environment	Loss of 0.26 – 0.5 per cent of budget Claim(s) between £10,000 and £100,000 Business loss / interruption of >1 day Moderate impact on environment	Uncertain delivery of key objective / Loss of 0.6 – 1.0 per cent of budget Claim(s) between £100,001 and £1 million Purchasers failing to pay on time Business loss / interruption of >1 week Major impact on environment	Non-delivery of key objective Loss of >1 per cent of Budget. Failure to meet specification / slippage. Payment by results Claim(s) >£1 million Permanent loss of service or facility Catastrophic impact on environment

Table 2 - Likelihood Scores (L)

What is the likelihood of the risk occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood Score	1	2	3	4	5
Description	Rare	Unlikely	Possible	Likely	Almost Certain
Frequency How often might it / does it happen	This will probably never happen / recur	Do not expect it to happen / recur but it is possible it may do so	Might happen / recur occasionally	Will probably happen / recur but it is not a persisting issue	Will undoubtedly happen / recur, possibly frequently

Table 3 - Risk Scoring = Impact x Likelihood (I x L)

Impact / Consequence	Likelihood				
	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
5 - Catastrophic	5	10	15	20	25
4 - Major	4	8	12	16	20
3 - Moderate	3	6	9	12	15
2 - Minor	2	4	6	8	10
1 - Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned as follows:

	1 to 6	Low Risk
	8 to 10	Moderate Risk
	12	High Risk
	15 to 25	Extreme Risk

APPENDIX G:

Risk Action and Reporting Requirements

NB: This is a procedural document separate to the Risk Management Policy and may be amended without requiring the amendment of the policy.

Score	Risk	Action	Reporting Requirements
1 to 6	Low	Tolerate / Managed Through Normal Control Measures	- Report to Line Manager. - Enter onto the local Team / Directorate Risk Register (TRR / DRR).
8 to 10	Moderate	Consider Treat / Review Control Measures	
12	High	Treatment Plans to be Developed, Implemented, and Monitored	- Entered onto the Corporate Risk Register (CRR) in liaison with Corporate Governance team. - Included in Corporate Governance team's bi-monthly report to the Executive Committee. - Oversight by the Executive Committee through bi-monthly report from Corporate Governance team.
15 to 25	Extreme	Immediate Action Required. Treatment Plans to be Developed, Implemented, and Monitored	- Report immediately to Corporate Governance team. - Entered on to the Risk Register in liaison with the Corporate Governance team. - Included in the Corporate Governance team's Board Assurance Framework (BAF) reporting bi-monthly to the Executive Committee. - Reported in Corporate Governance team's Board Assurance Framework (BAF) reporting to each meeting of the NHS Devon Board and Committee-specific risks reported via Board Assurance Committees where appropriate.

In addition the NHS Devon Board receives the Board Assurance Framework (BAF) at each meeting with:

- Details of all of the strategic risks, their control measures, and assurances.
- Changes to the strategic risks since the previous report, including scoring.
- Current review narratives for each of the strategic risks.
- The level of assurance on each of the NHS Devon corporate objectives or Statutory Purposes in light of the risks which may impact on those objectives.
- Changes in the totality of risk facing NHS Devon (the total of the strategic level risks) and how this may have changed in the previous twelve months.

This process, its robustness and its deployment is scrutinised by the NHS Devon Audit & Risk Committee (ARC). The Risk Management System is subject to annual review by the Internal Auditors and a report is received by the Audit & Risk Committee (ARC).

APPENDIX H – Risk Appetite

NB: This is a procedural document separate to the Risk Management Policy and may be amended without requiring the amendment of the policy.

Risk appetite specifies the overall risk levels NHS Devon is willing to accept while operating in full compliance with regulatory and legal requirements. In addition, it establishes principles for risk taking to ensure that the totality of risk remains within the defined risk appetite boundaries.

The 'Risk Appetite' will be reviewed and agreed at least annually by the NHS Devon Board.

The 'Risk Appetite' is framed around the priorities set out in the Risk Management Policy and the statement was agreed by the NHS Devon Board in [Month] [Year]. The statement is based on the premise that the lower the risk appetite, the less NHS Devon is willing to accept in terms of risk and consequently the higher levels of controls that must be in place to manage the risk.

UPDATE TO BE PROVIDED FOR 2023/24 FINANCIAL YEAR.

Priority	Board Assurance Committee	Risk Appetite	Maximum Acceptable Target Score
<u>EXAMPLE:</u>			
Patient Experience	Quality & Patient Experience Committee	LOW	6
- We will accept risks to the experience of people using services, their relatives and carer if they are consistent with the ultimate goal of achieving patient safety and quality improvements. - We will only accept service redesign and divest risks in the services we are commissioned to deliver if these are assessed as safe and effective, whilst high quality care is maintained.			

APPENDIX I: Risk Management Training Schedule

NB: This is a procedural document separate to the Risk Management Policy and may be amended without requiring the amendment of the policy.

To be included once the Risk Management Training Needs Analysis (TNA) has been completed.

Conflicts of Interest Policy

NHS Devon



Version	0.1
Policy Sponsor	Select Policy Sponsor
Policy Lead	Company Secretary
Approved by	NHS Devon Board
Approved on	Select a date
To be reviewed by	Select a date

Document change history (to add rows, copy and paste)		
Date	Change	Comments
Select a date	New Policy	
Select a date	Select	

Equality, diversity and inclusion statement

NHS Devon is committed to the promotion of equal opportunities, addressing health inequalities and fostering of good relations between people protected under the terms of the Equality Act 2010, the Health and Social Care Act 2012 and Human Rights legislation. We are equally committed to the elimination of unlawful discrimination, harassment and victimisation. To demonstrate this commitment, we develop, promote and maintain policies, strategies and operating procedures. Every effort is made to ensure that patients, employees, contractors or visitors do not experience discrimination; either directly or indirectly, because of their vulnerability; disadvantage; age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion and belief; sex (gender) or sexual orientation.

All staff must comply with this policy. Compliance must reflect our organisational commitment to and policy on, equality, diversity and inclusion. In addition, each manager and member of staff involved in implementing this policy must give due regard to the needs of those protected under law.

If you, or any other groups, believe you are discriminated against under the terms of the Equality Act, the Health and Social Care Act 2012 or Human Rights legislation by anything contained in this document; or you need this document in an alternative format, for example, large print, Braille, Easy read or other languages; please contact our Patient Advice and Complaints Team (PACT):

Tel: 0300 123 1672
Email: pals.devon@nhs.net

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4 – NHS Devon Conflicts of Interest Policy

1. Introduction

- 1.1 All NHS Devon Board members and staff have a duty to ensure that all their dealings are conducted to the highest standards of integrity and that NHS monies are used effectively, efficiently and in the best interests of patients.
- 1.2 Partnerships with other organisations have many benefits and should help ensure that public money is spent well, but there is a risk that conflicts of interest may arise. NHS Devon must ensure the integrity of the processes that it follows when making decisions for its communities, so that they are taken without the influence (or perceived influence) of external or private interests.
- 1.3 NHS Devon Board members and staff, as guardians of public money, need to have regard to the Good Governance Standards of Public Services and holders of public office need to uphold the Seven Principles of Public Life, often referred to as the Nolan Principles. (Appendix A).
- 1.4 Providing best value for taxpayers and ensuring that decisions are taken transparently and clearly (accountability to the public, communities and patients) are also key principles in the NHS Constitution.
- 1.5 There are also specific statutory requirements for managing conflicts of interest under the National Health Service Act 2006 (as inserted by the Health and Care Act 2022) and under the NHS (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 (and related substantive guidance).

2. Purpose and objectives

- 2.1. This policy will support NHS Devon in managing conflicts of interest effectively as it introduces consistent principles and rules for the management of interests.
- 2.2. This policy should be read in conjunction with the NHS Devon Standards of Business Conduct Policy.
- 2.3 This policy is supported by the Declaration of Interest, including Gifts, Hospitality and Sponsorship Standard Operating Procedure (SOP) owned by the Corporate Governance Team.

3. Scope

- 3.1 This policy applies to all NHS Devon Board members and staff (including interim and temporary staff, and contractors and seconded staff).
- 3.2 This policy also applies to those individuals who serve on Committees of the Board or who are involved in any NHS Devon decision-making forums but who are not NHS Devon Board members or staff.

4. Definitions

- 4.1 A conflict of interest (COI) is defined by NHS England in its “Managing Conflicts of Interest in the NHS” guidance (2017) as:

“a set of circumstances by which a reasonable person would consider that an individual’s ability to exercise judgement or act, in the context of delivering, commissioning or assuring taxpayer funded health and care services, is or could be, or is seen to be or could be seen to be, impaired or influenced by his or her involvement in another role or relationship.”

- 4.2 Interests fall into one of the following four categories:

4.2.1 Financial interests

Where an individual may get direct financial benefit. This may be a financial gain, or avoidance of a loss from the consequences of a decision they are involved in making. For example:

- A director, including a non-executive director, or senior employee in a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations.
- A shareholder (or similar owner interests), a partner or owner of a private or not-for-profit company, business, partnership or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations.
- A management consultant for a provider in secondary employment.

4.2.2 Non-financial professional interests

Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career. For example:

- An advocate for a particular group of patients.
- A GP with special interests.
- A member of a particular specialist professional body (although routine GP membership of the RCGP, BMA or a medical defence organisation would not usually by itself amount to an interest which needs to be declared).
- An advisor for Care Quality Commission (CQC) or National Institute for Health and Care Excellence (NICE).

4.2.3 Non-financial personal interests

Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career. This could include where an individual is a member of a voluntary sector board or has a position of authority within a voluntary sector organisation or is a member of a lobbying or pressure group with an interest in health and care. For example:

- A voluntary sector champion for a provider.
- A volunteer for a provider.
- A member of a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation.
- Suffering from a particular condition requiring individually funded treatment.
- A member of a lobby or pressure group with an interest in health.

4.2.4 Indirect interests

Where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making. A common sense approach should be applied to the term “close association”. Such an association might arise, depending on the circumstances, through relationships with close family members and relatives, close friends and associates, and business partners. For example:

- Spouse / Partner.
- Close relative e.g., parent, grandparent, child, grandchild or sibling.
- Close friend.
- Business partner.

4.3 A conflict of interest may be:

- **Actual** – there is a material conflict between one or more interests.
- **Potential** – there is the possibility of a material conflict between one or more interests in the future.
- **Perceived** – there is a possibility that a reasonably well-informed person could properly have a reasonable belief that an actual conflict of interest exists, even where that is not the case in fact.

4.4 Staff may hold interests for which they cannot see a potential conflict, but others may see the situation differently. The perception of wrongdoing, impaired judgement or undue influence can be as damaging as it actually occurring. All interests should be declared where there is a risk of perceived improper conduct.

- 4.5 The following table provides other key definitions in respect of Conflicts of Interests:

Terms	Definition
Decision Making Staff	For the purposes of this Policy, NHS Devon follows guidance from NHS England and includes all Board members together with all staff who are graded at 8D and above.
Breaches	There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of deliberate actions. For the purposes of this policy these instances are referred to as “breaches”.
Gifts	A gift is defined as any item of cash or goods, or any service that is provided for personal benefit, free of charge or at less than its commercial value.
Hospitality	For the purposes of this policy hospitality means offers of meals, refreshments, travel, accommodation, and other expenses in relation to attendance at meetings, conferences, education and training events.
Sponsorship	For the purposes of this Policy sponsorship is funding from an external source, including funding of all or part of the cost of a member of staff, NHS research, staff training, pharmaceuticals, equipment, meeting rooms, costs associated with meetings, meals, gifts, hospitality, hotel and transport costs, provision of free services (including printing costs) and buildings or premises.
Joint working	Where, for the benefit of patients, organisations pool skills, experience and/or resources for the joint development and implementation of patient-centred projects and share a commitment to successful delivery.

5. What should be declared

- 5.1 The following provides an overview of the types of interest that should be declared. This list is not exhaustive and if staff have any queries, advice is available from the Governance team via d-icb.governance@nhs.net

Loyalty interests

- 5.2 Loyalty interests should be declared by staff involved in decision making where they:
- Hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be

seen to influence decisions they take in their NHS role.

- Sit on advisory groups or other paid or unpaid decision-making forums that can influence how an organisation spends taxpayers' money.
- Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners.
- Are aware that their organisation does business with an organisation in which close family members and relatives, close friends and associates, and business partners have decision making responsibilities.

Gifts

5.3 Staff should not accept gifts that may affect, or be seen to affect, their professional judgement:

- Gifts from suppliers or contractors:
 - Gifts offered directly to individuals from suppliers or contractors doing business or likely to do business with the organisation should be declined, whatever their value, and should be declared.
 - Gifts offered to the organisation from suppliers or contractors doing business or likely to do business with the organisation may be accepted on a case-by-case basis to be offered as prizes or gifts to staff as part of a lottery and must be approved by the relevant Executive Director and Director of Governance and should be declared.
 - Low cost branded promotional aids such as pens or post-it notes may, however, be accepted where they are under the value of £6 in total and need not be declared. The £6 value has been selected with reference to existing industry guidance issued by the ABPI: <https://www.pmcpcpa.org.uk/media/3406/2021-abpi-code-of-practice.pdf>
- Gifts from other sources (for example patients, families, service users):
 - Any personal gift of cash or cash equivalents (for example: vouchers, tokens or offers of remuneration to attend meetings while working for or representing NHS Devon), whatever their value, should always be declined and should be declared.
 - Staff should not ask for any gifts.
 - Modest gifts under a value up to £50 may be accepted and do not need to be declared.
 - Gifts valued at over £50 should be treated with caution and only accepted on behalf of NHS Devon and not in a personal capacity and should be declared by staff. Prior written approval must be obtained from the appropriate line manager following due consideration in cases where it is deemed appropriate to accept a gift of this nature.
 - A common-sense approach should be applied to the valuing of gifts (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).
 - Multiple gifts from the same source over a 12-month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds £50.

Hospitality

- 5.4 Staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement.
- 5.5 Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event.
- 5.6 Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors. This hospitality can be accepted if modest and reasonable, but approval from an Executive Director must be obtained and a declaration made.

Meals and refreshments

- 5.7 Under a value of £25 may be accepted and need not be declared.
- 5.8 Of a value between £25 and £75 may be accepted and must be declared. (The £75 value has been selected with reference to existing industry guidance issued by the ABPI – Code of Practice, Clause 10.)
- 5.9 Over a value of £75 should be refused unless (in exceptional circumstances) approval is given in advance by an Executive Director. A clear reason should be recorded on the Gifts and Hospitality Register as to why it was permissible to accept.
- 5.10 A common-sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or a reasonable estimate).

Travel and accommodation

- 5.11 Modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared.
- 5.12 Offers which go beyond modest or are of a type that the organisation itself might not usually offer, need approval in advance by an Executive Director, should only be accepted in exceptional circumstances, and must be declared. A non-exhaustive list of examples includes officers of business or first class travel and accommodation (including domestic travel) and offers of foreign travel and accommodation.

Outside employment

- 5.13 Staff should declare any existing outside employment (including directorships, self-employment, contracted engagements and other similarly remunerated situations) to their line manager on appointment and any new outside employment when it arises.
- 5.14 Board members should disclose any outside employment, along with any other conflicts of interest, as requested during the recruitment process and any new outside employment when it arises.

- 5.15 Potential conflicts of interest with employment include:
- Employment with another NHS body;
 - Employment with another organisation which might be in a position to supply goods or services to the groups;
 - Self-employment, including consultancy and/or private practice, in a capacity which might conflict with the work of NHS Devon or which might be in a position to supply goods or services to NHS Devon;
 - Directorship of a GP Federation; and
 - Working whilst on sick leave.
- 5.16 Where a risk of conflict of interest arises, the general management actions outlined in this policy should be considered and applied to mitigate risks.
- 5.17 Where contracts of employment or terms and conditions of engagement permit, staff may be required to seek prior approval from the organisation to engage in outside employment.
- 5.18 The organisation may also have legitimate reasons within employment law for knowing about outside employment of staff, even when this does not give rise to risk of a conflict.

Shareholdings and other ownership issues

- 5.19 Staff should declare, as a minimum, any shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with the organisation.
- 5.20 Where shareholdings or other ownership interests are declared and give rise to risk of conflicts of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.
- 5.21 There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts.

Patents

- 5.22 Staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are ongoing, which are, or might be reasonably expected to be, related to items to be procured or used by the organisation.
- 5.23 Staff should seek prior permission from the organisation before, for example, entering into any agreement with bodies regarding product development, research, and work on pathways, where this impacts on the organisation's own time, or uses its equipment, resources or intellectual property.
- 5.24 Where holding of patents and other intellectual property rights gives rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

- 5.25 The Governance team will keep a register to record all patents / intellectual property. Gains from external work benefitting NHS Devon can give rise to conflicts of interest and actions to take to mitigate the risks should be agreed with the Director of Governance.

Donations

- 5.26 Donations made by suppliers or bodies seeking to do business with the organisation should be treated with caution and not routinely accepted. In exceptional circumstances they may be accepted but should always be declared. A clear reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value.
- 5.27 Staff should not actively solicit charitable donations unless this is a prescribed or expected part of their duties for the organisation.
- 5.28 Staff must obtain permission from the organisation if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign.
- 5.29 Donations, when received, should be made to a specific charitable fund (never to an individual) and a receipt should be issued.
- 5.30 Staff wishing to make a donation to a charitable fund in lieu of receiving a professional fee may do so, subject to ensuring that they take personal responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.

Clinical private practice

- 5.31 Clinical staff should declare all private practice on appointment, and / or any new private practice when it arises including:
- Where they practice (name of private facility);
 - What they practice (specialty, major procedures);
 - When they practice (identified sessions or time commitment);
 - Clinical staff should (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed);
 - Seek prior approval of their organisation before taking up private practice;
 - Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work;
 - Not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority guidelines:
assets.publishing.service.gov.uk/media/542c1543e5274a1314000c56/Non-Divestment_Order_amended.pdf

6. Declarations – submission, review, management and publication

6.1 Making a declaration of interest

6.1.1 All staff should identify and declare interests at the earliest opportunity (and in any event within 28 calendar days of the circumstances outlined below). If staff have no interests to declare, then a nil return must be made.

6.1.2 Declarations (including nil returns) should be made:

- On appointment to the organisation.
- When staff move to a new role or their responsibilities change significantly.
- At the beginning of a new project / piece of work / procurement.
- As soon as circumstances change and new interests arise.
- At a meeting should interests staff hold are be relevant to the matters in discussion. (See Section 8)
- At an annual review of interests each April.

6.1.3 Declarations are uploaded and managed by individuals on an online web-portal at <https://nhsdevonibc.mydeclarations.co.uk/home>, which can also be accessed via a desktop icon. Help and advice on completing and uploading declarations is available from the Governance team at: d-icb.governance@nhs.net.

6.2 Management Actions

6.2.1 Staff who declare material interests should discuss them with their line manager or the person(s) they are working to and agree a management action plan for mitigation of the risks. The general management actions that could be applied include:

- Restricting staff involvement in associated discussions and excluding them from decision making.
- Removing staff from the whole decision-making process.
- Removing staff responsibility for an entire area of work.
- Removing staff from their role altogether if they are unable to operate effectively in it because the conflict is so significant.

6.2.2 Each case will be different and context-specific, and the Governance team will clarify the circumstances and issues with the individuals involved. Staff should maintain a written audit trail of information considered and actions taken. Advice on management actions can be obtained from the Governance team. In the case of disputes about the most appropriate management action, the individual or their line manager should refer to the Conflicts of Interest Guardian or the Director of Governance.

6.3 Review of declarations of interest

- 6.3.1 When a Declaration of Interest(s) (DOI) is completed, the Governance team will check that sufficient information has been provided in order to complete the register and that it has been approved by the line manager of the declarer. The team will request clarification from the declarer if needed.
- 6.3.2 The Governance team will check on materiality of the declaration(s) and ensure there is a suitable management action plan for each material declaration. If any issues arise that are complex or unclear, the Governance team will refer to the Conflicts of Interest Guardian for advice or a decision.

6.4 Publication of registers

- 6.4.1 NHS Devon maintains the following registers associated with declarations:
- Declarations of Interest(s)
 - Gifts and Hospitality
 - Procurement Decisions
- 6.4.2 All declared interests that are material will be available on the appropriate register.
- 6.4.3 NHS Devon will:
- Publish the interests declared by decision making staff in the appropriate Register on the NHS Devon website.
 - Update these Registers at least annually.

6.5 Requests for non-publication of interests

- 6.5.1 If decision making staff have grounds for believing that publication of their interests should not take place then they should contact the Governance team to explain why. In exceptional circumstances, for instance where the publication of information might put a member of staff at risk of harm, information may be withheld or redacted on public registers.
- 6.5.2 All requests for non-publication will be considered by the Conflicts of Interest Guardian and the Director of Governance. Non-publication of interests will only be agreed as the exception and information will not be withheld or redacted merely because of a personal preference. A confidential, un-redacted version of the register(s) will be kept by the Governance team.

6.6 Leavers

- 6.6.1 Register entries for leavers will be removed from the live register and stored separately for a minimum of six years.

6.7 Expired Interests

- 6.7.1 After expiry, an interest will remain on the register for a minimum of six months. After six months, the Governance team will remove the interest from the live register and a private record of historic interests will be retained for a minimum of six years.

7 Management of interests in meetings

- 7.1 NHS Devon uses a variety of different groups to make key strategic decisions about things such as:
- Approving strategy and long term plans.
 - Entering into (or renewing) large scale contracts.
 - Making procurement decisions.
 - Selection of equipment and services.
- 7.2 The interests of those who are involved in these groups should be well known so that they can be managed effectively. The principles outlined in this policy apply to all committees and groups that have the power to make decisions on behalf of NHS Devon, such as those in relation to the spending of taxpayers' money, procurements, purchasing of goods, medicines, medical devices or equipment, formulary decisions and contract monitoring.
- 7.3 Committees and other decision-making groups should adopt the following principles:
- Chairs should consider any known interests of members in advance, and begin each meeting by asking for declarations of relevant material interests
 - Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise
 - Any new interests identified should be added to the organisation's register(s)
 - The Vice-Chair (or other non-conflicted member) should chair all or part of the meeting if the Chair has an interest that may prejudice their judgement.
- 7.4 The default response should not always be to exclude members with interests. Actions to mitigate conflicts of interest should be proportionate and should seek to preserve the spirit of collective decision-making wherever possible. Mitigation should take account of a range of factors including the perception of any conflicts and how a decision may be received if an individual with a perceived conflict is involved in that decision, and the risks and benefits of having a particular individual involved in making the decision. Potential options in relation to mitigation could include:
- including a conflicted person in the discussion but not in decision-making
 - excluding a conflicted person from both the discussion and the decision-making
 - including a conflicted person in the discussion and decision where there is a clear benefit to them being included in both – however, including the conflicted person in the actual decision should be done after careful consideration of the risk and with proper mitigation in place. The rationale for inclusion should also be properly documented and included in minutes
 - excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source.

- 7.5 The Chair of a meeting or committee has ultimate responsibility for deciding whether there is a conflict of interest and for taking the appropriate course of action to manage the conflict of interest.
- 7.6 If the Chair of a meeting has a conflict of interest, the Vice-Chair is responsible for deciding the appropriate course of action to manage the conflict of interest. If the Vice-Chair is also conflicted then the remaining non-conflicted voting members of the meeting should agree how to manage the conflict(s).
- 7.7 In making such decisions, the Chair, Vice-Chair or remaining non-conflicted members may wish to consult with the Conflicts of Interest Guardian or Director of Governance.
- 7.8 It is imperative that NHS Devon ensures complete transparency in its decision-making processes through robust record keeping. If any conflicts of interest are declared or otherwise arise at a meeting the Chair must ensure that the following information is recorded in the minutes:
- Who has the interest;
 - The nature of the interest and why it gives cause to a conflict;
 - The items on the agenda to which the items relate;
 - How the conflict was agreed to be managed; and
 - Evidence that the conflict was managed as intended.
- 7.9 The meeting administrator will then ensure that this information is provided to the Governance team to ensure the accuracy of records.

8 Management of interests during recruitment

- 8.1 Potential conflicts of interest for Board members, Executives and roles at Band 8d and above, should be considered during the recruitment process. Following shortlisting for interview, candidates will be asked to complete a Declaration of Interest so that any conflicts can be considered prior to and during interview. NHS Devon will need to consider whether the individual (or anyone they have a close association with) could benefit from any decision NHS Devon might make, which may cause an individual to be excluded from being appointed to the relevant role. These will have to be considered on a case-by-case basis.
- 8.2 Key considerations when appointing Board members or Executives include:
- Whether Conflicts of Interest should exclude individuals from appointment.
 - Assessing materiality of interests.
 - Determining the extent of the interest.

9 Procurement and contract monitoring

- 9.1 Procurements should be managed in an open and transparent manner, compliant with procurement and other relevant law, to ensure there is no discrimination against or in favour of any provider. Accordingly, the management of interests is required.
- 9.2 The management of interests in respect of procurement and contract monitoring is undertaken by the Procurement Team and is governed by the Procurement Policy for Clinical Healthcare Services, Non-Clinical Services and for all Supplies.

10 Working with industry and sponsorship

- 10.1 The Department of Health and Social Care recognises that joint working with the pharmaceutical industry or other third-party organisations, where the benefits to patient care and the difference it could make to their health and wellbeing are clearly advantageous, should be considered by NHS organisations and their employees.
- 10.2 NHS organisations are required to consider fully the impact of any sponsorship or joint working arrangements on wider healthcare services and the risks of conflicts of interest.
- 10.3 NHS Devon's approach to interacting with third party organisations and the potential conflicts of interest which may arise is set out in the Standards of Business Conduct Policy.

11 Raising concerns and breaches

11.1 Identifying and reporting breaches

- 11.1 There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate actions of staff or other organisations. For the purposes of this policy these situations are referred to as "breaches". Failing to respond to a request for information in relation to this policy, including a request to submit a declaration, will also be considered a breach of this policy.
- 11.1.2 Staff who are aware of actual breaches of this policy, or who are concerned that there has been, or may be, a breach should report these concerns to the Governance team.
- 11.1.2 To ensure that interests are effectively managed staff are encouraged to speak up about actual or suspected breaches. Every individual has a responsibility to do this. For further information about how concerns should be

raised see the Freedom to Speak Up Policy.

11.1.3 Each reported breach will be investigated according to its own specific facts and merits and relevant parties will be given the opportunity to explain and clarify any relevant circumstances. Investigations will be organised by the Governance team and, following investigation, the Conflicts of Interest Guardian and Director of Governance will:

- Decide if there has been or is potential for a breach and if so what the severity of the breach is.
- Assess whether further action is required in response; this is likely to involve any staff member involved and their line manager, as a minimum.
- Consider who else inside and outside the organisation should be made aware.
- Take appropriate action.

11.2 Taking action in response to breaches

11.2.1 Action taken in response to breaches of this policy will be in accordance with the disciplinary procedures of NHS Devon and could involve the organisational leads for staff support (for example Human Resources), fraud (for example Local Counter Fraud Specialists), or members of the Senior Leadership Team or Senior Executive Teams.

11.2.2 Breaches could require action in one or more of the following ways:

- Clarification or strengthening of existing policy, process and procedures;
- Consideration as to whether HR, employment law or contractual action should be taken against staff or others;
- Consideration being given to escalation to external parties. This might include referral of matters to external auditors, NHS Counter Fraud Authority, the Police, statutory health bodies (such as NHS England and Improvement or the CQC), and/or health professional regulatory bodies.

11.2.3 Inappropriate or ineffective management of interests can have serious implications for the organisation and staff. There will be occasions where it is necessary to consider the imposition of sanctions for breaches.

11.2.4 Sanctions should not be considered until the circumstances surrounding breaches have been properly investigated. However, if such investigations establish wrong-doing or fault then the organisation can and will consider the range of possible sanctions that are available, in a manner which is proportionate to the breach. This includes:

- Employment law action against staff, which might include;
 - informal action (such as reprimand or signposting to training and / or guidance).
 - formal disciplinary action (such as formal warning, the requirement for additional training, re-arrangement of duties, re-deployment, demotion, or dismissal).

- Reporting incidents to the external parties described above for them to consider what further investigations or sanctions there might be.
- Contractual action, such as exercise of remedies or sanctions against the body or staff which caused the breach.
- Legal action, such as investigation and prosecution under fraud, bribery and corruption legislation.

11.2.5 The LCFS works with key colleagues and stakeholders to promote anti-fraud work and effectively respond to system weaknesses and investigate allegations of fraud and corruption. This will include the undertaking of risk assessments to identify fraud, bribery, and corruption risks at NHS Devon.

11.3 Learning and transparency concerning breaches

11.3.1 Reports on breaches, the impact of these, and action taken will be reported to the Senior Executive Team on a quarterly basis and to each meeting of the Audit & Risk Committee to ensure lessons are learned and the management of interests can continually improve.

12 Accountabilities, Duties and Responsibilities

Chief Executive Officer	The Chief Executive Officer has ultimate accountability for the strategic direction and operational management of NHS Devon, including compliance with all legal, statutory and policy requirements.
Policy Sponsor	The Policy Sponsor is responsible for ensuring that this policy is appropriate for consideration for approval.
Policy Lead / Author	It is the responsibility of the Policy Lead / author to: • ensure as far as possible that the policy is in line with Department of Health and Social Care guidance, legal requirements and advice from clinical bodies; • to complete a QEIA and Implementation Plan where required • undertake a fair and proportionate consultation period with the relevant stakeholders as part of the document's development • to ensure that the policy is in alignment with NHS Devon's strategy and values • ensure that the policy is developed, approved, disseminated and monitored as set out in the document; • maintaining and updating procedures / protocols and other supporting documents for this policy. As Director of Governance, the Policy Lead is also responsible for (in conjunction with the Conflicts of Interests Guardian): • Consider any requests for non-publication of interests. • Following any investigation into a potential breach: ○ Deciding if there has been or is potential for a breach and

	if so what the severity of the breach is. ○ Assessing whether further action is required in response; this is likely to involve any staff member involved and their line manager, as a minimum. ○ Considering who else inside and outside the organisation should be made aware. ○ Taking appropriate action
Conflicts of Interest Guardian	The Chair of the Audit & Risk Committee is the NHS Devon Conflicts of Interest Guardian. The Guardian is supported by the Director of Governance and Governance Team to: • Act as a conduit for members of the public and healthcare professionals who have any concerns regarding conflicts of interest. • Be a safe point of contact for staff to raise concerns in relation to this policy and conflicts of interest. • Support the rigorous application of conflicts of interest principles and policies. • Provide independent advice and judgement to staff where there is any doubt about how to apply the Conflicts of Interest Policy. • Provide advice on minimising the risks of Conflicts of Interest. In conjunction with the Director of Governance, the Guardian is also responsible for considering any requests for non-publication of interests and actions following any investigation into a possible breach. (See above.)
Audit & Risk Committee	To receive reports in respect of compliance and any breaches, to take assurance from the policy and processes associated with Conflicts of Interest.
Executive Committee	Receive a quarterly report in respect of compliance together with any breaches and the impact of these breaches to ensure learning and improvement.
Meeting Chairs	Meeting Chairs have responsibility for ensuring that declarations of interest are a standing agenda item and addressed appropriately at the start of all meetings.
Procurement Team	The Procurement team is responsible for managing Conflicts of Interest in respect of procurement and contracts, liaising with the Governance team as required.
Governance Team	The Governance team is responsible for managing conflicts of interest processes and monitoring compliance.
Recruiting Managers	Managers involved in the recruitment of Board members, Executives and roles at Band 8d and above, should consider potential conflicts of interest during the recruitment process.
Line Managers	Line managers have a responsibility to ensure their staff comply with NHS Devon policies and standards within their areas of responsibility including Standing Financial Instructions.

	Line Managers also have a responsibility to ensure that all conflicts of interest declared by their staff have an appropriate management action plan.
All Staff	All employed or engaged staff (including interim and temporary staff, and contractors and seconded staff) have a duty to comply with NHS Devon policies and standards, including Standing Financial Instructions, as outlined in their contracts of employment and codes of conduct.

13. Implementation

- 13.1 All staff will be informed of the approval of the Policy via the Staff Bulletin which will provide a link to the document on the NHS Devon Intranet.
- 13.2 NHS Devon Senior Managers, or their designated representatives, will implement this policy by:
- Notifying all staff of its existence. New staff will be informed of this policy as part of their induction.
 - Destroying all superseded paper-based versions of the policy and electronic versions retained in their area.
 - Having adequate knowledge of, and / or access to, all relevant legislation in order to ensure that compliance with such legislation is maintained.
 - Discussing with staff as part of their regular one-to-ones how they seek to achieve their individual objectives around policy review and maintenance.
 - Ensuring themselves and their teams remain compliant, and relevant declarations are made in line with the policy.
- 13.3 Training in respect of conflicts of interest forms part of the training programme for all staff. This takes the form of two on-line modules provided which can be accessed via the Electronic Staff Record. (The training is currently being updated by NHSE and is anticipated to be available in Q4 2023-24)
- Module 1 – covers what conflicts of interest are; how to declare and manage conflicts of interest, including individuals' responsibilities; and how to report any concerns. (This is mandatory training for all staff and is required to be completed on an annual basis.)
 - Module 2 – provides further information on managing conflicts of interest throughout the whole commissioning cycle and in recruitment processes. (Confirmation is awaited as to the staff this module applies to and the required frequency of its completion.)
- 13.4 In addition to the mandatory training, the Governance Team will provide awareness sessions to staff via Staff Briefings and articles in the Staff Bulletin.

14. Approval and Review

- 14.1 This policy is subject to the approval of the NHS Devon Board following its consideration by the Senior Executive Team and the Audit & Risk Committee.
- 14.2 This policy will be reviewed annually, or sooner if required, in order to ensure that it is current, relevant and reflects the strategic aims, objectives, organisational structures and responsibilities of NHS Devon.

15. Monitoring compliance and effectiveness

- 15.1 The effectiveness of the way in which NHS Devon manages conflicts of interests and how it complies with this policy will be the subject of an annual internal audit review. The outcome of this audit is presented to the Audit & Risk Committee and is reported in the annual Head of Internal Audit Opinion.
- 15.2 The Chief Executive will review compliance and effectiveness as part of the Annual Report process, which includes the consideration of the Head of Internal Audit Opinion.
- 15.3 Compliance with conflicts of interest processes will be monitored by the Governance Team who will report to the Executive Committee on a bi-monthly basis and to each meeting of the Audit & Risk Committee in respect of compliance together with any breaches and the impact of these breaches to ensure learning and improvement.
- 15.4 Any trends resulting from non-compliance will be raised with staff through management routes.

16. Quality & Equality Impact Assessment (QEIA)

- 16.1 A QEIA has been completed in respect of this policy. No concerns were highlighted.

17. References

17.1 Other related NHS Devon policy documents

- Standards of Business Conduct Policy
- Procurement Policy for all ICB Expenditure
- Freedom to Speak Up Policy
- Anti Fraud and Bribery Policy
- Standing Financial Instructions
- Scheme of Reservation and Delegation

17.2 Legislation and statutory requirements

- Bribery Act 2010: www.legislation.gov.uk/ukpga/2010/23/contents
www.gov.uk/government/publications/bribery-act-2010-guidance
- Fraud Act 2006: www.legislation.gov.uk/ukpga/2006/35/contents
- National Health Service Act 2006:
www.legislation.gov.uk/ukpga/2006/41/contents
- Health and Care Act 2022:
www.legislation.gov.uk/ukpga/2022/31/contents/enacted
- NHS (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013

17.3 Best practice recommendations and other key guidance

- Department of Health - Confidentiality: NHS Code of Practice:
www.gov.uk/government/publications/confidentiality-nhs-code-of-practice
- General Medical Council (GMC) : www.gmc-uk.org/guidance/good_medical_practice.asp www.gmc-uk.org/guidance/ethical_guidance.asp
www.gmc-uk.org/about/council/register_code_of_conduct.asp
- Good Governance Standards of Public Services:
www.irf.org.uk/report/good-governance-standard-public-services
- NHS Counter Fraud Authority: cfa.nhs.uk/
- NHS England - Standards of Business Conduct for NHS Staff:
www.england.nhs.uk/publication/standards-of-business-conduct-policy/
- Seven Key Principles of the NHS Constitution:
www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england

APPENDIX 1 – Nolan Principles

1. Selflessness

Holders of public office should act solely in terms of the public interest. They should not do so to gain financial or other benefits for themselves, their family or their friends.

2. Integrity

Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

3. Objectivity

In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

4. Accountability

Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

5. Openness

Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

6. Honesty

Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

7. Leadership

Holders of public office should promote and support these principles by leadership and example.

Standards of Business Conduct Policy

NHS Devon



Version	1.0
Policy Sponsor	Chief Communications and Corporate Affairs Officer
Policy Lead	Company Secretary
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Equality, diversity and inclusion statement

NHS Devon is committed to the promotion of equal opportunities, addressing health inequalities and fostering of good relations between people protected under the terms of the Equality Act 2010, the Health and Social Care Act 2012 and Human Rights legislation. We are equally committed to the elimination of unlawful discrimination, harassment and victimisation. To demonstrate this commitment, we develop, promote and maintain policies, strategies and operating procedures. Every effort is made to ensure that patients, employees, contractors or visitors do not experience discrimination; either directly or indirectly, because of their vulnerability; disadvantage; age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion and belief; sex (gender) or sexual orientation.

All staff must comply with this policy. Compliance must reflect our organisational commitment to and policy on, equality, diversity and inclusion. In addition, each manager and member of staff involved in implementing this policy must give due regard to the needs of those protected under law.

If you, or any other groups, believe you are discriminated against under the terms of the Equality Act, the Health and Social Care Act 2012 or Human Rights legislation by anything contained in this document; or you need this document in an alternative format, for example, large print, Braille, Easy read or other languages; please contact our Patient Advice and Complaints Team (PACT):

Tel: 0300 123 1672 Email: pals.devon@nhs.net

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3 – NHS Devon Standards of Business Conduct Policy

1. Introduction

- 1.1 It is a long and well-established principle that public-sector organisations must be impartial and honest in their business and that their officers must act with integrity. As a publicly funded organisation NHS Devon aspires to the highest standards of corporate behaviour and responsibility.
- 1.2 The NHS Constitution sets out some of the key responsibilities of NHS staff. All officers, regardless of their role, are expected to act in the spirit set out in the seven principles of public life; the 'Nolan Principles' which are outlined in Appendix 1.
- 1.3 The Standards of Business Conduct Policy describes the standards and values which underpin the work of NHS Devon and reflects current guidance and best practice which all NHS Devon Board members, staff and decision-making groups should follow.

2. Purpose and objectives

- 2.1 This policy seeks to describe the public service values, which underpin the work of the NHS and to reflect the current guidance and best practice to which all individuals within NHS Devon must have regard when undertaking their role.
- 2.2 This policy will:
 - Set out a clear framework of the expected high standards of corporate behaviour and responsibility from NHS Devon Board members, staff and decision-making groups;
 - Support staff in ensuring that NHS Devon is impartial and honest in its business and that its staff act with integrity; and
 - Protect NHS Devon from any suggestion of corruption, partiality or dishonesty by providing a clear framework through which the organisation can provide guidance and assurance that its decision-makers conduct themselves appropriately.
- 2.3 This policy is supported by the Declaration of Interest, including Gifts, Hospitality and Sponsorship Standard Operating Procedure (SOP) owned by the Corporate Governance Team.

3. Scope

- 3.1 This policy applies to all NHS Devon employees including Members of the NHS Devon Integrated Care Board and of its committees. It also applies to any staff jointly appointed staff, including interims, agency workers, specialist contractors, consultants and secondees who carry out work for NHS Devon

but are not directly employed by the organisation. It also applies to members of committees and advisory groups who are not directly employed by NHS Devon and throughout this policy reference will be made to those who are and who are not employed by NHS Devon as officer.

4. Definitions

Terms	Definition
Third party	In this policy, “third party” refers to any individual or organisation that officers may come into contact with during the course of their work for NHS Devon, and includes actual and potential clients, suppliers, distributors, business contacts, agents, advisers, and government and public bodies, including their advisors, representatives and officials, politicians and political parties.
Joint Working	Joint working is defined as situations where, for the benefit of patients, organisations pool skills, experience and/or resources for the joint development and implementation of patient centred projects and share a commitment to successful delivery. Joint working agreements and management arrangements are conducted in an open and transparent manner.
Commercial sponsorship	Commercial sponsorship is defined as including: NHS funding from an external source, including funding of all or part of the costs of an officer, NHS research, training, pharmaceuticals, equipment, meeting rooms, costs associated with meetings, meals, gifts, hospitality, hotel and transport costs (including trips abroad), provision of free services (speakers), buildings or premises.
Industry	Commercial and non-commercial organisations (including patient groups) external to NHS Devon.
Officer	An individual who is directly or not directly employed by NHS Devon but is involved in the delivery of its work.

5. Managing Standards of Business Conduct

5.1 Conflicts and Declarations of Interest

- 5.1.1 Officers are expected to act at all times with the utmost integrity and objectivity and in the best interests of the organisation in performing their duties, and to avoid situations where there may be a potential conflict of interest. Officers must not use their position for personal advantage or seek to gain preferential treatment. Any actual or potential interests which may be perceived as conflicting with that overriding requirement must be declared.

5.1.2 Further information about what constitutes a conflict of interest and how these should be managed can be found in the NHS Devon Conflicts of Interest Policy. The Conflicts of Interest Policy also addresses the management of the following:

- Managing Conflicts of Interest at meetings
- Managing Conflicts of Interest in the procurement process
- Gifts and Hospitality
- Meals and Refreshments
- Travel and Accommodation
- Outside employment
- Patents

5.1.3 Registers of these interests are maintained by the governance team who will formally record the declared interests of all decision-making officers. They will retain a record of historic interests for a minimum of six years after the date on which the interest expired. There may be occasions when an officer declares an interest which the governance team later decides is not material. In such an instance the declaration will be recorded but not published.

5.2 Working with Industry and Sponsorship

5.2.1 The Department of Health and Social Care recognises that joint working with the pharmaceutical industry or other third-party organisations, where the benefits to patient care and the difference it could make to their health and wellbeing are clearly advantageous, should be considered by NHS organisations and their employees.

5.2.2 *Commercial Sponsorship - Ethical Standards in the NHS* requires local arrangements to be developed in relation to commercial sponsorship within a national framework. This document recognises that there can be mutual benefit in partnership arrangements with organisations external to the NHS, but only if they are agreed within a framework with the necessary safeguards and checks.

5.2.3 Positively engaging with companies and practices may lead to larger, longer term collaborations that meet the needs of all parties; however; the benefits of greater collaboration must be weighed against any potential risks and it is essential therefore that all projects are subject to the widest scrutiny; that the business priorities of commercial organisations do not lead to a distortion of local priorities or investment; and that any such arrangements are fully transparent and deliver maximum benefits for patients and the health economy.

5.2.4 The principles underpinning sponsorship and joint working are at Appendix 2

5.2.5 Potential joint working arrangements and sponsorship will be considered through a process for consideration, approval, recording, monitoring and evaluation. Initial consideration is undertaken by the Working with Industry & Sponsorship Group (Wwl&SG) which makes its recommendations to the

Executive Committee. Information as to the process to be followed in respect of joint working or sponsorship initiatives, including application form to be considered by the Wwl&SG can be found on the intranet at *link to be inserted upon withdrawal of Wwl&S Policy*.

5.2.6 One of the main ways in which officers may interact with industry is when an organisation sponsors an event or meeting; provides training or educational materials; offers gifts or hospitality; or offers to support other costs and equipment. The way in which such offers should be considered is set out in the NHS Conflicts of Interest Policy. However; as a general rule:

- Attendance at event or conference sponsored / hosted by an external organisation, e.g. clarify with the sponsor and record the sponsor's expectation from providing the sponsorship concerning attendance. If there are no known expectations from the sponsor the attendance can be acceptable but agreed by a line manager in advance and a declaration form completed.
- Offers of individual funding to allow officers to attend educational courses / obtain professional qualification - the offer should be declined and recorded on declaration form.

5.2.7 All offers of sponsorship, funding or gifts from pharmaceutical companies must comply with the current ABPI Code of Practice (available at <https://www.pmcpa.org.uk/the-code/>)

5.3 Bribery and Corruption

5.3.1 Under the Bribery Act (2010), it is a criminal offence for an employee to:

- offer, promise or give a bribe;
- request, agree to receive or accept a bribe; and
- make a representation that is false for personal or other gain or that puts NHS Devon at risk of loss.

5.3.2 It is also a criminal offence for NHS Devon to fail to prevent bribery.

5.3.3 Bribery can be money, gifts, hospitality or anything else that may be of benefit to the person, which in turn creates a conflict between his/her own interests and the interests of those that he/she is expecting to be serving.

5.3.4 The Bribery Act (2010) also covers individuals who have an association with an organisation - an 'associated person'. This term is not just limited to NHS Devon Board members and officers, but any person, company or legal entity that carries out a service under the ICB's name, represents NHS Devon in an official capacity, acts on behalf of NHS Devon or in the place of other NHS Devon. The maximum penalty for bribery is 10 years imprisonment for individuals engaging in bribery and an unlimited fine for NHS Devon.

- 5.3.5 NHS Devon is keen to prevent fraud and encourages officers with concerns or reasonably held suspicions about potentially fraudulent activity or practice, to report these. Officers must inform the Chief Finance Officer or NHS Devon's Local Counter Fraud Specialist (LCFS) sandra.bell19@nhs.net or anonymously by contacting the NHS Reporting Line on 0800 028 40 60 or via www.reportnhsfraud.nhs.uk. Officers must not ignore any suspicion and must not under any circumstances investigate the matter themselves or inform colleagues or members of the public about their suspicions.

5.4 Charitable Collections

Individual

- 5.4.1 Whilst NHS Devon supports officers who wish to undertake charitable collections amongst immediate colleagues, no reference or implication should be drawn to suggest that NHS Devon is supporting the charity.
- 5.4.2 Collection tins or boxes must not be placed in offices. With line management agreement, collections may be made among immediate colleagues and friends to support small fundraising initiatives, such as raffle tickets and sponsored events.
- 5.4.3 Permission is not required for informal collections amongst immediate colleagues on an occasion like retirement, marriage, birthday or a new job.

Organisational

- 5.4.4 Charitable collections which reference NHS Devon must be authorised and documented by the appropriate Executive in advance and reported to the Governance Team.

5.5 Political Activities

- 5.5.1 Any political activity should not identify an individual as an officer of NHS Devon. Conferences or functions run by a party-political organisation should not be attended in an official capacity, except with prior written permission from the relevant Executive Director.

5.6 Personal Conduct

Corporate Responsibility

- 5.6.1 All officers have a responsibility to respect and promote the corporate or collective decision of NHS Devon, even though this may conflict with their personal views. This applies particularly if NHS Devon is yet to decide on an issue or has decided in a way with which they personally disagree. Directors and officers may comment as they wish as individuals. However, if they decide to do so, they should make it clear that they are expressing their personal view and not the view of NHS Devon.

- 5.6.2 When speaking as a member of NHS Devon, whether to the media, in a public forum or in a private or informal discussion, officers should ensure that they reflect the current policies or view of the organisation. For any public forum or media interview, approval should be sought in advance.
- 5.6.3 All officers must ensure their comments are well considered, sensible, well informed, made in good faith, in the public interest and without malice and that they enhance the reputation and status of NHS Devon.
- 5.6.4 Officers must follow the guidance for communication with the media; disciplinary action may be taken if this is not followed.

Use of Social Media

- 5.6.5 Officers should be aware that social networking websites are public forums and should not assume that their entries will remain private. Officers communicating via social media must comply with the NHS Devon Social Media Policy.
- 5.6.6 Officers must not conduct themselves in a way that brings NHS Devon into disrepute or disclose information that is confidential to NHS Devon business, officers or patients.

Confidentiality

- 5.6.7 Officers must, at all times, operate in accordance with the Data Protection Act 2018, and maintain the confidentiality of information of any type, including but not restricted to patient information; personal information relating to officers; or commercial information.
- 5.6.8 This duty of confidence remains after officers (however employed) leave NHS Devon.
- 5.6.9 For the avoidance of doubt, this does not prevent the disclosure of information where there is a lawful basis for doing so (e.g. consent). Officers should refer to the suite of NHS Devon Information Governance policies for detailed information.

Lending or Borrowing

- 5.6.10 The lending or borrowing of money between officers is not permitted, whether informally or as a business.
- 5.6.11 It is a particularly serious breach of the NHS Devon Disciplinary Policy for any officer to use their position to place pressure on someone in a lower pay band, a business contract, or a member of the public to loan them money.

Gambling

- 5.6.12 No officer may bet or gamble when on duty or on NHS Devon premises, with the exception of small lottery syndicates or sweepstakes related to national events such as the World Cup or Grand National among immediate colleagues where no profits are made or the lottery is wholly for purposes that

are not for private or commercial gain (e.g. to raise funds to support a charity see section 5.4).

Trading on Official Premises

- 5.6.13 Trading on official premises is prohibited, whether for personal gain or on behalf of others. This includes but is not limited to flyers advertising services and/ or products in shared areas and catalogues in shared areas.
- 5.6.14 Canvassing within the office by, or on behalf of, outside bodies or firms (including non-NHS Devon interests of officers or their relatives) is also prohibited.
- 5.6.15 Trading does not include small tea or refreshment arrangements solely for officers.

Individual Voluntary Arrangements, County Court Judgment, Bankruptcy / Insolvency

- 5.6.16 Any officer who becomes bankrupt, insolvent, has an active County Court Judgment, or made individual voluntary arrangements with organisations must inform their line manager and the HR team as soon as possible. Officers who are bankrupt or insolvent cannot be employed, or otherwise engaged, in posts that involve duties which might permit the misappropriation of public funds or involve the approval of orders or handling of money.
- 5.6.17 An officer who is arrested, subject to continuing criminal proceedings, or convicted of any criminal offence must inform their line manager and the HR team as soon as is practicably possible. Cautions, penalty charge notices, and fixed penalty notices are not considered to be criminal convictions.

PREVENT

- 5.6.18 Any officer who has concerns regarding the possibility of a potential link to extremism or radicalisation in relation to the areas covered by this policy should refer to the NHS Devon PREVENT Policy which provides guidance on how to seek advice.

5.7 Publication

- 5.7.1 Declarations made in accordance with this policy by decision making officers will be published on the NHS Devon website. Registers of all officer declarations held by the governance team will be made available on request.
- 5.7.2 In exceptional circumstances, where the public disclosure of information could give rise to a real risk of harm or is prohibited by law, an individual's name and/or other information may be redacted from the publicly available register(s). Where an officer believes that substantial damage or distress may be caused to him/herself or somebody else by the publication of information about them, they are entitled to request that the information is not published. Such a request must be made in writing to the governance team, who will seek legal advice where required. All requests for non-publication will be considered by the Conflicts of Interest Guardian and the Director of Governance. Non-publication of interests would only be agreed as the

exception and information will not be withheld or redacted merely because of a personal preference. A confidential, un-redacted version of the register will be held securely by the governance team.

- 5.7.3 Officers should be aware that external organisations, e.g. Association of British Pharmaceutical Industries (ABPI), may also publish information relating to commercial sponsorship or other payments. We will review such publications to ensure that appropriate internal declarations have been made in accordance with this policy and will take appropriate action where they have not.
- 5.7.4 Anonymised information relating to breaches and how those breaches have been managed will be published on the NHS Devon website quarterly and held on the website for a year.

5.8 Raising a Concern or Reporting a Breach

- 5.8.1 There may be occasions when breaches have not been identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of deliberate actions. Officers should speak up about any genuine concerns in relation to compliance with this policy. These concerns can be raised directly with the officer's line manager or alternatively the Director of Governance, the Chief Finance Officer or the Conflicts of Interest Guardian.
- 5.8.2 All reported concerns will be treated with the appropriate confidentiality and investigated in line with NHS Devon's policies and procedures.
- 5.8.3 Compliance with this policy will be monitored by the Governance Team who will report to the Executive Committee on a bi-monthly basis and to each meeting of the Audit & Risk Committee in respect of compliance together with any breaches and the impact of these breaches to ensure learning and improvement.
- 5.8.4 Significant breaches should be reported to the Audit & Risk Committee as soon as practicably possible, together with the action being taken to address it.
- 5.8.5 Officers must report any suspicions of fraud, bribery and corruption as soon as they become aware of them to the Counter Fraud team to ensure that they are investigated appropriately and to maximise the chances of financial recovery.
- 5.8.6 Officers may also wish to report concerns via the Freedom to Speak Up Guardian.

5.9 Failure to comply with the Standards of Business Conduct Policy

- 5.9.1 Failure by an officer to comply with the requirements set out in this policy may result in action being taken in accordance with the relevant organisational disciplinary procedure. Such disciplinary action may include termination of employment (where applicable).
- 5.9.2 Where the failure to comply relates to an officer that is not a direct employee of NHS Devon, this may result in action being taken in accordance with the relevant engagement procedures (e.g. termination of a secondment agreement).
- 5.9.3 Any financial or other irregularities or impropriety which involve evidence or suspicion of fraud, bribery or corruption by any officer, will be reported to the Counter Fraud team in accordance with Standing Financial Instructions and the Fraud, Bribery and Corruption policy, with a view to an appropriate investigation being conducted and potential prosecution being sought.

6. Accountabilities, Duties and Responsibilities

Chief Executive Officer	The Chief Executive Officer has ultimate accountability for the strategic direction and operational management of NHS Devon, including compliance with all legal, statutory and policy requirements.
Policy Sponsor	The Policy Sponsor is responsible for: - ensuring that policy is appropriate for consideration for approval; - endorsing this policy ahead of submission for approval; - with the Policy Lead, maintaining and updating procedures/protocols and other supporting documents for this policy.
Policy Lead / Author	It is the responsibility of the Policy Lead / author to: - ensure as far as possible that the policy is in line with Department of Health and Social Care guidance, legal requirements and advice from clinical bodies; - to complete a QEIA and Implementation Plan where required - undertake a fair and proportionate consultation period with the relevant stakeholders as part of the document's development - to ensure that the policy is in alignment with NHS Devon's strategy and values - ensure that the policy is developed, approved, disseminated and monitored as set out in the document; - with Policy Sponsors, maintaining and updating procedures / protocols and other supporting documents for this policy;

	As Director of Governance, the Policy is also responsible for (in conjunction with the Conflicts of Interest Guardian): • Considering any requests for non-publication of interests. • Following any investigation into a potential breach: ○ Deciding if there has been or is potential for a breach and if so what the severity of the breach is. ○ Assessing whether further action is required in response; this is likely to involve any officer involved and their line manager, as a minimum. ○ Considering who else inside and outside the organisation should be made aware. ○ Taking appropriate action.
Conflicts of Interest (Col) Guardian	This role is undertaken by a Non-Executive Director of the NHS Devon Board and further strengthens scrutiny and transparency of NHS Devon's decision-making processes. The Col Guardian is supported by the Director of Governance to: • Act as a conduit for officers, members of the public and healthcare professionals who have any concerns regarding Col. • Be a safe point of contact for officers to raise concerns in relation to this policy. • Support the rigorous application of Col principles and policies. • Provide independent advice and judgement to officers where there is any doubt about how to apply Col policies and principles. • Provide advice on minimising the risks of Col. In conjunction with the Director of Governance, the Guardian is also responsible for considering any requests for non-publication of interests and actions following any investigation into a possible breach.
Audit & Risk Committee	Reports in relation to conflicts of interest and standards of business conduct (including Gifts and Hospitality, and Sponsorship and Joint Working) will be received by NHS Devon's Audit and Risk Committee for assurance.
Executive Committee	Reports in respect of compliance with the Standards of Business Conduct policy, together with any breaches and the impact of those breaches to ensure learning and improvement.
Working with Industry & Sponsorship Group	Reviews applications for sponsorship and joint working agreements (making recommendations to the Executive Committee) and monitors compliance with this policy.

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Governance Team	Ensuring that the Standards of Business Conduct Policy is implemented by teams across NHS Devon and that compliance is monitored and reported.
Line Managers	Line managers have a responsibility to ensure their staff comply with NHS Devon policies and standards within their areas of responsibility including Standing Financial Instructions.
All Officers	Employed or engaged staff have a duty to comply with NHS Devon policies and standards, including Standing Financial Instructions, as outlined in their contracts of employment and codes of conduct.

7. Implementation

- 7.1 NHS Devon staff will be informed of the approval of the Policy via the Staff Bulletin which will provide a link to the document on the NHS Devon Intranet.
- 7.2 NHS Devon Senior Managers, or their designated representatives, will implement this policy by:
- Notifying all staff of its existence. New staff will be informed of this policy as part of their induction.
 - Destroying all superseded paper-based versions of the policy and electronic versions retained in their area.
 - Having adequate knowledge of, and / or access to, all relevant legislation in order to ensure that compliance with such legislation is maintained.
 - Discussing with staff as part of their regular one-to-ones how they seek to achieve their individual objectives around policy review and maintenance.
- 7.3 Training in respect of conflicts of interest forms part of the training programme for all NHS Devon staff. This takes the form of two on-line modules provided which can be accessed via the Electronic Staff Record. (The training is currently being updated by NHSE and is anticipated to be available in Q4 2023-24)
- Module 1 – covers what conflicts of interest are; how to declare and manage conflicts of interest, including individuals' responsibilities; and how to report any concerns. (This is mandatory training for all staff and is required to be completed on an annual basis.)
 - Module 2 – provides further information on managing conflicts of interest throughout the whole commissioning cycle and in recruitment processes. (Confirmation is awaited as to the staff this module applies to and the required frequency of its completion.)
- 7.4 In addition to the mandatory training, the Governance Team will provide awareness sessions to staff via Staff Briefings and articles in the Staff Bulletin.

8. Approval and Review

- 8.1 This policy is subject to approval of the NHS Board following recommendation from Audit & Risk Committee.
- 8.2 This policy will be reviewed annually, or sooner if required, in order to ensure that it is current, relevant and reflects the strategic aims, objectives, organisational structures and responsibilities of NHS Devon.

9. Monitoring compliance and effectiveness

- 9.1 The Chief Executive will review compliance and effectiveness of the Standards of Business as part of the Annual Report process.
- 9.2 Compliance with this policy will be monitored by the Governance Team who will report to the Executive Committee on a bi-monthly basis and to each meeting of the Audit & Risk Committee in respect of compliance together with any breaches and the impact of these breaches to ensure learning and improvement.
- 9.3 Any trends resulting from non-compliance will be raised with officers through management routes.

10. Quality & Equality Impact Assessment (QEIA)

- 10.1 A QEIA has been completed in respect of this policy. No concerns were highlighted.

11. References

11.1 Other related policy documents

- Anti-Fraud and Bribery Policy
- Freedom to Speak Up Policy
- Conflict of Interests Policy
- Procurement Policy for all ICB Expenditure
- Social Media Policy
- Standing Financial Instructions
- Scheme of Reservation and Delegation.

11.2 Legislation and statutory requirements

- Bribery Act 2010: <https://www.legislation.gov.uk/ukpga/2010/23/contents> and www.gov.uk/government/publications/bribery-act-2010-guidance

- Equality Act 2010: www.legislation.gov.uk/ukpga/2010/15/contents
www.gov.uk/guidance/equality-act-2010-guidance
- European Public Contracts Regulations 2015:
www.legislation.gov.uk/uksi/2015/102/contents/made and
<https://www.gov.uk/government/publications/public-contracts-regulations-2015-for-nhs-commissioners>
- Fraud Act 2006: www.legislation.gov.uk/ukpga/2006/35/contents
- Freedom of Information Act 2000: [Freedom of Information Act 2000 \(legislation.gov.uk\)](http://www.legislation.gov.uk/ukpga/2000/36/contents) and [What is the Freedom of Information Act? | ICO](http://ico.org.uk/what-ico/what-ico-does/what-is-the-freedom-of-information-act-2000)
- Health and Care Act 2022: [Health and Care Act 2022 \(legislation.gov.uk\)](http://www.legislation.gov.uk/ukpga/2022/25/contents)
and <https://nhsproviders.org/topics/governance/health-and-care-act-2022>
- Medicines (Monitoring of Advertising) Regulations 1994:
<https://www.legislation.gov.uk/uksi/1994/1933/made>
- The Money Laundering Regulations 2007: [The Money Laundering Regulations 2007 \(legislation.gov.uk\)](http://www.legislation.gov.uk/ukpga/2007/29/contents)
- National Health Service Act 2006: [National Health Service Act 2006 \(legislation.gov.uk\)](http://www.legislation.gov.uk/ukpga/2006/42/contents)
- Public Contracts Regulations 2015:
<https://www.legislation.gov.uk/uksi/2015/102/contents/made>
- Proceeds of Crime Act 2002: [Proceeds of Crime Act 2002 \(legislation.gov.uk\)](http://www.legislation.gov.uk/ukpga/2002/29/contents)
- NHS England: Managing Conflicts of Interest: Statutory Guidance:
<https://www.england.nhs.uk/wp-content/uploads/2017/02/guidance-managing-conflicts-of-interest-nhs.pdf>

11.3 Best practice recommendations and other key guidance

- NHS England - Standards of Business Conduct for NHS Staff:
www.england.nhs.uk/publication/standards-of-business-conduct-policy/
- NHS England Guidance on Appearance of Bias:
<https://www.england.nhs.uk/professional-standards/medical-revalidation/ro/con-of-int/>
- Commercial Sponsorship – Ethical Standards for the NHS:
<https://data.parliament.uk/DepositedPapers/Files/DEP2009-1886/DEP2009-1886.pdf>

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- Association of the British Pharmaceutical (ABPI) Code of Practice:
<https://www.abpi.org.uk/reputation/abpi-2021-code-of-practice/>
- Department of Health - Confidentiality: NHS Code of Practice:
www.gov.uk/government/publications/confidentiality-nhs-code-of-practice
- General Medical Council (GMC) : www.gmc-uk.org/guidance/good_medical_practice.asp www.gmc-uk.org/guidance/ethical_guidance.asp
- Good Governance Standards of Public Services:
www.jrf.org.uk/report/good-governance-standard-public-services
- Department of Health. *Best Practice Guidance on joint working between the NHS and pharmaceutical industry and other relevant commercial organisations* 2008. https://www.networks.nhs.uk/nhs-networks/joint-working-nhs-pharmaceutical/documents/dh_082569.pdf.

APPENDIX 1 – Nolan Principles

1. Selflessness

Holders of public office should act solely in terms of the public interest. They should not do so to gain financial or other benefits for themselves, their family or their friends.

2. Integrity

Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

3. Objectivity

In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

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Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

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Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

6. Honesty

Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

7. Leadership

Holders of public office should promote and support these principles by leadership and example.

APPENDIX 2 – Principles of Sponsorship and Joint Working

Working in the interests of patients to deliver high quality care

- Joint projects between NHS Devon and industry must be for the benefit of their populations
- Any joint project must adequately respect and safeguard confidential patient information in line with the NHS Devon policy on confidentiality and the Data Protection Act 2018, incorporating the UK General Data Protection Regulations.
- Joint working between NHS Devon and industry must promote evidence-based medicine and support only those drugs and treatments that have an acceptable evidence base and which have local formulary approval where applicable.

Supporting the delivery of NHS Devon's strategic objectives and local needs

- NHS Devon will take a whole-systems approach to joint working. This will ensure that only arrangements that benefit the whole NHS are approved. Arrangement which would lead to higher costs or a reduction in quality in other areas of the NHS or shift the balance of investment in service in a manner not consistent with local priorities, are not acceptable.
- NHS Devon will not undertake joint working or accept sponsorship from industry to support projects that are contrary to their strategic priorities
- The continuity of any services funded through sponsorship or joint working must be fully considered before entering into any arrangements.

Selection and approval of sponsorship and joint working partners

- Where sponsorship or joint working is being sought by NHS Devon, the opportunity to participate should be offered to an appropriate range of companies within the pharmaceutical industry
- All joint working or sponsorship must be assessed and declared.
- NHS Devon may pursue joint working with any interested company of good standing regardless of its size.
- No preferential access to NHS Devon is to be given to any commercial company unless this is necessary as part of a specific NHS Devon approved project.

Transparency and openness

- All relationships with industry must be handled in an open and transparent manner as befits publicly funded bodies
- Joint working or sponsorship will not be accepted for projects that have the prime objective of increasing the usage of a specific brand of pharmaceutical or other product
- Collaborative working arrangements should take place at a corporate, rather than an individual, level

Relationship between NHS Devon and industry

- NHS Devon seeks to develop long term relationships with industry and will look favourably on undertaking joint projects with companies that have a proven history of ethical and productive joint working

- NHS Devon will preferentially support sponsorship and joint working that develops the expertise and capabilities of the employees and organisations within the health and social care community to provide high quality care for their populations
- All joint working projects and associated materials must comply with the current Association of the British Pharmaceutical Industry (ABPI) code of practice, whether or not the company is a member of the ABPI
- Any learning or products (such as protocols, guidelines, intellectual property) developed through joint working will be the property of NHS Devon unless specifically agreed otherwise in a signed contract with the company(ies) and may be shared with other NHS organisations.
- NHS Devon will consider supporting the dissemination of lessons learned from joint working but retain the right of approval of associated literature and material.

Policy for the Development and Management of Procedural Documents

NHS Devon



Version	2.0
Policy Sponsor	Chief Communications and Corporate Affairs Officer
Policy Lead	Philippa Harding
Approver	NHS Devon Board
Approval Date	04/10/2023
To be reviewed by	04/10/2026

Document change history (to add rows, copy and paste)			
Date	Change	Version number of policy	Comments
04/10/2023	New Policy	1.0	
01/03/2024	Policy Amendment	2.0	Update for Executive Committee to approve all new documents and agree approval routes

Equality, diversity and inclusion statement

NHS Devon is committed to the promotion of equal opportunities, addressing health inequalities and fostering of good relations between people protected under the terms of the Equality Act 2010, the Health and Care Act 2022 and Human Rights legislation. We are equally committed to the elimination of unlawful discrimination, harassment and victimisation. To demonstrate this commitment, we develop, promote and maintain policies, strategies and operating procedures. Every effort is made to ensure that patients, employees, contractors or visitors do not experience discrimination; either directly or indirectly, because of their vulnerability; disadvantage; age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion and belief; sex (gender) or sexual orientation.

All staff must comply with this policy. Compliance must reflect our organisational commitment to and policy on, equality, diversity and inclusion. In addition, each manager and member of staff involved in implementing this policy must give due regard to the needs of those protected under law.

If you, or any other groups, believe you are discriminated against under the terms of the Equality Act, the Health and Care Act 2022 or Human Rights legislation by anything contained in this document; or you need this document in an alternative format, for example, large print, Braille, Easy read or other languages; please contact our Patient Advice and Complaints Team (PACT):

Tel: 0300 123 1672
Email: pals.devon@nhs.net

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1. Introduction

- 1.1. The Devon Integrated Care Board (NHS Devon) is required to have procedural documents acknowledging and complying with the Health and Care Act 2022, other relevant legislative and regulatory requirements and national standards relevant to fulfilling planning and allocation decisions and promoting collaboration in the health and care system, as well as quality and safety of the population of Devon. This policy sets out how NHS Devon will go about developing, approving and reviewing these procedural documents.

2. Purpose and objectives

- 2.1. The purpose of this policy is to ensure a well governed, structured and systematic approach to the development, approval, implementation and review of all procedural documentation in use throughout NHS Devon.

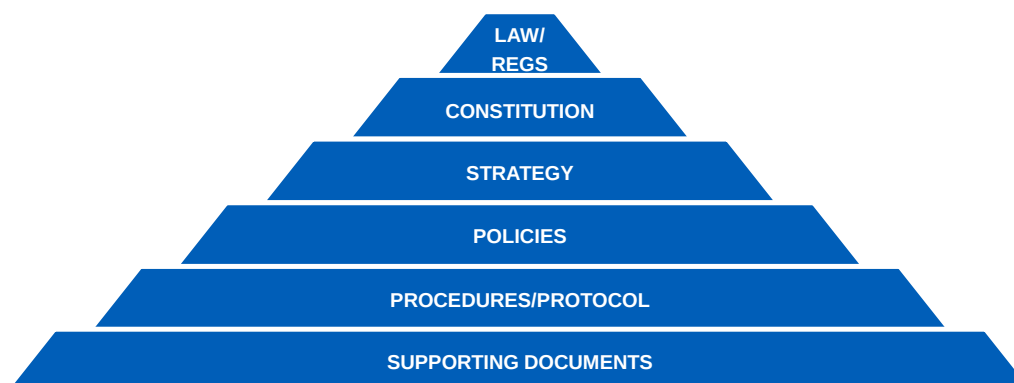
- 2.2. This policy will:

- Ensure that NHS Devon complies with the Health and Care Act 2022 and other relevant legislation and national standards in developing and reviewing its procedural documents.
- Provide a standard format and corporate style for drafting all NHS Devon procedural documents.
- Set out the requirements for the development and approval of all NHS Devon procedural documents.
- Establish the requirements for regular reporting and provision of assurance with regard to the efficacy and effectiveness of the NHS Devon policy framework.

3. Definitions

- 3.1. “Procedural documents” is a collective term relating to any of the following documents in the hierarchy set out below:

Figure 1: Procedural Document Hierarchy



4 – NHS Devon - Policy for the Development and Management of Procedural Documents

Table 1: Definitions

Terms	Definition
Law/ Regulations	Laws are created by an Act of Parliament or statute. The Health and Social Care Act 2006 and the Health and Care Act 2022 are the key statutes providing the law governing health and care in the UK. Regulations are secondary to statute as they are made under the authority derived from a statute. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Care Quality Commission (Registration) Regulations 2009 are examples of regulations.
Constitution	The NHS Constitution establishes the principles and values of the NHS in England and sets out rights to which patients, public and staff are entitled, and pledges that the NHS is committed to achieving. The NHS Devon Constitution outlines how it will comply with its statutory duties set out in the Health and Care Act 2022 and associated regulations.
Strategy	A high level plan of action designed to achieve a long-term or overall aim. Strategies identify the medium- to long-term aims and objectives of a given subject (for example the Digital Strategy).
Policy	A high level agreed statement intended to assign responsibility and to direct subsequent decisions, actions and other matters. Should state NHS Devon's commitment to deliver one or more duties and will be written for audiences at all levels. Acknowledges legislation, regulation, Department of Health and Social Care and NHS England direction or guidance and best practice that will be complied with in the discharge of NHS Devon's duties.
Procedure/ Protocol	An established or official way of doing something in the organisation. Describes the activities that, in support of the relevant policy, will deliver the discharge of NHS Devon's duties. Can be amended when NHS Devon assesses that the current procedure is not effectively supporting the relevant policy.
Supporting Documents	Describes the steps that are taken by individual teams in support of relevant procedures. These steps may be used a few or many times. Includes Guidelines, Forms, Handbooks and Manuals providing general advice but allow for local discretion.

4. Style and format of procedural documents

- 4.1. A standard template has been developed for the formation of NHS Devon policies. This can be found at Appendix D. There is no standard format requirement for any other procedural documents used by NHS Devon. The Corporate Governance team, with support from the Communications team, will be responsible for ensuring that the authors of procedural documents are aware of corporate style requirements. Procedural documents should be concise and clear, using unambiguous terms and language. The organisation's Style Guide should be referred to when drafting these documents.
- 4.2. Titles should be simple and informative of the document's contents. They should ensure that the procedural document is easy to find via the NHS Devon website search function. Document titles should not begin with "Approved", "Final" or a date.

5. Accountabilities, duties and responsibilities

- 5.1 Chief Officers will act as policy sponsors and will determine if a new strategy, policy, or other approved document is required. They will support policies appropriate to their responsibilities and approve the strategy or policy as set out in section 12 of this policy.
- 5.2 Policy owners are staff charged with producing or reviewing policies and must follow the guidance contained in this policy when writing their documents. They will be identified by the Chief Officer and tasked with producing a draft policy or taking responsibility for the review of an existing policy, and where appropriate forwarding to the appropriate group for feedback. They will then work through and consider any feedback on the policy. Policy owners will also be responsible for the review process which occurs on a regular basis.
- 5.3 The Corporate Governance team will maintain a Policy Register to prevent part or whole duplication of another approved strategy or policy in operation. Policy leads should liaise with the Corporate Governance team, who will check the Policy Register to ensure that proposed strategies or policies do not duplicate any other work. Where a potentially similar strategy or policy is already in operation, the policy lead will be asked to discuss with the policy sponsor whether it is more prudent to develop the existing document further, rather than develop a new one.

6. Developing a new procedural document

- 6.1. NHS Devon will identify the need to develop new procedural documents in line with the priorities of the organisation e.g., national guidance, legislation, organisational changes, service requirements and evidence-based practice whether in the form of the latest research, audit findings, national inquiries, or serious investigation reports.

- 6.2. Any proposals for a new procedural document should be discussed with the Corporate Governance team to determine applicable legislation, regulations, and standards. The Corporate Governance team will advise policy leads of the requirements of this policy and relevant approval routes for proposed procedural documents (see section 12 below).
- 6.3. The Corporate Governance team will also advise on the process and expected timeframes for the approval of any proposed procedural documents.
- 6.4. Once a procedural document requirement has been identified, a policy sponsor (relevant Chief Officer) and policy lead should be confirmed to the Corporate Governance Team. The policy sponsor and/or policy lead, will be responsible for confirming the nature of the procedural document (whether it is a strategy, policy, procedure/protocol or supporting document).
- 6.5. The Corporate Governance team will be responsible for ensuring that all new policies are presented to the Executive Committee for approval, including the approval route for any future amendments. A full list of approval routes for all strategies and policies can be found at Appendix B.
- 6.6. The policy sponsor will be responsible for ensuring that any proposed strategy or policy (procedures/protocols do not require a policy sponsor) is appropriate for consideration via the relevant approval route. The policy lead will be responsible for the content and drafting of the proposed strategy, policy, or procedure/protocol.
- 6.7. Any proposals for a new procedural document should be discussed with the Corporate Governance team to determine applicable legislation, regulations, and standards.

7. Reviewing and amending existing procedural documents

- 7.1. All approved strategies and policies will be published on either the NHS Devon intranet, the NHS Devon internet or in some cases both. Any strategy or policy available on the intranet should be considered to be the current version and the one by which NHS Devon stands, even if the review date has passed. An expired date does not automatically indicate that the strategy or policy has been superseded.
- 7.2. Policy sponsors and policy leads are responsible for maintaining and updating procedures/protocols and other supporting documents. These will not be included on the Policy Register maintained by the Corporate Governance team.
- 7.3. All procedural documents should be reviewed at least every three years and preferably annually. However, a review may take place earlier if new evidence

becomes available that renders this necessary e.g., changes in legislation, or to reflect changes to working practices.

- 7.4. The Corporate Governance team will take responsibility for contacting policy leads and policy sponsors 3 months before their policies are due to become overdue to advise on the process and expected timeframes for approval.
- 7.5. If, when undertaken, a review indicates that only minor amendments are required, which will not alter current practice and as such involve no significant change to the document, the requirement to consult on a revised strategy or policy (see section 10) does not apply. Similarly, appendices, which can be reviewed, revised and replaced at any point without the need to follow the consultation process set out below. Proposed minor updates to strategies or policies can go forward for approval via the relevant approval route (see section 12 below), once the relevant impact assessments (see section 8) and implementation plans (see section 9) have been completed.
- 7.6. If a review indicates significant changes in current practice and major amendments to the document will be required, the procedures outlined in section 5 above apply and must be followed.
- 7.7. If a policy lead is unclear whether the proposed changes to a procedural document constitute a significant change to current practice or not, they should consult with the Corporate Governance team, who will provide advice on this matter.

8. Impact Assessments

- 8.1. All public bodies have a specific duty under the Equality Act 2010 to carry out equality analysis and to have clear arrangements to assess and consult on how their policies and functions impact on the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex or sexual orientation.
- 8.2. A Quality, Equality Impact Assessment (QEIA) should be completed for all NHS Devon's new and reviewed (with significant changes) strategies and policies to ensure fairness, transparency and that the strategy or policy will not adversely impact individuals in protected groups as provided in the Equality Act 2010. An EHIA will also help the organisation to open services up to new groups and ensure focus on the impact of the change on the user. Further information on EHIAs can be found on the intranet: Equality and Health Inequalities Impact Assessment

9. Implementation

- 9.1. All strategies and policies need to identify arrangements for training, support and implementation as necessary. An implementation plan (template at

Appendix C) should be completed by the policy lead and included in the consultation on the policy (see section 9 below).

- 9.2. For strategies and policies with minor changes following a review, if the document already has an implementation plan in place, then a new one is not required to be completed. If a strategy or policy which requires minor changes following a review does not have an implementation plan in place, then one should be completed.
- 9.3. Completed implementation plans should be submitted alongside the proposed strategy or policy to the policy sponsor for sign off and with the final draft submitted for approval.

10. Consultation

- 10.1. In order to obtain approval for a strategy or policy, it must be accompanied by evidence of robust consultation. The policy sponsor will identify those stakeholders directly or indirectly involved and engaged with the policy area, who should take part in the consultation process and the policy lead should ensure that this takes place accordingly. The consultation process should be managed by the policy lead and the outcomes should be submitted alongside the proposed strategy or policy to the policy sponsor for sign off and with the final draft submitted for approval.
- 10.2. It should be noted that NHS Devon is committed to full Staff Partnership consultation on its people-related policies. People-related policies should always be subject to full Staff Partnership Forum consultation before being submitted for approval.
- 10.3. To allow a reasonable time for responses, a consultation period of two-four weeks is generally appropriate. All comments received should be recorded by the policy lead and amendments to the document considered accordingly. If the decision is taken not to amend the document in line with comments received during consultation, relevant consultees should be provided with a written response explaining why. If the consultation process results in a substantial change to the consultation document, a revised draft document should be sent out again to stakeholders for further consultation and comment.
- 10.4. For strategies and policies with minor changes following a review, a consultation period is not required.
- 10.5. Consultation is not required for the approval of protocols, procedures or other supporting documents; however, it is recommended.

11. Interagency Policies, Procedures and Guidelines

11.1 NHS Devon is signed up to a number of countywide interagency documents which support local practice and collaborative working arrangements as part of integration. For these documents, the lead agency is responsible for the style and format, distribution and archiving arrangements of the publication, regardless of whether it adheres to NHS Devon's recommendations. Wherever possible, each interagency document must have a relevant member of NHS Devon's staff on its working group to ensure that appropriate consultation at the development stage is achieved.

12. Approval

12.1. The approval routes for procedural documents are shown below:

Procedural document	Review	Assurance	Approval
Strategy	Executive Committee and approval of onward submission to Board	Relevant Board Committee	ICB Board
Policy	Core corporate governance and finance policies - Senior Executive Team and approval of onward submission to Board	Audit and Risk Committee	ICB Board
	New policies – Relevant Chief Officer	N/A	Executive Committee
	Existing high risk or high impact policies other than core corporate governance and finance policies - Relevant Chief Officer	N/A	Executive Committee
	Remaining existing policies - Relevant Chief Officer with the consultation of at least one other Chief Officer	N/A	Chief Officer
Procedure/Protocol	N/A	N/A	Senior Leadership Team member with responsibility

			for relevant policy area.
Supporting Documents	N/A	N/A	Team Leader with responsibility for implementing relevant policy area.

12.2. The review routes set out in the table above are a formal part of the corporate governance process for the approval of procedural documents and not part of the consultation process set out in section 9 above, which should be completed prior to the document's submission for review.

12.3. In the absence of a specified Chief Officer to approve a policy, policies can be approved by their nominated deputy for that period of absence. It is not possible for policies to be approved by any other member of staff than Chief Officers, or their nominated deputy in the event of their absence.

13. Dissemination and monitoring of compliance / effectiveness

13.1. All policies and procedures can be accessed electronically via the NHS Devon intranet. All newly uploaded policies and procedures are highlighted in the latest documents area on the intranet, to alert and direct staff who access the intranet, to their publication and availability. The Corporate Governance team will also provide a notification and a link to the policy or procedure via the staff bulletin.

13.2. Departmental managers, team leaders and professional leads are responsible for having a system in place within their sphere of responsibility that ensures their staff are aware of and have read and understood relevant new and revised policies.

13.3. The Corporate Governance team will make available a report to the Executive Committee on a quarterly basis setting out the details of all new policies and procedures that have been ratified and uploaded on to the intranet and those which are due for review in the next quarter.

APPENDIX A – Glossary of terms used

Terms	Definition
Health and Care Act 2022	The law establishing Integrated Care Boards as statutory bodies
NHS Devon	Name that will be used for the Devon Integrated Care Board (ICB).
Quality Equality Impact Assessment (QEIA)	The QEIA process considers the extent to which a policy or strategy (including strategic decisions, service or function) may impact, on any groups of the community within Devon. The impact may be neutral, negative or positive and where appropriate the QEIA process allows recommendations or alternative mitigation measures to be made to ensure equal access to services and opportunities
Dissemination	Policy dissemination will include publication of policies and enable target audience internally and externally to access and understand the policy
Implementation Plan	The Implementation Plan identifies the steps and communication strategies for new or amended policies and procedures.
Policy Sponsor	The policy sponsor should be a Chief Officer, who will be responsible for ensuring that any proposed strategy or policy (procedures/protocols do not require a policy sponsor) is appropriate for consideration via the relevant approval route.
Policy Lead	The policy lead will be responsible for the content and drafting of the proposed strategy, policy or procedure/protocol.
Chief Officer	A Chief Officer is a direct report of the Chief Executive.
NHS Devon Board	The NHS Devon Board is the “controlling mind” of NHS Devon – it acts as the agent for the organisation and exercises power on its behalf.
Executive Committee	The Executive Committee consists of the direct reports of the NHS Devon Chief Executive. It supports the Chief Executive in the discharge of their NHS Devon executive functions.
Policy Register	The Policy Register is the formal list of NHS Devon strategies and policies. It includes information about approval routes and review dates.
Law/ Regulations	Laws are created by an Act of Parliament or statute. The Health and Social Care Act 2012 and the Health and Care Act 2022 are the key statutes providing the law governing health and care in the UK.

Terms	Definition
	Regulations are secondary to statute as they made under the authority derived from a statute. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Care Quality Commission (Registration) Regulations 2009 are examples of regulations.
Constitution	The NHS Constitution establishes the principles and values of the NHS in England and sets out rights to which patients, public and staff are entitled, and pledges that the NHS is committed to achieving. The NHS Devon Constitution outlines how the organisation will comply with statutory duties set out in the Health and Care Act 2022 and associated regulations.
Strategy	A high level plan of action designed to achieve a long-term or overall aim. Strategies identify the medium- to long-term aims and objectives of a given subject (for example the Risk Management Strategy).
Policy	A high level agreed statement intended to assign responsibility and to direct subsequent decisions, actions and other matters. Should state NHS Devon's commitment to deliver one or more duties and will be written for audiences at all levels. Acknowledges legislation, regulation, Department of Health and Social Care and NHS England direction or guidance and best practice that will be complied with in NHS Devon's duties.
Procedure/ Protocol	An established or official way of doing something in the organisation. Describes the activities that, in support of the relevant policy, will deliver NHS Devon's duties. Can be amended when NHS Devon assesses that the current procedure is not supporting the relevant policy.
Supporting Documents	Describes the steps that are taken by individual teams in support of the relevant procedure. These steps may be used a few or many times. Includes Guidelines, Forms, Handbooks and Manuals providing general advice but allow for local discretion.

Appendix B(i) – Approval routes for NHS Devon non-clinical policies and strategies

NB: These are procedural documents separate to the Policy for the Development and Management of Procedural Documents and may be amended without requiring the amendment of the policy.

Strategy Title	Chief Officer	Approval requires the agreement of
Equality Diversity and Inclusion Strategy	Chief Communications and Corporate Affairs Officer	ICB Board
Green Plan	Chief Communications and Corporate Affairs Officer	ICB Board
People & Communities	Chief Communications and Corporate Affairs Officer	ICB Board
5 Year Joint Forward Plan	Chief Executive Officer	ICB Board
Digital Strategy	Chief Finance Officer	ICB Board
Primary Care Strategy	Chief Medical Officer	ICB Board
Community First Strategy	Chief Medical Officer	ICB Board
Children & YP Strategy	Chief Nursing Officer	ICB Board
Women's Health Strategy for England and Women's Health Hubs	Chief Nursing Officer	ICB Board
Workforce Strategy	Director of Workforce	ICB Board
Learning and Education Strategy	Director of Workforce	ICB Board

Policy Title	Chief Officer	Approval requires the agreement of
Policy for the Development and Management of Procedural Documents	Chief Communications and Corporate Affairs Officer	ICB Board
Risk Management Policy	Chief Communications and Corporate Affairs Officer	ICB Board
Standards of Business Conduct Policy	Chief Communications and Corporate Affairs Officer	ICB Board
Policy for Co-option to Board Committees	Chief Communications and Corporate Affairs Officer	ICB Board
Conflict of Interest Policy	Chief Communications and Corporate Affairs Officer	ICB Board
Receipt, Acceptance and Management of Petitions Policy	Chief Communications and Corporate Affairs Officer	ICB Board

Freedom to Speak Up policy	Chief Nursing Officer	ICB Board
Emergency Preparedness, Resilience & Response Policy	Chief Delivery Officer	ICB Board

Policy Title	Chief Officer	Approval requires the agreement of
Confidentiality & Data Protection Act policy	Chief Communications and Corporate Affairs Officer	Chief Finance Officer
Individual Rights policy	Chief Communications and Corporate Affairs Officer	Chief Finance Officer
Records Management Policy	Chief Communications and Corporate Affairs Officer	Chief Finance Officer
Safe Haven Policy	Chief Communications and Corporate Affairs Officer	Chief Finance Officer
Data Protection Framework	Chief Communications and Corporate Affairs Officer	Chief Finance Officer
DPIA Framework	Chief Communications and Corporate Affairs Officer	Chief Finance Officer
Freedom of Information Act and Environmental Information Regulations Policy	Chief Communications and Corporate Affairs Officer	Chief Medical Officer
Data Quality Assurance Policy	Chief Communications and Corporate Affairs Officer	Chief Finance Officer
Organisational Change Policy - HR019 NEWD Organisational Change policy	Chief Communications and Corporate Affairs Officer	Remuneration & Internal ICB Workforce Committee
Organisational Change Policy - HR22A SD&T Organisational Change, Redundancy and Redeployment policy	Chief Communications and Corporate Affairs Officer	Remuneration & Internal ICB Workforce Committee
Environmental Policy	Chief Communications and Corporate Affairs Officer	Chief Finance Officer

Policy Title	Chief Officer	Approval requires the agreement of
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Password Policy	Chief Finance Officer	Chief Communications and Corporate Affairs Officer
Registration Authority Policy	Chief Finance Officer	Chief Communications and Corporate Affairs Officer
Counter Fraud, Bribery and Corruption Policy	Chief Finance Officer	Chief Communications and Corporate Affairs Officer
Mobile Devices when Remote Working Policy	Chief Finance Officer	Chief Finance Officer and Chief Communications and Corporate Affairs Officer
Privileged Access Acceptable User Policy	Chief Finance Officer	Chief Communications and Corporate Affairs Officer
Procurement Policy for all ICB Expenditure	Chief Finance Officer	Chief Communications and Corporate Affairs Officer
IT Security Policy	Chief Finance Officer	Chief Communications and Corporate Affairs Officer

Policy Title	Chief Officer	Approval requires the agreement of
Patient Group Direction (PGD) Policy	Chief Medical Officer	Chief Nursing Officer
Defining the Boundaries between NHS & Private Healthcare	Chief Medical Officer	Chief Nursing Officer
Individual Funding Request Policy & Associated SOP	Chief Medical Officer	Chief Delivery Officer
Primary Care Prescribing Rebates Policy	Chief Medical Officer	Chief Finance Officer
Service Review Policy	Chief Medical Officer	Chief Nursing Officer

Policy Title	Chief Officer	Approval requires the agreement of
Previously Unassessed Periods of Care (Pupocs) Policy	Chief Nursing Officer	Chief Medical Officer
Individual Packages of Care Policy (IPOC)	Chief Nursing Officer	Chief Medical Officer
CHC Appeals Policy	Chief Nursing Officer	Chief Medical Officer
Personal Health Budgets	Chief Nursing Officer	Chief Medical Officer
Children in Care	Chief Nursing Officer	Chief Medical Officer
Mental Capacity and Deprivation of Liberty Policy	Chief Nursing Officer	Chief Communications and Corporate Affairs Officer
PREVENT Policy	Chief Nursing Officer	Chief Medical Officer
Safeguarding Adult Policy	Chief Nursing Officer	Chief Medical Officer

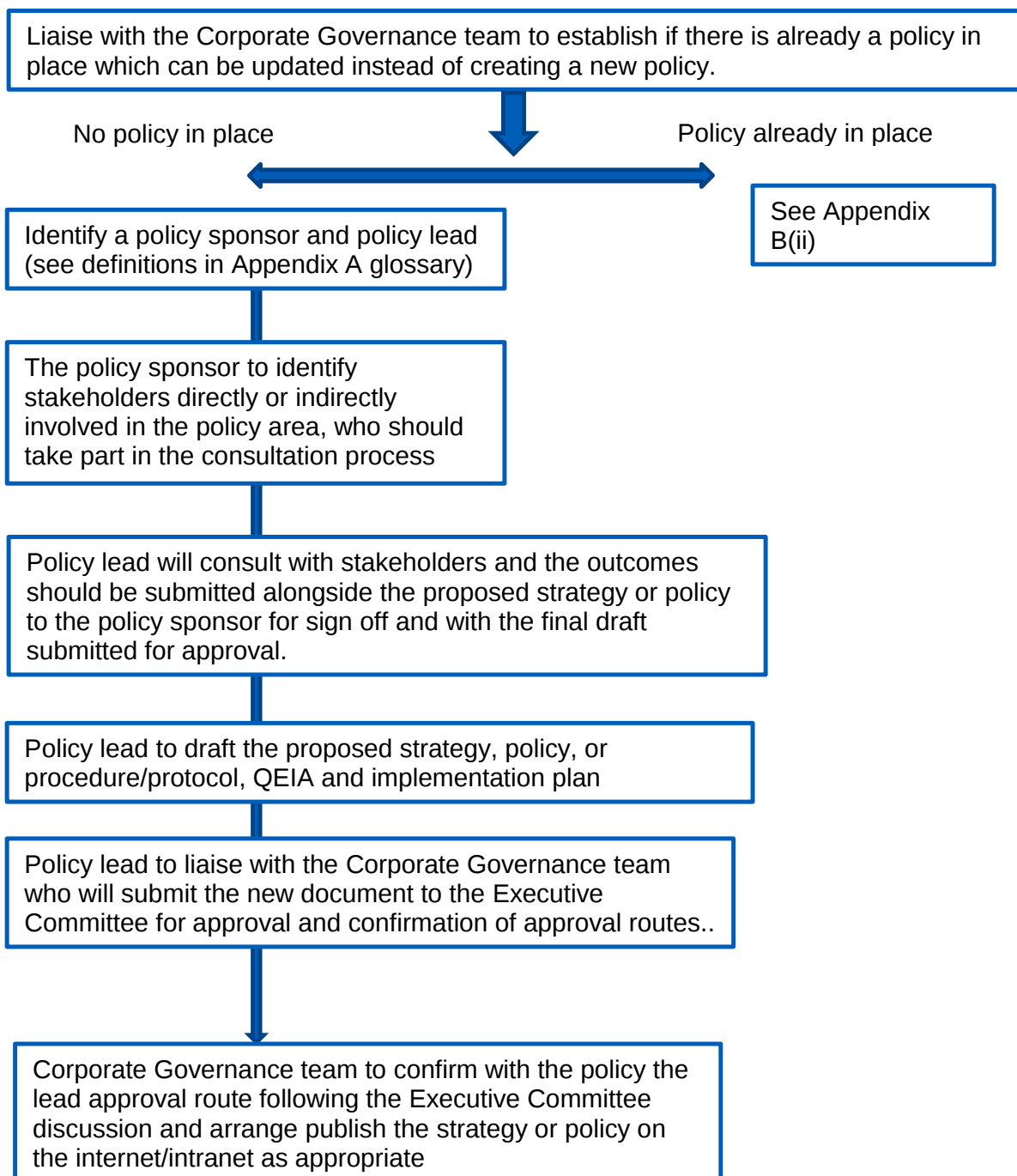
Policy Title	Chief Officer	Approval requires the agreement of
Safeguarding Children Policy	Chief Nursing Officer	Chief Medical Officer
Safeguarding Supervision Policy	Chief Nursing Officer	Chief Medical Officer
Dealing with persistent and unreasonable members of the public policy	Chief Nursing Officer	Chief Communications and Corporate Affairs Officer
Informal Feedback and Formal Complaints Policy	Chief Nursing Officer	Chief Medical Officer
Redress Policy	Chief Nursing Officer	Chief Finance Officer
Disputes Policy	Chief Nursing Officer	Chief Medical Officer
CHC Joint Funding Policy	Chief Nursing Officer	Chief Medical Officer
Quality Equality Impact Assessment (QEIA) Policy	Chief Nursing Officer	Chief Medical Officer
Serious Incident Policy	Chief Nursing Officer	Chief Medical Officer

Policy Title	Chief Officer	Approval requires the agreement of
Flexible Working Policy	Chief People Officer	Chief Communications and Corporate Affairs Officer
Disciplinary Policy	Chief People Officer	Chief Communications and Corporate Affairs Officer
Developing and Growing our People Policy	Chief People Officer	Chief Communications and Corporate Affairs Officer
Internal Incident and Accident Management Policy	Chief People Officer	Chief Communications and Corporate Affairs Officer
Health & Safety Policy	Chief People Officer	Chief Communications and Corporate Affairs Officer
Equality, Diversity, and Inclusion (EDI) Policy	Chief People Officer	Chief Communications and Corporate Affairs Officer
Attendance Policy	Chief People Officer	Chief Communications and Corporate Affairs Officer
Improving Performance Policy	Chief People Officer	Chief Communications and Corporate Affairs Officer
Fair Treatment Policy	Chief People Officer	Chief Communications and Corporate Affairs Officer
Mutually Agreed Resignation Scheme Policy	Chief People Officer	Chief Finance Officer

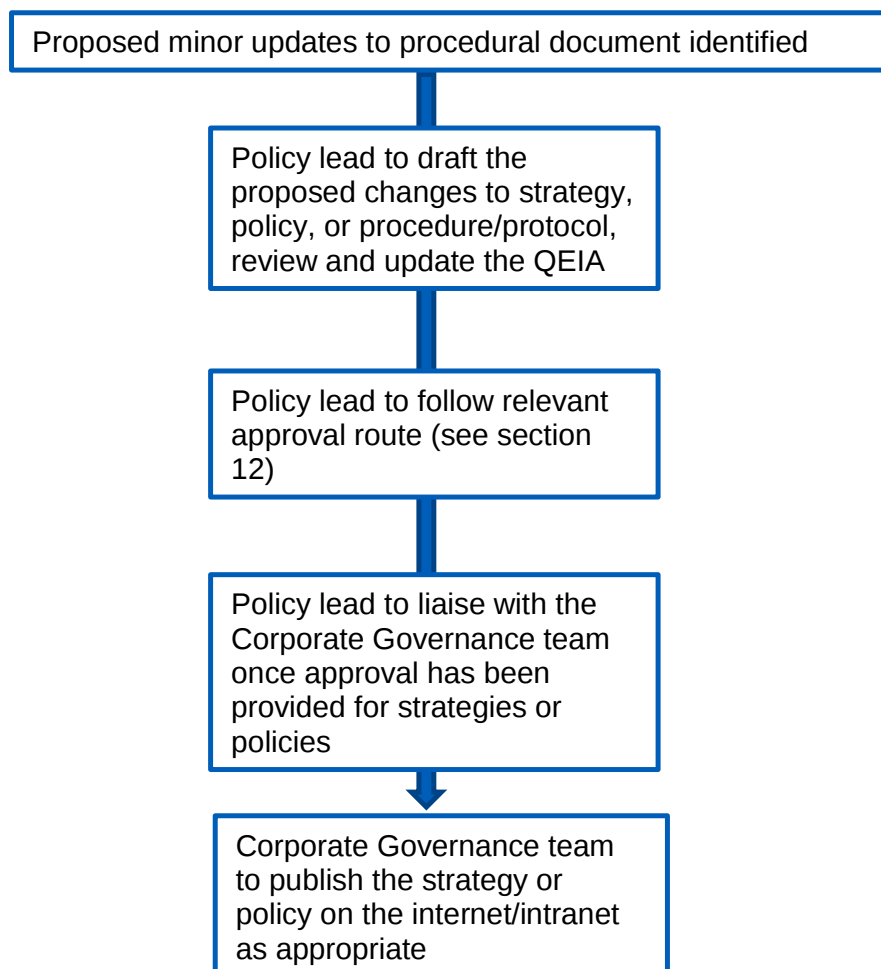
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Policy Title	Chief Officer	Approval requires the agreement of
Probation Policy Probation period for new starters	Chief People Officer	Chief Communications and Corporate Affairs Officer
Recruitment (Inc. movement of employees) Policy	Chief People Officer	Chief Communications and Corporate Affairs Officer
Leave and Pay for New Parents Policy	Chief People Officer	Chief Communications and Corporate Affairs Officer
Time Off Policy	Chief People Officer	Chief Finance Officer
Domestic Abuse Policy	Chief People Officer	Chief Nursing Officer
Social Media Policy	Chief People Officer	Chief Communications and Corporate Affairs Officer

APPENDIX B(ii) – Developing a new policies and strategies (flow chart)



APPENDIX B(iii) – Reviewing and amending policies and strategies (flow chart)



APPENDIX C – Procedural document implementation plan (Template)

Title	<i>Add in title of procedural document</i>
New/Revised	<i>Is this a new policy or a revision of an existing policy?</i>
Policy Sponsor	<i>Add information about Policy Sponsor (Chief Officer)</i>
Policy Lead	<i>Add information about Policy Lead (individual responsible for</i>
Overview	
<i>Provide a brief overview of the proposed procedural document.</i>	
Anticipated impact	
Changes in practice anticipated	<i>Provide a brief summary of the anticipated impact on working practices arising from the proposed procedural document and the outcomes expected as a result.</i>
Stakeholders likely to be affected	<i>Provide a brief summary of the members of staff, patients and the public likely to be affected by the proposed procedural document.</i>
QEIA outcome	<i>Provide a brief summary of the outcome of the Quality, Equality Impact Assessment undertaken in relation to the proposed procedural document.</i>
Implications	
Training	<i>Provide a brief summary of the likely training requirements associated with the proposed procedural document and how these will be addressed.</i>
Resources	<i>Provide a brief summary of the likely resource implications associated with the proposed procedural document and how these will be addressed.</i>
Communications	<i>Provide a brief summary of how the proposed procedural document will be disseminated.</i>
Effectiveness	
Monitoring and Measuring effectiveness	<i>Provide a brief summary of how the anticipated changes in practice and outcomes will be monitored and measured.</i>
Approval of Implementation Plan	
Policy Sponsor	
Signature:	
Date:	

APPENDIX D – Standard Policy Template

Policy Title

NHS Devon

Version	0.1 is first draft of new policy and first approved version is 1.0. First draft/amendment of version 1.0 is 1.1 and incremental until approved as version 2.0
Policy Sponsor	Select Policy Sponsor
Policy Lead	Enter job title of responsible Director
Approved by	Select the Approving Route
Approved on	Select a date
To be reviewed by	Select a date

Document change history (to add rows, copy and paste)		
Date	Change	Comments
Select a date	Select	
Select a date	Select	

Equality, diversity and inclusion statement

NHS Devon is committed to the promotion of equal opportunities, addressing health inequalities and fostering of good relations between people protected under the terms of the Equality Act 2010, the Health and Social Care Act 2012 and Human Rights legislation. We are equally committed to the elimination of unlawful discrimination, harassment and victimisation. To demonstrate this commitment, we develop, promote and maintain policies, strategies and operating procedures. Every effort is made to ensure that patients, employees, contractors or visitors do not experience discrimination; either directly or indirectly, because of their vulnerability; disadvantage; age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion and belief; sex (gender) or sexual orientation.

All staff must comply with this policy. Compliance must reflect our organisational commitment to and policy on, equality, diversity and inclusion. In addition, each manager and member of staff involved in implementing this policy must give due regard to the needs of those protected under law.

If you, or any other groups, believe you are discriminated against under the terms of the Equality Act, the Health and Social Care Act 2012 or Human Rights legislation by anything contained in this document; or you need this document in an alternative format, for example, large print, Braille, Easy read or other languages; please contact our Patient Advice and Complaints Team (PACT):

Tel: 0300 123 1672
Email: pals.devon@nhs.net

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5.1	Insert title of sub-section	
5.2	Insert title of sub-section	
6	Accountabilities, duties and responsibilities	
7	Implementation	
8	Approval and review	
9	Monitoring compliance and effectiveness	
10	Quality and Equality Impact Assessment	
11	References	
	Appendix 1: Glossary of Terms	
	Appendix 2: [insert the title of any other Appendix]	

Red text is provided to support you in writing your policy.
This text is to be removed once the policy is approved.

1. Introduction

Why is this policy needed? Provide a summary of the subject matter, legislation, regulation, national standards, NHS Devon Constitution context.

2. Purpose and objectives

Explain what this policy seeks to achieve e.g., meeting a regulatory or legislative requirement or how the policy will support NHS Devon in achieving its strategic objectives.

- 2.1 The aim of this policy is
- 2.2 This policy will:
 - Set out clearly and succinctly what will happen or change as a result of the adoption of the policy

3. Scope

- 3.1 This policy applies to all staff of NHS Devon [delete the following if not applicable – with the exception of insert any groups or individuals as appropriate]

4. Definitions

Include in the table brief definitions of the terms contained in the policy, such as abbreviations, technical terms and acronyms. (N.B. if required, more terms can be appended in a Glossary).

Terms	Definition

5. Content – key aspects of your policy [title this section as appropriate and ensure that this is reflected in the content list]

5.1 This is the main part of the document – the bit that the reader probably wants to get to and should include all of the key aspects of how NHS Devon will deal with the particular issue which is the subject of the policy.

5.2 Sub-Section title

5.2.1 Add the content relevant to the policy in as many sub-sections as necessary to aid clarity and in a way that concisely conveys the information.

6. Accountabilities, Duties and Responsibilities

This section is to clarify the specific duties associated with the policy and where the responsibilities lie.

Chief Executive Officer	The Chief Executive Officer has ultimate accountability for the strategic direction and operational management of NHS Devon, including compliance with all legal, statutory and policy requirements. [This paragraph to be included in all policies]
Policy Sponsor	The Policy Sponsor is responsible for: - ensuring that policy is appropriate for consideration for approval; - endorsing this policy ahead of submission for approval; - with the Policy Lead, maintaining and updating procedures/protocols and other supporting documents for this policy; [include any specific responsibilities in respect of this policy]
Policy Lead / Author	It is the responsibility of the Policy Lead / author to: - ensure as far as possible that the policy is in line with Department of Health and Social Care guidance, legal requirements and advice from clinical bodies; - to complete a QEIA and Implementation Plan where required - undertake a fair and proportionate consultation period with the relevant stakeholders as part of the document's development - to ensure that the policy is in alignment with NHS Devon's strategy and values - ensure that the policy is developed, approved, disseminated and monitored as set out in the document; with Policy Sponsors, maintaining and updating procedures / protocols and other supporting documents for this policy. [include any specific responsibilities in respect of this policy]

Title of any other relevant Officer	[Set out the specific responsibility for implementation of any part of the process, clearly stating what that officer's responsibility is, including who is responsible for drafting and updating any part of the document]
Titles of any Committee	[Set out the specific responsibility for any part of the process, including reviewing the policy and receiving updates on its effectiveness and compliance]
Line Managers	Line managers have a responsibility to ensure their staff comply with NHS Devon policies and standards within their areas of responsibility. [This paragraph to be included in all policies]
All Staff	Employed or engaged staff have a duty to comply with NHS Devon policies and standards as outlined in their contracts of employment and codes of conduct. [This paragraph to be included in all policies]

7. Implementation

- 7.1 All staff will be informed of the approval of the Policy via the Staff Bulletin which will provide a link to the document on the NHS Devon Intranet.
- 7.2 NHS Devon Senior Managers, or their designated representatives, will implement this policy by:
- Notifying all staff of its existence. New staff will be informed of this policy as part of their induction.
 - Destroying all superseded paper-based versions of the policy and electronic versions retained in their area.
 - Having adequate knowledge of, and / or access to, all relevant legislation in order to ensure that compliance with such legislation is maintained.
 - Discussing with staff as part of their regular one-to-ones how they seek to achieve their individual objectives around policy review and maintenance.

An implementation plan should be completed for all new policies. The template can be found here – [insert link](#). The completed implementation plan should be submitted with the policy to the Policy Sponsor with the final draft at approval stage.

- 7.3 If the need for training has been identified for all staff or particular groupings of staff, include an overview here. Reference should be made to who will require the training, the type of training, how it will be delivered and how often it should be undertaken.

8. Approval and Review

- 8.1 Insert the approval route for this policy. Please contact the Governance Team for confirmation of the correct route.

- 8.2 This policy will be reviewed annually, or sooner if required, in order to ensure that it is current, relevant and reflects the strategic aims, objectives, organisational structures and responsibilities of NHS Devon.

9. Monitoring compliance and effectiveness

- 9.1 Explain how the policy will monitored to provide assurance as to its application and effectiveness. Areas to consider are include:
- Is the policy achieving what we said it would?
 - Are we doing all of the things that we said we would?
 - Is the policy making a difference?

Be realistic around the frequency and detail of the monitoring process. Specify what will be monitored, how this will be done and by whom and where this will be reported and when.

10. Quality & Equality Impact Assessment (QEIA)

A QEIA should be completed for all new policies and where **significant amendments** are made. The NHS Devon QEIA can be found here – *insert link*.

Confirmation that a QEIA has been completed in respect of the policy should be included, together with a brief overview of the findings and any subsequent actions.

The completed QEIA should be submitted with the policy to the Policy Sponsor for sign off with the final draft at the approval stage.

11. References

Other related policy documents

- 11.1 List any other NHS Devon policies which relate to the subject matter of this policy.

Legislation and statutory requirements

- 11.2 List any relevant legislation and statutory documentation including a link the documents referred to.

Best practice recommendations and other key guidance

- 11.3 List any best practice and other guidance including a link the documents referred to.

APPENDIX A – Glossary of terms

List terms/definitions used in this document, including abbreviations, technical terms, and acronyms

Terms	Definition

APPENDIX B –[insert title, which should match the title included on the contents page]

Receipt, Acceptance and Management of Petitions Policy

NHS Devon



Version	1.0
Policy Sponsor	Chief Communications and Corporate Affairs Officer
Policy Lead	Company Secretary
Approved by	
Approved on	Select a date
To be reviewed by	Select a date

Document change history (to add rows, copy and paste)			
Date	Change	Version number of policy	Comments
22/01/2024	New Policy	1.0	N/A
Select a date	Select		

Equality, diversity and inclusion statement

NHS Devon is committed to the promotion of equal opportunities, addressing health inequalities and fostering of good relations between people protected under the terms of the Equality Act 2010, the Health and Social Care Act 2012 and Human Rights legislation. We are equally committed to the elimination of unlawful discrimination, harassment and victimisation. To demonstrate this commitment, we develop, promote and maintain policies, strategies and operating procedures. Every effort is made to ensure that patients, employees, contractors or visitors do not experience discrimination; either directly or indirectly, because of their vulnerability; disadvantage; age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion and belief; sex (gender) or sexual orientation.

All staff must comply with this policy. Compliance must reflect our organisational commitment to and policy on, equality, diversity and inclusion. In addition, each manager and member of staff involved in implementing this policy must give due regard to the needs of those protected under law.

If you, or any other groups, believe you are discriminated against under the terms of the Equality Act, the Health and Social Care Act 2012 or Human Rights legislation by anything contained in this document; or you need this document in an alternative format, for example, large print, Braille, Easy read or other languages; please contact our Patient Advice and Complaints Team (PACT):

Tel: 0300 123 1672

Email: pals.devon@nhs.net

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1. Introduction

A petition represents the expression of the views of the people who sign it. For the NHS Devon Integrated Care Board (NHS Devon) petitions are an important mechanism for local people to have a voice on local health matters.

Petitions can be raised as a discrete statement by the signatories or as a response to a public consultation or proposal being made by NHS Devon. To ensure that voices are heard appropriately and to avoid only listening to active lobby groups, NHS Devon will not view petitions in isolation, but as one piece of evidence and information which contributes to an overall picture of public opinion.

2. Purpose and objectives

The aim of this policy is to outline how NHS Devon will handle any petitions received from the local community.

3. Scope

This policy applies to the receipt, acceptance and management of all petitions received by NHS Devon, whether a hard copy or an e-petition. It does not apply to petitions received in response to a formal consultation on a proposal to change an existing service. These petitions will be managed instead through that formal consultation process.

4. Context

Petitions may be proactive, e.g., unsolicited where there is public opinion that a new service may be required to fill a perceived gap in service provision; or reactive, e.g., in response to an NHS initiated proposal to change an existing service or clinical policy.

There is currently no legally binding guidance to the NHS on handling petitions.

When considering the receipt and management of petitions, NHS Devon wishes to ensure that it follows best practice and has drawn on published terms and conditions for submitting e-petitions, utilised by HM Government.

4.1 Criteria for the consideration of petitions

In order to be received by NHS Devon for consideration, petitions should meet the criteria outlined below:

- Petitions will relate directly to:

- services provided and decisions made by NHS Devon or one of its partner organisations (where the service has been commissioned by NHS Devon);
 - or where there is a perceived gap in service provision or clinical policy.
- Petitions may be received in paper or electronic (e.g., email, web based or social media) format.
 - Petitions should include a statement of petition which should include:
 - the organisation to which the petition is being addressed
 - the proposition which is being promoted by the petition
 - the timeframe over which the petition has been collected
 - the number of signatures collected
 - The following information about each petitioner should be included:
 - Name
 - Postcode
 - Signature (in the case of a written petition)
 - Email address (in the case of an electronic petition). If this data is not collected due to the data controller not sharing the data e.g., a social media (e.g., Facebook) or 38 degrees petition, the petition will only be acknowledged as an indicator of public sentiment.
 - The name and address of the petition organiser, who must be resident within the area to which the petition relates, should be provided on the first page of the petition.

A petition amounting to any number of signatures will be considered by NHS Devon. Only those with more than 1000 signatures will be presented to the NHS Devon Board. For those petitions with fewer than 1000 signatures, the petition will be forwarded to the most appropriate NHS Devon Chief Officer for consideration and response.

Where a petition, with significant support (with a minimum of 1000 signatures) has been received by NHS Devon and meets the criteria above, the Chief Executive shall consult with the Chair as to how best to address the receipt of the petition at the next meeting of the NHS Devon Board. This could be as a specific item for the agenda, as a reference in either the Chair or Chief Executive's Report to the Board. The purpose of the presentation of the petition is to enable the Board to be aware of the issues raised and proposed actions to be taken in response.

4.2 Acceptance of Petitions

An acknowledgement of receipt of the petition will be provided to the lead petitioner within 5 working days of receipt with a clear explanation about what will happen next.

Petitions will not be considered if they are repeated, focus on individual grievances, are in respect of a subject of persistent contact with NHS Devon, or if they concern issues which are outside NHS Devon's remit such as health issues of national

5 – NHS Devon Receipt, Acceptance and Management of Petitions Policy

concern. Petitions will also not be considered if the information contained is confidential, libellous, false, defamatory or offensive.

A petition will be considered as a repeat petition if:

- a) it covers the same or substantially similar subject matter to another petition received within the previous six months;
- b) it is presented by the same or similar individuals or groups as another petition received within the previous six months.

A petition will be considered as the subject of persistent contact if:

- a) it focuses on individual grievances
- b) it focuses on the actions or decisions of an individual and not the organisation
- c) the subject matter or individual submitting the petitions meets any of the definitions contained within NHS Devon's "Dealing with Persistent and Unreasonable Members of the Public Policy".

A petition will be considered as outside NHS Devon's remit if:

- a) it focuses on a matter relevant to another organisation
- b) it focuses on a matter of national rather than local concern
- c) it requests information available via Freedom of Information legislation
- d) its aim is to correspond on personal issue(s) with an individual(s)
- e) signatories are not based in the UK

A petition will be considered as confidential, libellous, false or defamatory if:

- a) it contains information which may be protected by an injunction or court order
- b) it contains material which is potentially confidential, commercially sensitive, or which may cause personal distress or loss

A petition will be considered as offensive if:

- a) it contains language that may cause offence, is provocative or extreme in its views

The petition's concerns will be assessed in relation to the aims being put forward, and the rationale and constraints behind it. For example, a petition that proposes a realistic alternative option will normally be given greater weight than a petition that simply opposes an option that has been put forward for valid reasons.

The petition's concerns will also be assessed in relation to the impact on other populations if these demands were accepted. This assessment could take into account views expressed in other petitions (which may conflict) or in more direct responses to the consultation.

Where a petition does not meet the requirements set out in the criteria above then NHS Devon will respond in writing within ten working days to confirm this and the reason for rejection will be given clearly and explicitly. Should a petition be related to an individual grievance or treatment received by an individual then it will be referred to the Patient Experience Team for review and, if required, action.

4.3 Management of Petitions

A register of petitions received will be maintained by the Corporate Governance Team and reported to annually to the Audit and Risk Committee.

Hard copy and electronic petitions will be stored in a secure place for 3 years and will then be destroyed as confidential waste (in the case of hard copies) or deleted (e-petitions)

4.4 Submission of Petitions

Hard copy petitions should be addressed to:

The Chief Executive
NHS Devon Integrated Care Board
Aperture
Pynes Hill
Exeter
EX2 5SP

If you wish to make an appointment in advance to have your petition formally received, you should contact the ICB's Chief Executive's office at d-icb.corporateservices@nhs.net.

Electronic petitions can be brought to the attention of the Executive by sending a link to d-icb.corporateservices@nhs.net.

5.Accountabilities, Duties and Responsibilities

Chief Executive Officer	The Chief Executive has ultimate accountability for the strategic direction and operational management of NHS Devon, including compliance with all legal, statutory and policy requirements. The Chief Executive is responsible for receiving petitions submitted to NHS Devon. Where petitions include over 1000 signatures, the Chief Executive has the responsibility of, together with the Chair, for consideration to discuss at a meeting of the NHS Devon Board to agree any appropriate actions. The Chief Executive is responsible for ensuring that appropriate correspondence is sent informing petitioners of any rejected petitions providing clear and explicit reasons for the rejection.
Chair	The Chair is responsible for reviewing petitions with over 1000 signatures together with the Chief Executive for consideration to discuss at a meeting of the NHS Devon Board to agree any appropriate actions.

Corporate Governance Team	The Corporate Governance Team is responsible for maintaining a register of petitions received and reporting on this annually to the Audit and Risk Committee. The Corporate Governance Team is responsible for the management of responses to petitions.
Policy Sponsor	The Policy Sponsor is responsible for: - ensuring that policy is appropriate for consideration for approval; - endorsing this policy ahead of submission for approval; - with the Policy Lead, maintaining and updating procedures/protocols and other supporting documents for this policy
Policy Lead / Author	It is the responsibility of the Policy Lead / author to: - ensure as far as possible that the policy is in line with Department of Health and Social Care guidance, legal requirements and advice from clinical bodies; - to complete a QEIA and Implementation Plan where required - undertake a fair and proportionate consultation period with the relevant stakeholders as part of the document's development - to ensure that the policy is in alignment with NHS Devon's strategy and values - ensure that the policy is developed, approved, disseminated and monitored as set out in the document; with Policy Sponsors, maintaining and updating procedures / protocols and other supporting documents for this policy.
All Staff	Employed or engaged staff have a duty to ensure that any petitions received are shared with the Corporate Governance Team within an appropriate timeframe to allow a response within the timescales set out within this policy.

6. Implementation

All staff will be informed of the approval of the Policy via the Staff Bulletin which will provide a link to the document on the NHS Devon Intranet.

NHS Devon Senior Managers, or their designated representatives, will implement this policy by:

- Notifying all staff of its existence. New staff will be informed of this policy as part of their induction.
- Destroying all superseded paper-based versions of the policy and electronic versions retained in their area.

- Having adequate knowledge of, and / or access to, all relevant legislation in order to ensure that compliance with such legislation is maintained.
- Discussing with staff as part of their regular one-to-ones how they seek to achieve their individual objectives around policy review and maintenance.

7. Approval and Review

The approval route for the Policy will be via the NHS Devon Board.

This policy will be reviewed annually, or sooner if required, in order to ensure that it is current, relevant and reflects the strategic aims, objectives, organisational structures and responsibilities of NHS Devon.

8. Monitoring compliance and effectiveness

The log of petitions received along with any breaches in relation to this policy will be reported to the Audit and Risk Committee on an annual basis.

9. Quality & Equality Impact Assessment (QEIA)

A QEIA has been completed in respect of the policy and has highlighted no areas of concern.

10. References

Legislation and statutory requirements

There is currently no clear, legally binding guidance to the NHS on handling petitions. NHS Devon has drawn upon published terms and conditions for submitting e-petitions, utilised by HM Government.