Keele University Teaching Trust

NHS
North Staffordshire Combined Healthcare NHS Trust

Our Ref: NG/RM/25420
Date: 12th January 2026

Ben Richards
Chief Operating Officer
North Staffordshire Combined Healthcare NHS Trust
Lawton House
Bellringer Road
Trentham
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Reception: 0300 123 1535

Dear

Freedom of Information Act Request

I am writing in response to your e-mail of the 2nd December 2025**.** Your request has been processed using the Trust's procedures for the disclosure of information under the Freedom of Information Act (2000).

Requested information:
I am writing to request the following documentation under the FOI Act:

1. Board Assurance Framework and accompanying cover papers for the last 3 meetings where this has been presented to the Board and Committees.
   Board Assurance Framework was presented at Trust Board on the below dates
   - **Q4 2024/25- 08/05/2025**
   - **Q1 2025/26- 11/09/2025**
   - **Q2 2025/26- 13/11/2025**

   Trust Board Papers can be found here Board meetings - North Staffordshire Combined Healthcare NHS Trust

2. Risk Management policy. **Please see Appendix 1 attached.**

3. Business Conduct policy/ Conflicts of interest policy and relevant reports from Board/ Committees where declarations and performance has been reported in the last 12 months. **Please see Appendices 2- 4 attached.**
   Register of Board members can be found here Trust publications - North Staffordshire Combined Healthcare NHS Trust . This was reported to Audit Committee and same report to Trust Board in 2025 – 2nd February 2025 which can be found here Board meetings - North Staffordshire Combined Healthcare NHS Trust

4. Policy on policies. **Please see Appendix 5 attached.**

5. Trust Policy template. **Please see Appendix 6 attached .Description of how to write a policy is included in policy on policies above.**

6. Annual Report papers from Board/ Committee where this has been discussed/ approved in the last 2 years, including preparation for the annual report and accounts (i.e. approval of the process, confirmation of the timeframe for reporting). **Please see Appendices 7-9 attached.**

7. Committee structures, and Terms of Reference for the Board and Committees. **Please see Appendices 10-16 attached. Please note that PCDC and Charitable Funds Committees ToRs were due review in September 2025 but have been extended to Jan 2026.**

8. Committee business management policy. **The Trust does not have a Committee business management policy.**

9. Trust Constitution, a copy of it as well as Board and Committee papers where this has been discussed in the last 2 years. **North Staffordshire Combined Healthcare NHS Trust does not have a Trust constitution as we are not a Foundation Trust.**

10. Claims Management policy. **Please see Appendix 17 attached.**

11. Any policy or guideline relating to the management of inquests at the Trust. **Please see Appendices 18 and 19 attached.**

12. Governor and Board induction packs. **The Trust does not have a local induction pack for staff.**

13. Membership and engagement policy/ strategy. **The Trust does not have a Membership and engagement policy/ strategy**

14. Mental Health Act Committee papers for the last 3 meetings. **The Trust does not have a Mental Health Act Committee.**

15. Appraisal of Board members - any relevant Board and Committee papers from the last 12 months.
The Trust is applying Section 40 (2) to the request as disclosure of requested information could provide personal identifiable information which would contravene one or more of the data protection principles under the Data Protection Act 2018.

16. Recruitment of Board members - any relevant Board and committee papers from the last 12 months. **There has been no recruitment of Board members in the last 12 months.**

17. Risk appetite policy, including any papers that may have gone to the Board in the last 24 months on this. **The Trust does not have a Risk Appetite Policy although Risk Appetite is included in BAF papers. (Question 1)**

18. Programme of Board development sessions for the Board - current version. **Please see Appendix 20 attached.**

19. CQC Well Led inspection - action plans following most recent visit. **Please see Appendices 21 and 22 attached.**

20. Template for Board and Committee reports. **Please see Appendices 23 and 24 attached.**

21. Structure chart for governance team/ division. **Please see Appendix 25 attached.**

22. Copy of your Corporate Risk Register. **Please see Appendix 26 attached.**

We are refusing your request in part under the Freedom of Information Act 2000 (FOIA) on the basis of the following exemptions:

- **Section 31 – Law Enforcement**
- **Section 43 – Commercial Interests**
- **Section 38 – Health and Safety**

Section 31 - Law Enforcement. This exemption applies because disclosure would, or would be likely to, prejudice the exercise by any public authority of its functions for any of the purposes specified in subsection (2) of the Act.
Section 31 is subject to a prejudice test, as well as the public interest test. Given its different approach we have considered the prejudice and public interest elements in combination in relation to the information withheld under this section.
We acknowledge the public interest in transparency, accountability, and supporting public understanding of regulatory and enforcement processes and emergency planning. However, we have determined that the public interest in maintaining the exemption outweighs these factors:

- **Maintaining regulatory effectiveness: Disclosure would undermine investigatory methods and planning. This reduces the public benefit gained from effective and fair enforcement.**
- **Upholding deterrence and compliance: Trust in our enforcement process is built on confidentiality and the certainty that unlawful activity will be detected. Disclosure risks weakening deterrence, incentivising non-compliance.**
- **Protecting ongoing investigations: Some information requested pertains to live information where premature exposure could jeopardize outcomes or fairness therefore not serving the public interest.**

Consequently, we consider the likelihood of prejudice and resultant harm outweighs the benefits of transparency. Section 31(1)(g) is therefore engaged, and the information is withheld.

In relation to the other two exemptions applied:
Section 43– Commercial Interests: The requested information includes sensitive material. Disclosure would be likely to prejudice the commercial interests of the Authority and relevant named third parties by explain supplier rates, negotiation levers and processes or other commercially sensitive information

Section 38– Health and Safety: Disclosure would be likely to endanger the physical and/ or mental health and/ or safety of staff at named sites, service users, contractors, and/ or members of the public, as it could enable a number of different issues including enabling targeting, facilitating unlawful interference, or exacerbating risks to vulnerable individuals.
In relation to both the s43 and s38 exemptions we recognise the public interest in disclosure, including:

- **Promoting transparency and accountability in the use of public funds, and enabling informed public debate about service delivery; and**
- **Supporting public understanding of how the Authority delivers services, manages risk and ensures value for money.**

However, we have concluded that, in this case, the public interest favours maintaining the exemptions:

- **Commercial prejudice (s43): Disclosure would undermine live or future competitions and weaken our bargaining position, ultimately diminishing value for money for the public and deterring market participation by suppliers concerned about disclosure of competitively sensitive material. Protecting effective competition and fair procurement is itself a strong public interest.**
- **Health and safety (s38): There is a risk that disclosure would increase threats to individuals or sites and exacerbate mental health harms. The public interest strongly favours preventing avoidable harm and maintaining the effectiveness of security and safeguarding measures. Protecting life, health, and safety carries substantial weight in the balance.**

On balance, we consider that the harms from disclosure outweigh the general benefits of transparency. The exemptions are therefore maintained.
The remainder of the request has been released in unredacted form.

23. Standing Financial Instructions/ Standing Orders for the Board of Directors.
    Standing Orders Policy can be found here **Trust publications - North Staffordshire Combined Healthcare NHS Trust under Policies.**

If you are dissatisfied with the handling of your request, you have the right to ask for an internal review of the management of your request. Internal review requests should be submitted within two months of the date of receipt of the response to your original letter and should be addressed to: Dr Buki Adeyemo, Chief Executive, North Staffordshire Combined Healthcare Trust, Trust Headquarters, Lawton House, Bellringer Road, Trentham, ST4 8HH. If you are

not content with the outcome of the internal review, you have the right to apply directly to the Information Commissioner for a decision. The Information Commissioner can be contacted at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF.

Yours sincerely

Ben Richards
Chief Operating Officer

Doc level: Trustwide
Code ref: 4.18a
Issue number: 2

Risk Management Policy

Lead executive	Chief Executive
Authors details	Deputy Director of Governance

Type of document	Policy
Target audience	All Trust staff
Document purpose	This policy sets out the delivery of effective risk management within a clear infrastructure, systems, and processes.

Approving meeting	SLT Trust Board	Meeting date	8th June 2023
Implementation date	30th June 2023	Review date	31st May 2026

Trust documents to be read in conjunction with	
Document code	Document name
4.18a	Risk Management Policy
5.01	Incident Reporting Policy

Document change history		Version	Date
What is different?	– The policy has been revised to satisfy the recommendations made by the KPMG BAF and Risk Management Audit 2022/23.		
Appendices / electronic forms	– As previous		
What is the impact of change?	– Revised as per expiry date of policy		

Training requirements	There are no specific training requirements for this document.

Document consultation	
Directorates	N/A
Corporate services	N/A
External agencies	N/A

Financial resource implications	No

External references
1.

Monitoring compliance with the processes outlined within this document	This policy will be updated by the Associate Director of Governance on expiry and submitted to SLT for sign off and Audit Committee for approval.

Equality Impact Assessment (EIA) - Initial assessment	**Yes/No**	**Less favourable / More favourable / Mixed impact**
Does this document affect one or more group(s) less or more favorably than another (see list)?		
– **Age** (e.g. consider impact on younger people/ older people)	No	
– **Disability** (remember to consider physical, mental and sensory impairments)	No	
– **Sex/Gender** (any particular M/F gender impact; also consider impact on those responsible for childcare)	No	
– **Gender identity and gender reassignment** (i.e. impact on people who identify as trans, non-binary or gender fluid)	No	
– **Race / ethnicity / ethnic communities / cultural groups** (include those with foreign language needs, including European countries, Roma/travelling communities)	No	
– **Pregnancy and maternity, including adoption** (i.e. impact during pregnancy and the 12 months after; including for both heterosexual and same sex couples)	No	
– **Sexual Orientation** (impact on people who identify as lesbian, gay or bi – whether stated as 'out' or not)	No	
– **Marriage and/or Civil Partnership** (including heterosexual and same sex marriage)	No	
– **Religion and/or Belief** (includes those with religion and /or belief and those with none)		
– **Other equality groups?** (may include groups like those living in poverty, sex workers, asylum seekers, people with substance misuse issues, prison and (ex) offending population, Roma/travelling communities, and any other groups who may be disadvantaged in some way, who may or may not be part of the groups above equality groups)	No	
If you answered yes to any of the above, please provide details below, including evidence supporting differential experience or impact.		
Enter details here if applicable		
If you have identified potential negative impact: - Can this impact be avoided? - What alternatives are there to achieving the document without the impact? Can the impact be reduced by taking different action?		
Enter details here if applicable		
Do any differences identified above amount to discrimination and the potential for adverse impact in this policy?	No	

If YES could it still be justifiable e.g. on grounds of promoting equality of opportunity for one group? Or any other reason	N/A
Enter details here if applicable	

Where an adverse, negative or potentially discriminatory impact on one or more equality groups has been identified above, a full EIA should be undertaken. Please refer this to the Diversity and Inclusion Lead, together with any suggestions as to the action required to avoid or reduce this impact. For advice in relation to any aspect of completing the EIA assessment, please contact the Diversity and Inclusion Lead at Diversity@northstaffs.nhs.uk	
Was a full impact assessment required?	No
What is the level of impact?	Low

1 Introduction

North Staffordshire Combined Healthcare NHS Trust (the Trust) is a statutory body which came into existence on 1 April 1994. We are one of the main providers of Mental Health, Social Care and Learning Disability Services in the West Midlands and have been rated as Outstanding by the Care Quality Commission (CQC).

Our quality priorities are - SPAR –

S - Our services will be consistently **Safe**

P - Our care will be **Personalised** to the individual needs of our service users

A - Our processes and structures will guarantee **Access** to services for our service users and their carers

R - Our focus will be on the **Recovery** needs of those with mental illness

Our objectives - (measurable metrics against which we will deliver our goals)

- We will provide the highest quality, safe and effective services ☐
- We will attract, develop and retain the best people ☐
- We will actively promote partnership and integrated models of working ☐
- We will increase our efficiency and effectiveness through sustainable development ☐

2 Infrastructure, Systems and Processes

Locality Structure
Five Clinical Directorates:

- Acute and Urgent Care Directorate.
- Specialist Care Directorate.
- North Staffordshire Community Directorate.
- Stoke Directorate.
- Primary Care

From 1st July 2023, we will merge our Stoke and North Staffordshire Community Directorates

Our locality structure, our aims are to:

- Bring together all age community services by geography.
- Provide better services to our local communities.
- Bring together all ‘Specialist Services’ (wider than North Staffs catchment).
- Improve and bring together ‘Urgent Care’ pathways.

Develop a robust and integrated professional structure.
- Strengthen Clinical Leadership at a pathway level.

Our direction of travel is to ensure that transformation enables change at scale and delivers improved outcomes and demonstrable returns on investment.

Policy Statement

1.1 North Staffordshire Combined Healthcare Trust (NSCHT) is committed to establishing an effective and pro-active approach to managing all risks which may impact on its ability to deliver its statutory responsibilities and the achievement of its objectives and values. This policy sets outs the processes and responsibilities for risk management within the Trust.

1.2 Risk is an inherent part of the delivery of healthcare. The Risk Management Policy outlines the Trust`s approach to risk management with the aim of summarising the Trust's overall system of risk management, describing the vision to which it aspires. This policy details arrangements for the identification, measurement, and management of risks.

1.3 The objective of the Risk Management Policy is to promote an integrated and consistent approach across all parts of the Trust. The policy applies to staff at all levels. Staff are expected to ensure that risk management is a fundamental part of their approach to clinical and corporate governance which will in turn contribute to improved, safe and high-quality service provision. The Trust promotes a Being Open Culture with Freedom To Speak Up and encouragement to report incidents, near misses and risks. Risk Management is a central element of the Trust's quality, governance, and performance processes.

1.4 Achievement of objectives is subject to uncertainty, which gives rise to threats and opportunities. Uncertainty of outcome is how risk is defined. Risk management includes identifying and assessing risks and responding to them (treat, tolerate, terminate, transfer). Risk appetite will vary between organisations (the amount of risk an organisation is willing to seek or accept in pursuit of its long-term objectives). The Risk Appetite is as per Trust objectives as agreed by the Trust Board on a quarterly basis and documented in the Board Assurance Framework.

Scope

This Policy applies equally to all members of staff throughout the Trust or those working for the Trust under a contract of services.

The delivery of effective risk management is dependent on having a clear infrastructure, systems and processes which result in:-

a) The operation of a comprehensive risk management framework and effective processes for organisation-wide co-ordination and prioritisation of risks.

b) Systems and operating procedures which reduce reliance on memory and therefore minimise the opportunity for error and the harmful effects of errors by anticipating their occurrence - detecting them at an early stage rather than focusing on human failure, errors are seen as being shaped and provoked by systems failure.

c) Hazards/incidents/near misses being systematically identified, recorded, reported, managed, and analysed in an integrated way in accordance with an agreed policy of positive, non-punitive reporting.

d) The maintenance of a Trust Risk Register, including associated risk treatment plans with regular progress reports to the Senior Leadership Team (SLT) and sub-committees of the Trust Board in accordance with the Terms of Reference of those sub-committees.

3 Definitions

Risk is the combination of the probability of an event occurring and its consequence should it occur (likelihood and impact). Consequences can be negative or positive and therefore can be viewed as an opportunity or a threat.

Risk Management is a process which aims to help the Trust understand, evaluate and take action on all risks, with a view to increasing the probability of success and reducing the likelihood of failure to the benefit of the patients, staff and the public.

Threat - a risk that may hinder the achievement of objectives.

Opportunity - a risk that may help in the achievement of objectives.

Risk Appetite - the amount of risk an organisation is willing to seek or accept in pursuit of its long-term objectives.

Risk Tolerance - the boundaries of risk taking outside of which the organisation is not prepared to venture.

Board Assurance Framework (BAF) details the procedures and actions the Trust has identified for risk management against key strategic objectives.

Trust Risk Register - contains all risks escalated from Directorate Risk Registers and those that do not directly sit within the BAF.

Operational Risks - all risks associated with clinical and corporate, operational and administrative procedures related to service provision.

Risk Title – the risk title should describe the risk, the cause, and the consequence. Clear risk articulation is essential for ensuring the risk is understood and correctly managed.

Gross Risk Score – the initial score upon identification of the risk.

Residual Risk Score – the current score upon application of controls.

Target Risk Score – a reducing score to be achieved over an agreed period of time as further controls/mitigations are implemented until the risk can be eliminated or tolerated.

Risk Treatment – a process to modify risk (4 T's Tolerate, Treat, Transfer, Terminate).

Accepted Risks - It is accepted that it is not possible to completely eliminate all areas of risk. Levels of acceptable risk are determined by working within agreed Trust policies and procedures. Working outside of Trust policies and procedures is **unacceptable** to the organisation and may result in the Trust taking disciplinary action.

Key Process Objectives
The Risk Management Policy identifies key objectives for taking risk management forward, these are:

Objective 1: Alignment with the Board Assurance Framework

- The Trust`s highest scoring risks will be mapped to the strategic risks detailed within the BAF.
- Alignment will be reviewed on a quarterly basis.

Objective 2: Compliance with Regulators

- Further develop the Trust's risk management processes to ensure that the Trust is compliant with the CQC well led framework and other regulators e.g. Department of Health, NHS England and NHS Improvement through processes to effectively and efficiently identify and address all key risks to compliance within key domains (Safe, Responsive, Caring, Effective, Well led).

Objective 3: Raise awareness and promote a culture of monitoring and improvement.

- The Risk Manager will work with and provide guidance and support to Directorates via Clinical Directors, Associate Directors, Managers, nominated Directorate Risk Leads and a range of other clinical and non-clinical staff.
- Ensure that risk management awareness training is in place and provides full Trust coverage.
- Ensure guidance documents are available to staff alongside a dedicated risk management page on the Trust`s Intranet (CAT).

Objective 4: Provide Assurance of successful Risk Management

- Each strategic risk and Trust risk will be linked to the relevant Trust Committee who will receive monthly assurance reports with the exception of the Audit Committee who receive a quarterly report.
- Undertake a formal self-assessment and develop and implement plans to further enhance the Risk Management Framework.
- Successful audit of the risk management framework and BAF via Trust Internal Auditors, KPMG.
- Ensure that risk management processes are operating effectively at all levels.

Objective 5: Utilise effective Information Technology

- To use an electronic risk management system which meets the needs of the Trust reporting risk across the different layers of risk management within the Trust.
- Extract risk reports by Team, Directorate and Committee developing a matrix approach to extraction of reports by locality and function to provide increased monitoring and analysis of risk.

4 Risk Management Framework

The Trust has four risk levels within the management framework:

1. Board Assurance Framework (BAF)
2. Trust Risk Register
3. Directorate Risk Register
4. Team Risk Register

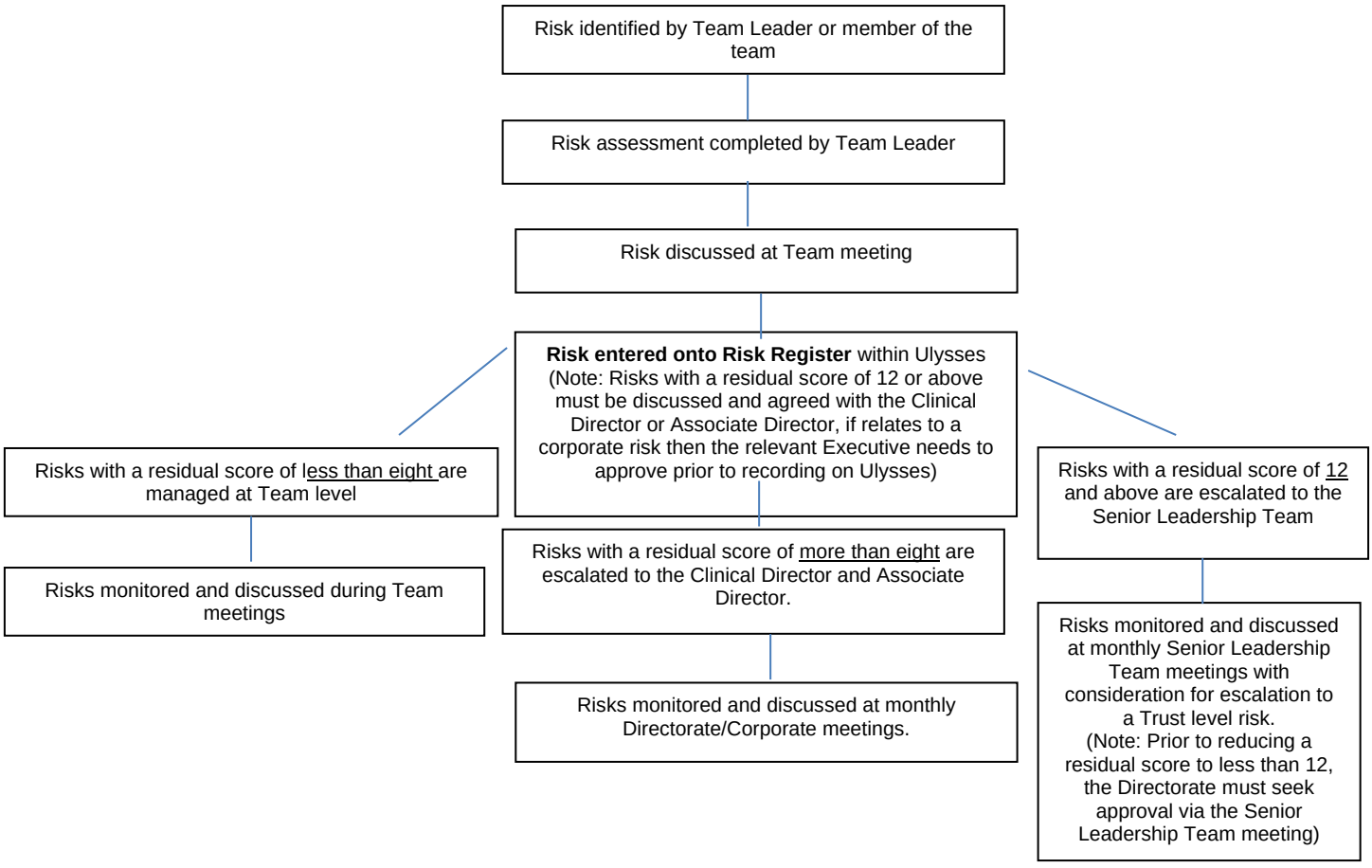
The Trust, Directorate and Team Operational Risk Registers are held on the Ulysses Risk Management system to further improve the clarity of reporting, linking and monitoring of risks evidencing mitigations and enabling accurate, clear reports to be extracted as required.

- Split by relevant Committee.
- By Directorate
- Financial risk where known.
- Demonstrating gross, residual and target risk scores with a trend arrow to reflect changes in the residual risk score.

In addition to risks, the Trust will also identify opportunities which will enhance the likelihood of achieving its objectives.

Trust, Directorate and Team Level Risk Management Process
Team risks with a residual score of 8 or above are escalated to Directorate level. The risk is then discussed at Directorate meetings where the decision is made to retain the score and escalation, therefore transferring ownership to the Clinical Director, unless a more appropriate person is identified, or reduction of the score, de-escalating back to team level. Risks with a residual score of 12+ (require risk ownership to be Clinical Director) and above are escalated to the Senior Leadership Team (SLT) for consideration and review and potential escalation to a Trust level risk.

The risk management process that is in place for identification, recording, review and escalation is summarised in the flowchart below:-



Risk Assessment/Scoring

Risk is the combination of the probability of an event and its consequence (likelihood and impact). Consequences can range from positive to negative.

When scoring the level of risk you should consider the following two factors:-

- Likelihood
- Impact

Each risk should be given a gross, residual and target score -

Gross Risk Score – the initial score upon identification of the risk.

Residual Risk Score – the current score upon application of controls/mitigations

Target Risk Score – a reducing score to be achieved over an agreed period of time as further controls/mitigations are implemented until the risk can be eliminated or tolerated.

Risks must be scored using the 5 x 5 scoring matrix as set out below (Using the guidance provided to determine impact and likelihood scores).

		LIKELIHOOD				
		Rare	Unlikely	Possible	Likely	Almost Certain
IMPACT	**Rating**	**1**	**2**	**3**	**4**	**5**
1. Negligible/Insignificant	**1**	1	2	3	4	5
2. Minor	**2**	2	4	6	8	10
3. Moderate	**3**	3	6	9	12	15
4. Major	**4**	4	8	12	16	20
5. Catastrophic	**5**	5	10	15	20	25

This process will then generate scores for each identified risk, they will then be categorised as follows:-

Residual Risk Rating	Risk Priority	Reporting Level	Action
1-3	Low	Team	• Risks will be considered at team level and recorded on the Team Risk Register. • Risks will be owned by Team Manager/Leader who will work with the team to determine and implement mitigating actions. • Risk will be a standing agenda item at team meetings, where the Manager will share the team's risk register and hold discussion under the key headings of Existing, New, Escalated/De-escalated, and Closed risks. • The risk will be reviewed and updated on Ulysses in accordance with the review frequency determined for the risk, which may be less frequently than monthly based on the nature of the risk and the lower risk score. • Review frequency – recommended at least annually unless the nature of the risk determines otherwise.

4-6	Moderate	Team	• Risks will be considered at team level and recorded on the Team Risk Register. • Risks will be owned by Team Manager/Leader who will work with the team to determine and implement mitigating actions. • Risk will be a standing agenda item at team meetings where the Manager will share the teams risk register and hold discussion under the key headings of Existing, New, Escalated and Closed risks. The risk will be reviewed and updated on Ulysses in accordance with the review frequency determined for the risk, which may be less frequently than monthly based on the nature of the risk and the lower risk score. • Review frequency – recommended at least 6 monthly as a minimum unless the nature of the risk determines otherwise.
8-10	Significant	Directorate	• Risks will be considered at team level and recorded on the Directorate/Corporate Risk Register. • Risks will be owned by the Clinical Director (unless a more appropriate person is identified) and reviewed during monthly Directorate meetings where key members of the Directorate are present. • Directorate Risk Leads will update risks on the Ulysses Risk Management System. • Review frequency – recommended monthly as a minimum unless the nature of the risk determines otherwise.
12	Significant	Directorate/ Senior Leadership Team (SLT)	• Risks will be considered at Directorate level, recorded on the Directorate Risk Register, and owned by the Clinical Director or Executive. • Reviewed monthly by the Directorate and by the Senior Leadership Team (SLT), these risks will also be considered by SLT for escalation to the Trust Risk Register for further review by the Executive Team. • The Risk Manager will update those risks recorded on the Trust Risk Register. • Directorate Risk Leads will update risks retained at Directorate level.

15-25	High	Directorate/ Senior Leadership Team (SLT)	• Operational risks will be considered at Directorate level, recorded on the Directorate Risk Register and owned by the Clinical Director or relevant Executive. • Reviewed monthly by the Directorate and the Senior Leadership Team (SLT), these risks will also be considered by SLT for escalation to the Trust Risk Register for further review by the Executive Team. • The Risk Manager will update those risks recorded on the Trust Risk Register. • Directorate Risk leads will update risks retained at Directorate level. • Escalation of a Directorate risk to Trust level will transfer ownership to the relevant Executive. • Trust level risks will be aligned to their relevant Committee and report directly into the Committee for monitoring and decision making.

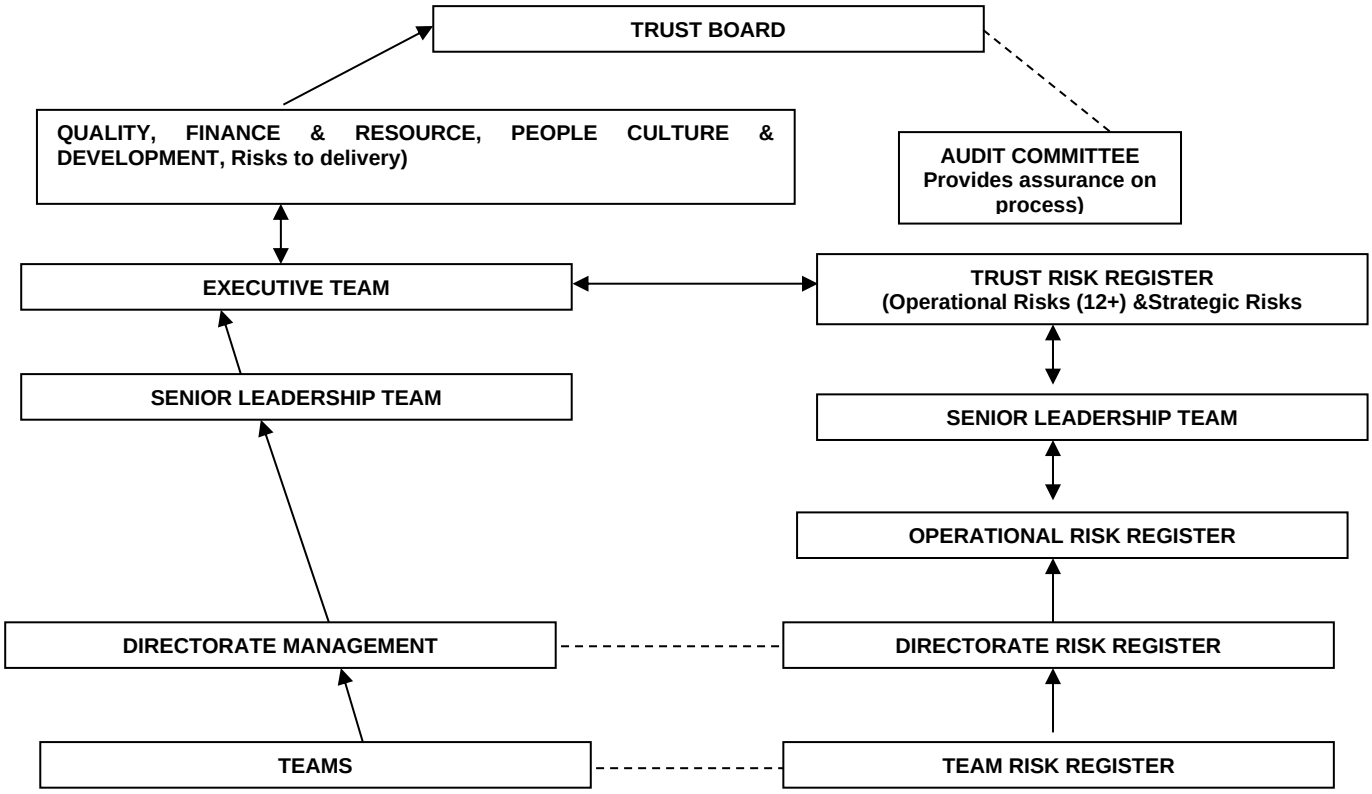
Trust level risks with a residual score of 12 and above are submitted to Committee for review, approval and decision-making purposes (such as score change and closure). They are also reviewed by the Senior Leadership Team on a monthly basis. Trust risks with a residual score of less than 12 will be submitted to SLT on a six-monthly basis.

All risk action plans, developed in line with the above grid, will be recorded on the Ulysses Risk Management system and will represent the Trust's organisation wide action plan following the risk assessments.

Where possible Risk Owners should ensure that actions are SMART:

- Specific – target a specific area for improvement.
- Measurable – quantify or at least suggest an indicator of progress.
- Assignable – specify who will do it.
- Realistic – state what results can realistically be achieved, given available resources.
- Time-related – specify when the result(s) can be achieved.

5 Roles and Responsibilities



A schedule of the key roles and responsibilities associated with risk management is set out below (Terms of Reference for Committees/Groups are available from the Trust Board Secretary).

Trust Board

The Board is responsible for setting the overall strategic direction of the Trust and for monitoring performance against its principal objectives ensuring adherence to the principles of good governance applicable to NHS organisations. It decides on policy and ensures that the Trust continues to provide high quality services. The Board also ensures that the Trust is financially sound and performing effectively within the local community. The Board of Directors with the support of Trust committees have a key role in ensuring that a robust risk management system is effectively maintained across the Trust, however effective risk management is the responsibility of every member of staff. The Trust has a strong risk management process which is embedded throughout the Trust and aids the effective management of potential opportunities and adverse effects.

The Trust Board will be responsible for Risk Management within the Trust and will:

a) Receive quarterly briefing reports updates on the BAF.
b) Receive 6 monthly briefing reports from the Audit Committee on the operation of the Risk Management Framework.
c) A Risk Management Annual Report as part of the wider Corporate Governance Annual Report will be produced and submitted to the Trust Board addressing the management of risks, analysing the effectiveness of the Trust's Risk Management System in managing the organisation's risk profile and implementation of the Risk Management Strategy and Policy. The

effectiveness of the Risk Management system (including the BAF) will be subject to annual audit by the Trust's Internal Auditors.

Executive Team

The Executive Team will:

a) Identify and measure all risks which pose a threat to the delivery of the Trust`s strategic and annual objectives.
b) Monitor and review the on-going processes for the effective management of Trust risks.
c) Take overall responsibility for managing Trust risks and monitor risk treatment plans to ensure that risks included in the Trust Risk Register are effectively managed.
d) Ensure that the Senior Leadership Team and the Trust Board are kept fully informed of all Trust Risks.
e) Each Director will be responsible for formally reviewing each Trust Risk owned by them (frequency based on risk score and nature of the risk).
f) The Executive Team will ensure that risk treatment plans are in place.

Finance, & Resources Committee

The Finance and Resources Committee will focus on risks which threaten the delivery of the Trust`s objectives in the areas of Finance and Resources and will report on mitigation or acceptance of identified risks to the Senior Leadership Team (SLT).

Quality Committee

The Quality Committee will focus on risks which threaten the delivery of the Trust`s objectives in the areas of quality and will report on mitigation or acceptance of identified risks to the Senior Leadership Team (SLT).

People Culture and Development Committee

The People and Culture Development Committee will focus on risks which threaten the delivery of the Trust`s objectives in the areas of workforce and organisational development and will report on mitigation or acceptance of identified risks to the Senior Leadership Team (SLT).

Each Committee meeting receives a risk report detailing the risks linked to their respective Committee with a residual score of 12 and above. The Committee is responsible for discussing and agreeing score changes, new risks and risk closures. This is then communicated to the next Senior Leadership Team meeting for information.

Each Committee should review their associated risks scoring less than 12 on at least a six-monthly basis.

Audit Committee

The Audit Committee shall seek assurance on behalf of the Trust Board that there is in place an effective system of integrated governance, overall system of risk management and system of internal control, across the whole of the Trust`s activities (both clinical and non-clinical), that supports the achievement of the organisation`s objectives. In particular, the Committee will review the adequacy of all risk and control related disclosure statements and seek assurances on behalf of the Trust Board in relation to:

- The adequacy of the controls to manage Trust risks by the Executive Team.
- The adequacy of the controls to manage all risks and in particular the key risks which threaten the delivery of the Trust`s strategic and annual objectives in the as of quality, finance, workforce and business development.

To achieve assurance the Audit Committee will:

a) Receive a six-monthly report providing assurance that risk management arrangements are operating in accordance with the Risk Management Policy.
b) Seek external assurances from the Internal Auditors, through an annual audit, that risk management arrangements are operating in accordance with the Risk Management Policy.
c) Seek additional assurances from the External Auditors as appropriate.

Senior Leadership Team (SLT)

The Senior Leadership Team (the Risk Review Group) holds meetings on a monthly basis and comprises the Executive Team, Clinical Directors and Deputy Director of Governance. The level of membership was decided to ensure that risk is considered at the highest level. The Senior Leadership Team (SLT) takes a lead role in supporting the maintenance of the Trust's Risk Register and related activities and in acting as a conduit for the reporting of operational/clinical risks in the prevention and management of risk. On a monthly basis The Senior Leadership Team (SLT) will review and monitor clinical Directorate risks with a residual score of 12 and above with consideration given for escalation to a Trust level risk. On a monthly basis the Senior Leadership Team (SLT) will receive Trust risks with a residual score of 12 and above as agreed by the Trust Committees. The Senior Leadership Team (SLT) will receive a report of Trust risks with a residual score of less than 12 at least six monthly. Corporate operational risks will be received by the Senior Leadership Team (SLT) six monthly.

The functions of the Senior Leadership Team (SLT) are contained in the Terms of Reference for that Group.

Clinical Directors, Associate Directors, Deputy Director of Governance and Risk Manager

In order to effectively manage risks locally, the Clinical Directors, Associate Directors, Deputy Director of Governance and Risk Manager will:

a) Actively manage the Directorate elements of the Directorate Risk Register in line with the listing of Risk Register responsibilities at Appendix A and using the standard format outlined at Appendix B.
b) Nominate an officer with responsibility for overseeing the management of this process (Directorate Risk Lead).
c) Ensure that a regular programme of environmental ligature risk assessment is undertaken and that all risk assessments are reviewed as a minimum on an annual basis.
d) Ensure that risk assessments and their associated risk treatment plans are developed and that they are implemented in a timely manner.
e) Ensure that any identified risk is included on the Directorate Risk Register and has a risk treatment plan developed within the required timescales.

f) Develop and implement robust monitoring arrangements for their Directorates through the formal review of the Directorate risks on a monthly basis during Directorate meetings with agreed action reflected in the minutes of the meeting.
g) Ensure that Risk is a standing agenda item at Directorate and Team meetings (monthly) recorded in according with audit requirements under the headings of: Existing, New, Escalated/De Escalated and Closed.
h) Ensure that risks managed at team level are escalated to the Directorate where appropriate; and;
i) Ensure that the Directorate and Trust Risk Registers align.

6 Individual responsibilities in Risk Management

All Staff
Every member of staff has a responsibility to ensure they are familiar with and understand the requirements of the Risk Management Policy.

Staff should have an awareness and understanding of operational risk and the risk management process that is in place for identification, recording, review and escalation. Staff should be pro-active in the identification and management of risk and adhere to the risk management process. Through regular discussion at team meetings staff should have knowledge of the risks (and mitigations) recorded on their team Risk Register and an awareness of the key risks to the Directorate.

a) Ensure that they are familiar with and understand the requirements of policies, procedures, guidelines and protocols which relate to their area and that they are adhered to.
b) Endeavour to be conscious of the risk issues associated with their job and take reasonable measures to eliminate or minimise those risks.
c) Report clinical and non-clinical risks, incidents and near misses in line with procedure.
d) Participate in mandatory training for Health & Safety on induction (and 3- yearly thereafter, in line with the Training Needs Analysis) which includes an overview of risk management arrangements and the Trust's risk assessment process.
e) If they see a risk/problem, own that problem until it is solved, or someone else takes over responsibility; and;
f) Initiate action to stop any practice which they believe is unsafe, regardless of the seniority or profession of the person undertaking that practice.

Trust Managers

Trust Managers will:

a) Continually demonstrate commitment in practice to a non-blaming approach when risks and incidents are identified and reported by staff in their area of responsibility.
b) Ensure effective implementation of risk management process, policy and procedures.
c) Identify where staff need further support in implementing the risk management process and provide the necessary support for staff to seek guidance from the nominated risk lead for their Directorate; and;
d) Raise awareness of risk management issues and systems with employees within their area of responsibility.

Chief Executive

The Chief Executive will:

a) As Accountable Officer for the Trust, be ultimately accountable for all risks in the Trust.
b) Delegated responsibility from the Board as the Trust lead on the overall system of Risk Management.
c) Provide the Audit Committee and Trust Board with the necessary assurance that supports the Annual Governance Statement.

The Trust has a number of posts with specific risk lead responsibilities as below and in Appendix A.

Deputy Director of Governance
The Associate Director of Governance has the following responsibilities in relation to risk management:

a) Risk Management Policy Leader.
b) Manage the Board Assurance Framework.
c) Responsible for the Policy document.
d) Manage the Trust Risk Register and control over contents.
e) Co-ordinate all aspects of Trust risk management and the Trust Risk Report.
f) Co-ordinate the formal reporting to the sub committees of the Trust Board (Audit Committee, Quality Committee, Finance and Resource Committee, People Culture & Development Committee).
g) Ensure that support and guidance is available for staff on request in relation to implementing the risk management process.

Risk Manager
a) To support the Associate Director of Governance in the improvement of effective risk management throughout the Trust.
b) Work with Clinical Directors, Associate Directors, and Managers to support the Directorates in reviewing and monitoring their risks ensuring process and policy guidance is followed.
c) Work with the Executive Team to review and update Trust level risks.

Risk Management Policy review and updates when required.

d) Produce monthly reports for the Senior Leadership Team (SLT) and Trust Committees.
e) Provide training, support and guidance to managers and staff in relation to implementing the risk management process.

7 Risk Register

Board Assurance Framework
The Board Assurance Framework (BAF) identifies the procedures for risk management against key strategic objectives, encompassing the management of all types of risk to which the Trust may be exposed and the controls and assurances that are in place.

It includes the effective integration and management of clinical and non-clinical risk and describes key risks, mapped against the Trust's seven strategic goals, categorising each objective against quality priorities. The BAF is reviewed on a

quarterly basis by the Senior Leadership Team (SLT) and submitted to Trust Committees.

Operational Risks
Operational risks will be recorded on the Ulysses Risk Management System and will be managed by the nominated Risk Owner. In order to establish and monitor the Trust's risk profile, the Risk Register will be a living document and will be kept up to date at all times.

a) The management of the Risk Registers will enable all risks identified within the Trust to be effectively managed and aggregated risk identified in order for decisions to be made with regard to resource allocation and risk reduction.

b) Each Directorate and team will actively manage its Risk Register in line with the listing of Risk Register responsibilities at Appendix A and using the standard format outlined at Appendix B.

c) The Trust is committed to achieving and maintaining compliance with all healthcare standards (Healthcare Standards/Health & Social Care Act 2008). All essential quality standards where the compliance is assessed as having a residual risk of 12+ will be considered for inclusion/escalation on the Trust Risk Register and will be submitted to the Senior Leadership Team (SLT) on a monthly basis for review.

8 Risk Identification and Measurement

The following stages are followed in identifying and assessing the BAF:

a) The Board refreshes its strategic objectives and defines its annual objectives on an annual basis. The annual assessment and re-assessment of strategic risk will take place in accordance with the Strategic Planning Cycle and the annual review of strategic objectives and will therefore result in a formal review of BAF risks on a quarterly basis.
b) Each Executive Director will undertake a formal risk assessment against the objectives for which they are responsible on at least an annual basis to identify risks that pose a threat to the delivery of the Trust's strategic objectives.
c) When the risks have been identified, each one will be assigned a Lead Executive Director and will be analysed in order to assess the likelihood of it occurring or recurring, how often it is likely to occur and the likely impact as well as the level of risk appetite associated with that risk.

The risk assessment will:

d) Calculate the **Gross Risk Score**, i.e., the score upon identification of the risk.
e) Identify and give consideration to the adequacy of the controls in place to minimise the risk, i.e., the controls, activities, actions, policies that are necessary to minimise the risk.
f) Identify gaps in control.
g) Identify potential sources of assurance that the Board can use to obtain information about the application and effective operation of controls.
h) Calculate the **Residual Risk Score** - the current score upon application of actions/controls.
i) Identify additional action necessary to further reduce the residual risk score in order to set a **Target Risk Score** – a reducing score to be achieved over an

agreed period of time as further controls/mitigations are implemented until the risk can be eliminated or tolerated.

j) Define the level of risk appetite against key areas (the amount of risk the Trust is willing to seek or accept in pursuit of its long-term objectives). The level of risk appetite will be measured against two domains: quality and safety and against four key components:

- Financial Risk
- Risk to Quality (Innovation)
- Regulation
- Reputation

The level of risk appetite will be defined as:

- None
- Low
- Moderate
- High
- Significant

Risk Management

Where gaps in control are identified the Executive Director will be responsible for developing a risk treatment plan to address the gaps.

Where residual risks are considered by the Executive team to be too high, i.e. higher than the risk appetite, the lead Executive Director will be responsible for developing a risk treatment plan to address the risk.

The culmination of this process is the prioritisation of the identified Trust risks in order to create a manageable programme of action.

Risk analysis and measurement uses descriptive scales to determine the magnitude of the potential consequences of an identified risk and the likelihood that those consequences would occur. The analysis and measurement process and the matrix used are consistent for analysing operational and clinical risk and are defined in Section 10.

Risk Identification

The identification process takes many forms and involves both a pro-active approach and one which reviews issues retrospectively. The Trust places great emphasis on predicting where incidents could occur and taking steps to prevent them.

Many lessons can be learned from examining why an incident occurred and then taking appropriate action to avoid reoccurrence. The Incident Reporting Policy and Guidance (Policy 5.01) details how incidents should be reported, and action taken on them.

In the main, operational risks are identified through:

a) A programme of formal and regular risk assessments in clinical and operational areas.
b) Undertaking a risk assessment in response to an incident.
c) Feedback from Serious Incident investigations.
d) Feedback from internal and external inspections.
e) Team Managers, Quality Improvement Leads and all staff.
f) Discussion at Directorate meetings including the review of performance data.
g) Risk areas as identified via the Performance Management Framework, which includes the assessment of compliance with the standards defined within the Health and Social Care Act.

Risk Measurement (Assessment & Controls)
When the risks have been identified, each one will be analysed in order to assess the likelihood of it recurring, how often it is likely to occur and what the likely impact would be. Consideration of the controls in place for that risk and more importantly the adequacy and effectiveness of those controls will form part of the assessment. The culmination of this process is the prioritisation of the identified risks, within the Trust's Risk Registers, in order to create a manageable programme of risk targets. The risk assessment process is based upon the following key definitions:

a) **Risk Area/Hazard** - An event which has the potential to inflict damage, loss or harm.
b) **Risk** - the combination of the probability of an event and its consequence (Likelihood and Impact). Consequences can be positive or negative or a deviation from the expected outcome.
c) **Loss** - The consequent damage, loss or harm.

The process of risk assessment is based on the key stages set out below:

Risk Identification:
a) What can go wrong?
b) How could it happen?
c) What would the effect be?

Risk Analysis:
a) How often is it likely to occur?
b) How much will it cost?
c) What would the impact be?

Risk Control:
a) How can the risks be eliminated?
b) How can they be avoided?
c) How can they be made less likely or reduce the impact?
d) How can they be made less costly?

Some risk assessments are legally required under various legislation, such as health and safety and food hygiene. Risk assessments should identify the significant risks arising out of the tasks/activities undertaken within the organisation and assess their potential to, for example:

a) Cause injury or ill health to people
b) Reduce quality of care/services
c) Result in civil claims/litigation

d) Result in enforcement action e.g., Health & Safety Executive (HSE).
e) Cause damage to the environment.
f) Cause damage or loss to property.
g) Result in operational delays.
h) Result in loss of reputation.
i) Result in financial loss.

In order to effectively manage these risks at a local level, the Clinical Directors, Associate Directors, Deputy Director of Governance and Risk Manager will undertake the actions described in this policy.

9 Risk Analysis

Risk analysis uses descriptive scales to determine the magnitude of the potential consequences of an identified risk and the likelihood that those consequences would occur. .The matrix below will be used to assign risk priority by combining their likelihood of occurring and consequences of the incidents.

Use of this method enables the production of a list of prioritised risks with an indication of the action that is required.

The Trust's General Risk Assessment form (see Appendix C) is available on the Risk Management page of the Trust's Intranet – CAT.

Measures of Consequence
These are based are adapted from National Patient Safety Agency (NPSA) guidance "A Risk Matrix for Risk Managers".

	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.

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Quality/Complaints/ Audit	Peripheral element of treatment or service sub-optimal. Informal complaint/inquiry.	• Overall treatment or servicer sub-optimal. • 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 service has significantly reduced effectiveness. • Formal complaint (Stage 2). • Local resolution (with potential to go to Independent Review). • Repeated failure to meet internal standards. • Major patient safety implications if findings are not acted upon.	• 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 upon. • Inquest/Ombudsman Inquiry. • Gross failure to meet national standards.

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
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. • On-going unsafe staffing levels or competence. • Loss of several key staff. • No staff attending mandatory training/key training on an on-going basis.
Statutory Duty/ Inspections	No 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.

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Adverse Publicity/ Reputation	Rumours. Potential for public concern.	• Local media coverage – short-term reduction in public confidence. • Elements of public expectation not being met.	• Local media coverage - long-term reduction in public confidence.	• National media coverage with (>3 days) service well below reasonable public expectation.	• National media coverage with (>3 days) service well below reasonable public expectation. • MP concerned (questions in the House).
Business Objectives/ Projects	Insignificant cost increase/schedule slippage	• >5% over project budget. • Schedule slippage.	• 5%-10% over project budget. • Schedule slippage.	• Non-compliance with national 10%-25% over project budget. • Schedule slippage. • Key objectives not met.	• Incident leading >25% over project budget. • Schedule slippage. • Key objectives not met.
Finance including Claims	Small loss. Risk of claim remote.	• Loss of 0.1%-0.25% of budget. • Claim less than £10,000.	• Loss of 0.25%-0.5% of budget. • Claim(s) between £10,000 and £100,0000.	• Uncertain delivery of key objective/losses of 0.5%-1% of budget. • Claim(s) between £100,000 and £1 million. • Purchasers failing to pay on time.	• Non-delivery of key objective/loss of >1% of budget. • Failure to meet specification/slippage. • Loss of contract/payment by results. • Claim(s) >£1 million)
Service Business interruption environmental impact	Loss/interruption of <1 hour. Minimal or no impact on the environment.	• Loss/interruption of >8 hours. • Minor impact on environment.	• Loss/interruption of >1 day. • Moderate impact on environment.	• Loss/interruption of >1 week. • Major impact on environment.	• Permanent loss of service for facility. • Catastrophic impact on environment.

	Rare	Unlikely	Possible	Likely	Almost Certainly
Descriptor	**1**	2	**3**	**4**	**5**
How often might it/does it happen	This will probably never happen/recur	Do not expect it happen/recur but is possible may do	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue.	Will undoubtedly happen/recur, possibly frequently
Time-framed descriptors of frequency	Not expected to occur for years.	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily

Measures of Likelihood

These are also adapted from the NPSA Guidance.

10 Training and Resources to support Risk Management

Board members and Senior Managers receive risk management awareness training via Trust Induction.

The Risk Manager works with Clinical Directors, Associate Directors, Quality Improvement Leads, Service Managers, Ward Managers/Deputies, Team Leaders and Directorate Risk Leads to provide guidance and support.

Risk Manager provides group and/or 1-1 training sessions with Managers as required to communicate and discuss the risk management process and also practical use of the Ulysses Risk Management system for recording and reviewing risks.

The Risk Manager and Risk Leads provide on-going advice and support.

There is a risk management page on CAT that contains useful information and guidance documents along with key contact names and telephone numbers.

11 Related Policies

- Incident Reporting Policy 5.01 Serious Incidents Policy 5.32 Claims Handling Policy 4.08 Clinical Risk Assessment Policy 1.41
- All incidents should be reported and managed in line with the Trust's Incident Reporting process.

12 Review and Evaluation of the Policy

- Compliance with this policy will be monitored through the mechanisms detailed in the table at Appendix B. Where compliance is deemed to be insufficient, and the assurance provided is limited an action plan will be developed to address the gaps; progress against the action plan will be monitored at the specified Group/Committee.
- This will be reviewed every 3 years or earlier in light of new national guidance/other significant changes. Implementation of the policy will be overseen by the Senior Leadership Team.

13 Assurance

The 2022/23 internal audit conducted by KPMG reviewed the processes for managing risk throughout the Trust and gave an assessment rating of `Significant` Assurance with minor improvement opportunities. The Trust will ensure that where recommendations have been made these will be explored and implemented. There is evidence within Risk Registers that the escalation and de-escalation process is now embedded and working effectively within the Trust.

In addition to the function of the Senior Leadership Team meetings, risk oversight, monitoring and review is undertaken by the sub-committees of the Board; (Audit Committee, Finance & Resources Committee, Quality Committee, People and Culture Development Committee,

Function	Risk	Assurance
Board	Board Quarterly Oversight of the BAF Committee oversight of 12+ Trust Risks Committee Oversight of the BAF quarterly	Monthly oversight of Integrated Quality Performance Report (IQPR) Board to Team announced and unannounced visits. Committee oversight of operational performance, internal audit, and rectification plans F&R – operational performance overview and digital strategy Quality Committee – quality metrics PCD – workforce and OD metrics Audit Committee – internal/external audit and Annual Governance Statement
Executive	Oversight of 12+ Trust and Directorate risks *SLT / Performance*	Monthly scrutiny of performance of directorates Internal audit scrutiny and monitoring action plans.
Directorate	Oversight of operational risk scoring 8-12 *Directorate Meetings/Corporate Meetings*	Monthly scrutiny of team level performance
Team	Oversight of team level risk scoring less than 8 *Team Meetings*	Monthly team level dashboards Monthly inpatient safety matrix, and community safety matrix and assessment safety matrix

Appendix A

Schedule of Trust Risk Register Responsibilities

RISK REGISTER	TRUST LEAD
BOARD ASSURANCE FRAMEWORK	
BAF & Trust Risks	Chief Executive / Assistant Chief Executive
OPERATIONAL RISKS	
Stoke Community	Clinical Director
North Staffordshire Community	Clinical Director
Specialist Services	Clinical Director
Acute and Urgent Care	Clinical Director
Primary Care	Clinical Director
Corporate Directorate	Deputy Director of Governance

Appendix B

Review and Evaluation of the Policy

Minimum requirement to be monitored	Process/ Method	Responsible individual/Group/ Committee	Frequency of Monitoring	Responsible individual/Group/ Committee for review of results	Responsible Group/ Committee for monitoring Action Plan
The organisation's risk management structure detailing all those committees and groups which have some responsibility for risk	Report	Deputy Director of Governance & Risk Manager	Annually	• Senior Leadership Team • Trust Board	• Executive Team • Senior Leadership Team
How the Board or high-level risk Committee(s) review the organisation-wide Risk Register	Report	Deputy Director of Governance & Risk Manager	Quarterly	• Executive Team • Senior Leadership Team • Trust Board	• Executive Team • Senior Leadership Team
How risk is managed locally	Report	Deputy Director of Governance & Risk Manager	Monthly	• Directorate Meetings/Corporate Meetings • Senior Leadership Team	• Directorate Meetings/Corporate Meetings • Senior Leadership Team
Duties of the key individuals for risk management activities	Report	Deputy Director of Governance & Risk Manager	Annually	• Senior Leadership Team • Trust Board	• Senior Leadership Team
How all risks are assessed	Report	Deputy Director of Governance & Risk Manager	Annually	• Senior Leadership Team • Trust Board	• Senior Leadership Team
How risk assessments are conducted consistently	Report	Deputy Director of Governance & Risk Manager	6 monthly	• Audit Committee	• Audit Committee
Authority levels for managing different levels of risk within the organisation	Report	Deputy Director of Governance & Risk Manager	6 monthly	• Audit Committee	• Audit Committee
How risks are escalated through the organisation	Report	Deputy Director of Governance & Risk Manager	6 monthly	• Audit Committee	• Audit Committee

Minimum requirement to be monitored	Process/ Method	Responsible individual/Group/ Committee	Frequency of Monitoring	Responsible individual/Group/ Committee for review of results	Responsible Group/ Committee for monitoring Action Plan
How risk management awareness training is delivered to Board members and Senior Managers, in line with the Training Needs Analysis (TNA)	Attendance report	Deputy Director of Governance	Monthly	• Associate Directors	• Associate Directors

Appendix C

General Risk Assessment

The purpose of the risk assessment is to identify hazards/concerns and to implement measures to control the risk. This form should be used where there is no specific legislative guidance, or risk assessment methodology available and as such is used for 'general' or 'non-specialist' risk assessment

The Management of Health and Safety at Work Regulations 1999, requires every employer to make a suitable and sufficient assessment of:-

(a) the risks to the health and safety of employees to which they are exposed whilst they are at work; and
(b) the risks to the health and safety of persons not in his employment arising out of, or in connection with the conduct by him of this undertaking

<table>
<tr><td colspan="2">Work activity/process/concern being identified</td><td colspan="3"></td></tr>
<tr><td colspan="2">Reason for assessment: (e.g. mandatory/ periodic review/ adverse incident / complaint / concern raised)</td><td colspan="3"></td></tr>
<tr><td>Department/Ward/Area:</td><td></td><td colspan="3" rowspan="3">Name(s) of Manager</td></tr>
<tr><td>Site:</td><td></td></tr>
<tr><td>Directorate:</td><td></td></tr>
<tr><td colspan="2">Date of Assessment</td><td>Date of first Review</td><td colspan="2">Review Frequency</td></tr>
<tr><td colspan="2"><u>Undertaking the risk assessment:</u></td><td colspan="3"><u>Identify hazards</u>
<u>Decide who might be harmed and how</u> Are they at risk?
<u>Consider the risks</u> Are the precautions already taken adequate to deal with the risks?
<u>Record your finding</u>
<u>Regularly review the assessment.</u> If any significant changes take place make ensure existing precautions and management arrangements are still adequate to deal with the risks</td></tr>
<tr><td colspan="5">Using the Trust's Risk Matrix what is the level of risk</td></tr>
<tr><td>Risk score without current control (Gross risk)</td><td></td><td>Risk score with current control (Residual risk)</td><td colspan="2"></td></tr>
<tr><td>Target risk score</td><td></td><td>Is this risk to be entered on the Risk Register held on Ulysses?</td><td colspan="2"></td></tr>
</table>

Name of Assessor	Signature	Date

Note: the Line Manager should sign below to show that the assessment is a correct and reasonable reflection of the hazards and of the control measures and actions required		
Line Manager`s Name	**Line Manager`s Signature**	**Date**

What are the hazards	Who might be harmed	What control measures are currently in place

What further actions are necessary to control the risk?	Action by who?	Action by when?	Date completed

Appendix D

Risk Assessment Review

Your risk assessment should be reviewed:

- Following an accident/incident
- If the assessment may no longer be valid
- If changes to the process have occurred
- At intervals dictated by the initial assessment
- If concerns are raised

Has there been any **major** changes affecting hazards and risks? If **Yes, complete new risk assessment**.	Yes/No
Name of person completing review	

Review Date	Outstanding actions	Action by who	Date completed

Note: the Line Manager should sign below to show that the assessment is a correct and a reasonable reflection of the review of hazards and of the control measures and actions required		
Line Manager`s Name	**Line Manager`s Signature**	**Date**

Appendix E

RISK ASSESSMENT MATRIX - From the Trust's Risk Management Strategy

Measurement of Likelihood

	Rare	Unlikely	Possible	Likely	Almost Certainly
Descriptor	**1**	**2**	**3**	**4**	**5**
How often might it/does happen	This will probably never happen/recur	Do not expect it to happen/ recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
Time-framed descriptors of frequency	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily

Measurement of Consequence

	Consequence score (severity levels) and examples of descriptors				
Domains	**1**	**2**	**3**	**4**	**5**
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff for 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.

	Consequence score (severity levels) and examples of descriptors				
Domains	**1**	**2**	**3**	**4**	**5**
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
Quality/Complaints/ Audit	Peripheral element of treatment or service sub-optimal. Informal complaint/inquiry	Overall treatment or services sub-optimal. 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 service has significantly reduced effectiveness. Formal complaint (Stage 2). Local resolution (with potential to go to Independent Review). Repeated failure to meet internal standards. Major patient safety implications if findings are not acted upon.	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 upon. Inquest/Ombudsman Inquiry. Gross failure to meet national standards.

	Consequence score (severity levels) and examples of descriptors				
Domains	**1**	**2**	**3**	**4**	**5**
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
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. On-going unsafe staffing levels or competence. Loss of several key staff. No staff attending mandatory training /key training on an on-going basis.

	Consequence score (severity levels) and examples of descriptors				
Domains	**1**	**2**	**3**	**4**	**5**
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
Statutory Duty/ Inspections	No 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 on 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. Elements of public expectation not being met.	Local media coverage - long-term reduction in public confidence.	National media coverage with (>3 days) service well below reasonable public expectation.	National media coverage with (>3 days) service well below reasonable public expectation. MP concerned (questions in the House). Totalloss of public confidence.

	Consequence score (severity levels) and examples of descriptors				
Domains	**1**	**2**	**3**	**4**	**5**
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
Business Objectives/ Projects	Insignificant cost increase/schedule slippage	>5% over project budget. Schedule slippage.	5%-10% over project budget. Schedule slippage.	Non-compliance with national 10%-25% over project budget. Schedule slippage. Key objectives not met.	Incident leading >25% over project budget. Schedule slippage. Key objectives not met.
Finance including Claims	Small loss. Risk of claim remote.	Loss of 0.1%-0.25% of budget. Claim less than £10,000.	Loss of 0.25%-0.5% of budget. Claim(s) between £10,000 and £100,0000.	Uncertain delivery of key objective/losses of 0.5%-1% of budget. Claim(s) between £100,000 and £1 million. Purchasers failing to pay on time.	Non-delivery of key objective/loss of >1% of budget. Failure to meet specification/slippage. Loss of contract/ payment by results. Claim(s) >£1 million)
Service Business interruption environmental impact	Loss/interruption of <1 hour. Minimal or no impact on the environment.	Loss/interruption of >8 hours. Minor impact on environment.	Loss/interruption of >1 day. Moderate impact on environment.	Loss/interruption of >1 week. Major impact on environment.	Permanent loss of service for facility. Catastrophic impact on environment.

Measurement of overall risk

Gross Risk Score – the initial score upon identification of the risk.

Residual Risk Score – the current score upon application of controls/mitigations

Target Risk Score – a reducing score to be achieved over an agreed period of time as further controls/mitigations are implemented until the risk can be eliminated or tolerated.

		LIKELIHOOD				
		Rare	Unlikely	Possible	Likely	Almost Certain
IMPACT	Rating	1	2	3	4	5
1.Negligible/Insignificant	1	1	2	3	4	5
2. Minor	2	2	4	6	8	10
3. Moderate	3	3	6	9	12	15
4. Major	4	4	8	12	16	20
5. Catastrophic	5	5	10	15	20	25

Once agreed at Team or Directorate Meeting, if applicable, this risk should be recorded on the Ulysses Risk Management System by the appropriate Manager. Where complete a risk assessment form should be uploaded to the risk and saved as supporting evidence.

Governance Team update regarding Gifts, Hospitality and Sponsorship and Declarations of Interest to the Audit Committee
May 2025

Introduction:

There have been a number of Trust level actions that have taken place to continuously improve on and give assurances as to the Trust's current position and approach to gifts, hospitality and sponsorship and declarations of interest.

Purpose of the Report (Executive Summary):

This paper seeks to provide ongoing assurance to Committee and outlines progress for actions that the Governance Team is leading on**.**

Key Recommendations to Consider:

Audit Committee is asked to receive the report for assurance and information.

Background

Gifts, Hospitality and Sponsorship

The Trust procedure for accepting gifts and hospitality is included within the 4.02 Standards of Business Conduct Policy 4.02 and is reviewed on a three yearly cycle. The last review was conducted in July 2024 and was brought in line with new legislation and internal audit recommendations.

The last gifts and hospitality register was presented to the Audit Committee in May 2024 and indicated a limited number of declarations had been made.

Declarations of Relevant and Material Interests

Following the internal audit review in 2024 (report was presented to Audit Committee in July 2024) a number of changes were made to the Standards of Business Conduct policy in relation to declarations of relevant and material interests these included:

- Sections added regarding breaches and sanctions, donations and sponsorship
- A new SBC3 template developed and appended in line with NHSE recommendations
- Update to decision making officers to include Board members, Chief Officers, Senior Managers and equivalent Officers at Agenda for Change Band 8c and above.

The last declaration of relevant and material interests' registers were presented to Audit Committee in May 2024 and although progress was noted it was acknowledged that further work was required.

Summary:

Gifts, Hospitality and Sponsorship

Previous and current gift, hospitality and sponsorship declarations made:

- In 2022/23 5 items were recorded
- In 2023/24 7 items were recorded
- In 2024/25 19 items were recorded
- A copy of the current Gifts / Hospitality and Sponsorship Register is attached. (Appendix 1)

Gifts, Hospitality and Sponsorship training now forms part of the Conflicts of Interest Training on LMS and Communications and Medical Teams have been asked to notify the Governance Team of Trust events to ensure sponsorships forms are completed as and when required. Annual checks of the Association of the British Pharmaceutical Industry (ABPI) Disclosure UK database are also undertaken.

Declarations of Relevant and Material Interests

Previous and current declarations of relevant and material interests' performance:

- April 2023 compliance was 66%.
- April 2024 compliance was 71%.
- April 2025 compliance was 97% the remaining 3% was a result of long-term sickness and maternity leave.
- A copy of the current Band 8c and above and Consultants registers have been included for information. (Appendix 2)
- Although we collate declarations for 'Other Staff' this information does not form part of the compliance figures.

Significant progress has been made in relation to relevant and material interests declarations due to:

- Additional training provided by the Governance Team at Consultant Away Days and internal meetings.
- Following an internal audit around job plans, declarations of interest must be captured within SARD and members of the Governance Team have been given access to SARD to retrieve signed declarations
- Professional leads, Clinical Directors, and Heads of Services have actively supported the Governance Team to follow up on outstanding declarations.

Action / Next Steps Required:

- Governance Team to consider regular meetings with Executive PAs to support declarations of hospitality for Board members.
- Governance and Directorate meetings have been arranged bi-monthly in 2025 to strengthen Governance in Directorates and Gifts, Hospitality and Sponsorship and relevant and material interest declarations will form part of those discussions.
- The Governance Team will continue to provide training and support to staff
- Line Managers will continue to be made aware of outstanding declarations and actively notified when staff are not complaint.

Appendix 1

Declarations of Gifts, Hospitality and Sponsorship - 2024/25

Directorate / Team	Forename	Surname	Role / Job Title	Date of Offer	Date of Receipt (If applicable)	Details of Gift / Hospitality	Estimated Value	Supplier / Offeror Name and Nature of business	Declined or Accepted ?	Reason for Accepting or Declining	Approved by Manager
Adult Mental Health Psychology Team	Kerry	Wheat	Psychological Therapist	19.12.24	19.12.24	£25 M&S gift voucher and small bag celebration chocolates with Christmas/thank you card	£27.00	Patient RB	Accepted	I am seeing the patient for therapy which he has found of great benefit, therefore I think he wanted to show his appreciation. I was not aware of the voucher until the following day when I opened the Christmas card.	Yes
Communication Team	Fiona	Campbell	Communications Manager	11.10.24		REACH AWARDS - Main event sponsor	£9,000	Interclass	Accepted		Yes
Communication Team	Fiona	Campbell	Communications Manager	11.10.24		REACH AWARDS - Diversity and Inclusion	£500	Stoke City FC	Accepted		Yes
Communication Team	Fiona	Campbell	Communications Manager	11.10.24		REACH AWARDS - Leading with Compassion	£500	Rowtype	Accepted		Yes
Communication Team	Fiona	Campbell	Communications Manager	11.10.24		REACH AWARDS - Proud to CARE	£500	Serco	Accepted		Yes
Communication Team	Fiona	Campbell	Communications Manager	11.10.24		REACH AWARDS - Research and Innovations/ Rising Star	£1,000	Dedalus	Accepted		Yes
Communication Team	Fiona	Campbell	Communications Manager	11.10.24		REACH AWARDS - Team of the Year	£500	Port Vale FC	Accepted		Yes
Communication Team	Fiona	Campbell	Communications Manager	11.10.24		REACH AWARDS - Unsung Hero	£250	Unison	Accepted		Yes
Communication Team	Fiona	Campbell	Communications Manager	11.10.24		REACH AWARDS - Lived Experience Shining Star	£500	Town Hospitals	Accepted		Yes
Communication Team	Fiona	Campbell	Communications Manager	11.10.24		REACH AWARDS - Learner of the Year	£500	RLDatix	Accepted		Yes

Directorate / Team	Forename	Surname	Role / Job Title	Date of Offer	Date of Receipt (If applicable)	Details of Gift / Hospitality	Estimated Value	Supplier / Offeror Name and Nature of business	Declined or Accepted ?	Reason for Accepting or Declining	Approved by Manager
Corporate	Elizabeth	Mellor	Chief Strategy Officer	07.11.24	20.11.24	Attending the Construction Awards of Excellence as a guest of Interclass PLC. Interclass have been shortlisted for an award for their work on our project.I will receive hospitality on the evening in the form of a meal which I am declaring as hospitality.	£100	Interclass - Construction Awards of Excellence	Accepted	The company were carrying out the construction work on the Trusts eradication of dormitories project.	Yes
Corporate	Nicola	Griffiths	Deputy Director of Governance / Trust Board Secretary	07.11.24	13.11.24	Attending the Construction Awards of Excellence as a guest of Interclass PLC. Interclass have been shortlisted for an award for their work on our project.I will receive hospitality on the evening in the form of a meal which I am declaring as hospitality.Invited on the basis that I was Chrysalis Programme Manager for the period 2022/23 when the Ward 3 Facility was constructed.	£100	Interclass - Construction Awards of Excellence	Accepted	Interclass are the main contractor for the Trust for Project Chrysalis and are currently in Year 3 of a 5 Year contract.	Yes
CYP ISH Team	N/A	N/A	N/A	11.07.24		4 x £10 Vouchers for Scrumbles Cake Shop	£40	Lauren Edwards-Fergusson 15 Belle Vue, Leek 07740592524	Accepted		Yes

Directorate / Team	Forename	Surname	Role / Job Title	Date of Offer	Date of Receipt (If applicable)	Details of Gift / Hospitality	Estimated Value	Supplier / Offeror Name and Nature of business	Declined or Accepted ?	Reason for Accepting or Declining	Approved by Manager
Education Team	Anne	Cooper	CPD Administrator	04.04.24		Sponsorship received from the Pharmaceutical companies who attend the CPD programmes for display stand area, attendance at meeting and breakfast catering.	£250 £50 £279	Takeda	Accepted		Yes
Education Team	Kia	Smith	Medical Education Administrator	27.10.24		Face to face CPD at the medical institute. IDORSIA PHARMACEUTICALS UK LTD paid for lunch for the medics attending the sessions. This was paid directly to the medical institute, no funds were passed to combined.	£450	INDORSIA PHARMACEUTICALS UK LTD	Accepted		Yes
Finance	Steve	Blaise	Assitant Chief Finance Officer	07.11.24		Attending the Construction Awards of Excellence as a guest of Interclass PLC. Interclass are shortlisted for an award on the night for the work they have done on our project. I will receive hospitality on the evening in the form of a meal which I am declaring as hospitality.	Value not known but estimated at £100.	Interclass - Construction Awards of Excellence	Accepted	The company were carrying out the construction work on the Trusts eradication of dormitories project.	Yes
Transformation Management Office	Rebecca	Stubbs	Project Management Officer	07.11.24	07.11.24	Attending the Construction Awards of Excellence as a guest of Interclass PLC. Interclass have been shortlisted for an award for their work on our project.I will receive hospitality on the evening in the form of a meal which I am declaring as hospitality.	£100	Interclass - Construction Awards of Excellence	Accepted	The company were carrying out the construction work on the Trusts eradication of dormitories project.	Yes

Appendix 2

Declarations of Relevant and Material Interests 2024/25 - Band 8c and above

Surname	Forename	Current position (s)	Declared Interest (Name of the organisation and nature of business)	Type of Interest	Nature of Interest	Date of Interest (From and To)	Action taken to mitigate risk	Date Declared
Aiyelabola	Mofolorunso	Salaried GP	Leadership training- Mental Health	Non-Financial Professional Interest				13/04/2024
Alpanseque	Laura	Salaried GP	I also do locum work as GP, and emergency medicine doctor. I have special interest in MSK. and looking to expand in this realm. I do MSK steroid injections	Non-Financial Professional Interest				14/05/2024
Anwar	Saeed	GP	I hold the GMS contract alongside Dr	Non-Financial Professional Interest				25/09/2024
Ault	Claire	Principal Pharmacist	I am on a zero hours contract with Keele University to review and mark their post-graduate mental health pharmacy module	Financial Interest				12/04/2024
Barraclough	Laura	Salaried GP	Nil		N/A			26/09/2024
Bird	Chris	Director	Non-Financial Professional: Chair of the Management Board, MERIT Pupil Referral Unit, Bucknall, Stoke-on-Trent Non-Financial Professional: Secondment to Project Director, University Hospital North Midlands NHS Trust	Non-Financial Professional Interest		01/07/2020 June 2024	ongoing June 2025	10/09/2024
Birks	Rachael	Deputy Chief Operating Officer	Nil		N/A			12/08/2024
Blaise	Stephen	Interim Assistant Chief Finance Officer	Nil		N/A			31/05/2024
Bloor	Rachel	Head of Nurisng & Profesisoanl Practice	Nil		N/A			06/08/2024
Boardman	James	Deputy Clinical Director	Nil		N/A			17/10/2024
Boswell	Vicky	Associate Director of Performace	Nil		N/A			07/08/2024
Bullock	Rachel	Clinical Director	Nil		N/A			29/07/2024
Chubb	Rebecca	Locum consultant	Nil		N/A			29/07/2024
Clarson	Samuel	GP Consultant	My wife is current Deputy Chief Medical Officer for Staffordshire and Stoke-On-Trent ICB	Non-Financial Personal Interest				18/04/2024
Cooke	Gill	Consultant Clinical Neuropsychologist/Clinical	Nil		N/A			27/08/2024
Cowan	Hannah	Consultant Clinical Psychologist	Private Practice Psychology assessment and treatment in Cheshire evening work, 1-4 hours per week	Finanicial Interest				09/04/2024
Crick	Daniel	Deputy Chief Information Officer	Nil		N/A			10/10/2024
Crowther	Rebecca	Interim Deputy Chief People Officer	Nil		N/A			22/07/2024
Devlin	Kate	Consultant Clinical Psychologist	Nil					06/11/2024
Dodds	Lisa	Assistant Director of Finance	Nil		N/A			30/05/2024

Surname	Forename	Current position (s)	Declared Interest (Name of the organisation and nature of business)	Type of Interest	Nature of Interest	Date of Interest (From and To)	Action taken to mitigate risk	Date Declared
Elgizawy	Fatima	Primary Care Clinical Director/ Salaried GP	GP Local Medical committee elected member from April 2024- April 2028 (Non Financial Professional interest) Other role is GP Training Programme Director for North Staffordshire.	Non-Financial Professional Interest				19/04/2024
Fawcett	Stephen	GP Consultant	Clinical Director Stafforshire and Stoke on Trent ICB	Finanicial Interest				18/04/2024
Ford	Michael	Associate Director	Nil		N/A			08/05/2024
Gaddes	Michelle	Assistant Chief Finance Officer	Nil					24/10/2024
Gaitley	Josephine	Associate Director	Nil		N/A			18/10/2024
Ghaut	Peter	Assistant Director of Finance - Costing and Contracting	Nil	Finanicial Interest	N/A			17/10/2024
Grant	Pauline	Associate Director of Organisational Developmen	Director of Pauline Grant Consulting	Finanicial Interest		Commenced prior to entering the Trust - Trust start date 1st July 2023	Ongoing	10/10/2024
Grant	Zoe	Deputy Chief Nurse	Nil		N/A			20/08/2024
Grant	Rachael	Salaried GP	1. Lecturer Keele University2. Director in a company providing private surgical services 3. I work in Canada as a locum GP					08/11/2024
Griffiths	Nicola	Deputy Director of Governance	Nil		N/A			09/09/2024
Groden	Michael	Senior Advanced Nurse Practicioner	I have a casual contract with Keeele Univirsity as a visiting Lecturer . I have also have an author contract with Specrum books limite. Work (s) published under a penname.					
Harris	Lindsey	GP Consultant	Nil		N/A			26/04/2024
Hewitt	Dave	Chief Digital Information Officer	Nil		N/A			16/08/2024
Holdcroft	Wesley	Acting Director of Estates and Capital	Nil					22/02/2025
Hutton	Rebecca	Principal Clinical Psychologist	Nil		N/A			15/01/1900
Joy Johnson	Lousie	Consultant Clinical Psychologist	I have my own private practice, prior to commencing my role at NSCHT (started role in Jan 2024) where I offer psychological assessments and therapy to private clients. I do not think there is a conflict of interest but declaring this for the avoidance of doubt. My husband (Nathan Joy-Johnson) is the Director of Procurement at UHNM overseeing contracts with NSCHT, this does not & should not impact on my role/clinical work. I do not think there is a conflict of interest but declaring this for the avoidance of doubt.			2019 - Current 2015 - Current		01/11/2024
Kaleem	Tabana	Salaried GP	Nil		N/A			22/04/2024
Kent	Simon	Senior Service Manager	Nil					07/11/2024

Surname	Forename	Current position (s)	Declared Interest (Name of the organisation and nature of business)	Type of Interest	Nature of Interest	Date of Interest (From and To)	Action taken to mitigate risk	Date Declared
Khan	Sobia	Consultant Clinical Psychologist	I am director of a private clinical psychology service based in newcastle under lyme. I deliver services to clients locally, nationally and internationally. I also act as an expert witness for the courts for adult ases of mental health. I am also a director of another company called Nurture Journal This is a product to aid child development I do not believe I have any additional material interests which require declaration	Finanicial Interest				20/04/2024
Kilanska	Ann	Consultant Clinical Psychologist	WHERE: Online WHAT: Psychological assessment, therapy, skills programme, supervision. WHEN: Ad hoc appointment times, not during my Trust working days (i.e Fridays and evenings) In my own time, I work privately as a Consultant Clinical Psychologist. I am registered as a sole trader with HMRC. This work is from my home base in South Staffordshire via video-call. I envisage rarely working with clients from the North Staffs area. I take referrals from online databases, other colleagues in private practice and insurance providers. I explore with referrers their NHS options on initial contact where appropriate. I do not use Trust record forms, nor do I use Trust premises or time to carry out my private practice. Additionally, I am also working as a Yoga Instructor at Chase Leisure Centre and online on a self-employed basis outside of my core working hours.	Financial Interest				17/04/2024
Killeen	John	Associate Director of Estates and Capital	Nil		N/A			11/09/2024
Kirkby	Antonia	Consultant Clinical Psychologist	Nil		N/A			28/08/2024
Larvin	Natalie	Clinical Director	Nil		N/A			19/09/2024
Lonsdale	Jennie	Consultant Clinical Psychologist	Outside of my working hours for the Trust I occasionally practice as a Clinical Psychologist on an independent basis. I only work on an independent basis with individuals who live outside of the remit of the team I am based in.	Non-Financial Professional Interest		For the past approx 6 years	ongoing	18/07/2024

Surname	Forename	Current position (s)	Declared Interest (Name of the organisation and nature of business)	Type of Interest	Nature of Interest	Date of Interest (From and To)	Action taken to mitigate risk	Date Declared
Lunt	Sarah	Head of Psychological Professions	1.) I work as an expert witness for an independent forensic psychology company (Tully Forensic Psychology), taking instruction from solicitors and the court. The work cannot be completed internally through the NHS as all assessments must be completed as an independent expert witness. Referrals all come through solicitors and are made directly to the clinical lead for the company in Nottingham, and not through any direct contact with me either in or out of my NHS post. 2.) I am a licensed tutor for the Association of Psychological Therapies. This is a Leicester based company which uses psychologists nationally to teach psychological therapies, practice and processes across the country/internationally. I use annual leave, weekends or non-working days in order to complete this teaching. N.B. I am also able to teach within my organization on behalf of this company. Where this is the case, I do not receive any additional payment for this and I work my usual NHS hours whilst the organization receives a reduction in the cost of the training All expert witness work takes place in prisons, in solicitor's offices, online or in courts. It is forensic risk assessment and assessment of mental health in relation to alleged offending, independently of the NHS or prison service. I am able to choose how much work I do and when. I complete all of this work and related activity in my own time whilst I am not in my NHS employment. 2.) My role as a licensed tutor takes place in venues across the country or online. The company organize this with sponsors across the country and request my input directly. I use my non-working days, annual leave and evenings and weekends to prepare for and deliver this training.	Finanicial Interest				16/04/2024
Lyons	Emily	Speciality Doctor	Nil		N/A			31/07/2024
Martin	Carole	Clinical Psychologist	Nil		N/A			21/10/2024
Mason	Heather	Consultant Clinical Psychologist	Indirect interest - I am chair of a local fundraising group for the Christie Charity (reg no 1201654)	Indirect Interest				16/10/2024
Matthew	Julia	Highly Specialist Family & Stemic Psychotherapist	Nil					08/08/2024
McCrea	Joe	Associate Director of Communications	Nil		N/A			06/08/2024
Morris	Charlotte	Consultant Clinical Psychologist	Nil		N/A			07/05/2024
O,Byrn	Evan	GP	Nil		N/A			18/04/2024
O'Neill	Siobain	Clinical Lead Primary Care	Nil		N/A			18/04/2024
Ochogwu	Jeremiah	Salaried GP	Health Internationa Ltd, Various depending on availability and shift time	Finanicial Interest				01/10/2024
Oyelade	Bolanle	Salaried GP	Nil		N/A			18/09/2024
Parker	Helen	Speciality Doctor in LD Psychiatry	Nil					09/04/2024
Smith	Laura	Deputy Chief Strategy Officer	Nil		N/A			15/08/2024
Srejic	Gabija	Consultant psychologist	Nil					23/10/2024
Stanyer	Kim	Associate Director	Nil		N/A			18/04/2024
Sweeney	Helen	Chief Pharmacist and Deputy Director of MACE	Nil		N/A			08/05/2024
Tighe	Catherine	Consultant Clinical Psychologist CAMHS	Nil		N/A			05/08/2024
Wall	Gemma	Consultant Clinical Neuropsycholgoist	Nil		N/A			31/07/2024
Woodall	Stephanie	Clincal Lead	Nil		N/A			18/04/2024
Wrench	Laurie	Deputy Director of Governance	Nil		N/A			18/09/2024

Declarations of Relevant and Material Interests 2024/25 - Consultants

Surname	Forename	Current position (s)	Declared Interest (Name of the organisation and nature of business)	Type of Interest	Nature of Interest	Date of Interest (From and To)	Action taken to mitigate risk	Date Declared
Adeyemo	Olubukola	Chief Executive	Membership of WRES – Strategic Advisory Group Board of Governors University of Wolverhampton CQC Reviewer Mental Health Network, NHS Confederation, NHS CEO representative	Non-Financial Professional Interest				06/03/2024
Andrew	Gemma	Consultant Psychaitrist	Nil		N/A			19/08/2024
Bashir	Fareed	Consultant Psychaitrist	Nil		N/A			06/04/2024
Belgamwar	Ravindra	Consultant Psychiatrist	Nil		N/A			05/04/2024
Egan	Rachel	Consultant liaison psychiatrist	Nil		N/A			09/09/2024
El-Nimr	George	Consultant Neuropsychiatrist	Educational events that I organise can be sponsored by relevant companies. I don't see private patients but am a director of a limited company through which I do occasional medicolegal work. I am a trustee for the Huntington's Disease Association of Englad and Wales. I am the Chair of the Faculty of Neuropsychiatry of the Royal College of Psychiatrists. My wife is a local GP.	Financial Interest				06/09/2024
Foster	Michael	Consultant Psychiatrist	nil					25/11/2024
Hofberg	Kristina	Consultant Psychiatrist	Nil		N/A			18/05/2024
Jorsh	Mike	Consultant Liaison Psychiatrist	GMC Assessor / supervisor – zero hours contract providing support to the GMC trainee doctors fitness to practice on health grounds and monitoring those doctors	Financial Interest				21/08/2024
Latif	Lubna	Consultant Psyhciatrist	Nil		N/A			27/02/2025
Mirza	Qasim	Consultant Old Age Psychaitry	Nil		N/A			30/07/2024
Mittal	Rahman	Consultant Psychiatrist	Nil		N/A			15/07/2024
Okolo	Dennis	Chief Medical Officer	GMC Medical /Health Supervisor (Ad hoc assessments) Director: Tzakt Services Limited Director: E Ezike Diaspora (Charitable activities	Financial Interestt				05/03/2024
Parker	Helen	Specialty Doctor in LD Psychiatry	Nil		N/A			09/04/2024
Poornamodan	Bindu	Consultant Child and Adolescent Psychiatrist	My husband has a company of which I am an associate director, no psychiatry private work is provided by this company	Indirect Interest		01/04/2018	Present	14/08/2024

Surname	Forename	Current position (s)	Declared Interest (Name of the organisation and nature of business)	Type of Interest	Nature of Interest	Date of Interest (From and To)	Action taken to mitigate risk	Date Declared
Rahman	Mohammad	Consultant Psychiatrist	Deputy medical Director at Nottingham and Nottinghamshire ICB / Designated Doctor for Adult Safeguarding for Nottingham Member, NICE guideline for Gambling Unpaid Volunteer Trustee for Liverpool Maths School Director, Four Oceans Services (related to real estate business, currently in dormant state) s.12 work @ Combined.	Financial Interest				05/07/2024
Salahudeeen	Siraj	Consultant Psychiatrist	Director of a private Limited Company- This company is not trading with the Trust. Private work as agreed in the Job plan with the Clinical Director Private work in my own time. Also on Wednesdays- PM (1pm-5pm) (as agreed in the job plan)			01/08/2018 16/11/2016 01/08/2022	Ongoing Ongoing Ongoing	19/08/2024
Shivamurthy	Sasalu	Consultant Psychiatrist	Nil		N/A			10/09/2024
Shridaran	Baskaran	Consultant Psychiatrist	Astro Healthcare - joint Director/Consultant - Providing ad hoc medico legal reports; private consultation. In non NHS times, evenings, weekends, in person and remote. Rushcliffe Care - Consultant - Ad hoc consultation remotely with occasional in person assesments - In non NHS time, evenings and weekends, in person and remote.			Feb 2020 Feb 2022	Ongoing Ongoing	27.11.24
Sivaji	Rajeswari	Consultant Psychiatrist	Nil		N/A			13/09/2024
Stevenson	Laura	Consultant psychiatrist	Nil		N/A			21/08/2024
Udeze	Bernard	Consultant	Medico-legal work, 2nd opinion report, adhoc court reports, adhoc private consultations Outside Contractual hours and on adhoc basis.	Financial Interest		01/10/2017	Present	19/08/2024
Zahid	Sadia	Consultant	Nil		N/A			20/08/2024

Document level: Trustwide
Policy Ref No:4.02
Issue number: 7

Standards of Business Conduct Policy

Lead executive	Chief Executive Officer
Authors details	Corporate Governance Manager and the Deputy Director of Governance

Type of document	Policy
Target audience	All Trust staff including volunteers, agency / locum staff.
Document purpose	The Policy describes the broad framework of arrangements for the management of standards of business conduct and the outlines the conduct expected of all Trust employees.

Approving meeting	Audit Committee	Meeting date(s)	12th July 2024
Implementation date	16th July 2024	Review date	31st July 2027

Trust documents to be read in conjunction with	
Document Code	Document name
2.03	Standing Financial Instructions
3.14	Alcohol and Drugs
4.40	Being Open incorporating Duty of Candour
3.01	Disciplinary Policy
2.14	Local Counter Fraud Policy
2.01	Budgetary Control of Related Issues
2.21	Anti-Bribery Policy
3.09	Freedom to Speak Up
4.06	Scheme of Delegation
4.04	Standing Orders

Document change history		Version	Date
What is different?	- This policy has been revised to support staff in line with NHSE Guidance - Introduction included that refers to the Nolan Principles, NHS Code of Conduct and Code of Accountability (2004) and the Bribery Act (2010). - Policy Statement included - Policy Aims added - Section regarding scope included - Explanation of terms and definitions included - Section on duties updated - Update to Management of Conflicts of Interest and Secondary Employment - Reference made to Appendix 9, The Chartered Institute of Purchasing and Supply (CIPS) Code of Ethics. - Sections added regarding breaches and sanctions, donations and sponsorship - New SBC3 template appended - Update to decision making officers being Board members and Executive and Senior Managers and equivalent Officers at Agenda for Change Band 8c and above	V6	June 2024
Appendices / electronic forms	1. Procedure for the offer of Gifts 2. Procedure for the offer of Hospitality 3. Procedure for the offer of Commercial Sponsorship 4. 7 Nolan Principles 5. Sponsorship Agreement 6. Declaration of Gifts and Hospitality (SBC1) 7. Declaration of Commercial Sponsorship (SBC2) 8. Declaration of Relevant and Material interests (SBC3) 9. The Chartered Institute of Purchasing and Supply (CIPS) Code of Ethics		
What is the impact of change?	Policy is in line with new legislation and internal audit recommendations		

Training requirements	There are no specific training requirements for this document.

Document consultation	
Directorates	Senior Leadership Team
Corporate services	Trust Executives and Audit Committee

External agencies	N/A

Financial resource implications	No

External references
1. The Code of Conduct for NHS Managers [www.nhsemployers.org October 2002] 2. The Fraud Act 2006 [www.legislation.gov.uk] 3. The Bribery Act 2010 [www.legislation.gov.uk] 4. Code of Conduct: Code of Accountability for NHS Boards (third revision 2013) [www.ntda.nhs.uk] 5. A Code of Conduct for Private Practice: Recommended Standards of Practice for NHS Consultants (January 2004) [www.nhsemployers.org] 6. The NHS Constitution for England (October 2015) [www.gov.uk] 7. Freedom of Information Act (2000) [www.gov.uk] The Seven Principles of Public Life (Nolan) [www.gov.uk] (see Appendix 1) 8. The Corporate Governance Code (2018) 9. Managing Conflicts of Interest in the NHS [www.england.nhs.uk] (2017)

Monitoring compliance with the processes outlined within this document	Compliance is monitored by the Corporate Governance Manager / Deputy Director of Governance / Trust Secretary, Audit Committee, Internal Audit and Trust Board

Equality Impact Assessment (EIA) - Initial assessment	**Yes/No**	**Less favourable / More favourable / Mixed impact**
Does this document affect one or more group(s) less or more favorably than another (see list)?		
– **Age** (e.g., consider impact on younger people/ older people)	No	
Equality Impact Assessment (EIA) - Initial assessment	**Yes/No**	**Less favourable / More favourable / Mixed impact**

– **Disability** (remember to consider physical, mental, and sensory impairments)	No	
– **Sex/Gender** (any M/F gender impact; also consider impact on those responsible for childcare)	No	
– **Gender identity and gender reassignment** (i.e., impact on people who identify as trans, non-binary or gender fluid)	No	
– **Race / ethnicity / ethnic communities / cultural groups** (include those with foreign language needs, including European countries, Roma/travelling communities)	No	
– **Pregnancy and maternity, including adoption** (i.e., impact during pregnancy and the 12 months after; including for both heterosexual and same sex couples)	No	
– **Sexual Orientation** (impact on people who identify as lesbian, gay, or bi – whether stated as 'out' or not)	No	
– **Marriage and/or Civil Partnership** (including heterosexual and same sex marriage)	No	
– **Religion and/or Belief** (includes those with religion and /or belief and those with none)	No	
– **Other equality groups?** (may include groups like those living in poverty, sex workers, asylum seekers, people with substance misuse issues, prison and (ex) offending population, Roma/travelling communities, and any other groups who may be disadvantaged in some way, who may or may not be part of the groups above equality groups)	No	

If you answered yes to any of the above, please provide details below, including evidence supporting differential experience or impact.	
If you have identified potential negative impact: - Can this impact be avoided? Staff are required to complete mandatory education to ensure a safe service provision. - What alternatives are there to achieving the document without the impact? Can the impact be reduced by taking different action?	
Do any differences identified above amount to discrimination and the potential for adverse impact in this policy?	N/A

If YES, could it still be justifiable e.g., on grounds of promoting equality of opportunity for one group? Or any other reason	Not applicable
Enter details here if applicable	

Where an adverse, negative, or potentially discriminatory impact on one or more equality groups has been identified above, a full EIA should be undertaken. Please refer this to the Diversity and Inclusion Lead, together with any suggestions as to the action required to avoid or reduce this impact. Discussed the above with the Inclusion & Diversity Lead – adjustments offered and made ensured equality and inclusion. For advice in relation to any aspect of completing the EIA assessment, please contact the Diversity and Inclusion Lead at Diversity@combined.nhs.uk	
Was a full impact assessment required?	No
What is the level of impact?	Low

CONTENTS

1. Introduction

1.1 The Standards of Business Conduct policy describes the standards and public service values which underpin the work of the NHS and reflects current guidance and best practice which all staff working for the Trust are expected to follow.

1.2 Public service values are and must be at the heart of the National Health Service. High standards of corporate and personal conduct, based on a recognition that patients come first, have been a requirement throughout the NHS since its inception. Moreover, since the NHS is publicly funded, it must be accountable to Parliament for the services it provides and for the effective and economical use of those public funds.

1.3 As a publicly funded organisation, the Trust has a duty to set and maintain the highest standards of conduct and integrity. The Trust expects the highest standards of corporate behaviour and responsibility from all employees. The NHS Constitution sets out key responsibilities of all NHS staff. In addition, all officers, regardless of their role, are expected to act in the spirit set out in the seven principles of public life, or commonly referred to as the 'Nolan Principles' (Appendix 4).

1.4 The Code of Conduct and Code of Accountability in the NHS (2004) sets out three crucial public service values which must underpin the work of the NHS.

- Accountability – everything done by those who work in the NHS must be able to stand the test of parliamentary scrutiny, public judgements on propriety and professional codes of conduct.
- Probity – there should be an absolute standard of honesty in dealing with the assets of the NHS. Integrity should be the hallmark of all personal conduct in decisions affecting patients, officers, members and suppliers and in the use of information acquired during the course of their NHS duties, and
- Openness – there should be sufficient transparency about NHS activities to promote confidence between the Trust, its staff, patients and the public.

1.5 The introduction of the Bribery Act 2010 places responsibility on the Trust to ensure robust procedures are in place to prevent bribery and corruption taking place within the Trust. The Trust believes it is the responsibility of all employees to ensure that they are not placed in a position which risks, or appears to risk, conflict between their private interests or benefits and their NHS duties.

1.6 All individuals within healthcare organisations are capable of being prosecuted for taking or offering a bribe. There is no maximum level of fines that can be imposed, and an individual convicted of an offence can be imprisoned for up to ten years. The Bribery Act (2010) came into force on 1 July 2011 and creates five basic offences:

- Bribing another person with the intention of inducing that person to perform a relevant function or activity improperly or to reward that person for doing so.

- Accepting a bribe with the intention that a relevant function or activity should be performed improperly as a result.
- Bribing a foreign public official
- A Director, manager or officer of a commercial organisation allowing or turning a blind eye to bribery within the organisation (The question of whether any particular organisation falls within the definition of a "commercial organisation" will be considered on the facts in individual cases. It is, however, reasonable to assume that an NHS Trust or NHS Foundation Trust could be deemed a "commercial organisation" for the purpose of this Act).
- Failing to prevent bribery – where a person (including employees, agents and external third parties) associated with a relevant commercial organisation bribes another person intending to obtain or retain a business advantage. This is a strict liability offence which can be committed by the organisation unless it can show, in its defence that it had adequate procedures in place to prevent bribery.

1.7 Compliance with this Policy and a requirement to declare certain hospitality and sponsorship, will serve to protect staff as well as the Trust, by having a culture of openness and thereby reducing the risk of suspicion of possibly being in breach of the Bribery Act 2010.

2. Policy Statement

2.1 It is a long-established principle that public sector bodies, which include the NHS, must be impartial and honest in the conduct of their business. This Policy outlines the conduct expected of all Trust employees and is consistent with:

- The Code of Conduct for NHS Managers [www.nhsemployers.org October 2002]
- The Fraud Act 2006 [www.legislation.gov.uk]
- The Bribery Act 2010 [www.legislation.gov.uk]
- Code of Conduct: Code of Accountability for NHS Boards (third revision 2013) [www.ntda.nhs.uk]
- A Code of Conduct for Private Practice: Recommended Standards of Practice for NHS Consultants (January 2004) [www.nhsemployers.org]
- The NHS Constitution for England (October 2015) [www.gov.uk]
- Freedom of Information Act (2000) [www.gov.uk] The Seven Principles of Public Life (Nolan) [www.gov.uk] (see Appendix 4)
- The Corporate Governance Code (2018)
- Managing Conflicts of Interest in the NHS [www.england.nhs.uk} (2017)

1. Selflessness
2. Integrity
3. Objectivity
4. Accountability
5. Openness
6. Honesty
7. Leadership

2.2 This Policy applies to all areas and staff employed by the Trust equally and includes (but not an exhaustive list):

- Volunteers.
- Agency staff.
- External secondees working temporarily with the Trust.
- Locum staff.
- Executive and Non-Executive Directors.
- Those employed in a temporary capacity.

2.3 The Trust expects all staff to ensure that the interests of patients is paramount at all times. Staff must be impartial and honest in the conduct of their official business and must use the public funds entrusted to them to the best advantage of the service, always ensuring value for money.

2.4 Staff must ensure that they are not placed in a position which risks, or appears to risk, conflict between their private interests, or the private interests of someone closely associated with them, and their NHS duties. Staff must not accept any reward or inducement (other than their normal pay and benefits from the Trust) for doing, or not doing, anything in their official capacity. Staff must ensure that they do not abuse their position of Trust by engaging in financial dealings with any patient or recent ex-patient that could be viewed as being to that patient's disadvantage. Staff found to be breaching these principles risk prosecution and disciplinary action which may result in loss of employment and superannuation rights.

2.5 The Trust expects its staff to declare when they, or someone closely associated with them, have a private interest in any business, voluntary or charitable body, or in any other activity or pursuit, which may compete for a contract to supply goods or services to the Trust, or be in any way in conflict or competition with the Trust.

2.6 The Chief Executive will ensure that formal registers of gifts, hospitality, commercial sponsorship and private interests are established to record declarations made by staff. These registers will be available to the public under the Freedom of Information Act (2000).

3. Aim

3.1 The aim of this policy is to provide employees of the Trust and persons working on behalf of the Trust with clear guidance to ensure that they are aware of their responsibilities in relation to the conduct of business within the Trust with respect to gifts, hospitality and sponsorship, and the consequences of failing to observe those responsibilities.

4. Scope

4.1 This Policy describes the broad framework of arrangements for the management of standards for business conduct.

4.2 This Policy follows and is deemed to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

5. Explanation of Terms and Definitions

Term	Meaning
Gift	An item transferred without the expectation of payment. Gifts are defined within this policy as being either (i) acceptable (and do not require declaration) or (ii) unacceptable.
Hospitality	the reception and entertainment of individuals which subject to exemptions defined in this policy, requires declaration for inclusion on the Trust's Register of Hospitality and Sponsorship.
Sponsorship	NHS funding from an external, commercial source, including but not restricted to, funding of all or part of the costs of a member of staff, NHS research, staff, 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. Subject to exemptions defined in this policy, sponsorship requires declaration for inclusion on the Trust's Register of Hospitality and Sponsorship. NB- Sponsorship does not include funding made available to the Trust by external, statutory agencies where such funding is made under statutory or discretionary powers.
Accountability	Everything done by those who work in the NHS must be able to stand the test of parliamentary scrutiny, public judgements on propriety and professional codes of conduct.
Probity	Means that there should be an absolute standard of honesty in dealing with the assets of the NHS. Integrity should be the hallmark of all personal conduct affecting service users, employees and suppliers and in the use of information acquired in the course of NHS duties.

Term	Meaning
Openness	Means that there should be sufficient transparency about NHS activities to promote confidence between the Trust and its employees, service users and the public.
Improper Performance	Under the Bribery Act 2010 improper performance is defined in summary as 'performance which amounts to a breach of an expectation that a person will act in good faith, impartially, or in accordance with a position of Trust'. The offence applies to bribery relating to any function of a public nature, connected with a business, performed in the course of a person's employment or performed on behalf of a company or another body of persons. Therefore bribery in both the public and private sectors is covered by the Act. NB: It is an offence for a person to offer, promise or give a financial or other advantage to another person in one or two cases: Case 1 applies where that person intends the advantage to bring about the improper performance by another person of a relevant function or activity or to reward such improper performance.
Improper Performance	Case 2 applies where the person knows or believes that the acceptance of the advantage offered, promised or given in it constitutes the improper performance or a relevant function or activity.
Register of Hospitality and Sponsorship	A register kept by the Trust which is open to public inspection, and which (i) serves to demonstrate openness and transparency and (ii) offer protection to staff and persons working on behalf of the Trust by ratifying Trust endorsement to the receipt of Hospitality and Sponsorship as deemed acceptable within the provisions of this policy.

6. Duties

6.1 Board Members (Directors and Non-Executive Directors)

It is the duty of Trust Board to:

- Adopt and act in accordance with the requirements of the i. Code of Conduct: Code of Accountability for NHS Boards (third revision 2013) and ii. Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England (www.professionalstandards.org.uk November 2013).

- Record the private interests of Trust Board members that are relevant and material in the Trust Board minutes at the time of declaration.
- Review the register of interests of the Trust Board members every six months.
- Publish the register of interests of the Trust Board members in the Trust's annual report.
- Exclude Trust Board members from proceeding with their duties on the Trust Board on account of pecuniary interest.
- Take action in respect of any failure to comply with this Policy.

6.2 Audit Committee

It is the duty of the Audit Committee to:

- Scrutinise the registers of gifts, hospitality, commercial sponsorship, private interests for staff and Board members on an annual basis.

6.3 Chief Executive

On behalf of the Chief Executive Officer, it is the duty of the Assistant Chief Executive to:

- Maintain formal registers of gifts, hospitality, commercial sponsorship, and private interests; and
- Report to the Trust Board any failure to comply with this Policy.

6.4 Chief Finance Officer

It is the duty of the Chief Finance Officer, in accordance with the Standing Financial Instructions, to:

- Ensure that all staff are aware of the process to follow for acceptance of gifts and other benefits in kind.

6.5 Chief People Officer

It is the duty of the Chief People Officer to:

- Ensure that compliance with the Code of Conduct and Accountability for NHS Boards is included in the contract for managers; and
- Acceptance of the Code of Conduct and Accountability for NHS Boards is included in the contract for new Trust Board members.

6.6 Executive Directors

It is the duty of the Executive Directors to:

- Agree with staff the acceptance and declaring of commercial sponsorship, gifts, hospitality and private interests in accordance with this Policy.

6.7 Deputy Director Governance/ Board Secretary

It is the duty of the Deputy Director Governance/ Board Secretary to:

- Ensure that there is a record of Trust Board members acceptance of the Code of Conduct and Accountability for NHS Boards.
- Operate the formal registers of gifts, hospitality, commercial sponsorship, and private interests on behalf of the Assistant Chief Executive.
- Make the registers of gifts, hospitality, commercial sponsorship, and private interests available to members of the public.
- Publish the register of interests of the Trust Board members on the Trust's website.
- Be proactive in communicating this Policy and the associated processes to staff.
- Organise training for staff on standards of business conduct as and where appropriate.

6.8 Medical Consultants

It is the duty of all Consultants and Associate Specialists (and other relevant medical staff) employed under the Terms and Conditions of Service of Hospital and Medical and Dental Staff to comply with the conditions set out in:

- A Code of Conduct for Private Practice: Recommended Standards of Practice for NHS Consultants (www.nhsemployers.org January 2004).

6.9 Senior Management

It is the duty of Medical Consultants and Senior Management to:

- Act in accordance with the Code of Conduct for NHS Managers.
- Agree with staff the acceptance of gifts and hospitality in accordance with this Policy.
- Declare gifts, hospitality, commercial sponsorship in accordance with this Policy.
- Make a declaration of interest (including nil declarations) on an annual basis (as a minimum) and as they arise.

The Trust Board has defined Senior Management as posts directly accountable to the Chief Executive, Executive Directors and other Directors with decision making authority. Failure to make a declaration could constitute disciplinary action.

6.10 All Managers and Supervisors

It is the duty of all managers and supervisors to:

- Act in accordance with the Code of Conduct for NHS Managers.

- Agree with staff the acceptance of gifts and hospitality in accordance with this Policy.
- Declare gifts, hospitality, commercial sponsorship in accordance with this Policy.
- Make a declaration of interests (including nil declarations) on an annual basis (as a minimum) and as they arise.

6.11 All Staff

Staff are expected to act with due diligence and utmost honesty at all times and to:

- Be aware and comply with responsibilities outlined within of the NHS Constitution.
- Act in accordance with the Seven Principles of Public Life and this Policy.
- Ensure that they are not placed in a position which risks, or appears to risk, conflict between their private interests and their NHS duties.
- Seek the permission of management to accept gifts and hospitality in accordance with this Policy.
- Seek the permission of the relevant Executive Director to accept commercial sponsorship in accordance with this Policy.
- Declare gifts, hospitality, commercial sponsorship in accordance with this Policy.
- Make a declaration of interest (including nil declarations) on an annual basis and as they arise should they have decision making authority.
- Adhere to the standards of conduct for tendering and contracting set out in the Trust's Standing Financial Instructions.
- Protect confidential information of the Trust; and
- Report concerns about standards of business conduct in the Trust and failure to comply with this Policy.
- Fully understand that any breach of the Bribery Act 2010 renders them liable to prosecution and may also lead to loss of their employment and pension rights.

7. Standards of Business Conduct Framework

7.1 The offer of Gifts

The principle of integrity requires that staff should not place themselves under an obligation that might influence or be perceived to influence the conduct of their duties. Under the Bribery Act 2010 it is an offence for employees to accept any gifts or consideration as an inducement or reward for carrying out their functions or activities improperly or to reward that person for having already done so.

Any money, gift of consideration received by an employee in public service from a person or organisation holding or seeking to obtain a contract will be deemed by the courts to have been received corruptly unless the employee proves to the contrary.

The Trust acknowledges that many patients, their carers, and relatives wish to give gifts to members of staff as a token of their gratitude and that refusal of such gifts can cause offence. Gifts of cash must not be accepted under any circumstances and the donator should be encouraged to donate the money for the benefit of the Trust, service, or department via the Trust's charitable funds.

Gifts with a value of less than £25 may be accepted e.g., Chocolates, biscuits. Such acceptance does not need to be declared. However, gifts should be declared if several small gifts worth a total of over £100 are received from the same or closely related source in a 12-month period. In most cases, gifts with a value greater than £25 should be firmly but politely declined unless for the benefit of patients, the department or service. If a gift is offered as a token of gratitude by a patient, their carer or relative and it is considered that refusal to accept the gift will cause offence then the employee must use their discretion about whether or not to accept. Any such acceptance must be discussed with the employee's line manager and receipt of the gift must be declared using Form SBC1. Staff are encouraged to offer any gift accepted to Charity or a Voluntary Sector Organisation.

Alcohol can be accepted; however, staff must be aware of the Trust's Alcohol and Drug Policy and Supporting Guidance, which prohibits the consumption of alcohol at work.

Gifts offered to staff by suppliers or potential commercial partners should only be accepted if they have a value of less than £25 e.g., Diaries, calendars or pens or are appropriate to the circumstances under which offered. Acceptance of any gift which has a value greater than £25 must be agreed by the employee's line manager and receipt of the gift must be declared in writing using Form SBC1. Staff are again encouraged to offer any gift accepted to Charity or a Voluntary Sector Organisation.

For any gift or hospitality received outside of the United Kingdom, the individual must ensure they have acknowledged the Law of the country in which it was received. Declaration Form SBC1 (Appendix 6) must be completed and submitted upon returning to the United Kingdom.

If a member of staff receives any payment for speaking at a conference during their NHS time this must also be declared using Form SBC1 (Appendix 6) and repaid back to the Trust. If a declaration is not made this could be seen as unethical and the staff member may be subject to a fraud investigation by the Local Counter Fraud Specialist and subsequent action taken.

The Deputy Director Governance/ Board Secretary will maintain, on behalf of the Chief Executive, a register of all declarations of gifts received by employees. The register will be available to the public.

Always remember Gifts, accepted, or declined with an approximate value of over £25 should be recorded on Form SBC1 (Appendix 6).

The procedure for the offer of Gifts is set out in Appendix 1.

7.2 Donations

7.2.1 A donation is a charitable financial payment, which can be in the form of direct cash payment or through the application of a will or similar directive. Charitable giving and other donations are often used to support the provision of health and care services. Staff will undertake voluntary work or fundraising activities for charity. However, conflicts of interest can arise.

7.2.2 Acceptance of donations made by suppliers or bodies seeking to do business with the Trust but should be treated with caution and not routinely accepted. In exceptional circumstances a donation from a supplier 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.

7.2.3 Staff should not actively solicit charitable donations unless this is a prescribed or expected part of their duties for the Trust, or is being pursued on behalf of the Trust's registered charity and is not for their own personal gain.

7.2.4 Staff must obtain permission from the Trust if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign.

7.2.5 Donations, when received, should be made to the Trust's charitable fund (never to an individual) and a receipt should be issued.

7.2.6 Staff wishing to make a donation to the Trust's charitable fund in lieu of a professional fee they receive 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

7.3 The offer of Hospitality

7.3.1 Hospitality in this context means the provision of meals and refreshments, invitations to functions such as ceremonies, receptions, presentations, and conference as well as invitations to social, cultural, and sporting events. Some offers may include overnight accommodation and travel to and from a venue at which an event is being held.

7.3.2 Meals and Refreshments

Staff may accept modest hospitality i.e. biscuits, tea, coffee, and non-alcoholic drinks) and working meals provided it is similar to the scale of hospitality which the Trust would be likely to offer and under the value of £25. Hospitality must be secondary to the purpose of the meeting or conference i.e. The meeting or conference is held in relation to Trust business and attendees are present in that capacity and lunch is restricted to a buffet or sandwich type meal – this does not need to be declared.

Meals and refreshments offered of a value £25 - £75 may be accepted and must be declared indicating whether it has been accepted or declined.

Offers over a value of £75 should be refused unless (in exceptional circumstances) approval is given in advance of acceptance. A clear reason should be recorded on the declaration as to why it was permissible to accept hospitality of this value.

A common-sense approach should be applied to the valuing of meals and refreshments, using an actual amount, if known, or an estimate.

7.3.3 Travel and Accommodation

Modest offers to pay some or all travel and accommodation costs related to attendance at events may be accepted but must be declared. A clear reason should be recorded on the declaration as to why it was permissible to accept travel and accommodation.

Examples of travel and accommodation which would not normally be funded are shown below although this list should not be regarded as exhaustive:

- Offers of business or first-class travel and accommodation (including domestic travel)
- Offers of foreign travel and accommodation.

All references to hospitality include that provided by contractors, organisations or individuals concerned with the supply of goods or services.

Where a meeting is funded by the pharmaceutical industry this must be disclosed in the paper relating to the meeting and in any published minutes or actions. The Department or Directorate organising or hosting the event must ensure that the funding has been approved in line with requirements set out it the Commercial Sponsorship section of this policy.

The Deputy Director Governance/ Board Secretary will maintain, on behalf of the Chief Executive, a register of all declarations of hospitality received by employees. The register will be available to the public.

The procedure for the offer of Hospitality is set out in Appendix 2.

7.4 Declaring Gifts and Hospitality

Staff must declare any gifts and hospitality in accordance with the guidance above as soon as is practicable and must be declared by completing form SBC1 (Appendix 6).

Your declaration will need to include the following:

- date of offer of gift or hospitality, and date of event where hospitality was offered.

- relevant name, job title and organisation of recipient / provider.
- nature and purpose of gift or hospitality received or declined the name of any other organisation involved.
- estimated value.
- confirmation of approval where relevant

7.5 Commercial Sponsorship

Commercial sponsorship is:

- Funding from an external source, including funding for all or part of the costs of a member of staff.
- NHS research.
- Staff training.
- Funding from pharmaceutical companies.
- Equipment.
- The provision of or funding for the hire of meeting rooms or costs associated with meetings.
- Costs associated with meals, gifts, and hospitality.
- Hotel and transport costs (including trips abroad).
- Provision of free services (such as speakers or training).
- Buildings or premises.
- Publications.

Commercial sponsorship does not include income from contracts for services or income generation schemes.

7.6 Sponsored Events

There is potential for conflicts of interest between the organiser and the sponsor, particularly regarding the ability to market commercial products or services

Sponsorship of events by appropriate external bodies should only be approved if a reasonable person would conclude that the event will result in clear benefit for the Trust. During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation. No information should be supplied to the sponsor from which they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied. Sponsors or their representatives may attend or take part in the event but they should not have a dominant influence over the content or the main purpose of the event. The involvement of a sponsor in an event should always be clearly identified in the interest of transparency. Sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event. Staff should declare involvement with arranging sponsored events to the Trust.

7.7 Sponsored Research

There is potential for conflicts of interest to occur, particularly when research funding by external bodies does or could lead to a real or perceived commercial advantage.

Funding sources for research purposes must be transparent. Any proposed research must go through the relevant approvals process. There must be a written protocol and written contract between staff, the Trust, and/or institutes at which the study will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services. The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service. Staff should declare involvement with sponsored research to the Trust.

Staff must ensure that offers of commercial sponsorship do not compromise purchasing decisions in any way. Permission must be sought from the relevant Executive Director before accepting sponsorship. Where a commercial sponsorship arrangement involves a pharmaceutical company, the pharmaceutical industry must comply with the Association of the British Pharmaceutical Industry (ABPI) Code of Practice which can be found here Code of Practice

Staff must also seek the permission of the relevant Executive Director before seeking donations of cash, goods, or services from the business community as part of any fund-raising activity.

The Deputy Director Governance/ Board Secretary will maintain, on behalf of the Chief Executive, a register of all declarations of commercial sponsorship. The register will be available to the public.

The procedure for the offer of commercial sponsorship is set out in Appendix 3.

Staff must declare any commercial sponsorship by completing Form SBC2 - see Appendix 7.

Any sponsorship received will require the completion of a Sponsorship Agreement – see Appendix 5.

7.8 Decision making officers.

Some officers are more likely than others to have a decision-making role or influence on the use of public money because of the requirements of their role. In the context of this policy, the officers listed below are referred to as ‘decision making officers’:

- Board members
- Executive and Senior Managers and equivalent Officers at Agenda for Change Band 8c and above

7.9 Management of Conflicts of Interest

A conflict of interest occurs where an individual's ability to exercise judgement or act in one role is, or could be, impaired or otherwise influenced, by his or her involvement in another role or relationship. A conflict of interest may be:

- Actual – there is a relevant and material conflict between one or more interests now.

- Potential – there is the possibility of a material conflict between one or more interests in the future.

- Perceived – i.e. an observer could reasonably suspect there to be a conflict of interest regardless of whether there is one or not.

An individual does not need to exploit his or her position or obtain an actual benefit, financial or otherwise; the potential for competing interests and/or a perception of impaired judgement or undue influence can also be a conflict of interest.

Staff should not allow their judgement or integrity to be compromised and should always be and seen to be honest and objective in the exercise of their duties in line with their terms of employment, duties, and responsibilities. All staff must declare any interests outside of their role, either on appointment or when the interest is acquired (which may directly or indirectly give rise to an actual or potential conflict of interest or duty).

Interests can be broadly defined as:

1. Financial Interests - where an individual may get direct financial benefits from the consequences of a commissioning decision.
2. Non-Financial Professional Interests - where an individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their professional reputation or status or promoting their professional career.
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 e.g. voluntary sector champion or a volunteer for a provider, or a member of a voluntary sector board etc.
4. Indirect Interests - where an individual may have a close association with someone who has a financial interest, a non-financial professional interest, or a non-financial personal interest in a commissioning decision (as those categories are described above) e.g. spouse or partner, close relative, or friend etc.

The Trust has clear principles and robust processes for minimising, managing, and registering real or perceived conflicts of interest which could be deemed or assumed to affect the integrity of decisions made by staff in awarding contracts,

procurement, policy development, employment, and other commissioning decisions. For the avoidance of doubt, the following are regarded as relevant and material interests:

- any directorship of a company.
- any interest held by a director in any firm or company or business which, in connection with the matter, is trading with the Trust, or is likely to be considered as a potential trading partner with the Trust.
- any interest in an organisation providing health and social care services to the health service.
- a position of authority in a charity or voluntary organisation in the field.

This list is not exhaustive. The key test is not whether the employee / Trust Board member thinks that there is an interest to declare but whether a member of the public, knowing the facts of the situation, might reasonably think so. The following shall not be treated as a material interest:

- the holding of shares not exceeding 1% of the total shares in use held in any company whose shares are listed on any public exchange; or
- the holding of shares not exceeding a value of £5,000 held in any company whose shares are listed on any public exchange.

Conflicts can occur because of interests held by a close family member, business partner, close friend, or associate. If officers are aware of material interests (or could be reasonably expected to know about these) then these should be declared. In this context, a close family member is defined as:

- spouse or civil partner.
- any other person with whom the individual cohabits.
- children or stepchildren
- spouse/partners' children or stepchildren.
- parents
- grandparents
- siblings

Advice on the declaration of interests is available from the Deputy Director Governance/ Board Secretary. If there is any doubt about the relevance or materiality of an interest the Chair will take a final decision on the matter.
The Deputy Director Governance/ Board Secretary will maintain, on behalf of the Chief Executive, registers of the private interests of Board Members, Consultants, and other decision-making staff these registers will be available to the public.

The Code of Conduct: Code of Accountability in the NHS, requires Trust Board Members to declare interests which are relevant and material to the NHS Board of which they are a member. A Trust Board member who has a relevant and material pecuniary, personal, or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which conflicts with the interests of the Trust, shall disclose that

interest to the Deputy Director of Governance Trust Secretary and it shall be recorded in the register of interests.

Declarations should be made as soon as is reasonably practicable, and within 28 days after the interest arises, using the SBC 3 Form – See Appendix 8. If officers are in any doubt as to whether they have an interest or whether it is declarable, they should consult their line manager or the Deputy Director Governance/ Board Secretary. In addition, officers are required to review and declare interests at the following points:

Board Members

- On appointment
- In formal meetings
- Annually (nil returns are to be made)

Decision making officers.

- On appointment
- At annual appraisals (nil returns are to be made)
- When moving to a new role, or responsibilities change
- In formal meetings

Annually

Formal, written declarations of interest should be submitted by all relevant individuals every year. Where there are no interests or changes to declare, a "nil return" should be made.

On changing role, responsibility, or circumstances

Whenever an individual's role, responsibility or circumstances change in a way that affects the individual's interests (e.g., where an individual takes on a new role outside the Trust or enters into a new business arrangement or relationship), a further formal, written declaration should be made to reflect the change in circumstances as soon as possible, and in any event within 28 days.

7.10 Managing Conflicts of Interest at meetings

All formal meetings, including the Board and its Committees, must have a standing agenda item at the beginning of each meeting to determine whether anyone has any conflict of interest to declare in relation to the business to be transacted at the meeting. The Rules of Procedure/Standing Orders and all Committee terms of reference will incorporate this requirement. Any new interests declared at the meeting should be included in the relevant register of interest as soon as practicable after the meeting.

In the event that the chair of the meeting has a conflict of interest, the deputy chair is responsible for deciding the appropriate course of action to manage

conflicts of interests. If the deputy chair is also conflicted, then the remaining non-conflicted voting members of the meeting should unanimously agree how to manage the conflict(s).

When a member of the meeting (including the chair or deputy chair) has a conflict of interest in relation to one or more items of business to be transacted at the meeting, the chair (or deputy chair or remaining non-conflicted members where relevant as described above) must decide how to manage the conflict. The appropriate course of action will depend on the particular circumstances, but could include one or more of the following:

- Where the chair has a conflict of interest, deciding that the deputy chair (or another non-conflicted member of the meeting if the deputy chair is also conflicted) should chair all or part of the meeting.
- Requiring the individual who has a conflict of interest (including the chair or deputy chair if necessary) not to attend the meeting.
- Ensuring that the individual does not receive the supporting papers or minutes of the meeting which relate to the matter(s) which give rise to the conflict.
- Requiring the individual to leave the discussion while the relevant matter(s) are being discussed and when any decisions are being taken in relation to those matter(s).
- Allowing the individual to participate in some or all of the discussion when the relevant matter(s) are being discussed but requiring them to leave the meeting when any decisions are being taken in relation to those matter(s).
- Noting the interest and ensuring that all attendees are aware of the nature and extent of the interest but allowing the individual to remain and participate in both the discussion and in any decisions. This is only likely to be an appropriate course of action where it is decided that the declared interest in either immaterial or not relevant to the matter(s) under discussion.
- Conflicts of interest arising at a Board meeting must be managed in accordance with the requirements of the Standing Orders/Rules of Procedure.

In all cases however, a quorum must be present for the discussion and decision; and interested parties cannot be counted in determining whether the meeting is quorate for that item.

All decisions under a conflict of interest must be recorded by the meeting secretariat and clearly reported in the minutes of the meeting. The minutes will include:

- Who has the interest.
- The nature and extent of the conflict.
- An outline of the discussion.
- The actions taken to manage the conflict and
- Evidence that the conflict was managed as intended.

Where an interest has been declared, the declarer will ensure that before participating in any activity connected with Trust activity or functions, they have received confirmation of and understand the arrangements to manage the conflict of interest or potential conflict of interest from the Accountable Officer or relevant Committee Chair. In cases of doubt or where the declarer is yet to receive details of the management arrangements, the declarer should withdraw from any such activity until these have been clarified. Further advice can be sought from the Deputy Director Governance/ Board Secretary.

7.11 Patents and Intellectual Property

Staff members should declare patents and other intellectual property rights they hold (either individually or by virtue of their association with a commercial or other organisation) relating to goods and services which are, or might reasonably be expected to be, procured, or used by the Trust.

Any patents, designs, trademarks, or copyright resulting from the work (e.g., research) of an officer carried out as part of their employment shall be the Intellectual Property of North Staffordshire Combined Healthcare NHS Trust.

Where the undertaking of external work, gaining patent or copyright or the involvement in innovative work, benefits or enhances our reputation or results in financial gain, consideration may be given subject to any relevant guidance for the management of Intellectual Property in the NHS issued by the Department of Health and Social Care (DHSC).

Permission must be sought from the direct line manager before entering into any agreement with bodies regarding product development where this impacts on normal working time or uses our equipment and/or resources.

Where holding of patents and other intellectual property rights give rise to a conflict of interest, then this must be declared in accordance with the section around Declaring Interests.

7.12 Procurement

Conflicts of interest need to be managed appropriately through the whole procurement process. At the outset of any process, the relevant interests of individuals involved should be identified and clear arrangements put in place to manage any conflicts. This includes consideration as to which stages of the process a conflicted individual should not participate in, and in some circumstances, whether the individual should be involved in the process at all.

Further guidance is provided in the Standing Financial Instructions.

7.13 Preferential Treatment in Private Transactions

Staff must not seek or accept preferential rates for private transactions with companies with which they have had, or may have, dealings on behalf of the Trust.

Staff may enjoy the benefit of concessionary schemes such as the NHS Benefits Scheme and the local Staff Benefits Scheme.

7.14 Private Use of Equipment and Materials

Staff must obtain prior permission from their line manager before making private use of any of the Trust's equipment or materials.

7.15 Secondary Employment

Employees, Board members, committee members, contractors and others engaged under contract with the Trust are required to inform the Accountable Officer and Deputy Director Governance/ Board Secretary if they are employed or engaged in, or wish to be employed or engaged in, any employment or consultancy work in addition to their work with the Trust. The purpose of this is to ensure that the Trust is aware of any potential conflict of interest. For the avoidance of doubt, "secondary employment" includes part-time, temporary, and fixed term contract work as well as "one-off" payments for advice or services provided.

Examples of work which might conflict with the business of the Trust include:

- Employment with another NHS body.
- Employment with another organisation which might be in a position to supply goods/services to the Trust or within the Integrated Care System area.
- Directorship of a Primary Care Network; and Self-employment, including private practice, in a capacity which might conflict with the work of the Trust, or which might be in a position to supply goods/services to the Trust.

Individuals must obtain prior permission to engage in secondary employment, and the Trust reserves the right to refuse permission where it believes a conflict will arise which cannot be effectively managed. Employees should not engage in outside employment during any periods of sickness absence from the Trust. To do so may lead to a referral being made to the Local Counter Fraud Specialist for investigation which may lead to criminal and/or disciplinary action.

7.16 Medical Staff Private Practice

Medical staff are expected to comply with their terms and conditions and also with the A Code of Conduct for Private Practice: Guidance for NHS medical staff, which sets out standards of best practice governing the relationship between NHS work, private practice, and fee-paying services.

Medical staff must declare any outside employment which may conflict with the interests of the Trust as a private interest.

Consultants (and Associate Specialists) employed under Terms and Conditions of Service of Hospital Medical and Dental Staff are permitted to carry out private

practice in NHS hospitals subject to the conditions outlined in the handbook "A Guide to the Management of Private Practice in the NHS". Consultants who have signed new contracts with Trusts will be subject to the terms applying to private practice in those contracts. Any such work must be undertaken outside their NHS contractual duties.

7.17 Contracting for Goods and Services

All staff who are in contact with suppliers and contractors, (including external consultants), and in particular those who are authorised to sign purchase orders or place contracts for goods and services must adhere to the Trust's rules on tendering and contracting set out in the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation.

This means that:

- no private, public, or voluntary organisation or company which may bid for NHS business should be given any advantage over its competitors, such as advance notice of contract requirements. This applies to all potential contractors, whether or not there is a relationship between then and the Trust; and
- each new contract should be awarded solely on merit, taking into account the requirements of the Trust and the ability of the contractors to fulfil them.

The Standing Financial Instructions set out the financial responsibilities which apply to everyone working for the Trust, but particularly budget holders. They are designed to ensure that taxpayers' money is spent wisely, efficiently, and effectively. In addition, they are also important in protecting individual staff members from accusations of impropriety.

7.18 Openness

Staff employed by the Trust are expected to comply with this Policy and also the NHS Constitution July 2015. The general principles included within this Policy are that the Trust will:

- respond positively to requests for information (except in certain circumstances for example patients' records must be kept safe and confidential);
- answer any requests for information quickly and helpfully and give reasons for not providing information where this is not possible.
- help the public to know what information is available, to that they can decide what they wish to see, and whom they should ask; and
- ensure that there are clear and effective arrangements to deal with complaints and concerns about local services and access to information, and that these arrangements are well publicised and effectively monitored.

7.19 Confidentiality

Staff must observe requirements.

- Confidentiality Policy (September 2019) produced by NHS England [www.england.nhs.uk].
- Information Sharing Policy – personal information (September 2019) produced by NHS England [www.england.nhs.uk]

All employees of the Trust are bound by a legal duty of confidence to protect personal information they may come into contact with during the course of their work. They must not disclose the confidential information of the Trust to any unauthorised person and must not use for their own purposes any information acquired in relation to the Trust's business. Confidential information is defined as information which, if it were to be disclosed, would harm the proper and effective operation of the Trust.

Staff should note that under common law and through their contract of employment they have an implied duty of confidence and fidelity to the Trust. A breach of this may result in disciplinary action being taken, up to and including dismissal.

7.20 Failure to comply with Standards of Business Conduct Policy

Failure by an employee 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).

Where the failure to comply relates to an officer that is not a direct employee of either NHS Improvement or NHS England, this may result in action being taken in accordance with the relevant engagement procedures (e.g. termination of a secondment agreement).

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 Local Counter Fraud Team in accordance with Standing Financial Instructions and the Anti- Bribery Policy, with a view to an appropriate investigation being conducted and potential prosecution being sought.

7.21 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 the deliberate actions of staff or organisations. For the purposes of this guidance these situations are referred to as 'breaches'.

Should a breach occur, the Deputy Director of Governance should be notified who will then identify a team or individual empowered to investigate breaches, involving organisational leads for human resources, fraud, audit etc. as

appropriate. Each breach will be investigated and judged on its own merits and those involved will be given the opportunity to explain and clarify any relevant circumstances.

The investigating team or individual will:

- Decide if there has been or is potential for an actual breach and the severity
- 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 of the breach
- Take appropriate action, such as clarifying existing policy, taking action against the staff member(s) responsible for the breach, or escalating to external parties such as auditors, NHS Protect, the Police, statutory health bodies and/or regulatory bodies

7.22 Potential Sanctions

Disciplinary Sanctions
Staff who fail to disclose any relevant interests or who otherwise breach an organisation's rules and policies relating to the management of conflicts of interest are subject to investigation and, where appropriate, to disciplinary action. This may include:

• Employment law action which might include:
• Informal action – such as reprimand or signposting to training and/or guidance.
• Formal action – such as formal warning, the requirement for additional training, re-arrangement of duties, redeployment, demotion or dismissal.
• Referring incidents to regulators.
• Contractual action against organisations or staff

Professional Regulatory Sanction
Statutorily regulated healthcare professionals are under professional duties imposed by their relevant regulator to act appropriately with regard to conflicts of interest. The Trust may consider reporting statutorily regulated healthcare professionals to their regulator if they believe that they have acted improperly, so that these concerns can be investigated. This could include fitness to practise proceedings being brought against an individual, and could, if appropriate result in the individual being struck off by their professional regulator as a result.

Civil Sanctions
If conflicts of interest are not effectively managed, the Trust could face civil challenges to decisions they make – for instance if interests were not disclosed that were relevant to the bidding for, or performance of contracts. In extreme cases, staff and other individuals could face personal civil liability, for example a claim for misfeasance in public office.

Criminal Sanctions
Failure to manage conflicts of interest could lead to criminal proceedings including for offences such as fraud, bribery and corruption. This could have

implications for the Trust and linked organisations, and the individuals who are engaged by them.

The Fraud Act 2006 created a criminal offence of fraud and defines three ways of committing it:

- Fraud by false representation
- Fraud by failing to disclose information and
- Fraud by abuse of position.

In these cases an offender's conduct must be dishonest and their intention must be to make a gain, or a cause a loss (or the risk of a loss) to another. Fraud carries a maximum sentence of 10 years imprisonment and/or a fine.
Bribery is generally defined as giving or offering someone a financial or other advantage to encourage a person to perform certain activities and can be committed by a body corporate. The Trust could be exposed to criminal liability, punishable by an unlimited fine, for failing to prevent bribery. The offences of bribing another person or being bribed carries a maximum sentence of 10 years imprisonment and/or a fine.

7.23 Raising Concerns

If staff have a genuine concern or suspect a colleague, patient or other person or organisation of a fraud, bribery, or corruption act against the Trust, they should report this to the Trust's Local Counter Fraud Specialist (LCFS). Alternatively, staff can report suspicions to the NHS Fraud and Corruption Reporting Line on 0800 028 40 60 in confidence and anonymously. The Trust's Policy Freedom to Speak Up encourages staff to report concerns as soon as possible without fear or penalty.

8. Implementation and monitoring

8.1 The Trust will be proactive in raising the standards of ethical conduct and will communicate these to staff.

8.2 The Trust will provide training for all staff at the time of induction on standards of business conduct. Refresher and advanced training will be available to staff, as required at regular intervals throughout the year. Training slides are also available on the Staff website (CAT)**.**

8.3 The Trust will ensure that all Trust Board members have formally signed up to the Code of Conduct: Code of Accountability in the NHS, and that acceptance of these Codes is included in the contracts of employment of new Board members**.**

8.4 The registers of gifts, hospitality, commercial sponsorship, and private interests are public documents and will be available for inspection by arrangement with the Deputy Director of Governance / Trust Secretary.

8.5 The registers of gifts, hospitality, commercial sponsorship, and private interests will be presented to the Audit Committee for scrutiny on an annual basis.

8.6 The register of private interests of the members of the Trust Board will be presented for review by the Trust Board every six months.

8.7 The register of private interests of the members of the Trust Board will be published on the Trust's internet site and in the Trust's annual report.

8.8 If for any reason requirements of this Policy are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Trust Board for action or ratification. All members of the Trust Board and staff have a duty to disclose any non-compliance with this Policy to the Assistant Chief Executive as soon as possible.

8.9 Alleged non-compliance with this Policy will be promptly investigated and any such investigation may result in disciplinary action. The Trust will ensure that all investigations are, and are seen to be, reasonable, fair and impartial.

9. Review Process

9.1 It is recognised that as legislation changes this Policy will need to be updated to reflect these requirements. Any revision will be made in consultation with relevant stakeholders.

10. Diversity and Inclusion Statement

The Trust aspires to ensuring Outstanding diversity and inclusion in its role as both an NHS service provider and as an employer. We are committed to continually improving our services and ensuring that these are safe, personalised, accessible and recovery-focused (SPAR) for all our patients, service users, visitors and carers. We are also committed to providing excellent employment experiences for those who work within our services. In short, we aim to see that everyone using our services - or working within them - experiences our CARE Values: compassion, approachable, responsible and excellent.

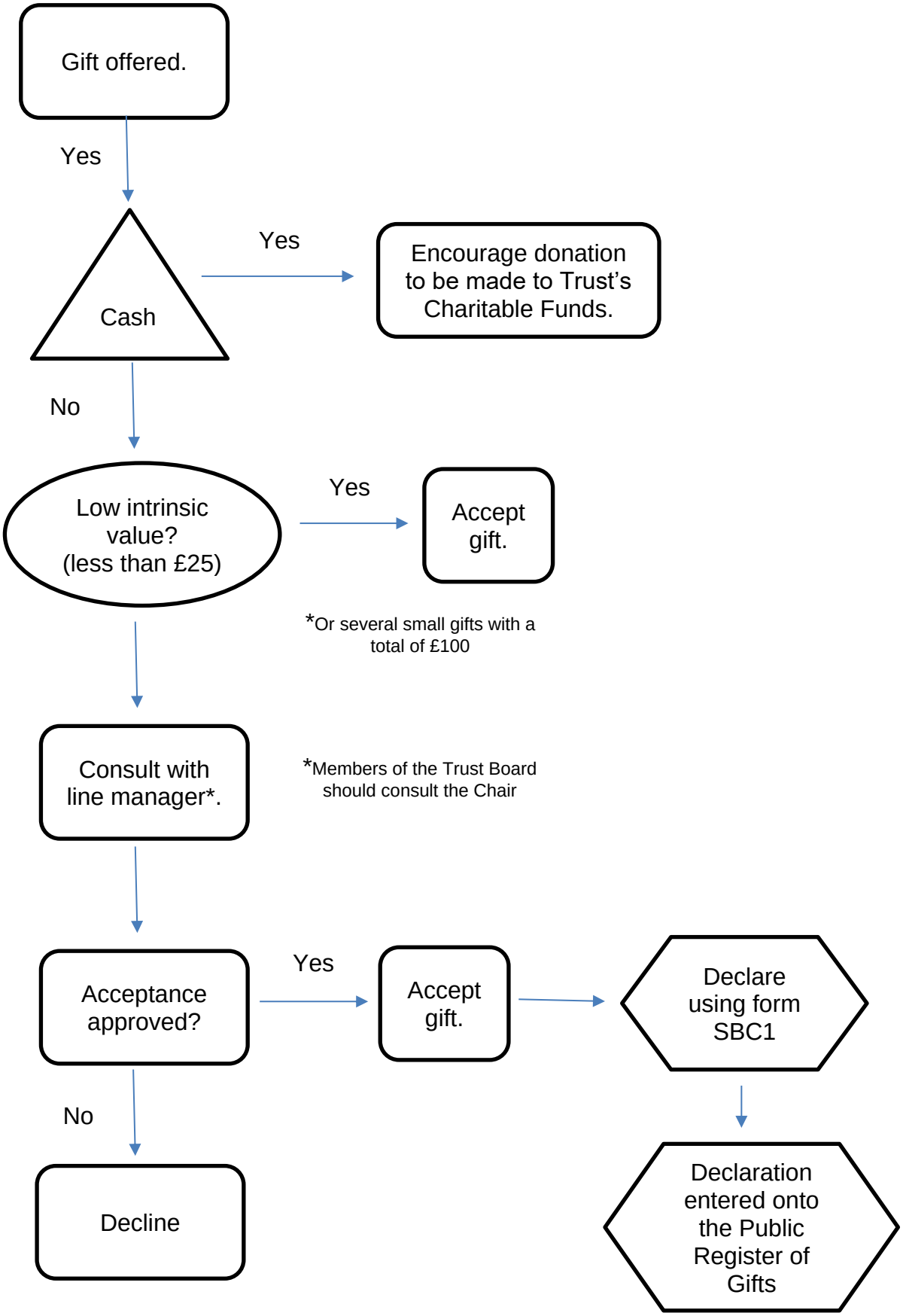
The Trust does not tolerate any form of racist, cultural, religious, sexist, misogynistic, ableist biphobic, homophobic and/or transphobic discrimination, bullying and harassment in any of our services, whether from service users and patients, members of the public, or those working on behalf of the Trust. Action will always be taken where this occurs. We work continuously to develop a positive culture of outstanding inclusion for all.

As part of its development, this policy was analysed to consider its impact on different groups protected from discrimination by the Equality Act 2010. The requirement is to consider if there are any unintended impact for some groups,

and to consider if the policy will minimise discrimination for all protected groups in accessing services across the Trust.

Appendix 1: Procedure for the offer of Gifts

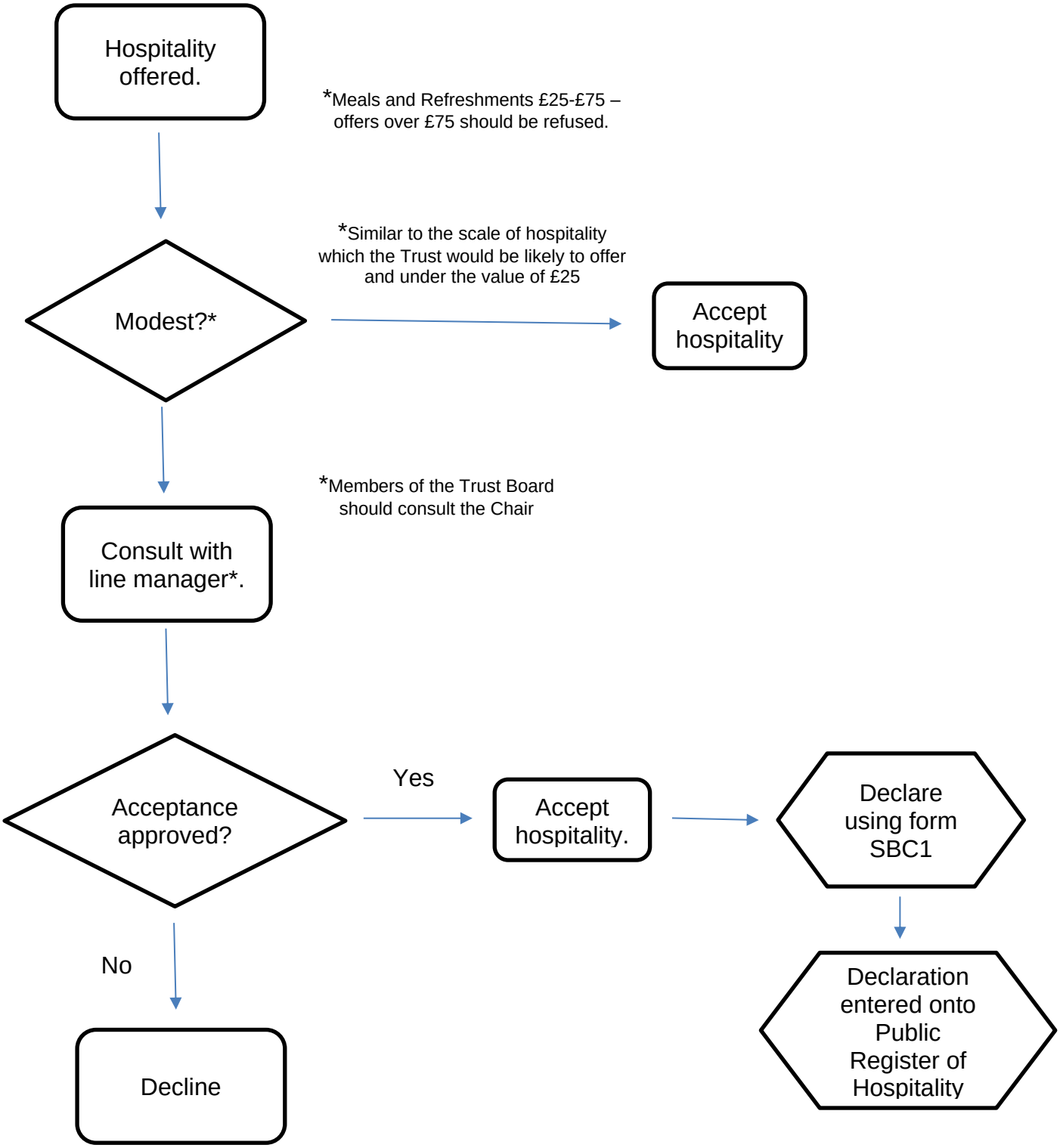
Staff must follow the following procedure for the offer of gifts.



*

Appendix 2: Procedure for the offer of Hospitality

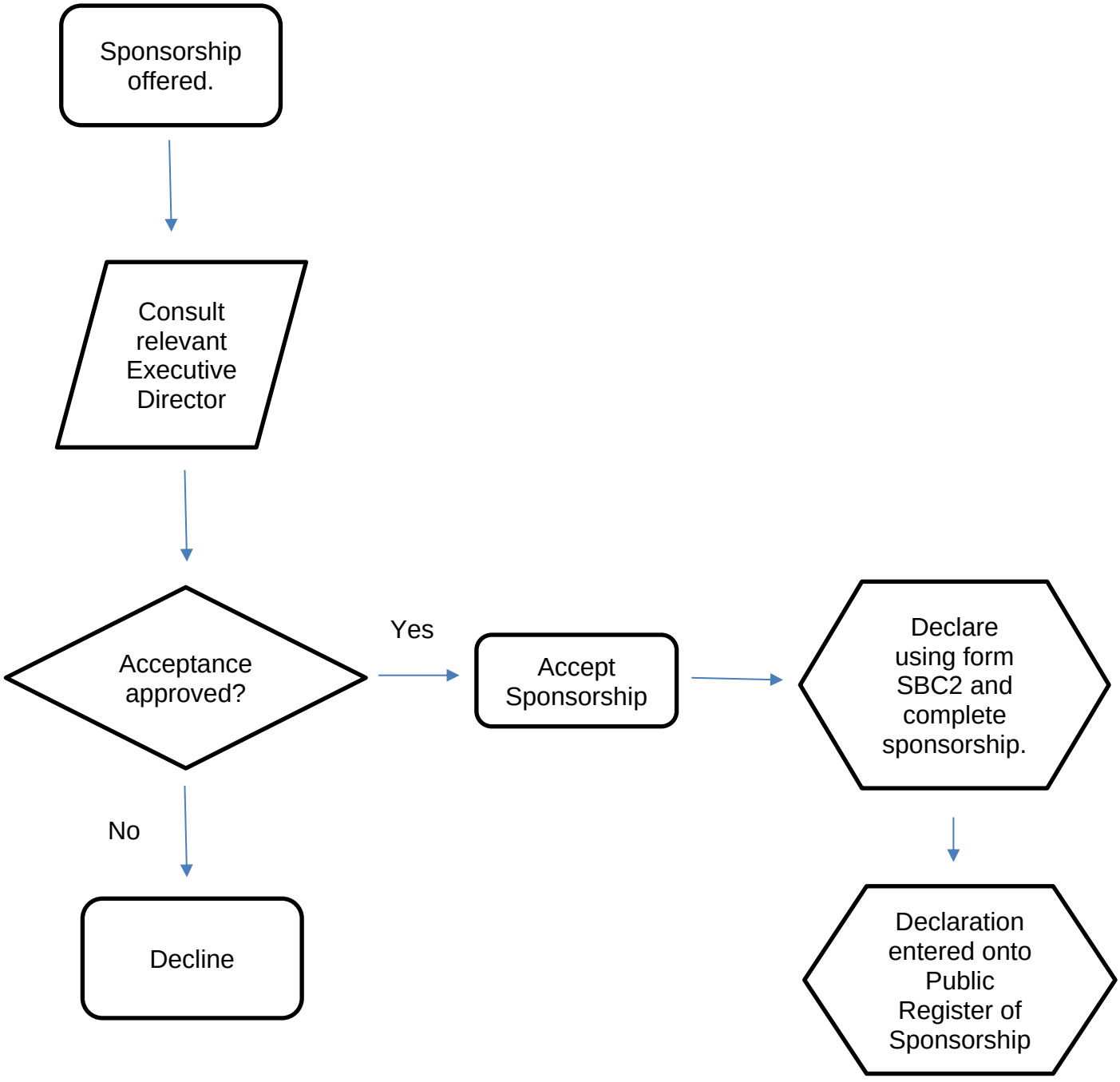
Staff must follow the following procedure for the offer of hospitality.



Appendix 3: Procedure for the offer of Commercial Sponsorship

Staff must seek the permission of the relevant Executive Director before seeking donations of cash goods or services from the business community as part of any fund-raising activity.

Staff must follow the following procedure for the acceptance of commercial sponsorship.



Appendix 4: Nolan Principles

Selflessness

Holders of public office should act solely in terms of the public interest.

Integrity

Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

Objectivity

Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

Accountability

Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.

Openness

Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.

Honesty

Holders of public office should be truthful.

Leadership

Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

www.gov.uk

Appendix 5: Sponsorship agreement

In line with NHS England's guidelines (February 2017) sponsored events offer the opportunity for learning, development and partnership working. However, there is potential for conflicts of interest between the organiser and the sponsor, particularly regarding the ability to market commercial products or services.

<table>
<tr><td colspan="3">Sponsorship Agreement

(To be updated annually and promptly after any changes.)</td></tr>
<tr><td>Objective:

See special condition 1.</td><td colspan="2">Please describe the objective, including duration and how this links to the Trust's Strategic Objectives.</td></tr>
<tr><td>Directorate / Department:</td><td colspan="2"></td></tr>
<tr><td rowspan="4">Key contact details:</td><td>North Staffordshire Combined Healthcare NHs Trust</td><td>Sponsor / Company Name</td></tr>
<tr><td>Address</td><td>Address</td></tr>
<tr><td>Telephone Number</td><td>Telephone Number</td></tr>
<tr><td>Name of contact person</td><td>Name of contact person</td></tr>
<tr><td>Value of sponsorship

Please liaise with finance representative to calculate the required sponsorship based on actual costs. See special condition 2.</td><td colspan="2"></td></tr>
<tr><td>Payment arrangements:</td><td colspan="2"></td></tr>
</table>

Sponsorship Agreement (To be updated annually and promptly after any changes.)		
Benefits for the Trust / Organisation *Commercial sponsorship arrangements should only be approved where there is a clear benefit for the organisation including organisation benefit derived from individual sponsorship arrangements. No information should be supplied to a company for their commercial gain unless there is a clear benefit.*		
Benefits for the Sponsor		
Confidentiality: *During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation.*	North Staffordshire Combined Healthcare NHs Trust	**Sponsor / Company Name**
Termination Arrangements: *The Trust holds the right to terminate this agreement early if good value for money / outcomes are not met.*	Address	Address
	Telephone Number	Telephone Number
Declaration & Signature *The senior individual responsible for arranging the commercial sponsorship is responsible for declaring it.*	Name of contact person	Name of contact person

Special conditions:

1. Should any of the objectives change throughout the period, please ensure that these are attached to the original **annual** (12 month) agreement.

2. The Trust hold the right to increase the rate for sponsorship if applicable. Should this change within the 12 month timeframe a new agreement will need to be signed.

3. All support detailed above will be recorded within the Trust's Register and accounting records.

4. The Sponsor is required to adhere to regulatory requirements - Medicines and Healthcare Products Regulatory Agency (MHRA): The Blue Guide (2014) Last updated 2019.

It is the responsibility of all staff to:

- Check companies for potential irregularities, i.e. anything that may affect a company's liability to meet the conditions of the agreement.
- Assess the costs and benefits in relation to alternative options and to ensure that the decision making process is transparent and defensible.
- Ensure that purchasing decisions (including pharmaceuticals and appliances) are based on best clinical practice and value for money, taking into account their impact on other parts of the healthcare system).
- Ensure that all partnerships involving a pharmaceutical company comply fully with the Medicines and Healthcare Products Regulatory Agency (MHRA): The Blue Guide (2014) Last updated 2019.
- Adhere to anti-corruption laws – UK Bribery Act 2010.
- Ensure that the interests of patients are taken into account including the requirement for protection and use of information.
- Determine how clinical and financial income will be monitored.
- Ensure that potential sponsors are informed that any sponsorship will have no effect on purchasing decisions within the Trust. Any member of staff who is able to influence purchasing decisions should be open and declare any sponsorship received.
- At an organisation's discretion, sponsors or their representatives may attend or take part in the event, but they should not have a dominant influence over the content or the main purpose of the event.
- The involvement of a sponsor in an event should always be clearly identified in the interest of transparency. It should also be clear that this is not an endorsement of the company or its products.

Appendix 6: SBC1 Declaration of Gifts and Hospitality

I wish to declare an offer or receipt of:

☐ a gift from a patient, relative or other user of services valued at over £25.

☐ a gift from a potential or actual contractor or supplier of services/products to the Trust valued at over £25.

☐ Hospitality from a potential or actual contractor or supplier of services/products to the Trust valued at over £25.

Employee / Director's Name:	
Job Title	
Department and work base	
Personal Number	
Date Gift or Hospitality received: *(include a description of the gift or hospitality, your relationship with the donator and the reasons why the gift or hospitality was made)*	
Approximate value of gift or hospitality:	
Accepted / declined / donated to charity	
Details of patient, relative or user of service, contractor or supplier:	

☐ I confirm that I am not involved in any purchasing authorisation of services or goods from the contractor/supplier detailed above.

Staff Signature……Date…….....

Part 2 – To be completed by the manager.

I have discussed acceptance of this gift or hospitality with the employee and agree that acceptance is reasonable in this instance.

Managers' Signature…….Date…….....

(Please print name)

Please return to:

Corporate Governance Manager, Lisa Wilkinson at LisaM.Wilkinson@combined.nhs.uk

Appendix 7: SBC2 Declaration of Commercial Sponsorship

Employee / Director's Name:	
Job Title	
Department and work base	
Personal Number	
Date Sponsorship received. *(include a description and reason for the sponsorship, the Trust's relationship with the sponsor and the reasons the sponsorship was offered)*	
Approximate value of sponsorship	

Staff Signature……Date…….....

Part 2 – To be completed by the Executive Director

I have discussed acceptance of this sponsorship with the employee and agree that acceptance is reasonable and in accordance with the Trust's Standing Financial Instructions.

Executive Director's Signature…….... Date…….

(Please print name)

Please return to:

Corporate Governance Manager, Lisa Wilkinson at
LisaM.Wilkinson@combined.nhs.uk

Appendix 8: SBC3 Declaration of Relevant and Material Interests

SBC3 - INTERESTS DECLARATION FORM

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	

Please see below for information on how to populate the above boxes

The information submitted will be held by **NORTH STAFFORDSHIRE COMBINED HEALTHCARE** for personnel or other reasons specified on this form and to comply with the organisation's policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 1998. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in registers that **NORTH STAFFORDSHIRE COMBINED HEALTHCARE** holds.
I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to **NORTH STAFFORDSHIRE COMBINED HEALTHCARE** as soon as practicable and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, internal disciplinary, or professional regulatory action may result.

I **do / do not [delete as applicable]** give my consent for this information to published on registers that **NORTH STAFFORDSHIRE COMBINED HEALTHCARE** holds.

If consent is NOT given please give reasons:

Signed:		**Date:**	
Managers Signature:		**Date:**	

Please return this form to **RANIA MOSEDALE, CORPORATE GOVERNANCE ADMINISTRATOR AT Rania.Mosedale@combined.nhs.uk**

GUIDANCE NOTES FOR COMPLETION OF SPECIMEN INTERESTS DECLARATION FORM

Name and Role: Insert your name and your position/role in relation to the Organisation you are making the return to

Description of Interest: Provide a description of the interest that is being declared. This should contain enough information to be meaningful (e.g. detailing the supplier of any gifts, hospitality, sponsorship, etc). That is, the information provided should enable a reasonable person with no prior knowledge should be able to read this and understand the nature of the interest.

Types of interest:

Financial interests - This is where an individual may get direct financial benefits from the consequences of a decision they are involved in making

Non-financial professional interests - This is 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 status or promoting their professional career

	Non-financial personal interests - This is 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
	Indirect interests - This is 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 who would stand to benefit from a decision they are involved in making
	A benefit may arise from both a gain or avoidance of a loss.
Relevant Dates:	Detail here when the interest arose and, if relevant, when it ceased
Comments:	This field should detail any action taken to manage an actual or potential conflict of interest. It might also detail any approvals or permissions to adopt certain course of action
Signature:	Please ensure the declaration is signed and dated by the person making the declaration and by the Manager. The form will not be accepted without a Managers Signature,

Appendix 9 The Chartered Institute of Purchasing and Supply (CIPS) Code of Ethics.

Use of the code

Members of CIPS are required to uphold this code and to seek commitment to it by all those with whom they engage in their professional practice. Members are expected to encourage their organisation to adopt an ethical purchasing policy based on the principles of this code and to raise any matter of concern relating to business ethics at an appropriate level. The Institute's Royal Charter sets out a disciplinary procedure which enables the CIPS Board of Trustees to investigate complaints against any of our members and, if it is found that they have breached the code to take appropriate action. Advice on any aspect of the code is available from CIPS. This code was approved by the CIPS Council on 11 March 2009.

As a member of The Chartered Institute of Purchasing & Supply, I will:

- Maintain the highest standard of integrity in all my business relationships.
- Reject any business practice which might reasonably be deemed improper.
- Never use my authority or position for my own personal gain.
- Enhance the proficiency and stature of the profession by acquiring and applying knowledge in the most appropriate way.
- Foster the highest standards of professional competence amongst those for whom I am responsible.
- Optimise the use of resources which I have influence over for the benefit of my organisation.
- Comply with both the letter and the intent of:
    - The law of countries in which I practice.
    - Agreed contractual obligations.
    - CIPS guidance on professional practice
- Declare any personal interest that might affect, or be seen by others to affect, my impartiality or decision making.
- Ensure that the information I give in the course of my work is accurate.
- Respect the confidentiality of information I receive and never use it for personal gain.
- Strive for genuine, fair, and transparent competition.
- Not accept inducements or gifts, other than items of small value such as business diaries or calendars.
- Always to declare the offer or acceptance of hospitality and never allow hospitality to influence a business decision.
- Remain impartial in all business dealing and not be influenced by those with vested interests.

Advice on any aspect of the code of ethics is available from CIPS.

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 12

Gifts, Hospitality and Sponsorship / Declarations of Relevant and Material Interests 2024/25

Report provided for:			
Information	☐	Assurance	☒
Discussion	☐	Approval	☐

Report to:	Audit Committee
Date of Meeting:	7th May 2025

Presented by:	Nicola Griffiths – Deputy Director of Governance
Prepared by:	Lisa Wilkinson – Corporate Governance Manager
Executive Lead:	Dr Buki Adeyemo, Chief Executive Officer

Aligned to Board Assurance Framework Risk	Risk 1 The Trust fails to deliver effective care leading to regulatory restrictions
Approval / Review:	SLT / Audit Committee
Strategic Priorities:	Prevention - To continue to grow high-quality, integrated services delivered by an innovative and sustainable workforce
Key Enablers:	People - We will attract, develop and retain the best people
Sustainability:	Share learning and best practice
Resource Implications:	No
Funding Source:	N/A
Diversity & Inclusion Implications	There is no direct impact on the protected characteristics as part of the completion of this report.
ICS Alignment / Implications:	N/A
Recommendation / Required Action	Committee are asked to receive the report and registers for assurance and information.
Executive Summary	This paper seeks to provide ongoing assurance to Audit Committee and outlines progress for actions that the Governance Team are leading on.

Gifts, Hospitality and Sponsorship

Previous and current gift, hospitality and sponsorship declarations made:

- In 2022/23 5 items were recorded
- In 2023/24 7 items were recorded
- In 2024/25 19 items were recorded
- A copy of the current Gifts / Hospitality and Sponsorship Register is attached. (Appendix 1)

Declarations of Relevant and Material Interests

Previous and current declarations of relevant and material interests' performance:

- April 2023 compliance was 66%.
- April 2024 compliance was 71%.
- April 2025 compliance was 97% the remaining 3% was a result of long-term sickness and maternity leave.
- A copy of the current Band 8c and above and Consultants registers have been included for information. (Appendix 2)

Although we collate declarations for 'Other Staff' this information does not form part of the compliance figures.

VERSION CONTROL:

Version	Report to	Date Reported
V1	SLT	11.04.25
V2	Audit Committee	30.04.25
V3	Public Trust Board	02.05.25

Doc level: Trustwide
Code ref: Governance 4.30
Issue number: 4

Policy for the development and management of Trustwide procedural / approved documents

Lead executive	Chief Executive
Authors details	Deputy Director of Governance

Type of document	Policy
Target audience	All Trust staff involved in the development of approved policy and guidance documents.
Document purpose	This policy sets out the standards for the development, consultation, approval, review and control / archive of all Trust approved policy and guidance documents.

Approving meeting	Audit Committee	Meeting date	31st October 2025
Ratification date	31st October 2025	Review date	31st October 2028

Trust documents to be read in conjunction with	
Document code	Document name

Document change history		Version	Date
What is different?	Flowchart updated. 6 policies updated that required final ratification to be undertaken by Trust Board. Quality Assurance and Approval section updated to reflect flowchart changes. Update to Policy Inclusivity Explanatory wording and email address.	4	Oct 2025
Appendices / electronic forms	Appendix 3 Consultation, approval and dissemination requirements for corporate Trustwide approved documents within North Staffordshire Combined Healthcare NHS Trust as per the Trust's Governance Framework updated Appendix 4 Training Needs Analysis for the policy for the development and management of Trustwide procedural / approved documents updated with up-to-date job titles		
What is the impact of change?	Changes made that reflect current practices. Appendix 4 Training Needs Analysis for the policy for the development and management of		

	Trustwide procedural / approved documents updated and will need to be rolled out for all new policies		

Training requirements	There are no specific training requirements for this document.

Document consultation	
Directorates	
Corporate services	Senior Leadership Team Meeting and Audit Committee
External agencies	N/a

Financial resource implications	No

External references
1.

Monitoring compliance with the processes outlined within this document	

Equality Impact Assessment (EIA) - Initial assessment	**Yes/No**	**Less favourable / More favourable / Mixed impact**
Does or might this policy / document, or the implementation or outcomes of the policy / document, affect one or more group(s) less or more favorably than another (see list)?		
– **Age** (e.g. consider impact on younger people/ older people)	No	
– **Disability** (remember to consider physical, mental and sensory impairments)	No	
– **Sex/Gender** (any particular M/F gender impact; also consider impact on those responsible for childcare)	No	
– **Gender identity and gender reassignment** (i.e. impact on people who identify as trans, non-binary or gender fluid)	No	
– **Race / ethnicity / ethnic communities / cultural groups** (include those with foreign language needs, including European countries, Roma/travelling communities)	No	
– **Pregnancy and maternity, including adoption** (i.e. impact during pregnancy and the 12 months after; including for both heterosexual and same sex couples)	No	
– **Sexual Orientation** (impact on people who identify as lesbian, gay or bi – whether stated as 'out' or not)	No	
– **Marriage and/or Civil Partnership** (including heterosexual and same sex marriage)	No	

– **Religion and/or Belief** (includes those with religion and /or belief and those with none) – **Other equality groups?** (may include groups like those living in poverty, sex workers, asylum seekers, people with substance misuse issues, prison and (ex) offending population, Roma/travelling communities, looked after children, local authority care leavers, and any other groups who may be disadvantaged in some way, who may or may not be part of the groups above equality groups)	No	
If you answered yes to any of the above, please provide details below, including evidence supporting differential experience or impact.		
Enter details here if applicable		
If you have identified potential negative impact: - Can this impact be avoided? - What alternatives are there to achieving the document without the impact? Can the impact be reduced by taking different action?		
Enter details here if applicable		
Do any differences identified above amount to discrimination and the potential for adverse impact in this policy?	Yes / No	
If YES could it still be justifiable e.g. on grounds of promoting equality of opportunity for one group or any other reason? On balance, is it considered that a Full Equality Impact Assessment is required?	N/A Yes / No	
Enter details here if applicable		
Where an adverse, negative or potentially discriminatory impact on one or more equality groups has been identified above, a full EIA should be undertaken. Please refer this to the Diversity and Inclusion Lead, together with any suggestions as to the action required to avoid or reduce this impact. For advice in relation to any aspect of completing the EIA assessment, please contact the Diversity and Inclusion Lead at Diversity@combined.nhs.uk		
Was a full impact assessment required?	No	
What is the level of impact?	Low	

CONTENTS

Quick reference flowchart - Approved document consultation, approval and dissemination process

New document

Reviewing existing document
Document author to determine if the document is still needed

Yes continue to **step 1** | **No** continue to **step 6**

↓

Step 1 – Write / review
Author develops / reviews the document using the approved template – Appendix 1

↓

Step 2 – Consultation
Send the working document for feedback to executive lead and other relevant stakeholders may include: appropriate meetings within the governance structure, training department (if a training need is identified), professional experts, patient and public representatives, partner/external agencies, JNCC, JLCC and Policy Governance Group. Length of time recommended for consultation may be 1-2 weeks.
Author to make agreed amends and progress to step 3

↓

Step 3 – Quality Assurance and Approval
Document is sent for agreement to 'Agreeing Meeting'. Final policy approval is granted by SLT (link to full policy sent via a monthly policy report). **Please note:** SOPS / Guidance do not require SLT approval and should be sent to the Corporate Governance Manager to upload to the Trust Intranet.

The relevant Committee will ratify the policy. See table below:

Trustwide documents	**Type of document**	**Agreeing meeting**	**Author to make agreed amends then forward policy to the Corporate Governance Manager. Policies will then be circulated to the Senior Leadership Team for approval**	**Ratifying Committee**	**Inform the Board of committee approval via the Quad A Assurance Report**
General and Corporate Governance	Policies	Policy Governance Group		Audit Committee	
Communications	Policies	People Policy Group		People, Culture and Development Committee	
Health and Safety and Security	Policies	Health, Safety and Wellbeing Group		Quality Committee	
Infection, Prevention and Control	Policies	Infection, Prevention and Control Group		Quality Committee	
Clinical practice	Policies	Clinical Effectiveness Group		Quality Committee	
Safeguarding	Policies	Safeguarding Group		Quality Committee	
Mental Health Act	Policies	Mental Health Law Governance Group		Quality Committee	
Human Resources Learning and Development	Policies	People Policy Group		People Culture & Development Committee	
Finance Digital, Estates	Policies	Policy Governance Group		Finance & Resource Committee	

Author to make any further agreed amends and progress to step 5

↓

Step 5 – Dissemination

Corporate Governance Team disseminates to all staff via CAT updates via Newsround and the Corporate Governance MS Teams Channel. Notification sent to Reception Team at Harplands

↓

Step 6 – Control and archive

All previous issues of documents are archived on the Trust Policy System by the Corporate Governance Team

↓

Step 7 – Monitoring

Adherence to policy, effective implementation and continued monitoring will be the responsibility of line managers and policy author.

↓

Step 8 – Reviewing document

Document author ensures that the document review is conducted before the agreed review date (default 3 years) unless guidance stipulates otherwise

There are a number of policies that will be approved by the Senior Leadership Team, relevant Committee and final ratification will be undertaken by Trust Board.

These policies are:

- Local Counter Fraud Policy
- Anit-Bribery Policy
- Standards of Business Conduct
- Scheme of Delegation
- Risk Management Policy
- Listening and Responding PALs and Complaints Policy

4.1 Policy
Policies are Trust documents which support staff and are used to enhance safety, as part of the Trust's framework on quality, risk and performance management. A policy is a formal document **which must be** followed by relevant staff, as non-compliance with Trust policies may leave the organisation and staff open to unacceptable risk and disciplinary action. A policy formally documents a Trust approved standard or procedure and may be relied upon for legal purposes. Policies can only be authorised by the Trust Board, a Committee of the Board or group with specific delegated authority.

4.2 Protocols/ Standard Operating Procedures
A protocol or standard operating procedure (SOP) is a formal document **which must be** followed. Protocols and SOPs outline a series of actions in order to conduct business or perform a task and do not require approval by the Senior Leadership Team, Committee or Trust Board.

4.3 Strategy
A strategy communicates the Trust's intentions and objectives in relation to a specific area. Many internal documents will include strategic content but a Trust Strategy can only be authorised by the Trust Board.

4.4 Guidance
Guidance documents are broad statements of good practice. Where possible, Trust staff are asked to follow guidance, but there may be instances where professional judgment may differ from the guidance advice. In these cases, Trust staff would be expected to record (either within clinical notes if a clinical issue or in minutes of meetings if a corporate issue) where they have not followed guidance, outlining their reasons for doing so.

In order to ensure ongoing effectiveness of policy documents it is essential that if any issues arise in relation to the practical implementation of a policy document, the Clinical Director/Associate Director or ward/team manager, must contact the Corporate Governance Manager to feedback concerns. In addition during the period of the policy if there are any changes to practice or national guidance that staff feel are not reflected within the policy then it is important for this feedback and any suggested changes to be communicated.

5. Process for approving documents

5.1 Consultation
Consultation is a key component of the policy development and approval process., It ensures that relevant staff have the opportunity to effectively input their views into policy development and thus supports successful implementation and engagement. The length of time recommended for consultation may be 1-2 weeks. Evidence of the consultation **must** be recorded on the policy template as per Appendix 1 which can be found on CAT Templates - CAT

5.2 Quality Assurance and Approval
Following consultation the document must be sent to the 'Agreeing Meeting'. Final policy approval is granted by the Senior Leadership Team meeting (SLT) which will be in the form of a monthly policy report (with a link to the full policy). In order to ensure that policy approval is appropriate to the terms of authorisation of the Committees and Groups, the Corporate Governance Manager will provide guidance to the policy author as to the appropriate level of approval that must be sought in line with the corporate governance structure.

The document will be received by the Committee in the form of a policy report and ratification **must** be evidenced in the agenda and minutes.

The Chair of the ratifying Committee can take action and approve documents outside of the meeting, in **exceptional** circumstances:

- Where the meeting has not been quorate;
- Where there is an urgent need for the document to be approved (operational/clinical need);
- Where Chair's require members to have further consultation on the document following feedback at the meeting.

In such cases the Chair will arrange for the document to be circulated to the group members for comments and ensure that the author receives direct feedback to be considered and then Chair's approval is given on the final document. Chairs action/ratification will be noted at the next available meeting.

The document will be received by the Trust Board by way of an assurance report of the relevant Committee; should the Trust Board be required to provide ratification for a particular policy this **must** be evidenced in the minutes of the meeting.

5.3 Review

Documents will be reviewed and revised in response to changed circumstances and at intervals of not more than three years. It is the Corporate Governance Team's responsibility to highlight review timescales for all policies with the policy author. The policy author must review the effective implementation and continued effectiveness of the policy. Consideration will also be given to any national or local changes that have been effective during the post approval period and a decision made as to whether the policy requires updating. The options are:

Minor changes required (**not procedural changes**)	Minor changes required e.g. spelling, grammar, job titles, locations, contact numbers or meeting names etc. The subject matter expert (SME), or relevant group can approve these amendments and the document will be published.
Review – no changes	Document is reviewed as per maximum timescale and no changes are required. Front sheet is updated to reflect this.
Review – changes required	If procedural changes are required, the cChair / group will request the detail behind the changes and start the review process.

5.4 Monitoring

The implementation of policies will be monitored by the author and the Policy Governance Group, which will ensure, via cycles of business, any relevant documents within their spheres of responsibility are current, reviewed and updated as appropriate. Any risks highlighted via the Committees will be risk modelled and if appropriate, will be included on the Trust's corporate risk register/assurance framework.

If a document author leaves the Trust the responsibility for the review of the document transfers to the post holder's successor, unless the post is not replaced in which case it is then the responsibility of the approving group to reassign responsibility to another individual.

Monitoring will be evidenced through Committee Cycles of Business, policy review logs and assurance reports submitted to SLT.

NB All documents remain in force and current until they are replaced or removed by the formal processes - even if the timeframe for review has elapsed.

6. Standards for Trust approved documents

6.1 Style and format

All documents **must** be in the approved format as per Appendix 1. Guidance on style and formatting is contained in Appendix 2.

To facilitate ease of reading and understanding, authors should have a definitions section, outlining the meaning/explanation of any terms used in the context of the document.

A flowchart can be incorporated after the opening introduction to visually show the detail of the steps within the document, this should include:

- The staff that are involved;
- Timeframes/deadlines of the process (where required);
- Appendices/forms/other Trust documents required to be used/read in conjunction with;
- Systems used and reporting / escalating routes (where required).

All appendices need to be referenced throughout the content of the document and may be highlighted to assist the reader.

6.2 Trust documents to be read in conjunction with

Document authors may signpost readers to relevant associated documentation to prevent duplication of information; these documents should be incorporated within the flowchart process and may be highlighted to assist the reader. These documents are to be recorded on the front page of the document, including policy codes and full titles.

6.3 Appendices and working forms

All appendices/working forms need to be referenced as part of the process throughout the document. The Corporate Governance Manager will create the downloadable version of the working form for staff access. To create additional clinical forms within the electronic health record system (e.g. Lorenzo), please contact the relevant electronic health record lead.

6.4 Supporting references

Any source used within the context of the document must be referenced within the references table and contain the following information: date, author, document title and publisher.

6.5 Version control

To aid version control, all documents should be saved with a file name as follows: number, document title and issue number will be recorded on the policy front sheet e.g. 1.02 Professional Registration Policy. The Corporate Governance Manager will format the document titles of all final issues including archived versions. It is an individual responsibility for all staff to keep up to date with policy development and review.

Paper versions of documents/working forms should not be retained and all documents should be accessed via Trust computers. In the event of computer downtime and the requirement to access a policy, hard copies of all policies can only be accessed via Harplands Reception.

7. Document addendums

An addendum is an urgent addition to a document, subsequent to its approval and distribution and is **only** appropriate when an immediate update is required, for further information please contact the Deputy Director of Governance / Trust Board Secretary.

8. Duties and responsibilities

8.1 Chief Officers

The Chief Executive has delegated responsibilities within executive's portfolios. Each Chief Officer is therefore responsible for development, implementation and review of approved documents, which fall within their remit. The operational overview of policy development is the responsibility of the Deputy Director of Governance.

8.2 Chairs of corporate meetings

Appendix 4 outlines mechanisms for the consultation, approval and dissemination of Trustwide documents. It is the responsibility of the Chairs of relevant meetings to ensure that minutes reflect the approval process. It is also their responsibility to ensure that the development and review of documents required by the Trust is linked to the meetings work programme (as per the Trust's governance framework).

8.3 Authors of approved documents

It is the responsibility of authors of approved documents to seek appropriate consultation and approval via appropriate channels (as per Appendix 3). The author of the document will then ensure that the document is disseminated appropriately to ensure relevant staff have awareness of the document. Please refer to the quick reference flowchart on page 5 for a summary of this process. Authors will agree review dates for their policies.

All authors must complete a training need analysis form, linked to implementation of the approved document, as per Trust template. If specific training is outlined within the policy, the author must ensure that learning and development is consulted and record this consultation on the front page of the approved documents template. Please see Appendix 4 for training needs analysis for this policy.

All authors must complete an equality & diversity/human rights assessment (EIA), as per Trust Single Equality Scheme. This assessment will be conducted by the document author and must be completed as per Appendix 1. Where an adverse or negative impact on equality group(s) has been identified during the initial assessment process a full EIA should be conducted. Please see the front page for the equality & diversity/human rights assessment for this policy. For further information or support contact the People Directorate.

8.4 Line managers

Line managers have the responsibility to cascade information on new and revised policies and relevant documents to the staff for who they manage.

8.5 Trust staff

It is the responsibility of Trust staff to keep up to date with the approved documents that are relevant to their working environment. To facilitate this each document contains a summary/outline of its content and target audience.

Appendix 1 – Approved document template for policies and guidance documents

Document level: _____
Code:_____
Issue number: _____

Policy / guidance title

Lead executive	
Authors details	

Type of document	
Target audience	
Document purpose	

Approving meeting		Meeting date	
Implementation date		Review date	

Trust documents to be read in conjunction with	

Document change history		Version	Date
What is different?			
Appendices / electronic forms			
What is the impact of change?			

Training requirements	

Document consultation	
Directorates	
Corporate services	
External agencies	

Financial resource implications	

External references
1.

Monitoring compliance with the processes	

outlined within this document	

Equality Impact Assessment (EIA) - Initial assessment	Yes/No	Less favourable / More favourable / Mixed impact
Does this document affect one or more group(s) less or more favorably than another (see list)?		
– **Age** (e.g. consider impact on younger people/ older people) – **Disability** (remember to consider physical, mental and sensory impairments) – **Sex/Gender** (any particular M/F gender impact; also consider impact on those responsible for childcare) – **Gender identity and gender reassignment** (i.e. impact on people who identify as trans, non-binary or gender fluid) – **Race / ethnicity / ethnic communities / cultural groups** (include those with foreign language needs, including European countries, Roma/travelling communities) – **Pregnancy and maternity, including adoption** (i.e. impact during pregnancy and the 12 months after; including for both heterosexual and same sex couples) – **Sexual Orientation** (impact on people who identify as lesbian, gay or bi – whether stated as 'out' or not) – **Marriage and/or Civil Partnership** (including heterosexual and same sex marriage) – **Religion and/or Belief** (includes those with religion and /or belief and those with none) – **Other equality groups?** (may include groups like those living in poverty, sex workers, asylum seekers, people with substance misuse issues, prison and (ex) offending population, Roma/travelling communities, and any other groups who may be disadvantaged in some way, who may or may not be part of the groups above equality groups)		
If you answered yes to any of the above, please provide details below, including evidence supporting differential experience or impact.		
Enter details here if applicable		
If you have identified potential negative impact: - Can this impact be avoided? - What alternatives are there to achieving the document without the impact? Can the impact be reduced by taking different action?		
Enter details here if applicable		
Do any differences identified above amount to discrimination and the potential for adverse impact in this policy?	Yes / No	
If YES could it still be justifiable e.g. on grounds of promoting equality of opportunity for one group? Or any other reason	Yes / No	

Enter details here if applicable	
Where an adverse, negative or potentially discriminatory impact on one or more equality groups has been identified above, a full EIA should be undertaken. Please refer this to the Diversity and Inclusion Lead, together with any suggestions as to the action required to avoid or reduce this impact. For advice in relation to any aspect of completing the EIA assessment, please contact the Diversity and Inclusion Lead at Diversity@combined.nhs.uk uk	
Was a full impact assessment required?	Yes / No
What is the level of impact?	Low / medium / high

CONTENTS

Appendix 2 Style guide

A corporate style helps us ensure that we have a consistent approach to writing across all our services. This style covers the presentation of information and also the way in which things are written.

Trust writing style - key tips

- There are many templates available for leaflets, letters, memos, minutes, agendas etc and these should always be used as part of our corporate identity - all templates are available on the Trust intranet site
- When referring to the organisation:
    - Use the full name – North Staffordshire Combined Healthcare NHS Trust - although don't do this too often within in a document
    - Call it the Trust or our Trust (but only use our if addressing service users, carers or staff)
- Always define abbreviations. When you first refer to an abbreviation, you must use the full version, but from then onwards, you are free to use the abbreviated version. The one exception to this rule is NHS as this is a widely known abbreviation.
- Don't use 'parentheses' or "speech marks" around phrases or words as it can confuse the meaning although you should always use speech marks around quotes.
- If you are writing a lengthy document e.g. a policy, appendices can be used to aid understanding. Always make clear reference to the appendices throughout a document naming them appendix 1, 2, 3 and so on.
- Try to keep paragraphs and sentences reasonably short as this makes documents easier to read. If you document is long, then breaking it up into smaller chunks with paragraphs or bullet points will make it more reader friendly.
- Check you have written in the same tense (past, present or future) all the way through your document.
- .
- Use Arial font size 12 for your main text - you can use a larger font for headings, but no text should be any smaller than size 12.
- Only use bold and italics in moderation because too much of either can make text look heavy and confusing.
- Don't use coloured backgrounds as it makes text hard to read.
- To use gender neutral language whenever possible (e.g. gender neutral words and post titles e.g. Chair not Chairman, they not he/she, them not him/her, their not his/hers etc.

Policy Inclusivity
Explanatory wording

At Combined Healthcare, we pride ourselves on being a diverse and inclusive organisation, expressly promoting and striving for greater equality and challenging discrimination and exclusion head-on.

The Trust is keen to ensure that we use language that is not just broadly but explicitly inclusive and does not cause groups or individuals to feel excluded. This includes making our Trust language (i.e. wording for Trust communications, policies, protocols, guidance, etc.) gender neutral wherever possible and appropriate. It also includes making explicit statements of inclusiveness where there is any potential doubt – for example explicitly stating that our family

policies and benefits are equally available to all staff regardless of their sexual orientation or gender identity.

For further information around language and terminology please contact Diversity@Combined.nhs.uk

Appendix 3 Consultation, approval and dissemination requirements for corporate Trustwide approved documents within North Staffordshire Combined Healthcare NHS Trust as per the Trust's Governance Framework

	Consultation	Approval	Dissemination/ Communication	Control/Archiving
Policies	Relevant stakeholders, which may include: Chief Officer's, appropriate meetings/groups within the Trust governance structure, Learning and Development Department (if training needs are identified), professional experts, service user and carer representatives, partner agencies and external agencies (e.g. Local Authority policies such as safeguarding).	Must be approved by Group level or above within the Trust governance structure.	Via Corporate Governance Manager, Newsround uploaded onto the Trust Intranet site.	Policy will be automatically archived within policy section of Intranet and digital policy stored on X Drive.
Protocols/ Operating procedures	Relevant stakeholders, which may include: Chief Officer Lead, appropriate group within the Trust governance structure, Learning & Development Department (if training needs are identified), professional experts, Patient and Public representatives, partner agencies and external agencies.	Must be approved at Group level	Via Corporate Governance Manager and uploaded onto the Trust Intranet site.	Policy will be automatically archived within policy section of Intranet and digital policy stored on X Drive.
Care pathways	Relevant stakeholders, which may include: Chief Officer Lead, appropriate group within the Trust governance structure, Learning & Development Department (if training needs are identified), professional experts, service user and carer representatives, experts by Lived Experience.	Must be approved at Clinical Effectiveness Group	Via communications from relevant meeting or Integrated into policy documents and disseminated via policy channels	All care pathways to be archived. The archived document must include a diagonal watermark stating 'Not current care pathway'. Responsibility for this archiving system lies with the relevant Group or Committee.

	Consultation	Approval	Dissemination/ Communication	Control/Archiving
Strategies/ frameworks[1]	Relevant stakeholders, which may include: Chief Officer Lead, appropriate group within the Trust governance structure, Learning & Development Department (if training needs are identified), professional experts, Patient and Public representatives, partner agencies and external agencies.	Strategies / frameworks must be approved by Committee level or above.	Via communications department or (if applicable) external publicity facilitated by communications department and Uploading onto the Trust Intranet site	All strategies / care pathways to be archived. The archived document must include a diagonal watermark stating 'Not current care pathway'. Responsibility for this archiving system relevant Group or Committee.
Guidance	Relevant stakeholders, which may include: Chief Officer Lead, appropriate group within the Trust governance structure, Learning & Development Department (if training needs are identified), professional experts, Patient and Public representatives, partner agencies and external agencies.	Must be approved/ratified by Committee / Group level or above within the Trust governance structure.	Via Corporate Governance Manager and uploaded onto the Trust Intranet site.	Policy will be automatically archived within policy section ofn Intranet and digital policy stored on X Drive.

[1] Integrated Governance Strategy (encompassing Risk Management Strategy) must have Board approval as per NHS Litigation Authority requirements

Appendix 4 Training Needs Analysis for the policy for the development and management of Trustwide procedural / approved documents

Training Needs Analysis for the policy for the development and management of Trustwide procedural / approved documents

Please tick as appropriate

There **is no** specific training requirements- awareness for relevant staff required, disseminated via appropriate channels (Do not continue to complete this form-no formal training needs analysis required)	✓
There **is** specific training requirements for staff groups (Please complete the remainder of the form-formal training needs analysis required-contact the Education and Widening Participation Manager who will support submission for approval to the Strategic Education, Apprenticeship and Learning (SEAL) group	

Staff Group	**✓ if appropriate and define professional group if not all**	**Frequency**	**Suggested Delivery Method (traditional/ face to face / e-learning/handout)**	**Is this included in Trustwide learning programme for this staff group (✓ if yes)**
Rotational Doctor				
Doctor				
Inpatient Registered Professionals				
Inpatient non-registered professionals				
Community Registered Professionals				
Community non-registered Professionals				
Clinical Psychologist				
Pharmacist				
Registered Therapist				

Clinical bank staff regular worker				
Clinical bank staff infrequent worker				
Non-clinical patient contact				
Non-clinical non patient contact				

Please give any additional information impacting on identified staff group training needs (if applicable)

Please give the source that has informed the training requirement outlined within the policy i.e. National Confidential Inquiry/NICE guidance etc.

Any other additional information

Completed by		Date	

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Document level: _____
Code: _____
Issue number: _____

Policy / guidance title

Lead executive	
Authors details	

Type of document	
Target audience	
Document purpose	

Approving meeting		Meeting date	
Implementation date		Review date	

Trust documents to be read in conjunction with	

Document change history		Version	Date
What is different?			
Appendices / electronic forms			
What is the impact of change?			

Training requirements	

Document consultation	
Directorates	
Corporate services	
External agencies	

Financial resource implications	

External references
1.

Monitoring compliance with the processes outlined within this document	

Equality Impact Assessment (EIA) - Initial assessment	Yes/No	Less favourable / More favourable / Mixed impact
Does this document affect one or more group(s) less or more favorably than another (see list)?		
– **Age** (e.g. consider impact on younger people/ older people) – **Disability** (remember to consider physical, mental and sensory impairments) – **Sex/Gender** (any particular M/F gender impact; also consider impact on those responsible for childcare) – **Gender identity and gender reassignment** (i.e. impact on people who identify as trans, non-binary or gender fluid) – **Race / ethnicity / ethnic communities / cultural groups** (include those with foreign language needs, including European countries, Roma/travelling communities) – **Pregnancy and maternity, including adoption** (i.e. impact during pregnancy and the 12 months after; including for both heterosexual and same sex couples) – **Sexual Orientation** (impact on people who identify as lesbian, gay or bi – whether stated as 'out' or not) – **Marriage and/or Civil Partnership** (including heterosexual and same sex marriage) – **Religion and/or Belief** (includes those with religion and /or belief and those with none) – **Other equality groups?** (may include groups like those living in poverty, sex workers, asylum seekers, people with substance misuse issues, prison and (ex) offending population, Roma/travelling communities, and any other groups who may be disadvantaged in some way, who may or may not be part of the groups above equality groups)		
If you answered yes to any of the above, please provide details below, including evidence supporting differential experience or impact.		
Enter details here if applicable		
If you have identified potential negative impact: - Can this impact be avoided? - What alternatives are there to achieving the document without the impact? Can the impact be reduced by taking different action?		
Enter details here if applicable		
Do any differences identified above amount to discrimination and the potential for adverse impact in this policy?	Yes / No	
If YES could it still be justifiable e.g. on grounds of promoting equality of opportunity for one group? Or any other reason	Yes / No	
Enter details here if applicable		

Where an adverse, negative or potentially discriminatory impact on one or more equality groups has been identified above, a full EIA should be undertaken. Please refer this to the Diversity and Inclusion Lead, together with any suggestions as to the action required to avoid or reduce this impact. For advice in relation to any aspect of completing the EIA assessment, please contact the Diversity and Inclusion Lead at Diversity@combined.nhs.uk uk

Was a full impact assessment required?	Yes / No
What is the level of impact?	Low / medium / high

Training Needs Analysis for the policy for the development and management of Trustwide procedural / approved documents

Please tick as appropriate

There is no specific training requirements- awareness for relevant staff required, disseminated via appropriate channels (Do not continue to complete this form-no formal training needs analysis required)	✓
There is specific training requirements for staff groups (Please complete the remainder of the form-formal training needs analysis required- contact the Education and Widening Participation Manager who will support submission for approval to the Strategic Education, Apprenticeship and Learning (SEAL) group	

Staff Group	✓ if appropriate and define professional group if not all	Frequency	Suggested Delivery Method (traditional/ face to face / e-learning/handout)	Is this included in Trustwide learning programme for this staff group (✓ if yes)
Rotational Doctor				
Doctor				
Inpatient Registered Professionals				
Inpatient non-registered professionals				
Community Registered Professionals				

Community non-registered Professionals				
Clinical Psychologist				
Pharmacist				
Registered Therapist				
Clinical bank staff regular worker				
Clinical bank staff infrequent worker				
Non-clinical patient contact				
Non-clinical non patient contact				

Please give any additional information impacting on identified staff group training needs (if applicable)

Please give the source that has informed the training requirement outlined within the policy i.e. National Confidential Inquiry/NICE guidance etc.

Any other additional information

Completed by		**Date**	

Report to Audit Committee

Date of Meeting:	7th June 2024		
Title of Report:	North Staffordshire Combined Healthcare NHS Trust Annual Report 2023/24 V2		
Presented by:	Nicky Griffiths Deputy Director of Governance		
Author:	Nicky Griffiths Deputy Director of Governance		
Executive Lead Name:	Dr Buki Adeyemo- Chief Executive Officer	**Approved by Exec**	☐

Enc. 5

Purpose of the report:								
Approval	☒	**Information**	☐	**Consider for Action**	☐	**Assurance**	☐	

Executive Summary:

The National Health Service (NHS) produces annual reports to provide accurate and comprehensive information on their performance, business model and strategy. These reports serve various stakeholders, including members, patients, commissioners and the public. By sharing details about their achievements, challenges, and financial statements, the NHS ensures transparency and accountability.

The NSCHT Annual Report 2023/24 V2 contains information on:

- our work this year and our achievements and challenges
- how we have performed against our priorities
- board members and governance
- financial statements for 2023 to 2024.

Committee is asked to note that-

- The Trade Union Facility is now included in this draft having been approved by JNCC in May 2024.
- Audit recommendations uploaded to the portal no later than the 31st May. (Finance)

Next Steps

- Annual Report to be submitted to Trust Board on the 13th June.
- Append financial statements after the Audit Review. (Finance)
- Independent Audit report to be returned no later than the 24th June, which will be included in the Annual Report.
- Annual report to be submitted 28th June.
- Annual report to be published in line with trust AGM scheduled for September 2024

**[Select return to make summary box larger]

Seen at:	SLT ☐ Execs ☒	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Resource Committee ☐ • Audit Committee ☒ • People, Culture & Development Committee ☐ • Charitable Funds Committee ☐		

Strategic Priorities (please indicate)	1. **Growth** - We will commit to investing in providing high-quality preventative services that reduce the need for secondary care ☐ 2. **Access** - We will ensure that everybody who needs our services will be able to choose the way, the time, and the place in which they access them ☐ 3. **Prevention** - To will continue to grow high-quality, integrated services delivered by an innovative and sustainable workforce. ☐	
BAF / Risk / legal implications: Risk Register Reference	1. We will provide the highest quality, safe and effective services ☒ 2. We will attract, develop and retain the best people ☒ 3. We will actively promote partnership and integrated models of working ☒ 4. We will increase our efficiency and effectiveness through sustainable development ☒ Any Risk/legal implications: (please reference if any)	
Sustainability:	1. Reduce the environmental impact of health and social care in Staffordshire and Stoke on Trent ☐ 2. Build a network of climate and sustainability champions across Staffordshire and Stoke on Trent ☐ 3. Share learning and best practice ☒	
Resource Implications: Funding Source:		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	There is no direct impact on the protected characteristics as part of the completion of this report.	
ICS Alignment / Implications:		
Recommendations:	Audit Committee is asked to approve the V2 of the NSCHT Annual Report 2023/24	
Version	Name/group	Date issued
	Audit Committee	3.06.2024

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 5

Annual Report 2024-2025 (Final)

Report provided for:			
Information	☐	Assurance	☐
Discussion	☐	Approval	☒

Report to:	Audit Committee
Date of Meeting:	5th th May 2025

Presented by:	Nicky Griffiths-Deputy Director Governance / Trust Board Secretary
Prepared by:	Nicky Griffiths-Deputy Director Governance / Trust Board Secretary
Executive Lead:	Dr Buki Adeyemo-Chief Executive Officer

Aligned to Board Assurance Framework Risk	Risk 1: The Trust fails to deliver effective care leading to regulatory restrictions
Approval / Review:	SLT and Audit Committee
Strategic Priorities:	The Annual Report is aligned to all of the Trust's strategic priorities- Prevention, Access & Growth
Key Enablers:	Quality - We will provide the highest quality, safe and effective services
Sustainability:	Share learning and best practice
Resource Implications:	N/A
Funding Source:	N/A
Diversity & Inclusion Implications	N/A
ICS Alignment / Implications:	
Recommendation / Required Action	• Audit Committee to receive the draft Annual Report 2024/25 for approval
Executive Summary	**Introduction** All NHS trusts are legally required to produce an annual report each year to help the public understand how well they are performing. The report and accounts enable stakeholders to assess how well the organisation has been governed and managed. In addition, every Trust is audited on its performance on an annual basis and NHS Trusts are required to include the annual governance statement (AGS) in its annual report and accounts. NHS trusts are obliged to comply with the determination and directions given by the Secretary of State in the preparation of their annual reports

and annual accounts. These directions are set out in the DHSC Group Accounting Manual (GAM) which is the technical accounting guide to the preparation of financial statements.

The year-end for all NHS organisations is 31 March and the timetable for the production of the annual accounts is provided in the NHSE 2024/25-year end timetable.

All NHS Trusts are required to present their audited accounts, annual reports and any report on the accounts to a public meeting on or before 30 September in every year.

Summary

The report should provide an honest and transparent appraisal of the organisation's performance during the year under review and the accounts should set out how the financial resources have been used to achieve that performance. The Annual Report should be clear and understandable to the reader.

The guidance sets out the minimum content of the annual report. Beyond this, however, the Trust must take ownership of the annual report. It should ensure that additional information is included where necessary to reflect the position of the NHS body within the community and give sufficient information to meet the requirements of public accountability.

The NSCHT Annual Report 2024/25 has been prepared as follows-

- Against national guidance and in line with reporting requirements.
- Content has been provided by Deputy Directors/ Senior Leads.
- Design has been provided by the Communications Team.
- Against recommendations made by External Audit

Recommendation

- Approve the final version of the NSCHT Annual Report

Version	Report to	Date Reported
V1	SLT	22nd April 2025
V2	Audit Committee	7th May 2025
V3	Audit Committee	5th June 2025

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 6

Draft Annual Report 2024-2025

Report provided for:			
Information	☐	Assurance	☐
Discussion	☒	Approval	☐

Report to:	Audit Committee
Date of Meeting:	7th May 2025

Presented by:	Nicky Griffiths-Deputy Director Governance / Trust Board Secretary
Prepared by:	Nicky Griffiths-Deputy Director Governance / Trust Board Secretary
Executive Lead:	Dr Buki Adeyemo-Chief Executive Officer

Aligned to Board Assurance Framework Risk	Risk 1: The Trust fails to deliver effective care leading to regulatory restrictions
Approval / Review:	SLT and Audit Committee
Strategic Priorities:	The Annual Report is aligned to all of the Trust's strategic priorities- Prevention, Access & Growth
Key Enablers:	Quality - We will provide the highest quality, safe and effective services
Sustainability:	Share learning and best practice
Resource Implications:	N/A
Funding Source:	N/A
Diversity & Inclusion Implications	N/A
ICS Alignment / Implications:	
Recommendation / Required Action	• Audit Committee to receive the draft Annual Report 2024/25 for review and discussion.
Executive Summary	**Introduction** All NHS trusts are legally required to produce an annual report each year to help the public understand how well they are performing. The report and accounts enable stakeholders to assess how well the organisation has been governed and managed. In addition, every Trust is audited on its performance on an annual basis and NHS Trusts are required to include the annual governance statement (AGS) in its annual report and accounts. NHS trusts are obliged to comply with the determination and directions given by the Secretary of State in the preparation of their annual reports

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The report should provide an honest and transparent appraisal of the organisation's performance during the year under review and the accounts should set out how the financial resources have been used to achieve that performance. The Annual Report should be clear and understandable to the reader.

The guidance sets out the minimum content of the annual report. Beyond this, however, the Trust must take ownership of the annual report. It should ensure that additional information is included where necessary to reflect the position of the NHS body within the community and give sufficient information to meet the requirements of public accountability.

The draft NSCHT Annual Report 2024/25 has been prepared as follows-

- Against national guidance and in line with reporting requirements.
- Content has been provided by Deputy Directors/ Senior Leads.
- Design has been provided by the Communications Team.
- There are a number of sections that have not been updated yet as they require year end data.

Recommendation

SLT and the Executive Team have reviewed the Draft v1 and provided feedback. The report has been updated on this basis and Committee have the updated version of that draft following this initial review.

Next steps - See appendix 1- Timeline

Version	Report to	Date Reported
V1	SLT	22nd April 2025
V2	Audit Committee	7th May 2025

AUDIT COMMITTEE
TERMS OF REFERENCE

Membership	▪ Three Non-Executives Directors ▪ Chief Finance Officer ▪ Staff Side Chair
Quorum	▪ Four members of the Committee are present to include two Non-Executive Directors (one of which must be the Chair or Vice Chair. ▪ A Chief Officer will count as a member for the purpose of quoracy if required.
In Attendance	▪ Associate Non-Executive Director ▪ Chief Medical Officer (by invite only) ▪ Chief Operating Officer (by invite only ▪ Chief Strategy Officer (by invite only) ▪ Deputy Director of Finance (as nominated) ▪ Deputy Director of Governance / Trust Board Secretary ▪ Executive PA (minute taker) ▪ External Audit ▪ Internal Audit ▪ Lived Experience Representative
Frequency of Meetings	▪ Four to Five meetings per annum (with a possible additional meeting to specifically review the annual report and accounts)
Accountability and Reporting	▪ Accountable to the Trust Board ▪ Summary Report to the Trust Board after each meeting ▪ Minutes of meetings available to all members upon request
Date of Approval by Trust Board	
Review Date	October 2025

AUDIT COMMITTEE TERMS OF REFERENCE

1. Constitution

The Trust Board hereby resolves to establish a Committee of the Trust Board to be known as the Audit Committee (The Committee). The Committee is a Non-Executive Committee of the Trust Board and has no executive powers, other than those specifically delegated in the Trusts Scheme of Reservation and Delegation (SoRD) and specified in these terms of reference (ToR).

2. Membership

The Committee shall be appointed by the Trust Board from the Non-Executive Directors and shall consist of not less than three members. The Trust Board should satisfy itself that at least one member of the Committee has recent and relevant financial experience.

A Chair and Vice-Chair of the Committee will be appointed by the Trust Board. A Vice Chair will also be appointed, who will be another Non-Executive Director member.

The Chair of the organisation shall not be a member of the Committee. The Chair of the Committee shall be independent and therefore may not Chair any other Committees.

Its membership shall consist of: -

- Three Non-Executives Directors
- Chief Finance Officer (Executive Lead)
- Staff Side Chair

No business shall be transacted unless four members of the Committee are present to include two Non-Executive Directors (one of which must be the Chair or Vice Chair. A Chief Officer will count as a member for the purpose of quoracy if required.

Members will possess between them knowledge, skills and experience in: accounting, risk management, internal, external audit; and technical or specialist issues pertinent to the Trust's business. When determining the membership of the Committee, active consideration will be made to diversity and equality.

3. Attendance at Meetings

In addition, the following post holders will be in attendance at the meeting:-

- Associate Non-Executive Director
- Chief Medical Officer (by invite only)
- Chief Operating Officer (by invite only
- Chief Strategy Officer (by invite only)
- Deputy Director of Finance (as nominated)
- Deputy Director of Governance / Trust Board Secretary
- Executive PA (minute taker)
- External Audit
- Internal Audit
- Lived Experience Representative

Any Lived Experience Representative will be allocated a 'buddy' from the membership of the Committee by the Chair, to offer support before, during and after the Committee meeting, should this be required.

The Chief Executive (Accountable Officer) and other Chief Officers may be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Director. The Chief Executive (Accountable Officer) should be invited to attend, at least annually, to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement. They should also attend when the Committee considers the draft annual governance statement and the annual report and accounts.

Representatives from other organisations (for example, the NHS Counter Fraud Authority (NHSCFA)) and other individuals may be invited to attend on occasion, by invitation. The counter fraud specialist (LCFS) will attend a minimum of two Committee meetings a year.

An Executive PA shall be secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair and Committee members.

At least once a year the Committee should meet privately with the internal auditors, external auditors and LCFS either separately or together. Additional meetings may be scheduled to discuss specific issues if required.

At least once a year the Chair from the Board Committees will be invited to attend and present a Committee Chair Report to the Audit Committee to provide assurance that their Committee has systems of assurance in place through their Terms of Reference.

Where an attendee of the Committee (who is not a member of the Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair.

The Committee will meet monthly. Members of the committee are expected to attend a minimum of 80% of the meetings held each financial year and not be absent for two consecutive meetings. Where attendance falls below 80% the Chair will discuss the matter with the individual concerned.

4. Access

The Head of Internal Audit and representative of external audit have a right of direct access to the Chair of the Committee. This also extends to the Local Counter Fraud Specialist, as well as the Security Management Specialist (where they do not report elsewhere)

5. Frequency of meetings

The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. A benchmark of four to five meetings per annum (with a possible additional meeting to specifically review the annual report and accounts) at appropriate times in the reporting and audit cycle is suggested. The Chair of the Committee, Board, Accountable/ Accounting Officer, External Auditors or Head of Internal Audit may request an additional meeting if they consider that one is necessary.

To assist in the management of business over the year an annual work plan will be maintained, capturing the main items of business at each scheduled meeting.

6. Authority

The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Trust Board to obtain reasonable

outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Decisions will be taken in according with the standing orders. The committee will ordinarily reach conclusions by consensus. When this is not possible the chair may call a vote. Only members of the committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the chair of the committee will hold the casting vote. If a decision is needed which cannot wait for the next scheduled meeting, the chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

The Committee is authorised to create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, Standing Orders and Scheme of Reservation and Delegation (SoRD) but may / not delegate any decisions to such groups.

7. Responsibilities
Governance, Risk Management and Internal Control

The Committee shall review the adequacy and effectiveness of the system of governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives.

In particular, the Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement) together with any accompanying Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to submission to the Trust Board;
- The underlying assurance processes that indicate the degree of the achievement of organisation's objectives, the effectiveness of the management of principal risks in relation to strategic objectives and the appropriateness of the above disclosure statements;
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements; and any related reporting and self-certifications, including the NHS Code of Governance and NHS Provider licence
- The policies and procedures for all work related to fraud and corruption as required by the NHSCFA.

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

As part of its integrated approach, the Committee will have effective relationships with other key committees (for example, the quality committee, or equivalent) so that it understands processes and linkages. However, these other committees must not usurp the Committee's role.

Internal Audit

The Committee shall ensure that the Trust has an effective internal audit function that meets the Public sector internal audit standards, 2017 and provides appropriate independent assurance to the Audit Committee, Chief Executive (Accountable Officer) and Trust Board. This will be achieved by:

Consideration of the provision of the Internal Audit service, and the cost involved.

- Review and approval of the Annual Internal Audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework;
- Consideration of the major findings of internal audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise the use audit resources;
- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;
- Annual review of the effectiveness of internal audit.

External Audit

The Committee shall review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process. In particular, the committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit (and make recommendations to the board when appropriate). Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors in the local health economy;
- Discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and any associated impact on the audit fee
- Review all External Audit reports, including agreement of the annual audit letter before submission to the Trust Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.

Other Assurance Functions

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, where relevant to Governance risk management and assurance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health and Social Care Arm's Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

In addition, the Committee will review the work of other Committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will include the Finance & Resource Committee, People, Culture and Development Committee, Quality Committee and the Charitable Funds Committee.

In reviewing the work of the Quality Committee, and issues around clinical risk management, the Audit Committee will wish to be satisfied that assurance

can be gained from audit and wider quality assurance functions. Similarly, in reviewing the robustness of the Trust's system for risk management, the Audit Committee will wish to be satisfied that assurance can be gained from the work of each of the respective Committees in managing their risks to achieving the Trust's strategic and annual objectives.

Counter Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud, bribery and corruption that meet NHSCFA's standards and shall review the outcomes of work in these areas.

With regards to the local counter fraud specialist it will review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans and discuss NHSCFA quality assessment reports.

Freedom to Speak Up

To review the adequacy and security of the ICB's arrangements for its employees, contractors and external parties to raise concerns, in confidence, in relation to financial, clinical management, or other matters. The committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action

Information Governance (IG)

To receive regular updates on IG compliance (including uptake & completion of data security training), data breaches and any related issues and risks.

To review the annual senior information risk owner (SIRO) report, the submission for the Data security and protection toolkit and relevant reports and action plans.

To receive reports on audits to assess information and IT security arrangements, including the annual Data security and protection toolkit audit.

To provide assurance to the board that there is an effective framework in place for the management of risks associated with information governance.

Management

The Committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control. They may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

Financial Reporting

The Committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.

The Committee should ensure that the systems for financial reporting to the board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

The Committee shall review the Annual Report and Financial Statements before submission to the Trust Board, focusing particularly on:

- The wording in the Annual Governance Statement and other

disclosures relevant to the terms of reference of the Committee;
- Changes in, and compliance with, accounting policies and practices;
- Unadjusted misstatements in the financial statements;
- Significant judgements in preparation of the financial statements
- Significant adjustments resulting from the audit.
- Letters of representation
- Qualitative aspects of financial reporting.

Ensure that the systems for financial reporting to the Trust Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Trust Board.

System for Raising Concerns

The Committee shall review the effectiveness of the arrangements in place for allowing staff (and contractors) to raise (in confidence) concerns about possible improprieties in any area of the organisation (financial, clinical, safety or workforce matters) and ensure that any such concerns are investigated proportionately and independently, and in line with the relevant policies.

Governance Regulatory Compliance

The Committee shall review the organisation's reporting on compliance with the NHS Provider Licence, NHS Code of Governance and the Fit and Proper Persons Test.

The Chair of the Committee will be the nominated conflicts of interest guardian.The Committee shall satisfy itself that the Trust's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the Trust policy and procedures relating to conflicts of interest.

8. Behaviours and Conduct

Trust values

Members will be expected to conduct business in line with the trust values and objectives.

Members of, and those attending, the committee shall behave in accordance with the Trust's standing orders, and standards of business conduct policy.

Equality and diversity

Members must demonstrably consider the equality and diversity implications of decisions they make.

9. Accountability and Reporting Arrangements

The Committee shall report to the Board on how it discharges its responsibilities.

The minutes of Committee meetings shall be formally recorded by an Executive PA and approved by the Chair of the Committee prior to distribution.

Copies of the minutes of Committee meetings shall be available to all Trust Board members on request.

The Deputy Director of Governance / Trust Board Secretary (or nominated deputy in their absence) shall prepare a report to the Trust Board after each meeting of the Committee. The Chair of the Committee shall draw to the attention of the Trust Board any issues that require disclosure to the full Trust Board, or

require executive action.

The Committee will report to the Trust Board at least annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the effectiveness of governance arrangements and appropriateness of the evidence that shows that the organisation is fulfilling regulatory requirements relating to its existence as a functioning business..

The Committee will provide the Board with an annual report, timed to support finalisation of the accounts and the governance statement. The report will summarise its conclusions from the work it has done during the year specifically commenting on:

- the fitness for purpose of the assurance framework
- the completeness and 'embeddedness' of risk management in the organisation
- the integration of governance arrangements
- the appropriateness of the evidence that shows the organisation is fulfilling its regulatory requirements
- the robustness of the processes behind the quality accounts

An Annual Committee Effectiveness evaluation will be undertaken and reported to the Committee and the Board.

The Terms of Reference, including the reporting procedures of any working group must be approved by the Committee and regularly reviewed.

10. Secretariat and Administration

The Committee shall be supported administratively by an Executive PA. Their duties in this respect will include:

- Development / agreement of agendas with the Chair and attendees
- Preparation, collation and circulation of papers 7 days ahead of the meeting
- Ensuring that those invited to each meeting attend
- Taking the minutes, ensuring sign off by Committee Chair and helping the Chair to prepare reports to the Board (if required)
- Keeping a record of matters arising and issues to be carried forward
- Arranging meetings for the Chair: for example, with the internal/ external audit or local counter fraud specialists
- Ensuring that action points are taken forward between meetings

11. Requirement for Review

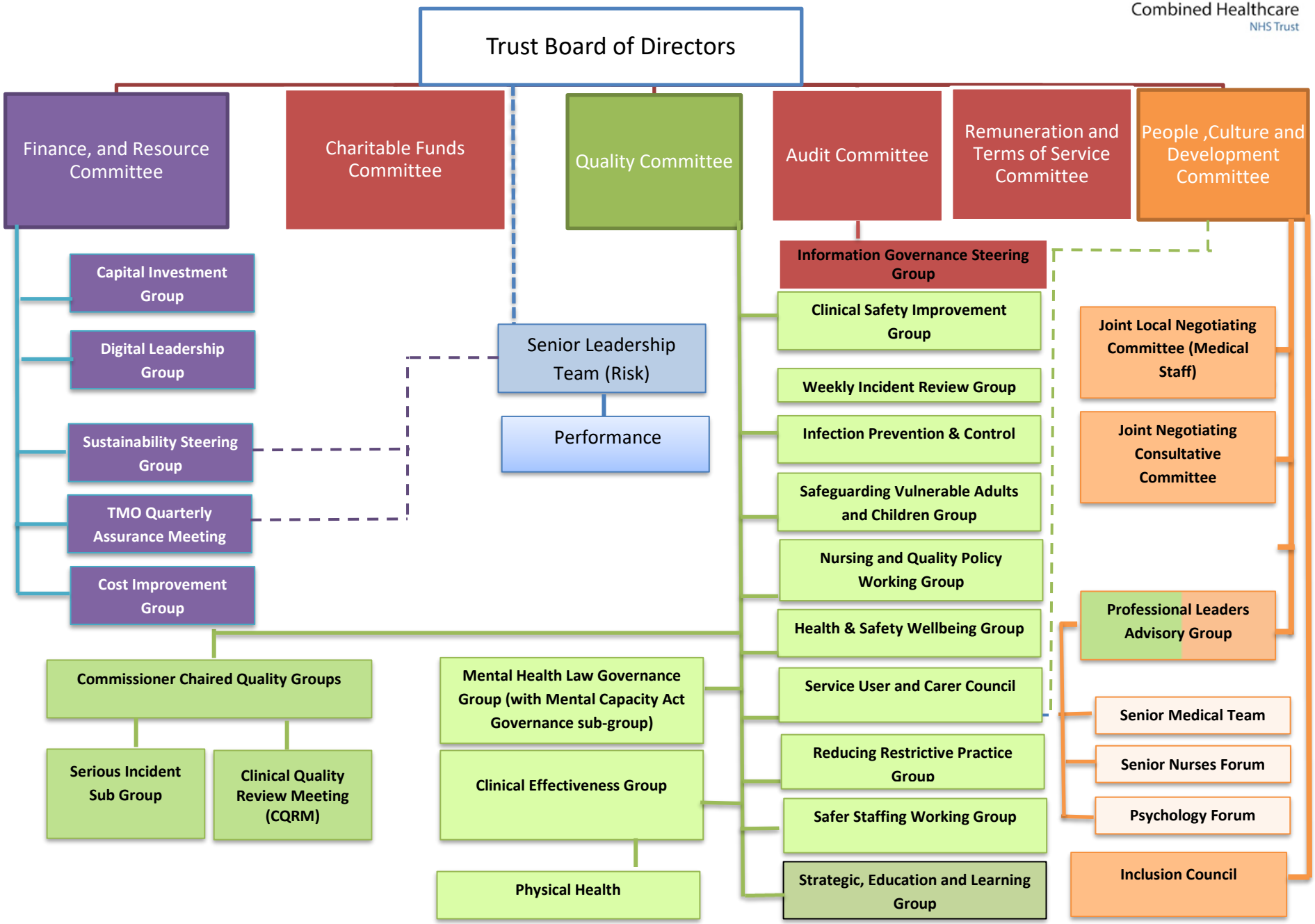
The Committee will review its effectiveness at least annually.

These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Date of approval:

Date of review: October 2025

Boards and Committees Structures December 2024



Executive Director Roles and Contributions:

Exec	Local	Regional	National
Buki Adeyemo	Chair MHLDA Portfolio Board	West Mids MHLDA Provider Collaborative	
Kenny Laing			
Eric Gardiner	Provider Collaborative Board MHLDA Portfolio Board System Performance Group	West Mids MHLDA Provider Collaborative - DoFs	HFMA Mental Health Steering Group
Dennis Okolo			
Liz Mellor	SRO Greener Board Provider Collaborative CYP Portfolio Board MHLDA Portfolio Board Staffordshire PLACE Exec Group SoT PLACE Executive Group Strategic Transformation Group Directors of Strategy Meeting	West Mids MHLDA Provider Collaborative Safe Centre Partnership Board (tbc) Regional Green Delivery Board Director of Strategy Forum	
CPO			
Ben Richards	SRO ICS MHLDA Programme Co-Chair LDAP Chair Community MH Transformation System Performance Group System Recovery Group Urgent & Emergency Care Board Staffordshire Civil Contingencies Unit Staffordshire LRP Staffordshire LHRP SoT PLACE Group ICS SRO Executive Group ICS Ambulance Handover Group ICS Winter Steering Group SOT Better Together Network ICS LGBT+ Network Staffordshire PfA Strategic Group Staffordshire Armed Forces Covenant Partnership	Regional Mental Health Oversight Group West Mids CAMHS Provider Collaborative Regional COO Network Regional COO/CNO/CMO Network Regional MHLDA Workforce Partnership Group West Midlands Coaching Network WMPC LDA Complex Advisory Panel Midlands MH Community of Practice	NHS Providers LGBT+ Leaders Network Veterans Aware Provider Network

CHARITABLE FUNDS COMMITTEE

TERMS OF REFERENCE

Membership	▪ Not less than two Non-Executive Directors (one of which will be the Chair) ▪ Not less than two Executive Directors (Chief Strategy Officer and Chief Finance Officer)
Quorum	▪ Non-Executive Director ▪ Executive Director
In Attendance (or as required)	▪ Deputy Chief Strategy Officer ▪ Deputy Director of Finance ▪ Financial Accountant ▪ Deputy Director of Governance / Trust Board Secretary ▪ Associate Director of Communications ▪ Staff Side Representatives (if required) ▪ Other officers as required by invitation ▪ Lived experience representative
Frequency of Meetings	▪ Quarterly meetings
Accountability and Reporting	▪ Accountable to the Corporate Trustees ▪ Report to the Corporate Trustees annually on work to fulfil the objectives of the charity ▪ Minutes of meetings available to all Trust Board members and Committee members on request. Annual report to Trust Board on actions taken to comply with terms of reference.
Review Date	▪ September 2025

CHARITABLE FUNDS COMMITTEE

TERMS OF REFERENCE

1. Constitution

The Charitable Funds Committee has been established to exercise the Trust's functions as sole corporate trustee of North Staffordshire Combined Healthcare NHS Trust Charity, operating under the formal working name of 'Combined Charity (registered charity number 1057104).

The Trust Board is regarded as having responsibility for exercising the functions of the Trustee. The Trust Board delegates these functions to the Committee, within any limits set out in these Terms of Reference and the charitable funds section of Standing Financial Instructions.

North Staffordshire Combined Healthcare NHS Trust was appointed as Corporate Trustee of the charitable funds by virtue of Statutory Instrument 1996/124, which came into force in February 1996. The Trust Board of North Staffordshire Combined Healthcare NHS Trust serves as the agent of the Corporate Trustee in the administration of the charitable funds held by the Trust.

The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on Trust and to the Secretary of State for all funds held on trust.

Further information can be found in the document Registration of Charities Administered by North Staffordshire Combined Healthcare NHS Trust.

2. Membership

Membership of the Committee will be determined by the Trustees and will include as a minimum:

- At least two non-executive directors and
- At least two executive directors, specifically the Chief Strategy Officer and Chief Finance Officer

No business shall be transacted unless one non-executive director and one executive director are present.

Members will possess between them knowledge, skills and experience in the management and development of charitable funds. When determining the membership of the Committee, active consideration will be made to diversity and equality.

3. Attendance at Meetings

In addition, the following post holders will be in attendance at the meeting:

- Deputy Chief Strategy Officer

- Deputy Director of Finance and / or Financial Accountant
- Deputy Director of Governance / Trust Board Secretary
- Associate Director of Communications
- Executive PA
- Other officers as required, by invitation
- Lived Experience representative(s)
- Staff Side Representatives (if required)

Other Charity and/or Trust officers may be asked to attend when the Committee is discussing areas that are the responsibility of that individual. The Committee may also invite external advisors to attend for appropriate items, especially if items require detailed knowledge in areas such as fundraising or investments.

An Executive PA shall be secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair and Committee members.

Members of the committee are expected to attend a minimum of 80% of the meetings held each financial year and not be absent for two consecutive meetings. Where attendance falls below 80% the Chair will discuss the matter with the individual concerned.

4. Quorum

For meetings to be quorate there must be one Non-Executive Director and one Executive Director in attendance.

5. Frequency of Meetings

The Committee must consider the frequency and timing of meetings needed to allow it to discharge all its responsibilities. Meetings shall be held quarterly and will be reviewed annually. The Chair of the Committee may call additional meetings as required. A schedule of meeting dates for the year shall be agreed at the first meeting of the financial year.

6. Authority

The Committee has delegated authority from the Trust Board and is authorised to pursue any activity within its Terms of Reference. It may seek and secure the information it requires from any employee of the Trust and all employees are directed to co-operate with any request made by the committee.

The Committee can seek external advice from any source if necessary, taking into consideration issues of confidentiality and Standing Financial Instructions.

Decisions will be taken in according with the Trust's Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote. Only Trustees of the charity may vote. Each member is allowed one vote and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the Committee will refer to the Trustees for a vote.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis using a telephone, email or

other electronic communication. This may include fundraising opportunities such as grant applications whereby the opportunity release and submission dates fall between Committee meetings. In such instances, and where a bid is supported by the Chair, Chief Strategy Officer and Chief Finance Officer, the details will be circulated to Committee members for comment and virtual approval.

The Committee is authorised to create task and finish sub-groups to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the Trust's constitution, Standing Financial Instructions and Scheme of Delegation. In accordance with paragraph 30.5 of the Trust Standing Orders Committees may not delegate their powers to a sub-committee unless expressly authorised by the Trust Board.

7. Responsibilities

The Committee will:

- Act as the committee which discharges the Trust Board's responsibilities (as Sole Corporate Trustee) as they relate to Charitable Funds under the Trust's custodianship.

- Ensure that the charitable funds held by the Trust are managed in a manner consistent with the requirements of the relevant regulatory and statutory frameworks and in accordance with the guidance on NHS Charities set out by the Charity Commission.

- When in this role act solely in the best interests of North Staffordshire Combined Healthcare NHS Trust Charity and in a manner consistent with the Charity Commission's requirements and expectations of Charity Trustees.

- Oversee the Charity's strategy, governance, major plans and key risks on behalf of the corporate Trustee.

- Establish, prioritise and approve major fundraising projects and grant applications over £5,000 but less than £50,000. Where approval is given and funds are raised or secured, no further approval is required in respect of spending the funds, providing this is in accordance with original plans.

- Monitor the performance of the fundraising and marketing activity, ensuring that the return on investment is satisfactory and that income targets are met.

- Devise and implement (through a sub-committee where appropriate) an investment strategy for the Charity, including the appointment and monitoring of any investment managers.

- Ensure the approval and submission of Annual accounts and Trustees' report via the Trust Board and in accordance with the Charity Commission's Statement of Recommended Practice.

- Oversee and monitor the functions performed by the Chief Finance Officer, as defined in Standing Financial Instructions.

- To monitor the Trust's scheme of delegation for expenditure for the levels as outlined below:

Lead	General Fund	Specific Fund
Fund holders	None	£2,000
Chief Strategy Officer or Chief Finance Officer	£5000	£5,000
Charitable Funds Committee	£50,000	£50,000
Trustees	£50,001	£50,001

(Note – delegated limits for Charitable funds are not the same as Trust limits)

8. Behaviours and Conduct

Trust values

Members will be expected to conduct business in line with the Trust values and objectives.

Members of, and those attending, the Committee shall behave in accordance with the Trust's standing orders, and standards of business conduct policy.

Equality and diversity

Members must demonstrably consider the equality and diversity implications of decisions they make.

9. Accountability and Reporting Arrangements

The Committee shall report to the Corporate Trustee on how it discharges its responsibilities.

The minutes of Committee meetings shall be formally recorded by an Executive PA and approved by the Chair of the Committee prior to distribution.

Copies of the minutes of Committee meetings shall be available to all Trust Board members on request.

The Deputy Chief Strategy Officer (or nominated deputy in their absence) shall prepare a report to the Trust Board after each meeting of the Committee. The Chair of the Committee shall draw to the attention of the Trust Board any issues that required disclosure to the full Trust Board or require executive action.

To support the continual improvement of governance standards, the Committee will:

- Complete an annual self-assessment of the effectiveness of the Committee.
- Review the terms of reference for the Committee, reaffirming the purpose and objectives in accordance with stated review dates.

- Prepare an annual work plan, where appropriate.
- Maintain an up-to-date Risk Register.
- Present a written annual report to the Corporate Trustees on the actions taken by the Committee to comply with its terms of reference.

10. Governance Secretariat and Administration

The Committee shall be supported administratively by an Executive PA. Their duties in this respect will include:

- Development / agreement of agendas with the Chair and attendees.
- Preparation, collation and circulation of papers 7 days ahead of the meeting.
- Ensuring that those invited to each meeting attend.
- Taking the minutes, ensuring sign off by Committee Chair and helping the Chair to prepare reports to the Board (if required).
- Keeping a record of matters arising and issues to be carried forward.
- Arranging meetings for the Chair as required
- Ensuring that action points are taken forward between meetings.

Their duties may also involve providing support to the Trust Board Secretary as required in terms of:

- Advising the committee on pertinent issues/areas of interest/policy development.
- Ensuring that committee members receive the development and training they need.

11. Requirement for Review

The Terms of Reference will be reviewed 6 monthly in the interim and annually thereafter and the next review must take place in September 2025, unless changes in accounting treatment or other relevant legislation requires earlier review.

FINANCE AND RESOURCE COMMITTEE
TERMS OF REFERENCE

Membership	▪ Three Non-Executive Directors ▪ Chief Finance Officer ▪ Chief Operating Officer ▪ Chief Strategy Officer
Quorum	▪ Four members of the Committee membership to include two Non-Executive Directors (one of whom must be the Chair or Vice-Chair and the Chief Finance Officer or designated deputy)
In Attendance	▪ Associate Non-Executive Director ▪ Deputy Chief Finance Officer ▪ Deputy Director of Governance ▪ Assistant Chief Finance Officer ▪ Associate Director of Estates & Capital ▪ Associate Director of Performance ▪ Chief Information Officer ▪ Executive PA ▪ Lived Experience Representative
Frequency of Meetings	▪ Monthly
Accountability and Reporting	▪ Accountable to the Trust Board ▪ Written Summary Report to the Trust Board following each meeting ▪ Minutes of meetings available to all Trust Board and Committee members
Date of Approval by Trust Board	
Review Date	August 2026

FINANCE AND RESOURCE COMMITTEE TERMS OF REFERENCE

1. Constitution

The Finance & Resource Committee, (the Committee) is constituted a standing Committee of the Trust Board. Its Terms of Reference are set out below and will be subject to amendment by the Trust Board as considered appropriate.

The Committee has no executive powers, other than those specifically delegated in the Trusts Scheme of Reservation and Delegation (SoRD) and specified in these terms of reference (ToR).

2. Membership

The Chair and Non-Executive members of the Committee shall be appointed by the Trust Chair and the Chief Officers by the Chief Executive Officer. The Trust Board should satisfy itself that the Non-Executive Directors sitting on the Committee have relevant financial and business expertise within their grouping.

In the absence of the Chair appointed by the Trust Chair, the Vice-Chair will Chair the meeting.

Members of the Committee will be:

- Three Non-Executive Directors
- Chief Finance Officer
- Chief Operating Officer
- Chief Strategy Officer

No business shall be transacted unless four members of the Committee are present (one of whom must be the Chair or Vice-Chair), one Non-Executive Director and the Chief Finance Officer or designated deputy.

Any Lived Experience Representative from the Service User and Carer Council invited by the Committee will be allocated a 'buddy' from the membership of the Committee by the Chair, to offer support before, during and after the Committee meeting, should this be required.

3. Attendance at Meetings

In addition, the following post holders will be in attendance at the meeting:--

- Associate Non-Executive Director
- Deputy Chief Finance Officer
- Deputy Director of Governance
- Assistant Chief Finance Officer
- Associate Director of Estates & Capital
- Associate Director of Performance
- Chief Information Officer
- Executive PA
- Lived Experience Representative

4. Frequency of meetings

The Committee will meet monthly. Members of the committee are expected to attend a minimum of 80% of the meetings held each financial year and not be absent for two consecutive meetings. Where attendance falls below 80% the Chair will discuss the matter with the individual concerned.

5. **Authority**

The Committee is authorised by the Trust Board to investigate any activity within its terms of reference.

The Committee is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Trust Board to request the Chief Executive Officer or Chief Finance Officer to obtain reasonable outside legal or other independent professional advice, but it has no delegated financial authority.

The Committee is authorised by the Trust Board in accordance with its Standing Orders to establish sub-groups as it deems necessary to enable it to fulfil its Terms of Reference. The Committee may not delegate executive powers and will have oversight of the functioning and output of such groups. The Terms of Reference of such sub-groups will be approved by the Committee and reviewed periodically, and those sub-groups will report directly to the Committee.

6. **Responsibilities**
Finance

To monitor the Trust's performance and the achievement of its financial plans (including the Cost Improvement Programme) and ensure that the Trust's financial plan is aligned with the Operational Plan and in line with changing NHS systems and financial performance requirements.

To review and recommend to the Trust Board the annual financial plan / budget, including workforce, and the associated financial budget with targets set in terms of key performance indicators including Cost Improvement.

To recommend to the Trust Board the Long Term Financial Plan included in the Five-year Integrated Business Plan.

To ensure the Trust Board is provided with regular reports on the financial performance of the Trust including forecast performance and associated risks and make recommendations to the Trust Board on remedial actions aimed at ensuring that the Trust's financial budget and plans are achieved.

To receive and consider the annual medium term capital plan prior to submission for approval to the Trust Board and to receive progress reports on the management of the capital programme from the Capital Investment Group (CIG) as reported within the monthly finance reporting suite along with copies of minutes of the CIG meetings.

To keep under review issues such as reference costs and to benchmark activity and performance and to act on any learning or remedial action required.

To monitor the development and implementation of Service Line Management and Reporting and the move towards patient level costing.

To monitor the financial performance of the Integrated Care System, taking into account the Trust's role and contribution. This includes reviewing system financial risks and monitoring CIP achievement and the overall system financial forecast.

Performance

Review the integrated performance of the Trust.

To receive and review regular updates to ensure that effective action is taken to enable the Trust to achieve its key statutory and performance targets.

The Committee will monitor the KPIs that are under its remit along with Trust performance against the NHSE compliance framework, Board Assurance Framework (BAF) and key national targets to ensure indicators are on target.

Estates

Oversight of the development and implementation of the estate's plan.

To keep under review the financial and operational aspects of the Trust's Estates Plan.

Sustainability

Oversight of the development of sustainability requirements in line with national NHS guidance.

Digital

Oversight of the implementation of the Trust Digital Plan.

To keep under review the investment into digital technology, data security standards and cyber security.

Compliance with Digital Maturity Assessment.

Partnerships

To overview the operational and performance aspects of established partnerships.

To scrutinize the effectiveness of strategic and operational relationships with partners through the Strategic Partnership Plan, demonstrating the impact this will have on our service users, staff and services.

Business Cases for Service Development and/or Capital Approval

To consider and approve / recommend to Trust Board, Business Cases, both clinical and commercial, in line with the delegated limits of authorisation as stipulated in the Trust's Financial Standing Orders and Scheme of Delegation.

To consider and as appropriate, approve / recommend to Trust Board all applications for capital expenditure in line with the delegated limits of authorisation as stipulated in the Trust's Financial Standing Orders and Scheme of Delegation.

To make recommendations to the Trust Board on schemes that do not meet the required rate of return on assets and/or result in a dilution of EBITDA (Earnings before interest, taxes, depreciation, and amortisation).

To approve the Trust's business case process and associated investment, appraisal, methodology.

To monitor as appropriate delivery of approved investments against time, cost and quality parameters and where necessary scrutinise recovery plans.

To monitor operational performance of capital schemes within the 5-year programme.

To ensure that all 'high risk' investments (as defined by NHSE) are subjected to

appropriate procedures and that appropriate recommendations are made to the Trust Board.

The Committee will be responsible for approving all relevant policies outlined in the Trust policy on policies.

Risk Management

To review the Trust's exposure to financial risk of all natures which might affect resources and the achievement of strategic objectives.

Have oversight of the risk management and mitigation of risks within the Committee's area of activity.

7. **Behaviours and Conduct**

Trust values

Members will be expected to conduct business in line with the trust values and objectives.

Members of, and those attending, the committee shall behave in accordance with the Trust's standing orders, and standards of business conduct policy.

Equality and diversity

Members must demonstrably consider the equality and diversity implications of decisions they make.

8. **Accountability and Reporting Arrangements**

The Committee shall report to the Board on how it discharges its responsibilities.

The minutes of the Committee meetings shall be formally recorded by an Executive PA, signed off by the Committee Chair and circulated within 7 days.

The Deputy Chief Finance Officer (or nominated person in their absence) shall prepare a Summary Report, to be presented by the Chair of the Committee, to the Trust Board after each meeting of the Committee.

Copies of the minutes of Committee meetings shall be available to all Trust Board and Committee members on request.

The Chair of the Committee shall draw to the attention of the Trust Board any issues that are a concern to the committee with recommendations on what remedial action should be taken.

The Committee must produce an Annual Report to the Trust Board. The Annual Report will include information about compliance with the requirement that members should attend regularly and should not be absent for more than two consecutive meetings. This Annual Report should also describe how the Committee has fulfilled its terms of reference and objectives and give details of any significant issues that the Committee considered during the year and how they were addressed.

An Annual Committee Effectiveness evaluation will be undertaken and reported to the Committee and the Board. The report will include information about compliance with the requirement that members should attend regularly and should not be absent for more than two consecutive meetings.

Cost Improvement Plan (CIP) minutes will be received by Committee following each meeting for information.

9. **Secretariat and Administration**

The Committee shall be supported administratively by an Executive PA. Their duties in this respect will include:

- Development / agreement of agendas with the Chair and attendees
- Preparation, collation and circulation of papers 7 days ahead of the meeting
- Ensuring that those invited to each meeting attend
- Taking the minutes, ensuring sign off by Committee Chair and circulate within 7 days.
- Keeping a record of matters arising and issues to be carried forward
- Arranging meetings for the Chair: for example, with the internal/ external auditors or local counter fraud specialists
- Ensuring that action points are taken forward between meetings

10. **Requirement for Review**

The Committee will review its effectiveness at least annually.

The Terms of Reference will be reviewed at least annually by the Committee for Trust Board approval.

Date of approval:

Date of review: August 2026

PEOPLE, CULTURE & DEVELOPMENT COMMITTEE
TERMS OF REFERENCE

Membership	▪ Three Non-Executives Directors, one of whom should be the Chair ▪ Chief Medical Officer ▪ Chief Nursing Officer ▪ Chief People Officer ▪ Staff Side Chair
Quorum	▪ Four members of the Committee are present to include two Non-Executive Directors (one of which must be the Chair or Vice Chair).
In Attendance	▪ Deputy Chief People Officer ▪ Deputy Director of Governance ▪ Deputy Chief Operating Officer ▪ Associate Director of Communications ▪ Associate Director of Education and Training ▪ Associate Director of Organisational Development ▪ Executive PA ▪ Lived Experience Representative
Frequency of Meetings	▪ Bi-monthly, but not less than quarterly
Accountability and Reporting	▪ Accountable to the Trust Board ▪ Written Summary Report to the Trust Board following each meeting ▪ Minutes of meetings available to all Trust Board members, Clinical Directors and Heads of Service on request
Date of Approval by Trust Board	October 2024
Review Date	September 2025

PEOPLE, CULTURE & DEVELOPMENT COMMITTEE
TERMS OF REFERENCE

1. Constitution

The Trust Board hereby resolves to establish a Committee of the Trust Board to be known as the People, Culture & Development Committee (The Committee). The Committee has no executive powers other than those specifically delegated in the Trusts Scheme of Reservation and Delegation (SoRD) and specified in these terms of reference (ToR).

2. Membership

The Chair and Non-Executive members of the Committee shall be appointed by the Trust Board and the Chief Officers by the Chief Executive Officer. The Trust Board should satisfy itself that the Chair of the Committee has had recent and relevant workforce experience. Its membership shall consist of: -

- Three Non-Executives Directors, one of whom should be the Chair
- Chief Medical Officer
- Chief Nursing Officer
- Chief People Officer
- Staff Side Chair

The Vice-Chair will be a Non-Executive Director. The Chair of the Trust and Chief Executive Officer may attend as appropriate.

No business shall be transacted unless four members of the Committee are present to include two Non-Executive Directors (this must include the Chair or Vice Chair).
Any Lived Experience Representative invited by the Committee will be allocated a 'buddy' from the membership of the Committee by the Chair, to offer support before, during and after the Committee meeting, should this be required.

3. Attendance at Meetings

Other officials attending on a regular basis will include:

- Deputy Chief People Officer
- Deputy Director of Governance
- Deputy Chief Operating Officer
- Associate Director of Communications
- Associate Director of Education and Training
- Associate Director of Organisational Development
- Executive PA
- Lived Experience Representative

Other managers and staff may be invited to attend meetings depending upon issues under discussion.

Any Service User Representative from the Service User and Carer Council invited by the Committee will be allocated a 'buddy' from the membership of the Committee by the Chair, to offer support before, during and after the Committee meeting, should this be

required.

4. Frequency of Meetings

The Committee will meet bi-monthly. Members of the committee are expected to attend a minimum of 80% of the meetings held each financial year and not be absent for two consecutive meetings. Where attendance falls below 80% the Chair will discuss the matter with the individual concerned.

5. Authority

The Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Trust Board in accordance with its Standing Orders to establish sub-groups as it deems necessary to enable it to fulfil its Terms of Reference. The Committee may not delegate executive powers and will have oversight of the functioning and output of such groups. The Terms of Reference of such sub-groups will be approved by the Committee and reviewed periodically and those sub-groups will report directly to the Committee.

6. Responsibilities

The Committee will have specific responsibility for seeking assurance regarding the delivery of:

- The objectives contained within the BAF (Board Assurance Framework) and will escalate and report issues of concern to the Trust Board and Chair/CEO if urgent.
- Maintain a risk register related to the remit of the Committee which will feed into the Corporate Risk Register and Board Assurance Framework.
- Monitoring the Trust's workforce performance (as detailed in the Trust's IQPR Organisational Health and Workforce) and ensure that the Trust's People and Cultural objectives are aligned with the Trust Strategy/People Plan 2023—2028.
- The organisation's People, Organisational Development and Communications plans.
- Gain assurance on risks and mitigation.
- Monitor progress with Policies and Procedures, ensuring they are reviewed and approved in a timely fashion.
- Consider and approve reports requiring formal approval as delegated by the Trust Board.
- Receive, discuss and make appropriate recommendations to the Board on key national reports that impact on workforce.
- The Committee has a role/responsibility for monitoring of agency use and workforce plan.

7. Behaviours and Conduct

Trust values

Members will be expected to conduct business in line with the trust values and objectives.

Members of, and those attending, the Committee shall behave in accordance with the Trust's standing orders, and standards of business conduct policy.

Equality and Diversity

Members must demonstrably consider the equality and diversity implications of decisions they make.

8. Accountability and Reporting Arrangements

The Committee shall report to the Board on how it discharges its responsibilities.

The minutes of the Committee meetings shall be formally recorded by an Executive PA, approved by the Chair of the Committee and circulated within 7 days.

Copies of the minutes of Committee meetings, including associated reports and action plans shall be available to all Trust Board members, Clinical Directors and Heads of Service on request.

The Deputy Chief People Officer or other nominated attendee shall prepare a report to the Trust Board for the Chair after each meeting of the Committee. The Chair of the Committee shall draw to the attention of the Trust Board any issues that require disclosure to the full Trust Board.

The Committee must produce an Annual Report to the Trust Board. The Annual Report will include information about compliance with the requirement that members should attend regularly and should not be absent for more than two consecutive meetings. This Annual Report should also describe how the Committee has fulfilled its terms of reference and objectives and give details of any significant issues that the Committee considered during the year and how they were addressed.

An Annual Committee Effectiveness evaluation will be undertaken and reported to the Committee and the Board. The report will include information about compliance with the requirement that members should attend regularly and should not be absent for more than two consecutive meetings.

The Committee will review these terms of reference, at least annually as part of the Annual Committee Effectiveness review and recommend any changes to the Board.

9. Secretariat and Administration

The Committee shall be supported administratively by an Executive PA. Their duties in this respect will include:

- Development / agreement of agendas with the Chair and attendees
- Preparation, collation and circulation of papers 7 days ahead of the meeting
- Ensuring that those invited to each meeting attend
- Taking the minutes, ensuring sign off by Committee Chair and circulating within 7 days
- Keeping a record of matters arising and issues to be carried forward
- Ensuring that action points are taken forward between meetings

10. Requirement for Review

The Committee will review its effectiveness at least annually.

These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Date of approval:

Date of review: September 2025

QUALITY COMMITTEE
TERMS OF REFERENCE

Membership	▪ Three Non-Executive Directors ▪ Chief Medical Officer ▪ Chief Nursing Officer ▪ Chief Operating Officer
Quorum	▪ Four members of the Committee are present to include two Non-Executive Directors (one of which must be the Chair or Vice Chair.
In Attendance	▪ Clinical Director (or their nominated deputy) for each Clinical Directorate Deputy ▪ Deputy Director of Nursing ▪ Deputy Director of MACE and Medicines ▪ Deputy Director of Governance and Board Secretary ▪ Deputy Director of Operations ▪ Lived Experience Representative
Frequency of Meetings	▪ Monthly
Accountability and Reporting	▪ Accountable to the Trust Board ▪ Written Summary Report to the Trust Board following each meeting ▪ Minutes of meetings available to all Trust Board members, Clinical Directors and Heads of Service on request.
Date of Approval by Trust Board	
Review Date	March 2026

QUALITY COMMITTEE TERMS OF REFERENCE

1. Constitution

The Trust Board hereby resolves to establish a Committee of the Trust Board to be known as the Quality Committee (hereafter referred to as the Committee). The Committee is a Non- Executive Committee of the Trust Board and has no executive powers, other than those specifically delegated in the Trusts Scheme of Reservation and Delegation (SoRD) and specified in these terms of reference (ToR).

2. Membership

The Committee shall be appointed by the Trust Board from amongst the Directors of the Trust and shall consist of not less than three members. One of the Non-Executive Director members will be appointed Chair of the Committee by the Trust Board. In the absence of the Chair appointed by the Trust Board one of the other Non-Executive Directors will be elected by those present to Chair the meeting.

- Three Non-Executive Directors (One of the NEDs will be appointed Chair of the Committee by the Board). A Vice Chair will also be appointed, who will be another Non-Executive Director member.
- Chief Medical Officer
- Chief Nursing Officer
- Chief Operating Officer

No business shall be transacted unless four members of the Committee are present. This must include the Chair or Vice Chair.

3. Attendance at meetings

In addition, the following post holders will be in attendance at the meeting:-

Clinical Director (or their nominated deputy) for each Clinical Directorate
Deputy Director of Nursing
Deputy Director of MACE and Medicines
Deputy Director of Governance and Board Secretary
Deputy Director of Operations
Lived Experience Representative

The Chair of the Trust and the Chief Executive Officer may attend as appropriate

Frequency of meetings

The Committee shall meet monthly to effectively manage matters such as performance and quality.

The agenda for the Quality Committee Meetings will alternate on a month-by-month basis to discuss Trust wide thematic quality issues and directorate level quality performance on an alternative basis.

Attendance at directorate level quality committees for Clinical Directors (or nominated deputies) is mandatory

The Committee will meet monthly. Members of the committee are expected to attend a minimum of 80% of the meetings held each financial year and not be absent for two consecutive meetings. Where attendance falls below 80% the Chair will discuss the matter with the individual concerned.

4. Authority

The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek information it requires from any employee and all employees are directed to co-operate with any request made by the committee. The Committee is authorised to obtain outside or legal advice or other professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary.

The Committee is authorised by the Trust Board in accordance with its Standing Orders to establish sub-groups as it deems necessary to enable it to fulfil its Terms of Reference. The Committee may not delegate executive powers and will have oversight of the functioning and output of such groups. The Terms of Reference of such sub-groups will be approved by the Committee and reviewed periodically and those sub-groups will report directly to the Committee.

5. Responsibilities

The duties of the Committee can be categorised as follows:

To provide assurance to the Trust Board on the quality and safety of healthcare provided by the Trust by developing and reviewing the Trust's Quality and Clinical plans.

Risk & Compliance
The Committee via the Senior Leadership Team Meeting will ensure that operational and clinical risks are identified; measured and adequate controls are in place. There will be a quarterly review of the Trust's Board Assurance Framework and the assurances that fall under the responsibility of the Quality Committee.

While the Audit Committee will give assurance to the Board that the overall system for risk management is in place and is effective, operational responsibility for the management of risk to quality of services lies with the Quality Committee supported by the Senior Leadership Team Meeting.

Quality Governance
Will report and provide assurance to the Trust Board on the quality of healthcare provided by the Trust through the monitoring of the Trust's quality objectives that are called SPAR:

Our services will be consistently **Safe**
Our care will be **Personalised**
Our processes and structures will guarantee **Access**
Our focus will be on **Recovery**

There will be streamlining of reports with the Committee receiving a learning from experience report and a clinical effectiveness report aligned to SPAR that will report on the work of the sub groups encompassing:

- Patient Safety
- Clinical Effectiveness (Patient Outcomes)
- Customer Focus (Patient Experience)
- Organisational Safety and Efficiency

Have a structured approach to storytelling designed to improve services by focusing on the actual experiences of patient, carers and staff. Stories will be

aligned to the Trust values and SPAR objectives as a useful monitoring tool alongside other feedback methods.

Oversee the planning and development of quality and governance activities in the Trust in line with national guidance. This is a statutory duty on all NHS trusts, which requires them to put and keep in place arrangements for monitoring and improving the quality of health care they provide.

Set the Trust's strategy for quality and ensure the development of the Trust's clinical and quality plans.

Ensure that accountability for the delivery of high-quality service to patients is with Directorates.

Encourage and foster greater awareness of quality and governance throughout the organisation at all levels.

Ensure the development of clinical policy and procedure having followed due process and approve any new clinical policy or procedure.

The Service User and Carer Council will be a conduit of information regarding patient and carer issues which will be shared through Directorate reporting arrangements through to the Senior Leadership Team and Quality Committee meetings, as appropriate.

Approve research and development and audit plans in line with strategic objectives.

Oversee the development of Quality Accounts and oversee the monitoring and reporting process, giving assurance to the Audit Committee in this regard.

Monitor the Quality Indicators (QIs) as defined in the Trust's Improving Quality and Performance Report (IQPR).

Monitor the Trust's performance via review of the IQPR.

Receive assurance on the quality impact assessment of proposed Cost Improvement Programmes.

Receive information and assurance on staffing levels

Monitor and guide Trust activity in relation to compliance with core standards and will also oversee the Trust's Registration and ongoing accreditation under the Health and Social Care Act.

Monitor the system and process for capturing and responding to service user and carer feedback.

Receive information in relation to Medicine's management and monitor any issues or concerns

Safeguarding

To provide regular and robust assurance to the Quality Committee that all requirements in relation to children and adult safeguarding are met.

To receive a quarterly report from the Safeguarding Steering Group on activities within their Terms of Reference.

To receive and approve an Annual Report for Children and Adult Safeguarding.

6. Behaviours and Conduct

Trust values

Members will be expected to conduct business in line with the Trust values and objectives.

Members of, and those attending, the committee shall behave in accordance with the Trust's standing orders, and standards of business conduct policy.

Equality and diversity

Members must demonstrably consider the equality and diversity implications of decisions they make.

7. Accountability and Reporting Arrangements

The Committee shall report to the Board on how it discharges its responsibilities.

The Chair, Chief Medical Officer and Chief Nursing Officer will:

- Agree the agenda and ensure the collation of the papers.
- Devise and maintain a schedule of matters and cycle of business for the Committee;
- Advise the Committee on pertinent areas.

The minutes of Committee meetings shall be formally recorded by the Executive PA who will ensure that a record is kept of matters arising and issues to be carried forward.

Copies of the minutes of Committee meetings shall be available to all Trust Board members, Clinical Directors and Heads of Service on request.

The Deputy Director of MACE / Deputy Chief Nurse (or nominated deputy in their absence) will prepare an assurance report to the Trust Board after each meeting of the Committee. The Chair of the Committee shall draw to the attention of the Trust Board any issues that require disclosure to the full Trust Board.

An Annual Committee Effectiveness evaluation will be undertaken and reported to the Committee and the Board. The report will include information about compliance with the requirement that members should attend regularly and should not be absent for more than two consecutive meetings.

9. Secretariat and Administration

The Committee shall be supported administratively by an Executive PA. Their duties in this respect will include:

- Development / agreement of agendas with the Chair and attendees
- Preparation, collation and circulation of papers 7 days ahead of the meeting
- Ensuring that those invited to each meeting attend
- Taking the minutes, ensuring sign off by Committee Chair and helping the Chair to prepare reports to the Board (if required)
- Keeping a record of matters arising and issues to be carried forward
- Ensuring that action points are taken forward between meetings

10. Requirement for Review

The Committee will review its effectiveness at least annually.

These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Date of approval:

Date of review: March 2026

REMUNERATION COMMITTEE

TERMS OF REFERENCE

Membership	▪ Chair of the Trust Board ▪ All Non-Executive Directors
Quorum	▪ Three members
In Attendance	▪ Chief Executive ▪ Chief People Officer, ▪ Deputy Director of Governance/ Trust Board Secretary
Frequency of Meetings	▪ Planned Quarterly but no less than twice per year
Accountability and Reporting	▪ Accountable to the Trust Board ▪ Report to the Trust Board after each meeting ▪ Minutes of meetings available to the Chief Executive Officer and all Non-Executive Directors upon request
Date of Approval by Trust Board	
Review Date	February 2026

REMUNERATION AND TERMS OF SERVICE COMMITTEE

1. Constitution

The Trust Board hereby resolves to establish a Committee of the Trust Board to be known as the Remuneration Committee (hereafter referred to as the Committee). The Committee is a Non- Executive Committee of the Trust Board and has no executive powers, other than those specifically delegated in the Trust's Scheme of Reservation and Delegation (SoRD) and specified in these terms of reference (ToR).

2. Membership

The membership of the Committee shall be the Chair of the Trust Board and all Non-Executive Directors appointed by the Trust Board.

The Trust Chair will chair the Committee. In the absence of the Chair one of the other Non-Executive Directors will be elected by those present to Chair the meeting.

No business shall be transacted unless three members are present.

3. In Attendance

Only the Chair and relevant members are entitled to be present at a meeting of the Committee, but others may attend by invitation of the Committee.

- The Chief Executive, Deputy Director of Governance, Associate Non-Executive Directors and Chief People Officer shall normally attend meetings.

- The Chief People Officer will attend to advise on:

  - trends in pay and benefit
  - alignment of reward policies and trust objectives
  - the relevance of surveys and changes in reward practice; and the application and impact of external regulation on appointment, compensation, benefit and termination practice (e.g. NHS England).
  - The Deputy Director of Governance or their nominee shall act as secretary of the Committee.
  - Those in attendance will be excluded from meetings when their own remuneration is considered.

4. Frequency of Meetings and Required Frequency of Attendance

The Committee shall plan to meet quarterly.

Meetings will be called more frequently when vacancies arise or meetings can be called at the discretion of the Chair. This can be undertaken virtually.

Members of the Committee should attend regularly and should not be absent for more than two consecutive meetings.

5. Authority

The Committee has been delegated responsibility to agree the remuneration arrangements for Executive Directors and other senior managers employed on Trust terms and conditions. The quantum of such remuneration for to be agreed by the Committee in advance of appointments.

The remuneration for Non-executive Directors is currently set by NHS England and will not be considered by the Committee.

The Committee is authorised to seek any information it requires from an employee of the Trust in order to perform its duties.

The Committee is authorised by the Trust Board to obtain reasonable outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

The Committee also has authority to commission reports and surveys that it considers necessary to fulfil its obligations.

The Committee is authorised by the Trust Board in accordance with its Standing Orders to establish sub-groups as it deems necessary to enable it to fulfil its Terms of Reference. The Committee may not delegate executive powers and will have oversight of the functioning and output of such groups. The Terms of Reference of such sub-groups will be approved by the Committee and reviewed periodically and those sub-groups will report directly to the Committee.

6. Responsibilities

The purpose of the Committee is to determine appropriate remuneration and terms of service for the Chief Executive, Executive Directors and other staff employed on Trust terms and conditions, including:

- all aspects of salary (including cost of living or other increments and any performance related elements / bonuses)
- additional non-pay benefits, including pensions and cars
- contracts of employment
- arrangements for termination of employment and other contractual terms; and
- severance packages (severance packages must be calculated using standard guidelines any proposal to make payments must be subject to the approval of NHS England and the Treasury)

The Committee shall receive reports from the Chief Executive with regard to performance of the Executive Directors against objectives for the previous year.

The Committee will receive reports relating to national and local market factors including benchmarking of senior managers pay. The Committee may request reports relating to the senior management workforce to ensure the consistent application of the Trust's equality obligations.

The Committee shall advise the Trust Board on its arrangements for succession planning for both executive and non-executive directors.

The Committee shall recommend to the Trust Board the form and content of the report on directors' remuneration for inclusion in the Trust's Annual Report.

7. Behaviours and Conduct

Trust values
Members will be expected to conduct business in line with the trust values and objectives.

Members of, and those attending, the committee shall behave in accordance with the Trust's standing orders, and standards of business conduct policy.

Equality and diversity
Members must demonstrably consider the equality and diversity implications of decisions they make.

8. Accountability and Reporting Arrangements

The Committee shall report to the Board on how it discharges its responsibilities.

The minutes of Committee meetings shall be formally recorded by the Deputy Director of Governance / Trust Board Secretary. Copies of the minutes of Committee meetings shall be available to the Chief Executive and all Non-Executive Directors on request.

The Trust Board Secretary (or nominated deputy) shall prepare a report to the Trust Board after each meeting of the Committee. The Chair of the Committee shall draw to the attention of the Trust Board any issues that require disclosure to the full Trust Board.

An Annual Committee Effectiveness evaluation will be undertaken and reported to the Committee and the Board. The report will include information about compliance with the requirement that members should attend regularly and should not be absent for more than two consecutive meetings.

9. Secretariat and Administration

The Committee shall be supported administratively by the Deputy Director of Governance / Trust Board Secretary, whose duties in this respect will include:

- Agreement of agenda with Chair and attendees and collation of papers
- Taking the minutes and keeping a record of matters arising and issues to be carried forward
- Advising the Committee on pertinent issues/ areas of interest/ policy developments
- Ensuring that action points are taken forward between meetings
- Ensuring that Committee members receive the development and training they need.

10. Requirement for Review

The Committee will review its effectiveness at least annually.

These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Date of approval:

Date of review: February 2026

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Document level: Trustwide
Code: 4.08
Issue number: v2

4.08 Claims Handling Policy

Lead executive	Executive Medical Director
Authors details	Associate Director MACE

Type of document	Policy
Target audience	Trust Policy
Document purpose	Sets out Trust Policy in response to claims made to the Trust, support in place for staff, and reporting arrangements.

Approving meeting	Quality Committee Trust Board	Meeting date	5th March 2020 12th March 2020
Implementation date	31st March 2020	Review date	31st March 2024

Trust documents to be read in conjunction with	
1.05	Attendance at Coroner's Court Policy
5.32	Serious Incident Policy
4.26	Listening and Responding Policy (PALS and Complaints)

Document change history		Version	Date
What is different?	Minor changes reflecting change to NHS Resolution from NHS Litigation Authority		
Appendices / electronic forms			
What is the impact of change?	Name change only of external body		

Training requirements	Highlighted in the policy for those directly involved in the handling of claims (both clinical and non-clinical)

Document consultation	
Directorates	N/A
Corporate services	N/A
External agencies	N/A

Financial resource implications	None

External references
1.

Monitoring compliance with the processes outlined within this document	

Equality Impact Assessment (EIA) - Initial assessment	**Yes**	**Less favourable / More favourable / Mixed impact**
Does this document affect one or more group(s) less or more favorably than another (see list)? No		
– **Age** (e.g. consider impact on younger people/ older people) – **Disability** (remember to consider physical, mental and sensory impairments) – **Sex/Gender** (any particular M/F gender impact; also consider impact on those responsible for childcare) – **Gender identity and gender reassignment** (i.e. impact on people who identify as trans, non-binary or gender fluid) – **Race / ethnicity / ethnic communities / cultural groups** (include those with foreign language needs, including European countries, Roma/travelling communities) – **Pregnancy and maternity, including adoption** (i.e. impact during pregnancy and the 12 months after; including for both heterosexual and same sex couples) – **Sexual Orientation** (impact on people who identify as lesbian, gay or bi – whether stated as 'out' or not) – **Marriage and/or Civil Partnership** (including heterosexual and same sex marriage) – **Religion and/or Belief** (includes those with religion and /or belief and those with none) – **Other equality groups?** (may include groups like those living in poverty, sex workers, asylum seekers, people with substance misuse issues, prison and (ex) offending population, Roma/travelling communities, and any other groups who may be disadvantaged in some way, who may or may not be part of the groups above equality groups)		
If you answered yes to any of the above, please provide details below, including evidence supporting differential experience or impact.		
Enter details here if applicable		
If you have identified potential negative impact: - Can this impact be avoided? - What alternatives are there to achieving the document without the impact? Can the impact be reduced by taking different action?		
Enter details here if applicable		

Do any differences identified above amount to discrimination and the potential for adverse impact in this policy?	Yes / No
If YES could it still be justifiable e.g. on grounds of promoting equality of opportunity for one group? Or any other reason	Yes / No
Enter details here if applicable	
Where an adverse, negative or potentially discriminatory impact on one or more equality groups has been identified above, a full EIA should be undertaken. Please refer this to the Diversity and Inclusion Lead, together with any suggestions as to the action required to avoid or reduce this impact. For advice in relation to any aspect of completing the EIA assessment, please contact the Diversity and Inclusion Lead at Diversity@northstaffs.nhs.uk	
Was a full impact assessment required?	No
What is the level of impact?	Low

Training Needs Analysis for the policy for the development and management of Trust wide procedural / approved documents

Please tick as appropriate

There **are no** specific training requirements- awareness for relevant staff required, disseminated via appropriate channels. (Do not continue to complete this form-no formal training needs analysis required)	✓
There **are** specific training requirements for staff groups. (Please complete the remainder of the form-formal training needs analysis required-link with learning and development department.	

Staff Group	✓ if appropriate	Frequency	Suggested Delivery Method (traditional/ face to face / e-learning/handout)	Is this included in Trust wide learning programme for this staff group (✓ if yes)
Career Grade Doctor				
Training Grade Doctor				
Locum medical staff				
Inpatient Registered Nurse				
Inpatient Non-registered Nurse				
Community Registered Nurse				
Community Non Registered Nurse / Care Assistant				
Psychologist / Pharmacist				
Therapist				
Clinical bank staff regular worker				
Clinical bank staff infrequent worker				
Non-clinical patient contact				
Non-clinical non patient contact				

Please give any additional information impacting on identified staff group training needs (if applicable)

Please give the source that has informed the training requirement outlined within the policy i.e. National Confidential Inquiry/NICE guidance etc.

Any other additional information The AD Mace and Head of Organisational Safety (and his / her deputies) complete required training to support implementation of this policy (e.g., legal, root cause analysis, investigating officer training.

Completed by	AD Mace	Date	19/2/20

Contents

1. Policy Statement

North Staffordshire Combined Healthcare Trust (The Trust) is committed to efficiently and effectively managing any claims that it may receive. Lessons that

we learn from claims are an important risk management tool which can be used to help improve the quality of our services.

2. Scope

This document outlines the procedure of the Trust on the management of clinical negligence, liability and property expenses claims. The procedure also provides guidance on the involvement of the process of Third Parties such as NHS Resolution (NHSR) formerly NHS Litigation Authority, Solicitors, Claimants and HM Coroner.

3. Duties within the organisation

3.1 Chief Executive

The Chief Executive is ultimately accountable for ensuring that all claims are dealt with effectively and efficiently.

3.2 Trust Board

The Trust Board requires assurance that the claims management system is working effectively and effectively. This will be achieved in the following ways:

- Inclusion in the Trust's Patient Experience Report;
- Reporting of significant individual claims to the meetings of the Clinical Safety Improvement Group and the Trust's Quality Committee.
- Exception reporting of very serious claims to the Trust Board by the Executive Nursing Director (for non-clinical claims) or Associate Director for Medical & Clinical Effectiveness (MACE) on behalf of the Executive Medical Director (for clinical claims).

3.3 Clinical Safety Improvement Group

The Trust's Clinical Safety Improvement Group has two key functions as determined in the Group's Terms of Reference. The first function relates to the duties on a monthly basis and the second relates to the functions on a quarterly basis. See 5.4 for further information.

3.4 Associate Director for MACE

This person has overall responsibility for the policy and procedure in respect to claims management.

Clinical claims will be managed by the Associate Director of MACE. They will be responsible for liaising with NHS Resolution and local investigation of claims as appropriate. This person will also obtain witness statements as required or assist the NHSR authorised solicitor in obtaining further evidence or witness statements from staff.

A representative of the Trust may be required to attend at Court at any time for a Case Management Conference. This representative may be required to make decisions on behalf of the Trust with the advice from an accompanying solicitor.

The Associate Director of MACE has authority to attend Case Conferences on behalf of the Trust and make decisions as required.

3.5 Head of Patient and Organisational Safety

The Head of Patient and Organisational Safety is responsible for liaising with NHSR in respect of Liability of Third Party Schemes (LTPS). He/she also has an overview of the incident database and is, therefore, in a position to provide the NHSR claims handler with all relevant information. It is the Trust's policy that all LTPS claims are managed by NHSR.

3.6 Role of clinicians / specialist advisors

Where appropriate those Directorate Associate Directors responsible for the management of clinical and non clinical claims and his/her Deputy will seek the advice of clinicians or specialist advisors in respect of individual claims. This will normally be clinicians within the Trust or specialists such as manual handling co-ordinators; or violence and aggression trainers.

4. Framework for claims handling

4.1 A claim involves civil action taken through the Courts by a third party claiming damages against the Trust for negligence. The Trust is a member of the NHS Resolution Risk Pooling Scheme providing cover similar to insurance against the main areas of potential claim i.e. clinical negligence and third party liability. The Risk Pooling Scheme also involves the Property Expenses Scheme (PES) which provides cover for the Trust for major losses of buildings and contents.

4.2 Clinical negligence claims may be made by patients who have received clinical services under the Trust or their representatives. The majority of LTPS claims are made by staff although a small portion of claims are made by members of the public who may have suffered some harm when visiting Trust premises.

The most common triggers for invoking the claims procedure would be a letter of claim from a solicitor representing the individual or, in clinical negligence claims, a request for records indicating that the patient is considering taking action against the Trust for clinical negligence. Access to records requests in

this regard will be dealt within the statutory 40-day timescale and are usually overseen by the Associate Director of MACE .

4.3 The Associate Director of MACE has authority from the Trust to agree settlement of clinical negligence claims.

He/she is also authorised to agree payment in respect of the LTPS scheme in addition to the Head of Patient and Organisational Safety.

Although most claims against the Trust will be handled by NHS Resolution (NHSR), the Trust is committed to operate in accordance with the Civil Procedure Rules. In particular, as well it supports the following principles:

- Encouraging pre-action contact with claimants and applying appropriate timescales as laid down in the Civil Procedure Rules, e.g. 14 days to acknowledge a formal letter of claim;
- Early exchange of information;
- In-depth investigation using Root Cause Analysis techniques where appropriate (as identified in the Trust's Serious Incident Reporting and Investigation Policy);
- Early settlement where appropriate to avoid the need for expensive litigation and escalation to NHSR;
- Co-operating with the Court proceedings so that they run smoothly.

The Trust recognises that involvement in claims puts high levels of stress on staff. Every effort therefore will be made to support staff through this difficult process. Staff involved in non-clinical claims as witnesses will be kept fully informed of the progress. In addition in the case of clinical claims, staff will be supported through the court process encouraging open communication and an audit trail for this. (Refer also to Trust Policy on Attendance at Inquests 1.05)

4.4 NHSR Risk Pooling Schemes

4.4.1 Clinical Negligence Scheme for Trust (CNST)

The Trust will comply with the CNST reporting guidelines. Indication of a potential claim will either be a request for records or a letter of claim.

If a request for disclosure of records is received, the Associate Director of MACE will take a view on the likelihood of this becoming a claim and discuss with NHSR whether it should be reported to them at this stage.

If a letter of claim is received copies of the correspondence from the claimant's solicitor and a completed CNST Claim Report Form and any incident report will be sent to NHSR within two working days. At this stage a time scale for obtaining comments from clinical staff and submission of the Preliminary Analysis will be agreed with the NHSR claims handler.

4.4.2 Liabilities Third Party Scheme (LTPS)

The LTPS will be managed within the Trust by the Head of Patient and Organisational Safety. Upon receipt of the letter of claim he/she will send an LTPS report form and a copy letter of claim to NHSR within two working days. The "NHSR LA disclosure list" will be submitted to the NHSR within one month.

4.4.3 Property Expenses Scheme (PES)

If there is a significant incident involving damage to building or contents over the NHSR scheme excess of £20,000, the Directorate Associate Director for the area will contact the Associate Director of MACE. He/she will liaise with the Estates Department concerning the cost of the damage and will advise NHSR of the Trust's intention to claim.

5. Implementation and Monitoring

5.1 Implementation of this policy

Action in respect of claims will follow the guidance set out in Section 4 (Framework) and Appendices A to D of this policy.

5.2 Analysis of Claims

A full analysis of claims is undertaken on a quarterly basis and is reported to the Clinical Safety Improvement Group and Quality Committee in a quarterly report. The Patient Experience report includes the following:

- the number of claims;
- the timescales for handling claims;
- qualitative data regarding the type of claims received;
- key trends; and
- key lessons learnt

5.3 Analysis Process for the aggregation of Complaints, Concerns and Claims at Directorate Level

Quarterly Complaints Monitoring meetings are held within each Directorate to review claims and complaints received during a quarter. The Trust Patient Advice & Liaison Service (PALS) also reports, where appropriate, any pertinent information in relation to themes and trends in respect to their contacts to this group. Monitoring meetings consider whether the complaint is justified, key actions and learning. The Associate Director of MACE also uses the opportunity where appropriate to share any learning or emerging trends in relation to claims to see how they compare with the complaints data.

5.4 Incident Review Group (Weekly)

The Trust's Incident Review Group has a key role to analyse key themes and trends identified via complaints, concerns, claims, incidents and serious incidents. The Incident Review Group has two key functions as determined in the Group's Terms of Reference: To meet weekly to review any complaints, concerns, claims and incidents reported during the previous week and identify any significant emergent patterns that require immediate action.

At the weekly meeting of the Incident Review Group, complaints, concerns, claims and incidents are analysed in order to identify any emergent key themes and trends. As appropriate, key actions, conclusions and recommendations are taken forward immediately and shared with the Chief Executive and other members of the Executive Team where relevant and in relation to the issues identified. Weekly notes are produced to record statistics, list trends, record key actions and also draw any relevant conclusions and recommendations as appropriate

5.5 Clinical Safety Improvement Group (CSIG)

The Clinical Safety Improvement Group is chaired by an Executive Director. The Trust's Clinical Safety Improvement Group has two key functions as determined in the Group's Terms of Reference, the first function relates to the duties on a monthly basis and the second relates to the functions on a quarterly basis. Minutes are maintained and reports made to the Quality Committee through the quarterly Serious Incident report.

- **Monthly Meeting of CSIG**
  - oversees the processes to manage and respond to serious incidents; incidents; complaints; claims; PALS activity; and Patient Experience and Engagement activity [Clinical Audit Group oversees processes for clinical audit]
  - reviews serious issues as identified by the above processes which require an immediate response
  - reviews all new Serious Incidents within the month

- **Quarterly Serious Incident Report**
  - Overview of the trends / lessons learnt from the above processes and drives improvements in service delivery
  - provides a comprehensive report on a quarterly basis in relation to
    - Serious Incidents

    this report includes:

    - Number of occurrences within the quarter (eg number of incidents)
    - Meeting investigation and reporting timescales
    - Occurrences by type
    - Occurrences by area

- Occurrences by speciality
- Key themes / concerns / messages
- Action being taken
-

- **Bi Monthly Learning from Experience Report**
  This report is written under the direction of the Director of Nursing and Quality and reports to Quality Committee. This report includes the following areas:

  - Incidents
  - Complaints
  - Non-clinical Claims
  - PALS
  - Patient Experience
  - Health & Safety and Operational Risks

  Also looking to:

  - commission investigations on clusters of complaints or incidents, either by types or location to further understand the common themes
  - identify the common themes
  - identify the action to be taken
  - oversee implementation of actions or action plans to drive improvements related to any aspect of the Group's Terms of Reference
  - Ensure that lessons learnt are cascaded to all appropriate staff in a timely manner

5.6 Risk Review group and Quarterly Risk Management Report

A Risk Management Report is produced on a quarterly basis. See the Risk Management Policy (4.1a) for information of the full content.

5.7 Quality Committee

The Quality Committee receives reports to identify the aggregated quantitative data, aggregated qualitative data, key themes, lessons learned, and improvements, thereby providing information and assurance to the Trust Board on governance processes in place.

5.8 Sharing the Learning

Where appropriate, details of lessons learned are presented in an anonymised fashion through the "Learning Lessons" bulletin and staff learning events or at the weekly junior medical staff training sessions. Details of these learning sessions are available on the Trust's intranet.

5.9 Analysis Process for the Aggregation of Complaints, Concerns, Claims and Incidents across the Local Health Economy

Where appropriate, details of serious incidents and lessons learned will be presented in an anonymised fashion to monthly Learning Lessons Seminars, or at the weekly junior medical staff training sessions. Details of these learning sessions are put on the Trust's intranet. External partners, such as General Practitioners and University Hospital of North Midlands staff may be invited to attend these sessions.

6. External Consultation and Communication with Stakeholders

Claims will usually result from serious incidents which will have already been reported to Stoke or Staffordshire Commissioners, HM Coroner, Care Quality Commission or the Health & Safety Executive. In the event of a claim occurring which has not been reported in this way, the Associate Director of MACE or his / her deputy will communicate with other external stakeholders in accordance with the nature of the claim. For example: neighbouring Health Trusts, other relevant public bodies. This communication will take place at appropriate times, throughout the process, depending on the nature of the claim. Other organisations may need to be informed dependent upon the type of claim, the Associate Director of MACE will be responsible for this.

Sharing lessons learnt, or themes and trends will be shared in an anonymised way in public reports, for example via Quality Committee to the Trust Board.

Safety lessons can be shared with external stakeholders through Serious Incident reporting to Commissioners. Shared learning is also communicated externally through Central Alert Broadcasts, NPSA Alerts, NHS England Alerts and inquiry reporting.

Following an incident, claim or complaint, the Trust encourages open, candid and honest communications with other healthcare organisations, healthcare teams, staff and services users and/or their carers (Please Refer to Being Open Policy 4.40). The Head of Patient and Organisational Safety and Associate Director of MACE can be contacted for advice and further information on being open and being candid (Duty of Candour).

The Trust's philosophy is to view feedback, expressions of concern and the formulation of claims by clients or their family members as valuable information about how its services and facilities are received and perceived and where quality improvements can be made.

Organisational learning and change is brought about in a number of ways:

- Individual learning and reflection from claims and HM Coroner inquiries;
- Team learning and reflection from claims and HM Coroner inquiries;
- Learning Lessons events where case studies are presented and all groups of staff are encouraged to attend;
- Reports are made available for all Trust staff to access
- Learning and action informs the training programmes, which all Trust staff are required to attend, thereby raising awareness to the issues raised and ensuring Trust wide dissemination;
- Commitment to learning and change is endorsed at Trust Board level and a culture adopted that sees feedback and the learning from claims as opportunities to improve and develop services.

7. Management of claims not covered by NHSR LA

There may be some circumstances where claims will not be covered by the NHSR scheme e.g. in respect of incidents occurring pre Risk Pooling Schemes when the Trust managed its own insurance or where there are gaps in the cover for the NHSR schemes. In such circumstances the Trust will consult with its contracted legal advisors on appropriate next steps.

8. Authorisation Limits

The Liability to Third Parties Scheme (LTPS) entails an excess of £10,000 for employee liability and £3,000 for public liability claims. Under normal circumstances, all third party liability claims will be referred immediately to NHSR for them to manage for a fixed fee in respect of sub-excess claims. However, the Associate Director of MACE has authority to agree settlement of damages up to £1,000 for straightforward third party liability claims. This will normally be for claims where liability is apparent and has been discussed with NHSR.

9. Release of Health Records

A request for health records, particularly from a solicitor is the earliest indication of a potential claim, in most cases for clinical negligence. The civil procedure rules specify that records must be released within 40 days of any approach (this conforms with the Data Protection Act 1998). It is essential that any department receiving a request for health records should ascertain whether the applicant is contemplating legal action against the Trust. If the request is from a solicitor, the application form included in the “pre-action protocol for resolution of clinical disputes” should be used (appendix 1). The Associate Director MACE must be informed immediately of any requests for records where there is any possibility of civil action against the Trust. In such circumstances the case will be managed centrally and records must be released by the Associate Director MACE and not direct by any department or staff member.

10. Authority to Sign Statements

The Civil Procedure (CP) rules require details of the claim and defence to be set out in a "Statement of Case", previously called pleadings. This "Statement of Case" must be verified by a "Statement of Truth" – "I believe that the facts stated are true". The "Statement of Truth" will be signed on behalf of the Trust by the Associate Director MACE.

Similarly a Trust representative must sign a "Disclosure Statement" in respect of documents disclosed which are relevant to the case. This statement sets out the extent to which a search has been made, certifies that the duty to disclose documents is understood, and that the duty has been carried out to the best of the knowledge of the signatory.

The "Disclosure Statement" will be signed by the Associate Director MACE for clinical claims. The Head of Patient and Organisational Safety will sign employee and public liability claims.

11. Training

The Associate Director MACE and Head of Patient and Organisational Safety and his/her deputy will have undertaken appropriate training in the handling of claims and investigation using Root Cause Analysis techniques.

If, by exception, the claim is investigated by another individual, this individual will be appropriately trained in investigation and Root Cause Analysis techniques and be included on the approved list of managers to investigate serious incidents.

Any persons involved in the handling of claims will also be expected to be abreast of any legal developments and current Civil Procedure rules.

12. Monitoring of the Procedure for Handling Claims against the Trust

This policy will be reviewed annually or earlier in light of new national guidance / other significant changes.

Compliance with this policy will be monitored through the mechanisms detailed in the table below. Where compliance is deemed to be insufficient, and the assurance provided is limited an action plan will be developed to address the gaps; progress against the action plan will be monitored at the specified group / committee.

Minimum requirement to be monitored	Process / Method	Responsible individual / group / committee	Frequency of monitoring	Responsible individual / group / committee for review of results	Responsible group / committee for monitoring action plan

Duties	Audit	Policy Lead	Annually	Quality Committee	Quality Committee
NHSR schemes relevant to the organisation (i.e. CNST, LTPS and PES)	Report Report	Policy Lead Policy Lead	Quarterly Quarterly	Clinical Safety Improvement Group - Quality Committee	Clinical Safety Improvement Group Quality Committee
Action to be taken, including timescales	Report Report	Policy Lead Policy Lead	Quarterly Quarterly	Clinical Safety Improvement Group - Quality Committee	Clinical Safety Improvement Group Quality Committee
Communication with relevant stakeholders	Audit	Policy Lead	Annually	Clinical Safety Improvement Group	Clinical Safety Improvement Group

What to do if you receive a Notification of a Personal Injury or Clinical Negligence Claim

Appendix A

For both clinical negligence and personal injury claims

Personal injury claims – contact the Patient & Organisational Safety Team. For clinical claims contact the Associate Director MACE

The Head of each Directorate will contact the necessary persons and inform the relevant Clinical Director

The Head of each Directorate will be responsible for obtaining all relevant paperwork

The responsibility for ensuring that the information is obtained within the timescale will be that of the Heads of each Directorate as described in this policy

The Heads of each Directorate will act as the Investigating Officer, with support, as appropriate from NHSR

Note: <u>For Clinical Negligence Claims</u> the Associate Director MACE has only **14 days** to acknowledge letter of claim therefore the initial paperwork must be sent to them within **10 working days**

If a Clinical Negligence Claim is made and a request for a patient's health records is made, copies of these must also be delivered to the Associate Director MACE

The Associate Director MACE will need to obtain the remaining relevant paperwork as soon as possible i.e. within **75 days** of the date of posting the letter of claim

<u>For Personal Injury</u> claims the Head of Patient and Organisational Safety needs to acknowledge the letter of claim within **21 days of the date of the posting of the letter of claim** therefore the initial paperwork must be sent to them within **10 working days**

The remaining paperwork and any further information that may be requested by the insurers and the team should be submitted **within 75 days of the of the acknowledgement letter**

Appendix B

Workplace Claims – Information Required

(i) Accident Book Entry
(ii) First Aider Report
(iii) Surgery Record
(iv) Manager/Supervisor accident report
(v) Safety Representatives accident report
(vi) Reporting of Injuries, Diseases, Dangerous Occurrences to Health and Safety Executive
(vii) Other communications between defendants and Health and Safety Executive
(viii) Minutes of Health and Safety Committee meeting(s) where accident/matter considered
(ix) Report to DSS
(x) Documents listed above relative to any previous accident/matter identified by the claimant and relied upon as proof of negligence
(xi) Earnings information where defendant is employer

Documents required to comply with the Management of Health and Safety at Work Regulations 1992 –

(i) Pre-accident Risk Assessment
(ii) Post-accident Risk Assessment
(iii) Accident Investigation Report prepared in implementing the requirement
(iv) Health Surveillance Records in appropriate class required
(v) Information provided to employees under Regulation 8
(vi) Documents relating to the employee's Health and Safety training

Workplace claims – disclosure where specific regulations apply

Section A

1. Repair and maintenance records
2. Housekeeping records
3. Hazard warning signs or notices

Section B

Provision and use of Work Equipment

1. Manufacturers specifications and instructions
2. Maintenance log/maintenance records
3. Documents providing information and instructions to employees
4. Training records

Section C

Personal protection Equipment (PPE)

1. Documents relating to the assessment of PPE
2. Documents relating to the maintenance and replacement of PPE

Section D

Manual Handling Operations

1. Manual Handling Risk Assessment carried out
2. Re-assessment carried out post-accident
3. Document showing the information provided to the employee to give general indications related to the load and precise indications on the weight of the load and the heaviest side of the load if the centre of gravity was not positioned centrally
4. Training Records

Section E
Health and Safety Display Screen Equipment

1. Analysis of work stations to assess and reduce risks carried out
2. Re-assessment of analysis of work stations to assess and reduce risks following development of symptoms by the claimant
3. Documents detailing the provision of training including training records
4. Documents providing information to employees to comply with the requirements

Section F
Control of Substances Hazardous to Health (COSHH)

1. Risk assessment carried out
2. Reviewed risk assessment carried out
3. Copy labels from containers used for storage handling and disposal
4. Records of maintenance procedures

This is some of the information required before North Staffordshire Combined Healthcare NHS Trust can submit the claim to the NHS Resolution . Other information may be requested depending on the nature of the claim

Appendix C

Additional Information:

Information required for personal injury/insurance claims

a. Incident Form
b. Photographs of accident area
c. First aid report
d. Health record/GP notes (requires permission)
e. Managers accident report
f. Safety Representatives accident report
g. Risk Assessments
h. Maintenance records
i. Witness statements
j. RIDDOR – Reporting of Injuries, Diseases, Dangerous Occurrences to HSE
k. Minutes of Health and Safety Committee meeting (s) where accident discussed
l. Report to DSS
m. Any of the above mentioned documents related to any previous accident by the claimant and relied upon as proof of negligence
n. Personnel records if appropriate
o. Training and development records
p. Occupational Health Records (require permission)
q. Earnings information where Trust is employer

Appendix D

Clinical Negligence Claims – Information Required

(i) Incident Form

(ii) Incident Investigation

(iii) SI Investigation (if undertaken)

(iv) Patient Notes

(v) Witness Statements

(vi) RIDDOR – Reporting of Injuries, Diseases, Dangerous Occurrences to HSE (if reported)

Document level: Trust
Code: 1.05
Issue number: 02

1.05 Coroners Court Policy

Lead executive	Executive Medical Director
Authors details	Associate Director MACE

Type of document	Policy
Target audience	Trust Policy
Document purpose	Sets out process for attendance at Coroner's Court including support for staff, preparation and disclosure of evidence including statements and reports

Approving meeting	Quality Committee Trust Board	Meeting date	2nd April 2020 9th April 2020
Implementation date	29th April 2020	Review date	30th April 2024

Trust documents to be read in conjunction with	
5.32	Serious Incident Policy
7.06	Trust Information Policy (Media)

Document change history		Version	Date
What is different?	Minor changes reflecting change to NHS Resolution from NHS Litigation Authority And support available to bereaved people		
Appendices / electronic forms			
What is the impact of change?	Name change only of external body		

Training requirements	Highlighted in the policy in terms of support available (as opposed to actual training) for those who may be involved in an inquest

Document consultation	
Directorates	N/A
Corporate services	N/A
External agencies	N/A

Financial resource implications	None

External references
1.The Coroners and Justice Act (2009) 2. Coroners reforms (Regulations) 2013

3. Ministry of Justice 92010) A Guide to Coroners and Inquests 4. A guide to Coroner Services for Bereaved People (Coroners@justice.gov.uk)

Monitoring compliance with the processes outlined within this document	

Equality Impact Assessment (EIA) - Initial assessment	**Yes**	**Less favourable / More favourable / Mixed impact**
Does this document affect one or more group(s) less or more favorably than another (see list)? No		
– **Age** (e.g., consider impact on younger people/ older people) – **Disability** (remember to consider physical, mental and sensory impairments) – **Sex/Gender** (any particular M/F gender impact; also consider impact on those responsible for childcare) – **Gender identity and gender reassignment** (i.e., impact on people who identify as trans, non-binary or gender fluid) – **Race / ethnicity / ethnic communities / cultural groups** (include those with foreign language needs, including European countries, Roma/travelling communities) – **Pregnancy and maternity, including adoption** (i.e., impact during pregnancy and the 12 months after; including for both heterosexual and same sex couples) – **Sexual Orientation** (impact on people who identify as lesbian, gay, or bi – whether stated as 'out' or not) – **Marriage and/or Civil Partnership** (including heterosexual and same sex marriage) – **Religion and/or Belief** (includes those with religion and /or belief and those with none) – **Other equality groups?** (May include groups like those living in poverty, sex workers, asylum seekers, people with substance misuse issues, prison and (ex) offending population, Roma/travelling communities, and any other groups who may be disadvantaged in some way, who may or may not be part of the groups above equality groups)		
If you answered yes to any of the above, please provide details below, including evidence supporting differential experience or impact.		
Enter details here if applicable		

If you have identified potential negative impact: - Can this impact be avoided? - What alternatives are there to achieving the document without the impact? Can the impact be reduced by taking different action?	
Enter details here if applicable	
Do any differences identified above amount to discrimination and the potential for adverse impact in this policy?	Yes / No
If YES, could it still be justifiable e.g. on grounds of promoting equality of opportunity for one group? Or any other reason	Yes / No
Enter details here if applicable	
Where an adverse, negative, or potentially discriminatory impact on one or more equality groups has been identified above, a full EIA should be undertaken. Please refer this to the Diversity and Inclusion Lead, together with any suggestions as to the action required to avoid or reduce this impact. For advice in relation to any aspect of completing the EIA assessment, please contact the Diversity and Inclusion Lead at Diversity@northstaffs.nhs.uk	
Was a full impact assessment required?	No
What is the level of impact?	Low

Training Needs Analysis for the policy for the development and management of Trust wide procedural / approved documents

Please tick as appropriate

There **are** specific training requirements- awareness for relevant staff required, disseminated via appropriate channels. (Do not continue to complete this form-no formal training needs analysis required)	✓
There **are** specific training requirements for staff groups. (Please complete the remainder of the form-formal training needs analysis required-link with learning and development department.	

Staff Group	✓ if appropriate	Frequency	Suggested Delivery Method (traditional/ face to face / e-learning/handout)	Is this included in Trust wide learning programme for this staff group (✓ if yes)
Career Grade Doctor				
Training Grade Doctor				
Locum medical staff				
Inpatient Registered Nurse				
Inpatient Non-registered Nurse				
Community Registered Nurse				
Community Non-Registered Nurse / Care Assistant				
Psychologist / Pharmacist				
Therapist				
Clinical bank staff regular worker				
Clinical bank staff infrequent worker				
Non-clinical patient contact				
Non-clinical non patient contact				

Please give any additional information impacting on identified staff group training needs (if applicable)

Please give the source that has informed the training requirement outlined within the policy i.e. National Confidential Inquiry/NICE guidance etc.

Any other additional information The AD Mace and Head of Organisational Safety (and his / her deputies) complete required training to support implementation of this policy (e.g legal, root cause analysis, investigating officer training. The AD MACE will provide information and support to those involved in an inquest.

Completed by	AD Mace	Date	17/03/20

INDEX **PAGE NO.**

1. POLICY STATEMENT

Her Majesty's Coroner is an independent Judicial Officer responsible only to the Crown, with a statutory duty to investigate sudden, violent, or unexplained death.
The Coroners and Justice Act 2009 requires an inquest to be held if there is reasonable cause to suspect that a person has died in the following circumstances:-

- A violent or unnatural death
- A sudden death, the cause of which is unknown.
- In custody or otherwise in state detention
- Circumstances as to require an inquest under any other Act of Parliament.

North Staffordshire Combined Healthcare NHS Trust (The Trust) is committed to an effective and timely response to any request by the coroner for assistance with investigations. Staff, employed by the Trust, may be approached to provide a statement or a report to assist with this and are required to fully cooperate in the preparation of evidence for submission to the coroner. Both the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) recognise that practitioners have a professional duty to cooperate with the coroner in this regard.

On 25 July 2013, The Coroner (inquests) Rules 2013 came into force. The Rules were introduced to implement a national framework of standards in investigations and inquests under the 2009 Act, with the aim of improving bereaved parties' experience of investigations undertaken by coroners and making the investigations themselves more efficient.
The purpose of this policy is to ensure that staff who are employed by the Trust are aware of the procedures to be followed when summoned by the coroner to attend an inquest; produce a report; or make a statement, and the standard that will be expected.

NOTE There are no litigating partners to an inquest, merely "interested persons". All staff will be supported in the event of being asked to complete a statement or attend at Court.

2. SCOPE OF THE POLICY.

This policy applies to all staff employed by the Trust and aims to ensure that all staff are fully aware of, and understand, the function of the coroner and the workings of the Coroner's Court and the procedure to be followed if a request for assistance is made by the coroner.
If the member of staff is a student, then the Line Manager should inform the appropriate Course Leader.

3. ROLES AND RESPONSIBILITIES.

3.1. The **Trust Chief Executive** through the Medical Director has overall responsibility to ensure that processes are in place to:

- Ensure that staff are aware of this policy and adhere to its requirements.
- Ensure that appropriate resources exist to meet the requirements of this policy.

3.2. The **Role of the Associate Director of Medical & Clinical Effectiveness (AD MACE)** This person is the central point of contact for the coroner:

- To receive requests for information and notification for all cases from the coroner and ensure that such requests are responded to in a comprehensive and timely manner.

- Will explain to staff the purpose of the inquest process, obtain statements and/or reports from staff and will disclose to the coroner once approved, together with other relevant information such as details of a clinical incident investigation or complaint investigation, where appropriate to do so.
- To consider the requirements for notifying NHS Resolution
- To liaise with senior managers and clinicians to ensure that staff attending the inquest are fully prepared and supported.
- To alert the Medical Director of all requests from the coroner and agree documentation for disclosure.
- To alert the Trust's Communications department of inquests where there may be media interest.

3.3. The role of **Clinical Directors and Associate Directors**

- To ensure that cases referred to the coroner, within their area of responsibility, have been considered for investigation i.e., root cause analysis and that any complaint or incident investigation findings are shared with family ahead of an inquest, where appropriate to do so.
- To ensure that staff are fully supported when writing statements and attending inquests.
- To advise staff to contact their appropriate governing body for support where applicable.
- The AD MACE will always be in attendance at inquests, where appropriate, to attend the inquest both to support staff and to represent the Trust.
- To involve the Medical / Nurse Director in cases, where necessary.

3.4. The role of **staff** is:

- To notify the AD MACE of any direct requests from the coroner for information or statements.
- To respond promptly to requests to provide a statement for the coroner.
- To ensure that the statement is comprehensive, factually accurate and follows the guidance in section 4.3.1.
- To liaise with appropriate others for any assistance required, when asked to write a statement and to attend an inquest.

4. FRAMEWORK

4.1. The Coroner

The Coroner (known as Senior Coroner) is an independent judicial officer appointed by the local authority and must be a doctor or lawyer, and in some cases is both.
Each Coroner has a deputy and must be available at all times.
The Coroner with jurisdiction for this Trust is:
HM Senior Coroner for Stoke on Trent and North Staffordshire
Coroner's Court and Chambers
Stoke Town Hall
Kingsway
Stoke on Trent
ST4 1HH
Telephone: 01782 234777
Facsimile: 01782 232074
E-mail: coroners@stoke.gov.uk

Coroner's Rules – July 2008 and July 2013

Child protection
The rules require a Coroner to report the death of any child to the Local Safeguarding Children Board (LSCB). Coroners will be allowed to supply information such as post mortem reports and documents given in inquests to these Boards. This will enable LSCB's to meet their statutory obligations, including their responsibility to conduct child death reviews.

Regulation 28 report (formerly Rule 43 reports) – report on action to prevent further deaths.
If any information is revealed as part of the Coroner's investigation or during the course of the evidence heard at inquest, which give rise to "a concern that circumstances creating a risk of other deaths will occur, or will continue to exist in the future", and if the Coroner is of the opinion that action needs to be taken. Regulation 28 affords Coroners a duty to report the findings of an inquest to an individual or body, local government or authority who may have the power to prevent a similar death occurring in the future.

The Regulation places a duty on NHS Trusts to respond to a Regulation 28 report within **8 weeks (56 days).** The Report will set out the concerns and actions to be taken. The response will be circulated beyond the Coroner's office and Trust staff preparing such responses should be mindful that any response may become public. The AD MACE will take the lead in preparing such responses and disclosure. The Chief Coroner publishes the reports and responses on the judiciary.gov.uk website.

4.2. Reporting Deaths to H.M. Coroner
The role of the Coroner is to ensure that the circumstances of deaths are subject to scrutiny, and in particular that violent, unnatural or unexplained deaths are afforded a full medico-legal investigation, and if necessary, an inquest.

In most cases deaths are not reported to the Coroner as the deceased own doctor or a hospital doctor, who has been treating them, is able to give a cause of death enabling the death to be registered and the body released for burial. However there are a number of instances when the death must be reported to the Coroner:

- The cause of death is unknown.
- The death was unnatural.
- The deceased was not attended by the doctor during their last illness or was not seen within the last 14 days or viewed after death.
- The death was in suspicious circumstances or where there was a history of violence.
- The death may be linked to an accident (whenever it occurred).
- Where there is any question of self neglect or neglect by others.
- The death has occurred, or the illness arisen during, or shortly after, detention in police or prison custody (including voluntary attendance at a police station).
- The deceased was detained under the Mental Health Act.
- The death is linked with a termination of pregnancy.
- It is a maternal death.
- The death might have been contributed to by the actions of the deceased (such as history of drug or solvent abuse, self injury or overdose).

- The death could be due to industrial disease or related in any way to the deceased employment.
- The death occurred during an operation or before full recovery from the effects of an anaesthetic or was in any way related to the anaesthetic (in any event a death within 24 hours should normally be referred).
- The death may be related to a medical procedure or treatment whether invasive or not.
- The death may be due to lack of care.
- There are any unusual circumstances or disturbing features to the case.
- The death occurs within 24 hours of admission to hospital (unless the admission was purely for terminal care).
- It is wise to report any death where there is an allegation of medical mismanagement.

The Coroner is obliged by law to hold an inquest where initial enquiries give reasonable cause to expect that the death was linked to one of the above. The purpose of the inquest is to determine who the deceased was, when / where / how the deceased came by their death and in what circumstances. The inquest is not concerned with matters of civil or criminal liability.

4.3. Request for Statements

Once a decision has been taken to hold an inquest on the death of a patient under the care of the Trust, the Coroner will write to the AD MACE to request statements. Statements will be required from all relevant clinical staff involved in the deceased person's care and treatment in the period of time prior to their death.

The AD MACE will request the statements from the relevant staff and will notify the relevant Clinical Director, Head of Directorate and Senior Managers of the impending inquest.

The time limit for completing inquests under the Rules is 3 months, although in some exceptional circumstances it may be longer. The Coroner will indicate the date by which the report or statement is required. Statements should be duly completed in accordance with this timescale and the AD MACE will manage this process and forward the statements to the Coroner.

Delays in the provision of statements can lead to criticism of both the Trust and the individual members of staff in open court. It is essential that statements are delivered promptly.

4.3.1. Statement Content

The statement should be typed on Trust headed A4 paper. It must clearly indicate to whom or which incident the statements refers, detailing names, dates of birth / death, identification including NHS number and the date of any specific incident.

The statement should clearly state your name, designation, qualifications, years of experience in the relevant clinical field and the clinical area where you are based.
The pages must be numbered and the foot of each page of the statement signed and dated.

NOTE Signed and dated statements are legal documents and may be disclosed to a patient's legal advisors.

Do not place copies of the statement in the patient's health records but always retain a personal copy of your statement for future reference. In certain circumstances advice may be sought, at this stage, from the AD MACE.

The statement should follow a chronological order and is an account of your involvement with the patient. The statement must be factual and not contain expressions of personal opinion about matters outside your field of expertise. It must not contain hostile, offensive or unnecessarily defensive comments.

The statement must be written in the first person singular, for example "I saw". It must be as accurate as possible with regards to dates, times and dosages of drugs etc. and must not be written without having had access to the patient's healthcare records.

The statement should clearly indicate what you can and cannot recollect from memory and what has been taken from the records. It should reference any relevant policies, procedures and guidelines in use at the time and attach a copy of each referenced item to the statement. Reasons should be given to explain any deviation from the policies, procedures or guidelines at the time.

If the use of abbreviations cannot be avoided, ensure that the full terminology is detailed at least once with the abbreviation following in brackets. It is permissible to use technical terms but these should be explained in lay terms wherever possible.
The statement should conclude with the phrase:
"The contents of this statement are true to the best of my knowledge"'.
Followed by your signature, name, the date, and your designation.

(Please see Appendix 2 – Guidelines for preparation of statements of evidence / reports for the court.
Appendix 3 – Medical Reports for the Coroner))

4.4. <u>Preparation for staff attending inquests.</u>

Once the Coroner is satisfied that all of the necessary information has been obtained an inquest date will be set and a request sent via the AD MACE who is required to attend to give evidence. The Coroner has the authority to call anyone as a witness if it is felt that they can provide information that will assist in establishing how the deceased came by his/her death.

It is important that witnesses confirm their intention to attend by providing confirmation to the AD MACE. If witnesses feel that they are unable to attend on the designated day they must inform the AD MACE so this can be discussed with the Coroner immediately and why attendance is unlikely. A proposal can then be made for a different member of staff to attend in their absence if this is appropriate to do so.

The Coroner may then decide to reschedule the inquest but does have the power to insist on any witness's presence notwithstanding any other commitments that they may have including illness.

Attendance at the inquest, once summoned is mandatory. Failure to attend may render any witness liable to a fine / or imprisonment, as case law confirms.
(See appendix 1 – general information).

Prior to the inquest, a briefing session will be held for any witness required to attend. The primary purpose of this is to explain the inquest process, to prepare witnesses as fully as possible for the anticipated questions that the Coroner, the family or their legal representative may ask.

You should familiarise yourself with any statement you have submitted to the Coroner's Court prior to attending. It is advisable to take your copy with you. You should also be familiar with the health care records for the deceased patient before attending the inquest. The AD MACE will also provide a copy of other evidence made available, as appropriate, and running order of witnesses.

4.5. The Inquest

The inquest is held in open court and in addition to the Coroner the following individuals may be present; usher, pathologist, family, legal representatives, press and the public.

The 'properly interested persons' will be informed of the date of the inquest by the Coroner's office and any witnesses will be asked to attend and provide evidence. The process is held in the public's interest and not on behalf of any individual.

Evidence is given under oath and all verbal evidence is recorded. The Coroner will go through the report or statement provided by the witness and ask certain questions to elaborate on any particular issue. It is therefore important that witnesses have a copy of their statement and are familiar with the contents together with any entries they may have made in the deceased health records. It is permissible to refer to these during the process.

Once the Coroner's questioning is complete, the family or their legal representative will have the opportunity to ask questions followed by the Trust's legal representative.

4.5.1. Juries

The vast majority of inquests are held by the Coroner alone; however there are a number of circumstances when a jury must be called:

- The death occurred whilst the deceased was in police custody or resulted from an injury believed to have been caused by the police officer during the execution of their duties.
- The death was caused by an accident, poisoning or disease notifiable to a government department, e.g., Health and Safety Executive.
- The death concerns public safety where there is evidence of"system neglect" or where any systematic failure contributing to the death might re-occur.
- Where the deceased was detained under the Mental Health Act (and therefore in the care of the State).
- The Coroner may also use discretion to summon a jury in cases other than those listed.

In every jury inquest, the Coroner decides matters of law and procedure and the jury decides the facts of the case and reaches a conclusion. The jury cannot blame someone for the death. If there is blame, this can only be established by other legal proceedings in either the civil or criminal court. The jury can state facts which make it clear that the death was caused by a specific failure or some sort of neglect.

4.5.2. The Conclusion (Record of Inquest)

On occasions the Coroner may adjourn the inquest to a later date if further witnesses are required, but most often the conclusion is delivered once all of the evidence has been heard. The possible verdicts include:

- **Natural causes** – where the death was caused by an underlying disease or illness.
- **Accident or misadventure** – the death was due to unintentional accident without any violation of law or criminal negligence.
- **He / she killed himself / herself** – the deceased took their own life and had intended to do so. (The standard of proof to record a conclusion of suicide will remain as the criminal standard (beyond reasonable doubt) as this has been developed by case law.
- **Unlawful killing** – the intentional taking of another person's life without legal justification or provocation.
- **Lawful killing** – certain defences, e.g., self-defence, can make a killing lawful.
- Industrial disease – death by any disease to which workers in a particular industry are prone.
- **Open** – where the Coroner is unable to decide between one and more of the other conclusions.

Alternatively, the Coroner may give a narrative conclusion which sets the facts surrounding the death in more detail and explains the reasons for the decision. If the evidence at the inquest gives rise to concern that a similar death may occur in the future, the Coroner has the power to issue a Regulation 28 report, as referred to above. . These reports are issued where the Coroner feels that action should be taken to reduce the risks of future deaths. Such letters may be received by the Trust where, for example, it appears to the Coroner that policies or procedures have not been followed or need review and amendment.

4.6. The Media

Members of the press may be present at the inquest. If any staff are approached by members of the media for any comment regarding the inquest, they should refer any such request to the AD MACE.

5. IMPLEMENTATION AND MONITORING

The AD MACE will monitor the compliance with and effectiveness of this policy and report to the Quality Committee where issues arising will be discussed and reviewed. Comprehensive feedback is required to ensure that any necessary learning requirements and service changes are addressed promptly.

Providing training to large numbers of staff is not appropriate as exceptionally few are likely to be called upon to give evidence in Coroner's Court.

Support and guidance will be given directly to any individual staff members or groups who are required to give evidence.

The policy will be reviewed every three years.

6. REFERENCES / BIBLIOGRAPHY

Reference has been made to the following documents in the review of this policy:

- The Coroners and Justice Act (2009)
- Coroner reforms – Regulations 2013

Guidance Documents:

- Ministry of Justice (2010) – A Guide to Coroners and Inquests
- A Guide to Coroner Services for Bereaved People (Coroners@justice.gov.uk)
- HM Coroner for Stoke on Trent and North Staffordshire – Guidance Notes: frequently asked questions about the Coroner's Service

7. ASSOCIATED POLICY AND PROCEDURAL DOCUMENTATION

Trust Information Policy 7.06 – Media
Serious Incident Policy 5.32

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Appendix 1

The Coroner's Court – general information

It is essential that staff are punctual, dressed appropriately, but not in uniform. Adequate time should be allowed for staff to return to home / base to change out of, and back into, uniform. On arrival the individual must inform the Coroner's Officer that they have arrived. While waiting to give evidence, staff may have to share a communal waiting room with relatives of the deceased and members of the 'Press'. This policy should be read in conjunction with the NHS Management Executive Guidance for Staff on Relations with the Public and the Media. If the persons concerned have no previous experience in giving evidence it is necessary to say so in order that the Officer can inform the Coroner so that the human elements of trust and understanding can be displayed.

It is necessary for the individual to state if they do not wish to use the normal oath, which is, "I swear by Almighty God, that the evidence I shall give shall be the truth and nothing but the truth". The Coroner's Officer directs the staff to the courtroom and explains the position of the courtroom and where to sit.

As the Coroner enters the courtroom, all those present stand as instructed by the officer.

As the Coroner opens the proceedings, the persons in the Courtroom remain silent as speech is prohibited. The use of mobile phones is also prohibited and phones must be switched off. The Coroner asks the various witnesses to come forward. The individual enters the witness box and takes the oath.

The questions that are posed should be answered in a direct manner. If an answer is not known then this must be stated. If the question is not understood, clarification should be sought from the Coroner. It is normal practice fro the whole of the proceedings to be recorded.

The Coroner goes through the individual's evidence first, which is normally straightforward, and they may refer to their written statement and health records.

The relatives or their advocates are then given the opportunity to question the witness. The Coroner will not allow improper questions or harassment of the individual as a witness, and will interrupt and advise as necessary.

An adjournment may be called if any unexpected allegation is made. On such an occasion the AD MACE will be asked for advice and may represent the Trust at subsequent reconvening of the inquest.

An opportunity is given to seek clarification of any points raised.

The Coroner then sums up the evidence, gives his conclusion and closes the inquest and the court then rises as the Coroner leaves the Courtroom.

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Appendix 2

Guidelines for the Preparation of Statements of Evidence/Reports for the Court

Introductory Paragraph

Provides details of the health professional, which sets out the credibility of the individual practitioner and their ability to express a professional opinion. (Must include: name, work address (***under no circumstances should staff give their home address)***, qualifications, employer and the length of employment in that capacity).

Family Composition

Provide a list or genogram identifying the subject/s of the statement, family members and significant others. (List the composition as known at the time of your involvement).

Main Body

The opening paragraph should include details of when the service first became involved. If this information is taken from records i.e. is not the author's information, this paragraph may contain a précis of the historical involvement of the service. The author then needs to detail when he/she first became involved with the family and in what capacity.

Chronology

The chronology should contain a list of factual recorded events; type of contact (Home, clinic, telephone, opportunistic or planned); the reason for contact; and the outcome. The chronology may be used to signpost supporting information/documentation to be submitted and read in conjunction with the statement e.g. Care plans and risk assessments.

Summary

The summary should include the author's observations e.g., professional relationship, home environment, family relationships.

The summary also gives the opportunity to express a professional opinion which must always be supported by facts in the statement.

Overview Report

Increasingly the Coroner is requesting a report from the Trust that gives an overview of the circumstances of the death. This will normally be completed by the Consultant for the area. The report should outline details as in the introductory paragraph of the statement above. The author should then state whether he/she has seen the deceased or is reporting only from records. The report should outline the chronology of the Trust's involvement in the case and any issues surrounding the death.

N.B. Please bear in mind that statements and reports are likely to be shared with relatives. It is good practice to offer to meet with relatives or other interested parties prior to the inquest to address any concerns and ensure that no information disclosed during the inquest comes as a surprise to the family/interested parties.

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Appendix 3

Medical Reports for HM Coroner

1. The report should identify the Doctor's full name, title (Professor, Dr., Mr., Mrs., etc.), qualifications and length of post qualification experience.
2. Technically a Coroner cannot insist upon a Doctor preparing a report and the Coroner only has the power to order a medical witness to attend an inquest. You will appreciate that the Coroner may have difficulty in working out from medical records who the relevant witnesses are and how they may be able to help the Coroner with his enquiry. It is hoped however that Doctors will continue to co-operate with the Coroner's service.
3. It would be much appreciated if reports could be completed within 4-6 weeks of the request being received by the Doctor. In the case of reports from Hospital, Doctors requests come via the AD MACE who will also collect the notes for the Doctor, and these reports should be returned to AD MACE for onward transmission to the Coroner.
4. It is often difficult to discern from reports whether the Doctor is writing from first hand experience of a case or simply interpreting notes. Part of the purpose of requesting a report is to identify which witnesses should attend the inquest, and to work out what they saw, did etc. It would be helpful if the Doctor bore this in mind when writing a report. If the Doctor feels that information should be sought elsewhere to assist the Coroner it would be helpful if the Doctor could liaise with the AD MACE.
5. The purpose of an inquest is to ascertain 'How' the deceased came by his death, not to enquire into issues of alleged clinical negligence or attribute blame. Doctors should bear in mind however that reports are frequently disclosed to families and sometimes solicitors, and not everyone has the same agenda as the Coroner.
6. It does not automatically follow that if a report is sent to the Coroner that the Doctor will be asked to attend the inquest and give evidence. Often reports are read out to the court though this will still form part of the evidence before the court.
7. The Coroner does not set the fees structure. This is set by the Department of Constitutional Affairs (for attendance at inquest) and the JNCC (for reports).

Document level: Trustwide
Code: 5.32
Issue number: 1

Patient Safety Incident Response Framework Policy

Lead executive	Chief Medical Officer
Authors details	Head of Patient and Organisational Safety

Type of document	Policy
Target audience	All trust staff
Document purpose	Information and guidance

Approving meeting	Quality Committee	Meeting date	4th April 2024
Implementation date	4th April 2024	Review date	30th April 2027

Trust documents to be read in conjunction with	
4.40	Being Open Duty of Candour
4.26	Listening and Responding PALS and Complaints Policy

Document change history		Version	Date
What is different?	Replacing policies 5.32 Serious incident policy update		
Appendices / electronic forms			
What is the impact of change?			

Training requirements	

Document consultation	
Directorates	
Corporate services	
External agencies	

Financial resource implications	Nil

Sustainability	1. Reduce the environmental impact of health and social care in Staffordshire and Stoke on Trent ☐ 2. Build a network of climate and sustainability champions across Staffordshire and Stoke on Trent ☒ 3. Share learning and best practice ☒

External references
1. NHS England » Patient Safety Incident Response Framework 2. NHS England » Patient Safety Incident Response Framework and supporting guidance 3. https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-1.-PSIRF-v1-FINAL.pdf 4. https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-2.-Engaging-and-involving...-v1-FINAL.pdf 5. https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-3.-Guide-to-responding-proportionately-to-patient-safety-incidents-v1.1.pdf 6. https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-4.-Oversight-roles-and-responsibilities-specification-v1-FINAL.pdf 7. https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-5.-Patient-Safety-Incident-Response-standards-v1-FINAL.pdf 8. https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-6.-PSIRF-Prep-Guide-v1-FINAL.pdf

Monitoring compliance with the processes outlined within this document	Annual review of policy, review via CSIG committee for assurance and compliance

Equality Impact Assessment (EIA) - Initial assessment	**Yes/No**	**Less favourable / More favourable / Mixed impact**
Does this document affect one or more group(s) less or more favourably than another (see list)?		
– **Age** (e.g., consider impact on younger people/ older people)	No	
– **Disability** (remember to consider physical, mental and sensory impairments)	No	
– **Sex/Gender** (any M/F gender impact; also consider impact on those responsible for childcare)	No	
– **Gender identity and gender reassignment** (i.e., impact on people who identify as trans, non-binary or gender fluid)	No	

– **Race / ethnicity / ethnic communities / cultural groups** (include those with foreign language needs, including European countries, Roma/travelling communities)	No	
– **Pregnancy and maternity, including adoption** (i.e., impact during pregnancy and the 12 months after; including for both heterosexual and same sex couples)	No	
– **Sexual Orientation** (impact on people who identify as lesbian, gay or bi – whether stated as 'out' or not)	No	
– **Marriage and/or Civil Partnership** (including heterosexual and same sex marriage)	No	
– **Religion and/or Belief** (includes those with religion and /or belief and those with none)	No	
– **Other equality groups?** (may include groups like those living in poverty, sex workers, asylum seekers, people with substance misuse issues, prison and (ex) offending population, Roma/travelling communities, and any other groups who may be disadvantaged in some way, who may or may not be part of the groups above equality groups)		
If you answered yes to any of the above, please provide details below, including evidence supporting differential experience or impact.		
Enter details here if applicable		
If you have identified potential negative impact: - Can this impact be avoided? - What alternatives are there to achieving the document without the impact? Can the impact be reduced by taking different action?		
Enter details here if applicable		
Do any differences identified above amount to discrimination and the potential for adverse impact in this policy?	No	
If YES, could it still be justifiable e.g., on grounds of promoting equality of opportunity for one group? Or any other reason	Yes / No	
Enter details here if applicable		
Does this document affect one or more group(s) less or more favourably than another (see list)?		
Where an adverse, negative or potentially discriminatory impact on one or more equality groups has been identified above, a full EIA should be undertaken. Please refer this to the Diversity and Inclusion Lead, together with any suggestions as to the action required to avoid or reduce this impact. For advice in relation to any aspect of completing the EIA assessment, please contact the Diversity and Inclusion Lead at Diversity@northstaffs.nhs.uk		
Was a full impact assessment required?	Yes / No	
What is the level of impact?	Low / medium / high	

Training Needs Analysis for the policy for the development and management of Trust wide procedural / approved documents

Please tick as appropriate

There **are no** specific training requirements- awareness for relevant staff required, disseminated via appropriate channels (Do not continue to complete this form-no formal training needs analysis required)	✓
There **are** specific training requirements for staff groups (Please complete the remainder of the form-formal training needs analysis required-link with learning and development department.	

Staff Group	**✓ if appropriate**	**Frequency**	**Suggested Delivery Method (traditional/ face to face / e-learning/handout)**	**Is this included in Trust wide learning programme for this staff group (✓ if yes)**
Career Grade Doctor	✓			
Training Grade Doctor	✓			
Locum medical staff	✓			
Inpatient Registered Nurse	✓			
Inpatient Non-registered Nurse	✓			
Community Registered Nurse	✓			
Community Non-Registered Nurse / Care Assistant	✓			
Psychologist / Pharmacist	✓			
Therapist	✓			
Clinical bank staff regular worker	✓			
Clinical bank staff infrequent worker	✓			
Non-clinical patient contact	✓			
Non-clinical non patient contact	✓			

Please give any additional information impacting on identified staff group training needs (if applicable)

Please give the source that has informed the training requirement outlined within the policy i.e., National Confidential Inquiry/NICE guidance etc.

Any other additional information

Completed by	Craig Stone	Date	03/05/2023

Contents

Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out **North Staffordshire Combined Healthcare Trusts** approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Application of a range of system-based approaches to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents and safety issues
- Supportive oversight focused on strengthening response system functioning and improvement.

Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across each service within the portfolio of services **by North Staffordshire Combined Healthcare Trust**

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error,' are stated as the cause of an incident.

There are response types that are outside of the PSRIF remit such as complaints, human resources investigations, professional standards investigations, coronial inquests, criminal investigations, claims management, financial investigations and audits, safeguarding concerns, information governance concerns, and estates and facilities issues however these will be managed via other trust processes.

There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

Our patient safety culture

Meaningful learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. PSIRF supports the trusts patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents.

It is important that our approach just culture is being able to explain the approach that will be taken if an incident occurs in a way that support understanding the identification of lessons that are learnt as a result of a patient safety incident occurring and not apportioning blame when an incident does occur, adhering to this policy it will help staff, patients and families understand how the appropriate response to a member of staff involved in an incident can and should differ according to the circumstances in which an error was made. As well as protecting staff from unfair targeting, using the guide helps protect patients by removing the tendency to treat wider patient safety issues as individual issues.

Those affected include staff and families in the broadest sense; that is: the person or patient (the individual) to whom the incident occurred, their family and close relations. Family and close relations may include parents, partners, siblings, children, guardians, carers, and others who have a direct and close relationship with the individual to whom the incident occurred. This policy uses the term ‘engagement lead’ to refer to anyone who leads on engaging with and involving those affected by a patient safety incident. These engagement leads have been identified as Quality Improvement Lead Nurses (QILN) or Service Managers as the role is required to be of a senior staff member (Band 8a or above) in accordance with national guidance.

The key components for fostering the right culture are identified as follows:

Leadership – Managers and/or leaders should demonstrate their commitment to compassionate engagement and involvement in their words and actions. Engagement and involvement must be communicated as a genuine priority and not a formality. For example, investment should be made in developing expertise in patient, family and staff support, engagement and involvement (e.g., through providing dedicated time and training for those undertaking and/or developing specific liaison roles across the organisation or system as required).

Training and competencies – PSIRF sets specific expectations regarding the training and competencies required for engaging and involving those affected by patient safety incidents. Engagement leads must attend a minimum of six hours of training in ‘Involving those affected by patient safety incidents in the learning process

Support systems – Families and staff may need to be signposted to support at any point during engagement or involvement in a learning response. We need to assure that there is equity in the support offered to families and staff, and that systems exist for internal and external support so that those affected can access support in the way they prefer wherever

possible. Sources of support for families may include bereavement and mental health services as well as via independent advocacy services.

Support for staff following patient safety incidents also needs to be factored into an overall response and this can include mental health first aid, CISM, staff counselling and well-being.

Ensuring inclusivity – Engagement with those affected and their involvement in patient safety reviews must take account of individual needs, the individual affected is the best person to advice on what their needs are, and they should be acted on where appropriate

Information resources – Those affected by a patient safety incident must have clear information about the purpose of a learning response, and what to expect from the process. The following will also be made available as to what the expectations are for NSCHT.

• Reviewer guidance: supports patient care reviews to involve patients, families, and staff in learning responses

• Patient and family information booklet informs the patient and their family about how to get involved in learning response.

• Staff information booklet informs staff about how to get involved in learning response.

• Patient safety incident response record supports and prompts investigators to undertake specific involvement activity in individual investigations.

Processes for seeking and acting on feedback – As an organisation NSCHT will maintain a curiosity about the effectiveness of how we conduct our business and patient safety is no difference. In addition, the feedback received from patient safety incident responses will be collated with that from other teams for instance Patient Experience Team (PET), to drive further improvement.

Processes for managing dissatisfaction – Where the mutually agreed expectations have not been met in relation to patient safety, families and staff must be given meaningful, open and honest as well as clear explanations into why this was not achieved.

Patient safety partners (PSPs)

The patient safety partners at North Staffordshire Combined Healthcare Trust are a key component of our patient safety team and are involved in our approach to managing and improving our patient safety outcomes and profile.

Our intention is to use them as subject matter experts as well as that direct link with our patients, service users and families by getting them visible on the inpatients ward areas as well as scoping out the need for this level of intervention in our community services, this will be an ongoing item of work during 2023/24.

With the support of PSP we will start to understand our incident profile from a differing perspective and a different lens this will help us to review the incidents in further detail and offer a differing viewpoint to help challenge the current position as well as support ongoing learning from incidents as well as reporting these back in a manner that is conducive for patients as well as their families.

The profile of PSPs will be one that continues to grow and there will be an increased visibility within our meeting and governance structures, with this growth we will also introduce these PSPs into oversight groups/committees to support feedback to a senior level of the work being completed and/or planned.

Addressing health inequalities

The Trust recognises that the NHS has a core role to play in reducing inequalities in health by improving access to services and tailoring those services around the needs of the local population in an inclusive way.

The Trust as a public authority is committed to delivering on its statutory obligations under the Equality Act (2010) and will use data intelligently to assess for any disproportionate patient safety risk to patients from across the range of protected characteristics.

Health inequalities are evident within society and our challenges at NSCHT, using PSIRF and how we are able to utilise the data we do collect from reported incidents we are able to utilise an inquisitive approach to help review the data to establish and understand the profile of our patient groups and to highlight any evident inequalities that may occur such as health status, access to services, wider determinants of health and their own demographic details/protected characteristics i.e. ethnic background, sex, sexual orientation and disability.

The way these factors combine and interact with each other also influences the health inequalities people experience, by being inquisitive within our patient review forms this allows some of that detail to be reviewed within systems engineering initiative for patient safety (SEIPS) and other human factors and these can be reviewed and added to the overall incident to provide further detailed review of the patients in a holistic way. If there were any lessons learnt from these, they can be detailed in the patient review response and safety actions added and completed.

These outcomes will form the basis of our learning and we will share this information with those that have been involved in the construction of the patient safety review, where there is wider systemic learning then these would be shared via the learning lessons platforms to share these findings across the organisation to help improve any inequalities for others that use our service to improve their own health and well-being.

Engaging and involving patients, families and staff following a patient safety incident

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required. It is the role of the patient safety incident investigation (PSII) oversight and learning lead to be the lead point of contact for patients, families and staff.

At the onset of all patient safety reviews, the patients, families and staff will be invited to take part of the process of reviewing the incident. This will be via letter in the first instance offering details of the reviewer and invite to contact them to agree or not to participate within the patient safety review.

Where there is acceptance to this every effort will be made to meet the identified person/s in a manner that is agreeable and safe for them which can be in person, by virtual platforms or via telephone contact.

The contact will be ongoing and completed as agreed at the outset introductory meeting however there is an expectation of frequency during the patient safety review process as directed below.

Patient Safety Incident Response	**Contact at which point**
Rapid review / Swarm Huddle / MDT review / After action Review (AAR)	Upon initiation of review to offer an understanding of the incident their family member had been involved in

Patient Safety Review (PSR) / Comprehensive Safety Review (CSR) / Falls PSR	When review is commissioned the identified family member will be written to inviting them to be a part of the review process
Patient Safety Incident Investigation (PSII) / Thematic review / Independent review	When review is commissioned the identified family member will be written to inviting them to be a part of the review process

At all points the staff involved will continue to review the incident in relation to the being open policy and where the threshold is met for Duty of Candour (DoC) (moderate level of harm or higher) then the reviewing person / governance group will review the information available with lessons learnt and findings to see if there has been a deficit in care and as a consequence moderate or higher harm was caused either physically or psychologically. If duty of candour applies, then the policy will be followed in relation to how we respond to patients and family members in offering that compassionate and meaningful apology for the deficit received in their care. It is important to recognise that patients, relatives and/or carers can be adversely affected by a serious incident. They may have questions about what has happened and should have access to appropriate support and information, such as discussion/explanation and should be supported by the most appropriate senior person.

It is important that the following policy is reviewed should the duty of candour be identified as applicable, and the policy followed as directed.

4.40-Being-Open-Policy-Inc-Duty-of-Candour.pdf (combined.nhs.uk)

In addition, we have a Patient advice and liaison service (PALS) (patientexperienceteam@combined.nhs.uk). People with a concern, comment, complaint or compliment about care or any aspect of the Trust services are encouraged to speak with a member of the care team. Should the care team be unable to resolve the concern then PALS can provide support and advice to patients, families, carers, and friends. PALS is a free and confidential service and the PALS team act independently of clinical teams when managing patient and family concerns. The PALS service will liaise with staff, managers and, where appropriate, with other relevant organisations to negotiate immediate and prompt solutions

PALS can help and support with the following:

• Advice and information

• Comments and suggestions

• Compliments and thanks

• Informal complaints

• Advice about how to make a formal complaint

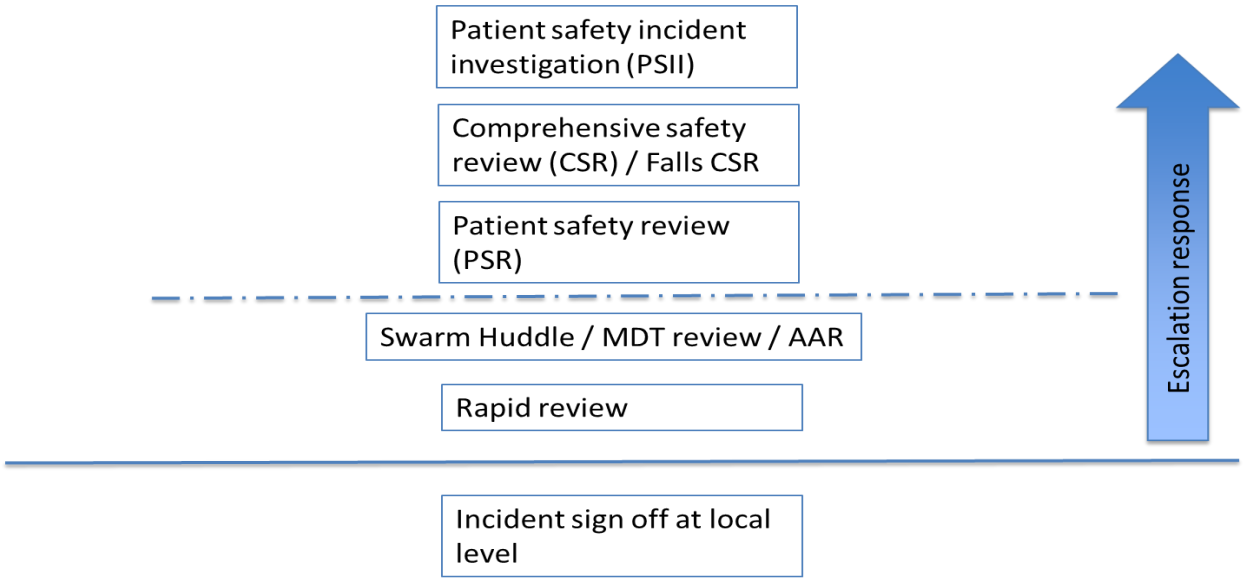
If the PALS team is unable to answer the questions raised, the team will provide advice in terms of how to obtain the response that the person raising the concern/complaint is seeking.

Patient safety incident response planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements by NHS England, CQC, Ofsted organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

We will engage with our external auditors / governing bodies to engage them with our approach and to highlight how we review incidents, learn from them as they occur and to provide feedback to all and openly engage with those affected.

At North Staffordshire Combined Healthcare Trust, we have adopted and escalation approach to our proportionate approach to managing patient safety reviews starting from Ulysses incident sign off and escalating as below:



All patient safety reviews commence from the incident form sign off by the designated ward / team management, the sign off will be enhanced to review areas against SEIPS methodology as well as human factors.

If there is an area of concern, then a rapid review would be required to review the incident in more detail to help understand the learning opportunities. Where there has been a death of a patient that falls within our criteria for review then the rapid review

would need to be completed within 72 hours so that we can have an immediate understanding of the incident and establish early learning if identified.

Where there is a parallel report being completed for instance a PSII for in-patient death, domestic homicide review or never event then this will take precedent and an initial review will be completed via rapid review to establish early learning lessons awaiting an outcome of the enhanced review process.

If following the designated proportionate patient review (Rapid review, swarm huddle, MDT review or after-action review) there is any further need to review the incident in more depth to enhance the learning then the next level of review can be commissioned i.e., proportionate review →(next level) → patient safety review → comprehensive safety review → PSII

Resources and training to support patient safety incident response

Our patient safety incident response plan

Our plan sets out how **North Staffordshire Combined Healthcare Trust** intends to respond to patient safety incidents over a period of 12 to 24 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

We will triangulate all data that we do have available from incidents reports, patient safety reviews, complaints to help understand our presenting profile which in turn will support the understanding of what response is required, this can be with local teams and providers to external partners or stakeholders to provide that support and assurance for that wider collaborative approach. Where there are any gaps or trends that require attention then a consideration is made to involve the use of current/existing quality improvement (QI) methodology to support sustainable and continued change.

With this local data being understood via inquisitive enquiry then this can be measured against regional or national data to see if this is a local issue that requires a bespoke approach or if we are being affected by wider national issues and pressures and need to work in that way to support our local response. The main source of this data will be from learning from patient safety events (LFPSE) as well as the national confidential inquiry into suicide and safety in mental health (NCISH), reports are annually produced for these to allow the profile to be reviewed at board level for oversight, awareness and assurance.

Training

The Trust has implemented a patient safety training package available on LMS to ensure that all staff are aware of their responsibilities in reporting and responding to patient safety incidents and to comply with the NHS England Health Education England Patient Safety Training Syllabus as follows:

- Essentials to patient safety for all staff
- Essentials of patient safety for boards and senior leadership team

In addition to this there are additional training to enhance further learning:

- Access to practice – systems thinking and risk expertise
- Access to practice – human factors and safety culture

For those with oversight and learning lead roles will complete the required training elements that are mandated to complete this role.

Reviewing our patient safety incident response policy and plan

Our patient safety incident response plan is a ‘living document’ that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 months.

Updated plans will be published on our website, replacing the previous version.

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our integrated care board {ICB}) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example PSII reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement

Responding to patient safety incidents

Patient safety incident reporting arrangements

The management of incidents forms via the Ulysses incident management system is part of the risk management framework for North Staffordshire Combined Healthcare NHS Trust (hereafter known as the Trust).

The Trust recognises that incident reporting is essential for developing a robust pro-active safety culture and aims to maintain an open and fair process. It is committed to ensuring that incident being reporting is encouraged, that incidents are investigated in a consistent way and that lessons learnt are shared within the organisation to reduce the likelihood of similar incidents occurring.

This guidance sets out a framework for identifying and minimising risks, for the protection of patients, staff, visitors, contractors, services and the Trust. This policy provides guidance to all staff in respect of managing incidents and near misses which may occur within the Trust. The Trust acknowledges the vital importance of robust systems and processes for ensuring that the underlying causes of any incident are not simply attributed to the actions of those individuals involved. They must also ensure effective and systematic exploration of all factors which may have potentially contributed to the root causes of the incident, such as the policies, systems, processes and culture that those individuals were working within at the time of the event itself.

To support the staff in the identification, reporting and minimizing of risk the Trust will ensure that there is a programme of education and awareness in relation to risk management and incident reporting.

Where the incident is reported as a patient safety incident (PSI) with the definition of Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare, the Ulysses reporting form will allow exploration of this via additional elements with additional taxonomy to help understand the incident profile based upon national datasets. These will be automatically sent to the learning from patient safety experience platform (LFPSE). Where the incidents do not meet this threshold then they will be kept within Ulysses and not sent out to LFPSE. All data is available for review locally.

The requirement by the ward / team management is that the completed incident forms on Ulysses are reviewed and appropriately signed off within 7 days of submission so that safety concerns can be identified, allows a timely response to reviewing the incident that has occurred, engage with those affected to understand what we can learn. If this deadline is breached then the POST team will be seeking assurance that the breached incidents are updated and reviewed, failure to adhere to the 7-day deadline will result in the directorate senior management team being informed to help resolve any barriers to this. By delaying the learning opportunity review will lead to possible increased risk of reoccurrence and increased harm to patients, family and staff

Where there has been an identified concern raised with system issues then these would be raised with the PSIRF lead for the respective organization for discussion and review. If there is no resolution at this stage, then the local ICB would be contacted to help support and facilitate the discussion required to review the patient safety incident.

IPC

Where there has been a patient safety incident in relation to an infection and prevention control measure then the review process would be a twofold approach, where there is established reviews such as outbreak meetings then these would be used to monitor and review the situation, however if the incident relates to a matter outside of this regular review process then at least an after action review would be completed to ascertain findings of the incident as the proportionate response to the incident occurrence.

Governance

The Clinical Safety Improvement Group has a standing agenda item for open serious incidents and will be updated by the Directorate Service Manager or representative of the Service Manager at each meeting and will reflect actions arising from the meeting via the meeting action monitoring schedule.

Minutes of the Clinical Safety Improvement Group will be available to the Quality Committee and will be submitted in a summary report to the committee**.** Minutes of the Quality committee meeting will be included in the monthly Trust Board meeting.

Senior managers will receive weekly synopses of all open SI’s with progress statement update each week.

Directorate Service Managers will be responsible for tracking progress implementation and impact upon practice of action plans and will provide a monthly update on action plan progress to CSIG as a standing agenda item. Once completed the Service Manager is responsible for forwarding the completed action plan to the Patient and Organisational Safety Team for uploading onto the Trust care review database.

Action plans arising from investigations will be agreed and written by the Directorate Service Manager and the relevant team leader/ward manager and agreed at Directorate level prior to submission with the SI report. Each action plan will have an identified person who is responsible for delivering the action.

The Directorate Service manager will be responsible for updating CSIG on the progress of completed action plans at intervals of 6 months and 12 months. This update will detail changes in practice and provide assurance as to the changes being embedded into practice.

Sign off process

The process for appropriate sign off that is agreed within the required timescales (See table Timeframes for learning responses), however the following will be used as the approved standard for approval of patient safety reviews

Approver	Reviews in scope	Remit	Timeframe for completion
QILN	Rapid review / Swarm huddle / MDT review / After action review	Check for factual accuracy, spelling and grammar is correct, all aspects completed as required to support accurate review of patient care	30 days
Clinical Director	PSR / CSR where there has not been a death related to the incident	To review the care offered and provide feedback and seek assurance of care delivery in preparation for chief medical officer review.	60 days
Chief Medical Officer	All sent requiring chief medical officer approval due to proportionate review completed as a result of a death	To review report into incident and seek assurance of learning from incident and to confirm/challenge the details in relation to service delivery and identified treatment offered.	60 days

For all commissioned PSR / CSR there will be a meeting called at the 30-day mark

to review the report completed so far and will include the following people:

- Care reviewer
- Ward/team manager
- QILN
- Associate director (or authorised deputy)
- Head of patient safety (or authorised deputy)
- Service manager

At this review stage the QILN overseeing the care review will co-ordinate and chair this meeting. The care review will look at all aspects of care and at the end of the meeting an agreement will be made on whether the review is appropriate for next level approval by the associate director. If this is not the case, then at this point an extension would have to be formally requested to allow time for due diligence to occur for remaining review processes. An extension may not always be granted but will be reviewed on a case-by-case basis.

Associate directors will then have up to 15 days to review the report, provide feedback/support/challenge to the review, and obtain feedback from the reviewer. In this also is the need to obtain QILN approval prior to re-submission to the associate director. Once the associate director has approved the review it is then sent on to the chief medical officer for final validation.

At this stage, the chief medical officer has a further 15 days to review the report, provide feedback/support/challenge to the review, and obtain feedback from the directorate. If further responses are required then this must also be completed as above within this period, however at this point the chief medical officer can mandate an extension based upon their findings from the report if this is required to support additional learning. An extension may not always be granted but will be reviewed on a case-by-case basis.

Patient safety incident response decision-making

The decision-making process for patient safety incidents can be complex but with the guidance from PSIRF it has allowed organisations to become more responsive a respond in a proportionate manner to allow the exploration of learning around the incident rather than focusing on the causation of the incident. With this the below will identify a method of use to follow when we are starting to review our patient safety incidents. In addition, we can focus on using data intelligently to allow the identification of themes and trends and allow us to respond appropriately to manage the presenting risks and reduce the likelihood by sharing lessons learnt from these clustering of incidents.

Emergent themes and trends

Within the patient and organisational safety team we will utilise the data collection from the incident management system Ulysses to help identify themes and trends of incidents occurring across the trust, with the intelligent ways of monitoring this data it allows us increased visibility of data such as time of occurrence, areas of occurrence, identified patients, incident profile/cause and then associated harm. Not all incidents will require extended inquisitive enquiry and will be managed at local team/ward level by the respective management team, however where there are discernible trends notified during the incident sign off process or by the oversight group being the incident review group then we can request a specific review into patient safety incidents based upon levels of concern with emerging trends, the lowest element of review would be a rapid review into these incidents to understand the profile and learning, this can continue to escalate to other learning responses dependent upon the level of concern raised or found as a result of the rapid review.

Appropriate response framework

The below table is constructed to act as a guide to the required level of patient safety proportionate response required, with all frameworks it will act a as a guide to support the appropriate decision making in relation to what response is required for which incidents. The response is not linear and if due to review and further enquiry a further details review is required, or the risk has increased because of the review then the next level of reviews can be completed.

Activity / Learning Response	Description	Impact score threshold for activity	Examples However not an exhaustive list, please contact POST / PSII oversight lead for support if required
Ulysses incident form completion	Standard response to all identified patient safety incidents	Identification of patient safety incident	Any patient safety incident regardless of impact
Rapid review	This is completed on incidents where there was a deviation from the perceived normal outcome requiring review into circumstance to identify concern and mitigation for this episode of care. This would be completed as a precursor to any death of patient in receipt of service (last 6 months) to determine further patient review response. To be completed if request is received from an external reviewer in relation to a current PSII, if further learning response is required then this can be agreed upon to illicit the correct response.	Patient safety incident that meets threshold of minor impact	Medication errors, self-harm, violence and aggression, post notification of a death to be completed for initial review and findings (within 72 hours)
MDT review / After Action Review (AAR)	These should be completed where there has been a deviation from the perceived normal outcome requiring further review due to the impact of the incident to patient care. These reviews are to be completed alongside CSIM or formal debriefs if there has been psychological trauma identified from the incident as to not adversely affect staffs wellbeing. If concern please review appropriateness with PSII oversight lead	Patient safety incident that meets the threshold of minor / moderate impact	MDT review / AAR - Falls, medication error leading to harm caused, self-harm leading to treatment required, patient on patient incidents
Patient Safety Review (PSR)	This is completed on incidents where there has been a deviation from the perceived normal outcome where we need to explore potential implications of care delivery in care that require a detailed review to understand the circumstances that lead to the event	Patient safety incident that meets the threshold of minor / moderate impact and there is a potential deficit in care identified	Falls leading to a fracture of a minor bone, harm caused direct from episode of care, harm caused requiring external acute hospital treatment, breach of mental health act framework
Comprehensive Safety Review (CSR)	This is completed on incidents where there has been a deviation from the perceived normal outcome where we need to explore potential implications of care delivery that require an in depth review to understand the circumstances that lead to the event	Patient safety incident that meets the threshold of moderate / severe / catastrophic impact and there is a potential deficit in care identified	Injury requiring hospitalisation / complex treatment, death, falls leading to a fracture of a major bone, safeguarding concern as a result of care received

Patient Safety Incident Investigation (PSII	This is completed when an incident or near-miss indicates significant patient safety risks and potential for new learning	Patient safety incident that meets the threshold of severe / catastrophic impact and there is an identified deficit in care identified	Deaths related to care delivery received, death of an inpatient detained upon the mental health act, never events

NB - It is important to distinguish that the approaches taken can be used in an escalating manner to, so incident forms will always be completed however the proportionate response will be directed by local understanding of the incident and the proportionate response can be selected from the menu available. If there is any concern, please refer to the policy for further direction or contact a member of the POST team for additional support / guidance. All examples are not exhaustive and clinical judgement is required in formulating the appropriate proportionate response in managing the identified patient safety incident

Additional incidents that are recorded but out of scope for PSIRF

Children and Vulnerable Adults Safeguarding Incidents

Incident Reporting and Children: All incidents that occur within the Trust's premises which involve children must be entered onto the trust incident reporting system. Consideration must always be given as to if a child protection referral is required, (this must be completed within 24 hrs). If the incident involves a member of staff who has harmed a child or acted in a way which would deem them to be unsuitable to work with children, then this must **ALWAYS** be reported via the safeguarding team in conjunction with internal management procedures.

Incident Reporting and Vulnerable adults: All incidents should be considered in relation to safeguarding, when the incident involves a vulnerable adult then this should be identified by entering onto the trust incident reporting system and ticking the vulnerable adult box on the incident form. If "harm" has been caused to a vulnerable adult, then this will **ALWAYS** require a vulnerable adult referral. If a Vulnerable adult referral is required, then this needs to be identified by ticking the box which states "Interagency policy invoked;" completing this form will produce a vulnerable adult referral form which needs to be forwarded to the relevant local authority

All safeguarding alerts / referrals must be completed immediately and **always within 24 hours**. Relevant policies are detailed on the front page of this policy

Near Miss

A near miss is an event not causing harm but has the potential to cause injury or ill health. Near misses are as important to record and investigate as those incidents where actual harm was sustained. Near misses can highlight potential problems and allow the organisation to remedy matters before actual harm.
For the purpose of reporting, a near miss must be treated as an actual incident and reported by using the incident reporting form.

Dangerous Occurrence

A dangerous occurrence is one of several reportable adverse incidents as defined in the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

Responding to cross-system incidents/issues

There are occasions where there is a need to work across systems and these are some examples of that are work with coroner's office, medical examiners (at present we do not have these at North Staffordshire Combined Healthcare Trust, however we will have established links with medical examiners locally), incidents of patient safety will be reported by our staff and if there is any external service that may have had a direct impact upon that persons care then the expectation would be that they are invited to the review process to obtain additional support and awareness of service delivery and expected outcomes for that care delivered.

The Patient Safety team will act as the liaison point for such working and will have supportive operating procedures to ensure that this is effectively managed.

If the incident meets the threshold for a PSII then the terms of reference and scope of review would be clearly marked out for specific services involvement and again if there are any barriers to this presented from the service providers, then the local ICB representative would be contacted to help facilitate attendance and support.

Where there is a PSII commissioned where we are not the lead for this learning event, we would complete a rapid review to identify learning that we can use to illicit the next stage approach that we would like to use to enhance the learning outcome form the identified event, as this information would be shared with the lead for the external PSII review upon request.

The Trust will defer to the ICB for co-ordination where a cross-system incident is felt to be too complex to be managed as a single provider. We anticipate that the ICB will give support with identifying a suitable reviewer in such circumstances and will agree how the learning response will be led and managed, how safety actions will be developed, and how the implemented actions will be monitored for sustainable change and improvement.

Timeframes for learning responses

Activity / Learning Response	Description	Timescales for completion (*medical director sign off required)							
		24 hours	3 days	7 days	14 days	30 days	60 days	90 days	180 days
Ulysses incident form entered	Standard response to all identified patient safety incidents	✓							
Ulysses incident form signed off	Incident form to be signed off by designated manager for ward/team area			✓					
Rapid review	This is completed on incidents where there was a deviation from the perceived normal outcome requiring review into circumstance to identify concern and mitigation for this episode of care		✓ For deaths		✓				
MDT review / After Action Review (AAR)	These should be completed where there has been a deviation from the perceived normal outcome requiring further review due to the impact of the incident to patient care					✓			
Patient Safety Review (PSR)	This is completed on incidents where there has been a deviation from the perceived normal outcome where a detailed review to understand the circumstances that lead to the event.					First draft	✓*		
Comprehensive Safety Review (CSR)	This is completed on incidents where there has been a deviation from the perceived normal outcome where an in-depth review to understand the circumstances that lead to the event.					First draft	✓*		
Thematic review	This is completed on a collection of patient safety reviews where there is a concern raised over a particular element.						First draft	✓*	
Patient Safety Incident Investigation (PSII)	This is completed when an incident or near-miss indicates significant patient safety risks and potential for new learning							First draft	✓*

The above table looks at the timeframes for completion of the patient learning responses, it covers across all areas and focuses upon sign off timescales however were indicated there is a first draft timescale attached and these are for a comprehensive review at the halfway point to ensure trajectory for completion and to discuss any pertinent areas of lessons learnt and for highlighting.

A learning response must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within one to three months of their start date. No learning response should take longer than six months to complete.

Extensions can be considered based upon clinical direction/request and would be agreed upon to maintain the integrity of the review into patients care, however this would need to be done at the earliest opportunity available.

There is an expectation that within the first 72 hours of a patient safety incident occurring requiring further review beyond the Ulysses incident form sign off then a care reviewer will be assigned to complete the review and patient and organisational safety team (POST) team. If there are any concerns with adhering to this timescale, then this should be reported to the POST team and remedial actions put into place.

Once a care reviewer has been identified then a verbal update would be given to the POST team, this will be done via established weekly meetings for this to be completed.

Safety action development and monitoring improvement

All our patient safety incident reviews include the ability to record learning opportunities and outcomes of the reviews that then directly translate to meaningful actions to enhance the patient safety profile.

While safety action development may be led by one individual (e.g., a learning response lead) or team, a wider team must be engaged during development, including the local team, the quality improvement team and those with broader knowledge of ongoing improvement work related to the defined areas of improvement, or whose work may be informed by the findings from the learning response under consideration.

Quality improvement colleagues are a valuable resource for tools to develop safety actions and associated measures. Where possible, those affected by the patient safety incident should also be involved

Action plans arising from patient care reviews will be agreed and written by the Directorate Service Manager and the relevant team leader/ward manager and agreed at Directorate level prior to submission with the patient care review. Each action plan will have an identified person who is responsible for delivering the action. Directorate Service Manager will be responsible for tracking progress implementation and impact upon practice of action plans and will provide a monthly update on action plan progress to CSIG as a standing agenda item.

Once completed the Service Manager is responsible for forwarding the completed action plan to the Patient and Organisational Safety Team for uploading onto the Trust patient safety incident database.

The Directorate Service manager will be responsible for updating CSIG on the progress of completed action plans at intervals of 6 months and 12 months. This update will detail changes in practice and provide assurance as to the changes being embedded into practice.

The directorate feedback can be done via a delegated/authorised person if this person is not the service manager i.e., quality improvement lead nurse (QILN).

By early review of patient safety incidents, we can start the early understanding of incident profile and make meaningful change to patient care / treatment pathways. By utilising this approach fits alongside the trusts wider vision of utilising quality improvement to help sustain meaningful change that increases the delivery of services, this then can be made available to across the trust via the Life QI platform to allow transference of projects across teams / service lines.

The key points of safety actions are as follows:

1. Identify the measures - Consider what can be measured to increase confidence that the safety action is influencing what it was intended to
2. Prioritise and select safety measures - To prioritise your safety measures, consider the practicalities and data available to provide assurance to the action being achieved.
3. Define the measure - Once a measure has been selected, it must be clearly defined so that it is consistently recorded, reported, and understood across the organisation.

4. Safety actions should be SMART (specific, measurable, achievable, relevant, time bound).

The Clinical Safety Improvement Group (CSIG) will provide oversight of these and contribute to sharing of these learning lessons across all service lines within the trust, any areas of concern would be able to be challenged and assurance requested on reoccurring themes/trends and to understand the barriers/challenges in reducing the likelihood of occurrence.

Safety improvement plans

The Clinical Safety Improvement Group will review all open patient safety reviews monthly ensuring that any concerns or actions to be taken arising from patient's safety reviews are recorded in the group minutes and an action monitoring schedule maintained for progress and completion of actions.

Safety action plans for each safety review will be reviewed at 6 monthly and 12 monthly intervals to ensure that there is embedded learning, and these will take place during the directorate governance meetings or within service line meetings

Aggregation of numbers, themes, trends and links with complaints, PALS, claims and safeguarding reports will be monitored and analysed via the Trust quarterly Learning from Experience report which will reflect qualitative and quantitative data presented in a standard template.

The report will be facilitated by the Performance Team and be made available to the Quality Committee and Trust Board prior to submission to Commissioners. In addition, the report will be presented at the Directorate Management meetings and cascaded through directorate structures.

The Trust will ensure that there is a system in place to ensure that “lessons learned” from incidents and investigations are shared and disseminate throughout the organisation. The process will support the Trust’s efforts to reduce adverse incidents of a similar nature occurring in other areas of the organisation and externally where appropriate.

Learning following patient safety incidents is essential, not only for the ward/team that has been directly affected by the incident, but relevance to other teams and services across the Trust must be considered and shared

The Trust philosophy is to view feedback from patient care reviews and recommend actions arising out of review reports and associated actions as valuable information about the quality of the service we deliver and how we can strive to improve.

Learning from serious incidents to ensure that positive change occurs will be facilitated in the following ways:

- Operational debriefing following a patient safety incident to reflect on the incident will serve as an opportunity to consider the wellbeing of the team affected and provide an opportunity to consider current systems and ensure safe systems are completed to avoid further re-occurrence of an incident. Operational debrief should occur as soon as is practicable following the incident, ideally prior to the end of that shift. The team/service manager will be responsible for ensuring this is completed.

- Care reviewer to offer feedback to the ward/service area team to inform on the findings of the investigation, reflecting on notable practice, lessons learned, identified causative factors and any recommendations following executive director agreement for submission to commissioners.

- Ward/service area will complete an action plan in conjunction with the directorate Service Manager in response to investigation recommendations to ensure initial local ownership and improvement to ensure safe practice.

- Bi-Monthly learning lessons events where an anonymised single case study/investigate or a collection of investigations with common themes are presented to a multidisciplinary audience. This can include GPs, commissioner, UHNM and any other external parties as appropriate.

Oversight roles and responsibilities

At North Staffordshire Combined Healthcare Trust the role of oversight and learning leads will be the same person but to have these across all directorates to help enhance the clinical awareness of the challenges and successes for those specific directorates and service lines as well as spreading the resource so that there can be resilience put into our oversight structure and allow the potential for challenge cross directorates to help enhance the learning from our incidents.

The identified staff member for this oversight role and learning lead are from the senior staffing group (band 8a and above) and have the ability to have their time protected to complete the required elements of oversight of safety incident reviews as well as completing PSII, the designation or role is not specific across the organisation and the senior leadership in the directorates have nominated the key people within their areas to appropriately support this requirement within our PSIRF plan.

The staff identified will lead on the governance and collation of patient safety response reports and lead on the approval process and escalation to relevant authority for approval, in addition they will lead on trust response PSII reviews when clinically indicated that this is the required proportionate review. They will also ensure that all reviews are completed within the required timeframes and that the learning from these are reported and co-ordinated across the directorate and wider trust. Once this is achieved then the QILN would provide first level approval for the review to be submitted as per governance process.

The Trust Board has overall responsibility for governance, including safe clinical and non-clinical practice. The Board will ensure that effective management systems are in place to achieve high standards, the provision of mandatory reports to the Board including minutes of sub-committee meetings.

The Chief Executive Officer (CEO) has overall responsibility for patient safety and risk management within the Trust. The CEO will be responsible for ensuring that the Board, Chairman and Non-Executive Directors are kept informed as appropriate. The CEO will liaise with the Communications Department should media involvement arise following a Serious Incident.

The Chief Medical Officer will be responsible for final approval and ensuring that the report is comprehensive in highlighting the factors for occurrence as well as awareness of safety challenges and subsequent learning opportunities are followed. The viewpoint will be strategic and the review could support wider action across the organisation to support a reduction in likelihood of reoccurrence.

Where there is an external interest then we should actively liaise with these organisations and support them as directed through due process of the PSII process, the PSII process clearly explains to what these are for and who is the lead person for this. Local trust guidance would be to complete a rapid review and decide on next steps in relation to proportionate patient safety review.

When we are reviewing the deaths of our patients we liaise directly with the coroner's office and there is minimal contact with a medical examiner, in addition as any death of our patients under our care would result in a comprehensive safety review (CSR) then we would have minimal involvement with a medical examiner, however if there was a need to liaise with a medical examiner this would be done via the head of patient and organisational safety as well as the

medical lead for mortality to review the concerns and decide the proportionate patient review response.

Where it is required, they will also provide support for other areas if this is required to as a result of leave (planned or unexpected).
The mind-set of the oversight function is to:

1. Have improvement as the focus
2. Focus on system factors rather than individuals to blame
3. Use learning from patient safety incidents as a proactive step towards improvement
4. Collaboration – with individuals and organisations
5. Psychological safety allows learning to occur
6. Being professionally curious

The directorate clinical director will be responsible for the second level approval of incidents and they would be checking the clinical impact of the information obtained in the report and to validate and review the evidence provided in the report whilst ensuring that the learning opportunities are highlighted and appropriate recommendations in place to improve safety.

The PSII oversight lead will regularly meet with a member of the POST team to review current progress of all patient reviews, and this will be completed on a weekly basis. Where there are concerns then these will be escalated to the head of patient and organisational safety for further support and resolution. In addition the PSSI oversight lead will report progress and status of action plans at the Clinical Safety Improvement Group ensuring that a programme of audit is implemented to ensure implementation of action plans and record measurable outcomes.
This role will also be the lead named contact who would support with learning responses as well as any ongoing support that may be required above and beyond already offered during this review process.

Furthermore, it will be required that the appointed care reviewer is in receipt of the terms of reference set out for the investigation care review level and the timescales and milestones for completion.

Ensure that the appointed care reviewer is in receipt of all relevant information relating to the incident including completed incident form.
Ensure that each completed care review, (including an action plan, where required) is submitted within the identified timescale. Where reviews are forecast to exceed the agreed timescale; Service Managers will inform the Patient and Organisation Safety Team (POST) at the earliest opportunity, in order that possible extensions to the investigation time scales may be negotiated.

Where there is learning identified that there is a completed action plan to support safety and that the details of these are cascaded for learning purposes, these will be monitored within the patient safety team and added to learning lessons platform and disseminated as required via the learning lessons platform.

The care reviewer will have received the required training to help support the completion of the required patient safety proportionate review, as well as utilising a system learning approach and in accordance with the agreed Terms of Reference, levels and scope of the investigation and within the timescales set out by the Directorate Service Manager. There will be close liaison with POST as well as the PSII oversight and learning lead to ensure that the review is on timescales identified.

The service manager will ensure that any recommendations, learning points and actions are articulated to the teams that they oversee to ensure effective cascade of pertinent information

to the ward/team managers that they oversee, as well as actively collaborating with the completion of these items to ensure learning is completed and evidenced. This is also to be an agenda item to the service line meetings to allow oversight within the governance structure of the directorate.

The Ward/Team Manager will ensure that the recommendations, learning points and actions are articulated to their team, as well as actively collaborating with the completion of these items to ensure learning is completed and evidenced. This is also to be an agenda item to the service line meetings to allow oversight within the governance structure of the directorate.

All staff have a responsibility for risk management and for reporting incidents. All patient safety incidents must be reported via the electronic Trust incident reporting system Ulysses within 24 hours of the incident occurring or the identification that an incident has occurred and recorded within the electronic patient care record.

The complaints manager will liaise with the Patient and Organisational Safety Team regarding any complaint indicating requirement for a proportionate review in accordance with NPSA guidance and ensure cohesive communication to monitor trends arising from complaints and serious incidents.

Complaints and appeals

The Trust is committed to providing any service user, families or member of the public with the opportunity to make a compliment, seek advice, raise concerns or make a complaint about any of the services it provides. The Trust views all feedback, as valuable information about how its services and facilities are received and perceived.

The Trust aims to develop a culture that sees feedback and the learning from complaints as opportunities to improve and develop services. In addition, it sees the giving of accurate information about its services and other health- related matters as means of empowering service users and promoting health.

Emphasis is placed on responding to enquiries, feedback and concerns as quickly as possible through an immediate response by front-line members of staff in an open and non-defensive way. However, other processes are also available when desirable or appropriate, through PALS or the Complaints Department.

We are therefore very committed to ensuring that the complaint process is fair to all parties i.e., both complainants and staff. When dealing with complaints we aim to adhere to NHS England's organisation principles and follow the 'Good Practice Standards for NHS Complaints Handling' (Sept 2013)15 outlined by the Patients Association:

- Openness and Transparency - well publicised, accessible information and processes, and understood by all those involved in a complaint.
- Evidence based complainant led investigations and responses. This will include providing a consistent approach to the management and investigation of complaints.
- Logical and rational in our approach.
- Sympathetically respond to complaints and concerns in appropriate timeframes.
- Provide opportunities for people to offer feedback on the quality of service provided.
- Provide complainants with support and guidance throughout the complaints process.
- Provide a level of detail appropriate to the seriousness of the complaint. • Identify the causes of complaints and to take action to prevent recurrences. •

Effective and implemented learning - use 'lessons learnt' as a driver for change and improvement.

- Ensure that the care of complainants is not adversely affected as a result of making a complaint.

For full details on how to support someone through this process please use the following policy,

4.26-Listening-and-Responding-PALS-and-Complaints-Policy.pdf (combined.nhs.uk)

Board Development and Seminars – 18 Month Programme – 2024-26 V13

Suggested Calendar of Board Strategy and Development Activities

Activity	Oct *BOD*	Nov *Seminar*	Dec *Full Day BOD*	Jan *Seminar*	Feb *BOD*	Mar *Seminar*	Apr *BOD*	May *Seminar*	Jun *BOD*	Jul *Seminar*	Aug *Full Day BOD*	Sept *Seminar*	Oct *BOD*	Nov *Seminar*	Dec *Full Day BOD*	Jan *Seminar*	Feb *BOD*	Mar *Seminar*
External / Internal Facilitator	Internal	Internal	External Facilitator - **Deloitte**	Internal	**WRES and WDES - Yvonne Coghill**	Internal	External		**Kenny Laing – CQC Preparedness**	Internal	**10.30am – 12.30pm – Organisational Purpose – Liz Mellor / 1.00pm – 3pm MIAA Risk Appetite**	Internal	**Board Development Action Plan 12.30pm – 13.15pm / Volker - Trust Fire Officer 13.15pm – 15.30pm**	Internal	Internal	Internal	**Sexual Safety – Frieza Mahmood / Staff Survey – Frieza Mahmood / Nicola Griffiths BAF 26/27 risk session**	Internal
Strategic Priority	Prevention	Prevention	Growth	Access		Growth	Growth			Growth		Access		Growth	Access	Prevention		Access
Exec Lead	Kenny Laing	Liz Mellor / Dennis Okolo	Dr Buki Adeyemo	Liz Mellor		Kerry Smith	Dr Buki Adeyemo			Dr Buki Adeyemo		Ben Richards		Frieza Mahmood / Liz Mellor / Kenny Laing	Ben Richards / Liz Mellor	Dr Buki Adeyemo		Kenny Laing / Eric Gardiner / Ben Richards / Liz Mellor
Topic	Safe-guarding and Prevent – Laura Collins	Our role as a strategic partner (1 hr) PSIRF	Board Connectivity	Operational Planning and Trust Forward Plan - Laura Smith (2 hrs)		Staff Survey Results (1hr) BAF 2025/26 (Nic)	Chris Lake – Integrated Development	CANCELLED		Chris Lake – Integrated Development		CYP ADHD / CAMHS Waits (National / Local Picture) 2-3PM ONLY – AGM 3.30PM		Planning Session – Liz Mellor Frieza Mahmood – Recommendations from the People Plan (invite SLT members) -	Oliver McGowan Tier 2 Training TBC - 9.30 - 4.30	Nicola Griffiths – MOCK CQC Interviews and / or Elizabeth Mellor - Planning		Quality Improvement / Enabling Plans – Estates / Clinical / Quality / Green and Sustainability
Relation to BAF Risk	Risk 1	Risk 1	Risk 1	Risk 2, 3 & 5		Risk 3	Risk 1			Risk 1		Risk 4		Risk 1	Risk 6	Risk 2		Risk 2
Add Info																		*Review of achievements. Strategic intent and future priorities for QI across the system*

Items to carry forward:

- Health Inequalities / Health Inequalities Self-Assessment Tool – Kenny Laing
- BAF 26/27 – Nicola Griffiths
- Freedom to Speak Up Self- Assessment – Kenny Laing
- PSIRF
- Digital or Cyber Security

RAG Rating Criteria	Rating
Complete with Assurance	BLUE
On target for delivery	GREEN
Risk to delivery, plan in place	AMBER
Not deliverable by target	RED

Corporate CQC Action Plan
Well-led Inspection January 2019

VERSION CONTROL			
Version	Date	Author	Description of Change
1	30.01.19	Zoe Grant (Quality & Improvement Manager)	Draft action plan produced based on post inspection feedback to CEO
2	15.05.19	Zoe Grant (Quality & Improvement Manager)	Assurances added & shared with Associate Director of Governance for further review / update
3	05.06.19	Laurie Wrench (Associate Director of Governance)	Progress updated in preparation for review at SLT

RAG Rating Criteria	Rating
Complete with Assurance	BLUE
On target for delivery	GREEN
Risk to delivery, plan in place	AMBER
Not deliverable by target	RED

No.	Issue / Concern	Intended Outcome	Action to be taken	Due Date	Responsible officers		Assurance/ Evidence	RAG	Expected Completion Date
1	**The Trust must ensure applications made for authorisation of Deprivation of Liberty Safeguards and their outcomes are notified to the CQC. CQC Registration Regulation 18 (4).** (Older persons Inpatient core service)	CQC receive full assurance that the Trust is reporting all Deprivation of Liberty Safeguards outcomes as required.	1.1 The Mental Health Law Team manager will report all Deprivation of Liberty safeguards via the CQC designated portal at the point of an outcome being reached even if there is no outcome e.g. patient is discharged.	**Complete**	**Executive Lead** Buki Adeyemo	**Operational Lead** Sam Dawson	100% compliance with all Deprivation of Liberty applications since January 2019. The CQC are notified once of the DOLS outcomes once patients are discharged. The outcome therefore being 'no outcome.'	**G**	**COMPLETE**
2	**The trust should consider plans to eliminate the use of dormitories** (Older Persons Inpatient core service)	To eliminate shared dormitory sleeping spaces in order to improve the dignity and safety of all patients receiving in patient care.	2.1. A working group will be established to review quality standards relating to the sexual safety of patients receiving care in the inpatient wards. 2.2 An options appraisal process will be initiated to inform a longer term plan of eliminating shared dormitory spaces throughout the Trust.	**TBC**	**Executive Lead** Lorraine Hooper	**Operational Lead** 2.1 Julie Anne Murray 2.2 TBC	2.1. A sexual safety task and finish group has been commenced with key leads from inpatient services.	**A**	**TBC**
3	**The trust should consider developing the role of the non-executive directors in informing the performance review process for executives.** (Well Led action)	To maximise the opportunity of wider development considerations for executive team.	3.1 Suggestion that report on Director performance based on the BAF to go to Remuneration Committee 6 monthly	**End of Q2**	**Executive Lead** Peter Axon	**Operational Lead** Laurie Wrench	3.1 Director Performance Report reviewed by Remuneration Committee	**A** **Not yet Due**	**End of Q2** **End of Q4**
4	**The trust should review the balance of detail in the Board Assurance Framework to gain maximum effectiveness.** (Well Led action)	To ensure that the Board Assurance Framework process is concise to allow a high level overview of progress and performance.	4.1 2019/20 Board Assurance Framework to be drafted and agreed by Committee and Board with consideration of the balance of detail	**Complete**	**Executive Lead** Peter Axon	**Operational Lead** Laurie Wrench	4.1 Content of BAF condensed to focus on key strategic deliverables and agreed by Committee and Board	**B**	**Complete**

RAG Rating Criteria	Rating
Complete with Assurance	BLUE
On target for delivery	GREEN
Risk to delivery, plan in place	AMBER
Not deliverable by target	RED

5	**The trust should consider the further development of assurances around the independence of the Freedom to Speak Up Guardian team from the executive.**	To ensure that all Trust staff feel able to speak up in confidence	5.1. To Promote Chief Executive's support of 'speaking up' safely. 5.2 To Promote Non Executive Trust board members leads role in ensuring that all staff can 'speak up' safely and in confidence. 5.3 To further promote FTSU Champions role to ensure all staff have a variety of people who they can 'Speak up' to.	**Complete**	**Executive Lead** Peter Axon	**Operational Lead** Zoe Grant	5.1 CEO Blog and CEO endorsed LIA Big Conversation 5.2 Initial meeting taken place between Zoe Grant (FTSU Guardian) and Janet Dawson (Non-Executive lead) regarding roles and responsibilities. 5.3 FTSU Champions contact details with a photograph of them handed out at all Trust inductions. The same information is available on CAT. Champion walk through Harplands was carried out in April 2019 with the BAME & Inclusion champion.	**B**	**Complete**
6	**The trust should undertake further work to improve both the validity and reliability of the community safety matrix.**	To ensure that quality indicators reliably indicate when improvements are required and that teams are taking action to address the required improvements.	6.1 Clinical audit to carry out an audit of the tools validity. 6.2 Assurance to be obtained to ensure teams are addressing issues raised via the audit within individual patient's records and with the staff concerned. 6.3. Obtain assurance that results are reviewed and areas of improvement are discussed within teams.	**31st July 2019**	**Executive Lead** Maria Nelligan	**Operational Lead** Zoe Grant	6.1 A Process Mapping exercise will be completed to ensure reliability of data gathering e.g. informs data collection protocol To ensure validity, an independent audit of 10% cases will be undertaken on a quarterly basis 6.2. Regular team manager meetings are carried out to review and discuss any challenges with the tool and also team assurances.	**G**	**31st July 2019 and ongoing thereafter**
7	**The trust should consider reviewing the balance the extent of external commitments with the capacity, skills and support of the new senior leadership team required to continue the deliver on the trust's internal goals.**	To ensure that senior Trust staff have adequate oversight and involvement in supporting Trust assurance and Improvement, alongside the STP goal implementations.	7.1 Review of existing arrangement to be undertaken 7.2 Position of Deputy Director of Operations to be appointed to	**30th September 2019**	**Executive Lead** Peter Axon	**Operational Lead** Jonathan O'Brien	7.1 • CEO remains SRO for Mental Health • DO remains Mental Health Work-stream lead • DWODI remains OD Work-stream lead • Consideration to be given as to whether CEO remains SRO for OD 7.2 DDOPs position out to advert. Once appointed to then can be RAG'd green	**A**	**30th September 2019**

CQC Improvement Monitoring as at 13.02.2020
(Post 2019 Well Led Inspection)

NHS
North Staffordshire Combined Healthcare NHS Trust

Older Persons Wards
Clinical Director - Carol Sylvester / Associate Director – Nicky Griffiths

MUST DO'S	DUE	RAG	Performance / Quality Indicator Progress	What is required for completion / Assurance	Expected assurance date
DOLS Notifications & Outcomes reported to CQC	Complete	G	Summary table of all applications available in Mental Health Law Team.	• Assurance from CQC that current process is correct.	25/6/19
Comprehensive & Personalised Care plans	31/8/19	B	ISM / Oct / Nov / Dec Ward 4: 93% / 100% / 90% Ward 6: 96% / 100% / 100% Ward 7: 97% / 97% / 100%	• Ward Managers will complete monthly audits to ensure compliance of 90% and above.	Complete

CRISIS
Clinical Director - Carol Sylvester / Associate Director – Nicky Griffiths

SHOULD DO's	DUE	RAG	Performance / Quality Indicators	What is required for completion / Assurance	Expected assurance date
Intervention planning tool to have a prompt re Physical Health maintenance.	30/6/19	B	Clinical Health template available on Lorenzo. Weekly assurance audit undertaken with action plans to address any areas of non-compliance	• Functionality to be added to Lorenzo • Weekly local audit.	Complete

Adult Community
Clinical Director - Dennis Okolo & Darren Carr / Associate Director – Jane Munton – Davies & Sam Mortimer

SHOULD DO's	DUE	RAG	Performance / Quality Indicators	What is required for completion / Assurance	Expected assurance date
Cleaning schedules in place in all clinic rooms in all locations	Complete	B	Cleaning schedule is displayed and clear arrangements are in place. IPC audit ensures cleanliness.	• Assurance confirmed by ICP lead inspection of locations	Complete
To consistently complete the Glasgow side effects monitoring forms and the drug indication on drug charts.	31/7/19	G	Review of Physical Health policy is complete. Clinical Leads have undertaken a sample audit of drug indication charts for each Centre. Weekly Medication Management Clinics have been initiated at all Centres. GASS C form is now live on Lorenzo.	• Baseline audit followed by improvement audit - Clinical Leads to provide a trajectory for achievement of compliance.	30/9/19
Crisis plans to be in place for all patients where required.	31/5/19	G	Guidance circulated to Team Leaders. QI project has commenced within the Stoke Directorate. Current audit compliance: 1st audit / 2nd audit / 3rd audit Ashcombe: 45% / 71% / 90% Lymebrook: 53% / 80% / 99% Sutherland: 86% / 83% / 100% Greenfields: 60% / 90% / 90% A fourth audit is underway to demonstrate further improvement/consistent compliance.	• Memo to be issued by CD to all staff • Compliance against audit via MDT case presentation.	30/06/19
All records for patients detained under a Community Treatment Order should demonstrate how Mental Capacity was assessed for patients who are deemed to lack capacity.	30/6/19	B	Guidance circulated to Team Leads. CTO monitoring form updated – revised tool circulated. CTO to be carried out monthly.	• CTO audit to be fully compliant	Complete
Ligature risk assessment to be followed by a detailed management plan that clearly outlines what actions are taken to mitigate the risks identified	30/6/19	B	Guidance on completion of annual ligature risk assessments sent to Centre Managers & Deputies. Completed assessments reviewed by Directorates.	• Assurance confirmed by H&S Advisor and QI Lead that actions & mitigations are clear.	Complete

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No:

INSERT EXECUTIVE SUMMARY TITLE (to be the same as agenda title)

Report provided for:			
Approve	☐	Alert	☐
Assure	☐	Advise	☐

Report to:	Choose an item.
Date of Meeting:	02 September 2025

Presented by:	Name / Title
Prepared by:	Author Name / Title
Executive Lead:	Name / Title

Aligned to Board Assurance Framework Risk:	Choose an item.
7 Levels of Assurance:	Choose an item.
Approval / Review:	Choose an item.
Strategic Priorities:	Choose an item.
Key Enablers:	Choose an item.
Sustainability:	Choose an item.
Resource Implications:	Choose an item.
Diversity & Inclusion Implications:	Choose an item.
ICS Alignment / Implications:	Demonstrate where we are aligning our Strategy to the ICS
Recommendation / Required Action:	Set out clearly the action or decision required i.e. funding or resource approval.
Executive Summary:	This section can be as large as is required with a return. This section is to be used to provide rationale as to why the report is being received and draw attention to key points and outline next steps

VERSION CONTROL:

Version	Report to	Date Reported

REPORT TEMPLATE
Title of Report

Introduction:

Purpose of the Report (Executive Summary):

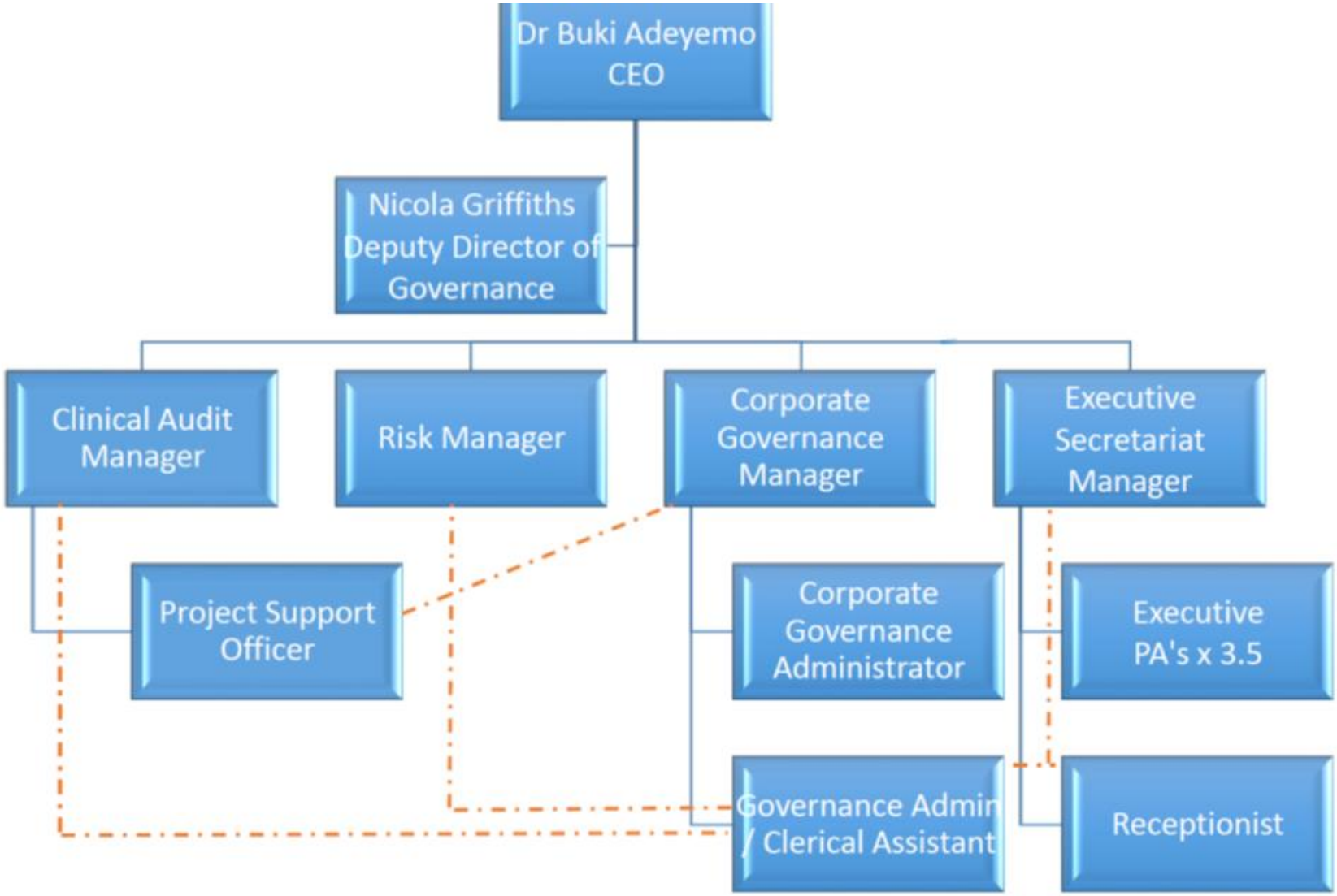
Key Recommendations to Consider:

Background:

Recommendations:

Summary:

Next Steps (including timesframes):


Dr Buki Adeyemo
CEO
Nicola Griffiths
Deputy Director of Governance
Clinical Audit Manager
Risk Manager
Corporate Governance Manager
Executive Secretariat Manager
Project Support Officer
Corporate Governance Administrator
Executive PA's x 3.5
Governance Admin / Clerical Assistant
Receptionist

Trust Risk Register - Open Only

Emergency Planning

Ref	Risk	Risk Owner	Gross Risk			Residual Risk			Trend	Target Score
			Impac	Likelih	Risk Rat	Impac	Likelih	Risk Rat		
942	**Pandemic Influenza**	Benjamin Richards (Chief Operating Officer)	4	5	20	4	2	8	↔	4 1 Target score of 4 set, to be achieved 31.3.2026
2120	**Emerging infectious disease.**	Benjamin Richards (Chief Operating Officer)	4	4	16	4	2	8	↔	4 1 Target score of 4, set to be achieved by 31.3.26.
1193	**[Exemption engaged - Sec 31(g) Law Enforcement]**									
1014	**[Exemption engaged - Sec 31(g) Law Enforcement]**									
2122	**Wide spread failure of utilities, including electricity, gas, sewerage and telecoms.**	Benjamin Richards (Chief Operating Officer)	5	3	15	5	2	10	↔	5 1 Target score of 5, set to be achieved by 31.3.26.
1875	**Low temperatures and heavy snow.**	Benjamin Richards (Chief Operating Officer)	3	4	12	3	3	9	↔	3 Target score 3, set to be achieved by 31.3.26.
2121	**Constraint on fuel supply.**	Benjamin Richards (Chief Operating Officer)	4	3	12	4	2	8	↔	4 Target score of 4, set to be achieved by 31.3.26.

Trust Risk Register - Open Only

Emergency Planning

Ref	Risk	Risk Owner	Gross Risk			Residual Risk			Trend	Target Score
			Impac	Likelih	Risk Rat	Impac	Likelih	Risk Rat		
2124	**Evacuation of bedded healthcare premises.**	Benjamin Richards (Chief Operating Officer)	4	3	12	4	2	8	↔	4 Target score of 4, set to be achieved by 31.3.26
1877	**Surface water flooding.**	Benjamin Richards (Chief Operating Officer)	3	4	12	3	2	6	↔	3 1 Target score of 3, set to be achieved by 31.3.26.
2125	**Business continuity and loss of critical services or premises.**	Benjamin Richards (Chief Operating Officer)	3	3	9	3	2	6	↔	3 Target score of 3, set to be achieved by 31.3.26.
2123	**Public or Environmental Health Incident (e.g waste or industrial fire, chemical spillage)**	Benjamin Richards (Chief Operating Officer)	3	3	9	3	1	3	↔	3 Target score 3, set to be achieved by 31.3.26.
2132	**There is a risk to delivery of care and safety due to the potential risk of industrial action, the consequence of this is the potential inability to deliver care.**	Benjamin Richards (Chief Operating Officer)	4	2	8	4	2	8	↔	4 1 Target score of 4 set, to be achieved by 31.03.26
940	**Storms and Gales**	Benjamin Richards (Chief Operating Officer)	2	4	8	2	3	6	↔	2 1 Target score of 4 set to be achieved by 31.3.2026
944	**High temperatures and heatwaves are classified according to the Met Office and UK Health Security Agency (UKHSA) heat definitions, meeting Level 3 (Yellow) or Level 4 (Amber) thresholds.**	Benjamin Richards (Chief Operating Officer)	3	2	6	3	2	6	↔	3 1 Target score of 3 is achieved, review 31.3.26

Trust Risk Register - Open Only

Finance And Resource Committee (F&R)

Ref	Risk	Risk Owner	Gross Risk			Residual Risk			Trend	Target Score
			Impact	Likelih	Risk Rat	Impact	Likelih	Risk Rat		
2161	**[Exemption applied - Sec 43 Commercial Interests]**									
2031	**[Exemption applied - Sec 43 Commercial Interests]**									
1896	**[Exemption applied - Sec 38 Health and Safety]**									

Trust Risk Register - Open Only

Finance And Resource Committee (F&R)

Ref	Risk	Risk Owner	Gross Risk			Residual Risk			Trend	Target Score
			Impact	Likelih	Risk Rat	Impact	Likelih	Risk Rat		
1955	**[Exemption applied - Sec 38 Health and Safety]**									
2140	**[Exemption applied - Sec 43 Commercial Interests]**									
1997	**There is a risk to the recurrent delivery of the Trust's Cost Improvement Plan, due to recurrent schemes not being identified resulting in future**	Benjamin Richards (Chief Operating Officer)	4	4	16	4	3	12	↔	4 Target score of 8, set to be achieved by

Trust Risk Register - Open Only

Finance And Resource Committee (F&R)

Ref	Risk	Risk Owner	Gross Risk			Residual Risk			Trend	Target Score
			Impact	Likelih	Risk Rat	Impact	Likelih	Risk Rat		
	financial risk to the Trust. Specialist Services 2016									31.3.2026.
2185	**[Exemption applied - Sec 43 Commercial Interests]**									
1945	**[Exemption applied - Sec 38 Health and Safety]**									
2044	**[Exemption applied - Sec 38 Health and Safety]**									

Trust Risk Register - Open Only

Finance And Resource Committee (F&R)

Ref	Risk	Risk Owner	Gross Risk			Residual Risk			Trend	Target Score
			Impact	Likelih	Risk Rat	Impact	Likelih	Risk Rat		
2194	**[Exemption applied - Sec 43 Commercial Interests]**									
1828	**[Exemption applied - Sec 38 Health and Safety]**									

Trust Risk Register - Open Only

Finance And Resource Committee (F&R)

Ref	Risk	Risk Owner	Gross Risk			Residual Risk			Trend	Target Score
			Impact	Likelih	Risk Rat	Impact	Likelih	Risk Rat		
2105	**There is a risk that performance levels of Trust data may reduce due to the data migration from Lorenzo to Orbis and cause concern with regulators and commissioners which may** **impact data quality, data completeness and accuracy of information recorded within patient records, including DQMI (Data Quality Maturity Index).**	Eric Gardiner (Chief Finance Officer)	4	3	12	4	3	12	↔	4 1 Target score of 4, to be achieved by 31.08.26.
2138	**There is a risk that the Trust may not fully achieve the Year 1 actions set out in its revised Green Plan (2025-28), due to delays in the publication of national guidance, which has** **deferred the requirement for Green Plan submission to Q2 2025. This reduces the available**	Elizabeth Mellor (Chief Strategy Officer)	3	4	12	3	3	9	↔	3 2 Target score of 6, set to be achieved by 31.3.26.

Trust Risk Register - Open Only

Finance And Resource Committee (F&R)

Ref	Risk	Risk Owner	Gross Risk			Residual Risk			Trend	Target Score
			Impact	Likelih	Risk Rat	Impact	Likelih	Risk Rat		
	delivery period by four months in the first year of a 3 year plan. As a consequence, this will add time and resource pressure to be able to meet national and local planned objectives.									
1954	**[Exemption applied - Sec 43 Commercial Interests]**									
2139	**There is a risk that delivery of the Green Plan (2025-28) may be limited due to a lack of identified lead/s and required capacity across its nine Areas of Focus. The absence of a Net Zero Clinical Transformation Lead, a nationally mandated role with Board-level links, further risks reducing oversight, coordination, and progress against sustainability commitments.**	Elizabeth Mellor (Chief Strategy Officer)	3	4	12	3	2	6	↓	3 2 Target score of 6, set to be achieved by 31.3.26

Trust Risk Register - Open Only

People, Culture And Development Committee

Ref	Risk	Risk Owner	Gross Risk			Residual Risk			Trend	Target Score
			Impact	Likelih	Risk Rat	Impact	Likelih	Risk Rat		
1856	**There is a threat to not achieving a small number of face to face statutory and mandatory training subjects, due to a combination of issues, safer staffing levels;** **impacting negatively on release to attend training and new mandated face to face subjects. The potential consequence is** **staff may not be up to date with legal requirements.** Corporate Human Resources 2055	Frieza Mahmood (Chief People Officer)	4	4	16	4	4	16	↔	4 Target score of 4, set to be achieved by 31.3.26

Trust Risk Register - Open Only

People, Culture And Development Committee

Ref	Risk	Risk Owner	Gross Risk			Residual Risk			Trend	Target Score
			Impact	Likelih	Risk Rat	Impact	Likelih	Risk Rat		
900	**There is a risk that the Trust may not consistently deliver inclusive services as a result of insufficient training, insight and representation within our workforce, to reflect the diverse needs of our local population. This may result from ongoing structural and societal inequalities across the NHS and wider UK. If not addressed, some communities may experience barriers to care or feel underserved.**	Frieza Mahmood (Chief People Officer)	4	4	16	4	3	12	↔	4 2 Target score of 8 set to be achieved by 30.06.2028.

Trust Risk Register - Open Only

People, Culture And Development Committee

Ref	Risk	Risk Owner	Gross Risk			Residual Risk			Trend	Target Score
			Impact	Likelih	Risk Rat	Impact	Likelih	Risk Rat		
1699	**There is a staff Health and wellbeing risk due to a cumulative effect of increased service demand and current staffing vacancies. As a consequence this may impact on staff fatigue, staff sickness which may negatively affect sickness absence rates, and increase the Trusts vacancy/turnover position, thereby potentially impacting the quality of services.**	Frieza Mahmood (Chief People Officer)	4	4	16	4	3	12	↔	4 Target score of 8, set to be achieved 31st March 2026.
1908	**[Exemption applied - Sec 38 Health and Safety]**									

Trust Risk Register - Open Only

People, Culture And Development Committee

Ref	Risk	Risk Owner	Gross Risk			Residual Risk			Trend	Target Score
			Impac	Likelih	Risk Rat	Impac	Likelih	Risk Rat		
1948	**There is a risk that our employees will continue to experience harm, both physical and psychological, in the workplace from individuals using our services. This is due to the complexity and diversity of the patient population, which can be influenced by the nature and severity of their illness, the restrictive environment of mental health services, and broader sociodemographic factors. The consequence of this risk is that staff may suffer harm, impacting their personal wellbeing.**	Kenneth Laing (Chief Nursing Officer)	3	5	15	3	4	12	↔	3 2 Target score of 6, set to be achieved by 31.3.26.
2055	**There is a risk to the delivery of people services and legislative requirements due to service demand exceeding team capacity. This includes delivery of WRES, WDES, disciplinary investigations sickness absence case management and not meeting policy guidance which could result in a consequence of legal complaints against the trust, increased cost pressures due to inadequate service, increased/prolonged sickness absence, negative impact on patient care and inability to deliver the agreed deliverables of the people plan.** Corporate 1856 *Amended to Trust level risk per Interim CPO risk review meeting 13.11.24*	Frieza Mahmood (Chief People Officer)	3	5	15	3	4	12	↔	3 2 Target Score of 6 to be achieved 31.3.26
1072	**There is a risk that some staff may not be accessing high quality clinical supervision due to capacity and workload and a lack of priority being afforded to attend supervision as a consequence there is an increased risk of work related stress due to staff not feeling supported in their professional**	Kenneth Laing (Chief Nursing Officer)	3	4	12	3	3	9	↔	3 2 Target score of 6 set to be achieved 31.3.2026

Trust Risk Register - Open Only

People, Culture And Development Committee

Ref	Risk	Risk Owner	Gross Risk			Residual Risk			Trend	Target Score
			Impac	Likelih	Risk Rat	Impac	Likelih	Risk Rat		
	practice and decision making.									
2059	**There is a risk we are not conforming to GPDR requirements, and the Trust cannot track and account for all personal files due to the lack of process and digital system and as a consequence we cannot assure that staff files are stored appropriately nor have the appropriate information required within them.**	Frieza Mahmood (Chief People Officer)	3	4	12	3	3	9	↔	3 Target score of 3 set to be achieved by 31/3/26
2180	**There is a data integrity risk with the existing electronic learning management system (LMS) due to issues with the age and functionality of the system with low assurance that the issues will be corrected. This is impacting on the Trust's inability to report accurate performance data in relation to training and appraisals, leading to duplication of input and inaccurate performance reporting.**	Frieza Mahmood (Chief People Officer)	3	4	12	3	3	9	↔	3 Target score of 6, set to be achieved by 30.4.26.
2181	**[Exemption applied - Sec 43 Commercial Interests]**									
2182	**There is a risk that there is insufficient staff to deliver appropriate care to patients because of vacancies and skill mix, in particular, within the psychiatry specialism. Whilst recruitment to Band 5 nursing staff has been successful, this has led to a gap in experience and pressure on the Band 6 role. This has a consequence of potential increased pressure**	Frieza Mahmood (Chief People Officer)	3	4	12	3	3	9	↔	3 Target score of 6, set to be achieved by 30.9.26.

Trust Risk Register - Open Only

People, Culture And Development Committee

Ref	Risk	Risk Owner	Gross Risk			Residual Risk	
			Impact	Likeliho	Risk Rat	Impact	Likelihood
	upon existing staff; leading to failure to achieve performance targets and deliver service user expectations.						

Trust Risk Register - Open Only

Quality Committee

Ref	Risk	Risk Owner	Gross Risk			Residual Risk			Trend	Target Score
			Impact	Likelih	Risk Rat	Impact	Likelih	Risk Rat		
1112	**There is a risk that patients will continue use anchored & non anchored ligature points within the Trusts estates due to the nature of their illness and environments which contain anchored ligature points, as a result there is a potential consequence of death or serious harm.**	Kenneth Laing (Chief Nursing Officer)	5	4	20	5	3	15	↔	5 2 Target score of 5 set (8 year plan), set to be achieved by 31.3.26.

Trust Risk Register - Open Only

Quality Committee

Ref	Risk	sk Owr	Gross Risk			Residual Risk			Trend	Target Score
			Impact	Likelih	Risk Ra	Impact	Likelih	Risk Ra		
1957	**There is a risk of reduced bed availability due to a reduction in beds (Project Chrysalis), increasing demand within the community and social care delays for discharges from local authorities [clinically ready for discharge]. This could result in patients waiting in the community for a bed or being admitted to an out of area bed [OOA placements].**		Benjamin Richards (Chief Operating Officer)	4	4	16	4	4	16	4 2 Target score set of 8 to be achieved by 31.03.26
1277	**There is a risk that the Trust fails to comply with the MHA/MCA, resulting in a risk to quality of care (including patients rights) which could lead to poor feedback from MHA compliance visits and risk of greater regulatory scrutiny.** Acute Services And Urgent Care 2102 Specialist Services 2118		Dennis Okolo (Chief Medical Officer)	4	4	16	4	3	12	4 2 Target score of 8 set to be achieved 31.3.2026

Trust Risk Register - Open Only

Quality Committee

Ref	Risk	Risk Owner	Gross Risk			Residual Risk			Trend	Target Score
			Impact	Likelih	Risk Rat	Impact	Likelih	Risk Rat		
1880	**There is a risk that the capacity of the current CYP ASD service cannot meet the increased demand for ASD assessments and as a consequence of this the service will have an unsustainable wait list leading to increased complaints and poor service user experience.**	Benjamin Richards (Chief Operating Officer)	3	5	15	3	5	15	↔	3 2 A target of 6 has been set to be achieved by 31 March 2027.
1982	**There is a risk of longer wait times for treatment across Stoke CAMHS Teams REFERRAL TO TREATMENT [RTT] due to increasing the number of initial assessments completed to achieve 4 week wait impacting on demand for treatment. As a consequence of this, Children and Young People will experience delays in accessing therapy.**	Benjamin Richards (Chief Operating Officer)	3	5	15	3	5	15	↔	3 A target score of 6 has been agreed to be achieved by 30 April 2026

Trust Risk Register - Open Only

Quality Committee

Ref	Risk	Risk Owner	Gross Risk			Residual Risk			Trend	Target Score
			Impact	Likelih	Risk Rat	Impact	Likelih	Risk Rat		
	There is a risk of longer wait times for treatment across Stoke CAMHS Teams REFERRAL TO TREATMENT [RTT] due to increasing the number of initial assessments completed to achieve 4 week wait impacting on demand for treatment. As a consequence of this, Children and Young People will experience delays in accessing therapy. *Per action from RRG 11.3.25, and confirmed with COO 24.3.25 to escalate from Operational risk (Community Dir) to Trust level risk, QC.*									
1609	**There is a risk of the Stoke Community CAMHS Teams not achieving the 4 week wait target REFERRAL TO ASSESSMENT [RTA] due an increase in demand for services as a consequence of this there will be increased** **waiting times for service users.** *Approved at QC 3.7.25*	Benjamin Richards (Chief Operating Officer)	3	5	15	3	5	15	↔	3 2 A target of 6 has been set to be achieved by 30 April 2026.
2170	**[Exemption applied - Sec 38 Health and Safety]**									

Trust Risk Register - Open Only

Quality Committee

Ref	Risk	Risk Owner	Gross Risk			Residual Risk			Trend	Target Score
			Impact	Likelih	Risk Rat	Impact	Likelih	Risk Rat		
1889	**[Exemption applied - Sec 38 Health and Safety]**									
1919	**There is a risk that capacity of the current Adult ADHD Service cannot meet the demand of referrals being received as a consequence of this it could lead to an unsustainable wait list poor service user experience due to timliness in accessing the service.**	Benjamin Richards (Chief Operating Officer)	3	4	12	3	5	15	↔	3 2 A target of 3 was set, to be achieved by 31 March 2027.
2127	**There is a risk to the safety and continuity of psychological services due to the professional leadership structure not being fit for purpose. This results in employee departures, complaints and wider retention difficulties, thus impacting on service provision.**	Dennis Okolo (Chief Medical Officer)	3	4	12	3	3	9	↔	3 Target score of 6, set to be achieved by 31.5.26.
1988	**There is a risk that if the Trust fails to meet MHRA legal requirements to inform all patients in risks in pregnancy and to use adequate contraception. This is due to MHRA guidance which was amended in January 2024 mandating additional safeguards in relation to valproate initiation, prescribing and annual patient reviews. Failure to follow and document this could result in poor and unsafe patient care.** **Consequences could be exposure to valproate in**	Dennis Okolo (Chief Medical Officer)	4	3	12	4	2	8	↔	4 1 Target score of 4, set to be achieved by 31.1.26.

Quality Committee

Ref	Risk	Risk Owner	Gross Risk		
			Impact	Likeliho	Risk Rat
	pregnancy, litigation against the Trust and reputational damage.				

Trust Risk Register - Open Only

		Likelihood				
		Rare	Unlikely	Possible	Likely	ost Certain
Impact	Rating	1	2	3	4	5
Negligible / Insignificant	1	1	2	3	4	5
Minor	2	2	4	6	8	10
Moderate	3	3	6	9	12	15
Major	4	4	8	12	16	20
Catastrophic	5	5	10	15	20	25

Overall Rating

1 - 3 = Low

4 - 6 = Moderate

8 - 12 = Significant

15 - 25 = High