Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 17 January 2024

TB2024.13

Title:	**Trust Management Executive Report**

Status:	**For Decision**
History:	**Regular Reporting**

Board Lead:	**Chief Executive Officer**
Author:	**Laura Lauer, Deputy Head of Corporate Governance**
Confidential:	**No**
Key Purpose:	**Assurance**

Trust Management Executive Report

1. Purpose

1.1. The Trust Management Executive [TME] has been constituted by the Trust Board and is the executive decision-making committee of the Trust. As such, it provides a regular report to the Board on some of the main issues raised and discussed at its meetings.

1.2. Under its terms of reference, TME is responsible for providing the Board with assurance concerning all aspects of setting and delivering the strategic direction for the Trust, including associated clinical strategies; and to assure the Board that, where there are risks and issues that may jeopardise the Trust's ability to deliver its objectives, these are being managed in a controlled way through the Trust Management Executive Committee. This regular report provided aims to contribute to the fulfilment of that purpose.

2. Background

2.1. Since the preparation of its last report to the Trust Board, the Trust Management Executive [TME] has met on the following dates:

- 16 November 2023
- 30 November 2023
- 14 December 2023

3. Key Decisions

<u>Spinal Endoscopy at the Nuffield Orthopaedic Centre (NOC)</u>

3.1. TME approved the purchase of a new spinal endoscopy system for the NOC, funded by Oxford Hospitals Charity.

3.2. The equipment allows open spinal decompression surgery to be done as a day case endoscopic procedure, which leads to much faster recovery for patients.

3.3. Acquiring a further system at the NOC (there is already a system at the JR) would represent an expansion of the service, support other surgeons in the Trust to perform these procedures, and allow patients greater access to the surgery.

Digital Consent

3.4. Following a successful pilot programme in Ophthalmology, TME approved the Trust-wide rollout of a digital consent service. The benefits of the service included a reduction in time to consent patients before surgery and reduced administrative time processing paper records.

Neurophysiology Staffing

3.5. TME approved a proposal from Neurosciences, Orthopaedics, Trauma, Specialist Surgery, Children's & Neonates (NOTSSCaN) to convert activity provided by insourcing using an external company to activity provided in-house by Trust staff.

3.6. This would deliver 2,800 annual appointment slots from April 2024 for Electromyography (EMG) and Electroencephalography (EEG), providing twice the level of activity currently provided through insourcing and reduce waiting times for the EMG and EEG service.

E-Rostering system for Medical and Dental Staff

3.7. TME approved a proposal to carry out a full, detailed review of current e rostering systems and to develop a specification to support the Trust's longer-term needs. Options would be presented to TME for consideration.

Policies

3.8. Minor revisions to the Trust's Declaration of Interests including Gifts, Hospitality and Sponsorship Policy were reviewed by TME. These small changes were necessitated by a new, internally-developed system to simplify declarations by staff. TME recommended the Trust Board approve the revised policy.

3.9. TME approved an updated High Profile Visitors Policy which provides staff with guidance on visits to the Trust from high profile individuals such as royals, politicians, and celebrities, and outlines the steps people need to take when such people are visiting our hospitals to ensure that we uphold excellent care and patient dignity and confidentiality.

3.10. TME reviewed the Asbestos Management Policy and Pest Control Policy before recommending these be approved by the Trust Board.

4. Other Activity Undertaken by TME

OUH Anchor Development

4.1. TME received an update on progress in developing the role of OUH as an 'Anchor' Institution at the heart of the communities served by the Trust.

4.2. The update included a report of an event at Barton Neighbourhood Centre on 28 September with representatives from partner organisations, as well as patient and public representatives, to talk about working together to improve the lives of Oxfordshire residents, and the Trust's Anchor role as a major employer and provider of healthcare.

4.3. The proposed next steps include the formation of an OUH Anchor Working Group and the Trust's participation in wider system planning to establish an Oxfordshire Anchor Network.

Radiotherapy Late Effects Service

4.4. TME approved a proposal accept three-year grant funding from Macmillan to set up and run a Late Effects Service. s run by Therapeutic Radiographers, who are experts in radiotherapy side effects, are being set up across the country and he presented a fully funded proposal to create a multi-disciplinary team here at OUH in order to provide this much-needed type of care for many more people.

4.5. The proposal included an independent evaluation, funded by Thames Valley Cancer Alliance, of the clinical, patient, and system-wide benefits of a Radiotherapy Late Effects Service.

Maternity Incentive Scheme Compliance

4.6. TME noted that an action plan to ensure the neonatal unit could meet the British Association of Perinatal Medicine standard of medical staffing would be presented to the Trust Board.

4.7. Members of TME sought assurance that all MIS compliance issues had been identified.

Financial Forecast

4.8. The Trust Management Executive continued to be updated on the financial position including a summary of current forecast performance, the actions that TME had approved to improve this and the key current risks and opportunities.

4.9. TME considered the capital reforecast at the half-yearly point in the financial year and noted potential areas of slippage.

4.10. The wide range of scenarios which reflected the ongoing significant uncertainty over key assumptions was noted

OPEL Status

4.11. TME noted the publication of the OPEL Framework 2023/24. This updated framework was linked to assessing OPEL status at ICS level.

4.12. TME agreed that the existing OPEL measures would be retained for internal use to ensure local escalation in response to Trustwide operational pressures.

National Interim Patient Choice Guidance

4.13. TME members discussed how best to implement this guidance in a way that reduced the burden on administrative and clerical staff and mitigated the risk of a patient being "lost" from the waiting list.

4.14. Until a digital solution was available, TME approved partial adoption of the guidance and agreed to escalate the issue to the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board and South-East Regional Team.

Public Engagement, Patient Experience, PALS, and Complaints Annual Report 2022/23

4.15. The Trust Management Executive received the Trust's Public Engagement, Patient Experience, PALS, and Complaints Annual Report. TME heard that there was an increased focus on the lived experience of patients using the Trust's services.

4.16. Following the Patient Perspective presented at the November 2023 Trust Board, the patient (Mr Julian Ward) was now co-Chair of a task and finish group focusing on the needs of D/deaf patients in accessing healthcare and ensuring their needs were met.

4.17. TME noted the opportunities presented by the use of the patient engagement portal.

Other Annual Reports

4.18. TME also received the following annual reports:

- Emergency Preparedness, Resilience and Response (EPRR) Annual Report; this included minor revisions to EPRR policies which were recommended to the Trust Board for approval;
- Mental Health Act in OUHFT Annual Report.

5. Regular Reporting

5.1. In addition, TME received the following regular reports:

- Integrated Performance Report (this is now received by TME prior to presentation to the Trust Board and Integrated Assurance Committee);
- Capital Schemes: TME continues to receive updates on a range of capital schemes across the Trust;
- Health and Safety Quarterly Update;
- Finance Report: TME continues to receive financial performance updates;
- Workforce Performance Report: TME receives and discusses monthly updates of the key KPIs regarding HR metrics;
- Clinical Governance Committee Report;
- An update on the Quality Improvement Programme;
- A briefing on Research and Development Metrics;
- Business Planning Pipeline Report;
- Procurement Pipeline Report; and
- Summary Impact of TME Business (which allows TME members to more easily track the combined financial impact of decisions taken.)

6. Key Risks

6.1. **Risks associated with the financial performance:** TME continued to recognise the risks and opportunities to deliver at pace the changes required to recover the financial position.

6.2. **Risks associated with workforce:** TME maintained continued oversight on ensuring provision of staff to ensure that services were provided safely and efficiently across the Trust and to maintain staff wellbeing in the light of substantial operational pressures. The impact on staff of cost-of-living pressures continued to be recognised.

6.3. **Risks to operational performance:** TME continued to monitor the risks to operational performance and the delivery of key performance indicators and the mitigations that were being put in place.

7. Recommendations

7.1. The Trust Board is asked to:

- **note** the regular report to the Board from TME's meetings held on 16 November 2023, 30 November 2023 and 14 December 2023;
- **approve** the revised Declaration of Interests including Gifts, Hospitality and Sponsorship Policy (Appendix 1)
- **approve** the revised Asbestos Management Policy (Appendix 2); and
- **approve** the revised Pest Control Policy (Appendix 3).

Oxford University Hospitals
NHS Foundation Trust

Declaration of Interests including Gifts, Hospitality and Sponsorship Policy

(Identifying and Managing Conflicts of Interest)

Category:	Policy
Summary:	This policy outlines the standards of conduct expected of all Trust staff, including all members of the Board, regarding the identification and management of any actual or potential conflict between their private interests and public service duties. This policy also provides a mechanism for declaring, recording and monitoring interests, gifts, hospitality and sponsorship.
Equality Impact Assessed:	July, 2021.
Valid From:	September, 2021
Date of Next Review:	September, 2024
Approval Date/ Via:	8 September, 2021 approved by the Trust Board
Distribution:	Trust-wide
Related Documents:	Counter Fraud & Bribery Policy and Reporting Procedures, Standing Orders, Standing Financial Instructions, Raising Concerns (Whistleblowing) Policy Human Resources Policies, including Home Working Policy
Author(s):	Corporate Governance Consultant
Further Information:	Contact via company.secretary@ouh.nhs.uk
This Document replaces:	Declarations of Interests, Declaration of Gifts, Hospitality and Sponsorship Policy v2.1 issued in November 2017

Lead Director: Chief of Assurance

Issue Date: September 2021

Document History

Date of revision	Version number	Author	Reason for review or update
10 April, 2017	V2.0	Corporate Governance Manager	Policy reviewed and revised in the light of initial NHS England [NHSE] Guidance issued to CCGs in February 2017.
24 October, 2017	V2.1	Head of Corporate Governance	Revised and updated Policy submitted for approval by the Board.
8 February, 2021	v.3	Corporate Governance Consultant	Policy reviewed to ensure full compliance with relevant NHSE Guidance; draft Policy circulated for consultation.
July/August, 2021	V3.1	Corporate Governance Consultant	Draft Policy updated, taking into account comments elicited through consultation.
12 August, 2021	V3.2	Corporate Governance Consultant	Revised and updated Policy endorsed by TME.
8 September 2021	V3.3	Corporate Governance Consultant	Revised and updated Policy approved by the Board.

Consultation Schedule

Who? Individuals or Committees	Rationale and/or Method of Involvement
Financial Consultant and Anti-Crime Specialist	Shared initial draft to elicit comments on adequacy of provision; in particular for declaration of shareholdings and loyalty interests
Director of Procurement and Supply Chain	Shared draft to elicit comments on adequacy of provision; in particular to ensure and protect the integrity of the procurement process
Director of Pharmacy	Shared draft to elicit comments on adequacy of provision; to ensure that the policy will support compliance with wider transparency initiatives such as the ABPI Disclosure UK scheme[i]

Director of Communications	Shared draft to elicit general comments, and in particular to seek advice in developing communications plan
Trust Management Executive [TME]	Submitted for approval at meeting of TME held on 12 August, 2021
Trust Board	*Submitted for approval at meeting of the Trust Board held in public on* 8 September, 2021

Endorsement

Endorsee Job Title
Financial Consultant and Anti-Crime Specialist
Deputy Director of Finance, Technical and Development
Director of Procurement and Supply Chain
Commercial Director
Programme Director, TheHill
Director of Pharmacy
Chief Finance Officer
Chief Assurance Officer
Executive Directors and Divisional Directors at TME

Contents

Declaration of Interests, Gifts, Hospitality and Sponsorship Policy (Identifying and Managing Conflicts of Interest)

Who should read this document?

1. This policy should be read by all staff in the Trust. Responsibilities under the policy are summarised at ***Appendix 1***.

Key Messages

2. **Always act in the public interest** NHS England Guidance emphasises that, in public services, decision makers must act in the public interest and be seen to do so. The Trust is accountable for the decisions it takes, and is committed to operating in an open and impartial manner. All decision-makers acting for or on behalf of the Trust must act free from the influence of any factors that may be in conflict with the interests of the Trust. The Trust must be able to demonstrate that all of its dealings are conducted to the highest standards of integrity and probity and that NHS monies are used wisely, so that finite resources are used appropriately and always in the best interests of patients.

3. **Potential conflicts of interest must be identified in order that they can be properly managed**. This policy establishes a framework to declare and manage any actual or potential conflict that may arise between the private interests and public duties of anybody who is working with, for or on behalf of the Trust; whether on a permanent, occasional, temporary or 'interim' basis. **All those who are engaged by, for or on behalf of the Trust are expected to adhere to the standards set.** This requirement applies to all employees, 'office holders', contractors, sub-contractors and agents, those who hold an honorary contract, and those who otherwise may be regarded as representing the Trust whether or not directly employed or engaged by the Trust. [All such are hereafter referred to as "staff"].

4. **Every individual is responsible for regularly considering what interests they have and for declaring any interests as they arise**, as is advised in NHS England Guidance, in which it is also made clear that, if an individual is in any doubt as to whether a declaration is required in any given circumstances, they should make a declaration.

5. **All staff are required to observe the principles of good governance** in the way that Trust business is conducted and to comply with this policy as well as with Standing Orders and Standing Financial Instructions.

6. **All public office-holders must adhere to the Seven Principles of Public Life** (the 'Nolan Principles'[ii]), as is advised in NHS England Guidance:
   - **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.

Background/Scope

7. The standard NHS contract 2016/17 introduced an express requirement that healthcare providers must ensure that staff declare all actual or potential conflicts of interest and offers of gifts, hospitality or sponsorship.

8. Guidance on Managing Conflicts of Interest in the NHS was published by NHS England in June 2017[iii].

9. Under the Bribery Act 2010, the acceptance of gifts, hospitality, preferential treatment in private transactions, sponsorship or loyalty schemes as an incentive for entering into business transactions is specifically prohibited. In addition, the Bribery Act also created a corporate offence of failing to prevent bribery and members of the Trust Board may be liable if it cannot be demonstrated that the Trust has adequate procedures in place to prevent bribery.

10. Gifts, hospitality and sponsorship offered where there is no possibility that their acceptance could act as an incentive to act dishonestly, or in breach of the law, will not constitute a bribe, but may still need to be refused.

11. The Trust's Counter Fraud & Bribery Policy and Reporting Procedures specify the process of investigating any suspected fraud, bribery and corruption, and gives instruction to staff about what to do, and whom to contact if they have any fraud related concerns.

Aims of the Policy

12. This policy aims:

12.1. to ensure that the Trust is open, transparent and honest in the way it conducts its business, and to ensure that all members of staff operate in an open and impartial manner (and that they can be seen to do so); and

12.2. to identify and manage any actual or potential conflict of interest that may arise between the private interests and public duties of NHS staff, including all members of the Board, by ensuring that there is:

12.2.1. A clear and **consistent set of principles and rules**, to support good judgement about how to approach and manage interests;

12.2.2. A clear **mechanism** for all staff, including all members of the Board, **to declare interests, gifts, hospitality and sponsorship**; and

12.2.3. A clear **framework** for **maintaining and reviewing the Registers** of Interests, Gifts, Hospitality and Sponsorship, and for **managing conflicts of interest**.

Interests

13. At the earliest opportunity (and in any event within 28 days) **all staff must** declare any personal, professional or business interest which may conflict with their official duty or may be seen to compromise their personal integrity in any way, This may include an interest held by a close member of their family (as defined in Appendix 2).

14. A 'conflict of interest' is defined as:

> "A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold."

15. 'Interests' can arise in a number of different contexts, *for example* in connection with a role or position held in another organisation, the ownership of assets, or benefit gained through sponsorship, hospitality or gift.

16. Interests may fall into the following categories:

16.1. **Financial interests:** Where an individual may get direct financial benefit (either by making a gain or avoiding a loss) from the consequences of a decision they are involved in making;

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

16.3. **Non-financial personal interests:** Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career;

16.4. **Indirect interests:** Where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit from a decision they are involved in making.

17. The starting point for **interests which are regarded as "relevant and material"** and which must be declared, is provided in NHS England Guidance. Although not exhaustive, they may include:

17.1. Directorships, including Non-Executive Directorships held in private companies or public limited companies (PLCs), including dormant companies, and including any directorship from which an individual has resigned within 28 days of taking up appointment at the Trust ;

17.2. Ownership of publicly traded or privately traded investments in which the Trust also holds shares;

17.3. Ownership or part-ownership of publicly-traded investments, private companies, business or consultancies likely or possibly seeking to do business with the NHS;

17.4. Majority or controlling share holdings in organisations likely or possibly to do business with the NHS;

17.5. A position of authority in a charity or voluntary organisation in the field of health and social care;

17.6. Any connection with a voluntary or other organisation contracting for NHS services;

17.7. Research funding/grants that may be received by an individual or their department;

17.8. Interests in pooled funds that are under separate management;

17.9. Royalties, licence fees or other similar payments that may be received by an individual or their department.

18. Interests which should be declared also include **"loyalty interests"**, which are defined as those which relate to:

18.1. a position of authority held in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role (including a position as a local County Councillor, District Councillor or Parish Councillor and including any position of authority at any body that is a member of the local integrated care system);

18.2. participation in an advisory group or other paid or unpaid decision-making forum that can influence how an organisation spends taxpayers' money (including decision-making groups of an Integrated Care System);

18.3. involvement in the recruitment or management of close family members and relatives, close friends and associates, and business partners (refer to Definitions in ***Appendix 2***);

18.4. awareness that the Trust does business with an organisation in which close family members and relatives, close friends and associates, or business partners have decision making responsibilities.

19. There may be further, specific situations where the requirement to make a declaration of interest needs to be extended to that of a close relative, close friend or close business or professional associate (as defined in ***Appendix 2***). A judgement may have to be made in individual circumstances regarding the appropriateness for a declaration to be made, for example:

19.1. when a close relative, friend or professional associate owns publicly traded or privately traded investments in which the Trust also holds shares; or

19.2. when the closeness of a connection may be perceived to have a bearing on a specific contractual situation or set of circumstances.

20. If a member of staff is in doubt as to whether the interest of a close family member, friend or close business or professional associate should be declared, advice should be sought from the Head of Corporate Governance.

Process for declaring interests.

21. Declarations should be made by completing a declarations form that can be accessed on ~~The process for making a declaration of interest may be accessed on~~ the OUH intranet here ~~. Those without access to the OUH intranet should contact their line manager in the first instance.~~ Advice may be sought from the Head of Corporate Governance *via* email sent to declarations@ouh.nhs.uk. ~~o r to company.secretary@ouh.nhs.uk~~

21.1. Every member of staff (as defined in paragraph 3) is responsible for regularly considering what interests they have and for declaring any interests (including gifts, hospitality and sponsorship) as they arise. In particular, declarations of any relevant and material interest should be made:

- On appointment;
- When moving to a new role or changing responsibilities significantly;
- At the beginning of any significant new project or piece of work which will have a bearing on how taxpayers' money is to be spent;
- Upon a change in circumstances which might give rise to new interests, and

every member of staff is encouraged to consider whether they should enter into early dialogue with colleagues/managers as soon as they are actively considering a change in circumstances which might give rise to new interest (*e.g.* by taking up another role, or stake in an another organisation)

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~~21.2. An offer of a gift, hospitality or sponsorship should be declared at the time of receipt.~~

~~21.3.~~21.2. **Decision-makers** (as defined under paragraphs ~~26~~25~~-27~~ 26 below) will be asked explicitly to confirm whether or not they have any relevant and material interests to declare at least once a year. :

~~21.3.1. At the beginning of any new role, project or piece of work in which they will be acting as decision-makers, ie having a bearing on how taxpayers' money is spent;~~

~~and in any event~~

~~21.3.2. At least once a year.~~

~~21.4.~~21.3. Declaration of interests should be **a standing item on meeting agendas**. All material interests that may be relevant to any item under discussion should be declared and recorded in the minutes of the meeting (and submitted for inclusion in the Register of Interests if not previously declared). The Chair of the meeting will generally be responsible for taking the appropriate course of action to manage any conflict of interest (in accordance with paragraph 30 below). Where the Chair is conflicted, non-conflicted attendees should consider how the conflict of interest should be managed, and if in doubt should refer to the Head of Corporate Governance.

~~21.5.~~21.4. In **any procurement process, commercial decision or other strategic decision- making process** all individuals who are involved in the process (whether or not they would generally come within the definition of 'decision-maker' under paragraphs 26-27 below) should declare any material interest that could have a bearing (whether actual or perceived) on the decision (see further under paragraphs 42-48 below).

22. Whenever a declaration of interest is made, consideration should be given to whether the interest may give rise to a conflict and, if so, what management action should be taken in accordance with paragraph 30 below.

23. All staff must declare interests in line with this policy. A failure to declare a relevant and material interest may give rise to disciplinary action and, in certain circumstances, may render the individual and/or the Trust liable to criminal proceedings for bribery, fraud or corruption.

24. In case of doubt as to what to declare, and how, advice should be sought from the Head of Corporate Governance, who may be contacted *via* company.secretary@ouh.nhs.uk .

Decision-making staff

25. Anyone working with, for or on behalf of the Trust must ensure that any decisions they make in the course of their work are free from the influence of any factors that may be in conflict with the interests of the Trust.

26. NHS England Guidance recognises that there are staff whose role means that they may be more likely than others to have a decision-making influence on the use of taxpayers' money
; they are defined as "decision-making staff". As such, they should at least once a year review and update their declarations of interests, gifts, hospitality or sponsorship, or make a nil return, and will be prompted annually to do so.

27. NHS England Guidance advises that decision-making staff are likely to include:

- Members of the Trust Board;
- All members of the Trust Management Executive;
- Those at Agenda for Change Band 8d and above or equivalent, including all Medical and Dental Consultants[iv];
- Any member of staff (at any grade) who has the authority to enter into a contract on behalf of the Trust;
- Administrative and clinical staff at any grade who are involved in decision-making concerning funding allocation, investment decisions and investment management, the commissioning of services, purchasing of goods, medicines, medical devices or equipment and formulary decisions.

Staff who are subject to wider transparency initiatives

28. Staff who are subject to wider transparency initiatives such as the ABPI Disclosure UK scheme[v] must comply with them.

Management action where there is (or may be) a conflict of interest

29. Paragraphs 42-48 below make further express provision for managing any actual or potential conflict of interest that may arise in relation to a procurement decision and other strategic decision-making processes including all commercial decisions.

30. In general, any interest declared should be considered initially by the line manager of the individual who has made the declaration and if it is considered to give rise to any actual or potential conflict with the interests of the Trust, the line manager should decide on the most appropriate course of action. In line with NHS England Guidance, this may include:

30.1. deciding that no action is warranted at this time;

30.2. restricting the individual's involvement in discussions and excluding them from decision making in relation to a matter in which they have declared an interest;

30.3. removing an individual from the whole of any decision-making process relating to a matter in which they have declared an interest;

30.4. removing an individual's responsibility for an entire area of work (if it relates to a matter in which they have declared an interest); or

30.5. requiring an individual to relinquish the interest declared, if the conflict is so significant that they would be unable to operate effectively in their Trust role; or to remove the individual from their Trust role, if they are unwilling to relinquish the conflicting interest.

30.6. The line manager of the individual who has made a declaration should seek support from senior management as and where appropriate, and advice may also be sought from the Head of Corporate Governance. The involvement of an individual in a particular matter may be paused, pending the outcome of referral to more senior management within the directorate or division, or ultimately to Executive Directors and the Board, as may be advised by the Head of Corporate Governance.

31. In all cases, an audit trail of the actions taken should be kept and recorded on the declaration submitted.

Managing conflicts of interest at the Board

32. It is a requirement for all members of the Board to declare any personal or business interests they may have which may affect, or be perceived to affect, the conduct of their role. This includes any interest that may influence, or be perceived to influence, their judgment in the course of conducting the Board's business.

33. Members of the Board must notify the Head of Corporate Governance of any such interests at the time of their appointment, and any further interests as they arise through their tenure as Board Members. Members of the Board must also declare any interests held by family members or people or bodies with which they are connected. In the case of Non-Executive Directors, any interest declared should be considered by the Chair.

34. Members of the Board will be prompted annually by the Head of Corporate Governance to review and update their declarations of interests, gifts, hospitality and

sponsorship, or to make a nil return.

35. The Head of Corporate Governance will provide advice to the Trust Chair as to what should be considered a material interest, taking account of regulatory requirements. If individual members of the Board are in any doubt about what may be considered a material interest that should be declared, they should seek advice from the Head of Corporate Governance. The onus will rest on each individual member of the Board to declare any interest that could give rise to a conflict with the interests of the Trust.

36. Further information on the declaration of interests, including declaring interests at meetings of the Trust Board, can be found in the Trust's Standing Orders and may be requested from the Head of Corporate Governance.

Maintaining the Registers of Interests, Gifts, Hospitality and Sponsorship

37. The Head of Corporate Governance will ensure that a Register is established and maintained as a formal up to date organisational register(s) of interests, which will include a record of interests, including gifts, hospitality, and sponsorship.

~~37. The Head of Corporate Governance will ensure that a Register is established and maintained as a formal record of~~

~~37.1. all interests declared by staff, including all members of the Board; including~~

~~37.2. all declarations made in relation to gifts, hospitality and sponsorship.~~

38. ~~The Register(s) will be maintained in two parts: Part I relating to all members of the Board; and Part II including declarations made by other decision-making staff.~~ In line with NHS England Guidance, the declarations of all decision-makers will be published on the Trust's website. The Register(s) relating to members of the Board will be ~~published~~ referenced in the Trust's Annual Report~~, which will be available on the Trust's website, as will a link to Part II of the Register(s).~~ .

39. There may be occasions where staff declare an interest but, upon closer consideration, this is not material and so does not give rise to the risk of a conflict of interest. The Head of Corporate Governance should decide whether it is necessary to transfer such declarations to the published register(s) of interests.

40. Individuals can request that information on their interests should not be published. This will allow for information to be redacted from the publicly available register where public disclosure of information could give rise to a real risk of harm or is prohibited by law.

41. If a change to details recorded on the Register(s) arises during the year, it is the individual staff member's responsibility to ~~notify the Head of Corporate Governance~~make a new declaration or update their existing declaration (s) at the earliest opportunity (and in any event within 28 days)~~, using the process accessed on the OUH intranet~~ here ~~, so that any conflict between private and public interests can be managed appropriately.~~

~~39.~~42. Decision making staff should update their declaration of interest or make a nil return at least annually.

43. At least once a year, ~~after all members of the Board and other decision-making staff have reviewed and updated their declarations of interests, gifts, hospitality and sponsorship, or made a nil return~~, the Head of Corporate Governance will ~~review~~review the Register(s) to ensure that there is an accurate and comprehensive

record of all declarations made.

40.44. In accordance with NHS England's guidance, an interest will generally remain on the Register(s) for a minimum of 6 months after the date of its expiry and a private record of historic interests will be retained for a minimum of six years.

Procurement, Commercial decision-making and other strategic decision-making processes

41.45. The Trust will seek to ensure that procurement decisions and other strategic decision-making processes including all commercial decisions are managed in an open and transparent manner, with no discrimination against or in favour of any provider.

42.46. Any procurement should be managed in an open and transparent manner, compliant with procurement and other relevant law, to ensure there is no discrimination against or in favour of any provider. Procurement processes should be conducted in a manner that does not constitute anti-competitive behaviour, which is against the interest of patients and the public.

43.47. At every stage of any procurement or commercial decision-making process, steps must be taken to identify and manage any conflicts of interest, to ensure and protect the integrity of the process. The Register(s) of Interests, Gifts, Hospitality and Sponsorship will be available for scrutiny by the Director of Procurement and Commercial Director, or a delegated member of staff, at the start of any strategic decision-making process.

44.48. It is the responsibility of individual members of staff to declare any interests which may impact on any part of a procurement, commercial decision or other strategic decision-making process. Where they have already previously declared any such interest(s), they should also draw them to the attention of colleagues who are involved in the specific procurement, commercial decision or other strategic decision-making process.

45.49. During any procurement, commercial decision or other strategic decision-making process, it is important that the interests of each individual involved are well known to all those who will be involved in making the decision. Depending upon the nature and extent of the interest declared by an individual, it may be judged appropriate to exclude the individual from all or part of the discussion and/or decision, although NHS England's Guidance expressly advises that the default response should not always be to exclude individuals who have declared an interest, as this may have a detrimental effect on the quality of the decision being made.

46.50. Where an individual involved in a procurement process, commercial decision or other strategic decision-making process

- has been identified as having an interest which is or may be in significant conflict with the interests of the Trust, and
- where that may give rise to undue influence on their decision, or may be perceived as so doing the Manager who is leading the procurement process, commercial decision or other strategic decision-making process must inform the appropriate lead Director (*e.g.* Director of Procurement, Commercial Director or the Executive Director who is ultimately responsible for the strategic decision to be taken) **and** the Head of Corporate Governance, who will determine to what extent it is appropriate for the

individual to continue to be involved in the procurement process, commercial decision or other strategic decision-making process. As is expressly recognised in NHS England's Guidance, in some cases the individual concerned may be vital to the procurement process, commercial decision or other strategic decision- making process e.g. where they are providing specialist advice that cannot easily otherwise be accessed. In such a case, the individual's involvement should be subject to the oversight of a designated senior manager who will be responsible for documenting how they have been satisfied that there has been no undue influence and no discrimination against or in favour of any provider. A record of all decisions must be retained.

47.51. The Director of Procurement, the Commercial Director and any other Director with ultimate responsibility for a strategic decision-making process will consider whether the relevant Divisional Director and/or Executive Director should be specifically notified that an interest has been declared which may give rise to actual or potential conflict with the interests of the Trust, and whether further consideration needs to be given to taking management action (by reference to paragraph 30 above). Advice may be sought from the Head of Corporate Governance as appropriate.

Gifts, Hospitality and Sponsorship: Managing interests

48.52. In line with the Bribery Act 2010, employees should refuse gifts, hospitality or sponsorship or benefits from a third party which may compromise or may be seen to compromise their professional position. This may in certain circumstances also include a gift, hospitality or sponsorship offered to a family member.

49.53. A breach of the provisions of the Bribery Act renders staff liable not only to dismissal but to criminal prosecution under the Act, and a prison term of up to 10 years if convicted.

50.54. If the Trust is found to have failed to prevent bribery, it will be guilty of the "corporate offence," and both the organisation and its directors can receive a sanction including unlimited fines. A "twin track" approach may be used, to prosecute an individual member of staff, and the Trust simultaneously.

51.55. Any concerns or suspicions must also be reported to the Anti-Crime Specialist and Chief Finance Officer (refer to the Counter Fraud & Bribery Policy and Reporting Procedures).

52.56. All staff have a personal responsibility to volunteer information regarding offers of gifts, hospitality and sponsorship, including those offers that have been refused where there are grounds for concern or suspicion that the offer may be construed as an attempt to induce preferential treatment.

53.57. **Staff should seek approval from their line manager, prior to accepting any offer of gifts, hospitality or sponsorship.** The process for making a declaration of gifts, hospitality or sponsorship may be accessed on the OUH intranet here Those without access to the OUH intranet should contact the Head of Corporate Governance *via* email sent to declarations@ouh.nhs.uk or to company.secretary@ouh.nhs.uk The Head of Corporate Governance will ensure that the details of all declarations made are entered on the Register..

Guiding principles

~~54.~~58. It is not possible to make explicit in exactly what situations gifts, hospitality or sponsorship may be considered acceptable. Each offer should be considered independently. In determining whether any offer of a gift, hospitality or sponsorship should be accepted, an individual should consider the following **guiding principles**, endorsed by NHS England:

55.1. **Openness:** It has been openly offered and the offer will not be construed as any form of inducement and will not put the individual under any obligation to those offering it;

55.2. **Legitimate interest:** Regard should be paid to the reason for the contract on both sides and whether it is a contract that is likely to benefit the Trust i.e. further the aims of the organisation;

55.3. **Relationship:** Consideration should be given as to whether the Trust is likely to enter into a contractual relationship with the organisation/individual making the offer, or is currently tendering for a product/service supplied by the organisation/individual;

55.4. **Value:** Gifts and benefits of a trivial or inexpensive seasonal nature e.g. diaries/calendars, are more likely to be acceptable and can be distinguished from more substantial offers. Similarly, hospitality in the form of aworking lunch would not be treated in the same way as more expensive social functions, travel or accommodation.

Gifts

~~55.~~59. As is stated in NHS England Guidance, “Staff in the NHS offer support during significant events in people’s lives. For this work they may sometimes receive gifts as a legitimate expression of gratitude. We should be proud that our services are so valued. But situations where the acceptance of gifts could give rise to conflicts of interest should be avoided. Staff and organisations should be mindful that even gifts of a small value may give rise to perceptions of impropriety and might influence behaviour if not handled in an appropriate way. A gift means any item of cash or goods, or any service, which is provided for personal benefit, free of charge, or at less than its commercial value.”

~~56.~~60. Staff should not ask for any gifts and must refuse gifts that may affect, or be seen to affect, their professional judgement or integrity, or which seek to exert influence to obtain a preferential consideration.

~~57.~~61. Staff must not accept gifts, whatever their value, offered by suppliers or contractors or others involved in the procurement process, even if the offer is not in any way connected with the performance of duties or contract so as to constitute an offence under the Bribery Act 2010. In cases of doubt the Head of Corporate Governance should be consulted.

~~58.~~62. Low cost branded promotional aids such as pens or post-it notes offered by suppliers or contractors may however be accepted where they are under the value of £6 in total,

and they need not be declared (selected by NHSE with reference to existing industry guidance issued by the ABPI http://www.pmcpa.org.uk/thecode/Pages/default.aspx).

59.63. Anybody working with, for or on behalf of the Trust should exercise the utmost discretion in accepting gifts from service users or their relatives. Further ***Guidance on accepting and declaring gifts*** (in alignment with NHS England Guidance) is provided at ***Appendix 1A***.

What to declare in relation to Gifts

60.64. In line with NHS England Guidance, and subject to paragraohs 57 and 58 above, modest gifts under a value of £50 do not need to be declared, Whenever the offer of a gift worth over
£50 (or multiple gifts with an aggregate value of over £50) is accepted, staff should submit a declaration in accordance with the process that may be accessed on the OUH intranet here following guidance provided at ***Appendix 1A***.

Hospitality

61.65. Hospitality offered may include meals and refreshments, and/or travel and accommodation. In line with NHS England Guidance, staff must refuse hospitality which may compromise or be seen to compromise their professional judgement or integrity, or which seeks to exert influence to obtain a preferential consideration.

62.66. Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors; such hospitality may be accepted if it is modest and reasonable but must be declared and it may only be accepted if it has been approved in advance by a senior manager. Further ***Guidance on accepting and declaring hospitality*** (in alignment with NHS England Guidance) is provided at ***Appendix 1B***.

What to declare in relation to Hospitality

63.67. If a member of staff wishes to accept an offer of meals and refreshments worth over £25, and/or an offer to pay travel and accommodation costs related to attendance at an event, they should submit a declaration in accordance with the process that may be accessed on the OUH intranet here , following further guidance provided at ***Appendix 1B***.

Sponsorship

64.68. As is expressly recognised in NHSE Guidance, external sponsorship can benefit the Trust. In all cases, sponsors should be selected using criteria to avoid conflicts of interest, subject to the over-arching principle of transparency, and subject always to compliance with the Trust's Standing Financial Instructions.

65.69. It is noted that TheHill, established as part of the Trust, is a health and care digital transformation catalyst that aims to generate funding through sponsorship, and in collaboration with partners, to secure long-term sustainability and achieve strategic objectives; whilst operating in accordance with the guidance contained in this policy.

66.70. Under no circumstances may "linked deals" be agreed, whereby any sponsorship is linked to the purchase of particular products or to supply from particular sources.

Sponsorship should not fetter the Trust's intellectual property rights.

~~67.~~71. Staff should bear in mind that their acceptance of sponsorship, including attendance at a sponsored event, may preclude them from participating in an adjudication panel or giving advice on purchasing decisions, or other strategic decisions, in the future.

~~68.~~72. Staff should follow the further ***Guidance on accepting and declaring sponsorship*** (in alignment with NHS England Guidance) which is provided at ***Appendix 1C***, whether the offer of sponsorship relates to:

69.1. Sponsored events;

69.2. Sponsored research; or

69.3. Sponsored posts.

What to declare in relation to sponsored events

~~69.~~73. Details of the sponsored event should be declared by the member of staff who is the lead organiser (or the lead point of liaison with the external sponsor), in accordance with the process that may be accessed on the OUH intranet here , following guidance provided at ***Appendix 1C***.

What to declare in relation to sponsored research

~~70.~~74. Written records should be retained and individual members of staff who are involved in the sponsored research should make a declaration, in accordance with the process that may be accessed on the OUH intranet here , following guidance provided at ***Appendix 1C***.

What to declare in relation to sponsored posts

~~71.~~75. Details of any sponsored post should be declared by the member of staff who has secured the external sponsorship, in accordance with the process that may be accessed on the OUH intranet here , following guidance provided at ***Appendix 1C***.

Sponsorship from the pharmaceutical or medical technology industries

~~72.~~76. Offers of sponsorship from the pharmaceutical or medical technology industries should be referred to the relevant Divisional Director for consideration and notified to the Commercial Directorate. Offers of sponsorship from other sources may also need to be referred. In determining whether an offer should be accepted or not, the Divisional Director should refer to the Commercial Director where appropriate. They should consider the **guiding principles** in **paragraph 55** above, and should take into account the further specific guidance relating to sponsorship at ***Appendix 1C*** to the extent that it is relevant. Where sponsorship is accepted, it must be made clear to the company concerned that the sponsorship will have no effect on purchasing or other strategic decisions.

~~73.~~77. All offers of any sponsorship accepted from the pharmaceutical or medical technology industries should be reported annually to the Trust Management Executive [TME], via the Head of Corporate Governance.

~~74.~~78. The pharmaceutical industry is expected to adhere to the ABPI Code of Practice for the pharmaceutical industry which clearly specifies what is and what is not acceptable.

~~75.~~79. No member of staff may enter into individual arrangements for sponsorship with the pharmaceutical or medical technology industries.

Managing interests in other common situations

~~76.~~80. NHS England Guidance sets out principles and rules to be adopted in a range of common situations where interests may need to be managed, and stipulates what should be declared in each situation. Beyond situations where gifts, hospitality and sponsorship are offered, other "common situations" covered in NHS England Guidance include:

- Outside employment
- Clinical private practice
- Patents
- Shareholdings
- Loyalty interests
- Offers of an honorarium; and
- Donations

Outside employment

~~77.~~81. As is recognised in NHS England Guidance, the involvement of staff in outside employment alongside their NHS roles can be of benefit, but such involvement must be declared so that any conflict of interest can be identified and managed appropriately.

~~78.~~82. In line with NHS England Guidance, (and in addition to the requirements of any other policy, for example in relation to Working Time Regulations), staff should declare any existing outside employment on appointment to their role at the Trust. Any new outside employment which arises during the course of their employment with the Trust must be declared at the point when it arises.

79.1. **Working for NHSProfessionals** Shifts worked at the Trust will not be regarded as "outside employment" even if the individual is paid for those shifts by NHS Professionals, (but **NB** such shifts may need to be notified in the context of compliance with Working Time Regulations). Any shifts worked outside the Trust (whether through NHS Professionals, another agency, or in the direct employment of another organisation) will be regarded as "outside employment" which must be declared.

~~79.~~83. Where outside employment may give rise to an actual or potential conflict with interests of the Trust, including where there is any risk that the Trust's intellectual property rights may be diminished, the Trust may require action to be taken to manage the conflict of interest (as outlined in paragraph 30 above). Further advice may be sought from Human Resources.

~~80.~~84. Subject to the terms and conditions of the individual's contract of employment, and compliant with relevant Trust policy, the Trust may require staff to seek prior approval before engaging in outside employment.

What to declare in relation to outside employment

~~81.~~85. Staff should declare any outside employment in accordance with the process that may be accessed on the OUH intranet here , stating their name and role at the Trust, and providing a description of the nature of their outside employment (including name of employer, duties and time commitment), relevant dates (including expected duration, if known) and any other relevant information *e.g.* action taken to mitigate any conflict of interest, and details of any approvals given to depart from the terms of this policy.

Clinical private practice

~~82.~~86. As with other outside employment, in addition to the requirements of any other policy (for example in relation to Job Planning), and in line with NHS England Guidance, clinical staff should declare all private practice that they undertake on appointment to their role at the Trust. Any new private practice which arises during the course of their employment with the Trust must be declared at the point when it arises.

~~83.~~87. Any clinical private practice that is undertaken must be undertaken in compliance with Trust policy.

~~84.~~88. In line with NHS England Guidance and the provisions of the NHSE Model Policy, clinical staff should (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed):

85.1. Seek prior approval from the Trust before taking up private practice;

85.2. Ensure that, where there would otherwise be an actual or potential conflict of interest, NHS commitments take precedence over private work;

85.3. Not accept direct or indirect financial incentives from private providers other than those allowed by the Competition and Markets Authority guidelines .

~~85.~~89. In line with NHS England Guidance, Hospital Consultants should not initiate discussions about providing their Private Profrssional Services for NHS patients, nor should they ask other staff to initiate such discussions on their behalf.

What to declare in relation to clinical private practice

~~86.~~90. Clinical staff should declare private practice in accordance with the process that may be accessed on the OUH intranet here , stating their name and role at the Trust, describing the nature of the private practice (*e.g.* what, where and when they practise, sessional activity etc), relevant dates, and any other relevant information (*e.g.* action taken to mitigate a conflict, and details of any approval given to depart from the terms of this policy).

Patents

~~87.~~91. As is recognised in NHS England Guidance, the development and holding of patents and other intellectual property rights allows staff to protect something that they create, preventing unauthorised use of products or the copying of protected ideas. Staff are encouraged to be innovative in their practice and therefore this activity is welcomed. However, conflicts of interest can arise when staff who hold patents and other intellectual property rights are involved in decision making and procurement. In addition, where product development involves use of time, equipment or resources from their organisation, then this too could create risks of conflicts of interest, and it is important that the organisation is aware of this and it can be managed appropriately

~~88.~~92. In line with NHS England Guidance, staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are ongoing which are, or might be reasonably expected to be, related to items to be procured or used by the Trust.

~~89.~~93. Staff should seek prior permission from the Trust before entering into any agreement with bodies regarding product development, research, work on pathways etc, where this impacts on the Trust's own time, or uses its equipment, resources or intellectual property.

~~90.~~94. Where holding of patents and other intellectual property rights do or may give rise to a conflict of interest then appropriate management action should be considered and applied to mitigate the risks, as outlined in paragraph 30 above.

What to declare in relation to patents

~~91.~~95. Staff should patents and any other intellectual property rights held in accordance with the process that may be accessed on the OUH intranet here , stating their name and role at the Trust, and providing a description of the patent or other intellectual property right and its ownership, including relevant dates and any other relevant information *e.g.* action taken to mitigate any conflict of interest, and details of any approvals given to depart from the terms of this policy.

Shareholdings

~~92.~~96. As is recognised in NHS England Guidance, holding shares or other ownership interests can be a common way for staff to invest their personal time and money to seek a return on investment. However, conflicts of interest can arise when staff personally benefit from this investment because of their role with an organisation. For instance, if they are involved in their organisation's procurement of products or

services which are offered by a company they have shares in then this could give rise to a conflict of interest. In these cases, the existence of such interests should be well known so that they can be effectively managed.

~~93.~~97. In line with NHS England Guidance, and the provisions of NHSE's Model Policy, all staff should as a minimum declare any material shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with the Trust.

~~94.~~98. Where shareholdings or other ownership interests are declared and give rise to a risk of conflicts of interest then appropriate management action should be considered, as outlined in paragraph 30.

~~95.~~99. In line with the provisions of NHSE's Model Policy, there is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts.

What to declare in relation to shareholdings

~~96.~~100. Staff should declare shareholdings in accordance with the process that may be accessed on the OUH intranet here , stating their name and role at the Trust, and providing a description of the shareholding or other ownership interest, including relavant dates and any other relevant information *e.g.* action taken to mitigate any conflict, and details of any approvals given to depart from the terms of this policy.

Loyalty interests

~~97.~~101. As is recognised in NHS England Guidance, as part of their role, staff (including all members of the Board) may need to build strong relationships with colleagues across the NHS and in other sectors. These relationships can be hard to define as they may often fall into the category of indirect interests. They are unlikely to be directed by any formal process or managed via any contractual means, however these 'loyalty' interests can influence decision making. Conflicts of interest can arise when decision making is influenced subjectively through association with colleagues or organisations out of loyalty to the relationship they have, rather than through an objective process. The scope of loyalty interests is potentially huge, so judgement is required for making declarations.

~~98.~~102. In line with NHS England Guidance, and the provisions of NHSE's Model Policy, loyalty interests (as defined in paragraph 18) should be declared by staff involved in decision making where they:

99.1. Hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role.

99.2. Sit on advisory groups or other paid or unpaid decision making forums that can influence how an organisation spends taxpayers' money.

99.3. Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners.

99.4. Are aware that their organisation does business with an organisation in which close family members and relatives, close friends and associates, and business partners have decision making responsibilities.

What to declare in relation to loyalty interests

~~99.~~103. Staff should declare loyalty interests in accordance with the process that may be accessed on the OUH intranet here , stating their name and role at the Trust, and providing a description of the nature of the loyalty interest, including relevant dates and any other relevant information *e.g.* action taken to mitigate any conflict of interest and details of any approvals given to depart from the terms of this policy.

Offers of Honorarium

~~100.~~104. An honorarium is an ex gratia payment (i.e. one which is made other than on the basis of any legal obligation).

~~101.~~105. The offer of honoraria to a member or members of staff may be made in connection with sponsorship. In some cases, staff may be offered an honorarium for deploying their professional expertise to the benefit of others outside the Trust, *e.g.* through responding to market research, being interviewed, or delivering a lecture. Wherever a member of staff has received an offer of an honorarium they must consider the appropriateness of acceptance and whether this might be perceived as impacting on their impartiality. Staff should refer to their line manager in the first instance, and advice may be sought from the Head of Corporate Governance .

~~102.~~106. Where a member of staff wishes to accept an honorarium and it is determined to be appropriate that they may do so, they must declare the paid honorarium as "outside employment" (see further under paragraph 78-82) and the activity in respect of which the honorarium has been offered should be undertaken outwith the individual member of staff's contracted hours of paid employment by the Trust. (If undertaken within usual "business hours", then the time should be made up, or taken as leave). The member of staff should note that acceptance of an honorarium may have tax implications and that they will need to make appropriate declarations for tax purposes.

~~103.~~107. An honorarium should be declared in accordance with the process that may be accessed on the OUH intranet here –- stating the member of staff's name and role at the Trust, and providing relevant information *e.g.* why it was considered appropriate to accept, whether it could be perceived as impacting on impartiality, and any action taken to mitigate any conflict of interest.

Donations

~~104.~~108. 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. As a major public sector employer the NHS holds formal and informal partnerships with national and local charities. In their private lives, staff may undertake voluntary work or fundraising activities for charity. A supportive environment across the NHS and charitable sector should be promoted. However, conflicts of interest can arise.

~~105.~~109. In line with NHS England Guidance, donations made by suppliers or bodies

seeking to do business with the Trust should be treated with caution and should not be routinely accepted. Such donations should never be accepted in a personal capacity and should not routinely be accepted by the Trust. In exceptional circumstances they may be accepted as a donation to the Oxford Hospital Charity but should always be declared. A clear reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value.

~~106.~~110. Staff should not actively solicit charitable donations from any source unless this is a prescribed or expected part of their duties for the Trust, or is being pursued on behalf of the Oxford Hospital Charity or other charitable body and is not for their own personal gain.

~~107.~~111. 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 for a charity other than the Oxford Hospital Charity.

~~108.~~112. Donations when received should be made to a specific charitable fund of the Oxford Hospital Charity (never to an individual) and a receipt should be issued.

~~109.~~113. Staff wishing to make a donation to a charitable fund of the Oxford Hospital Charity in lieu of receiving a professional fee or honorarium 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.

~~110.~~114. The Trust will maintain records in line with the above principles and rules and relevant obligations under charity law.

Consequences of breaching this Policy

~~111.~~115. In line with NHS England Guidance, action taken in response to breaches of this policy will be in accordance with the Trust's disciplinary procedures and could involve organisational leads for staff support (e.g. Human Resources), fraud (e.g. Local Counter Fraud Specialists), members of the management or executive teams and organisational auditors.

~~112.~~116. Disciplinary action for gross misconduct may be initiated, after investigation, if any member of staff fails to make a declaration as required under this policy, provides false information or participates in a decision making process where special favour is shown to unfairly award a contract, or if any member of staff otherwise abuses their official position or knowledge for the purpose of benefit to themselves, family or friends.

~~113.~~117. If staff have any concerns or suspicions that a fraud may have occurred in relation to other staff not declaring gifts, hospitality or sponsorship received or failing to declare an interest, the concern should immediately be reported to the Anti-Crime Specialist and Chief Finance Officer (please refer to the Counter Fraud & Bribery Policy and Reporting Procedures). It should be noted that individuals may also be liable to prosecution under the Fraud Act 2006 or the Bribery Act 2010.

Review

~~114.~~118. This policy will be reviewed every 3 years, as set out in the *Policy for the Development and Implementation of Procedural Documents.*

References

NHS England Guidance on Managing Conflicts of Interest in the NHS, found here NHS England Model Policy, found here
Guidance issued by the Information Commissioner's Office with regard to Freedom of Information legislation, Home | ICO

ABPI Disclosure UK Scheme details are found here

Appendix 1: Responsibilities under the Policy

1. **All members of staff** whether acting on behalf of the organisation or in partnership with another organisation must:

   - Be impartial and honest in the conduct of their official business;
   - Ensure that the interest of the service user is paramount at all times;
   - Use the Trust's funds delegated to them to the best advantage of the service, always ensuring value for money;
   - Be open and explicit about companies that offer incentives for awarding or renewing a contract for goods and services. These companies must be excluded from consideration during the tendering process of a contract.

2. In addition, staff including all **members of the Board** are expected to ensure that they **do not**:

   - Abuse their official position for the benefit of themselves, family or friends;
   - Seek to gain advantage for a business or other interest during the course of their official business.

3. It is recommended that where there is doubt, a declaration of interest should be made.

4. **All staff** should adhere to the Seven Principles of Public Life (the 'Nolan Principles'):

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

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

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

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

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

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

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

Who is responsible for what?

1. Under the Bribery Act 2010, **the Trust** must have procedures in place to prevent bribery; and must be able to demonstrate that these procedures are followed.
2. Under procurement law and regulations, **the Trust** must ensure that procurement processes are in place to prevent discrimination against or in favour of any provider of goods, services or equipment; and must be able to demonstrate that these processes are being followed.
3. Under guidance issued by NHS England, **the Trust** must have procedures and processes in place to ensure that potential conflicts of interest are being identified and properly managed, as part of the Trust's commitment to ensuring that all its dealings are conducted to the highest standards of integrity and that NHS monies are used wisely so that finite resources are always used in the best interests of patients.
4. **All members of the Trust Board** have specific duties under the NHS Act 2006, which include:
    a. A duty to avoid conflict between their own interest(s) and those of the Trust[vi];
    b. A duty not to accept in their capacity as a member of the Board any benefit from a third party; and
    c. A duty to declare an interest in any proposed transaction or arrangement which may give rise to a conflict of interests.
5. **All staff** (including anybody working for, with or on behalf of the Trust – whether on a permanent, occasional or 'interim'/consultancy basis) may have personal interests, but must ensure that a conflict between their personal interests and the interests of the Trust does not inappropriately affect decisions made on the use of taxpayers' money.
6. **All staff** should declare a material interest at the earliest opportunity, and in any event within 28 days of the interest arising, using the process accessed on the OUH intranet here . Common situations in which an actual or potential conflict of interest may arise include – but are not limited to - the receipt of gifts, hospitality or sponsorship, as well as positions held at another organisation or body, and shareholdings in any publicly-listed or private company with which the Trust may do business.
7. All **staff involved in any part of a procurement, commercial decision or other strategic decision-making process** should at the outset of their involvement in the process declare any relevant interests (to their colleagues, and for entry on the Trust's Register).
8. The **Director of Procurement** will be responsible for implementing processes to ensure that any procurement is managed in an open and transparent manner, compliant with procurement and other relevant law, to ensure there is no discrimination against or in favour of any provider. They will have oversight of the procurement processes to ensure that they are conducted in a manner that does not constitute anti-competitive behaviour, which is against the interest of patients and

the public.

9. Those members of staff who, because of the requirements of their role, are more likely than others to have a decision-making influence on the use of taxpayers' money ["**decision- making staff**"] should at least once a year review and update their declarations of interest (including those arising from the receipt of gifts, hospitality or sponsorship), or make a nil return. Decision-making staff will include:
    a. All members of the Trust Board;
    b. All members of the Trust Management Executive;
    c. Staff at Agenda for Change Band 8d and above or equivalent, including all Medical and Dental Consultants;
    d. Any member of staff with authority to enter into a contract on behalf of the Trust;
    e. Administrative and clinical staff involved in decision-making concerning funding allocation, investment decisions and investment management, the commissioning of services, purchasing of goods, medicines, medical devices or equipment and formulary decisions.
10. Any **line manager** of a member of staff who has made a declaration should determine whether it may give rise to a conflict of interest. If so, they should decide on the most appropriate course of management action, with support from senior management and advice from the Head of Corporate Governance as and where appropriate. This may include making arrangements to:
    a. restrict the individual's involvement in discussions and exclude them from decision making relating to the matter in which they have declared an interest;
    b. remove an individual from the whole of any decision-making process relating to the matter in which they have declared an interest;
    c. remove an individual's responsibility for an entire area of work (if it relates to the matter in which they have declared an interest);
    d. require an individual to relinquish the interest declared, if the conflict is so significant that they would be unable to operate effectively in their Trust role; or to remove the individual from their Trust role, if they are unwilling to relinquish the conflicting interest;
    e. suspend any involvement by the individual, pending referral to more senior management within the directorate or division, or ultimately to Executive Directors and the Board, as may be advised by the Head of Corporate Governance.
11. Any member of **staff leading a procurement process, commercial decision or other strategic decision-making process** should consider the interests declared by all those involved in the process and determine whether any give rise to a conflict of interest. If so, they should decide on the most appropriate course of management action (as under paragraph 10 above), although the default response should not always be to exclude individuals who have declared an interest, as this may have a detrimental effect on the quality of the decision being made.
12. The **Director of Procurement, Commercial Director** or the **Executive Director with responsibility for a strategic decision** and the **Head of Corporate Governance** should be notified in any case where an individual involved in a procurement process, commercial decision or other strategic decision has been identified as having an interest which is in significant conflict with the interests of the

Trust. They will advise on the extent to which it is appropriate for the individual to continue to be involved in the procurement process. **NB** It is recognised that in some cases the individual may be vital to the procurement process
e.g. where they are providing specialist advice that cannot easily otherwise be accessed. In such a case, the individual's involvement should be subject to the oversight of a designated senior manager who will be responsible for documenting how they have been satisfied that there has been no undue influence and no discrimination against or in favour of any provider. A record of all decisions should be retained.

13. The **Head of Corporate Governance** will be responsible for ensuring that an annual reminder is issued to all members of the Board and other decision-making staff to review and update their declarations of interest (including those arising from the receipt of gifts, hospitality or sponsorship), or make a nil return.
14. The **Head of Corporate Governance** will be responsible for maintaining a record of all declarations received in the Registers of Interests, Gifts, Hospitality and Sponsorship. The Registers will be maintained in two parts: Part I relating to all members of the Board; and Part II including declarations made by other decision-making members of staff. Part I of the Register will be published in the Trust's Annual Report which will be available on the Trust's website, as will a link to Part II of the Register, making both parts of the Register available for inspection by the public and by the Trust's auditors.
15. The **Head of Corporate Governance** will annually review the Registers to ensure that they constitute an accurate and comprehensive record of all declarations made. (An interest will generally remain on the Register for a minimum of 6 months after expiry. Interests removed from the Register after they have expired will be archived and a private record of these will be retained for a minimum of 6 years).

Appendix 1A: Guidance on accepting and declaring gifts

1. As is stated in NHS England Guidance, "Staff in the NHS offer support during significant events in people's lives. For this work they may sometimes receive gifts as a legitimate expression of gratitude. We should be proud that our services are so valued. But situations where the acceptance of gifts could give rise to conflicts of interest should be avoided. Staff and organisations should be mindful that even gifts of a small value may give rise to perceptions of impropriety and might influence behaviour if not handled in an appropriate way. A gift means any item of cash or goods, or any service, which is provided for personal benefit, free of charge, or at less than its commercial value."

2. Staff should not ask for gifts and must refuse gifts that may affect, or be seen to affect, their professional judgement or integrity, or which seek to exert influence to obtain a preferential consideration.

3. Staff must not accept gifts, whatever their value, offered by suppliers or contractors or others involved in the procurement process, even if the offer is not in any way connected with the performance of duties or contract so as to constitute an offence under the Bribery Act 2010. In cases of doubt the Head of Corporate Governance should be consulted. The only exception to this is that low cost branded promotional aids such as pens or post-it notes offered by suppliers or contractors may be accepted where they are under the value of £6 in total

4. In other cases, and where the gift offered is not of high value and is of a non-cash nature –

   for example a box of chocolates - it may be accepted graciously, and with thanks.

5. Subject to paragraphs 2 and 3 above (consistent with paragraphs 57 and 58 of the policy), gifts may be accepted **up to a value of £50** and **do not need to be declared**.

6. When valuing a gift offered, the actual purchase price should be used if known, or an estimate that a reasonable person would make as to its value.

7. Gifts valued at over £50 should be treated with caution and should not be accepted in a personal capacity, but only on behalf of the Trust, for donation to a specified charitable fund of the Oxford Hospitals Charity. Staff may contact The Oxford Hospitals Charity https://www.ouh.nhs.uk/charity/ and if accepted the gift must be declared. Multiple gifts from the same source over a 12 month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds £50, *i.e.* a second or subsequent gift which takes the cumulative value to over £50 may only be accepted on behalf of the Trust, for donation to a specified charitable fund of the Oxford Hospitals Charity (not in a personal capacity), and must be declared if accepted.

8. If a gift is offered to a member of staff in lieu of a professional fee for work that has been undertaken as part of the individual's NHS role (*e.g.* for a lecture, presentation, publication or broadcast), then, subject to consideration of the guiding principles as outlined in **paragraph 55** of the policy, there may be circumstances in which the gift can be accepted on behalf of the Trust, for donation to a specified charitable fund of

the Oxford Hospitals Charity, but not in a personal capacity. If the gift is valued at over £50 it must be declared.

9. Gifts of cash and vouchers should always be declined. The putative donor may be advised that they can make a donation to charitable funds by contacting The Oxford Hospitals Charity https://www.ouh.nhs.uk/charity/. If it is not possible to trace and/or contact the donor of cash or vouchers received (for example, if cash or vouchers are contained within a card and it is not clear from whom the card came), then the cash or vouchers should be paid into a specified charitable fund of the Oxford Hospitals Charity, and a full declaration made.

10. In case of any doubt as to whether a gift can be accepted, and whether it needs to be declared, the Head of Corporate Governance should be consulted.

What to declare in relation to Gifts

11. Whenever the offer of a gift worth over £50 (or multiple gifts with an aggregate value of over
£50) is accepted, staff should submit a declaration in accordance with the process that may be accessed on the OUH intranet here , stating

- their name and role;
- a description of the nature and value of the gift, including its source;
- the date of receipt; and
- any other relevant information (e.g. circumstances surrounding the gift and action taken to mitigate against the gift being perceived as an inducement). To the extent that acceptance of the gift departs from the guidance contained in this policy, details should be documented of the basis upon which approval was given.

Appendix 1B: Guidance on accepting and declaring hospitality

1. Meals, refreshments, travel costs and accommodation can all constitute hospitality offered.

2. In line with NHS England Guidance, staff must refuse hospitality which may compromise or be seen to compromise their professional judgement or integrity, or which seeks to exert influence to obtain a preferential consideration.

3. Staff may accept offers of hospitality that are compatible with the **guiding principles** outlined in **paragraph 55** of the policy, provided that there is a legitimate business reason and the hospitality is proportionate to the nature and purpose of the event.

4. Meals and refreshments up to a value of £25 may be accepted and need not be declared. Meals and refreshments of a value between £25 and £75[vii] must be declared and should be approved prior to accepting the offer of hospitality. Over a value of £75, the offer of meals and refreshments as hospitality should be refused unless there are exceptional circumstances and senior approval is given. A clear reason should be recorded on the Register as to why it was permissible to accept the hospitality.

5. When valuing meals and refreshments offered as hospitality, the actual amount should be used, if known, or an estimate that a reasonable person would make as to its value.

6. Where more than one member of staff receives hospitality in the form of a mealand/or other refreshments, each individual must complete a Declaration of Gifts, Hospitality and Sponsorship form and submit this to the Head of Corporate Governance.

7. When hospitality is received in any form, the person(s)/organisation offering the hospitality should be made aware that the Trust will not and does not agree to preferential treatment as a result of receiving the hospitality.

8. Modest offers to pay some or all of the travel and/or accommodation costs related to attendance at events may be accepted and must be declared.

9. Offers of travel and/or accommodation which go beyond that which could be regarded as modest, or that are of a type that the Trust itself might not usually offer:
   - need prior approval by a senior manager;
   - should only be accepted in exceptional circumstances; and
   - must be declared.

   A clear reason should be recorded on the Register as to why it was permissible to accept the travel and/or accommodation, in particular (but not limited to):

   9.1. offers of business class or first class travel and accommodation (including domestic travel); and/or

   9.2. offers of foreign travel and accommodation.

What to declare in relation to Hospitality

8. If a member of staff wishes to accept an offer of meals/refreshments worth over £25,

or any offer to pay for travel and/or accommodation, they should submit a declaration in accordance with the process that may be accessed on the OUH intranet here stating

8.1. their name and role;

8.2. a description of the nature and value of the hospitality, including the circumstances;

8.3. the date of receipt; and

8.4. any other relevant information (e.g. action taken to mitigate against any actual or perceived conflict of interest). To the extent that acceptance of the hospitality departs from the guidance contained in this policy, details should be documented of the basis upon which approval was given.

Appendix 1C: Guidance on accepting and declaring sponsorship

1. As is recognised in NHSE Guidance, external sponsorship can benefit the Trust. Established as part of the Trust, TheHill is a health and care digital transformation catalyst that aims to generate funding through sponsorship, and in collaboration with partners, to secure long- term sustainability and achieve strategic objectives. Sponsors approved by TheHill are selected using criteria to avoid conflicts of interest, and subject to the over-arching principle of transparency.

2. Offers of sponsorship made other than through TheHill may be accepted in accordance with the guidance contained in this policy, consistent with the principles applied by TheHill, and subject always to compliance with the Trust's Standing Financial Instructions.

3. Under no circumstances may "linked deals" be agreed, whereby any sponsorship is linked to the purchase of particular products or to supply from particular sources. Sponsorship should not fetter the Trust's intellectual property rights.

4. Staff should bear in mind that their acceptance of sponsorship, including attendance at a sponsored event, may preclude them from participating in an adjudication panel or giving advice on purchasing decisions, or other strategic decisions, in the future.

Sponsored events

5. In line with NHS England Guidance

5.1. 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 and the NHS.

5.2. During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation.

5.3. 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.

5.4. At the Trust'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.

5.5. The involvement of a sponsor in an event should always be clearly identified in the interest of transparency.

5.6. It should be made clear that 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.

5.7. Staff should declare their involvement with arranging any sponsored events.

5.8. Where a member of staff is required to take study leave to attend a sponsored event or conference, details of the sponsorship arrangements should be recorded on their application for study leave.

6. Where the Trust receives or invites offers of sponsorship for events, which are hosted wholly or partly by the Trust, the relevant line manager must apply the **guiding principles** outlined in **paragraph 55** of the Policy and consider whether it is appropriate to accept the offer. The relevant line manager must complete a Declaration of Gifts, Hospitality and Sponsorship form and submit it to the Head of Corporate Governance.

What to declare in relation to sponsored events

3. Details of the sponsored event should be declared by the member of staff who is the lead organiser (or the lead point of liaison with the external sponsor), by submission of a declaration in accordance with the process that may be accessed on the OUH intranet here

3.1. The declaration should record that sponsorship of the event complies with paragraphs 1-8 above, or document the reasons for any departure therefrom.

Sponsored research

4. As is recognised in NHS England Guidance, research is vital in helping the Trust to transform services and improve outcomes. Without sponsorship of research some beneficial projects might not happen. More broadly, partnerships between the Trust and external bodies on research are important for driving innovation and sharing best practice. However, 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. There needs to be transparency and any conflicts of interest should be well managed.

5. In line with NHS England Guidance:

5.1. Funding sources for research purposes must be transparent and any benefit derived from funding or grants secured should be declared;

5.2. Any proposed research must go through the relevant approvals process;

5.3. There must be a written protocol and written contract between staff, the Trust and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services;

5.4. The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service;

5.5. Staff should declare involvement with sponsored research to the Trust (even if the research is being undertaken under contract with another organisation, *e.g.* The University of Oxford).

What to declare in relation to sponsored research

6. Written records should be retained and individual members of staff who are involved in the sponsored research should make a declaration in accordance with the process that may be accessed on the OUH intranet here , including:

6.1. their name and their role with the Trust;

6.2. a description of their involvement in the sponsored research;

6.3. relevant dates; and

6.4. any other relevant information (e.g. what, if any, benefit the sponsor derives from the sponsorship, action taken to mitigate against a conflict, and details of any approvals given to depart to any extent from Trust guidance).

Sponsored posts

7. Any offer to sponsor a post (i.e. where an organisation external to the NHS offers to fund a position in whole or in part) should initially be referred by the member of staff to their line manager, who should consider whether there may be on-going financial

implications for the Trust after the term of sponsorship has ended. Where necessary, further advice should be sought from the Divisional Management Team, to confirm whether approval will be required from Executive Directors.

8. As is recognised in NHS England Guidance, sponsored posts can offer benefits to the delivery of care, providing expertise, extra capacity and capability that might not otherwise exist if funding was required to be used from the NHS budget. However, safeguards are required to ensure that the deployment of sponsored posts does not cause a conflict of interest between the aims of the sponsor and the aims of the Trust, particularly in relation to procurement and competition.

9. In line with NHS England Guidance, when considering whether to approve a sponsored post, the following principles should be taken into account:

9.1. Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and confirm the appropriateness of arrangements continuing;

9.2. Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. For the duration of the sponsorship, auditing arrangements should be established to ensure this is the case. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements if conflicts of interest which cannot be managed arise;

9.3. Sponsored post holders must not promote or favour the sponsor's specific products, and information about alternative products and suppliers should be provided;

9.4. Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.

What to declare in relation to sponsored posts

10. Details of any sponsored post should be declared by the member of staff who has secured the external sponsorship who should make a declaration in accordance with the process that may be accessed on the OUH intranet here The declaration should record that sponsorship of the post complies with paragraphs 13-19 above, or document the reasons for any departure from the guidance.

Appendix 2: Definitions

TERM	EXPLANATION
Staff	Any individual who is working with, for, or on behalf of the Trust, whether on a permanent, occasional or temporary/'interim' basis, including all employees, 'office holders', contractors, sub-contractors and agents, those who hold an honorary contract, and those who otherwise may be regarded as representing the Trust whether or not directly employed or engaged by the Trust.
Benefit	Any type of benefit*, reward, financial gain, equitable right or commodity received either directly or indirectly by an individual. *A benefit may arise from the making of a gain or avoiding a loss
Close relative	Partner or spouse, Parents (or parents of a partner or spouse) Children (or children of a partner or spouse) Siblings (or siblings of a partner or spouse) Grandparent or grandchild Aunt or uncle Niece or nephew Partners or the above
Close friend, business or professional associate	Someone with whom you have a close association, the nature of which is such that you are likely to be pre-disposed to acting in their favour – and/or to be perceived as likely to act in their favour

Conflict of Interest[1]	A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act - in the context of delivering, commissioning, or assuring taxpayer funded health and care services - is, or could be, impaired or influenced by another interest they hold. A conflict of interest may be: Actual – where there is a material conflict between one or more interests; or Potential – where there is the possibility of a material conflict between one or more interests in the future.
Declaration	A formal statement of any (or no) interests that have arisen.
Gifts	Any item over £50 (or cash of any value) that is for personal use.

Hospitality	The provision of food, drink, accommodation or an event for which no payment (or minimal payment) is required to be made by the recipient.
Interest (in relation to a matter or organisation)	Something which a reasonable person would be likely to take into account as relevant when making a decision on a matter regarding the use of taxpayers' money.

Appendix 3: Education and Training

1. There is no mandatory training associated with this policy.
2. Guidance is availaible from the Head of Corporate Governance (contacted via company.secretary@ouh.nhs.uk), with whom the need for ad hoc training sessions may be discussed, based on any training needs identified as part of an individual's annual appraisal or supervision.

Appendix 4: Monitoring Compliance

3. Use the following statement and mandatory table to list specifically what will be monitored to ensure that the policy is effective, including the minimum standards for compliance or non- compliance.

4. Compliance with the document will be monitored in the following ways.

What will be monitored:	How will it be monitored:	By whom:	Minimum standard/ Frequency of monitoring	Reporting to:
Maintenance of the Register of Interests, Gifts, Hospitality and Sponsorship.	Register will be reviewed annually, prior to publication of Trust's Annual Report	Head of Corporate Governance/ Corporate Governance Manager	Annual review (March)	Audit Committee
Compliance with requirement for all staff to submit Declarations of Interests, Gifts, Hospitality and Sponsorship in accordance with the Policy	Dissemination of email alert by the Corporate Governance Department, disseminated through Directorates	Head of Corporate Governance/ Corporate Governance Manager	Annual reminder (February/March)	Trust Management Executive

Compliance with requirement to manage conflicts of interest at the Trust Board.	Any change in the interests of members of the Board will be declared and recorded at every meeting of the Board; and Register of Board members' interests will be reviewed and updated before publication in the Trust's Annual Report.	Trust Chair, with advice as appropriate from the Head of Corporate Governance	At Trust Board meetings; and Annually, upon publication of Trust's Annual Report.	Audit Commttee And Trust Board
Compliance with requirement to manage conflicts of interest in relation to procurement and other strategic decisions, including commercial decisions.	Scrutiny of the Register to identify interests declared by staff involved in any procurement decisions.	Director of Procurement and Commercial Director, in liaison with Head of Corporate Governance.	Periodically (as required in relation to any procurement or other strategic decision-making process, including commercial decisions)	Audit Committee

Appendix 5: Equality Impact Assessment

1. Information about the policy, service or function

What is being assessed	Revisions to existing Policy
Job title of staff member completing assessment	Corporate Governance Consultant
Name of policy / service / function:	Declaration of Interests, Gifts, Hospitality and Sponsorship Policy
Details about the policy / service / function	Identifying and Managing Conflicts of Interest
Is this document compliant with the Web Content Accessibility Guidelines?	Yes
Review Date	September 2024
Date assessment completed	31/08/21
Signature of staff member completing assessment	
Signature of staff member approving assessment	

2. Screening Stage

Who benefits from this policy, service or function? Who is the target audience?
Staff are the target audience

Does the policy, service or function involve direct engagement with the target audience?
Yes - *continue with full equality impact assessment*

3. Research Stage

Notes:

- If there is a neutral impact for a particular group or characteristic, mention this in the 'Reasoning' column and refer to evidence where applicable.
- Where there may be more than one impact for a characteristic (e.g. both positive and negative impact), identify this in the relevant columns and explain why in the 'Reasoning' column.
- The Characteristics include a wide range of groupings and the breakdown within characteristics is not exhaustive, but is used to give an indication of groups that should be considered. Where applicable please detail in the 'Reasoning' column where specific groups within categories are affected, for example, under Race the impact may only be upon certain ethnic groups.

Impact Assessment

Characteristic	Positive Impact	Negative Impact	Neutral Impact	Not enough information	Reasoning
Sex and Gender Re-assignment – men (including trans men), women (including trans women) and non-binary people.			□		Legal and regulatory requirements to identify and manage conflicts of interest apply universally
Race - Asian or Asian British; Black or Black British; Mixed Race; White British; White Other; and Other			□		
Disability - disabled people and carers			□		
Age			□		
Sexual Orientation			□		

Religion or Belief			□		
Pregnancy and Maternity			□		
Marriage or Civil Partnership			□		
Other Groups / Characteristics - for example, homeless people, sex workers, rural isolation.			□		

Sources of information

None

Consultation with protected groups

None

4. Summary stage

Outcome Measures
List the key benefits that are intended to be achieved through implementation of this policy, service or function and state whether or not you are assured that these will be equitably and fairly achieved for all protected groups. If not, state actions that will be taken to ensure this.

The key benefit intended to be achieved through implementation of this policy – which should be equitably and fairly reached for all protected groups - is that all decision-makers acting for or on behalf of the Trust will act free from the influence of any factors that may be in conflict with the interests of the Trust; and that the Trust will be able to demonstrate that all of its dealings are conducted to the highest standards of integrity and probity and that NHS monies are used wisely, so that finite resources are used appropriately and always in the best interests of patients.

Positive Impact
List any positive impacts that this policy, service or function may have on protected groups as well as any actions to be taken that would increase positive impact.
None

Unjustifiable Adverse Effects
List any identified unjustifiable adverse effects on protected groups along with actions that will be taken to rectify or mitigate them.
None

Justifiable Adverse Effects
List any identified unjustifiable adverse effects on protected groups along with justifications and any actions that will be taken to mitigate them.
None

Equality Impact Assessment Action Plan

Complete this action plan template with actions identified during the Research and Summary Stages **Not applicable**

Identified risk	Recommended actions	Lead	Resource implications	Review date	Completion date

[i] http://www.abpi.org.uk/ourwork/disclosure/Pages/disclosure.aspx

[ii] The Seven Principles of Public Life - GOV.UK (www.gov.uk)

[iii] NHS England Guidance on Managing Conflicts of Interest in the NHS, found here

[iv] reflecting guidance issued by the Information Commissioner's Office with regard to Freedom of Information legislation: https://ico.org.uk/media/1220/definition-document- health-bodies-inengland.pdf

[v] http://www.abpi.org.uk/ourwork/disclosure/Pages/disclosure.aspx

[vi] In limited circumstances, and where a matter has been duly and expressly authorised in accordance with the Constitution, there will be no breach of this duty

[vii] selected with reference to existing industry guidance issued by the ABPI http://www.pmcpa.org.uk/thecode/Pages/default.aspx

Asbestos Management Policy

Category:	Policy.
Summary:	This policy introduces measures to ensure, so far as is reasonably practicable, to minimise or, where possible, eliminate fully the exposure of all individuals to respirable asbestos containing materials.
Equality impact assessment undertaken:	April 2023.
Valid from:	April 2023.
Date of next review:	This will be 3 years from the approval date unless otherwise specified.
Approval date/ via:	Trust Health & Safety Committee -
Distribution:	Via Risk & Quality Department to: Divisional Directors and Directorate Managers. Clinical Governance Intranet Site. Via Estates & Facilities Directorate to: Estates & Facilities Managers. Contractors. Estates & Facilities Intranet Site. Project Co [PFI Services Providers] (via Contracts office).
Related documents:	Health & Safety Policy. Risk Management Policy. Risk Assessment Policy. Control of Substances Hazardous to Health Policy (COSHH). Estates Asbestos Management Procedures. Hospital Technical Memoranda 00. Health and Safety at Work Act 1974. Workplace (Health, Safety and Welfare) Regulations 1992. The Management of Health & Safety at Work Regulations (2006 Amendment & 1999). Control of Asbestos Regulations 2012, ACOP L143. The Construction (Design & Management) Regulations 2015. HSG 247 Asbestos: The Licensed Contractors' Guide & associated technical, appendixes & memo updates. HSG 248 Asbestos: The Analysts' Guide for Sampling, Analysis and Clearance Procedures, second edition. HSG 264 Asbestos: The Survey Guide. HSG 227 A comprehensive guide to managing asbestos in premises. HSE Asbestos Essentials HSG210 (A0-A38) & supporting Equipment and Method Sheets EM0 – EM10. HSG53 Respiratory Protective Equipment at Work: A practical guide (fourth edition).
Author(s):	Umer Saeed - Compliance Manager & Global Environmental Consultancy Ltd - Independent Asbestos Advisor.
Further information:	Site Estates & Facilities Managers.
This document replaces:	Version 0.7
Amendments reference:	Various amendments from appointment of new Asbestos AE including the following section number references:

	Amendments to 5.1, 8, 9, 10.1, 10.3, 10.4, 10.5, 10.7, 10.8, 11.3, 11.4, 11.5, 11.6, 11.7, 11.8, 11.9, 11.10, 11.11, 15.1, 15.2, 15.3, 21, Full update to 10.6, update to references page and 3. Evidence section.

Lead Director: Director of Estates, Facilities and Capital Development.

Issue Date: April 2023.

Contents

Introduction

1. The Trust recognises its management responsibility for asbestos containing material and will prioritise all asbestos remedial works as defined in our asbestos risk register.

2. This policy sets out the detailed requirements to minimise or, where possible, eliminate fully the exposure of all individuals to respirable asbestos containing materials.

Policy Statement

3. It is the policy of the Trust to minimise the risk of contamination from asbestos containing materials by ensuring all asbestos is inspected and maintained and appropriate measures taken in accordance with all Statutory Instruments, Approved Codes of Practice, HSE Guidance, NHS Guidelines or similar current memos, appendices and technical guidance at the time of application.

4. To achieve this objective the Trust has an established Asbestos Management Group which shall ensure that all Trust asbestos is managed in accordance with this policy, the Asbestos Procedures document and all regulative and legislation requirements.

5. All Asbestos is to be managed in accordance with the following reference documents:

   5.1. As per the following:

   - Health and Safety at Work etc. Act 1974.
   - Workplace (Health, Safety and Welfare) Regulations 1992.
   - The Management of Health and Safety at Work Regulations (2006 Amendment & 1999).
   - Control of Asbestos Regulations 2012.
   - ACOP L143 Managing & Working with Asbestos second edition.
   - The Construction (Design & Management) Regulations 2015.
   - HSG 247 Asbestos: The Licensed Contractors' Guide.
   - HSG 248 Asbestos: The Analysts' second edition.
   - HSG 264 Asbestos: The Survey Guide.
   - HSG 227 A comprehensive guide to managing asbestos in premises.
   - HSE Asbestos Essentials HSG210 (A0-A38) & supporting Equipment and Method Sheets EM0 – EM10.
   - ALG memos & ALG Technical appendices to HSG 247 & L143.

6. All staff shall ensure compliance with the Trust Policy and Procedures on Asbestos Management; all legislation; Approved Codes of Practice; HSE Guidance; HSE Asbestos Essentials; and best practice current at the time of application. Where legislation supersedes any of these documents or standards, the most up to date standard will take precedent.

Scope

7. This Policy and associated Asbestos Procedures document applies to all buildings owned or occupied by the Trust and all employees of the Trust, including individuals employed by a third party, by external contractors, as voluntary workers, as students, as locums or as agency staff.

8. This Policy covers all activities where inadvertent exposure to asbestos may occur (e.g. maintenance & installation works, refurbishment) but does not cover in depth the management of activities where it is clearly known that exposure will occur, e.g. the planned removal of asbestos, this is covered further in our asbestos management plan.

Aim

9. The purpose of this Policy is to ensure Trust premises containing Asbestos are managed to minimise the risk to the health, safety and wellbeing of patients, visitors and staff, and others who may be affected by our undertakings.

Definitions

10. The terms in use in this document are defined as follows:

    10.1. Asbestos - is a general term for fibrous silicates, minerals which have crystallised to form long thin fibres and it is a naturally occurring mineral that has been mined in various countries around the world. Asbestos falls into two groups, amphibole (brown/blue) and serpentine (white); amphibole asbestos is a greater hazard than serpentine, although both can cause the same health issues. The inhalation of asbestos fibres can cause serious illnesses, including malignant lung cancer, mesothelioma (a formerly rare cancer strongly associated with exposure to asbestos) and asbestosis (a type of pneumoconiosis).

    10.2. Asbestos Containing Materials – It will be rare to encounter pure asbestos. The most common use of asbestos was as an additive or composite. These materials that contain asbestos can vary greatly in appearance, density and composition, but all are known as Asbestos Containing Materials (ACM's).

    10.3. Asbestos Risk Assessment (Survey) – These risk assessments will meet the requirements of regulation 6 of the Control of Asbestos Regulations 2012, and any other relevant legislation. The organisation will ensure that all assessments are performed in accordance with HSE method in HSG 264. The criteria for asbestos surveys is contained in the HSE document HSG 264 "Asbestos: The Survey Guide". There are three forms of survey specified: Management Survey, Refurbishment Survey and Demolition Survey.

    HSG264 Management Survey

    A management survey is the standard survey, and its purpose is to locate, as far as reasonably practicable, the presence and extent of any suspect ACMs in the building which could be damaged or disturbed during normal occupancy, including foreseeable maintenance and installation, and to

assess their condition. Management surveys will often involve minor intrusive work and some disturbance. The extent of intrusion will vary between premises and depend on what is reasonably practicable for individual properties, i.e. it will depend on factors such as the type of building, the nature of construction, accessibility etc. A management survey must include an assessment of the condition of the various ACMs and their ability to release fibres into the air if they are disturbed in some way. This 'material assessment' will give a good initial guide to the priority for managing ACMs as it will identify the materials which will most readily release airborne fibres if they are disturbed or those that will be more prone to breakdown over a short period of time causing further risk.

The survey will usually involve sampling and analysis to confirm the presence or absence of ACMs. However, a management survey can also involve presuming the presence or absence of asbestos, where strong evidence is available to confirm these presumptions. A management survey can be completed using a combination of sampling ACMs and presuming ACMs or, indeed, just presuming. Any materials presumed to contain asbestos must also have their condition assessed as part of the material assessment.

Default presumption must only be used in circumstances where it is requested by the client and/or where access genuinely cannot be obtained.

All areas must be accessed and inspected as far as is reasonably practicable. Areas must include under floor coverings, above false ceilings, and inside risers, service ducts, lift shafts, etc. Surveying may also involve some minor intrusive work, such as accessing behind fascia and panels, unscrewing access panels or superficial materials and other such easily accessible surfaces. The extent of intrusion will depend on the degree of disturbance that is or will be necessary for foreseeable maintenance and related activities, including the installation of new equipment/cabling.

Our management surveys must cover routine and simple maintenance work. However, it must be recognised that where 'more extensive' maintenance or repair work is involved, there may not be sufficient information in the management survey and a localised refurbishment survey will be needed.

HSG264 Refurbishment & Demolition Survey

The description of these 2 types of surveys are very similar, although as the wording suggests one is relevant to refurbishment works and the other, only undertaken for demolition works. A refurbishment survey will be required for all work which disturbs the fabric of the building in areas where the management survey has not been intrusive. The decision on the need for a refurbishment survey must be made by our appointed Duty Holder.

This type of survey will be used to locate and describe, as far as reasonably practicable, all ACMs in the area where any refurbishment work will take place. If the whole building is planned for demolition, generally the Trust will have appointed a competent demolition contractor to undertake this level of survey, or the building will have been sold for development and we

will pass on all previous surveys for their reference. The survey will be fully intrusive and involve destructive inspection, as necessary, to gain access to all areas, including those that may be difficult to reach.

A refurbishment may also be required in other circumstances, e.g. when more intrusive maintenance and repair work will be carried out or for old plant removal or dismantling, ensuring that isolation/purging has been completed and any other likely hazardous substances are assessed.

There is a specific requirement in CAR 2012 (Regulation 7) for all ACMs to be removed as far as reasonably practicable before major refurbishment or final demolition. Removing ACMs is also appropriate in other smaller refurbishment situations which involve structural or layout changes to buildings (e.g., removal of partitions, walls, units etc.). Under CDM, the survey information must be used to help in the tendering process for removal of ACMs from any of our buildings/premises before work starts.

The survey report must be supplied by us to all designers and contractors who may be bidding for the work, so that the asbestos risks can be addressed. For this level of survey, the asbestos is identified so that it can be removed prior to commencing works, and therefore does not have a requirement to assess the condition of the asbestos, other than to indicate areas of damage or where additional asbestos debris may be present.

However, where the asbestos removal may not take place for some time, the ACMs' condition will need to be assessed and the materials managed.

Refurbishment and demolition surveys are disruptive and fully intrusive, which may need to penetrate all parts of the building structure. Aggressive inspection techniques will be needed to lift carpets and tiles, break through walls, ceilings, cladding and partitions, and open-up floors. In these situations, controls must be put in place to prevent the spread of debris, which may include asbestos.

Refurbishment and demolition surveys must only be conducted in unoccupied areas to minimise the risks to the public, patients and employees on any of our premises. Ideally, the building must not be in service, and all furnishings removed, in some situations in the Trust premises it may be difficult to remove specialist or fixed equipment, for these situations' specialist arrangements must be made for protection to be installed prior to commencing. For minor refurbishment, this would only apply to the room involved or even part of the room where the work is small and the room large. In these situations, there must be effective isolation of the survey area (e.g. full floor to ceiling partition,), and furnishings should be removed as far as possible or protected using a minimum of 1000 gauge polythene sheeting.

10.4. Asbestos Essentials – Revised manual from the HSE with guidance and an extensive list of task sheets for the building, maintenance and allied trades who may come into contact with asbestos, such as electricians, builders, plumbers, carpenters and other such trades. The 38-specific task sheets cover many different types of hazardous work on, or near, asbestos materials including drilling, removing, repairing, painting, enclosing and

cleaning. Broader issues relating to uncovering or damaging asbestos, the required training, vacuuming, damp wetting, decontamination and disposal are covered by general advice given in stage-by-stage method sheets. To undertake such works persons must have the minimum of asbestos awareness and the additional non-licensed training thereafter.

10.5. Asbestos Register – The formal product of the asbestos risk assessment (survey) shall be a risk management system or risk register. This is held as an electronic database system called MiCAD and is the core of information that assists with our duty to manage asbestos requirements. This system must be accurate; readily accessible and regularly reviewed and is maintained by our appointed analytical contractors.

10.6. The Control of Asbestos Regulations 2012 specifies the statutory requirements for working with asbestos, with regards to its handling, removal, disposal and management. A brief on our required legal compliance of each regulation is as stated below:

Regulation 1 & 2 – To understand the general interpretation of the regulations to be applied and the terms used within the regulations, including definition of material types, the categories of different works that we need to understand with regards to those that need a licence contractor and those that are deemed as notifiable non-licensed and non-licensed.

Regulation 3 – How we as the duty holder must apply the regulations and coordinate with all others that may be involved in our asbestos works, including removal, surveying and analytical contractors and others who may be affected or involved in works thereafter. And ensuring that our appointed contractors have assessed the category of works correctly and where exemptions may apply to certain regulation requirements.

Regulation 4 – To ensure that we set out our duty to manage plan and locate materials, assess their condition and define a duty holder to monitor and maintain this plan.

Regulation 5 - By identifying the presence of such asbestos containing materials in our premises, the type and location prior to any maintenance, building works, refurbishment, demolition or other such works that may disturb the fabric of the building being undertaken.

Regulation 6 – Ensuring that risk assessments are carried out by competent persons and that the necessary steps to prevent or reduce exposure to our employees, staff, patients, public and others have been put in place.

Regulation 7 – When appointing asbestos removal contractors, undertaking non-licensed works, analytical works or surveying, that a site-specific plan of work has been completed and a copy forwarded for our reference and future records.

Regulation 8 - That the appointed asbestos removal contractors hold an in date asbestos licence to undertake such works and that a copy has been forwarded for our verification.

Regulation 9 - Ensure that the appointed asbestos removal contractor has carried out the required notification via an ASB 5 or ASBNNLW 1 form as applicable to the relevant Enforcing Authority and a copy has been made available for our reference.

Regulation 10 - All our employees receive the required level of training relevant to their status within the Trust and the works that they are expected to undertake. This is to be backed up with regular updates of information and further instruction given throughout employment. Including undertaking training needs analysis and identifying areas for further training.

Contractors required to undertake works for the Trust or work on the Trust premises, will be required to be trained to the required standard applicable to their works.

Regulation 11 – Our first duty to prevent asbestos exposure to our employees, where this is not possible, we will ensure we reduce to as low as is reasonably practicable by putting in place other measures and controls. Contractors working on the Trust premises must also apply to this regulation.

Regulation 12 - We will have a detailed management plan in place to check that all employees and contractors are using and making full and proper use of the control measures that we have put in place by routine monitoring of the works being undertaken.

Regulation 13 - Regular inspection of all plant and equipment is required to ensure it remains safe to use, therefore all appointed asbestos removal contractors, surveying and analytical must apply the required testing and examination standards to ensure compliance.

Regulation 14 - We will provide all employees with the required Personal Protective Equipment and Respiratory Protective Equipment to undertake their works and ensure it is maintained in a safe and compliant manner.

The appointed asbestos removal, surveying and analytical contractors must provide the protective clothing, cleaning, maintenance and storage to the required standards to undertake their works in a safe and compliant manner.

Regulation 15 – Have a detailed management plan in place to deal with foreseen accident, incidents and emergencies that may occur when undertaking our works, and ensure that when appointing contractors, they coordinate their work activities with the designated person with regards to putting arrangements in place.

Particularly with reference to having a good communication system in place for raising the alarm and implementing such emergency arrangements.

Regulation 16 – Prevent the spread of asbestos, where this is not reasonably practicable, we must reduce the spread to all places under our control.

Appointed removal, surveying and analytical contractors must apply the necessary controls to ensure compliance such as enclosure building, correct decontamination procedures, coordinating areas, safe access and egress and waste disposal.

Air monitoring to be carried out where applicable to the works and risk to confirm that this regulation is being complied with.

Regulation 17 – All works to be undertaken are carried out in such a way to maintain a high standard of cleanliness to the premises and plant that are within our facilities.

Appointed removal, surveying and analytical contractors must apply the required standards to comply with this regulation and ensure that the 4-stage process is completed where applicable, and copies of the paperwork are made available for our files.

Regulation 18 – That designated work areas for asbestos are maintained by the appointed removal, surveying and analytical contractors including waste and transit routes, segregation and that areas occupied by others are avoided as far as is possible, where this is not possible good communication and coordination to be set up.

Regulation 19 – The appointed removal, surveying and analytical contractors to undertake regular air monitoring and provide copies of the records for our files where applicable to the works and risk to the surrounding areas.

Regulation 20 & 21 – That the appointed analytical companies are competent and accredited to ISO 17025 and ISO 17020 as applicable and checking and verifying that their accreditation is current and valid before undertaking the works.

Regulation 22 – The appointed removal contractors are maintaining health records and surveillance to undertake their works and where our employees undertake notifiable non-licensed works records are maintained in their employee files. Where our employees are required to be involved in such works, records to be maintained for 40 years.

Regulation 23 – The provision of suitable and sufficient washing, changing and storage facilities as required for the category of works being undertaken.

The appointed removal, surveying and analytical contractors to provide hygiene facilities and decontamination set up and procedures applicable to their works and ensure it is maintained. Welfare facilities to be made available or arranged as required.

Regulation 24 – All asbestos waste removed from our premises must be properly packaged, labelled, stored and transported correctly by the

appointed removal, surveying and analytical contractors or waste transportation contractors as applicable to the works.

10.7. Asbestos Management Group – This group is established within Operational Estates and meets formally on a quarterly basis to ensure thorough audit and the proper management of ACM's and to discuss progress on removal works completed.

10.8. Asbestos Management Procedures – Operational Estates / Capital Projects procedures for Asbestos Management. The Asbestos Procedures document is designed with the sole purpose of managing the risk from Asbestos Containing Materials (ACMs) identified within buildings owned / occupied / operated (in accordance with tenancy obligations) by Oxford University Hospitals NHS Foundation Trust.

This document exists to detail operational procedures for the management of asbestos during use and maintenance of buildings as described above.

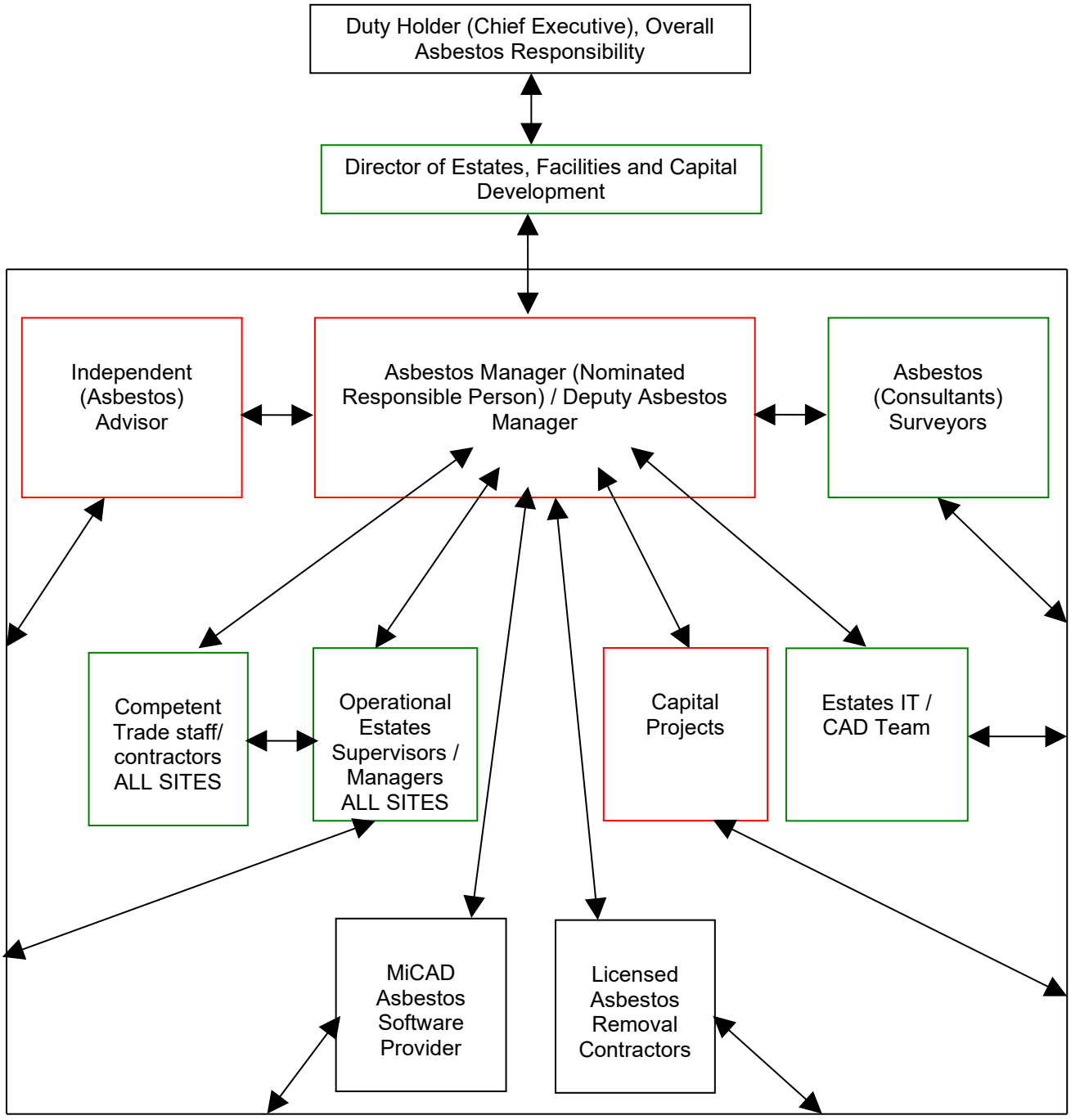
It is an integral part of Oxford University Hospitals NHS Foundation Trust's strategy for compliance to all current legislation regarding asbestos.

This procedure introduces measures to ensure, so far as is reasonably practicable, to minimise or, where possible, eliminate fully the exposure of all individuals to respirable asbestos containing materials. Organogram – organisational chart showing management structural as follows, defines the communication channels and how we must all work together to maintain compliance.

Organogram

Key:

Red Box = Constant members of the Estates Asbestos Management Group.
Green Dashes Box = Sometimes attend the Estates Asbestos Management Group.



Responsibilities

11. The following responsibilities are held.

11.1. The Chief Executive has overall responsibility for all aspects of Asbestos Safety within the Trust (the Duty Holder) ensuring the effective implementation of the procedures and that, where necessary, agreed programmes of investment in achieving prevention and control of the risk associated with asbestos are properly funded and accounted for in the Trust's Annual Business Plan.

11.2. The Director of Estates, Facilities and Capital Development - will have delegated responsibility for the full operational implementation and monitoring of this procedure and for the appointment in writing of a suitable and competent Asbestos Manager. In addition, they will bring to the Chief Executive's attention details of any matters of concern requiring attention. The Director of Estates, Facilities and Capital Development will ensure that all Estates departments are aware of the existence of the Trust policies and procedures and have access to them and that all Estates departments have sufficient managers to carry out the obligations below. The Director of Estates is required to appoint the Asbestos Manager / Deputy Asbestos Manager.

11.3. The Asbestos Manager -This individual is appointed formally in writing by the Director of Estates, Facilities and Capital Development. This is the nominated responsible person (asbestos). The role involves ensuring that adequate management time is spent on the co-ordination and risk management of ACM's. The individual shall be trained and competent. The Trust shall provide suitable and sufficient resources for the discharge of the duties.

In addition, they will manage the necessary procedures for the prevention and control of the risks associated with asbestos and are responsible for:

- Ensuring Asbestos management provision across Oxford University Hospitals NHS Foundation Trust.
- Overseeing the implementation of all asbestos procedures and safe systems of work put in place for Oxford University Hospitals NHS Foundation Trust and ensure the procedures are reviewed regularly.
- Maintaining an Asbestos Register through instructing a systematic auditing process of the register by the Independent (Asbestos) Advisor.
- Ensuring that Operational Estates / Capital Projects (Managers / Supervisors / Project Managers) are providing third party contractors with access to all available asbestos records upon arrival to site and are fully site inducted.
- Where appropriate, ensuring the incident reporting system is enforced.

- Ensuring a re-inspection survey is undertaken by a UKAS Accredited contractor at least annually.
- Acting on / implementation of re-inspection / survey / consultant recommendations to ensure asbestos exposure is avoided. Produce and issue an annual PID / business case for asbestos remediation / asbestos management resource where additional funding is required.
- Ensuring that the asbestos records are updated following the completion of the annual re-inspections, further surveys, remedial works or bulk sampling exercises.
- Ensuring that asbestos master plans are devised and updated to accurately reflect the location and extents of ACMs present.
- Ensuring that adequate information, instruction and training is provided for all staff and others who are liable to be exposed to asbestos, with full training records maintained.
- Where employees are exposed to asbestos, air monitoring is carried out and records kept for at least 40 years with the Occupational Health Service.
- Undertaking investigations into asbestos incidents and provide a report with recommendations that can be utilised to improve procedures.
- Reporting applicable asbestos related RIDDOR incidents as dangerous occurrences where the criteria for inadvertent exposure to asbestos has been assessed.
- Ensuring assessments of the hazards and risks from asbestos containing materials are undertaken with appropriate control measures employed.
- Ensuring only suitable and competent staff are appointed to survey, manage, undertake work with asbestos and asbestos based products. The competence must be demonstrated and documented- such as applicable training / audits / licence / UKAS.
- Ensuring that no licensed asbestos work is carried out by Oxford University Hospital NHS Foundation Trust staff and only those that have received the applicable training for non-licensed undertake such tasks, with a minimum of qualitative half mask face fits in place and ensuring no works come under the notifiable non-licensed works category.
- Ensuring that licensed asbestos work is only carried out by Licensed Asbestos Removal Contractors with a minimum 3-year term license.

- When asbestos is located or is suspected of being present, the presence or otherwise is established and the type identified and recorded.
- Ensuring risk assessments and plan of works / method statements are prepared and revised as necessary and those that are preparing such documents are using the MiCAD asbestos register to form the basis of their risk assessments and that any further surveys (such as refurbishment surveys) are being carried out where required.
- Ensuring that all asbestos analytical works are carried out by UKAS Accredited Laboratories (ISO/IEC 17025:2005 Asbestos fibres in air / bulk identification / ISO/IEC 17020:2012 Surveying for asbestos in premises).
- Where additional asbestos services such as refurbishment surveys / air monitoring / bulk sampling / clearance testing are undertaken, the appropriate reports / certificates are utilised to update our MiCAD database.
- Ensuring that all those that are required to access MiCAD are competent in its use and how to interpret asbestos related data present on the asbestos module / register.
- Where asbestos has been or shall be disturbed or removed, the applicable control measures will be put in place to prevent or reduce exposure.
- Specifications, plans and tender documents are properly prepared for removal or other works that may disturbance of asbestos.
- Ensuring all protective equipment/clothing is provided to our employees, and is maintained and properly used, with appropriate records maintained.
- Ensuring employees receive regular medical surveillance applicable to asbestos exposure where required in accordance with this policy document and that records are maintained.
- Ensuring our waste asbestos is disposed of correctly in accordance with HSG 210 em9, regulation 24 of CAR 2012, the Hazardous Waste Regulations and the Carriage of Dangerous Goods Regulations and that only EA registered waste carrier's transport such waste. A waste consignment note must be provided for all asbestos waste and the certificates added to the MiCAD register against the asbestos items removed.
- Ensuring that known asbestos containing materials remaining 'in-situ' is inspected regularly, maintained in a good condition, the asbestos register is updated, and all necessary steps are taken to ensure asbestos is protected from disturbance and that all persons entering the premises are aware of the potential hazard.

- Ensuring that the correct permits to work are issued and copies retained.
- Undertaking the review of licensed asbestos removal contractors / asbestos (consultants) surveyors' certification / insurance details prior to appointment to our approved contractor lists.
- Ensuring that all records are maintained in accordance with the regulatory requirements and the code of practice L143 for managing and working with asbestos.
- Reporting any asbestos incidents in accordance with this policy and our asbestos management plan.
- Ensuring that asbestos emergency procedures detailed in this policy and our asbestos management plan.
- Liaising with other departments to ensure that asbestos is being assessed and managed in accordance with this policy and our asbestos management plan.
- Co-ordinating appropriate asbestos training with other departments for all persons who may come into contact with asbestos during their everyday work and for those who may influence such works.
- Ensuring that all staff and contractors are aware of their individual responsibilities regarding the asbestos policy and our asbestos management plan.
- Receiving the appropriate level of asbestos training to facilitate their role.

11.4. Deputy Asbestos Manager - This individual is appointed formally in writing by the Director of Estates, Facilities and Capital Development. The role of this individual is to assist and deputise for the Asbestos Manager in the responsibilities detailed above, to assist with holiday and sickness cover to ensure the responsibilities continue to be maintained. The individual shall be trained and competent. The Trust shall provide suitable and sufficient resources for the discharge of the duties.

11.5. Independent (Asbestos) Advisor - Held on an annual retainer basis by Operational Estates to advise and audit the asbestos management system, their role is not to undertake, removal, surveys or analytical, but to provide independent and impartial advice and guidance on such activities to assist the Trust with compliance. This consultant will audit and advise the Trust on Strategic Asbestos Management issues, this will include:

- A formal annual audit of the MiCAD register / asbestos management. Audits to include compliance with Asbestos Procedures document and this Policy.
- Attend quarterly Asbestos Management Group meetings.
- Attend annual asbestos re-inspection progress meetings to represent the client's best interest with delivery of consistent data, database compliance, high risk and data gap identification.

- To assist with reviewing of MiCAD database / portal, asbestos surveys, asbestos removal specifications, asbestos contractor risk assessments and plans of work.
- Advising on asbestos remediation strategies.
- Preparing asbestos management survey specifications where required.
- Provide training as required to assist with maintaining our appointed persons competency in their roles.
- Assist with asbestos incident investigations / reporting.

This individual must hold the relevant asbestos competency qualifications and have the experience and knowledge of working with asbestos in hospital environments and have a minimum of at least 10 years asbestos consultancy experience.

11.6. Asbestos (Consultants) Surveyors – appointed company that will assist and advise the Trust on Strategic Asbestos Management issues, this will include:

- Completing annual re-inspections of all known and suspected Asbestos Containing Materials (ACMs), to ensure that any changes in deterioration or degradation of ACMs is reassessed. The company shall appoint a client representative and shall be appropriately accredited and competent to undertake the works.
- Dealing with detailed asbestos problems including undertaking / preparing; management surveys, R&D surveys, asbestos removal specifications, bulk sampling, air-tests, and 4 stage clearance.
- Having a detailed understanding of the MiCAD database and include provision to update the register following all consultancy work undertaken. Where consultancy work has been undertaken or they have been provided with third party information and instructed to carry out updates, then this must be carried out within 10 days of completion / instruction.
- Maintaining independency of any conflicts of interest (i.e. asbestos removal companies shall not be appointed to undertake this role). Note: This is a separate company to the Independent (Asbestos) Advisor noted above.
- The Asbestos (Consultants) Surveyors maintaining their accredited standards:

  ISO/IEC 17025:2005 Asbestos fibres in air / bulk identification

  ISO/IEC 17020:2012 Surveying for asbestos in premises
- Asbestos surveys must be carried out in accordance with the HSE's guidance document HSG264.

- Having the following insurances as minimum Public Liability: £5 Million, Employers Liability: £10 million, Professional Indemnity: £5 Million.
- Being available 24 hours per day / 7 days per week.
- For emergency incidents: Arriving on site within 4 hours.

11.7. Estates Managers and Supervisors

- Undertake task assessments - checking the asbestos records against the proposed scope of works. The aim of this assessment is to establish whether or not asbestos will affect works / workers. If asbestos is present that is likely to be disturbed by the activity, then this is to be escalated to the Asbestos Manager. Competence in understanding of how to navigate the MiCAD register and interpret the data is essential.
- Provide access to the MiCAD asbestos portal to all external contractors where asbestos is liable to be disturbed as part of their works.
- Where external contractors are to undertake work that may involve exposure to asbestos and asbestos based products then such works must be referred to the Asbestos Manager before any work on site commences.
- Report any asbestos incident, no matter how small, to the Asbestos Manager as soon as possible. Where an asbestos incident has occurred then the Asbestos Emergency Procedures must be followed.
- Where minor work is being carried out in areas with known deteriorated asbestos containing materials then the Access Procedures - Access into Areas with Deteriorated Asbestos (Ceiling Voids, Plant Rooms, Risers, under crofts and Basement Ducts) must be followed with the permit to be authorised by the Asbestos Manager.
- Comply with the requirements of The Construction (Design & Management) Regulations 2015
- Receive and attend appropriate training to assist with their asbestos responsibilities.

11.8. Estates Workshop Staff - Their role is to assist in compliance with the following:

- Undertake task assessments - checking the asbestos records against the proposed scope of works. The aim of this assessment is to establish whether or not asbestos will affect works / workers. If asbestos is present that is likely to be disturbed by the activity, then this is to be escalated to

the Asbestos Manager. Competence in understanding of how to navigate the MiCAD register and interpret the data is essential.

- Responsible for co-operating with Managers and Supervisors in achieving compliance with this procedure and in adopting safe systems of work when undertaking activities liable to disturb asbestos. Employees must make full and proper use of any control measures, personal protective equipment or anything else provided by the Trust, to comply with their statutory duties.
- Report any asbestos incident, no matter how small. Where an asbestos incident has occurred then the Asbestos Emergency Procedures must be followed.
- Report any uncovered suspect ACM to the Asbestos Manager.
- Only undertake non-licensed asbestos works in accordance with HSG210, where you have received the correct level of non-licensed work training and subsequent re-fresher training has been completed, medical assessments are in place, and they have received minimum of a qualitative face fit for half mask with P3 filter or FFP3 NR D.
- Where minor work is being carried out in areas with known deteriorated asbestos containing materials then the Access Procedures - Access into areas with deteriorated asbestos (ceiling voids, plant rooms, risers, under crofts and basement ducts) must be followed.
- Receive and attend appropriate training to assist with their asbestos responsibilities.

11.9. Architects/Designers - are responsible for ensuring compliance with Legislation and NHS specific Guidance on asbestos when designing new or refurbished facilities and compliance with the duties of The Construction (Design & Management) Regulations 2015.

11.10. Capital Projects Team - Their role is to assist in compliance with the following:

- Responsible for undertaking suitable and sufficient risk assessments (Asbestos) prior to undertaking any refurbishment / construction project. Capital Projects Team are to be provided with access to the MiCAD asbestos register to assist with assessing the asbestos risk. Should refurbishment works be deemed to require a refurbishment survey then this is to be carried out by a UKAS accredited surveying company approved by the Trust. This type of

survey is fully intrusive in nature (but can be localised) and will cover the fabric of the building as well as all areas not covered or inspected during the asbestos management survey. The refurbishment survey must be undertaken in every area where works are planned to be undertaken.

- Ensure that the Asbestos Manager is aware of all projects carried out in pre-2000 constructed buildings.
- Access to the MiCAD Asbestos Module Portal / Additional refurbishment survey reports must be provided to all contractors undertaking works in buildings likely to contain ACMs. Such asbestos information shall be passed on to contractors and or direct labour, together with a warning that not all asbestos containing material may have been identified.
- Capital Projects Team and every contractor shall aim to prevent the exposure of employees to asbestos. The following measures shall be implemented to reduce the risk of exposure to asbestos.
- The removal, repair or encapsulation where necessary of materials containing asbestos before any major work begins.
- Asbestos abatement work methods must be used that minimise breakage, abrasion, machining or cutting of asbestos materials. Dust suppression by wetting where appropriate.
- Carrying out asbestos work and other work in the same vicinity at the same time must be avoided where possible. Where this cannot be achieved asbestos related work must be appropriately segregated from non-asbestos work.
- Any contractor intending to undertake work with any asbestos must comply with the Control of Asbestos Regulations 2012.
- Ensure that all licensable asbestos work (as defined in section 11.15) is carried out by a Licensed Asbestos Removal Contractor.
- Copies of any surveys and subsequent removal POWs / clearance certificates / waste notes must be provided by Capital Projects to the Asbestos Manager within 10 days of project completion so that register updates can be carried out.
- Comply with the requirements of The Construction (Design & Management) Regulations 2015.
- Receive and attend appropriate training to assist with their asbestos responsibilities.

11.11. Contractors –

- Must access the MiCAD Asbestos Portal and undertake suitable and sufficient risk assessments (Asbestos). All site personal to complete site induction.
- Must not undertake works that may disturb or remove asbestos without the consent of Oxford University Hospitals NHS Foundation Trust.
- Have appropriate and current asbestos training relevant to the works they will be undertaking.

11.12. Operational Estates Managers - It will be the responsibility of the Trust's Non-Clinical Risk Team to advise the Director of Development and the Estate on the progress of the management programme and matters of concern requiring attention. In addition, the Trust's Occupational Health Service will provide information and guidance on health surveillance.

11.13. The PFI Contracts Management Team - will be responsible for ensuring that PFI partners are compliant with this Policy, including the maintenance of appropriate records.

11.14. Private Finance Initiative Services Providers will appoint in writing their own Authorised/Deputy Persons, who will ensure that adequate arrangements are in place to achieve compliance with the Trust's Policy and associated procedures. Details of such persons must be notified in writing to the Trust's Director of Development and the Estate.

11.15. Asbestos Removal Contractors

All appointed asbestos removal contractors must hold a valid Health and Safety Executive (HSE) Asbestos Removal Licence and it is the Trusts policy to only use companies that have a 3-year license issued by the HSE.

They will be assessed by the relevant competent person instructing the work prior to commencement to ensure they are aware of their legal duties. They will be assessed for competency and that they have the necessary resources to undertake the works in compliance with Control of Asbestos Regulations 2012 as defined in the asbestos management plan.

They must be fully conversant with the categories of work defined in the Control of Asbestos Regulations 2012 and make the required assessment to ensure that the works are correctly identified as either licensed, notifiable non-licensed or non-licensed works and submit the notifications (ASB5 or ASBNNLW1 as applicable) to the relevant authority.

When assessed as competent to undertake the works the Trust expects the following to be complied with:

a) Attend site to assess and prepare quotations against asbestos related works requests.

b) Provide the required risk assessment and plan of works to the competent person who has authorised the works and ensure that the works are carried out in accordance with the submitted works.

c) Any changes must be brought to the attention of the competent person for further approval as required.

d) The plan of works will be required to be compliant with Regulation 7 of Control of Asbestos Regulations 2012, the HSE memo 04/12 alongside Asbestos Regulation 7 plans of work –purpose and core principles memo.

e) Methods of work for emergencies must be discussed and agreed with the competent person, or in his absence the analyst appointed to be monitoring the works.

f) The plan of works must be agreed by the Estates Competent Person before the works proceed.

g) Provide statutory notice to the notifying authority prior to commencing asbestos work or by agreement at the request of the competent person applying for a waiver against the minimum notice period.

h) To carry out their obligations under their works contract, including monitoring high standards of safety and hygiene in asbestos work areas, supplying labour, materials and equipment of a high standard with all necessary supporting documentation.

i) Arranging transport and disposal of asbestos waste materials in accordance with current regulations and best practice. Copies of all records of waste consignment to be provided to the competent person for inclusion in the project files.

j) Carrying out regular inspections of the work environment and defects found or reported by the competent person or the consultant/analyst. Copies of audits/inspections to be provided to the competent person.

k) Provide copies of HSE notification, consignment notes, air tests or re-occupation certificates and other related documents as soon as available to the competent person.

l) Report any incidents and accidents to the competent person immediately by the quickest possible means without raising concern to other parties that may be in the immediate area, so that the necessary emergency arrangements can be implemented.

Responsibilities – Organisational

12. Organisational responsibilities:

12.1. The Health & Safety Committee, chaired by the Director of Development and the Estates and involving partners from across the OUH Trust.

12.2. The principal purpose of the Estates & Facilities Quarterly Asbestos Management Meeting is to provide Assurance to the Trust Health & Safety Committee and the Trust, that the Estate is being managed in accordance with the Control of Asbestos Regulations (CAR) 2012.

12.3. The meeting will also review and monitor compliance with the Trusts Health & Safety Policy, The Health & Safety at Work Act (1974) and all other appropriate statutory instruments in relation to asbestos.

12.4. The Estates Health & Safety Quarterly Management meeting, chaired by Head of Estates / Facilities. Meetings are held quarterly to assess the progress with respect to management issues, risk assessments, action plans, training needs and reviews of the procedure's manual for Asbestos Management for OUH Trust including third parties.

12.5. The Estates Health & Safety Quarterly Management Meeting will convene meetings sooner than quarterly to discuss or resolve issues that may occur from time to time.

Reporting Mechanism

13. Any breaches to the Asbestos Policy need to be reported using; Ulysses [Trust incident reporting system]; the Estates Help Desk and also reported to the Asbestos Manager / Deputy Asbestos Manager.

Training

14. Training required to fulfil this policy is based on the training needs analysis details below. The management and monitoring of training needs is undertaken and co-ordinated by the Asbestos Manager in conjunction with the Senior Operational [Estates] Managers for each site.

15. Training Needs Analysis:

15.1. Asbestos Manager to receive training as detailed below and where indicated the duration of updates and refreshing training to maintain compliance with regulation 10 of CAR 2012.

- British Occupational Hygiene Society – P405 – Management of Asbestos in Buildings or other similarly high level advanced asbestos training that provides the background knowledge required to manage identified asbestos in buildings and ensures that appropriate management processes are followed and documented properly. It must give the candidates the knowledge to make better procurement decisions, and to monitor the quality of the services provided by other asbestos professionals through understanding the standards and procedures that they must be following. Updated at least 3 yearly.
- UKATA or IATP Asbestos Awareness - given to employees whose work could foreseeably disturb the fabric of a building and expose them to asbestos or who supervise or influence the work. Annual refresher.

- RPE Competent Person - For those who are responsible for the selection, use, maintenance and the record keeping for employees RPE. Updated at least 3 yearly.
- UKATA or IATP Non-licensable work with asbestos. For an understanding of how work with low-risk asbestos containing materials are carried out. Annual refresher, note if this level of training is held, they do not need to undertake awareness annual refresher as this should be incorporated within this level.
- MiCAD Asbestos Module / Portal - Practical exercise in utilising the database via tablet access to allow task-based risk assessments.

15.2. Deputy Asbestos Manager to receive training as detailed below and where indicated the duration of updates and refreshing training to maintain compliance with regulation 10 of CAR 2012.

- British Occupational Hygiene Society – P405 – Management of Asbestos in Buildings or other similarly high level advanced asbestos training that provides the background knowledge required to manage identified asbestos in buildings and ensures that appropriate management processes are followed and documented properly. It must give the candidates the knowledge to make better procurement decisions, and to monitor the quality of the services provided by other asbestos professionals through understanding the standards and procedures that they must be following. Updated at least 3 yearly.
- UKATA or IATP Asbestos Awareness - given to employees whose work could foreseeably disturb the fabric of a building and expose them to asbestos or who supervise or influence the work. Annual refresher.
- RPE Competent Person - For those who are responsible for the selection, use, maintenance and the record keeping for employees RPE. Updated at least 3 yearly.
- UKATA or IATP Non-licensable work with asbestos. For an understanding of how work with low-risk asbestos containing materials are carried out. Annual refresher, note if this level of training is held, they do not need to undertake awareness annual refresher as this should be incorporated within this level.
- MiCAD Asbestos Module / Portal - Practical exercise in utilising the database via tablet access to allow task-based risk assessments.

15.3. Trades Staff and Estates Supervisors and Estates Managers will attend Asbestos Awareness and Best Practice Training on an annual basis.

- UKATA or IATP Asbestos Awareness - given to employees whose work could foreseeably disturb the fabric of a building and expose them to asbestos or who supervise or influence the work.

- RPE Competent Person - For those who are responsible for the selection, use, maintenance and the record keeping for employees RPE.
- UKATA or IATP Non-licensable work with asbestos. For an understanding of how work with low-risk asbestos containing materials is carried out.
- MiCAD Asbestos Module / Portal - Practical exercise in utilising the database via tablet access to allow task-based risk assessments. To include Scenario Training – examples of everyday use of the MiCAD database to facilitate learning.
- Access Procedures - Access into areas with deteriorated asbestos (ceiling voids, plant rooms, risers, under crofts and basement ducts) is followed. Practical training exercise whereby access procedures are explained / witnessed by the Asbestos Consultant, Asbestos Manager or Independent Asbestos Advisor.

15.4. All other Employees throughout the Trust to receive the below training where applicable.

- UKATA or IATP Asbestos Awareness – given to employees whose work could foreseeably disturb the fabric of a building and expose them to asbestos or who supervise the influence of such work.

Monitoring Compliance

16. Compliance with the document will be monitored in the following ways:

Aspect of compliance or effectiveness being monitored:	Monitoring method:	Responsibility for monitoring (job title):	Frequency of monitoring:	Group or Committee that will review the findings and monitor completion of any resulting action plan:
Staff Medicals (Estates Managers and Workshop Operatives).	Examination of Medical files.	Asbestos Manager.	At least annually. For all new starters.	Estates & Facilities Quarterly Asbestos Management Committee.
Staff training must be undertaken and reviewed.	Examination of training files.	Asbestos Manager / Compliance Manager.	At least annually.	Estates & Facilities Quarterly Asbestos Management Committee.
All installations must comply with current legislation for Asbestos Management.	Review of specification for new works.	Operational Estates Managers.	As undertaken.	Operational Estates Group.
Implementation of procedures and arrangements supporting this document.	Sample audits.	Asbestos Manager.	As undertaken.	Estates & Facilities Quarterly Asbestos Management Committee.
Implementation of procedures and arrangements supporting this document.	Sample audits.	Independent Advisor.	Annual.	Estates & Facilities Quarterly Asbestos Management Committee.
Audit of MiCAD register during annual re-inspection.	Annual audits.	Independent Advisor.	Annual.	Estates & Facilities Quarterly Asbestos Management Committee.
Compliance with the Health & Safety at Work Act 1974.	Periodic Inspection and Observation.	Asbestos Manager.	Annual.	Operational Estates Health & Safety Committee.
ACM re-inspection.	Re-inspect ACMs in accordance with CAR2012.	Asbestos Manager.	Annual.	Estates & Facilities Quarterly Asbestos Management Committee.

17. In addition to the monitoring arrangements described above the Trust may undertake additional monitoring of this policy as a response to the identification of any gaps or as a result of the identification of risks arising from the policy prompted by incident review, external reviews, or other sources of information and advice. This monitoring could include:

    17.1. Commissioned audits and reviews.

    17.2. Detailed data analysis.

    17.3. Other focused studies.

    17.4. Results of this monitoring will be reported to the nominated Committee.

Review

18. This policy will be reviewed in 3 years, as set out in the Policy for the Development and Implementation of Procedural Documents.

19. This policy requires full ratification every 3 years by the Board of the Trust. Changes cannot be made to the policy without full ratification.

20. It may need to be revised before this date, particularly if national guidance or local arrangements change.

21. The asbestos management plan must be reviewed at least annually and can be amended without the requirement of full ratification by the Board of the Trust.

22. The review process requires:

    22.1. Policy reviewed by the following persons, in accordance with the metadata on the cover sheet to ensure it remains valid and fit for purpose:

    - Independent (Asbestos) Advisor.
    - Asbestos Manager / Deputy Asbestos Manager.
    - Compliance Manager.

    22.2. Any amendments identified will require the policy to be edited. As part of any editing the policy will be subjected to system of version control as set out in the Trust`s Policy for the Development and Implementation of Procedural Documents.

    22.3. The policy will be sent to the Health and Safety Committee (Non-Clinical Risk) for approval.

    22.4. This policy will be maintained by the Board Secretary within the Trust`s electronic archiving system, recording date of approval and validity, date of issue, version number and date for review.

    22.5. The policy will be retained in accordance with the Trust Records Management Policy.

References

There are a large number of official publications relating to asbestos and general health and safety requirements. The following list contains the most significant and relevant items but is not exhaustive as updates and legislation changes may occur after the revision of this document. It will be the duty holder's role to ensure they monitor legislation changes and update the document list as appropriate.

We must ensure that all works, management and general reference with regards to asbestos is made to the following asbestos specific documents where applicable:

1. Control of Asbestos Regulations 2012 (CAR).
2. ACOP Managing and working with asbestos L143 second edition.
3. HSG53 Respiratory Protective Equipment at Work: A practical guide (fourth edition).
4. RPE Face fit guidance OC 282/28.
5. HSG210 Asbestos Essentials – Task manual 2017.
6. HSG 247 Asbestos: Licensed Contractors Guide.
7. HSG 248 Asbestos: The Analysts Guide second edition.
8. HSG 264 Surveying, Sampling, and Assessment of Asbestos Containing Materials.
9. The Hazardous Waste Regulations 2005 & amendment 2009.
10. Carriage of Dangerous Goods & Use of Transportable Pressure Equipment Regs 2009.
11. The Waste (England & Wales) Regulations 2011, & amendment to regulation 13 – 2012.
12. BS 8520-1:2009 Controlled Wetting of Equipment.
13. BS 8520-1:2009 Negative Pressure Unit: specification.
14. BS 8520-1:2009 Operation, cleaning & maintenance of class H, vacuum cleaners.
15. ALG Memo 01/09 Maintenance of air extraction equipment and Class H vacuum.
16. ALG Memo 02/09 Asbestos Licenses and the role of consultants.
17. ALG Memo 01/10 Ancillary asbestos licences for scaffolding.
18. ALG Memo 03/12 Removal of External AIB soffits.
19. ALG Memo 07/12 Notification of licensed asbestos works.
20. ALG Memo 07/12 Site Documentation.
21. ALG Memo 04/12 Suitable and Sufficient Plan of Works.
22. ALG Memo 05/12 Supervision of licensed work.
23. MS 31 Medical guidance for Doctors – licensed workers.
24. MS 34 Medical guidance for Doctors – non-licensed workers.
25. Appendix 4-15 Other Trades entering enclosure/asbestos work areas.
26. Appendix 1-17 Asbestos Ventilation Research Summary.
27. Appendix 2-17 Asbestos in Soil.
28. Appendix 3-17 Work with Asbestos Paper.
29. Appendix 4-17 Dust Wipe Sampling.
30. Appendix 5-17 Guidance on AIB Soffit Removal.
31. Appendix 6-17 Abrasive Blasting Removal Systems.
32. Appendix 2/19 Measuring the inward Air Flow of a Negative Pressure Unit.
33. Appendix 1a-21 Asbestos Cleans (Environmental Cleaning).
34. Appendix 01/22 Non-Asbestos Risk Assessment.
35. Appendix 01-22 Decontamination Unit (DCU) Services (Gas and Electrical).

We will ensure that all works, management and general reference with regards to all other health and safety duties is made to the following specific documents where applicable:

1. Health & Safety at Work Act 1974 (as amended).
2. Construction (Design & Management) Regulations 2015 – ACOP L153.
3. Confined Space Regulations 1997 & ACOP L101.
4. Control of Substances Hazardous to Health Regulations 2002 & ACOP L5.
5. Electricity at Work regulations 1989 (amended 1997) & ACoP L128.
6. The Gas Safety (Installation and Use) Regulations 1998 & ACoP L56.
7. HSG 140 Safe use and handling of flammable liquids.
8. Environmental Protection Act 1990
9. Fire Regulatory Reform Order 2005.
10. Health & Safety (Safety, Signs and Signals) Regulations 1996 & ACoP L64.
11. Health and Safety (First Aid) Regulations 1981 & ACoP L74.
12. The Health and Safety (Consultation with Employees) Regulations 1996.
13. Dangerous Substances and Explosive Atmospheres Regulations 2002.
14. Lifting Operations and Lifting Equipment Regulations 1998 & ACoP L113.
15. The Provision and Use of Work Equipment Regulations 1998 & ACoP L22.
16. Management of Health & Safety at Work Regulations 1999.
17. The Working Time Regulations 1998.
18. Manual Handling Regulations 1992 & ACoP L23.
19. Personal Protective Equipment at Work Regulations 1992 ACOP L25.
20. Reporting of Injuries Disease & Dangerous Occurrences Regulations 2013.
21. Workplace (Health & Safety & Welfare) Regulations 1992 & ACOP L24.
22. Working at Height Regulation 2005 & guidance.
23. Control of Vibration at Work Regulations 2005 & L141.
24. Control of Noise at Work Regulations 2005 & L108.
25. Chemicals (Hazard Information & Packaging for Supply) Regulations 2009.
26. Corporate Manslaughter Act 2007.
27. Control of Lead at Work Regulations 2002 & ACoP L132.
28. Health and Safety (Display Screen Equipment) Regulations 1992 & INDG 36.
29. Health and Safety (Fees) Regulations 2012 & HSE 47 Fees for Intervention.

Equality Impact Assessment

1. As part of its development, this policy and its impact on equality has been reviewed. The purpose of the assessment is to minimise and, if possible, remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation or religious belief. No detriment was identified.

Equality Impact Assessment Document History

Date of revision	Version number	Reason for review or update
	0.1	New document
July 2012	0.2	Revisions to version 0.1
August 2012	0.3	Minor revisions to version 0.2
Sept 2015	0.4	Minor revisions to version 0.3
December 2018	0.5	Minor revisions to version 0.4
November 2019	0.6	Minor revisions to version 0.5
October 2020	0.7	Minor revisions to version 0.6
April 2023	0.8	Update and revisions to version 0.7

Appendix 1: Equality Impact Assessment

Oxford University Hospitals NHS
NHS Trust

EQUALITY ANALYSIS

- **Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.**
- **Advance equality of opportunity between people who share a protected characteristic and those who do not.**
- **Foster good relations between people who share a protected characteristic and those who do not.**

Please consider whether the policy or function/service/proposal, is likely to have an adverse impact on grounds of: **race, disability, age, religion or belief, sex or sexual orientation, gender re-assignment, pregnancy and maternity, marriage or civil partnership, deprivation or human rights.**

Please include this in the preparation to write a policy *and refer to the "Policy on Writing Policies."*

Equality Analysis:
Policy / Plan / proposal name: **Asbestos Policy.**
Date of Policy: **April 2023.**
Date due for review: **April 2026.**
Lead person for policy and equality analysis: Jason Borley of Global Environmental Consultancy Ltd. - **Independent Asbestos Advisor.**
Does the policy /proposal relate to people? If yes, please complete the whole form. **YES**

Note: The only policies and proposals not relevant to equality considerations are those not involving people at all. (E.g., Equipment such as fridge temperature).

1. Identify the main aim and objectives and intended outcomes of the policy.

The policy confirms that the Trust will manage its Asbestos in compliance with legislation, guidance and best practice.

Note: The policy does not discriminate on the grounds of age, disability, gender, gender re-assignment, race, religion or belief, sexual orientation, pregnancy and maternity or human rights.

2. Involvement of stakeholders.

Internal stakeholders involved in the development and drafting of the policy; Members of the Estates & Facilities Health& Safety Quarterly Management Meeting.
External stakeholder involved in the development and drafting of the policy; Jason Borley of Global Environmental Consultancy Ltd. - Independent Asbestos Advisor.

3. Evidence.

The following guidance and statutory documents were reviewed prior to the drafting of the Asbestos policy:

- Health and Safety at Work etc. Act 1974.
- Workplace (Health, Safety and Welfare) Regulations 1992.
- The Management of Health and Safety at Work Regulations and HSG 65.
- Control of Asbestos Regulations 2012 and ACOP L143.
- The Construction (Design & Management) Regulations 2015.
- HSG 247 Asbestos: The Licensed Contractors' Guide and applicable appendixes, technical and general memos updates.
- HSG 248 Asbestos: The Analysts Guide second edition.
- HSG 264 Asbestos: The Survey Guide.
- HSG 227 A comprehensive guide to managing asbestos in premises.
- HSE Asbestos Essentials HSG210 (A0-A38) & supporting Equipment and Method Sheets EM0 – EM10.
- The Hazardous Waste Regulations 2005 & amendment 2009.

▪ Carriage of Dangerous Goods & Use of Transportable Pressure Equipment Regulations. ▪ HSG53 Respiratory Protective Equipment at Work: A practical guide (fourth edition).
Disability. **This policy does not discriminate against anyone with a disability.**
Learning Disability: **This policy does not discriminate against anyone with a learning disability.**
Sex: **This policy does not discriminate against either male of female patients, staff or visitors.**
Age : **This policy does not discriminate by age.**
Race: **This policy does not discriminate by race.**
Sexual orientation: **This policy does not discriminate by sexual orientation.**
Pregnancy and maternity: **This policy does not discriminate by pregnancy or maternity.**
Religion or belief: **This policy does not discriminate by religion or belief.**
Gender re-assignment: **This policy does not discriminate by gender re-assignment.**
Marriage or civil partnerships: **This policy does not discriminate by marriage or partnership.**
Carers: **This policy does not discriminate against carers.**
Safeguarding people who are vulnerable:

The policy follows current legislation, guidance and best practice to ensure water systems are compliant and fit for purpose.
Other potential impacts e.g., culture, human rights, socio economic e.g. homeless people. **N/A**
Section 4 Summary of Analysis: **As part of its development, this policy and its impact on equality has been reviewed to minimise and if possible, remove any disproportionate impact on the grounds of race, gender, disability, age sexual orientation or religious belief. Following this process, no detriment was identified.**
How does the policy advance equality of opportunity? **N/A**
How does the policy promote good relations between groups? **N/A**

Pest Control Policy

Category:	Policy
Summary:	This policy re-enforces measures, so far as is reasonably practicable, to provide an environment which is safe and compliant with best practice, Health Technical Memoranda, Approved Codes of Practice, and Statutory & Mandatory requirements.
Equality Impact Assessed:	30-3-23
Valid From:	
Date of Next Review:	This will usually be 3 years from the approval date unless otherwise specified.
Approval Date/ Via:	
Distribution:	Via Risk & Quality Department to: ▪ Divisional Directors and Directorate Managers ▪ Clinical Governance Intranet Site Via Estates & Factitlies Directorate to: ▪ Estates & Facilities Managers ▪ Project Co (PFI Services Providers) Via contractors Office Estates & Facilities Intranet Site
Related Documents:	▪ Health & Safety Management Policy ▪ Risk Management Policy ▪ Risk Assessment Policy ▪ COSHH Procedure ▪ Health Technical Memoranda ▪ Approved Codes of Practice ▪ Health & Safety at Work Act, 1974 ▪ The Health & Social Care Act 2008 ▪ Infection Prevention and Control Policy ▪ Waste Policy
Author(s):	Amanda Simpson, Project Support Manager Denise Pawley, Senior Operational Facilities Manager
Further Information:	Site Estates & Facilities Managers
This Document replaces:	Version 3.0

Lead Director: Charmaine Hope, Director of Estates, Facilities and Capital Development

Issue Date:

This document is uncontrolled once printed.

It is the responsibility of all users to this document to ensure that the correct and most current version is being used.
This document contains many hyperlinks to other related documents.
All users must check these documents are in date and have been ratified appropriately prior to use.

Document History

Date of revision	Version number	Author	Reason for review or update
March 2009	1.00 (rev b)		New Document
April 2009	2.0		Minor Revisions
May 2012	2.1		Minior Revisions
Jan 2013	2.2		Minor Revisions to version 2.1
Sept 2015	2.3		Minor Revisions to version 2.2
March 2023	3.0		Minor Revisions to version 2.3

Consultation Schedule

Who? Individuals or Committees	Rationale and/or Method of Involvement

Endorsement

This table to list relevant Divisional and/Directorate leads who have endorsed the policy document.

Endorsee Job Title
Director of Estates, Facilities and Capital Development

Contents

1. Introduction

1.1 Hospitals, like many large busy buildings, can be a magnet for pests that have the potential to cause problems. These include: rats, mice, pigeons, squirrels, cockroaches and other insects.

1.2 Pests can be destructive, for example gnawing through packaging, furniture, electrical cables etc. They can access and contaminate sterile supplies and transmit disease e.g. salmoneilosis, dysentery, leptospirosis, cryptococcosis etc. Cockroaches carry bacteria on their bodies and in their faecal pellets (including Escherica coli, Klebsiella pneumoniae, Serratia marcescens, pseudomonas aeruginosa and Salmonella spp.)

2. Who should read this document?

This policy should be read by all staff and PFI providers across the Trust sites.

3. Key Standards / Messages

Oxford University Hospitals NHS Foundation Trust recognises its responsibility to all patients, visitors and staff to provide a safe and clean environment.

This policy forms part of this responsibility, in regards to the prevention and control of pests within its sites and premises.

4. Background and Scope

The aim of this policy is to ensure that the Trust is exposed to minimum risk relating to pest infestation. Oxford University Hospitals NHS Foundation Trust recognises its obligation to take necessary measures to prevent the risk of pest infestation in all food storage, distribution and catering areas and to ensure good standards of pest control in all other areas of the site.

5. Key Updates

- Appendix 1: Basic Pest Control Measures.
- Appendix 2: In the event of a Suspected Pest Infestation

6. Aim

- Ensure as far as practicable that the Trust buildings and grounds are pest free.
- Ensure good hygiene practice in the eradication of pests by application of the policy and associated procedures.
- Maintain adequate public health regimes throughout the Trust buildings and grounds.

7. Review

This policy will be reviewed every 3 years.

8. References

- Infection Prevention and Control Policy
- Waste Policy
- COSHH Procedures
- Health and Safety at Work Act, 1974

9. Responsibilities

The Chief Executive has overall responsibility for ensuring that all premises are maintained to the relevant standards, including the control of pests. This responsibility is delegated to the Director of Estates, Facilities and Capital Development.

The Director of Estates, Facilities and Capital Development is responsible for organisational arrangements which are to ensure compliance with the policy.

The Head of Operational Estates & Facilities will for operational purposes, under the direction of the Chief Executive, be the manager with responsibilties for co-ordinating resources, ensuring the policy is followed and appointing a responsible person for each Trust site.

A **Senior Operational Estates Manager** on each site is responsible for the implementation of the policy and procedures relating to pest control.

The appropriate **Estates Manager** for each site will be appointed to support the Senior Operational Estates Manager. They will be responsible for managing pest control on their respective sites and ensuring that all work is carried out at the appropriate intervals and to the standards as detailed in regulations or guidelines. Records and programmes are to be provided at regular intervals to confirm that work is being carried out and completed on time.

Directorate Managers and all staff, including staff employed by any third party employed on Trust sites, are responsible for reporting any evidence of pest infestation on any of the Trust premises, including any premises occupied by the Trust under lease or contract.

PFI Contracts Management Team is responsible for ensuring that the PFI partner is compliant with this policy including the maintance of appropriate records.

Site Helpdesks are responsible for receiving and logging any calls for pest control services ensuring any issues are reported in a timely manner. They are responsible for liaising with the Trust approved Contractor.

Pest Control Contractor shall provide, manage and operate a wide-ranging system of pest control management. They must respond, if requested via the Helpdesk teams, visit the site(s), and take the appropriate action.

Infection Prevention Control will be part of an investigate clinical areas where there is a suspicion or presence of pests. The risk will be assessed according to the clinical area and the pest.

All staff have a duty to ensure that appropriate measures are taken to discourage pest infestation, to report any issues follow the advice in appendix 1 and 2 of this policy.

10. Education and Training

There is no mandatory training associated with this policy. Ad hoc training sessions based on an individual's training needs will be defined within their annual appraisal or job plan.

11. Monitoring Compliance

Compliance with the document will be monitored in the following ways;

Aspect of compliance or affectiveness being monitored	Monitoring method	Responsibility for monitoring (Job Title)	Frequency of monitoring	Group or committee that will review the finding and monitor completion of any resulting action plan
Minimal signs of activity of pest infestation	Site inspections	All Staff & Contractors	Daily	PFI Contract Compliance Manager (Estates) & Waste Contractors Manager
Adequate provision of bait stations in all identified susceptible areas.	Site inspections	Approved Pest Control Contractor	Monthly	PFI Contract Compliance Manager (Estates) & Waste Contractors Manager
Evidence of regular replenishment of baits and regular attendance to monitor activity.	Site inspection/contract meeting	PFI Contract Compliance Manager (Estates) & Waste Contractors Manager	Monthly	PFI Contract Compliance Manager (Estates) & Waste Contractors Manager
Provision of adequate Pest Control records regime.	Quarterly records audit.	PFI Contract Compliance Manager (Estates) & Waste Contractors Manager	Quarterly	Estates & Facilities Quarterly Risk Management Group.

In addition to the monitoring arrangements described above, the Trust may undertake additional monitoring of this policy as a response to the indentification of any gaps or as a result of the identification of risks arising from the policy prompted by incident review, external reviews, or other sources of information and advice.

This monitoring could include:

- Commissioned audits and reviews
- Detailed data analysis
- Other focused studies
- Results of this monitoring will be reported at the Quarterly Estates & Facilities Health & Safety meeting

Appendix 1: Basic Pest Control Measures.

1.1 There are some basic measures that must be carried out to minimise the risk of pest infestation. Oxford University Hospital's staff and contractors must adhere to the following recommendations.

1.2 Do not feed birds or animals as apart from attracting pigeons, the residual food will attract vermin and insects.

1.3 Buildings should be maintained in a sound state, well maintained with drains covered, holes sealed, leaking pipes repaired and damaged surfaces made good.

1.4 Cracks in plaster and woodwork, unsealed areas around pipework, damaged tiles, badly fitted equipment and kitchen units can provide excellent harbourage for pests and therefore should be maintained in a good condition.

Any defects must be reported to the relevant helpdesk.

Food storage

1.5 Food stock must be rotated to ensure items do not remain in the back of cupboards.

1.6 All food debris must be cleared up immediately. Wipe off kitchen counters, paying particular attention to areas where food debris accumulate,e.g, under the microwave or toaster.

1.7 Doors to food preparation areas must be kept closed.

1.8 Spillages on the floor must be cleared promptly.

Waste disposal

1.9 When removing waste from a functioning area, ensure that it is placed in the appropriate designated waste location. **Waste must not be placed on the floor.**

1.10 All external waste bins must have tight fitting lids.

1.11 All external clinical waste bins must be locked at all times.

1.12 Domestic and recycling waste bins must be washed, both internally and externally on a regular basis, to ensure these are kept free from spillages and odour.

1.13 All waste bins must be emptied and replaced regularly throughout the day to ensure they are not overflowing.

1.14 Damaged bins must be reported to the appropriate site helpdesk.

Appendix 2: In the event of a suspected pest infestation

2.1 Staff must immediately notify the relevant site Help Desk:

2.2 All pest sighting or evidence of their existence on any of the sites must always be reported through the relevant site help desk as follows:-

Site	Area	Help Desk Number
Churchill Hospital	Retained Estates G4S (PFI Building)	20600 35353
Horton General Hospital	Retained Estates	20600
John Radcliffe Hospital	Retained Estates Bouygues (PFI Building)	20600 40404
Katharine House Hospice	Retained Estates	20600
Nuffield Orthopaedic Hospital	G4S	38010

2.3 The following information must be given to the help desk;

- Your name
- Telephone extension
- Location of the pest activity within the functional area i.e room number/outside area.
- Possible numbers of pests present or frequency of sightings
- Type of pest (If known)

2.4 The Help desk will then contact the approved pest control contractor who will attend site for an inspection of the area and undertake the necessary course of action.

Equality Impact Assessment

What is being assessed	Existing Policy
Job title of staff member completing assessment	Project Support Manager
Name of policy / service / function:	Pest Control
Details about the policy / service / function	This procedure will define and provide guidance for Pest Control across Trust sites.
Is this document compliant with the Web Content Accessibility Guidelines?	Yes
Review Date	Every 3 Years
Date assessment completed	30-3-23
Signature of staff member completing assessment	Amanda Simpson
Signature of staff member approving assessment	Denise Pawley

1. Screening Stage

Who benefits from this policy, service or function? Who is the target audience?
Delete as appropriate

- Patients
- Staff
- Family / Carers
- Others

Does the policy, service or function involve direct engagement with the target audience?

Yes - *continue with full equality impact assessment*

2. Research Stage

Notes:

- If there is a neutral impact for a particular group or characteristic, mention this in the 'Reasoning' column and refer to evidence where applicable.
- Where there may be more than one impact for a characteristic (e.g. both positive and negative impact), identify this in the relevant columns and explain why in the 'Reasoning' column.
- The characteristics include a wide range of groupings and the breakdown within characteristics is not exhaustive, but is used to give an indication of groups that should be considered. Where applicable please detail in the 'Reasoning' column where specific groups within categories are affected, for example, under Race the impact may only be upon certain ethnic groups.

Impact Assessment

Characteristic	Positive Impact	Negative Impact	Neutral Impact	Not enough information	Reasoning
Sex and Gender Re-assignment – men (including trans men), women (including trans women) and non-binary people.			X		This Policy does not discriminate against sexual orientation.
Race - Asian or Asian British; Black or Black British; Mixed Race; White British; White Other; and Other			X		This Policy does not discriminate against race.
Disability - disabled people and carers			X		This Policy does not discriminate against disability.
Age			X		This Policy does not discriminate against age.
Sexual Orientation			X		This Policy does not discriminate against sexual orientation
Religion or Belief			X		This Policy does not discriminate against religion or belief.
Pregnancy and Maternity			X		This Policy does not discriminate against pregnancy and maternity.

Characteristic	Positive Impact	Negative Impact	Neutral Impact	Not enough information	Reasoning
Marriage or Civil Partnership			X		This Policy does not discriminate against marriage or civil partnership.
Other Groups / Characteristics - for example, homeless people, sex workers, rural isolation.			X		This Policy does not discriminate against other groups/characteristics.

Sources of information

- National standards of healthcare cleanliness 2021: Pest Control

Consultation with protected groups
List any protected groups you will target during the consultation process, and give a summary of those consultations

Group	Summary of consultation
PFI Partners	Sent to Cleo Hadfield for PFI consultation 30-3-23. Feedback received 26-4-23.
Estates & Facilities Risk Management Group	RMG meeting 6-6-23

Consultation with others

Estates & Facilities Health & Safety Committee
Trust Health & Safety Committee

3. Summary stage

Outcome Measures
List the key benefits that are intended to be achieved through implementation of this policy, service or function and state whether or not you are assured that these will be equitably and fairly achieved for all protected groups. If not, state actions that will be taken to ensure this.

To ensure that the Trust is exposed to minimum risk relating to Pest Infestation.

Positive Impact
List any positive impacts that this policy, service or function may have on protected groups as well as any actions to be taken that would increase positive impact.

To ensure that the Trust is exposed to minimum risk relating to Pest Infestation.

Unjustifiable Adverse Effects
List any identified unjustifiable adverse effects on protected groups along with actions that will be taken to rectify or mitigate them.

None anticipated

Justifiable Adverse Effects
List any identified unjustifiable adverse effects on protected groups along with justifications and any actions that will be taken to mitigate them.

None anticipated

Equality Impact Assessment Action Plan
Complete this action plan template with actions identified during the Research and Summary Stages

Identified risk	Recommended actions	Lead	Resource implications	Review date	Completion date
None					