Item: 4e
Enclosure 7

NHS
North East & North Cumbria

REPORT CLASSIFICATION	✓	CATEGORY OF PAPER	✓
Official	✓	Proposes specific action	✓
Official: Sensitive Commercial		Provides assurance	
Official: Sensitive Personal		For information only	

BOARD MEETING

1 July 2022

Report Title:	**Adoption of Key and High-Risk Area Strategies and Policies**

Purpose of report

As part of ICB establishment, the Board is asked to approve and ratify those corporate policies that are considered high-risk and substantive, as outlined in Schedule A, and agree a proposal to ensure the early approval of all other policies and strategies.

Key points

All strategies/policies/plans have been developed and reviewed by subject experts, the ICS Integrated Governance workstream (operational lead), and pre-approved by the relevant ICB Executive Director. All strategies, policies and plans are compliant with legislation and best practice. The NECS Governance team have facilitated and coordinated all corporate ICB policies and the NECS Human Resources team have facilitated all HR ICB policies.

In line with the Scheme of Reservation and Delegation (SoRD), **all other corporate** related ICB policies will be discussed and approved by the Executive Committee on 5 July. In respect of the **adoption of the ICB HR policies**, the Board is asked to delegate this 'first approval' to the Executive Committee. Subsequent consideration and approval of HR Policies would be undertaken in line with the SoRD.

Should there be a need to apply a policy in the intervening period (1st July 2022 – 5th July 2022) then the draft as currently approved by the Executive Director (or in the case of HR Policies, the policy that was approved at the Partnership Forum on 15th June 2022) would apply.

The Board is asked to acknowledge that there are some strategies, policies and plans, outlined in Schedule A, that are under final review, as the Operating Model and ICB structure is being developed:

- Serious Incident Management policy.
- Standards of Business Conduct policy
- Health and Safety related policies

It is proposed that these policies are still ratified by the Board in their current form, on the understanding that they will be scheduled for an early review post-July 2022. At that stage

(subject to Board approval of the SORD), future approvals will be delegated to the Executive Committee and Quality and Safety Committee.

The Board is asked to provide delegated authority for Executive Directors to approve any minor/immaterial future updates, taking into account that ICB policies have been drafted by subject matter experts and governance colleagues.

Risks and issues

The approval of the suite of policies and strategies will ensure the ICB is in a strong position from its inception. Should there be delays to the approvals process, then there would be exposure to varying risks due to the absence of an agreed organisational policy approach.

Assurances

Policy development has been carried out by subject experts and are in line with national guidance and best practice.

Recommendation/Action Required

The Board is asked to:

- Ratify the strategies, policies and plans outlined at Schedule A
- Delegate authority for Executive Directors to approve any minor/immaterial future updates, taking into account that the policies have been drafted by subject matter experts and governance colleagues
- Delegate the 'first approval' of HR related and other corporate related strategies, policies and plans to the Executive Committee. Subsequent approvals would be in line with the SoRD

Sponsor/approving director	C Riley, Executive Director of Corporate Governance, Communications and Involvement (Designate)
Report author	A Tunney, Governance and Assurance Manager, North of England Commissioning Support (NECS)

Link to ICB corporate aims (please tick all that apply)

CA1: Improve outcomes in population health and healthcare	✓
CA2: tackle inequalities in outcomes, experience and access	✓
CA3: Enhance productivity and value for money	✓
CA4: Help the NHs support broader social and economic development	✓

Relevant legal/statutory issues

All proposed ICB strategies, policies and plans outline the relevant statutory and regulatory duties. No issues identified.

Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**		**N/A**	✓
If yes, please specify						
Equality analysis completed (please tick)	**Yes**	✓ enclosed in individual documents.	**No**		**N/A**	
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken? (please tick)	**Yes**		**No**		**N/A**	✓

Key implications	
Are additional resources required?	None identified.
Has there been/does there need to be appropriate clinical involvement?	As required for individual strategies, policies and plans
Has there been/does there need to be any patient and public involvement?	As required for individual strategies, policies and plans.
Has there been/does there need to be partner and/or other stakeholder engagement?	As required for individual strategies, policies and plans.

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Schedule A

Key and High-Risk Area Policies and Plans

The Board should be satisfied that members have read and understood the following ICB strategies, policies, and plans, prior to Board ratification. All draft policies are outlined in Annex 1.

ICB Ref	Title
ICBP007	**Complaints Policy**
Health and Safety related:	
ICBP011	**Driving at work policy**
ICBP017	**Fire Safety Policy**
ICBP018	**Health & Safety Strategy**
ICBP019	**Health and Safety Policy**
ICBP030	**Physical Security**
ICBP029	**Moving and Handling Policy**
ICBP034	**Provision of Use of Work Equipment Policy**
ICBP041	**Violence, Aggression and Abuse Management Policy**
ICBP046	**Serious Incidents (SIs) Management Policy**
ICBP039	**Standards of Business Conduct and Declarations of Interest Policy**
ICBP040	**Value Based Commissioning** • Note branding exception due to current NENC regional implementation.
EPRR related policies:	
ICBP013	**Incident Response Plan**
ICBP014	**EPPR Policy**
ICBP015	**EPRR On-Call Policy**

Schedule B

Other ICB Corporate Strategies, Policies and Plans and HR Policies Recommended for 'first approval' by Executive Committee (5th July 2022)

Other Corporate Policies

ICB Ref	Title
ICBP001	• Access and Choice Policy
ICBP006	• Commercial Sponsorship and Joint working with pharmaceutical industry
ICBP009	• Counter Fraud, Bribery and Corruption Policy
ICBP020	• Incident Reporting and Management Policy
ICBP025	• Intellectual Property Rights Policy
ICBP027	• Involvement and Engagement Strategy
ICBP028	• Media Handling Policy
ICBP031	• Policy for the Approval and Development of Policies
ICBP032	• Policy for the Development and Authorisation of Patient Group Directions
ICBP033	• Procurement Policy
ICBP035	• Receipt of Petitions Policy
ICBP037	• Risk Management Policy
CHC related:	
ICBP002	• Local Resolution and CHC Appeals Policy (CHC)
ICBP003	• Choice & Equity Policy (CHC)
ICBP004	• Partner Dispute Policy (CHC)
ICBP005	• Safe Observation Policy (CHC)
Quality and Safeguarding related	
ICBP042	• Safeguarding Children Policy
ICBP043	• Safeguarding Vulnerable Adults Policy
ICBP044	• MCA / DOLs Policy
ICBP045	• Prevent Policy
ICBP046	• Serious Incidents (SIs) Management Policy
ICBP047	• Adults and Children Safeguarding Supervision Policy
Information Governance related	
ICBP008	• Confidentiality and Data Protection Policy
ICBP010	• Data Quality Policy
ICBP012	• Electronic Signature policy
ICBP021	• Information Access Policy
ICBP022	• Information Governance and Information Risk Policy
ICBP023	• Information Governance Strategy
ICBP024	• Information Security Policy
ICBP026	• Internet and Email Acceptable Policy
ICBP036	• Records Management Policy and Strategy
ICBP038	• Social Media & Instant Messaging (IG and Communications related)

Human Resource Policies

ICB Ref	Title
HR02	• Absence Policy
HR03	• Adoption Leave Policy
HR04	• Annual Leave Policy
HR18	• Appraisal/Ongoing review and objectives policy
HR50	• Buying and Selling Annual Leave
HR05	• Career Break Policy
HR06	• Change Management Policy
HR07	• Disciplinary Policy
HR41	• Domestic Abuse and the Workplace
HR08	• Equality & Diversity Policy
HR09	• Flexible working Policy
HR10	• Further Education, Training & Development Policy
HR11	• Grievance and Disputes Procedures
HR12	• Harassment and Bullying Policy
HR37	• Incremental pay progression
HR13	• Induction Policy (corporate & local - perm & temp staff)
HR14	• Job Evaluation
HR40	• Managing Allegations Against Staff
HR16	• Managing work performance (Capability)
HR17	• Maternity Leave Guide and Policy
HR19	• Other Leave Policy
HR20	• Parental Leave Policy
HR22	• Paternity Leave Policy
HR24	• Professional Registration Policy
HR51	• Probationary Period
HR43	• Promoting Mental Health & Wellbeing At Work
HR35	• Raising Concerns Policy (Whistleblowing)
HR25	• Recruiting Ex-Offenders Policy & DBS
HR26	• Recruitment and Retention Premia
HR27	• Recruitment and Selection
HR28	• Redeployment Policy
HR46	• Relocation Expenses
HR29	• Retirement Policy
HR30	• Secondment Policy
HR39	• Shared Parental Leave
HR31	• Substance Misuse Policy
HR32	• Temporary Promotion
HR49	• Time off for Reserve/Cadet Forces
HR34	• Travel Expenses & Subsistence
HR44	• Volunteers
HR45	• Work Experience
HR36	• Working Time Directive Policy

Annex 1

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Corporate	ICBP007 - Complaints Policy

Version Number	Date Issued	Review Date
1	July 2022	July 2024

Prepared By:	Clinical Quality Manager, Clinical Quality team, CSU North of England Commissioning Support Unit.
Consultation Process:	ICS Integrated Governance Workstream ICS Clinical Leadership Workstream
Formally Approved:	July 2022
Approved By:	ICB Board

EQUALITY IMPACT ASSESSMENT

Date	Issues
June 2022	None

POLICY VALIDITY STATEMENT

Policy users should ensure that they are consulting the currently valid version of the documentation. The policy will remain valid, including during its period of review. However, the policy must be reviewed at least once in every 3-year period.

ACCESSIBLE INFORMATION STANDARDS

If you require this document in an alternative format, such as easy read, large text, braille or an alternative language please contact NECSU.comms@nhs.net

Version Control

Version	Release Date	Author	Update comments
1	July 2022	CSU Clinical Quality team.	Not Applicable

Approval

Role	Name	Date
Approver	ICB Board	July 2022

Contents

1. Introduction

This complaints handling procedure describes how the core expectations given in the NHS Complaint Standards will be put into practice by the North East and North Cumbria Integrated Care Board For the purposes of this policy the North East and North Cumbria Integrated Care Board will be referred to as 'the ICB'.

Commissioning involves deciding what services are needed for diverse local, regional or national populations and ensuring that they are provided.

The ICB aspires to the highest standards of corporate behaviour and clinical competence, to ensure that safe, fair and equitable procedures are applied to all organisational transactions, including relationships with patients their carers, public, staff, stakeholders and the use of public resources. In order to provide clear and consistent guidance, the ICB will develop documents to fulfil all statutory, organisational and best practice requirements and support the principles of equal opportunity for all.

This policy is designed to outline the process for handling complaints generated by patients or their representatives and aims to set out clear guidelines for staff, managers and complainants around how complaints will be managed.

It is our aim that all patients, relatives and their carers will not be treated differently as a result of making a complaint. This will be achieved by ensuring that complaints are handled fairly and openly. It is clearly not always possible for the complainant to receive the outcome they hoped for, but if they feel that their complaint has been handled appropriately and that they have had a fair hearing, this is a positive outcome.

The ICB will make sure that everyone who uses its services, and the services commissioned by the ICB (and those that support them), know how they can make a complaint. This includes making people aware that they can also complain to the ICB about any commissioned service. The complaints policy and/or materials that promote the procedure will be visible in public areas and on the ICB website. The ICB also ensures that the commissioned services have similar information available. The ICB will ensure there are a range of ways to do this so that people can do this easily in a way that suits them. This includes providing access to the complaints process online.

The ICB is very keen to ensure that complaints are used as learning opportunities and that trends are analysed and reported on. It is essential that information we gain from complaints is used to improve the quality and safety of the services we commission. A patient or service user's ongoing or future care and treatment will not be adversely affected because they have made a complaint.

This policy has been written in accordance with the 'Local Authority Social Services and National Health Service Complaints (England) Regulations 2009*'.* Reference is also made to the Department of Health guidance in complaints handling 'Listening, Responding, Improving', Parliamentary and Health Service Ombudsman's (PHSO) 'Principles of Good Complaints Handling', PHSO's 'Complaints Handing Framework' and 'Model Complaints Procedure', the NHS Constitution (2008) and 'A Review of the NHS Hospitals Complaints System Putting Patients Back in the Picture' (Right Honourable Ann Clwyd MP and Prof Tricia Hart, 2013).

2. Status

This policy is a corporate policy.

3. Purpose and scope

The ICB recognises that issues cannot always be resolved as they arise and that sometimes people want to make a complaint. A complaint is an expression of dissatisfaction, either spoken or written, that requires a response. It can be about:

- an act, omission or decision made by the ICB, or a service commissioned by the ICB
- the standard of service provided or commissioned by the ICB

This policy describes the systems in place to effectively manage all complaints received by the organisation in accordance with NHS complaints regulations. It outlines the responsibilities and processes for receiving, handling, investigating and resolving complaints relating to the actions of the organisation, its staff and services.

The policy also includes the process used for complaints received relating to commissioned services such as NHS trusts independent contractors (general practices, dental practices, pharmacies and opticians) and independent sector providers.

The purpose of this policy is to ensure that the ICB promotes best practice within its complaints management function, and also that it is compliant with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. The ICB also adheres to the NHS Constitution including the five rights covering complaints and redress.

This policy sets out how the NHS complaints procedure will be implemented locally and must be followed by all staff employed or hosted by the ICB.

4. Definitions

The following terms are used in this document:

4.1 **Complaint**: a written or oral expression of dissatisfaction which requires a response.

4.2 **Issues/concerns**: a written or oral expression of dissatisfaction that can be resolved without the need for formal investigation or correspondence.

4.3 **Independent Complaints Advocacy (ICA)**: is the organisation that provides independent help and support for people pursuing an NHS complaint.

4.4 **Investigating officer**: the person identified as responsible for handling and investigating an individual complaint.

4.5 **The Parliamentary and Health Service Ombudsman (PHSO)**: is the organisation that manages the second stage of the NHS complaints procedure

4.6 **Serious Incident (SI)**: is an incident or near miss occurring on health service premises or in relation to health services provided, resulting in death, serious injury or harm to patients, staff or the public, significant loss or damage to property or the environment, or otherwise likely to be significant public concern.

Any other special terms or abbreviations used in this document are defined as they occur.

5. NHS complaints procedure and process

When a complaint is received, the ICB is committed to making sure it is addressed and resolved at the earliest opportunity. ICB staff/commissioning support unit (CSU) complaints team will identify any complaint that may be resolved quickly as an informal concern or enquiry. If staff consider that the issues cannot be resolved quickly, these will be looked at more closely using the complaints procedure.

When an early resolution is possible, ICB staff/CSU complaints team will take action to address and resolve the issues raised and put things right for the person raising them. This may mean giving a quick explanation or apology or making sure a colleague who is more informed of the issues does. ICB staff/CSU complaints team will promptly resolve such issues in person or by telephone or email; a timescale for this will be agreed with the person raising the concern.

A reformed complaints procedure covering both health and adult social care was introduced from April 2009. This enables organisations and the person complaining to agree on the best way to handle the complaint to achieve a satisfactory outcome. Within this process both concerns and complaints can be made either verbally, in writing or electronically via email.

There are two stages to the NHS complaints procedure:

- Stage One: Local resolution of complaint through investigation and response by the ICB or provider
- Stage Two: Independent Review of complaint by the PHSO

5.1 Who can complain?

5.1.1 Anyone who is receiving, or has received, NHS treatment or services or who is affected or is likely to be affected by an action, omission or decision can complain. This includes being able to complain about services provided by independent providers as part of an NHS contract.

5.1.2 If a patient (including a child over the age of 13, in line with General Data Protection Regulations) does not wish to complain themselves then someone else, usually a relative, friend or other representative, can complain on their behalf providing written authorisation is given.

5.1.3 If a complainant is the parent or guardian of a child under the age of 13 (to whom the complaint relates) the organisation must be satisfied that there are reasonable grounds for the complaint being made by the representative. Where the child is aged 13 to 18, their written consent should be provided for a parent/guardian or other representation to act on their behalf with regard to the complaint.

5.1.4 If a patient is unable to act, for instance due to physical incapacity or lack of capacity within the meaning of the Mental Capacity Act (2005) their authorisation is not required. A consent form should be completed by the complainant showing the reason why the patient is unable to act. In such situations, a suitable representative may pursue the complaint on their behalf, however, evidence of their authority to act will be required. Guidance from the Information Governance Team will be obtained as required in relation to consent/authority to act.

5.1.5 If a complaint is raised concerning a patient who is deceased, this must be made by a suitable representative, for example next of kin or person who holds legal authority to act on behalf of the deceased person. Where clarification is required on whether the complainant is a suitable representative, guidance should be obtained from the information governance team and/or the ICB's complaints lead. If the complaints team/ICB does not consider that the complainant is a suitable representative, they may decline to deal with the complainant and recommend that another person acts on the deceased patient's behalf.

5.1.6 If it is believed at any time that a representative is not acting in the best interests of the person affected, the ICB will assess whether to stop the consideration of the complaint. If this happens, the CSU complaints team will share the ICB's reasons with the representative in writing. In such circumstances, the representative will be advised that they may complain to the PHSO if they are unhappy with the decision.

5.2 Support for persons making a complaint

ICA provides a free, impartial and independent service for people wishing to make a complaint about the NHS. All complainants will be provided with information about the ICA. Information regarding other specialist advocacy services will be provided, as required.

5.3 Process for verbal complaints

5.3.1 Clear information about the complaints process is made available to patients, the public and staff via the ICB's website.

5.3.2 Complaints can be made verbally to a member of the CSU complaints team and in this instance a written statement will be taken from the complainant ensuring all salient points requiring a response are documented. Where a complainant telephones the ICB to raise their complaint and does not wish to be transferred to the CSU, ICB staff should take details of the complaint during the call and subsequently email notes of this to the CSU complaints team.

5.3.3 The written statement will be sent to the complainant asking them to review this and, if necessary, make any changes to ensure it is an accurate reflection of their complaint. The complainant will then be asked to sign and return the statement to the CSU complaints team. The complainant will be advised that their complaint will not be processed until the signed statement is returned; this can be by post or email, in which case the email will be accepted in lieu of a physical signature.

5.3.4 There may be instances when it is not appropriate to take a formal complaint over the telephone, for example, if the concerns raised are complex. In cases such as this a face to face or online/virtual meeting will be offered to clarify the complaint or with the complainant's permission a referral can be made to ICA. Face to face appointments with the CSU complaints team are by appointment only.

5.4 Time limit for making a complaint

5.4.1 The timescale within which an NHS or social care complaint must be made is 12 months from the date on which a matter occurred, or the matter came to the notice of the complainant.

5.4.2 The regulations set out that the organisation has the discretion to investigate beyond this time, especially if there is good reason for a complaint not being received within the 12 months. The time limit can, and should, be waived if it is still practical and possible to investigate the complaint, for example, the records still exist, and the individuals concerned are still available to be questioned.

5.4.3 When a complaint is made outside these limits and the time limits are not waived, the ICB (or complaints team on behalf of the ICB) will advise the complainant of their rights to request that the PHSO consider their case.

5.5 Issues that cannot be addressed within the complaints procedure

This policy does not address:

5.5.1 A complaint made by a responsible body to another responsible body. For example, disputes on contractual matters between providers and the ICB should not be handled through this procedure. However, the issues raised should still be subject to a thorough investigation and appropriate action taken for service improvement.

5.5.2 Complaints regarding privately funded treatment.

5.5.3 Complaints which are made verbally and resolved to the satisfaction of the complainant no later than the next working day after the complaint was made.

5.5.4 Complaints regarding an alleged failure to comply with a request for information under the Freedom of Information Act (2000) or complaints about Access to Health Records Act 1990 requests and Subject Access Requests. These will be dealt with via information governance processes.

5.5.5 A complaint made by an employee about any matter relating to his/her employment. These matters will be handled via human resources procedures.

5.5.6 Complaints that have already been locally investigated under the complaints regulations or which are being, or have been, investigated by a Local Commissioner under the Local Government Act 1974 or the Health Service Commissioner under the 1993 Act.

5.5.7 If the organisation decides that a complaint meets any of the criteria detailed in sections 5.5.1 – 5.5.6 the complainant will be notified in writing of this decision and the reasons why.

5.5.8 Complaints disputing a funding decision or eligibility criteria/policy; these will be managed via the appropriate appeals process (where applicable) or other agreed process.

5.5.9 If the complaint is about detention under the Mental Health Act, or a Community Treatment Order or Guardianship the CSU complaints team will inform the person making the complaint that if they are not happy with the outcome, they can take their complaint to the Care Quality Commission.

5.5.10 When another process may be better suited to cover other potential outcomes, the CSU complaints team will seek advice and provide clear information to the individual raising the complaint. The team will make sure the individual understands why this is relevant and the options available and will also signpost the individual to sources of specialist independent advice.

5.5.11 If an individual is already taking part or chooses to take part in another process (where this is appropriate) but wishes to continue with their complaint as well, this will not affect the investigation and response to the complaint. The only exceptions to this are if:

- the individual requests or agrees to a delay
- there is a formal request for a pause in the complaint process from the police, a coroner or a judge.

In such cases the complaint investigation will be put on hold until those processes conclude.

5.6 Written complaints received

5.6.1 Formal complaints received by ICB staff must be forwarded within one working day to the CSU generic email account, necsu.complaints@nhs.net.

5.6.2 For complaints relating to the services/care given by a provider commissioned by the ICB, the complainant has a choice of complaining directly to the ICB as commissioner rather than to the organisation which provided the care. The final decision on who will investigate the complaint rests with the ICB once all mitigating circumstances are taken into account. Complaints about primary care should be directed to NHS England/Improvement, see para 5.9.7

5.6.3 This will include taking into consideration the complainant's wishes and the seriousness of the complaint, for example where there has been a poor record of complaints handling or the complaint suggests a significant risk to patient safety or there appears to be a trend. Please refer to section 5.9 for guidance on how provider complaints are handled.

5.7 Process for complaints handled by the ICB

5.7.1 Acknowledging the complaint

5.7.1.1 Upon receipt of a complaint (received either directly from the complainant or via the ICB) the CSU complaints team will assess the issues raised for wider governance issues, such as patient safety issues, safeguarding or potential poor performance concerns.

5.7.1.2 All complaints received will be acknowledged verbally or in writing by the CSU complaints team within three days of receipt or from when the signed verbal statement is received. This may be via telephone or email/letter.

5.7.1.3 At the time of acknowledging the complaint the CSU complaints team must offer to discuss and agree the following with the complainant:

- An action plan for handling the complaint
- When the investigation is likely to be completed
- What reasonable outcome is desired
- When the response is likely to be sent
- Offer a local resolution meeting if appropriate
- Advise the complainant of advocacy services, such as ICA.

5.7.1.4 The agreed action plan and timescales for response will be confirmed in writing to the complainant.

5.7.1.5 If the complainant does not take up the offer of a discussion, the CSU complaints team should determine the response period and the complainant will be notified of this in writing.

5.7.1.6 As outlined in 5.6.2, where it is agreed that the CSU on behalf of the ICB will handle the complaint rather than the provider or where it has been agreed that the ICB will co-ordinate the response, consent will be required from the complainant to obtain access to relevant medical records and/or to seek a response from the provider organisation(s). The complaints team will request the relevant consent from the complainant.

5.7.1.7 If the complainant fails to provide written consent, they will be notified in writing of the elements of the complaint that are unable to be investigated and responded to.

Acknowledging a complaint from an MP

5.7.8 Where a complaint about an individual's care/treatment/funding is received by the ICB from a member of parliament (MP), this should be forwarded to the ICB Chief Executive and both the CSU complaints team (necsu.complaints@nhs.net) and the CSU communications and engagement Team (necsu.info-comms@nhs.net) within one working day. Both teams will liaise to identify whether the case is already recorded on the complaints system and the most appropriate route for its management i.e., via the complaints procedure or via MP enquiry process. This agreement will be reached in conjunction with the ICB. Complaints which fall within the remit of ICB will be coordinated by the CSU complaints team in line with the Complaints Policy. Where the complainant has provided consent, a copy of the complaint response will be shared with the MP.

5.7.9 Where a complaint relates to a provider organisation, the CSU communications and engagement team will provide advice to

the MP on which organisation to contact or redirect the complaint, if appropriate.

5.7.10 Communication received from an MP of a more general nature, i.e., not specific to an individual constituent's care, will be managed via the MP enquiry process and are not required to be shared with the CSU complaints team.

5.7.2 Investigation

5.7.2.1 The investigation will be conducted in a timely manner, proportionate to the complaint.

5.7.2.2 The CSU complaints team, on behalf of the chief executive will:

- Forward the complaint to the appropriate lead for investigation, with details of the issues to be investigated and agreed in the complaint plan.
- Send a copy of the complaint to the investigating officer.
- Identify at an early stage whether it would be helpful to offer a local resolution meeting and/or to meet with the complainant before sending the response to discuss the findings and any intended actions.
- Keep the complainant up to date with the progress of the investigation.

5.7.2.3 The investigating officer will:

- Be someone who is not involved in the events complained about. If this is not possible, the CSU complaints team will explain to the person making the complaint the reasons why it was assigned to that person. This should address any perceived conflict of interest
- Establish what happened, what should have happened and who was involved and make written records of the investigation/staff statements.
- Make sure a sincere and appropriate apology is made as appropriate.
- Identify what actions can be implemented to ensure that there is no recurrence and address any training issues and learning points.
- Prepare a report addressing the issues raised by the complainant and comment on what action is being taken to prevent a recurrence in the future.

5.7.2.4 Staff involved in a complaint:

- Will be made aware of the complaint, be kept up to date and have the opportunity to give their views on the events and respond to emerging situation; this includes preparing written statements, where required, as part of the investigation.
- Are required to co-operate with the requirements of the Complaints Policy as part of their terms of employment. Where an employee refuses to give an interview or a written account without reasonable grounds, this should be considered a disciplinary offence.

5.7.2.5 Where the complaint relates to a clinical matter, written reports from any appropriate clinician should be obtained. These reports form part of the complaint record which can potentially be disclosed to the complainant via a Subject Access Request; therefore, documents must be written in plain English and without jargon or abbreviations.

5.7.3 <u>The Response</u>

5.7.3.1 The written response will be drafted by the CSU complaints team; this will incorporate the investigation report (where appropriate) and will:

- Address all the issues raised by the complainant
- Provide explanations and apologies, where appropriate.
- Indicate lessons learned from the complaint.
- Include what steps have been taken to prevent a recurrence.
- Outline what options are available if the complainant is not satisfied with the response, including details of the PHSO.
- Provide a reminder of where to obtain independent advice or advocacy

5.7.3.2 The CSU complaints team will forward the formatted written response for approval to the investigating officer and any other relevant staff involved in the complaint.

5.7.3.3 The response will then be forwarded for final approval and signature to the chief executive (or nominated deputy).

5.7.3.4 If for any reason a response cannot be made within the agreed timescale (for example a person involved in the complaint is absent from work) the complainant will be contacted by the CSU complaints team and an extension to the specified revised timescale will be agreed. If the complaint cannot be concluded and a response issued within 6 months, the CSU complaints team will write to the person on behalf of the ICB to explain the reasons for the delay and the likely timescale for completion. The CSU complaints team will continue to maintain oversight until the complaint is completed and a final written response issued.

5.7.3.5 If the complainant is satisfied with the response, the case will then be closed. Implementation of any changes made to practice or procedures as a result of the investigation will be monitored by the CSU complaints team; this via review of a complaint action plan completed by the relevant manager. Lessons learned from complaint investigations will be included in the ICB Board report.

5.7.3.6 If a complainant is dissatisfied with the response, every effort will be made to achieve a satisfactory outcome at local level by:

- identifying outstanding issues
- arranging further meetings
- providing a further written response
- involving a conciliator, where appropriate.

5.7.3.7 If, following all attempts to resolve the complaint locally, the complainant remains dissatisfied they will be notified that local resolution (Stage One) is at an end and that they can ask the PHSO to consider their case in line with Stage Two of the NHS Complaints Procedure. Information on the PHSO will be routinely given to complainants at the completion of local resolution.

5.7.3.8 Staff who are involved in complaints management will have the appropriate: training, resources, support and protected time to respond to and investigate complaints effectively.

5.8 Conciliation Process

5.8.1 A conciliation service with access to trained lay conciliators can be made available to assist in the resolution of complaints. Arrangements for conciliation will be made via the CSU complaints team throughout the complaints process, as required.

5.8.2 The lay conciliator will report back to the CSU complaints team on outcomes and agreed action points but will not disclose the substance of any discussions.

5.8.3 The conciliation process is confidential. However, where information is raised within that process regarding safeguarding children or adults or a general patient safety issue, the conciliator may have to seek further advice from the manager responsible for complaints.

5.9 Process for complaints received about NHS providers

5.9.1 In the majority of cases when a complaint is received by the ICB, the provider will normally be given the opportunity to respond to the complaint directly. The complaint will be acknowledged verbally or in writing by the CSU complaints team within three working days and consent will be sought by the CSU complaints team to forward the complaint to the provider.

5.9.2 When consent is received, the complaint will be passed to the provider who will handle it in accordance with the NHS complaints procedure. Correspondence confirming that the complaint has been passed to the provider will then be sent to the complainant. The CSU complaints team will request that a copy of the provider's signed complaint response is shared with the ICB/CSU.

5.9.3 There may be occasions when the ICB considers it appropriate to handle the complaint rather than the provider. This decision will be taken once all mitigating circumstances have been taken into account, including the complainant's wishes, seriousness of complaint or significant patient safety issues or where there appears to be a pattern.

5.9.4 In such cases both the complainant and provider will be notified, and the complaint will be processed in accordance with section 5.7.

5.9.5 The ICB will ensure, via contractual agreement, that all NHS providers and any private provider with whom it has a contract or service level agreement have arrangements in place for handling complaints made about services they provide that is comparable with the NHS complaints procedure.

5.9.6 Providers routinely share with the ICB information on the number and nature of complaints, concerns, comments and compliments received along with details of lessons learned and improvements to services to prevent a reoccurrence of similar complaints.

5.9.7 Where a complaint is received about a primary care contractor (i.e., GP practice, dentist, community pharmacy, optician), the ICB or CSU complaints team will advise the complainant to send their complaint to NHS England for investigation and response or offer to forward the complaint to NHS England with the complainant's consent.

5.10 Process for handling joint NHS and local authority complaints

5.10.1 When complaints are received about both health and local authority services, with the complainant's consent, the organisations involved will co-operate with each other to deal with the aspects of the complaint that relates to them. Both agencies will agree who will lead on the complaint and will aim to provide a single co-ordinated response.

5.10.2 The chief executive (or nominated deputy) of the lead organisation will sign the response. Irrespective of lead responsibility, each organisation retains its duty of care to the complainant and must handle its part of the complaint in accordance with its own procedures.

5.11 Process for complex complaints that span several NHS organisations

5.11.1 Where a complaint is received that spans a number of NHS provider organisations the CSU, on behalf of the ICB, will seek assurance that there will be a co-ordinated approach to the handling of the complaint across the various parties involved, prior to passing the complaint to the lead organisation.

5.11.2 The organisation to lead on the handling of the complaint will be agreed following discussion with the parties involved. This decision will be made taking into account the organisation that has the greater part in the complaint as well as the complainant's wishes.

5.11.3 Where the complaint is particularly complex or where serious patient safety issues have been identified, instead of the provider co-ordinating the response and leading in the investigation of the complaint, the ICB may choose to do this with the complainant's consent.

5.12 Process for handling complaints about non-NHS services

Occasionally complaints are received about services not provided by the NHS, e.g., private treatment. In such cases, wherever possible, the CSU complaints team will advise the complainant of the correct agency to contact and will offer to forward the complaint for investigation with the complainant's consent. Beyond this, the CSU/ICB will have no further input.

5.13 Staff support during the complaints process

5.13.1 It can be very stressful for those involved in the complaint process and advice and support is available to staff. The CSU complaints team or a senior manager within the ICB will make sure any staff being complained about are made aware and will provide advice on how they can get support from within the organisation, and external representation if required.

5.13.2 Staff who are complained about will have the opportunity to give their views on the events and respond to emerging information. Staff will act openly and transparently and with empathy when discussing these issues.

5.13.3 Staff complained about will be kept updated by their line manager. These staff will also have an opportunity to see how their comments are used before the final response is issued.

5.14 Equality and diversity

5.14.1 Making a complaint does not mean that a patient/complainant will receive less help, or that things will be made difficult for them or that the quality of their care will be compromised.

5.14.2 Every complainant will be treated fairly and equally regardless of age, disability, race, culture, nationality, gender, sexual orientation and faith.

5.14.3 In line with NHS England's Accessible Information Standard, for people who require language or signed interpreting this will be made available throughout the complaints process.

5.15 Disciplinary procedures

5.15.1 The Complaints Policy is concerned with resolving complaints to the satisfaction of complainants and learning lessons for improvement and not for investigating disciplinary matters.

5.15.2 A complaint investigation may occasionally reveal the need for an investigation under the disciplinary policy. In such an event, the CSU complaints team will not be involved in any disciplinary investigation.

5.15.3 Where it is considered that a staff member within the ICB or in a commissioned service should be subject to remedial or disciplinary procedures or referral to a health professional regulator, the CSU complaints team will advise the person raising the complaint that appropriate processes have been followed, for example HR processes. Where the person raising the complaint chooses to refer the matter to a health professional regulator themselves or where they subsequently choose to, it will not affect the way that their complaint is investigated and responded to. They will also be signposted to sources of independent advice on raising health professional fitness to practise concerns.

5.16 Serious incidents (SIs) and complaints

5.16.1 The procedure for investigating SIs is separate from the Complaints Policy and is managed in accordance with the SI Policy. If during the course of investigating a SI, a complaint is also received, the SI Policy/process will normally take precedence in terms of the investigation.

5.16.2 If a complaint investigation reveals the need to take action under the SI Policy, the serious incident process will normally take precedence in terms of investigation.

5.16.3 In these circumstances, the complainant will be notified of the SI investigation and will be kept updated on the progress by the CSU complaints team. It should be remembered that the issues raised in a complaint will not always be exactly the same as those investigated under the SI policy and, in those circumstances, a separate and full response to the complaint will be required.

5.17 Process for dealing with anonymous complaints

All anonymous complaints received will be investigated if there is enough information to carry out an investigation. Investigating officers will be requested to report to the chief executive (or nominated deputy) and make appropriate recommendations based on the allegations raised.

5.18 Withdrawal of a complaint

If a complainant withdraws a complaint at any stage in the procedure, which involves issues raised against an individual, those complained against will be informed. In such circumstances, the relevant head of service or line manager will consider if/how to address issues highlighted in the complaint.

5.19 Learning and monitoring of complaints

5.19.1 The ICB's philosophy for the management of complaints is to recognise their positive value through the effective monitoring of complaints. In applying these principles and sharing the learning we can all effect change. The ICB expects all staff and commissioned services to identify what learning can be taken from complaints, regardless of whether mistakes are found or not.

5.19.2 The ICB will use the intelligence gained from complaints information (individual complaints received and provider complaints reports) to develop a greater awareness of services commissioned and where these may not meet quality standards.

5.19.3 Monthly reports will be provided to the ICB complaints lead by the CSU complaints team. The Quality and Safety committee will receive regular complaints reports, as determined in its Annual Cycle of Business, as part of governance and performance reporting. The reports will identify any trends and patterns arising from complaints, and any subsequent action taken as a result of lessons learned.

5.19.4 An annual report will be prepared for the ICB Board on the handling and consideration of complaints, outlining actions, monitoring compliance and outcomes. This will be published on the ICB's website.

5.19.5 Complaint outcomes may be anonymised and shared within the organisation and may be published on the ICB's website to promote service improvement.

5.20 Recording of complaints

5.20.1 Accurate and up to date records will be maintained in accordance with the Records Management Policy. The Safeguard Incident Reporting and Management System (SIRMS) will be used to record and collate all complaints information.

5.20.2 The complaints record will not be filed within a clinical record but held within a separate complaints file.

5.21 Confidentiality/consent

5.21.1 Care will be taken at all times throughout the complaints procedure to ensure that any information disclosed about the patient/service user is confined to that which is relevant to the investigation of the complaint. Information will only be disclosed to people who have a demonstrable need to know it for the purpose of investigating the complaint or ensuring that the complaints process is followed.

5.21.2 In transferring complaints between agencies (including the PHSO) confidentiality will be maintained at all times. Every effort will be made to obtain the patient/service user (or their representative's) consent before sharing confidential information with another body or organisation. Consent will be obtained in writing or where this is not possible the CSU complaints team will seek further advice from the Caldicott Guardian, if required. Where a complainant declines to provide consent for their complaint to be shared with another organisation, the CSU complaints team will provide them with contact details in order that they can make direct contact themselves.

5.21.3 It is recognised that there may be circumstances in which the nature of, or aspects of, a complaint indicate safeguarding or wellbeing concerns about a child or adult. In these circumstances a complaint will be escalated as necessary and in line with the ICB and Local Safeguarding Children and Adults Boards safeguarding procedures and such information contained in the complaint disclosed in the best interests of the complainant/patient.

5.21.4 If the receiving manager or member or the CSU Complaints Team is made aware of safeguarding children or adult concerns they must consult with the Head of Quality and Adult Safeguarding or the Head of Safeguarding Children (or equivalent role) as appropriate for advice the same day.

5.21.5 Where a complaint refers to allegations against a member of staff of a safeguarding children or adult nature, the Managing Allegations Against Staff Policy must be followed – this can be found on the ICB's website.

This will either supersede the Complaints Policy where such concerns form the whole of the process, or where only part of the complaint, the two processes occur simultaneously with decisions about response times and involvement of the member of staff being taken jointly. In cases where the Safeguarding Policy is invoked, the complainant must be notified immediately.

5.21.6 Following the identification of safeguarding concerns within a complaint, the complainant will be notified within one working day of the escalation and rationale for disclosure of information. Where safeguarding concerns form only part of a complaint the complainant will be informed of how the differing aspects of the complaint will be handled.

5.22 Access to personal information/medical records

5.22.1 Under the General Data Protection Regulation (GDPR), individuals (both service users and employees) have certain rights regarding the way information about them is used. These include having the rights to see information that is recorded about them (subject access request) and to have any part of it that they do not understand explained.

5.22.2 Where clinical records are used in a complaint investigation, investigating officers must comply with regulations for sharing of information across services or external agencies (incorporating the Code of Practice on Openness in the NHS).

5.22.3 Any requests received for access to complaint documentation will be sent to the information governance department for appropriate action.

5.23 Complaints and Litigation and complaints involving potential fraud or other criminal offences

5.23.1 On receipt of a complaint in which legal action is being taken or the police are involved the ICB should continue to resolve the complaint unless there are clear legal reasons not to do so.

5.23.2 Advice will be sought from relevant authorities (such as legal advisors or NHS Resolution) to determine whether progressing the complaint might prejudice subsequent legal action.

5.23.3 If there is likely to be any prejudice to the legal case the complaint will be put on hold and the complainant will be advised of this in writing and provided with an explanation.

5.23.4 Documentation relating to the complaints investigation can be used in a court of law.

5.23.5 Where a complaint includes allegations of a criminal offence, the CSU complaints team/member of ICB staff will immediately notify the relevant ICB director for advice/appropriate action e.g., notifying the police. Where this is applicable, the ICB/CSU will comply with the requirements of the ICB's Counter Fraud, Bribery and Corruption Policy.

5.24 Complaints about Freedom of Information

Complaints about Freedom of Information requests, Access to Health Records Act 1990 requests and Subject Access Requests are not dealt with through the NHS complaints procedure. Any complaint of this nature will be forwarded to the appropriate information governance officer for investigation and response through relevant channels.

5.25 Dealing with media interest

All enquiries from the media must be immediately referred to the communications department ensuring that confidentiality is maintained at all times.

5.26 Retention of complaint records

Complaint files will be retained securely for a minimum of 10 years in accordance with the Records Management Policy.

5.27 Habitual and/or persistent complaints

5.27.1 Some complainants find it difficult to accept the findings following an investigation even when it has been to the second stage of the complaints procedure. The difficulty in managing such complaints places a strain on resources and causes undue stress for staff.

5.27.2 In such cases, it is important to ensure that the complaints procedure has been correctly implemented as far as possible and that no material element of the complaint has been overlooked or inadequately addressed.

5.27.3 The procedure on how to handle unreasonable and persistent complainants is attached at Appendix 1.

6. Implementation

6.1 This Policy will be available to all staff for the effective management of complaints received by the organisation in accordance with NHS complaints regulations.

6.2 All managers are responsible for ensuring that relevant staff within the ICB have read and understood this document and are competent to carry out their duties in accordance with the procedures described.

7. Training Implications

The CSU complaints team will provide or arrange coaching or training in complaints handling and good customer care. Managers should ensure that appropriate staff in their areas who require such support contact the CSU complaints team to arrange training.

Complaints awareness is included in the corporate induction programme for all new members of staff.

8. Related Documents

8.1 Other related policy documents

- Safeguarding and Looked After Children Policy
- Safeguarding Adults Policy
- Records Management Policy
- Serious Incidents & Management Policy
- Managing Allegations Against Staff Policy
- Counter Fraud, Bribery and Corruption Policy

8.2 Legislation and statutory requirements

- General Data Protection Regulation (GDPR), 2018.
- Cabinet Office. (2006) *Equality Act 2006.* London. HMSO.
- Cabinet Office. (2005) *Mental Capacity Act 2005.* London. HMSO.
- Cabinet Office. (2000) *Freedom of Information Act 2000.* London. HMSO
- Cabinet Office. (1990) *Access to Health Records Act.* London. HMSO.
- Cabinet Office. (2018) *Data Protection Act 2018.* London. HMSO.
- Cabinet Office. (1998) *Human Rights Act 1998.* London. HMSO.
- Department of Health. (2009) *Local Authority Social Services and National Health Service Complaints (England) Regulations.* London. HMSO.
- Department of Health. (2009) *The NHS Constitution for England.* London. HMSO.
- HM Government (2015): *Channel Duty Guidance – protecting vulnerable people from being drawn into terrorism* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/425189/Channel_Duty_Guidance_April_2015.pdf
- HM Government (2015): *Prevent Duty Guidance* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417943/Prevent_Duty_Guidance_England_Wales.pdf
- HM Government (2015): *Working Together to safeguard Children* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf
- HM Government (2015): *Information Sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers.*

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419628/Information_sharing_advice_safeguarding_practitioners.pdf

- The Care Act 2014 http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted
- HM Government (2011): *The Prevent Strategy* http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

8.3 Best practice recommendations

- PHSO. *Complaints Handing Framework (2021)*
- NHS England. (2015) *Accessible Information Standard*
- Independent report, Ann Clwyd and Professor Tricia Hart. (2013) review of *NHS hospitals complaints system: Putting Patients Back in the Picture*
- Department of Health. (2009) *Listening, Responding, Improving*
- HMSO. (2009) A *guide to better customer care*
- PHSO. (2009) Principles *of Good Administration*
- PHSO. (2009) Principles *of Remedy*
- PHSO. (2008) Principles *of Good Complaint Handling*
- Department of Health. (2008) *Records Management: NHS Code of Practice.* London: DH.
- NHS Litigation Authority. (2008) *Risk Management Standard for Primary Care Trusts.* London: NHSLA.
- Healthcare Commission. (2007) *Spotlight on Complaints.*

9. Monitoring, Review and Archiving

9.1 Monitoring

The ICB Board will agree a method for monitoring the dissemination and implementation of this policy.

9.2 Review

9.2.1 The ICB Board will ensure that this policy document is reviewed in accordance with the timescale specified at the time of approval. No policy or procedure will remain operational for a period exceeding three years without a review taking place.

9.2.2 Staff who become aware of any change which may affect a policy should advise their line manager as soon as possible. The Executive Director will then consider the need to review the policy or procedure outside of the agreed timescale for revision.

9.2.3 For ease of reference for reviewers or approval bodies, changes should be noted in the 'version control' table on the second page of this document.

9.3 Archiving

The ICB Board will ensure that archived copies of superseded policy documents are retained in accordance with Records Management: Code of Practice for Health and Social Care 2021.

10. Equality Analysis

Initial Screening Assessment (STEP 1)

As a public body organisation, we need to ensure that all our current and proposed strategies, policies, services and functions, have given proper consideration to equality, diversity and inclusion, do not aid barriers to access or generate discrimination against any protected groups under the Equality Act 2010 (Age, Disability, Gender Reassignment, Pregnancy and Maternity, Race, Religion/Belief, Sex, Sexual Orientation, Marriage and Civil Partnership).

This screening determines relevance for all new and revised strategies, policies, projects, service reviews and functions.

Completed at the earliest opportunity it will help to determine:

- The relevance of proposals and decisions to equality, diversity, cohesion and integration.
- Whether or not equality and diversity is being/has already been considered for due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED).
- Whether or not it is necessary to carry out a full Equality Impact Assessment.

Name(s) and role(s) of person completing this assessment:

Name: Katharine Humby
Job Title: Clinical Quality Manager
Organisation: North of England Commissioning Support Unit (NECS)

Title of the service/project or policy: Complaints Policy (2)

Is this a;
Strategy / Policy ☒ **Service Review** ☐ **Project** ☐
Other Not applicable

What are the aim(s) and objectives of the service, project or policy:
This policy describes the systems in place to effectively manage all complaints received by the organisation in accordance with NHS complaints regulations. It outlines the responsibilities and processes for receiving, handling, investigating and resolving complaints relating to the actions of the organisation, its staff and services.

The policy also includes the process used for complaints received relating to commissioned services such as NHS trusts, independent contractors (general practices, dental practices, pharmacies and opticians) and independent sector providers.

The purpose of this policy is to ensure that the ICB promotes best practice within its complaints management function, and also that it is compliant with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

Every complainant will be treated fairly and equally regardless of age, disability, race, culture, nationality, gender, sexual orientation and faith. The patient/complainant will not receive less help, will not have things made difficult for them and will not have the quality of their care will be compromised as a result of a complaint. For people who require language or signed interpreting this will be made available throughout the complaints process.

Who will the project/service /policy / decision impact?
(Consider the actual and potential impact)

- **Staff** ☒
- **Service User / Patients** ☒
- **Other Public Sector Organisations** ☒
- **Voluntary / Community groups / Trade Unions** ☒
- **Others, please specify** N/A

Questions	Yes	No
Could there be an existing or potential negative impact on any of the protected characteristic groups?	☐	☒
Has there been or likely to be any staff/patient/public concerns?	☐	☒
Could this piece of work affect how our services, commissioning or procurement activities are organised, provided, located and by whom?	☐	☒
Could this piece of work affect the workforce or employment practices?	☐	☒
Does the piece of work involve or have a negative impact on: • Eliminating unlawful discrimination, victimisation and harassment • Advancing quality of opportunity • Fostering good relations between protected and non-protected groups in either the workforce or community	☐	☒

If you have answered no to the above and conclude that there will not be a detrimental impact on any equality group caused by the proposed policy/project/service change, please state how you have reached that conclusion below:

Click here to enter text.

If you have answered yes to any of the above, please now complete the 'STEP 2 Equality Impact Assessment' document

Accessible Information Standard	Yes	No
Please acknowledge you have considered the requirements of the Accessible Information Standard when communicating with staff and patients. https://www.england.nhs.uk/wp-content/uploads/2017/10/accessible-info-standard-overview-2017-18.pdf	☒	☐
If any of the above have not been implemented, please state the reason: N/A		

Governance, ownership and approval

Please state here who has approved the actions and outcomes of the screening		
Name	**Job title**	**Date**
Claire Riley	Executive Director of Corporate Governance, Communications and Involvement	June 2022

Publishing

This screening document will act as evidence that due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED) has been given.

Equality Impact Assessment: Policy – Strategy – Guidance (STEP 2)

This EIA should be undertaken at the start of development of a new project, proposed service review, policy or process guidance to assess likely impacts and provide further insight to reduce potential barriers/discrimination. The scope/document content should be adjusted as required due to findings of this assessment.

This assessment should then be updated throughout the course of development and continuously updated as the piece of work progresses.

Once the project, service review, or policy has been approved and implemented, it should be monitored regularly to ensure the intended outcomes are achieved.

This EIA will help you deliver excellent services that are accessible and meet the needs of staff, patients and service users.

This document is to be completed following the STEP 1 – Initial Screening Assessment

STEP 2 EVIDENCE GATHERING

Name(s) and role(s) of person completing this assessment:

Name: Katharine Humby
Job Title: Clinical Quality Manager
Organisation: North of England Commissioning Support (NECS)

Title of the service/project or policy: Complaints Policy (2)

Existing ☒ **New / Proposed** ☐ **Changed** ☐

What are the intended outcomes of this policy/ service / process? (Include outline of objectives and aims;
As outlined in the screening document above.

Who will the project/service /policy / decision impact?
(Consider the actual and potential impact)

- **Consultants** ☒
- **Nurses** ☒
- **Doctors** ☒
- **Staff** ☒
- **Service User / Patients** ☒
- **Others, please specify** N/A

Current Evidence / Information held	Outline what current data / information is held about the users of the service / patients / staff / policy / guidance? Why are the changes being made?
(Census Data, Local Health Profile data, Demographic reports, workforce reports, staff metrics, patient/service users/data, national reports, guidance, legislation changes, surveys, complaints, consultations/patient/staff feedback, other)	Complaints / Incidents

STEP 3: FULL EQUALITY IMPACT ASSESSMENT

The Equality Act 2010 covers nine 'protected characteristics' on the grounds upon which discrimination and barriers to access is unlawful. Outline what impact (or potential impact) the new policy/strategy/guidance will have on the following protected groups:
Age
Neutral
Disability
Information about the complaints policy is available in other languages and formats upon request. Interpreters, including BSL interpreters, will be provided as required for face-to-face meetings with complainants. Information is provided virtually and physically to ensure that staff and service users are aware of the facilities available for meeting a complainant or patient's communication requirements.
Gender reassignment (including transgender) and Gender Identity
Neutral
Marriage and civil partnership
Neutral
Pregnancy and maternity
Neutral

Race
Information about the complaints procedure is available in other languages and formats upon request. Interpreters, including BSL interpreters, will be provided as required for face-to-face meetings with complainants.
Religion or Belief
Neutral
Sex/Gender
Neutral
Sexual orientation
Neutral
Carers
Neutral
Other identified groups relating to Health Inequalities
Neutral

STEP 4: ENGAGEMENT AND INVOLVEMENT

Have you engaged stakeholders in testing the policy/guidance or process proposals including the impact on protected characteristics? **Guidance Notes** • List the stakeholders engaged • What was their feedback? • List changes/improvements made as a result of their feedback • List the mitigations provided following engagement for potential or actual impacts identified in the impact assessment.
Not applicable.
If no engagement has taken place, please state why:
Not applicable

STEP 5: METHODS OF COMMUNICATION

What methods of communication do you plan to use to inform service users/staff about the policy/strategy/guidance?
☐ Verbal – meetings ☐ Verbal - Telephone ☐ Written – Letter ☒ Written – Leaflets/guidance booklets ☐ Written - Email ☒ Internet/website ☐ Intranet page ☒ Other – Staff Briefing If other please state: In addition to sharing the changes to the policy via websites and information leaflets, other specific methods of communication will be considered case by case.

Step 6 – Accessible Information Standard Check

From 1st August 2016 onwards, all organisations that provide NHS care and / or publicly funded adult social care are legally required to follow the Accessible Information Standard. The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

https://www.england.nhs.uk/wp-content/uploads/2017/10/accessible-info-standard-overview-2017-18.pdf

Tick to confirm you have you considered an agreed process for:
☒ Asking people if they have any information or communication needs and find out how to meet their needs. ☒ Have processes in place that ensure people receive information which they can access and understand, and receive communication support they need it.
If any of the above have not been implemented, please state the reason: NA

STEP 7: POTENTIAL IMPACTS IDENTIFED; ACTION PLAN

Ref no.	Potential/actual Impact identified	Protected Group Impacted	Action(s) required	Expected Outcome	Action Owner	Timescale/ Completion date
1	Access to information in other formats, including access to interpreters	All	Complaints literature/web content is being reviewed/amended to ensure that staff and service users are aware of the facilities available for meeting a complainant or patient's communication requirements.	Information about the complaints procedure is available in other languages and formats upon request. Interpreters, including BSL interpreters, will be provided as required for face-to-face meetings with complainants.	Complaints Team	complete

GOVERNANCE, OWNERSHIP AND APPROVAL

Please state here who has approved the actions and outcomes of the screening		
Name	**Job title**	**Date**
Claire Riley	Director of Corporate Governance, Communications and Involvement	June 2022

Presented to (Appropriate Committee)	**Publication Date**
ICB Board	July 2022

Appendix 1

Duties and Responsibilities

ICB Board	The ICB Board is responsible for setting the strategic context in which organisational process documents are developed, and for establishing a scheme of delegation for the formal review and approval of such documents.
Chief executive	The chief executive has overall responsibility for the strategic direction and operational management, including ensuring that ICB process documents comply with all legal, statutory and good practice guidance requirements.
Quality and Safety Committee	In line with the Scheme of Reservation and Delegation and the Committee's Terms of Reference the Quality and Safety Committee will have responsibility for monitoring the themes of complaints.
CSU Complaints Team	The CSU complaints team is responsible for the day-to-day handling of complaints and will be readily available to receive complaints, support staff with the local resolution process and to give information and advice where required. Where appropriate, the CSU complaints team will also arrange a conciliation service to assist in the resolution of complaints. Information will also be relayed to the complainant regarding advocacy services that are available. The CSU complaints team will co-ordinate and collate all the information required in order to produce a draft response to the complainant. All actions arising as a result of a complaint investigation will be monitored by the CSU complaints team to ensure implementation, in conjunction with line managers and heads of service. The CSU complaints team is responsible for entering information onto the risk management database and producing appropriate reports as required, including the collection of data to enable the annual complaints return to the Department of Health. The CSU complaints team will keep up to date with current legislation and advise others as appropriate. In cases that involve the PHSO, the CSU complaints team will be the point of contact for the Ombudsman and will liaise with them in any investigation.

Investigating officer	The investigating officer is responsible for undertaking the detailed investigation of complaints, to provide information in order that the CSU complaints team can draft the written response for signature by the chief executive (or nominated deputy). The investigating officer will establish the underlying causes of complaints and ensure that these are properly understood, lessons are learned and where appropriate, improvements are implemented. The investigating officer is also responsible for ensuring that any actions arising from complaints are implemented and the outcome is fed back to the CSU complaints team.
Senior Management Team	The senior management team is responsible for ensuring that complaints are investigated in accordance with this policy; working with the CSU complaints team to ensure satisfactory resolution of complaints, including the implementation of any lessons learned.
CSU Staff	Whilst working on behalf of the ICB, CSU staff will be expected to comply with all policies, procedures and expected standards of behaviour within the ICB, however they will continue to be governed by all policies and procedures of their employing organisation.
All staff	All staff, including temporary and agency staff, are responsible for: • Compliance with relevant process documents. Failure to comply may result in disciplinary action being taken. • Co-operating with the development and implementation of policies and procedures and as part of their normal duties and responsibilities. • Identifying the need for a change in policy or procedure as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and advising their line manager accordingly. • Identifying training needs in respect of policies and procedures and bringing them to the attention of their line manager. • Attending training / awareness sessions when provided.

Appendix 2

Procedure for Handling Habitual and/or Persistent Complainants

1 Introduction

The organisation is committed to dealing effectively and empathetically with people who complain about NHS services and also to learning from the findings of complaints investigations. However, sometimes organisations need to deal with persistent complainants. Handling such complaints can place a strain on time and resources and cause undue stress for staff - some may need support in difficult situations. NHS staff are trained to respond with patience and sympathy to the needs of all complainants but there are times when there is nothing further that can reasonably be done to assist them or to rectify a real or perceived problem.

In determining arrangements for handling complainants there are two key considerations. The first is to ensure that the complaints procedure has been correctly implemented so far as possible and that no material element of a complaint is overlooked or inadequately addressed and to appreciate that habitual or persistent complaints may have issues which contain some genuine substance. The need to ensure an equitable approach is crucial. The second is to be able to identify the stage at which a complainant has become habitual or persistent. This appendix is the ICB's approved procedure and is an integral part of the overall Complaints Policy.

It is important to note that implementation this procedure would only occur in exceptional circumstances.

2 Purpose of the Procedure

Complaints are processed in accordance with NHS complaints procedures and the ICB's Complaints Policy . During this process staff inevitably may have contact with a small number of complainants who can absorb a disproportionate amount of NHS resources in dealing with their complaints. The aim of this procedure is to identify situations where the complainant might be considered habitual or persistent and to suggest ways of responding to these situations.

It is emphasised that this procedure should only be used as a last resort and after all reasonable measures have been taken to try to resolve complaints following the NHS complaints procedures, for example, through local resolution, conciliation, or involvement of the relevant independent complaints advocacy service as appropriate. Judgement and discretion must be used in applying the criteria to identify potential habitual or persistent complainants and in deciding action to be taken in specific cases.

The procedure should only be implemented following careful consideration by, and with authorisation of, the ICB chair and chief executive (or nominated deputy) of the organisation. Where deputies are used, the reason for the non-availability of the ICB chair or chief executive should be recorded on file.

3 Definition of a Habitual or Persistent Complaint

Complainants (and/or anyone acting on their behalf) may be deemed to be habitual or persistent complainants where previous or current contact with them shows that they meet **TWO OR MORE** of the following criteria:

Where complainants:

i Persist in pursuing a complaint where the NHS complaints procedure has been fully and properly implemented and exhausted (e.g., where investigation has been denied as "out of time", where the PHSO has declined a request for independent review or has already investigated the matter).

ii Change the substance of a complaint or continually raise new issues or seek to prolong contact by continually raising further concerns or questions upon receipt of a response whilst the complaint is being addressed. (Care must be taken not to discard any new issues, which are significantly different from the original complaint. These might need to be addressed as separate complaints).

iii Are unwilling to accept documented evidence of treatment given as being factual, e.g., drug records, manual or computer records, nursing records or deny receipt of an adequate response in spite of correspondence specifically answering their questions, or do not accept that facts can sometimes be difficult to verify when a long period of time has elapsed.

iv Do not clearly identify the precise issues which they wish to be investigated, despite reasonable efforts of NHS staff and, where appropriate, the independent complaints advisory service to help them specify their concerns, and/or where the concerns identified are not within the remit of the organisation to investigate.

v Focus on a trivial matter to an extent which is out of proportion to its significance and continue to focus on this point. (It is recognised that determining what a "trivial" matter is can be subjective and careful judgement must be used in applying the criteria).

Vi Have threatened or used actual physical violence towards staff or their families or associates at any time. This will in itself, cause personal contact with the complainant and/or their representatives to be discontinued and the complaint will, thereafter, only be pursued through written communication. (All such incidents should be reported via SIRMS).

Vii Have in the course of addressing a registered complaint, had an excessive number of contacts with the organisation placing unreasonable demands on staff. (A contact may be in person or by telephone, letter or email. Discretion must be used in determining the precise number of excessive contacts applicable under this section, using judgement based on the specific circumstances of each individual case).

Viii Have harassed or been personally abusive or verbally aggressive on more than one occasion towards staff dealing with their complaint or their families or associates. (Staff must recognise that complainants may sometimes act out of character at times of stress, anxiety, or distress and should make reasonable allowances for this. They should document all incidents of harassment and report via SIRMS).

ix Are known to have recorded meetings or face-to-face/telephone conversations without the prior knowledge and consent of other parties involved.

x Display unreasonable demands or patient/complainant expectations and fail to accept that these may be unreasonable (e.g., insist on response to complaints or enquiries being provided more urgently than is reasonable or normal recognised practice).

4 Options for Dealing with Habitual or Persistent Complaints

Where complainants have been identified as habitual or persistent in accordance with the above criteria, the chief executive and (or appropriate deputies in their absence) will determine what action to take. The chief executive (or nominated deputy) will implement such action and will notify complainants in writing of the reasons why they have been classified as habitual or persistent complainants and the action to be taken. A copy this procedure should be shared with the complainant, and they will be advised to consider its contents, particularly the criteria in paragraph 3, when they are communicating with the ICB/CSU/other NHS organisation . This notification may be copied for the information of others already involved in the complaint, e.g., practitioners, mediators, conciliators, ICA, MP. A record must be kept for future reference of the reasons why a complainant has been classified as habitual or persistent. It may also be appropriate to suggest that complainant seeks advice in processing their complaint, e.g., through the relevant independent advocacy service for their area.

The chief executive and chair (or deputy) may decide to deal with complainants in one or more of the following ways:

- Try to resolve matters, before invoking this procedure, by drawing up a signed “agreement” with the complainant (and if appropriate involving the relevant member of staff in a two-way agreement) which sets out a code of behaviour for the parties involved if the organisation is to continue processing the complaint. If these terms are contravened consideration would then be given to implementing other action as indicated in this section.
- Decline contact with the complainants either in person, by telephone, by letter/email or any combination of these, provided that one form of contact is maintained or alternatively restrict contact to liaison through a third party. (If staff are to withdraw from a telephone conversation with a complainant it may be helpful for them to have an agreed statement available to be used at such times).
- Notify the complainants in writing that the chief executive has responded fully to the points raised and has tried to resolve the complaint but there is nothing more to add and continuing contact on the matter will serve no useful purpose. The complainants should also be notified that the correspondence is at an end and that further letters received will be acknowledged but not answered.
- Temporarily suspend all contact with complainants or investigation of a complaint whilst seeking legal advice or guidance from relevant agencies.

5 Withdrawing 'Habitual or Persistent' Status

Once complainants have been determined as "habitual or persistent" there needs to be a mechanism for withdrawing this status at a later date if, for example, complainants subsequently demonstrate a more reasonable approach or if they submit a further complaint for which normal complaints procedures would appear appropriate. Staff should previously have used discretion in recommending "habitual or persistent" status at the outset and discretion should similarly be used in recommending that this status be withdrawn when appropriate. Where this appears to be the case, discussion will be held with the chief executive and chair (or their deputy). Subject to their approval, normal contact with the complainants and application of NHS complaints procedures will then be resumed.

6 Review of the Procedure

This procedure will be reviewed as appropriate and at any time there is a review of The Local Authority Social Services & NHS Complaints [England] Regulations 2009 or the ICB's Complaints Policy.

NHS
North East &
North Cumbria

Corporate	ICBP011 - Driving at Work Policy

Version Number	Date Issued	Review Date
V1	July 2022	July 2024

Prepared By:	Senior Governance Manager, CSU
Consultation Process:	Integrated Governance Workstream
Formally Approved:	July 2022
Approved By:	ICB Board

EQUALITY IMPACT ASSESSMENT

Date	Issues
March 2022	None

POLICY VALIDITY STATEMENT

Policy users should ensure that they are consulting the currently valid version of the documentation. The policy will remain valid, including during its period of review. However, the policy must be reviewed at least once in every 3-year period.

ACCESSIBLE INFORMATION STANDARDS

If you require this document in an alternative format, such as easy read, large text, braille or an alternative language please contact NECS.comms@nhs.net

Version Control

Version	Release Date	Author	Update comments
1	July 2022	Senior Governance Manager, NECS	First issue.

Approval

Role	Name	Date
Approver	ICB Board	July 2022

Contents

1. Introduction

NHS Integrated Care Board (the ICB) has a number of general specific duties to protect the health, safety and wellbeing of those in their employment and of those who are affected by the conduct of their business. Within the Health and Safety at Work Act 1974 the ICB must;

- Lay down a safe system of work;
- Provide safe premises and/or place of work; and
- Provide safe plant and equipment.

1.1 Status

This policy is a corporate policy.

1.2 Purpose and scope

HSE Guidelines, 'Driving at Work', state that "health and safety law applies to on-the-road work activities as to all work activities and the risks should be effectively managed within a health and safety system".

The ICB recognises that it employs large numbers of staff who are required as part of their employment to drive vehicles whilst at work. In this context driving at work means 'driving whilst paid and in connection with the drivers work activities'. In driving at work staff are exposed to significant risks and could place colleagues and members of the public at risk also.

Eligible drivers within the ICB can be those who lease or use their own car for business purposes (e.g., travelling between sites or to non-ICB offices for ICB business) which must be insured for business purposes.

The ICB recognises that failure in their duty of care towards employees who drive for business purposes could result in a breach of the Corporate Manslaughter and Homicide Act 2007. This affects all vehicles used for work - under Health and Safety Law employers must make sure that work equipment is suitable for its intended use and that it is properly maintained and used under the Provision and Use of Work Equipment Regulations1998. Within this policy the Management of Health and Safety at Work Regulations 1999 and Road Traffic legislation will be considered to ensure that both employees and vehicles (including private ones) are fit to be on the road. The additional occupational risks associated with driving for business purposes are related to a wide range of factors including:

- driver competence
- vehicle fitness for purpose
- total hours worked
- unaccompanied working
- journey planning
- the nature of any goods being transported

The aim of this policy is for the ICB to commit to developing, implementing and maintaining all reasonable measures to protect the health and safety of those driving for business purposes and will act in a proactive manner to anticipate, avoid and manage situations that may expose employees to any additional or increased occupational risk that may result from driving on business for work.

2. Definitions

- DVLA – Driver and Vehicle Licensing Agency

3. Safe Systems of Work

With respect to reducing occupational risks to employees who are required to drive for business purposes procedures will be put in place to ensure:

3.1 Fitness to drive

Employees should inform their manager about any health issue or personal circumstances that may affect their driving. Employees are legally required to inform the DVLA of any medical condition that may affect your ability to drive safely.

The 'At a Glance Guide to the Current Medical Standards of Fitness to Drive' outlines the conditions that must be reported can be found at the following link: http://www.dft.gov.uk/dvla/medical/ataglance.aspx

3.2 Safe Vehicle

- The organisation will ensure vehicles leased through NHS/ICB scheme through contract arrangements have competent personnel maintain all lease vehicles registered for business use to a sufficient standard.
- Employees using their own vehicles for work purposes should ensure that their vehicles are adequately maintained, road worthy and are serviced as recommended by the car manufacturer - see appendix 3.
- The organisation will ensure that drivers of lease vehicles have access to technical and personal support in the case of breakdown or accidents; this is provided through vehicles leased through NHS/ICB scheme
- Employees using their own vehicle for work purposes should ensure that adequate access to breakdown facilities is available.
- All employees must follow the accident, incident and breakdown guidance in the Safe Driving for Work Handbook.

3.2.1 Plug-in Electric Vehicles (PEV)

Should the ICB use PEVs as Pool Vehicles the organisation will:

- Ensure that the pool vehicle is insured for business purposes and is maintained by a competent person to the standard recommended by the manufacturer.
- Where required an MOT certificate is available for the vehicle.
- Ensure that all eligible drivers have sufficient information, instruction and training before using the pool vehicle.
- Have a responsible person(s) maintain a suitable and sufficient system for monitoring pool vehicle use with the signature of the person borrowing the vehicle recorded, the date and time, the purpose of its use, the time and signature on return and any problems identified with the vehicle noted. This is a minimum standard.
- Ensure that a responsible person(s) carries out a pre-use assessment check on the pool vehicle daily and logs this check in a suitable and sufficient recording system.
- Ensure that the re-charging plug-in lead is kept in the pool vehicle.
- Ensure that drivers of the pool vehicle have access to technical and personal support in the case of breakdown or accidents.
- Ensure that the pool vehicle is clean and valeted regularly.

When using the pool vehicle employees will:

- Ensure that they have had sufficient information, instruction and training on the use of the vehicle before driving it.
- Sign for the pool vehicle when taking and returning, ensuring that they report any problems identified, if any.
- Ensure the vehicle appears roadworthy before driving off.
- Ensure that they plan their journey in good time, ensuring that the full battery charge is adequate for an outward and inward journey, considering traffic flow, roadworks etc. Where provision is made for re-charging the vehicle at the venue visited, the vehicle should be re-charged, where permitted.
- Report all accidents/incidents associated with driving whilst on ICB business via the SIRMS incident reporting management system.
- Where an accident or incident occurs, follow the guidelines laid down in this policy.
- Ensure that only the organisation's technical and personal support is used in the case of breakdown or accidents.
- Ensure that they follow the same conditions as applied in this policy and drivers' handbook as expected when driving their own vehicle.

3.3 **Safe Journey**

- All journeys should be planned in advance to ensure there is sufficient time for employees to remain within the statutory speed limits. Long journeys should be avoided where alternative transport could be used.
- The organisation recognises the particular importance of guarding against fatigue and driving stress.
- The organisation will ensure that effective and robust policies and procedures are in place to manage the hours worked by those driving on work business.
- The organisation will take all reasonably practicable measures to develop and maintain a culture of risk awareness in all drivers
- No employee driving for business purposes will be encouraged to drive in a manner that may increase the risks to themselves or to other road users.
- The organisation recognises that those driving on work business may face additional occupational risks related to lone working and will take steps to ensure that they can remain in contact with co-workers and others in a manner that allows them to seek assistance when necessary.
- The ICB will take all reasonably practicable steps to protect employees from violence and/or harassment resulting from driving for work purposes.
- The organisation recognises that those driving on work business may face additional occupational risks related to lone working and will take steps to ensure that they can remain in contact with co-workers and others in a manner that allows them to seek assistance when necessary. However, employees who need to use their mobile phone must use hands free devices and avoid lengthy calls whilst driving as this can lead to distraction and divided attention whilst driving.

Further guidance on driving at work can be seen in the organisation's Safe Driving for Work Handbook.

3.4 **Organisational Driver Guidance**

The ICB will take all reasonably practicable measures to ensure that those who drive as part of their employment are eligible (as outlined in 1.2)and competent to do so. An organisational risk assessment (Appendix 2) has identified the risks associated with employees driving for business purposes. It is deemed low risk therefore further practical driver training is deemed as unnecessary by the ICB.

The ICB will also ensure that all drivers receive information on their duties under the road traffic legislation and the Highway Code. All staff will receive a copy of the organisation’s Safe Driving for Work Handbook which highlights safety of the driver, safety whilst driving and vehicle safety. All staff will be expected to familiarise themselves with this and the policy. The policy and the handbook will be placed onto the intranet site.

3.5 **Record Keeping**

To ensure that full compliance measures are demonstrated the ICB will keep the following records:

- The manager will retain records of detailed risk assessments – these should clearly indicate which staff and situation are covered by a risk assessment and they should detail the actions taken as a result of the assessment (Appendix 2)

- The manager will retain copies of driving licence for those driving for business purposes

- The manager will ensure accidents relating to driving at work are reported via the ICB incident reporting system

- The line manager (as part of pre-employment checks) will ensure that the the employee has completed form Appendix 4 and the following documents: the employee's driving licence; evidence of current car insurance (which includes cover for business purposes); MOT; and road tax (where applicable).

- Annually, it is the employee's responsibility to provide to their manager a completed form Appendix 4 and associated documents (as listed on Appendix 4). The manager will check Appendix 2 and associated documentation (actioning as necessary).

4. Implementation

4.1 This policy will be available to all Staff for use in relation to the specific function of the policy.

4.2 All directors and managers are responsible for ensuring that relevant staff within their own directorates and departments have read and understood this document and are competent to carry out their duties in accordance with the procedures described.

5. Training Implications

It has been determined that there are no specific training requirements associated with this policy/procedure.

6. Documentation

6.1 **Other related policy documents**

Driving at Work Handbook.

6.2 **Legislation and statutory requirements**

- Health and Safety at Work Act.
- Management of Health and Safety at Work Regulations.

6.3 **Best practice recommendations**

- **The Highway Code**
  http://www.direct.gov.uk/en/TravelandTransport/Highwaycode/index.htm

- **DVLA**
  www.dvla.gov.uk

7. Monitoring, Review and Archiving

7.1 Monitoring

The ICB Board will agree with the Executive Director a method for monitoring the dissemination and implementation of this policy. Monitoring information will be recorded in the policy database.

7.2 Review

7.2.1 The ICB Board will ensure that this policy document is reviewed in accordance with the timescale specified at the time of approval. **No policy or procedure will remain operational for a period exceeding three years without a review taking place.**

7.2.2 Staff who become aware of any change which may affect a policy should advise their line manager as soon as possible. The Executive Director (or nominated deputy) will then consider the need to review the policy or procedure outside of the agreed timescale for revision.

7.2.3 For ease of reference for reviewers or approval bodies, changes should be noted in the 'document history' table on the front page of this document.

NB: If the review consists of a change to an appendix or procedure document, approval may be given by the executive Director and a revised document may be issued. Review to the main body of the policy must always follow the original approval process.

7.3 Archiving

The ICB Board will ensure that archived copies of superseded policy documents are retained in accordance with the NHS Records Management Code of Practice 2021.

Schedule of Duties and Responsibilities

ICB Board	The ICB Board has responsibility for setting the strategic context in which organisational process documents are developed, and for establishing a scheme of governance for the formal review and approval of such documents.
Executive Committee	The Executive Committee has delegated responsibility from the ICB Board to review and approve policies on its behalf.
Chief Executive	The Chief Executive has overall responsibility for the strategic direction and operational management, including ensuring that CCG process documents comply with all legal, statutory and good practice guidance requirements.
Senior Governance Manager	The Senior Governance Manager will. • Advise and assist management in the interpretation and application of this policy and liaise with the Executive lead on any changes to the policy following updates on legislative/guidance information.
ICB Responsibility	To ensure safe systems of work for employees who are expected to drive for business purposes the organisation is responsible for: • Ensuring that an organisational risk assessment is carried out which identifies risks associated with driving on work business and remedial action is taken to reduce the risks to the lowest level possible (see Appendix 2). • Where necessary, individual risk assessments are carried out in exceptional circumstances e.g., bad weather reports, exceptionally long or unusual journey. • Ensuring as far as it reasonably practicable that all those driving on business are competent and fit to do so (see Appendix 3) • Provide employees with any additional information and guidelines on their duties under road traffic legislation and Highway Code. These can be found in the organisations Safe Driving at Work Handbook. • Ensuring the Health and Safety and Welfare of employees are considered including good journey planning. • Encouraging a sensible and mature attitude towards motor vehicles and driving for all employees. • Ensuring so far as is reasonably practicable that vehicles are suitable and fit for purpose.

All Managers	All managers must: • Use the organisational risk assessment to ensure that eligible drivers have the required information and instruction to reduce risks of driving to the lowest level possible. • Where necessary, individual risk assessments are carried out in exceptional circumstances e.g., bad weather reports, exceptionally long or unusual journey. • Must ensure employees are fit to drive (see Appendices 2 and 3) • **Check documents as submitted by the employee on an annual basis.** All employees driving licenses should be checked. For privately owned vehicles they should comply with DVLA Licensing requirements for: ▪ MOT Certificate (where applicable) ▪ Road Tax (where applicable) ▪ Current Certificate of Insurance, with business class use to undertake their role Lease vehicles will be regulated via the ICB leasing arrangements. • Ensure that work plans provide adequate time for safe driving. • Ensure that the vehicle is suitable for the task for which it is being used; (e.g., where equipment is being carried). • Ensure all eligible drivers have read this policy, the Safe Driving for Work Handbook and signed the declaration (Appendix 4), before driving on business purposes.

All ICB Staff	Employees who are required to drive for business purposes on public roads during their employment must: • Follow the risk assessments carried out by the organisation. • Where necessary, individual risk assessments are carried out in exceptional circumstances e.g., bad weather reports, exceptionally long or unusual journey. • Ensure that their vehicle is roadworthy, by carrying out inspections in accordance with Appendix 2 as a minimum standard. • Sign an annual declaration of their fitness to drive, current penalty points on their license and that they have read the policy and the Safe Driving for Work Handbook (Appendix 5). Submit to their line manager for inspection and retention copies of the relevant documents listed in Appendix 3 to be kept in personal file. • Observe national speed limits. • Inform their manager immediately when an accumulation of penalty points will mean disqualification of their license. • Report any health problems, which would affect their fitness to drive to their manager and the DVLA where appropriate. • Report all accidents/incidents associated with driving whilst on ICB business via the SIRMS incident reporting management system. • Observe the Highway Code at all times, being courteous to other road users and avoiding situation, which might result in road rage.
Commissioning Support Staff.	Whilst working on behalf of the ICB NECS staff will be expected to comply with all policies, procedures and expected standards of behaviour within the ICB, however they will continue to be governed by all policies and procedures of their employing organisation.

Appendix 1

Equality Impact Assessment

Initial Screening Assessment (STEP 1)

As a public body organisation we need to ensure that all our current and proposed strategies, policies, services and functions, have given proper consideration to equality, diversity and inclusion, do not aid barriers to access or generate discrimination against any protected groups under the Equality Act 2010 (Age, Disability, Gender Reassignment, Pregnancy and Maternity, Race, Religion/Belief, Sex, Sexual Orientation, Marriage and Civil Partnership).

This screening determines relevance for all new and revised strategies, policies, projects, service reviews and functions.

Completed at the earliest opportunity it will help to determine:

- The relevance of proposals and decisions to equality, diversity, cohesion and integration.
- Whether or not equality and diversity is being/has already been considered for due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED).
- Whether or not it is necessary to carry out a full Equality Impact Assessment.

Name(s) and role(s) of person completing this assessment:

Name: Lee Crowe
Job Title: Governance Manager, H&S/Fire/Security
Organisation: NHS North of England CSU

Title of the service/project or policy: Driving at Work

Is this a;
Strategy / Policy ☒ **Service Review** ☐ **Project** ☐
Other Click here to enter text.

What are the aim(s) and objectives of the service, project or policy:
The aim of the policy is to ensure ICB considers Health and Safety along with its other business objectives and to ensure that the ICB follows the details stipulated within H&S Regulations.

Who will the project/service /policy / decision impact?
(Consider the actual and potential impact)

- **Staff** ☒
- **Service User / Patients** ☐
- **Other Public Sector Organisations** ☐
- **Voluntary / Community groups / Trade Unions** ☐
- **Others, please specify** Click here to enter text.

Questions	Yes	No
Could there be an existing or potential negative impact on any of the protected characteristic groups?	☒	☐
Has there been or likely to be any staff/patient/public concerns?	☐	☐
Could this piece of work affect how our services, commissioning or procurement activities are organised, provided, located and by whom?	☐	☐
Could this piece of work affect the workforce or employment practices?	☐	☐
Does the piece of work involve or have a negative impact on: • Eliminating unlawful discrimination, victimisation and harassment • Advancing quality of opportunity • Fostering good relations between protected and non-protected groups in either the workforce or community	☐	☐

If you have answered no to the above and conclude that there will not be a detrimental impact on any equality group caused by the proposed policy/project/service change, please state how you have reached that conclusion below:

Click here to enter text.

If you have answered yes to any of the above, please now complete the 'STEP 2 Equality Impact Assessment' document

Accessible Information Standard	Yes	No
Please acknowledge you have considered the requirements of the Accessible Information Standard when communicating with staff and patients. https://www.england.nhs.uk/wp-content/uploads/2017/10/accessible-info-standard-overview-2017-18.pdf	☒	☐

Governance, ownership and approval

Please state here who has approved the actions and outcomes of the screening		
Name	**Job title**	**Date**
Claire Riley	Executive Director of Corporate Governance, Communications and Involvement	June 2022

Publishing

This screening document will act as evidence that due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED) has been given.

ICB	**Appendix 2**			**Driving at Work**				
	Organisational Risk Assessment							
	Completed by: Lee Crowe Senior Governance Manager			Date: to be added				
Description of the Hazard	Who might be harmed and how	Consequence (C)	Likelihood (L)	Risk rating (C X L)	Existing control measures *All existing control measures as follows are set out in detail in the Driving at Work Policy, the Travel and Expenses Policy, the Lone Worker Policy and the organisations Handbook, Safe Driving at Work*	Further remedial action	Risk rating following existing control measures and remedial action	Action by whom and when
Not medically fit to drive/have not declared medical conditions to DVLA	Employees who are eligible drivers as set out in the Driving at Work and Travel and Expenses Policy	3	2	6	All eligible drivers are personally responsible to declare that they are fit to drive and comply with road traffic legislation on an annual basis.	Review and Re-enforce policy and procedures and documented declaration and checks	4	
Do not hold the appropriate driving licence or not qualified to drive	Colleagues who are passengers in the car	3	2	6	All eligible drivers must produce their driving licence on an annual basis and sign a declaration stating the number of penalty points they have currently, if any. The line manager will review dependant on the number stated.	Review and Re-enforce policy and procedures and documented declaration and checks	4	
Do not hold appropriate insurance	Other road users or pedestrians	3	2	6	Those employees using their own vehicle for business purposes will produce an annual certificate of insurance with business class use for the work they undertake.	Review and Re-enforce policy and procedures and documented declaration and checks	4	

Description of the Hazard	Who might be harmed and how	Consequence (C)	Likelihood (L)	Risk rating (C X L)	Existing control measures *All existing control measures as follows are set out in detail in the Driving at Work Policy, the Travel and Expenses Policy, the Lone Worker Policy and the organisations Handbook, Safe Driving at Work*	Further remedial action	Risk rating following existing control measures and remedial action	Action by whom and when
Driving whilst under the influence of drugs/medication/alcohol	Prosecution of the organisation for duty of care failing	3	2	6	All eligible drivers have been made aware that they must inform their line manager if they are suffering from any medical condition/illness which may adversely affect their ability to drive safely and must sign a declaration annually stating that. All eligible drivers must not drive under the influence of alcohol, or other intoxicating chemicals, including illicit substances, prescribed or non-prescription medicines that may cause drowsiness or otherwise make you unsafe to drive.		4	
Lone Working whilst driving	Driver	3	2	6	All eligible drivers must follow lone worker and personal safety guidelines.	Review and Re-enforce policy and procedures and documented declaration and checks	4	
Accident or incident whilst employee driving at work	Loss of reputation of organisation to stakeholders	3	2	6	All eligible drivers are aware of policy and procedures to follow if accident or an incident occurs.	Review and Re-enforce policy and procedures and documented declaration and checks	4	

Description of the Hazard	Who might be harmed and how	Consequence (C)	Likelihood (L)	Risk rating (C X L)	Existing control measures *All existing control measures as follows are set out in detail in the Driving at Work Policy, the Travel and Expenses Policy, the Lone Worker Policy and the organisations Handbook, Safe Driving at Work*	Further remedial action	Risk rating following existing control measures and remedial action	Action by whom and when
Accident or incident occurs due to poor journey planning	Employees who are eligible drivers as set out in the Driving at Work and Travel and Expenses Policy	3	2	6	Journey must be considered essential.	Review and Re-enforce policy and procedures and documented declaration and checks	4	
Contravening road traffic act whilst driving	Colleagues who are passengers in the car	4	2	8	Eligible drivers are aware that journey planning must take into account factors such as allowing sufficient time to enable drivers to comply with speed limits, weather and road traffic conditions.	Review and Re-enforce policy and procedures and documented declaration and checks	4	
Complacency when driving poor driving standards	Other road users or pedestrians Prosecution of the organisation for duty of care failing Loss of reputation of organisation to stakeholders	4	2	6		Review and Re-enforce policy and procedures and documented declaration and checks	4	

Description of the Hazard	Who might be harmed and how	Consequence (C)	Likelihood (L)	Risk rating (C X L)	Existing control measures *All existing control measures as follows are set out in detail in the Driving at Work Policy, the Travel and Expenses Policy, the Lone Worker Policy and the organisations Handbook, Safe Driving at Work*	Further remedial action	Risk rating following existing control measures and remedial action	Action by whom and when
Eligible drivers spending excessive hours driving for business purpose	Prosecution of the organisation for duty of care failing	4	2	6	Eligible drivers are aware that they must plan their journey in advance, especially driving for long periods where alternative transport should be considered. Eligible drivers must adhere to driving legislation and safe driving guidance at all times. All eligible drivers are aware of the standards required to drive at work including tolerance and concentration whilst driving.	Review and Re-enforce policy and procedures and documented declaration and checks	4	
Accident or incident occurs due to poor car maintenance	Loss of reputation of organisation to stakeholders	4	2	6	All eligible drivers are aware of policy and procedures to follow if accident or an incident occurs.	Review and Re-enforce policy and procedures and documented declaration and checks	4	
No pre-journey checks carried out	Employees who are eligible drivers as set out in the Driving at Work and Travel and Expenses Policy	4	2	6	All eligible drivers are aware of the need for pre-journey preventative checks. Risk assessment carried out on time spent by eligible drivers driving for business purposes by directorate.	Review and Re-enforce policy and procedures and documented declaration and checks	4	
Car breakdown and driver alone with the car	Colleagues who are passengers in the car Other road users or pedestrians	4	2	6	All eligible drivers must follow lone worker and personal safety guidelines. Lease car holders have vehicle serviced annually through Lease Company. Eligible drivers are aware for the need of an annual service to manufacturer's specification. All lease car drivers have access to a breakdown service. All drivers using their own vehicle should ensure they have breakdown cover.	Review and Re-enforce policy and procedures and documented declaration and checks	4	

Appendix 3

FITNESS TO DRIVE

1. Pre-employment

A copy of the individual's driving licence must be obtained prior to appointment and a pre-employment health assessment is required for all individuals, whose work requires them to drive at work.

2. Review Health Assessments

Will be required in the event of:

- Accident associated with driving;
- Absences from work due to ill health of 4 weeks or longer;
- Any absence from work due to ill health, which raise management concerns with reference to continuing fitness to drive safely;
- Where management has any basis of concern with reference to fitness to drive.

A qualified Occupational Health Nurse or Occupational Physician, following formal written request with referral details from the Line Manager, will undertake all health assessments. A written report will be provided to the Line Manager providing specific advice with reference to fitness to drive.

3. Health Surveillance

All drivers are required to inform their line manager immediately if their health has any impact on their ability to drive. Line managers should refer employees to the Occupational Health department where they deem it necessary e.g., where the employees condition / illness affects their driving at work for more than 4 weeks or longer.

Management will be formally notified of continuing fitness or otherwise.

Appendix 4

Documentation and declaration form for eligible drivers

Whether employees lease a car through the NHS salary sacrifice or they use their own vehicle for business purposes they **must** provide the following documentation to their manager before using their car (lease or owned) for business use and before travel expenses can be claimed.

NOTE: Lease car users (as above) only have to provide a full valid driving licence

Documentation to be provided	Effective date and expiry date (where applicable)	Date verified by manager
DRIVING LICENCE All eligible drivers must provide full, valid driver's licence applicable to the vehicle driven		
CAR INSURANCE Business use including carriage of passengers and equipment		
CAR TAX Proof available from https://www.gov.uk/check-vehicle-tax by entering the vehicle registration number		
MOT A valid MOT certificate (where applicable)		

These checks must be carried annually as part of the policies and procedures of ICB. On completion the form shall be stored in the employee's personal file.

Employee declaration

- I confirm that I have read and will fully comply with the ICB Driving at Work Policy and Safe Driving for Work Handbook.
- **I understand that I have to provide my line manager with the above documents on an annual basis (on renewal and where applicable).**
- I will inform my line manager and the DVLA (where applicable) of any medical condition that may affect my ability to drive.
- I understand that I must inform my manager of any current road traffic offences following conviction and/or whether I currently have penalty points on my licence. In either case, I understand that my line manager may need to review my declaration on a more frequent basis (than annually).
- I will inform my line manager if I have been involved in a road accident or incident whilst driving for business purposes and complete the relevant forms.

Employee name: …… Department: ……..

Employee signature: …… Date: ……

Manager name: …… Directorate: ……

Manager signature: …… Date: ……

Appendix 5

Safe Driving for Work

A Handbook for ICB Employees

1. Introduction

Driving for many Integrated Care Board employees is an essential part of their working day. It can be enjoyable and pleasant, but it can also be stressful and dangerous.

In fact, driving is one of the most dangerous activities that we do. Every year in the UK, almost 3,000 people are killed in road crashes and over 25,000 are seriously injured. In total, there are around a quarter of a million road casualties annually.

Driving for work is riskier than driving for private reasons. At-work drivers have a higher accident rate than the general driving population, even after higher mileages are taken into account. This is not just due to driving skills and attitudes, but also to the nature of the driving that at-work drivers may do e.g., time pressures, meeting schedules.

By law, Integrated Care Board needs to know that employees are:

- Legally entitled to drive the vehicle they are using
- Insured fully to drive the vehicle
- Properly informed, instructed and trained, competent and fit to drive safely
- Using a vehicle that is safe and road legal
- Using the vehicle safely

Health and Safety Executive (HSE) Guidelines, **'Driving at Work'**, state that "*health and safety law applies to on-the-road work activities as to all work activities and the risks should be effectively managed within a health and safety system*".

The ICB therefore, has a legal duty to put in place suitable arrangements to manage road safety. This is a wide-ranging requirement. The organisation will follow the above HSE guidelines which adopts a common-sense and practical approach.

The importance of safe driving can be outlined using a few simple facts from the HSE:

- 95% of all road incidents involve some form of driver error
- In 76% of road incidents, the driver is solely to blame
- Most road incidents occur in built-up areas
- The most dangerous times on the road are weekdays during the rush hours between 7 and 9 a.m. and between 3 and 6 p.m.
- Traffic incidents account for the largest single cause of death and injury for young adults

This handbook will help employees to work with the ICB to avoid accidents and injuries to themselves, their passengers and other people. It should be used and read in conjunction with the ICB Driving at Work and Travel and Expenses

2. Driver Safety

Most road incidents can be prevented with care and simple common sense actions.

As a driver, you must play your part by ensuring that you are legally able to drive the vehicle for work, you are fit to drive, and you plan your journeys safely and comply with road traffic laws when driving. You also need to understand and follow the organisations driving for work policy and procedures.

2.1 Your legal duty

The ICB is committed to employing safe and courteous drivers. Whether you lease a car through the NHS salary sacrifice scheme or you use your own vehicle for driving at work you **must** provide the following documentation (appendix 4) to your manager before travel expenses can be claimed:

2.1.1 All Drivers

- A full, valid driver's licence applicable to the vehicle you drive
- **As well as the above,** IF YOU USE YOUR OWN VEHICLE for work purposes, which includes travelling between sites and to other premises to attend meetings.
- Car insurance, you must have business use cover including carriage of passengers and equipment and anything else expected for your role
- A valid MOT certificate (where appropriate)
- Proof of car road tax payment or that your vehicle does not require road tax.

After the initial check, licence checks on all drivers will be carried out annually along with insurance, MOT and road tax for staff that use their own vehicle for work purposes.

You will also have to inform your line manager of any current driving offenses following conviction and the current number of penalty points held on your licence. If you do have penalty points your manager may want to review your licence status more regularly than annually.

2.2 Fitness to drive

Your physical health, psychological and emotional state and your general attitude towards driving play a major part in your fitness to drive. You should inform your manager about any health issue or personal circumstances that may affect your driving. You are also legally required to inform the DVLA of any medical condition that may affect your ability to drive safely. The **'At a Glance Guide to the Current Medical Standards of Fitness to Drive'**, free from **http://www.dft.gov.uk/dvla/medical/ataglance.aspx**, outlines the conditions that must be reported.

2.3 Eyesight

You must be able to read a new-style / old-style number plate at the required distances, wearing glasses/contact lenses if required to do so. Have your eyesight checked regularly (as recommended by your optician).

2.4 Substance misuse

The consumption of alcohol or use of any substance whilst at work, that may impede your driving capability, is prohibited. This is dealt with in the Substance Misuse Policy.

2.5 Medicines

Check with your GP or pharmacist whether any over-the-counter or prescribed medicines you are taking are likely to affect your driving (for example, by causing drowsiness). If so, ask for an alternative that does not affect driving. If you need to avoid driving whist taking short term medication, discuss this with your line manager. Always check the label of medicines and the patient information leaflet for any warnings. If the label says that certain side-effects may occur, assume that they will do so.

2.6 Illness

Common conditions, such as colds, flu, migraine, stomach upsets, hay fever, etc. can affect your ability to drive safely. If severe enough any illness can impair your concentration, reactions and judgement. Discuss any issues with your line manager.

3. Personal safety

- A well-maintained and regularly-serviced vehicle is less likely to break down and leave you stranded.
- Join a reliable breakdown organisation (where applicable).
- Take a mobile phone with you for emergencies, but never use it while actually driving.
- Don’t pick up hitchhikers or offer lifts to people you do not know.
- Keep valuables and bags out of sight and out of reach.
- It is better not to keep the car doors locked while driving, except in slow moving or stationary traffic if you feel vulnerable. But always lock the door when you are away from the vehicle – even when paying for fuel.

3.1 Safe parking at other venues

The golden rule is to ensure that others can see you. Bear in mind the time you will be returning to your vehicle – a safe place during daylight may be quite different at night. Choose a car park that is close to your final destination. Many car parks have won safety awards having attendants, CCTV, and good lighting.

Note what time the car park closes. Lock your doors and close the windows as you enter the car park.

If possible, choose a location that is:

- Visible to other people
- In an open area, so that you have a good all-round view
- Well-lit
- Not close to bushes or dark corners

In multi-storey car parks choose a space that is:

- Near the manned kiosk if there is one
- Close to the exit level required
- Reverse into your chosen space if possible, so you can pull away more easily.

3.2 Leaving the vehicle

- Listen and look around before getting out.
- Put all valuable items out of sight, e.g., in the boot.
- Lock all doors, windows and the sunroof.
- Note the name of the street and/or car park and the level you parked on.

3.3 Returning to the vehicle

- If you are alone, try to follow a group.
- Approach the vehicle with your keys in your hand so you can get in quickly if necessary.
- Check the vehicle as you approach. If there are any signs of it having been tampered with, do not get in – call the police.
- If you have one, keep a personal attack alarm to hand – it's no good at the bottom of a bag or left in the car!

3.4 Parking at Integrated Care Board sites

- Use only allocated car park bays
- Do not park in disabled bays at any time unless you have a valid disabled pass
- Do not double park when spaces are available. In instances where this is necessary, please ensure that this is recorded with reception. When a parking bay becomes available you are expected to move your vehicle into this space. Use overflow parking where this is available and do not double park.
- You **MUST NOT** park on red/yellow lines or lined boxed areas at any time. They must be left clear for Emergency and delivery vehicles.

3.5 Road rage

- Avoid getting into conflict with another driver. There will be some bad drivers who are looking for a reaction or conflict. “Competing” with another driver could lead to the incident becoming serious. Keep your mind focused on your driving.
- Do not overreact to, or panic about, another driver’s error, bad driving or poor attitude. They may be unaware of their actions. Try to stay away from them and concentrate on your driving.
- Stay calm and think logically – when confronted by an irate driver don’t engage in gestures, headlight flashing or sounding the horn as this will serve no purpose and may exacerbate the situation. It will also distract you. Concentrate on driving responsibly.
- Refrain from eye contact with an angry or aggressive driver as this has the potential to make the situation worse.
- If you find you are being followed by an impatient driver (tailgated) – do not allow yourself to be “pushed” along, intimidated or made to increase your speed. Without actually pulling over or stopping – find a safe opportunity to allow that driver to pass. Circumnavigating a roundabout to enable a tailgater to get past you will add little time to your journey but can make a significant difference to stress levels.
- If you find that you are being persistently followed by an aggressive driver try to make your way to a public place, police station or busy street and if necessary call the police. Do not allow an aggressive driver to follow you home.
- Under no circumstances endanger yourself by getting out of the car to deal with an angry or aggressive driver. If confronted with a road rage situation remain in the car with the windows closed and door locked. If necessary, call for help on a mobile phone (not while driving).
- If you accidentally cause another driver to become angry – hold up your whole hand as a friendly acknowledgement of your mistake – this can diffuse the situation.
- If your mood is affected by an incident during your journey, once you have moved away from any danger, find an opportunity to stop and take time out.

4. After your journey

If you are able to recognise when you’re becoming stressed, angry or impatient while driving, you will be better-equipped to deal with these emotions. Try to find time occasionally to reflect on your driving and how mood or stress has affected your actions.

5. Accidents and incidents

If you are driving on business and are involved in a road traffic accident or incident which results in damage to vehicles, loss or damage to property or persons you must complete the necessary forms for insurance purposes and an organisation accident/incident form at the first opportunity and inform your line manager after the event. Forms should be completed for accidents in a leased vehicle as well as in an individual's private vehicle. An accident/incident pack can be found in appendix 5 which should be kept in your vehicle at all times and followed in the event of an emergency.

A summary of the main points to remember is below, but always follow the procedures set down by the ICB:

- Stop in the event of an accident. It is an offence not to stop, if your vehicle is involved and damage is caused to property, or someone is injured
- Use hazard warning lights and switch off your engine
- Do not move injured passengers unless they are in immediate danger of further injury from other vehicles or from fire or explosion
- Call the emergency services immediately; provide them with information about the situation, any special circumstances (for example, if carrying oxygen bottles) and if any passengers have special needs
- Give first aid if required and if you are competent to do so
- If the emergency services are called, stay at the scene until they allow you to leave
- Obtain the names and addresses of all independent witnesses (if possible)
- Complete an accident/incident form, contact your insurance company and inform your line manager as soon after the incident as possible

6. Safe Journey

6.1 Safe journey planning

Thousands of crashes are caused by tired drivers. They are usually severe because a sleeping driver cannot brake or swerve and so the impacts occur at high speed.

You are most likely to feel sleepy when driving:

- On long journeys on monotonous roads
- Between 2am and 6am
- Between 2pm and 4pm
- After having less sleep than normal
- After drinking alcohol
- After taking medicines which cause drowsiness

Most, if not all, of the risk could be avoided by a little forethought and planning.

6.2 Reduce road journeys

Where possible, avoid the drive by using the phone, email or video-conferencing, or the train or plane. Maximise car-sharing to reduce the number of journeys.

6.3 Avoid the most dangerous times

Avoid driving at night, especially after a long shift. Do not drive after drinking alcohol or taking medicine that makes you drowsy. Check weather forecasts and traffic reports before you set off and try to avoid driving in poor conditions.

6.4 Reduce your driving time

On long journeys plan where you can take a break after every two hours of driving and build in enough time to do so. Take rest breaks as planned – resist the temptation to carry on. If possible, share the driving with a colleague. If necessary, plan an overnight stop.

7. Make sure you are well rested

Avoid driving when you would normally be asleep, and make sure you get plenty of sleep before a long drive. Keep meals light during or immediately before you drive. Heavy meals can make you drowsy.

7.1 Stop if you feel tired

If you start to feel tired, find somewhere safe to stop (not the hard shoulder).

7.2 Discuss concerns with your line manager

If you are concerned about your driving hours, journeys or schedules or if you find yourself driving when too tired, discuss this with your line manager.

7.3 Before you get in the vehicle

The Road Traffic Act states that the driver is responsible for the roadworthiness of any vehicle, the load being carried and the wearing of seat belts by passengers, whilst travelling on the public highway.

8. Good driving

Almost all road crashes involve human error, ranging from simple, ‘honest’ mistakes to deliberate dangerous and illegal behaviour.

Every year:

- Over 400 people are killed in crashes in which someone was ‘careless, reckless or in a hurry’
- A third of crashes involve someone who ‘failed to look properly’
- Around 700 people die in crashes in which someone was speeding
- Around 500 people are killed in crashes involving alcohol
- One third of fatal crashes occurs due to ‘loss of control’
- About 20% of crashes involve someone ‘failing to judge other person’s path/speed’

Driving is a very personal thing; we all have our own views, attitudes and habits. Our attitude as drivers, how we deal with our own mistakes and our reaction to those made by other people, will influence our own safety and wellbeing and that of other road users.

Aggressive, selfish or impatient attitudes when we drive can develop into a tendency to take irresponsible risks, such as tailgating, exceeding speed limits, undertaking, or jumping red lights.

Our emotional mood also influences our behaviour; drivers commonly express how they feel in the way they drive. Traffic delays and congestion can also influence our frame of mind. Life stresses, such as relationship anxieties, financial or employment problems, domestic or workplace arguments, influence our mood and can affect our driving.

Be tolerant towards others – shouting at another driver after their mistake or poor driving will not change anything, but anger will affect your judgement for some time after. Accept that drivers (including you!) make honest mistakes and have lapses in concentration. Be courteous and thank others for their courtesy.

Smile – it does work!

8.1 Seat belts

Make sure that everyone, including rear seat passengers, wears a seat belt on every journey, no matter how short the journey. This applies in vans, as well as cars, and in larger vehicles if they have seat belts fitted.

In a crash at just 30 mph, an unrestrained person is thrown forward with a force 30 to 60 times their body weight. They are thrown about inside the vehicle, injuring themselves and quite possibly seriously injuring (or killing) other occupants. They could also be ejected from the car through one of the windows.

Seat belts save thousands of lives every year. They could save 400 more lives a year if everyone always wore their seat belt.

9. In the vehicle

9.1 Distractions

Driving requires your full concentration all of the time. Trying to do something else while driving will distract you, slow your reactions and make a crash more likely.

9.2 Mobile phones

Using a hand-held or hands-free mobile phone while driving is a significant distraction, and substantially increases the risk of crashing.

It is illegal to use a hand-held mobile phone while driving (this includes any activity that involves holding the phone such as dialling a number or writing a text). It can also be illegal to use a hands-free phone while driving. Depending upon the circumstances, drivers could be charged with ‘failing to have proper control of their vehicle’, or careless or dangerous driving if they are distracted because they are using a hands- free phone.

Using a hands-free phone while driving does not significantly reduce the risks because the problems are caused mainly by the mental distraction and divided attention of taking part in a phone conversation at the same time as driving.

9.3 Other equipment

An increasing number of vehicles are being fitted with various devices designed to help the driver, with satellite navigation being the most common. While these devices can make driving safer and easier if used when set before the journey starts, risk remains (e.g., by distracting you) if used improperly. If it is necessary to make adjustments or to input new information, do so when the vehicle is stationary

9.4 Eating, drinking, smoking, choosing music

Many other things that might seem simple and innocent can be distracting when driving. Fatal crashes can and do occur because a driver chose to unwrap a sweet, take a drink or light a cigarette whilst driving. Again, you can be charged with related road traffic offences.

Safe driving needs concentration; avoid unnecessary distractions.

10. Motorway driving

Motorways are the safest type of road, but also the least forgiving. High speed driving means that dangerous situations develop quickly; vehicles travel much further before drivers even start to react. If you drive too close to the vehicle in front, or forget to use your mirrors before moving out, it could be disastrous.

10.1 Motorway breakdowns

Stand as far away from the running motorway lane as possible – over the crash barrier and on the embankment is best.

Call for help on the emergency telephones rather than on your mobile. The emergency telephones are at approximately one mile intervals along the back of the hard shoulder. Walk to the nearest telephone keeping to the inside of the hard shoulder (arrows on the marker posts at the back of the hard shoulder point to the nearest emergency telephone).

Tell the operator the number shown on the telephone box (this will enable them to pinpoint your exact location so that help can be provided quickly) and the details of your emergency. If you are a woman on your own, make this clear.

Return to the vicinity of your vehicle so that you can see help arrive. Wait on the embankment if possible. There is far greater risk of an accident on the hard shoulder than of being attacked. If you feel threatened return to your car and lock all doors until any perceived danger has passed.

- ONLY use the hard shoulder in an emergency.
- Switch on your hazard lights.
- You and any passengers should leave the vehicle by the nearside doors.
- DO NOT attempt repairs, even changing a wheel, on the offside of your vehicle. Seek assistance.
- DO NOT cross the carriageway in ANY circumstances

11. Weather Conditions

- Heavy rain, floods, snow and ice, fog and low sunshine in the winter and spring can reduce visibility. Only travel at a speed at which you can stop within the distance you can see to be clear. Always adjust your driving accordingly.
- Think about taking warm clothes, boots, a shovel, a blanket and a torch placed in the car boot and a couple of energy bars in the glove box in the winter
- Listen to local/national weather broadcasts and travel bulletins
- Remember that you will need about TWICE your normal braking distance in poor weather conditions

- **Remember** to test your brakes when you have gone through a flooded road (where safe to do so).

If conditions are very bad, avoid making your journey unless it is absolutely necessary. If you decide to travel, let someone know where you are going and what time you hope to arrive, so that they can raise the alarm if you are uncontactable. Ensure that you carry a fully charged mobile phone for emergencies but do not use whilst driving.

12. Speed

Many car drivers unintentionally exceed the speed limit, often without realising it. Modern cars are so powerful and comfortable they give drivers little sensation of their speed. It is too easy to creep above the limit, and in particular, many drivers believe it is difficult to drive a modern car at no more than 30mph on a road with a 30mph limit.

You are responsible for the speeds at which you choose to drive, but there are some simple and practical things drivers who find it difficult to stay within speed limits can do to help themselves:

- Check your speedometer regularly, especially when leaving high speed roads
- Know the limits – look for signs, especially at junctions
- Assume lamp posts mean 30mph, until signs say otherwise, but remember it could be 20mph
- 20's plenty when kids are about – and may even be too fast
- Try no higher than 3rd gear in a 30mph limit
- Recognise what makes you speed – keeping up with traffic, overtaking or being tailgated
- Concentrate – distracted drivers speed
- Slow down when entering villages
- Give yourself time – there's no need to speed and you won't get there quicker
- Even a small amount above the speed limit makes a big difference

Remember, speed limits are a maximum, not a target

13. Vehicle Safety

13.1 Pre-use checks

If you are intending to drive any vehicle on business you should undertake appropriate checks prior to using the vehicle, for example:

- Tyre tread
- Foot and hand brake operation
- Lights, indicators and hazard warning lights operate
- Horn operates
- Screenwash and wipers operate

- Seat belts fitted and functioning
- Mirrors adjusted/adjustable
- Any loads are securely restrained
- Fluid levels (oil, coolant)
- Tyre pressures are correct and undamaged
- Locks and security functional
- Fuel level

These are tasks which do not require any technical expertise and are the basic checks included in the current UK driving standards examination.
It is not intended that checklists are provided or that records of pre-use checks are kept, as it remains your responsibility to ensure that a vehicle is roadworthy. Ensure that your vehicle is serviced as recommended by the manufacturer.

13.2 Annual Service

Every eligible driver should ensure that their vehicle has a service to manufacturers specification usually annually or as recommended by the manufacturer

Remember – the most common cause of vehicle breakdown is simple neglect. Preventative checks are simple and less time-consuming than the breakdown that may follow if you don’t do them.

Appendix 1

Documentation and declaration form

Whether employees lease a car through the NHS salary sacrifice scheme, or they use their own vehicle for business purposes they **must** provide the following documentation to their manager before travel expenses can be claimed.

NOTE: Lease car users (as above) only have to provide a full valid driving licence

Documentation to be provided	Effective date and expiry date (where applicable)	Date verified by manager
DRIVING LICENCE All eligible drivers must provide full, valid driver's licence applicable to the vehicle driven		
CAR INSURANCE Business use including carriage of passengers and equipment		
CAR TAX Proof of payment or proof that it is not required for class of vehicle		
MOT A valid MOT certificate (where applicable)		

These checks **must** be carried annually as part of the policies and procedures of the ICB. On completion the form shall be stored in the employee's personal file.

Employee declaration

- I confirm that I have read and will fully comply with the ICB's Driving at Work Policy and Safe Driving for Work Handbook.
- I understand that I have to provide my line manager with the above documents on an annual basis (on renewal and where applicable).
- I will inform my line manager and the DVLA (where applicable) of any medical condition that may affect my ability to drive.
- I understand that I must inform my manager of any current road traffic offenses following conviction. I currently have..... penalty points on my licence and understand that my line manager may need to review this on a more regular basis than annually.
- I will inform my line manager if I have been involved in a road accident or incident whilst driving for business purposes and complete the relevant forms.

Employee name: …… Department: ……..

Employee signature: …… Date: ……..

Manager name: …… Directorate: ……

Manager signature: …… Date: …….

Appendix 2

Incident Recording Form

If you have an incident:

1. **Stop.**

2. Remain calm.

3. Call the emergency services if anyone is injured or if vehicles or property are seriously damaged.

   If the police attend the scene, note the reporting officer's name, identity number and station.

4. Use this incident form to record information about the accident, to exchange details with third parties and to take the names and addresses of witnesses and police officers.

5. Third parties are obliged to give you their name, the vehicle registration number and insurance details under **section 170 of the Road Traffic Act 1988**.

6. If you have a camera facility on your phone photograph the scene from different angles. Take pictures of the vehicles involved and of the damage to your own and third party vehicles/property, any skid marks on the road, road markings, signs or hazards.

7. Contact your line manager and your insurance company (Fleet Solutions if a lease car) as soon as it is practicable to do so after the incident.

Please complete the following forms at the scene of the incident.

Please note that it is essential this incident is reported via SIRMS (Incident Reporting system for the ICB).

To be retained by ICB employee

Incident Details

Your Name:_____

Date:_____Time: _____

Location: _____

_____

Road speed limit: _____

Road conditions: _____

Police Details

Police attended: Y/ N Time: _____

Officer's name and Number: _____

Contact phone number:_____Station: _____

Your Vehicle/Property Damage

Vehicle type: _____

Make/model: _____

Registration number: _____

Insurance Company:_____

Damage to vehicle/property:_____

_____

_____

_____

_____

Write a brief description of what happened:_____

_____

_____

_____

_____

_____

_____

_____

Exchange the above details with the third party verbally. Please retain this document and any photographs you have taken.

Third party details

Third party name:_____

Date:_____ Time_____

Address:_____

Telephone number:_____

Insurance Company:_____

Policy Number (if known)_____

Vehicle type:_____

Make/Model:_____

Registration number:_____

Damage to third party vehicle/property:_____
_____
_____
_____
_____
_____

Witness Details

Witness 1
Name:_____

Address:_____

Telephone number:_____

Witness 2

Name:_____

Address:_____

Telephone number:_____

Incident sketch

Make a sketch of the incident scene below. Show the direction of the vehicles involved and note their approximate speeds. Indicate road markings, skid marks, hazards and the witness locations.

NHS
North East &
North Cumbria

Corporate	ICBP017 - Fire Safety Policy

Version Number	Date Issued	Review Date
V1 draft 2	July 2022	July 2024

Prepared By:	Senior Governance Manager, North of England Commissioning Support Unit.
Consultation Process:	ICS Integrated Governance Workstream
Formally Approved:	July 2022
Approved By:	ICB Board

EQUALITY IMPACT ASSESSMENT

Date	Issues
March 2022	None identified.

POLICY VALIDITY STATEMENT

Policy users should ensure that they are consulting the currently valid version of the documentation. The policy will remain valid, including during its period of review. However, the policy must be reviewed at least once in every 3-year period.

ACCESSIBLE INFORMATION STANDARDS

If you require this document in an alternative format, such as easy read, large text, braille or an alternative language please contact NECSU.comms@nhs.net

Version Control

Version	Release Date	Author	Update comments
1.0	July 2022	Senior Governance Manager, NECS	First Issue

Approval

Role	Name	Date
Approver	ICB Board	July 2022

Contents

1. Introduction

1.1 For the purposes of this policy the NHS Integrated Care Board will be referred to as “the ICB”.

1.2 The ICB recognises it has a statutory duty towards the safety of its employees and others working in or visiting its premises, including contractors and visitors who might be subject to fire risk.

1.3 The main statutory requirements are found in the Regulatory Reform (Fire Safety) Order 2005, Health and Safety at Work Act 1974, Management of Health and Safety Regulations 1992. The ICB will also comply with current Department of Health Policy on fire precautions as set out in the ‘Firecode’.

1.4 This document sets out the ICB’s approach to minimising the incidence of fire within its premises and the impact of fire on life safety, delivery of service, the environment and property. It applies to all ICB staff, functions, actions and services.

1.5 The purpose of the policy is to ensure that on all sites:

- The risk of fire will be reduced through good housekeeping measures being implemented throughout the ICB, raising staff fire safety awareness, fire training, appointing fire wardens and carrying out fire risk assessments.

- Trained personnel will respond to fire alarm calls. They will take initial control of fire procedures with regard to the safety of visitors, staff and premises.

- The ICB has in place appropriate fire response and control measures, and fire alarm incidents are recorded, monitored and managed in order to minimise the number of incidents over time.

2. Definitions

1.1 Nominated Officer of Fire is the most senior person on site who will take charge in the event of an emergency.

1.2 Fire Warden is the appointed person who will assist with the safe evacuation of premises and who may also be asked to undertake other specific site-related fire duties.

3. Policy for Fire Safety

The Secretary of State for Health has mandated that all NHS organisations:

- have a clearly defined Fire Safety Policy covering all buildings they occupy.
- comply with legislation.
- nominate a board level executive accountable to the accountable officer for fire safety.
- nominate a Fire Safety Manager to take the lead on all fire safety activities.
- implement fire safety precautions through a risk management approach.
- comply with monitoring and reporting mechanisms appropriate to the management of fire safety.
- develop partnerships initiatives with other agencies and bodies in the provision of fire safety.

3.1 Fire Risk Assessments

3.1.1 In order to comply with statutory requirements Fire Risk Assessments will be carried out for all ICB premises. To achieve this outcome a 'Fire Risk Assessment' form must be completed to identify all fire risks and where a risk cannot be removed, to indicate what control measures have been implemented to reduce the risk to an acceptable level.

3.1.2 Where an individual risk cannot be reduced to an acceptable level, the risk should be added to the risk register.

3.1.3 The Fire Risk Assessment form and other supporting documentation must be kept in the relevant premises and be available for inspection by external auditors and the Fire and Rescue Service. A copy will be kept by the CSU for review purposes.

3.2 Fire Training

3.2.1 Suitable and relevant training will be provided for all staff. This will be achieved by induction training for all new staff and also regular specific fire training as set out in the Statutory and Mandatory Training requirements. Fire warden training will also be provided where appropriate.

3.2.2 Managers must ensure that practice fire drills intended to test communications, staff reaction and the effectiveness of training will be carried out at regular intervals in all ICB premises (at least once annually). The ICB will be provided with a copy of drill details and actions for record purposes.

3.3 Arson Prevention and Control

3.3.1 The ICB will comply with the Fire Practice Note 6 “Arson Prevention and Control in NHS Health Care premises” issued under Firecode but will consider other related guidance that may be published over time.

3.4 Fire Precaution Schemes

3.4.1 The Governance Manager Health and Safety from the CSU in consultation with NHS Property Services, Landlords and the ICB will identify on-going measures needed to improve standards in fire precautions. This will be added to on-going programmes of work.

3.5 Unwanted Fire Signals (False Alarms)

3.5.1 The NHS has imposed a duty on NHS organisations to reduce the number of false alarm calls to the Fire & Rescue Service. In order to achieve this requirement a fire alarm activation will be investigated to determine if the alarm is an actual fire or a false alarm. If it is discovered to be a false alarm the Fire and Rescue Service would be informed of this.

3.5.2 Given the disruption of any false alarm, whether the Fire and Rescue Services has been called or not, it is incumbent on all staff to ensure that the principles of good fire safety housekeeping are followed and that it is reported as an Incident on the relevant reporting system.

3.6 Fire Risk Assessment for Furniture, Furnishings and Apparel

3.6.1 The ICB must comply with Firecode HTM05-03 regarding furniture, furnishings and apparel.

4. Implementation

4.1 This policy will be available to all staff for use.

4.2 All managers are responsible for ensuring that relevant staff within the ICB have read and understood this document and are competent to carry out their duties in accordance with the procedures described.

4.3 On the first day of employment to either the organisation or the department, each new member of staff will receive a local induction from their line manager which will include a walk-through of the following fire safety points:

- Actions to be taken on discovering a fire.
- Actions to be taken on hearing the fire alarm.
- The location of the nearest fire alarm break glass call points.
- The location of the nearest fire exit.
- The location and type of the nearest fire extinguisher.

- The location of assembly points.

5. Training Implications

5.1 The sponsoring Executive will ensure that the necessary training or education needs, and methods required to implement the policy or procedure(s) are identified and resourced or built into the delivery planning process. This may include identification of external training providers or development of an internal training process.

5.2 It is mandatory for all ICB employees to undertake fire safety training sessions as per mandatory training requirements.

5.3 All Fire Wardens are required to attend a Fire Warden training session and any refresher training deemed necessary.

6. Related Documents

6.1 Other related policy documents

- Health and Safety Policy
- Incident Reporting and Management Policy
- Health, Safety Strategy.

6.2 Legislation and statutory requirements

- Cabinet Office (1974) *Health and Safety at Work Act 1974*. London. HMSO.
  General duties of employers and employees.

- Cabinet Office (1998) *Human Rights Act 1998.* London. HMSO
  Rights and freedoms protected under the European Convention on Human Rights.

- Cabinet Office (2000) *Freedom of Information Act 2000.* London. HMSO
  ICB policies and procedures are subject to disclosure under the Freedom of Information Act 2000 (FOI). From January 2005 the Act allows anyone, anywhere to ask for information held by organisations, although some information, such as patient identifiable information, is exempt.

- Cabinet Office (2006) *Equality Act 2006.* London. HMSO
  Provisions relating to Human Rights and discrimination on grounds of race, religion or belief sexual orientation; sex; amends the Disability Discrimination Act 1995.

- Cabinet Office (2007) *Corporate Manslaughter and Corporate Homicide Act 2007.* London. HMSO
  Enables the prosecution of companies and other organisations where there has been a gross failing throughout the organisation in the management of health and safety with fatal consequences.

- Cabinet Office (2008) *Health & Safety Offences Act 2008.* London. HMSO
  Amends Section 33 (Prosecutions for criminal offences) of the Health and Safety at Work Act 1974.

- Management of Health & Safety at Work Regulations 1999
  Generally, make more explicit what employers are required to do to manage health and safety under the Health and Safety at Work Act. Requires employers to carry out risk assessments, make arrangements to implement necessary measures, appoint competent people and arrange for appropriate information and training.

- Regulatory Reform (Fire Safety) Order 2005
  Requires a fire safety risk assessment to be carried out and that reasonable steps be taken to reduce the risk from fire and ensure occupants can safely escape if a fire does occur.

6.3 Best practice recommendations

- Department of Health "Records Management: NHS Code of Practice" 2006.

- NHS Litigation Authority "Standard for Primary Care Trusts": guidance on minimum policy and procedure requirements.

- Firecode – Department of Health (NHS Estates) Management of Fire Safety in Healthcare (Firecode consists of a number of Health Technical Memoranda (HTM) which consider policy, technical guidance and specialist aspects of fire precautions)

7. Monitoring, Review and Archiving

7.1 Monitoring

The ICB Board will agree a method for monitoring the dissemination and implementation of this policy. Monitoring information will be recorded in the policy database.

7.2 Review

7.2.1 The ICB Board will ensure that this policy document is reviewed in accordance with the timescale specified at the time of approval. No policy or procedure will remain operational for a period exceeding three years without a review taking place.

7.2.2 Staff who become aware of any change including legislative change, which may affect a policy should advise their line manager as soon as possible. The Executive Director or nominated deputy will then consider the need to review the policy or procedure outside of the agreed timescale for revision.

7.2.3 For ease of reference for reviewers or approval bodies, changes should be noted in the ‘version control’ table on the second page of this document.

NB: If the review consists of a change to an appendix or procedure document, approval may be given by the Executive Director of nominated deputy and a revised document may be issued. Review to the main body of the policy must always follow the original approval process.

7.3 Archiving

The ICB Board will ensure that archived copies of superseded policy documents are retained in accordance with Records Management: NHS Code of Practice 2021.

8. Equality Impact Assessment

Initial Screening Assessment (STEP 1)

As a public body organisation we need to ensure that all our current and proposed strategies, policies, services and functions, have given proper consideration to equality, diversity and inclusion, do not aid barriers to access or generate discrimination against any protected groups under the Equality Act 2010 (Age, Disability, Gender Reassignment, Pregnancy and Maternity, Race, Religion/Belief, Sex, Sexual Orientation, Marriage and Civil Partnership).

This screening determines relevance for all new and revised strategies, policies, projects, service reviews and functions.

Completed at the earliest opportunity it will help to determine:

- The relevance of proposals and decisions to equality, diversity, cohesion and integration.
- Whether or not equality and diversity is being/has already been considered for due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED).
- Whether or not it is necessary to carry out a full Equality Impact Assessment.

Name(s) and role(s) of person completing this assessment:

Name: Lee Crowe
Job Title: Governance Manager, H&S, Fire, Security
Organisation: NECS

Title of the service/project or policy: Fire Safety policy

Is this a;

Strategy / Policy ☒Service Review ☐ Project ☐
Other Click here to enter text.

What are the aim(s) and objectives of the service, project or policy:
The aim of the policy is to ensure the ICB considers Fire Safety along with its other business objectives and to ensure that the ICB follows the details stipulated within the Regulatory Reform Order (Fire Safety) 2005.

Who will the project/service /policy / decision impact?
(Consider the actual and potential impact)

- **Staff ☒**
- **Service User / Patients ☐**
- **Other Public Sector Organisations☐**
- **Voluntary / Community groups / Trade Unions ☐**
- **Others, please specify** Click here to enter text.

Questions	Yes	No
Could there be an existing or potential negative impact on any of the protected characteristic groups?	☐	☒
Has there been or likely to be any staff/patient/public concerns?	☐	☒
Could this piece of work affect how our services, commissioning or procurement activities are organised, provided, located and by whom?	☐	☒
Could this piece of work affect the workforce or employment practices?	☐	☒
Does the piece of work involve or have a negative impact on: • Eliminating unlawful discrimination, victimisation and harassment • Advancing quality of opportunity • Fostering good relations between protected and non-protected groups in either the workforce or community	☐	☒

If you have answered no to the above and conclude that there will not be a detrimental impact on any equality group caused by the proposed policy/project/service change, please state how you have reached that conclusion below:

The policy is a review of an existing policy and has received only minor updates. There is no fundamental change to the content therefore the previous EIA which concluded 'no impact' remains appropriate.

If you have answered yes to any of the above, please now complete the 'STEP 2 Equality Impact Assessment' document

Accessible Information Standard	Yes	No
Please acknowledge you have considered the requirements of the Accessible Information Standard when communicating with staff and patients. https://www.england.nhs.uk/wp-content/uploads/2017/10/accessible-info-standard-overview-2017-18.pdf	☒	☐

Governance, ownership and approval

Please state here who has approved the actions and outcomes of the screening		
Name	**Job title**	**Date**
Claire Riley	Executive Director of Corporate Governance, Communications and Involvement	June 2022

Publishing

This screening document will act as evidence that due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED) has been given.

Schedule of Duties and Responsibilities

ICB Board	The ICB Board has responsibility for setting the strategic context in which organisational process documents are developed, and for establishing a scheme of governance for the formal review and approval of such documents.
Executive Committee	The Executive Committee has delegated responsibility from the ICB Board to review and approve policies on its behalf.
Chief Executive	The Chief Executive has overall responsibility for the strategic direction and operational management, including ensuring that CCG process documents comply with all legal, statutory and good practice guidance requirements. In addition, they are required to have appropriate fire safety policies and programmes of work in place in order to improve and maintain fire policies within the organisation's premises.
Nominated Executive for Health and Safety.	The responsibilities for Fire Safety are discharged through the Nominated Executive for Health and Safety. They will ensure that: • the ICB complies with all statutory obligations in relation to health and safety. • mechanisms are in place to effectively monitor performance on behalf of the Board and that they are fully implemented. • the Board and appropriate committees are informed and advised regarding action needed on any significant Fire Safety event and actual or potential risk. • the establishment and maintenance of an effective health and safety advisory service to the ICB through the appointment and/or training of adequate numbers of Competent Persons. • the availability of adequate Fire Safety training programmes for all levels of staff. • adequate resources are made available to ensure compliance with statutory Fire Safety obligations. • update and review with the Health and Safety team the Fire Safety Policy in accordance with the Regulatory Reform Order Fire Safety 2005 and the associated regulations issued by the Health and Safety Executive. • the appropriate committee reviews ICB's compliance in accordance with statutory and mandatory Fire Safety regulations. • so far as is reasonably practicable that all Managers are aware of their responsibilities. • a management system exists for reporting and investigating incidents. • Fire Safety performance is measured, strategic targets set, and progress monitored and reviewed.

	• adequate provision for health and safety is included in any service level agreements/contracts
Senior Governance Manager CSU	The Senior Governance Manager will: • Advise and assist management in the interpretation and application of all fire legislation and give relevant guidance in liaison with the Executive lead and Nominated Officer of Fire for premises. • Organise Fire Risk Assessments and reviews where required. • Lead in the development of Personal Emergency Evacuation Plans when required. • Ensure that appropriate individuals have been identified as Fire Wardens to be responsible for each premise occupied by the ICB • Ensure that adequate fire safety training is provided for staff and that the training is documented accordingly. Staff should receive fire training as set out in the ICB's mandatory training schedule. • Ensure that regular testing and servicing of fire precautions (fire detection systems, firefighting equipment etc.) is carried out. • Implement workplace fire safety policy's and develop a written fire plan for their area in conjunction with the relevant Governance Manager. • Ensure that an appropriate investigation is carried out and a report is prepared following a fire in conjunction with the ICB. • Consult the relevant parties in advance of any proposed changes to either room occupancy levels and/or room use. • Ensure fire wardens are appointed for their area and they attend appropriate training. • Ensure that suitable fire drills are carried out and recorded on an annual basis within their service area. • Monitor compliance with fire safety training. • Provide advice and support to all staff with regards to all fire safety issues and initiate appropriate actions. • Liaise with NHS Property Services/landlord staff, local building control and the Fire & Rescue Service in the specification of fire precautions in new and existing premises. • Prepare specific fire safety training programmes and ensure delivery of this training. The ICB has a responsibility to ensure the safety of its staff working in buildings owned by a third party. The Governance Manager Health and Safety along with ICB colleagues must therefore discuss fire safety issues with the relevant organisation and gain assurance that appropriate fire safety systems are in place and that staff have access to, for example relevant information and training. This should include:

	• Instruction and information before occupying the building on Fire Safety issues and policies:
	  ○ How to raise the alarm.
	  ○ Access/egress routes.
	  ○ Position of fire extinguishers and “information” on their use.
	  ○ Information on any fire prevention measures in place.
	  ○ Any responsibilities staff have e.g., to ring 999, or to aid in the evacuation of other people, e.g., patients.
	• Access to Fire Safety training at the location if available.
	• Access to any risk assessments that have been undertaken.

Nominated Officer of Fire/All Fire Wardens	• Act as focal point on fire safety issues for local staff. • Organise and assist in the fire safety regime within local areas. • Raise issues regarding local area fire safety with line management. • Assist with co-ordination of the response to an incident within the immediate vicinity. • Be responsible for roll-call during an incident. • Be trained to tackle fire with first aid fire-fighting apparatus where appropriate. • Support line managers and the responsible person on fire safety issues.
All managers	• Assist the Executive lead responsible for fire safety and the responsible people in the day-to-day implementation of the Fire Safety Policy throughout their areas. • Ensure that any fire safety hazards are brought to the attention of the Health and Safety Team within the Commissioning Support Organisation. • Ensure that local fire policies are brought to the attention of all their staff, particularly new starters as part of local induction. • Ensure that provision is made for all their staff to attend fire training sessions when required and to ensure that they do so in line with the organisational requirements. • Ensure that staff co-operate with the implementation of the policy and adhere to policies. • Ensure that new starters carry out the Core Mandatory training. • Inform “new starter” employees of the relevant fire evacuation policies, means of escape, location of fire alarm points and firefighting equipment on their first working day.
All Staff	ICB employees are responsible for actively co-operating with managers in the application of this policy to enable the ICB to discharge its legal obligations and in particular; • Actively co-operate in the application of fire policies. • Ensure they are aware of and understand evacuation policies and any operational policies relating to specific

	places of work and events and comply fully with them at all times. • Ensure they are aware of specific hazards relating to fire and the policy to be followed. • Inform managers of any failure or shortcoming in any fire safety measures which come to their attention. • Ensure they are familiar with fire policies including location of fire exit routes, the positions of fire alarms, manual operation points and first aid and firefighting equipment. • Undertake fire safety training as per the ICB mandatory training requirement. • Be aware of all fire risks within their premises and act accordingly at all times as per this policy. • Liaise with the Nominated Office of Fire to ensure effective co-ordination of the situation where Fire & Rescue services personnel arrive on site.
CSU staff	Whilst working on behalf of the ICB, CSU staff will be expected to comply with all policies, policies and expected standards of behaviour within the ICB, however they will continue to be governed by all policies of their employing organisation.

NHS
North East &
North Cumbria

Health and Safety (H&S), Fire & Security Strategy

2022-2024

Version Number	Date Issued	Review Date
V1	July 2022	July 2024

Prepared By:	Senior Governance Manager, North of England Commissioning Support Unit.
Consultation Process:	ICS Integrated Governance Workstream
Formally Approved:	July 2022
Approved By:	ICB Board

EQUALITY IMPACT ASSESSMENT

Date	Issues
March 2022	None identified.

POLICY VALIDITY STATEMENT

Policy users should ensure that they are consulting the currently valid version of the documentation. The policy will remain valid, including during its period of review. However, the policy must be reviewed at least once in every 3-year period.

ACCESSIBLE INFORMATION STANDARDS

If you require this document in an alternative format, such as easy read, large text, braille or an alternative language please contact NECSU.comms@nhs.net

Version Control

Version	Release Date	Author	Update comments
1.0	July 2022	Senior Governance Manager, NECS	First Issue

Approval

Role	Name	Date
Approver	ICB Board	July 2022

Contents

1. Introduction

1.1 This Strategy sets out:

- the approach and arrangements for the management of health & safety (H&S), fire and security within ICB
- the approach to the management of H&S, fire and security.

Subsequent reviews of the ICB H&S, Fire and Security Strategy will reflect material changes, which are relevant during the period.

1.2 This Strategy aims to set out ICB's approach to H&S, fire and security ensuring the health, safety and welfare of its employees, clients, contractors, visitors and members of the general public as a matter of prime importance and will, so far as is reasonably practicable, establish procedures and systems necessary to implement this strategy and to ensure compliance with their legal and statutory obligations under the Health and Safety at Work act, Regulatory Reform Order Fire Safety and Health & Safety Regulations. In addition, the adoption and embedding within the organisation of an effective strategy and processes will ensure that the reputation of ICB is maintained and enhanced, to ensure business success, continuing financial strength.

1.3 As part of this Strategy, it is also acknowledged that not all H&S, fire and security risks can be eliminated. Ultimately, it is for the organisation to decide which risks it is prepared to accept based on the knowledge that an effective risk assessment has been carried out and the risk has been reduced to an acceptable level as a consequence of effective controls.

1.4 The Strategy will help the ICB fulfil its legal and statutory obligations under the Health and Safety at Work Act 1974 and Regulatory Reform Order Fire Safety, and to develop action plans and objectives in line with Health and Safety Executive, Health and Safety Guidance HSG65.

2. General Approach to H&S, Fire and Security: Principles, Aims and Objectives

2.1 This Strategy sets out the ICB's approach to the way in which in general terms H&S, fire and security is managed. This will be achieved by having robust processes in place. This will provide a useful tool for the systematic and effective management of H&S, fire and security and will inform and guide managers and staff as to the way in which all H&S, fire and security matters are to be controlled.

2.2 The aims of the Strategy are summarised as follows;

- to ensure that ICB meets its legal and statutory obligations under the Health and Safety at Work Act 1974 and subsequent regulations;
- to ensure that ICB meets its legal and statutory obligations under the Regulatory Reform Order Fire Safety (2005);
- to ensure that H&S, fire and security management is understood and effectively managed;
- to maintain H&S, fire and security compliance and to assure the Executive Committee that Health and Safety is effectively managed;
- to ensure that H&S, fire and security management is a cohesive element of the internal control systems within the ICB.
- to ensure that H&S, fire and security is an integral part of the ICB culture and its operating systems;
- to assure partner organisations that the ICB is committed to managing H&S, fire and security;
- to protect the services, staff, reputation and finances of the ICB through the process of early identification of risks relating to H&S, fire and security and where these risks are identified ensuring sufficient risk assessment, risk control and elimination is undertaken;
- to ensure safe system of work are set and followed;
- to provide a safe working environment without risks to health;
- to ensure there is provision of adequate welfare facilities;
- to ensure there is provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control risks;
- to ensure plant and equipment are safe;
- there are safe arrangements for the use, handling and storage and transport of articles, materials and substances;
- to ensure there is safe access and egress; and
- to ensure that buildings used by the ICB are safe and free from dangers working collaboratively with NHS Property Services with respective responsibilities in line with the Memorandum of Occupation.
- To ensure that H&S, fire and security considerations are reviewed by all managers, the CSU H&S Team and ICB Estates Staff when procuring new buildings and also ensuring that compliance is sought where staff are based with other tenants.

2.3 In order to achieve these aims the ICB is committed to ensuring that:

- H&S, fire and security management is embedded as an integral part of the management approach to the achievement of our objectives.
- Support is given to managers and staff in achieving levels of competency and health and safety knowledge.
- Communication and consultation takes place between all organisation where shared occupancy of buildings is identified in relation to H&S, fire and security.
- Staff understand the need to comply with H&S, fire and security standards.
- There is a top-down commitment to H&S, fire and security, in order to progress the effective health and safety working arrangements as the daily norm.
- Workplace risks are assessed, and safe systems of work introduced
- The management of H&S, fire and security is seen as a collective and individual responsibility, managed through the agreed committee and management structures.
- The ICB will ensure a supportive and "fair blame" culture and approach, staff are encouraged to report H&S, fire and security problems and incidents with a view to individuals and the organisation learning the lessons.
- Key objectives are set around H&S, fire and security.
- Robust work plans are developed in relation to H&S, fire and security
- Appropriate training and development is provided to all staff in the application of this strategy and the approach to H&S, fire and security which it describes.

3. Duties and Responsibilities

ICB Board	The ICB Board has overall responsibility for H&S, fire and security management. The Executive Committee has a duty to assure itself that the organisation has properly identified the requirements for H&S, fire and security and that it has processes and controls in place to mitigate any risks and the impact they have on the organisation and its stakeholders. The Executive discharges this duty as follows: • Ensures that there is a structure in place for the effective management of H&S, fire and security in the ICB • Approves and reviews the H&S, Fire and Security Strategy on a 2 yearly basis annual basis. • Receives regular reports from the Executive committee identifying significant risks and mitigating actions following review of the annual work plan and other documentation.

	• Demonstrates leadership, active involvement and support in H&S, fire and security management.
Chief Executive	The Chief Executive has the overall responsibility for: • Ensuring the implementation of an effective H&S, Fire and Security Strategy, supporting the work undertaken under the health and safety agenda as set out in the Strategy. • Continually promoting H&S, fire and security, demonstrating leadership, commitment and support. • Ensuring an appropriate committee structure is in place. • Planning for adequate staffing, finances and other resources, to ensure the effective management of H&S, fire and security within the ICB. • Meeting all the statutory requirements and ensuring positive performance towards the achievement of ICB's H&S, fire and security objectives. • Ensuring all directors and senior leads are appointed with managerial responsibility for H&S, fire and security. • Ensuring an Annual Health and Safety Report, adequately reflecting the H&S, fire and security management issues within the ICB is prepared for the Executive Committee
Executive Committee	The Executive Committee will exercise on behalf of the ICB Board those functions that are delegated to it in respect of the development, implementation and monitoring of health and safety, fire, security ensuring compliance with relevant Legislation. This is in particular by providing assurance on the systems and processes by which the ICB Board leads, directs and controls its functions in order to achieve the ICB's organisational objectives. The Executive Committee will keep the health and safety, fire and security matters under regular review. Members of the Executive committee will ensure that all health, safety, fire and security issues are coordinated, managed, monitored and reviewed including: • Notifying the Senior Governance Manager regarding any health and safety issues that have not been addressed and that would need

	to be escalated to Committee or nominated director for consideration • Ensuring staff comply with all organisational policies and procedures. • Leading the management of H&S, fire and security by following the HSFS strategy and any action plans arising from this Strategy at a directorate level. • Ensuring all staff fulfil their responsibility regarding H&S, fire and security as set out within the relevant regulations and approved codes of practices. • Ensuring that all activities undertaken within their directorates are consistent with the safe operation of the ICB • Ensuring that the organisation adheres to the ICB Policy for Health and Safety at Work in respect of its employees, visitors and others • Ensuring that there are established H&S, Fire and Security procedures. • Ensuring that all liability is covered by adequate insurance through NHS Resolution • Ensuring sufficient resources are made available to enable the ICB to fulfil its legal and statutory obligations in relation to H&S, fire and security.
Director of Corporate Governance, Communications and Involvement	The Director of Corporate Governance, Communications and Involvement reports directly to the Chief Executive and is a member of the ICB Boards the organisational lead for health and safety, fire and security and is responsible for: • Ensuring H&S, fire and security management systems are in place throughout the ICB, co-ordinating H&S, fire and security in accordance with this Strategy. • Scrutinising the controls and assurances in place. • Scheduling H&S, fire and security matters on the relevant Committee agenda. • Ensuring arrangements are in place for the co-ordination and collation of regular reports regarding H&S, fire and security. • Ensuring that there is an appropriate review of ICB H&S, fire and security systems and that these are reported to the Executive Committee; • Overseeing the management of H&S, fire and security as identified by the Committee,

	ensuring action plans are put in place, regularly monitored and implemented. • Ensuring any additional training required for the Executive Group on their responsibilities is delivered.
All Directors and Senior Leads	All Directors and senior leads have a responsibility to incorporate H&S, fire and security management within all aspects of their work and are responsible for ensuring the implementation of this Strategy by: • demonstrating personal involvement and support for the promotion of H&S, fire and security; • ensuring staff under their management are aware of their responsibilities in relation to this Strategy; • setting personal objectives for H&S, fire & security and monitoring their achievement; • ensuring risks relating to H&S, fire & security are identified, managed and mitigating actions are implemented in the functions for which they are accountable, and. • ensuring that where staff are employed and new accommodation is sought that they fully engage with the Health and Safety Team and Estates Team to enable all necessary compliance checks to take place and also relevant discussions between 3rd parties such as NHSPS, Architects, other tenants etc.
All Staff	All staff working within the ICB, including temporary/agency staff, have a responsibility to: • be aware of their responsibilities around H&S, fire and security in line with this Strategy; • have a duty under legislation to take reasonable care of their own safety and the safety of others who may be affected by the ICB's business and to comply with appropriate policies, procedures and guidelines; • identify and report H&S, fire and security risks to their line manager in line with this Strategy; • ensure incidents, are reported using the appropriate procedures and systems; and • attend statutory, mandatory and other appropriate training as determined by ICB and their line manager. Managers must ensure that where they are employing or contracting agency staff those staff are aware of, and adhere

	to, all relevant policies, procedures and guidance of ICB All contracting staff are required to complete Statutory/ Mandatory training.

4. Legal Requirements

4.1 To ensure the ICB provides a safe and secure environment for patients, public, staff and contractors the following regulations underpin the approach to safety management:

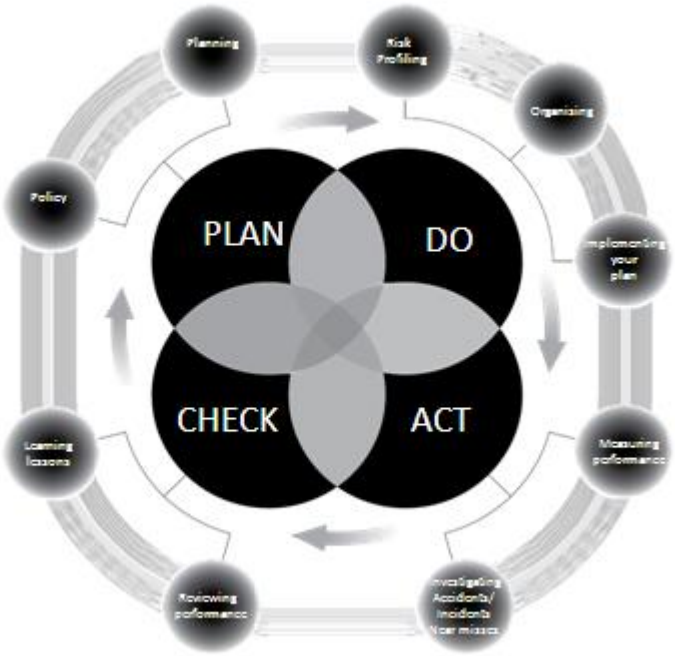
- The Health and Safety at Work Act 1974
- The Management of Health and Safety at Work Regulations 1999
- Workplace (Health, Safety and Welfare) Regulations 1992
- Health and Safety (Display Screen Equipment) Regulations 1992
- Health and Safety (Consultations with Employees) Regulations 1996
- Manual Handling Operations Regulations 1992
- Health and Safety (Safety signs and signals) regulations 1996
- Control of substances Hazardous to Health (COSHH) Regulations 2002
- Electricity at Work Regulations 1989
- Noise at Work regulations 1989
- Personal Protective Equipment at work Regulations 1998
- Provision and Use of Work Equipment Regulations 1998
- Reporting of Injuries and Dangerous Occurrences Regulations 1995
- Regulatory Reform Order (Fire Safety) 2005

5. Approach to Health and Safety Management

5.1 The ICB will follow the approved Health Service Guidance (HSE) guidance for management of Health and Safety known as HSG65.

5.2 HSG65 provides guidance for management, health and safety professionals and employee representatives who wish to improve health and safety in their workplaces as it focuses on effective health and safety policies, organising for health and safety, planning and implementation, measuring performance and auditing and reviewing performance.

5.3 The diagram below describes the essential requirements of successful health and safety management.



5.4 **PLAN**

5.4.1 The ICB will ensure that H&S, fire and security Policies and Procedures are developed ensuring that they set out the general approach, objectives and arrangements that need to be put in place for managing health and safety within its business. These documents will clearly identify who does what, when and how and will influence the activities throughout the ICB ensuring that it works in safe manner whilst discharging its day to day duties.

5.4.3 Planning is vital to implementing the ICB's H&S, Fire and Security Strategy. Annual action plans will be developed to ensure a systematic approach is taken to implement the Strategy and the health and safety duties required by ICB as an organisation.

5.5 **DO**

5.5.1 The ICB needs to have in place an effective management structure and arrangements in place for executing its health and safety requirements. The H&S, fire and security policies and procedures will empower and encourage staff to work safely within their and others place of work without apportioning blame.

5.5.2 HSFS responsibilities within ICB will be sustained by following the four C's:

Control – methods within the organisation in relation to governance structure and the reporting between committees.

Co-operation - between individuals through staff meetings and health and safety spot checks. Close working and co-operation between the ICB and the CSU health and safety team.

Communication – Ensuring there is clear two-way communication throughout the organisation and with the Commissioning Support Unit. Team meetings

will be used to ensure effective communication on all aspects of health, safety and wellbeing and to ensure learning is shared. There are also clear reporting lines for the identification of risks at the earliest opportunity.

Competence – All staff are required to undertake statutory and mandatory training at regular intervals. A system of spot checks will ensure that the ICB is operating at high levels of good practise at an operational level in line with all the appropriate controls. An Annual Health & Safety Audit will also be carried out and action plans implemented to address any areas requiring improvement.

5.6 CHECK

5.6.1 Performance standards and key performance indicators will be set and used for measuring achievement across the organisation in relation to H&S, fire and security and these will be given the same attention as other organisational standards with an emphasis on senior management responsibility.

5.6.2 Active monitoring will be in place to identify the effectiveness of the ICB H&S, fire and security systems and to identify any failures in the controls Monitoring will take the form of Health and Safety Audits, workplace inspections and spot-checks and monitoring of training compliance.

5.6.3 Reactive monitoring will be in place, including incident and accident investigations, near-misses that could result in harm or loss, claims and complaints. These will be used to plan corrective action required. Reactive monitoring can determine causes of gaps in knowledge, performance and controls. The

5.6.4 Any measures identified from the proactive or reactive monitoring will be addressed and actions will be taken to introduce or strengthen controls to support prevention of future accidents or incidents.

5.7 ACT

5.7.1 Key performance indicators will be reviewed by the Executive Committee.

5.7.2 H&S Audits and subsequent work arising from these audits will be monitored via the Committee to ensure lessons learned are taking forward.

5.7.3 Monitoring of staff sickness absence and workplace health will be monitored by the HR department and any relevant issues will be reported to the Executive Committee

5.7.4 The Occupational Health Department will provide data to the Committee when required.
Accident and Incidents will be reviewed by the Committee ensuring that all injuries, illnesses and dangerous occurrences are reported through the RIDDOR system

.5.7.5 The Executive Director of Corporate Governance, Communications and Involvement will be presenting progress reports to the Executive Committee.

5.7.6 Any prosecutions for H&S, Fire Offences and H&S enforcement notices served on ICB will be reported and monitored by the Committee.

6. Incident Reporting

6.1 ICB staff are required to comply with Incident Reporting Policies. These policies require that all incidents are reported and that the lessons learned are appropriately shared across the organisation and, where appropriate, more widely within the NHS locally and nationally.

6.2 The ICB aims to foster a culture of openness and learning, and staff are encouraged to be open about raising problems and reporting incidents.

6.3 Incidents will be recorded & analysed using the Safeguarding Incident Reporting Management System (SIRMS) and the impact of an incident will be graded according to the matrix together with the likelihood of occurrence or recurrence.

7. Equality, Diversity & Inclusion statement

7.1 The ICB is committed to promoting human rights and providing equality of opportunity; not only in employment practices, but also in the way we commission or provide services. The organisation also values and respects the diversity of our employees and the communities we serve. In applying this strategy, the organisation will have due regard for the need to:

- Promote human rights
- Eliminate unlawful discrimination
- Promote equality of opportunity
- Provide for good relations between people of diverse groups

7.2 This Strategy aims to be accessible to everyone regardless of age, disability (physical, mental or learning), gender (including transgender), race, sexual orientation, religion/belief or any other factor which may result in unfair treatment or inequalities in health or employment.

7.3 Throughout the development of this Strategy, the ICB has sought to promote equality, human rights and tackling health inequalities by considering the impacts and implications of the Strategy. The Strategy is subject to an on-going process of review through the Equality Impact Assessment.

8. Equality impact analysis

8.1 In accordance with our equality duties an Equality Impact Assessment has been undertaken (section 12). There is no evidence to suggest that the strategy would have an adverse impact in relation to race, disability, gender, age, sexual orientation, religion and belief or infringe individuals' human rights.

9. Dissemination and implementation

9.1 The Strategy will be circulated to all individuals identified with specific responsibilities and will be communicated to all staff and stakeholders by the most appropriate means. All line managers are required to share the Strategy with their staff.

9.2 For H&S, fire and security management to be effective within the organisation, this strategy will become a living document and a natural “part of everyday working practice”.

10. Accountability, responsibilities and training

10.1 Overall accountability for procedural documents across the organisation lies with the Chief Executive who has overall responsibility for establishing and maintaining an effective document management system, for meeting all statutory requirements and adhering to guidance issued in respect of procedural documents.

10.2 Overall responsibility for the implementation of the Strategy lies with the Director of Corporate Governance, Communications and Involvement who has delegated responsibility for managing the development and implementation of H&S procedural documents.

10.3 Training and education are key to the successful implementation of this Strategy and embedding a culture of a safe working environment in the organisation. Staff will have the opportunity to develop more detailed knowledge and appreciation of the role of H&S, Fire & Security through:

- Policy/strategy manuals
- Induction
- Line manager
- Specific training courses

11. Review

11.1 This strategy will be updated every 2 years or sooner and in accordance with the following as and when required:

- legislative changes
- good practice guidance
- case law
- significant incidents reported
- new vulnerabilities; and
- changes to organisational infrastructure.

11.2 The ICB Board be responsible for approving the Strategy.

12. Equality Impact Assessment

Initial Screening Assessment (STEP 1)

As a public body organisation, we need to ensure that all our current and proposed strategies, policies, services and functions, have given proper consideration to equality, diversity and inclusion, do not aid barriers to access or generate discrimination against any protected groups under the Equality Act 2010 (Age, Disability, Gender Reassignment, Pregnancy and Maternity, Race, Religion/Belief, Sex, Sexual Orientation, Marriage and Civil Partnership).

This screening determines relevance for all new and revised strategies, policies, projects, service reviews and functions.

Completed at the earliest opportunity it will help to determine:

- The relevance of proposals and decisions to equality, diversity, cohesion and integration.
- Whether or not equality and diversity is being/has already been considered for due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED).
- Whether or not it is necessary to carry out a full Equality Impact Assessment.

Name(s) and role(s) of person completing this assessment:

Name: Lee Crowe
Job Title: Senior Governance Manager
Organisation: NECS

Title of the service/project or policy: Health and Safety-Fire-Security Strategy

Is this a;
Strategy / Policy ☒Service Review ☐ Project ☐
Other Click here to enter text.

What are the aim(s) and objectives of the service, project or policy:

The aim of the strategy is to ensure ICB considers Health and Safety along with its other business objectives and to ensure that ICB follows the details stipulated within H&S Regulations.

Who will the project/service /policy / decision impact?
(Consider the actual and potential impact)

- **Staff** ☒
- **Service User / Patients** ☐
- **Other Public Sector Organisations** ☐
- **Voluntary / Community groups / Trade Unions** ☐
- **Others, please specify** Click here to enter text.

Questions	Yes	No
Could there be an existing or potential negative impact on any of the protected characteristic groups?	☐	☒
Has there been or likely to be any staff/patient/public concerns?	☐	☒
Could this piece of work affect how our services, commissioning or procurement activities are organised, provided, located and by whom?	☐	☒
Could this piece of work affect the workforce or employment practices?	☐	☒
Does the piece of work involve or have a negative impact on: • Eliminating unlawful discrimination, victimisation and harassment • Advancing quality of opportunity • Fostering good relations between protected and non-protected groups in either the workforce or community	☐	☒

If you have answered no to the above and conclude that there will not be a detrimental impact on any equality group caused by the proposed policy/project/service change, please state how you have reached that conclusion below:

The strategy is a review of an existing strategy and has received only minor updates. There is no fundamental change to the content therefore the previous EIA which concluded 'no impact' remains appropriate.

If you have answered yes to any of the above, please now complete the 'STEP 2 Equality Impact Assessment' document

Accessible Information Standard	Yes	No
Please acknowledge you have considered the requirements of the Accessible Information Standard when communicating with staff and patients. https://www.england.nhs.uk/wp-content/uploads/2017/10/accessible-info-standard-overview-2017-18.pdf	☒	☐

Governance, ownership and approval

Please state here who has approved the actions and outcomes of the screening		
Name	**Job title**	**Date**
Claire Riley	Executive Director of Corporate Governance, Communications and Involvement	June 2022

Publishing

This screening document will act as evidence that due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED) has been given.

NHS
North East &
North Cumbria

Corporate	ICBP019 - Health and Safety Policy

Version Number	Date Issued	Review Date
1	July 2022	July 2024

Prepared By:	Senior Governance Manager, North of England Commissioning Support Unit.
Consultation Process:	ICS Integrated Governance Workstream
Formally Approved:	July 2022
Approved By:	ICB Board

EQUALITY IMPACT ASSESSMENT

Date	Issues
March 2022	None identified

POLICY VALIDITY STATEMENT

Policy users should ensure that they are consulting the currently valid version of the documentation. The policy will remain valid, including during its period of review. However, the policy must be reviewed at least once in every 3-year period.

ACCESSIBLE INFORMATION STANDARDS

If you require this document in an alternative format, such as easy read, large text, braille or an alternative language please contact NECSU.comms@nhs.net

Version Control

Version	Release Date	Author	Update comments
1.0	July 2022	Senior Governance Manager, NECS	First issue.

Approval

Role	Name	Date
Approver	ICB Board	July 2022

Contents

1. Policy Statement of Intent

1.1 The Integrated Care Board (ICB) is committed to ensuring the health, safety and welfare of its staff and visitors as a matter of prime importance and will, so far as is reasonably practicable, establish procedures and systems necessary to implement this commitment and to comply with its statutory obligations under Section 2 of the Health and Safety at Work etc Act 1974.

1.2 The ICB will provide and maintain a healthy and safe working environment with the objective of minimising the number of instances of occupational accidents and illnesses.

1.3 The ICB will pay particular attention to ensuring that:

- safe systems of work are set and followed.
- a safe working environment without risks to health is maintained.
- there is provision of adequate welfare facilities.
- there is provision of sufficient training, instruction, supervision, and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control risks.
- plant and equipment are safe.
- there are safe arrangements for the use, handling and storage and transport of articles, materials and substances.
- there is safe access and egress.

1.4 Whilst the ICB will take all reasonable steps to ensure the health, safety and welfare of its employees, health and safety at work is also the responsibility of the employees themselves. It is the duty of each employee to take reasonable care of their own and other people's health, safety and welfare, and to report any situation which may pose a serious or imminent threat to the wellbeing of themselves or any other person.

1.5 The Executive Committee endorses the need for managers and staff to work together positively to achieve a situation compatible with the provision of high-quality services where the risk of personal injury and hazards to the health of staff and others can be reduced to a minimum. Thus, risk must be assessed, and significant findings recorded.

1.6 This policy is supplemented by other policies/procedures on specific areas of law. This document sets out the arrangements for health and safety management; it determines the levels of responsibility at all levels and the channels of communication for health and safety matters.

1.7 It is the responsibility of employees at all levels to familiarise themselves and comply with the ICB's procedures and systems on health and safety.

Signed…… Date……
Chief Executive

2. Definitions

2.1 **Manager** – the Corporate Manslaughter and Corporate Homicide Act 2007 defines senior managers as those who play a significant role in making decisions about the management of the whole or a substantial part of their organisation's activities and those who actually manage or organise those activities.

2.2 **Competent Persons** – the Management of Health and Safety at Work Regulations 1999, Regulation 7 requires every employer to appoint one or more competent persons to assist with putting measures in place to ensure legal compliance. The Competent Person can be either an individual or a company providing these services. The person is regarded as competent if they have 'sufficient training and experience or knowledge and other qualities to properly assist the employer to meet their safety obligations.'

3. Organisational Arrangements for Health and Safety

3.1 The ICB has ultimate responsibility for managing Health and Safety.

3.2 A Health & Safety Service Level Agreement exists with the CSU and specific responsibilities are outlined within this document.

3.3 It is a disciplinary offence, which could lead to dismissal, to work or permit others to work in a way which is contrary to the requirements of health and safety legislation and the ICB's Health and Safety Policy.

3.4 The relevant legislation includes the following:

- Health & Safety at Work etc. Act 1974
  - It is the duty of every employer, so far as is reasonably practicable, to ensure the health, safety, and welfare at work of all his employees.
  - Every employer must conduct his undertaking in such a way as to ensure, so far as is reasonably practicable, that persons not in his employment are not exposed to risks to health or safety.
  - Employees are to take reasonable care for the health and safety of himself and of others who may be affected by his acts or omissions at work.
- Corporate Manslaughter & Homicide Act 2007
  - An organisation is guilty of the offence of corporate manslaughter if the way in which any of the organisation's activities are managed or organised by its senior managers –
    a) causes a person's death; and
    b) amounts to a gross breach of a relevant duty of care owed by the organisation to the deceased.

- Health & Safety Offences Act 2008
  - The maximum penalties under this Act are:
    - £20,000 fines in lower courts for nearly all summary offences, unlimited fines in higher courts;
    - Imprisonment for nearly all offences – up to six months in Magistrates Courts and two years in the Crown Court.

3.5 Health and Safety Policies

Policy documents and Standard Operating Procedures on particular aspects of health and safety will be developed in consultation with stakeholders and will be approved at the Executive committee on behalf of the ICB Board..

3.6 Health and Safety Training

All staff are made aware of their responsibilities in relation to mandatory training (including health & safety training) and this is included within their ESR record and regular updates, as an addition to this, Health and Safety training could be included in Personal Development Plans. In addition to mandatory training requirements, additional training necessary for the job should be determined as a result of the risk assessment process.

3.7 Health and Safety Communication

The ICB will ensure that suitable and relevant information relating to health, safety and welfare in the workplace is communicated to staff and users. Statutory notices will be displayed throughout the workplace. Consultation and communication over health and safety issues will be encouraged at all levels within the ICB.

3.8 Specialist Advice

3.8.1 Whilst the Senior Governance Manager CSU should be considered as the primary source for expert legal advice on complying with health and safety legislation and ICB policy, where necessary the Chief Executive will ensure staff have access to other Competent Persons (as defined in the Management of Health and Safety at work Regulations 1999) either through separate appointments or robust and appropriately monitored Service Level Agreements with third party providers.

3.8.2 These will include as a minimum;

- Occupational Health Service (including physiotherapy)
- Advice relating to infection prevention and control
- Estates/ facilities services
- Human Resources
- Fire
- Security

4. Implementation

4.1 This policy will be available to all staff for use in relation to dealing with issues pertaining to health and safety.

4.2 All managers are responsible for ensuring that relevant staff within the ICB have read and understood this document and are competent to carry out their duties in accordance with the procedures described.

5. Training Implications

It has been determined that there are no specific training requirements associated with this policy, however, all staff are aware of their obligations to undertake their statutory and mandatory training in relation to health and safety.

6. Related Documents

6.1 Other related policy documents

- Fire Safety Policy
- Moving and Handling Policy
- Incident Reporting and Management Policy
- Risk Management Policy
- H&S Procedures

6.2 Legislation and statutory requirements

- Cabinet Office (1974) *Health and Safety at Work Etc. Act 1974*. London. HMSO.
- Cabinet Office (2007) *Corporate Manslaughter and Homicide Act 2007*. London. HMSO
- Cabinet Office (2008) *Health and Safety Offences Act 2008*. London. HMSO.

6.3 Best practice recommendations

- Management of Health and Safety at Work Regulations 1999

7. Monitoring, Review and Archiving

7.1 Monitoring

7.1.1 The ICB Board will agree a method for monitoring the dissemination and implementation of this policy. Monitoring information will be recorded in the policy database.

7.1.2 The ICB Board has delegated responsibility for all Health and Safety Matters, this is included within the Scheme of Reservation and Delegation, or Terms of Reference Copies of minutes are forwarded to the ICB Board.

7.2 Review

7.2.1 The ICB Board will ensure that this policy document is reviewed in accordance with the timescale specified at the time of approval. No policy or procedure will remain operational for a period exceeding three years without a review taking place.

7.2.2 Staff who become aware of any change, including legislative changes, which may affect a policy should advise their line manager as soon as possible. The Executive Director or nominated deputy, will then consider the need to review the policy or procedure outside of the agreed timescale for revision.

7.2.3 For ease of reference for reviewers or approval bodies, changes should be noted in the 'version control' table on the second page of this document.

NB: If the review consists of a change to an appendix or procedure document, approval may be given by the Executive director and a revised document may be issued. Review to the main body of the policy must always follow the original approval process.

7.3 Archiving

The ICB Board will ensure that archived copies of superseded policy documents are retained in accordance with Records Management: NHS Code of Practice 2021.

8. Equality Impact Assessment

Initial Screening Assessment (STEP 1)

As a public body organisation, we need to ensure that all our current and proposed strategies, policies, services and functions, have given proper consideration to equality, diversity and inclusion, do not aid barriers to access or generate discrimination against any protected groups under the Equality Act 2010 (Age, Disability, Gender Reassignment, Pregnancy and Maternity, Race, Religion/Belief, Sex, Sexual Orientation, Marriage and Civil Partnership).

This screening determines relevance for all new and revised strategies, policies, projects, service reviews and functions.

Completed at the earliest opportunity it will help to determine:

- The relevance of proposals and decisions to equality, diversity, cohesion and integration.
- Whether or not equality and diversity is being/has already been considered for due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED).
- Whether or not it is necessary to carry out a full Equality Impact Assessment.

Name(s) and role(s) of person completing this assessment:

Name: Lee Crowe
Job Title: Governance Manager, H&S, Fire, Security
Organisation: NECS

Title of the service/project or policy: Health and Safety policy

Is this a;
Strategy / Policy ☒Service Review ☐ Project ☐
Other Click here to enter text.

What are the aim(s) and objectives of the service, project or policy:
The aim of the policy is to ensure ICB considers Health and Safety along with its other business objectives and to ensure that the ICB follows the details stipulated within H&S Regulations.

Who will the project/service /policy / decision impact?
(Consider the actual and potential impact)

- **Staff ☒**
- **Service User / Patients ☐**
- **Other Public Sector Organisations☐**
- **Voluntary / Community groups / Trade Unions ☐**
- **Others, please specify** Click here to enter text.

Questions	Yes	No
Could there be an existing or potential negative impact on any of the protected characteristic groups?	☐	☒
Has there been or likely to be any staff/patient/public concerns?	☐	☒
Could this piece of work affect how our services, commissioning or procurement activities are organised, provided, located and by whom?	☐	☒
Could this piece of work affect the workforce or employment practices?	☐	☒
Does the piece of work involve or have a negative impact on: • Eliminating unlawful discrimination, victimisation and harassment • Advancing quality of opportunity • Fostering good relations between protected and non-protected groups in either the workforce or community	☐	☒

If you have answered no to the above and conclude that there will not be a detrimental impact on any equality group caused by the proposed policy/project/service change, please state how you have reached that conclusion below:

The policy is a review of an existing policy and has received only minor updates. There is no fundamental change to the content therefore the previous EIA which concluded 'no impact' remains appropriate

If you have answered yes to any of the above, please now complete the 'STEP 2 Equality Impact Assessment' document

Accessible Information Standard	Yes	No
Please acknowledge you have considered the requirements of the Accessible Information Standard when communicating with staff and patients. https://www.england.nhs.uk/wp-content/uploads/2017/10/accessible-info-standard-overview-2017-18.pdf	☒	☐

Governance, ownership and approval

Please state here who has approved the actions and outcomes of the screening		
Name	**Job title**	**Date**
Claire Riley	Executive Director of Corporate Governance, Communications and Involvement	June 2022

Publishing

This screening document will act as evidence that due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED) has been given.

Schedule of Duties and Responsibilities

ICB Board	The ICB Board has delegated responsibility for setting the strategic context in which organisational process documents are developed, and for establishing a scheme of governance for the formal review and approval of such documents.
Chief Executive	The Chief Executive has overall responsibility for the strategic direction and operational management, including ensuring that CCG process documents comply with all legal, statutory and good practice guidance requirements.
Director of Corporate Governance, Communications and Involvement	The Executive lead Responsible for Policy will: • Identify the appropriate process for regular evaluation of the implementation and effectiveness of this policy. • Identify and implement revisions to this policy and arrange for superseded versions of this policy to be retained in accordance with Records Management: NHS Code of Practice (2009). • Maintain the policy database.
Executive Committee	The ICB, as the employer, is responsible for ensuring health and safety and conducting the ICB's undertakings in such a way as to ensure the safety of staff, visitors and others affected by its undertaking so far as is reasonably practicable. The Executive committee is responsible for giving the ICB Board assurance on the following: • ensuring that there is an effective policy for Health and Safety at Work in respect of its employees, visitors, others and that it is reviewed and updated on a regular basis. • the promulgation of the policy and of health and safety information among ICB's staff. • the establishment of health and safety procedures (Management of Health and Safety at Work Regulations 1999). • ensuring that all liability is covered by adequate insurance. • ensuring that sufficient resources are made available to enable managers of the ICB to fulfil their legal obligations.

Appendix A

Health & Safety Leadership Checklist

This list is designed to check your status as a *leader* on health and safety.

- How do you demonstrate the relevant committee's commitment to health and safety?

- What do you do to ensure appropriate relevant committee level review of health and safety?

- What have you done to ensure your organisation, at all levels including the relevant committee, receives competent health and safety advice?

- How are you ensuring all staff – including the relevant committee – are sufficiently trained and competent in their health and safety responsibilities?

- How confident are you that your workforce, particularly safety representatives, are consulted properly on health and safety matters, and that their concerns are reaching the appropriate level including, as necessary, the relevant committee?

- What systems are in place to ensure your organisation's risks are assessed, and that sensible control measures are established and maintained?

- How well do you know what is happening on the ground, and what audits or assessments are undertaken to inform you about what your organisation and contractors actually do?

- What information does the relevant committee receive regularly about health and safety, e.g., performance data and reports on injuries and work related ill-health?

- What targets have you set to improve health and safety, and do you benchmark your performance against others in your sector or beyond?

- Where changes in working arrangements have significant implications for health and safety, how are these brought to the attention of the relevant committee?

(Taken from the Institute of Directors and Health & Safety Commission's publication "Leading Health and Safety at Work – Leadership Actions for Directors and Board Members")

Appendix B

Checklist for Managers

- Are all relevant health and safety policies and procedures accessible to your staff?
- Are your staff aware of their health and safety legal obligations?
- Have your staff undertaken Mandatory health and safety training?
- Are health and safety responsibilities included in Job Descriptions?
- Are specific health and safety roles recognised e.g., Fire Wardens, Risk Assessors?
- Do your staff have any problems discharging their health and safety responsibilities? If so, please note on 1:1/appraisal document.
- Is health and safety a discussion item at team meetings?
- Do you have suitable and sufficient risk assessments, relevant to the risks from your environments/activities?
- Are staff involved in the risk assessment process, and/or included in their circulation/communication?
- Are risk assessments reviewed regularly, (when any changes happen or annually)?
- Do your staff know how to report accidents/incidents?
- Are your staff aware of their emergency procedures, and is it adequately covered as part of their local induction?

This list is not exhaustive, and can be added to by managers, and can be used as a questionnaire at team meetings to inform all relevant persons.

NHS
North East & North Cumbria

Corporate	ICBP030 - Physical Security Policy

Version Number	Date Issued	Review Date
V1	July 2022	July 2024

Prepared By:	Senior Governance Manager, CSU North of England Commissioning Support Unit.
Consultation Process:	ICS Integrated Governance Workstream
Formally Approved:	July 2022
Approved By:	ICB Board

EQUALITY IMPACT ASSESSMENT

Date	Issues
March 2022	None identified

POLICY VALIDITY STATEMENT

Policy users should ensure that they are consulting the currently valid version of the documentation. The policy will remain valid, including during its period of review. However, the policy must be reviewed at least once in every 3-year period.

ACCESSIBLE INFORMATION STANDARDS

If you require this document in an alternative format, such as easy read, large text, braille or an alternative language please contact NECSU.comms@nhs.net

Version Control

Version	Release Date	Author	Update comments
1.	July 2022	Senior Governance Manager, NECS	First issue.

Approval

Role	Name	Date
Approver	ICB Board	July 2022

Contents

1. Introduction

For the purposes of this policy the NHS Integrated Care Board will be referred to as 'the ICB'.

The (ICB) aspires to the highest standards of corporate behaviour and clinical competence, to ensure that safe, fair and equitable procedures are applied to all organisational transactions, including relationships with patients, their carers, public, staff, stakeholders and the use of public resources. In order to provide clear and consistent guidance, the ICB will develop documents to fulfil all statutory, organisational and best practice requirements and support the principles of equal opportunity for all.

The ICB is committed to promoting and improving security for all of its staff, patients and visitors. The ICB aims to provide and maintain a calm, pleasant and secure working environment, where patients, visitors and staff are confident of their personal safety and the security of their property, buildings and equipment are safeguarded. Whilst the ICB recognises that it would be impossible to prevent every security incident it will provide resources to assist in handling such matters.

All ICB employees have a responsibility to ensure that security measures and procedures are observed at all times. Managers of the ICB should take a leading role in promoting and developing a security conscious culture.

1.1 Status

This policy is a Health and Safety policy.

1.2 Purpose and scope

The ICB is committed to promoting and improving the security of its premises/assets and the safety of staff, patients and visitors to the ICB. The ICB will do its utmost to safeguard against crime and against loss or damage to property and equipment.

The ICB recognises and accepts its responsibility to provide a safe and healthy workplace and working environment for all employees and for those using its premises as required by the Health and Safety at Work etc. Act 1974.

Security is the responsibility of all staff in not only safeguarding their own wellbeing and personal property but also that of visitors and ICB property. The primary objectives of security management are:

- the prevention of violent or aggressive behaviour towards ICB staff, patients, clients and visitors
- the protection of life from malicious criminal activity or other hazards
- the protection of premises and assets against fraud, theft and damage
- the smooth and uninterrupted delivery of health care
- the detection and reporting of suspected offenders committing offences against patients, clients, staff, property or private property within ICB premises
- the education of all staff in proactive security and general security awareness

Security management can be defined as an environment where the risks to people and property are minimised from any actions that may lead to personal injury, threat to life or the disruption of the business activity of the ICB.

Effective security management is linked to other policy areas, including but not limited to counter fraud, the management of violence and aggression and lone working.

2. Definitions

The following terms are used in this document:

ICB – Integrated Care Board
NHS – National Health Service
LSMS – Local Security Management Specialist

2.1 Designated Manager for Security

The Designated Director for Security within the ICB is the Director of Corporate Governance, Communications and Engagement

3. Security Policy

3.1 Responsibilities of ICB managers

All managers in the ICB are responsible for security within their work area. Managers are required to assess security risks as part of the general assessments for their department/service, develop action plans and implement security measures.

Managers' responsibilities are summarised in section 8, below.

3.2 Responsibilities of ICB employees

All ICB employees, whether permanent, temporary or working through an agency or other third party, are responsible for acquainting themselves with this policy, following the guidance contained in it and complying with all security measures in their department.

Employee responsibilities are summarised in Appendix 1, below.

3.3 Security of Physical Environment

Appropriate security controls and processes will be implemented to ensure the physical and environmental security of facilities. These processes will include controls to prevent unauthorised physical access, damage, loss, theft and interference to the organisation's facilities.

The following measure are in place within ICB to ensure physical security:

- Within ICB offices there may be restricted areas in line with the organisation's requirements.
- Communication rooms formally known as IT server rooms are "secure areas", and can only be accessed by identified staff
- ICB sites will only be accessible using security access devices (Cards, Fobs, Tokens, digital locks) or lock and key
- Authorised staff must follow appropriate guidelines for working in secure areas, e.g., communication rooms, please refer to ICT CSU for guidance
- "Tailgating" is not permitted on any ICB sites.
- Arrangements are in place for the unlocking and locking-up of premises.
- Lone working/ personal safety please refer to "ICB's Lone Working Procedure".
- Contractors attending site should be agreed with ICB and Landlords/NHSPS
- Power and telephone cabling is protected from interception, interference and damage

3.4 Unauthorised visitors

Staff should be alert to the fact that the organisation may receive unauthorised visitors. Staff who identify potential unauthorised visitors to ICB sites should alert their line manager immediately. Any such visitors should be approached only if it is thought safe to do so. If someone is identified in ICB work areas that has no legitimate reason to be there, they should be asked respectfully to leave.

3.5 Bomb Threats

The vast majority of bomb threats are hoaxes. Making such malicious calls is an offence contrary to *Section 51 of the Criminal Law Act 1977* and should always be reported to the police with support from the LSMS . Any member of staff receiving such a call should seek the immediate advice of the most senior manager available and contact necsu.healthandsafety@nhs.net. Any suspicious packages must be reported to the Health and Safety or Facilities Manager immediately.

4. Building Access

4.1 Security access devices (Cards, Fobs, Tokens)

Security devices are allocated/returned to staff via the HR new starter/leavers process.

- Lost security devices should be reported via SIRMS before a replacement fob can be issued.
- Lost devices should also be reported to your Line Manager.
- Security devices should not be shared with others.

4.2 **Identification Badges**

ID Badges are issued to all staff on commencement of employment. ID badges must be worn at all times whilst on ICB premises or business. Persons not wearing an ID badge should be challenged and asked to identify themselves.

When staff leave ICB employment, all ID badges should be returned to the Manager and destroyed as per HR leavers process. If an ID badge is lost or stolen this must be reported to the Line Manager and reported onto the incident reporting system (SIRMS) before a new ID badge is supplied.

4.3 **Visitors / Contractors**

All visitors/contractors are to be signed in and out of ICB premises and issued with a visitor pass, which must be displayed at all times whilst on ICB premises. For security reasons all visitors must be escorted to and from their destination within ICB buildings.

5. ICB Property/assets

All ICB property should be securely managed. Managers and staff should follow the roles and responsibilities set out within this procedure. All IT equipment is secured behind door access controls with the exception of some reception areas where the desktop PCs are encrypted.

It is an offence for members of staff to remove property belonging to the ICB without receiving prior authority from their line manager or the custodian of the equipment. Failure to seek authority could result in disciplinary action or criminal proceedings being taken.

5.1 **Personal Property/assets**

Staff should be aware that the ICB cannot accept liability for loss or damage to staff property brought onto its premises.

- Staff are advised to take adequate precautions to ensure the safety of their possessions and not bring valuables to work. Where storage has been provided for personal use, the individual to whom it is allocated will be responsible for ensuring it is locked.

- Staff must report any loss of or damage to their belongings and co-operate in any consequent enquiry into the loss or damage. If private property has been stolen, then it is the owner's and not the ICB's responsibility to report the matter to the Police. This should be after notifying a line manager and reporting the incident on the ICB Incident Reporting System (SIRMS). Any incident management or Police reference number assigned should also be recorded on the incident log.

6. Security of Information

All safeguards should be taken by staff that handle, receive and use confidential patient/personal information. It is essential that all staff within the ICB understand and follow relevant Information Governance policies which can be found on the ICB intranet or website.

7. Security of Motor Vehicles

The ICB cannot accept liability for any motor vehicle or its contents when they are parked on a ICB site or when the car is in being used by staff on ICB business, please refer to the ICB driving at work Policy.

7.1 Lease Cars

In the event of an incident or accident involving a lease car, the employee must notify their manager and the lease company in accordance with the car lease agreement and also report onto the incident reporting system.

8. Prevention of violence to staff

The ICB has a duty to provide a safe and secure environment for all employees and visitors and has a zero-tolerance approach to violence or abusive behaviour. The ICB takes a very serious view of violence, abuse and aggression at work and recognises its responsibility to protect employees and others who may be subjected to any acts of violence, abuse or aggression whether or not the act results in physical or non-physical assault and whether carried out by members of the public, patients, relatives or by members of staff. Violent or abusive behaviour will not be tolerated, and decisive action will be taken by the ICB to protect staff and visitors.

Please refer to lone working procedures available on ICB intranet site and the Violence Aggression and Abuse Management Policy.

9. Reporting of Security Incidents

All staff have a responsibility to report all crimes and breaches of security and should refer to the Incident Reporting and Management Policy.

Reporting falls into the following categories:

- **Assault or abuse of a staff member or visitor**. All incidents of assault or abuse must be reported through the incident reporting system and should be reported as soon as practical after the incident. All physical assaults to staff should be reported by the Manager through the incident reporting system

(SIRMS). Visitors and staff should always be asked if they would like the police to be involved.

- Where a **security incident or crime is in progress** it should be reported immediately to the Police and the senior manager on site and advice sought from the LSMS if required. The incident must be reported via the incident reporting system (SIRMS) as soon as possible after the incident and passed on as per the ICB Incident Reporting and Management Policy

- Where a **criminal incident is discovered after the fact** and the time of the offence is not known, the incident must be reported as soon as the crime is discovered and then dealt with in line with the ICB Incident Reporting and Management Policy. The manager should then inform the police as it may be necessary to obtain a crime reference number for insurance purposes etc.

- Where a security incident involved the **theft of personal information** this must immediately be reported via SIRMS. Any theft or loss of data storage e.g., computer, laptop etc should all be reported in this way. Also, incidents where systems are suspected of being compromised should be reported on SIRMS.

- Where a security incident involves the **theft of patient identifiable information** this must be immediately reported via SIRMS. Any theft or loss of data storage e.g., computer, laptop etc should all be reported via SIRMS the incident reporting system. Also, incidents where systems are suspected of being compromised should be reported to the ICB IT support desk.

- Where a security incident involved the **theft of patient identifiable information** this must immediately be reported to the Senior Information Risk Owner, Caldicott Guardian; Data Protection Officer and the Director of Corporate Governance, Communications and Engagement (or nominated deputy). Any theft or loss of data storage e.g., computer, laptop, should all be reported in this way as well as via the incident reporting form.
- All cases of **suspected fraud or corruption** should be notified immediately to the relevant director who will then give advice or arrange investigation of the incident.

10. PREVENT Duty

The ICB should have due regard to compliance with the requirements of the Prevent Duty guidance for England and Wales. With regards to security management this will include:

- Using meeting request forms with relevant information detailing who to contact should there be a concern if rooms or buildings are being used for radicalisation/terrorism.
- Ensuring staff know which personnel to contact if there are concerns relating to the use of the building - this will include contact details for the Governance Manager H&S who has responsibility for Security within the ICB demised area and to also ensure the Prevent Referral Pathway is followed if applicable.
- Ensure staff have received Prevent training as per Prevent Policy and that staff report issues to relevant managers for escalation relating to terrorism and radicalisation

- Have an identified Prevent Lead.

11. Implementation

4.1 This policy will be available to all staff for use in the circumstances described on the title page.

4.2 All managers are responsible for ensuring that relevant staff within the ICB have read and understood this document and are competent to carry out their duties in accordance with the procedures described.

12. Training Implications

It has been determined that there are no specific training requirements associated with this policy/procedure.

13. Related Documents

13.1 Other related policy documents

- Violence, Aggression and Abuse Management Policy
- Prevent Policy
- Lone Working Policy

13.2 Legislation and statutory requirements

- Health and Safety Executive (1974) *Health and Safety at Work etc Act 1974*. London HSE.

14. Monitoring, Review and Archiving

14.1 Monitoring

The ICB Board will agree with the sponsoring Director a method for monitoring the dissemination and implementation of this policy. Monitoring information will be recorded in the policy database.

14.2 Review

14.2.1 The ICB Board will ensure that this policy document is reviewed in accordance with the timescale specified at the time of approval. No policy or procedure will remain operational for a period exceeding three years without a review taking place.

14.2.2 Staff who become aware of any change which may affect a policy should advise their line manager as soon as possible. The Executive Director (or nominated deputy) will then consider the need to review the policy or procedure outside of the agreed timescale for revision.

14.2.3 For ease of reference for reviewers or approval bodies, changes should be noted in the ‘document history’ table on the front page of this document.

NB: If the review consists of a change to an appendix or procedure document, approval may be given by the sponsor director and a revised document may be issued. Review to the main body of the policy must always follow the original approval process.

14.3 Archiving

The ICB Board will ensure that archived copies of superseded policy documents are retained in accordance with the NHS Records Management Code of Practice 2021.

15. Equality Analysis

Equality Impact Assessment
Initial Screening Assessment (STEP 1)

As a public body organisation, we need to ensure that all our current and proposed strategies, policies, services and functions, have given proper consideration to equality, diversity and inclusion, do not aid barriers to access or generate discrimination against any protected groups under the Equality Act 2010 (Age, Disability, Gender Reassignment, Pregnancy and Maternity, Race, Religion/Belief, Sex, Sexual Orientation, Marriage and Civil Partnership).

This screening determines relevance for all new and revised strategies, policies, projects, service reviews and functions.

Completed at the earliest opportunity it will help to determine:

- The relevance of proposals and decisions to equality, diversity, cohesion and integration.
- Whether or not equality and diversity is being/has already been considered for due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED).
- Whether or not it is necessary to carry out a full Equality Impact Assessment.

Name(s) and role(s) of person completing this assessment:

Name: Lee Crowe
Job Title: Senior Governance Manager
Organisation: NECS

Title of the service/project or policy: Physical Security policy

Is this a;
Strategy / Policy ☒Service Review ☐ Project ☐
Other Click here to enter text.

What are the aim(s) and objectives of the service, project or policy:
The aim of the policy is to ensure ICB considers Health and Safety along with its other business objectives and to ensure that the ICB follows the details stipulated within H&S Regulations.

Who will the project/service /policy / decision impact?
(Consider the actual and potential impact)

- **Staff ☒**
- **Service User / Patients ☐**
- **Other Public Sector Organisations☐**
- **Voluntary / Community groups / Trade Unions ☐**
- **Others, please specify** Click here to enter text.

Questions	Yes	No
Could there be an existing or potential negative impact on any of the protected characteristic groups?	☐	☒
Has there been or likely to be any staff/patient/public concerns?	☐	☒
Could this piece of work affect how our services, commissioning or procurement activities are organised, provided, located and by whom?	☐	☒
Could this piece of work affect the workforce or employment practices?	☐	☒
Does the piece of work involve or have a negative impact on: • Eliminating unlawful discrimination, victimisation and harassment • Advancing quality of opportunity • Fostering good relations between protected and non-protected groups in either the workforce or community	☐	☒

If you have answered no to the above and conclude that there will not be a detrimental impact on any equality group caused by the proposed policy/project/service change, please state how you have reached that conclusion below:

The policy is a review of an existing policy and has received only minor updates. There is no fundamental change to the content therefore the previous EIA which concluded 'no impact' remains appropriate

If you have answered yes to any of the above, please now complete the 'STEP 2 Equality Impact Assessment' document

Accessible Information Standard	Yes	No
Please acknowledge you have considered the requirements of the Accessible Information Standard when communicating with staff and patients. https://www.england.nhs.uk/wp-content/uploads/2017/10/accessible-info-standard-overview-2017-18.pdf	☒	☐

Governance, ownership and approval

Please state here who has approved the actions and outcomes of the screening		
Name	**Job title**	**Date**
Claire Riley	Executive Director of Governance, Communications and Innovation	June 2022

Publishing

This screening document will act as evidence that due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED) has been given.

Schedule of Duties and Responsibilities

ICB Board	The ICB Board has responsibility for setting the strategic context in which organisational process documents are developed, and for establishing a scheme of governance for the formal review and approval of such documents.
Executive Committee	The Executive Committee is responsible for formal review and approval of organisational process documents.
Chief Executive	The Chief Executive has overall responsibility for the strategic direction and operational management, including ensuring that ICB process documents comply with all legal, statutory and good practice guidance requirements.
Management responsibility	All Directors, Managers and Supervisory Staff are responsible for the adherence and monitoring compliance with this policy. In particular they shall ensure: • Arrangements are in place to ensure the security of premises and assets and the safety of staff, patients and visitors taking all preventative measures to safeguard people and property (including occupied but not owned by the ICB). • That risk assessments are in place and where significant security risks exist local procedures are in place to minimise or reduce the impact. • That staff are aware of local and ICB security procedures and the results of risk assessments by effective training and communication. • Security arrangements are reviewed following incidents and ensure necessary changes in procedures are implemented. • Disciplinary procedures are initiated for staff who breach security arrangements. • That all criminal activities are reported to the Police and that all security incidents are reported, and safeguard are completed. • That all staff are briefed with regard to their own personal security and local procedures, and where appropriate, are supported to attend security training. • That all staff are issued with staff identification badges (ID badges). • That work areas under their control are operated in accordance with this policy and any associated procedures. • That all breaches of security arrangements are investigated and reported immediately in accordance with laid down procedures. • That all staff on leaving the ICB return their ID badges, uniforms, keys and electronic passes.

	• That rules with regard to confidential paperwork are adhered to. • That advice is sought, as appropriate, from the LSMS and others where there is any doubt as to the standards that are to be applied in adhering to this policy. • That arrangements are in place to summon the Chief Executive or appointed deputy directly in the event of any serious incident occurring in the area under their control. • That official visitors/contractors are issued with the relevant visitor badge, and this is monitored to ensure they are carried at all times when on ICB premises. • That all security incidents are recorded using the ICB's incident reporting system. • That any suspicion of fraud is reported to the local counter fraud service. • That a response is made at the earliest opportunity to any request from employees for advice on security concerns. • That appropriate support is given to staff involved in any security related incident.
Employees' responsibility	All employees have a duty to co-operate with the implementation of this policy. In particular it should be ensured: • That they are vigilant and responsible in the workplace, bringing to the attention of their immediate manager, as appropriate, any suspicious activity they observe on ICB premises. • That they attend appropriate security training or education. • That they co-operate with managers to achieve the aims of the security policy, highlighting any identified risks. • That they complete incident report forms for all security related incidents. • That they wear their staff identification badges at all times. • That they report immediately to their departmental manager any loss of or malicious damage to their own patients.

All Staff	All staff, including temporary and agency staff, are responsible for: • Compliance with relevant process documents. Failure to comply may result in disciplinary action being taken. • Co-operating with the development and implementation of policies and procedures and as part of their normal duties and responsibilities. • Identifying the need for a change in policy or procedure as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and advising their line manager accordingly. • Identifying training needs in respect of policies and procedures and bringing them to the attention of their line manager. • Attending training / awareness sessions when provided.

NHS
North East &
North Cumbria

Corporate	ICBP029 - Moving and Handling Policy

Version Number	Date Issued	Review Date
V1	July 2022	July 2024

Prepared By:	Senior Governance Manager, NECS
Consultation Process:	ICS Integrated Governance Workstream
Formally Approved:	July 2022
Approved By:	ICB Board

EQUALITY IMPACT ASSESSMENT

Date	Issues
March 2022	None identified

POLICY VALIDITY STATEMENT

Policy users should ensure that they are consulting the currently valid version of the documentation. The policy will remain valid, including during its period of review. However, the policy must be reviewed at least once in every 3-year period.

ACCESSIBLE INFORMATION STANDARDS

If you require this document in an alternative format, such as easy read, large text, braille or an alternative language please contact NECSU.comms@nhs.net

Version Control

Version	Release Date	Author	Update comments
1.0	July 2022	Senior Governance Manager, NECS	First Issue

Approval

Role	Name	Date
Approver	ICB Board	July 2022

Contents

1. Introduction

The Integrated Care Board (ICB) has a Duty of Care under the Health & Safety at Work Act (1974), The Management of Health and Safety at Work Regulations (1999) and the Manual Handling Operations Regulations 1992 as amended 2002) and is fully committed to safeguarding the health and safety of its staff.

The members of the ICB Board recognise they have a statutory duty towards the safety of their employees and others working in or visiting their premises, including patients, contractors and visitors who might be subject to moving and handling risks.

Statistically it has been recognised within the NHS, that the major cause of skeletal and muscular injuries to staff is due to inappropriate manual handling techniques, use of inadequate equipment and in some instances a disregard of good practice and local manual handling policies. It is also recognised that personal injuries to health service staff arising out of manual handling operations can impose a severe financial burden on the NHS.

This document sets out the ICB's approach to minimising the incidence of manual handling injuries within its premises and the impact of manual handling on health and wellbeing, delivery of service, the environment and property. It applies to all ICB people, functions, actions and services. It is intended for all types of healthcare buildings including those that perform administrative functions.

1.1 Status

This policy is a Health and Safety policy.

1.2 Purpose and Scope

1.2.1 The aim of this policy is to reduce the incidence of manual handling related injuries and its associated costs, provide a safer environment for staff and ensure sufficient, suitable equipment designed to reduce manual handling is available.

1.2.2 This document outlines the ICB Policy on Manual Handling which includes:

- Avoiding the need for hazardous manual handling, so far as is reasonably practicable;
- Assessing the risk of injury from any hazardous manual handling that can't be avoided; and
- Reducing the risk of injury from hazardous manual handling, so far as is reasonably practicable

1.2.3 The Policy details the responsibilities of specific individuals and groups for implementing the Policy and supporting procedures.

2. Definitions

Moving and Handling or Manual Handling is defined as any transporting or supporting of a load by hand or bodily force, and includes lifting, putting down, pushing, pulling carrying or moving. “Load” means any item or object that is being transported or supported. The definition includes the handling of a person. So, for example, the actions taken by a nurse to move a patient in a hospital, home or clinic would constitute manual handling operations, as would an office worker carrying files or equipment.

3. Policy for Moving and Handling

3.1. Risk Assessment - Manual Handling of objects

3.1.1 A risk assessment of all manual-handling activities must be undertaken before commencement of the task.

3.1.2 The purpose of a risk assessment is to carry out a systematic analysis of all the work undertaken by employees to identify manual handling operations and to ascertain which of these pose a significant risk of injury. Factors to be considered are the task, the load, the individual and the working environment including available equipment (Further information is provided in Appendix A) and a risk assessment form for assessing the manual handling of objects is provided in Appendix B.

3.2 Back Care Treatment/Occupational Health

Any ICB staff member can self-refer to the Occupational Health Service.

4. Implementation

4.1 This policy will be available to all staff

4.2 All managers are responsible for ensuring that relevant staff within the ICB have read and understood this document and are competent to carry out their duties in accordance with the procedures described.

5. Training Implications

5.1 Appropriate mandatory training in manual handling techniques will be provided to all staff. Training will be provided through ESR. Managers must ensure that staff within their area of responsibility undertake this training.

5.2 Managers must ensure that all lifting equipment is used correctly. Training in the use of equipment must be undertaken in the workplace so that staff feel safe using the equipment and it should be incorporated into the statutory training programmes provided for staff. Managers can arrange for the training to be provided in the workplace by the manufacturer or may identify a member of staff to be trained and then carry out cascade training for existing staff and any new staff. Record any advice given.

5.3 Records of training will be held by the ICB via the ESR system. Managers will be informed via ESR and an ICB nominated lead, of staff who have not attended their mandatory training. Managers should then ensure staff undertake training as soon as possible.

5.4 The frequency of manual handling training sessions is identified on the ESR system.

6. Related Documents

6.1 Other related policy documents

ICB Health and Safety Policy

6.2 Legislation and statutory requirements

- Health and Safety at Work Etc. Act 1974, HMSO.
- Management of Health and Safety at Work Regulations 1999: Approved Code of Practice, L21 HSE Books.
- Manual Handling Operations Regulations (amended 2002). Guidance on regulations (revised 1998) London. HSE Publications (as amended).
- Provision and Use of Work Equipment Regulation 1998 (PUWER): Approved Code of Practice and Guidance L22, HSE Books.
- Lifting Operations and Lifting Equipment 5. 1998 Regulations LOLER), Approved Code of Practice and Guidance L113, HSE Books.

7. Monitoring, Review and Archiving

7.1 Monitoring

The ICB Board will agree a method for monitoring the dissemination and implementation of this policy. Monitoring information will be recorded in the policy database.

7.2 Review

7.2.1 The ICB Board will ensure that this policy document is reviewed in accordance with the timescale specified at the time of approval. No policy or procedure will remain operational for a period exceeding three years without a review taking place.

7.2.2 Staff who become aware of any change which may affect a policy should advise their line manager as soon as possible. The Executive Director or nominated deputy will then consider the need to review the policy or procedure outside of the agreed timescale for revision.

7.2.3 For ease of reference for reviewers or approval bodies, changes should be noted in the ‘version control’ table on the second page of this document.

NB: If the review consists of a change to an appendix or procedure document, approval may be given by the Executive director, or nominated deputy, and a revised document may be issued. Review to the main body of the policy must always follow the original approval process.

7.3 Archiving

The ICB Board will ensure that archived copies of superseded policy documents are retained in accordance with Records Management: NHS Code of Practice 2021.

8. Equality Impact Assessment

Initial Screening Assessment (STEP 1)

As a public body organisation, we need to ensure that all our current and proposed strategies, policies, services and functions, have given proper consideration to equality, diversity and inclusion, do not aid barriers to access or generate discrimination against any protected groups under the Equality Act 2010 (Age, Disability, Gender Reassignment, Pregnancy and Maternity, Race, Religion/Belief, Sex, Sexual Orientation, Marriage and Civil Partnership).

This screening determines relevance for all new and revised strategies, policies, projects, service reviews and functions.

Completed at the earliest opportunity it will help to determine:

- The relevance of proposals and decisions to equality, diversity, cohesion and integration.
- Whether or not equality and diversity is being/has already been considered for due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED).
- Whether or not it is necessary to carry out a full Equality Impact Assessment.

Name(s) and role(s) of person completing this assessment:

Name: Lee Crowe
Job Title: Governance Manager, H&S, Fire, Security
Organisation: NECS

Title of the service/project or policy: Moving and Handling policy

Is this a;
Strategy / Policy ☒Service Review ☐ Project ☐
Other Click here to enter text.

What are the aim(s) and objectives of the service, project or policy:
The aim of the policy is to ensure ICB considers Health and Safety along with its other business objectives and to ensure that the ICB follows the details stipulated within H&S Regulations.

Who will the project/service /policy / decision impact?
(Consider the actual and potential impact)

- **Staff ☒**
- **Service User / Patients ☐**
- **Other Public Sector Organisations☐**
- **Voluntary / Community groups / Trade Unions ☐**
- **Others, please specify** Click here to enter text.

Questions	Yes	No
Could there be an existing or potential negative impact on any of the protected characteristic groups?	☐	☒
Has there been or likely to be any staff/patient/public concerns?	☐	☒
Could this piece of work affect how our services, commissioning or procurement activities are organised, provided, located and by whom?	☐	☒
Could this piece of work affect the workforce or employment practices?	☐	☒
Does the piece of work involve or have a negative impact on: • Eliminating unlawful discrimination, victimisation and harassment • Advancing quality of opportunity • Fostering good relations between protected and non-protected groups in either the workforce or community	☐	☒

If you have answered no to the above and conclude that there will not be a detrimental impact on any equality group caused by the proposed policy/project/service change, please state how you have reached that conclusion below:

The policy is a review of an existing policy and has received only minor updates. There is no fundamental change to the content therefore the previous EIA which concluded 'no impact' remains appropriate

If you have answered yes to any of the above, please now complete the 'STEP 2 Equality Impact Assessment' document

Accessible Information Standard	Yes	No
Please acknowledge you have considered the requirements of the Accessible Information Standard when communicating with staff and patients. https://www.england.nhs.uk/wp-content/uploads/2017/10/accessible-info-standard-overview-2017-18.pdf	☒	☐

Governance, ownership and approval

Please state here who has approved the actions and outcomes of the screening		
Name	**Job title**	**Date**
Claire Riley	Executive Director of Corporate Governance, Communications and Involvement	June 2022

Publishing

This screening document will act as evidence that due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED) has been given.

Schedule of Duties and Responsibilities

ICB Board	The ICB Board has delegated responsibility for setting the strategic context in which organisational process documents are developed, and for establishing a scheme of governance for the formal review and approval of such documents.
Executive Committee	The Executive Committee has delegated responsibility to the ICB Board for setting the strategic context in which organisational process documents are developed, and for establishing a scheme of governance for the formal review and approval of such documents. It is responsible for monitoring compliance with the Moving and Handling policy.
Chief Executive	The Chief Executive has overall responsibility for the strategic direction and operational management, including ensuring that ICB process documents comply with all legal, statutory and good practice guidance requirements. In addition, the Chief Executive is required to have appropriate health and safety policies and programmes of work in place in order to improve and maintain procedures within the organisation's premises.
Executive Director of Corporate Governance, Communications and Involvement	The Executive Director of Corporate Governance, Communications and Involvement is responsible for Health and Safety and will lead in: • Ensuring that moving and handling measures are implemented by agreeing a programme of action for moving and handling, setting objectives and monitoring their effectiveness and achievements. • Ensuring that managers are familiar with moving and handling procedures and implement them. • Ensuring that appropriate advice is sought from the Senior Governance Manager Commissioning Support or external agencies whenever any modification to working practices is planned. • Ensuring the generation and formulation of this policy. • Identifying the appropriate process for regular evaluation of the implementation and effectiveness of this policy. • Identifying the competencies required to implement this policy, and either identifying a training resource or approaching Workforce Learning and Development department within the Commissioning Support Organisation for assistance. • Notifying the Policy Co-Ordinator of any revisions to this document. • Arranging for superseded versions of this document to be retained in accordance with HSC 199/053 NHS Retention and Disposal Schedule.

All line managers	Heads of Service and managers are responsible for:- • Ensuring the release of staff time to undertake Manual Handling Training as set out in the Mandatory Training requirements for commencing employment and at refresher training at appropriate intervals; • Ensuring that risk assessments of manual handling activities are carried out and appropriate control measures put in place to manage the risks as far as reasonably practicable. This may include provision to provide appropriate equipment; • Enabling staff to utilise their learning from the training when back in their working environment; • Determining that all agency staff and short-term staff, prior to employment commencing manual handling activities, have received Manual Handling Training. • Identification and provision of moving and handling equipment needs through assessment and practical evaluation of equipment suitability and compatibility; • Ensuring that moving and handling equipment is maintained in a safe and serviceable working state. That its use remains appropriate to the task for which it is intended, and that relevant staff are trained and competent to operate the equipment in use in line with the Provision and Use of Work Equipment Regulations (PUWER) 1998 (7) and the Lifting Operations and Lifting Equipment Regulations (LOLER) 1998 (8); • Identification of moving and handling risks by monitoring practices, auditing department incident reports and thorough, prompt, accident investigation and reporting to the Senior Governance Officer, Health and Safety • Maintaining a list of moving and handling equipment available for staff to use, with information on where it is kept, how to access it and any loan arrangements.
All Staff	ICB employees are responsible for actively co-operating with managers in the application of this policy to enable the ICB to discharge its legal obligations and in particular; Regulation 5 of the Manual Handling Operations Regulations 1992 (as amended) states that: “Every employee while at work shall make full and proper use of any system of work provided for his use by his employer in compliance with Regulation 4(1)(b)(ii) of these regulations.” All employees already have a duty under the Health and Safety at Work Act 1974 to report any areas where they feel they are working at risk to themselves, their colleagues Shall ensure that: • They take care of their own health and safety and that of others who may be affected by their activities when involved in manual handling operations;

	• They know their role in the implementation of the Moving and Handling Policy and comply with the policy; • They participate in any training (including required updates) given in manual handling principles relevant to their work prior to undertaking any hazardous manual handling operations as part of their duty. This training is mandatory; • They are competent in the use of, and do utilise any equipment that has been provided to reduce the risk of injury in moving and handling activities or other factors relating to this activity; • They bring to their manager's attention any equipment that is needed to reduce the potential risk of injury in moving and handling operations or report any defects/problems in mechanical aids relating to this activity; • They participate in the risk assessments of hazardous moving and handling operations to determine measures to reduce the potential risk of injury; • They report any change in working conditions, personnel involved in moving and handling operations or a significant change in the nature of the task or the load that may necessitate a review of the risk assessment procedure; • They report to their managers any medical conditions (including pregnancy) that might affect their ability to undertake manual handling operations; • They report promptly to their managers any accidents and incidents resulting from moving and handling operations and complete an incident report form. They self-refer to Occupational Health if they suspect their injury resulted from a manual handling operation.

Appendix A

Further Guidance for Manual Handling Operations & the Safety of Equipment

The Manual Handling Operations Regulations 1992 (as amended) stipulates a hierarchy of strategies with regard to handling:

Avoid or eliminate hazardous manual handling operations as far as is reasonably practicable; this may be done by redesigning the task to avoid moving the load or by automating or mechanising the process.

Assess a task where manual handling cannot be avoided, in a suitable and sufficient manner; and

Reduce or control the risk as far as is reasonably practicable – particular consideration should be given to the provision of mechanical assistance, but where this is not practicable other improvements to the task, the load, and the working environment should be explored.

Inform, instruct and train (to change behaviour) employees, supported by supervision.

Review and re-assess tasks following any changes to ensure other risks are not introduced.

Good manual handling risk assessment should include the:

- Task
- Individual
- Load
- Environment

Individual Capability

NB: There are no maximum weights that anyone can safely lift as everyone's capability is different. There is a wide range of physical capability amongst the working population.

Lifting and Lowering

To obtain maximum capability when carrying out a manual handling operation that involves lifting or lowering the object should be held at waist height and close into the body. If the object is held at arm's length, below the waist or above shoulder this will result in a significant reduction in capability to safely lift or lower loads.

Equipment

It is accepted that in many cases the use of suitable handling equipment will greatly reduce the occurrence of skeletal or muscular injury. Manual handling problems can be exacerbated by inappropriate purchase of equipment, the lack of equipment, using the wrong equipment or inappropriate training in the use of the equipment.

Chairs

All NHS equipment including chairs must conform to NHS Supplies requirements with regards to fire retardancy, construction and covering.

Advice on the suitability of manual handling equipment can be obtained from the Governance Manager (Health and Safety) within North of England Commissioning Support Unit (NECS).

Appendix B

Manual Handling Risk Assessment – North East & North Cumbria ICB

Section A	
Site……Department……..	
Task description:	
Operations covered by this assessment (detailed description): Location(s): Personnel Involved (numbers, staff, contractor etc)	Control measures currently in use (e.g., deliveries brought to point of use): Equipment currently in use (e.g., trolleys, barrows, etc)

Re-assess the risk taking into consideration the control measures already in place

Likelihood of incident: Rare ☐ **(1)** Unlikely ☐ **(2)** Possible ☐ **(3)** **L**ikely ☐ **(4)** Certain ☐ **(5)**

Consequence of incident: Negligible ☐ **(1)** Minor ☐ **(2)** Moderate ☐ **(3)** Major ☐ **(4)** Catastrophic ☐ **(5)**

The numbers in the brackets are the risk score. Multiply the likelihood X consequence to achieve the risk score. **Risk score** ☐

If the risk Score is 8 or over/ consequence is 4 or 5 go to section B. If the Score is less than 8 go to section C. Sign the assessment at the end of section B

Section B - More detailed assessment, where necessary:

Questions to consider:	If yes, tick appropriate level of risk			Problem occurring from the task (Make rough notes in this column in preparation for the possible remedial action taken)	Possible remedial action (Possible changes to be made to system/task, load, workplace/space, environment. Communication that is needed)
	Low	Med	High		
The tasks - do they involve: • Holding loads away from trunk? • Twisting? • Stooping? • Reaching upwards? • Large vertical movement? • Long carrying distances? • Strenuous pushing or pulling? • Unpredictable movement of loads? • Repetitive handling? • Insufficient rest or recovery? • A work rate imposed by process?	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		
The loads - are they: • Heavy? • Bulky/unwieldy? • Difficult to grasp? • Unstable/unpredictable? • Intrinsically harmful (e.g., sharp/hot)?	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐		
The working environment - are there: • Constraints on posture? • Poor floors? • Variations in levels? • Hot/cold/humid conditions? • Strong air movements? • Poor lighting conditions? • Restricted access and egress?	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐		
Individual capability - does the job: • Require unusual capability? • Hazard those with health problem? • Hazard those who are pregnant? • Call for special information/training?	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐		
Other factors: Is movement or posture hindered by clothing or personal protective equipment**?**	Yes ☐ No☐				

Section C – Remedial action to be taken

Remedial steps that should be taken, in order of priority:	Person responsible for implementing controls	Target implementation date	Completed Y/N
1			
2			
3			
4			
5			
Date by which actions should be completed……..:			
Risk score following remedial action taken: ……..			
Assessors Name:……Signature:……Date of assessment……...			
Date for 1st review of assessment:…….Date of 2nd review……..Date of 3rd review……			

ACTIVITY

Task

YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO

Individual

YES NO YES NO YES NO YES NO YES NO

Load

YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO

Environment

YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO

Other Factor

NHS
North East &
North Cumbria

Corporate	ICBP034 - Provision of Use of Work Equipment Policy

Version Number	Date Issued	Review Date
V1	July 2022	July 2024

Prepared By:	Senior Governance Manager, NHS North of England Commissioning Support Unit
Consultation Process:	Integrated Governance Workstream
Formally Approved:	July 2022
Approved By:	ICB Board

EQUALITY IMPACT ASSESSMENT

Date	Issues
March 2022	None identified.

POLICY VALIDITY STATEMENT

Policy users should ensure that they are consulting the currently valid version of the documentation. The policy will remain valid, including during its period of review. However, the policy must be reviewed at least once in every 3-year period.

ACCESSIBLE INFORMATION STANDARDS

If you require this document in an alternative format, such as easy read, large text, braille or an alternative language please contact NECSU.comms@nhs.net

Version Control

Version	Release Date	Author	Update comments
1.0	July 2022	Senior Governance Manager, NECS	First issue

Approval

Role	Name	Date
Approver	ICB Board	July 2022

Contents

1. Introduction

The aim of this policy is to ensure that the NHS Integrated Care Board (the ICB) meets its statutory obligations in reducing the risks in relation to the provision and use of workplace equipment and any equipment used in the course of any ICB employees' daily duties.

The Provision and Use of Work Equipment Regulations 1998 (PUWER 98) are made under the Health and Safety at Work etc. Act 1974 (HSW Act) and came into force on 5 December 1998. PUWER 98 brings into effect the non-lifting aspects of the Amending Directive to the Use of Work Equipment Directive (AUWED). The primary objective of PUWER 98 is to ensure that work equipment should not result in health and safety risks, regardless of its age, condition or origin.

1.1 Status

This policy is a corporate policy.

1.2 Purpose and scope

This policy is available to all employees, volunteers contractors and any others identified as being at risk.

The purpose is to:

- Enable the ICB to provide a safe working environment;
- Ensure that the appropriate risk assessments and control measures are in place.

2. Definitions

There are no abbreviations, technical terms or acronyms within this policy.

3. Safe use of Work Equipment

3.1 Procurement

All equipment purchased for use in the ICB including work and lifting equipment, must be procured in accordance with the organisation's Standing Financial Instructions and Procurement Policy.

Equipment should be ordered via the Established Procurement Route, irrespective of the funding source. Details regarding on-going maintenance and servicing must be agreed and arranged at the time of purchase.

3.2 Equipment Risk Assessment and Suitability

There is a requirement under the Management of Health and Safety at Work Regulations 1999 (as amended) for a general risk assessment which may include:

- weather conditions and environment that the equipment is used in;
- selection of suitable work and lifting equipment and accessories for the tasks and processes that make it possible to eliminate or reduce risks;
- safety measures that can be taken to make the use of equipment safer;
- the positioning of work and lifting equipment to make it safer.

3.3 **Special Inherent Equipment Risks**

Some equipment will have a specific risk associated with it and the manager must ensure that use of that equipment is restricted to those individuals who have been trained and given the task of using it.

3.4 **Marking of Equipment Associated with Health & Safety Hazards**

Where necessary equipment should be clearly marked in respect of any aspect relating to health and safety.

4. Implementation

4.1 This policy will be available to all Staff.

4.2 All directors and managers are responsible for ensuring that relevant staff within their own directorates and departments have read and understood this document and are competent to carry out their duties in accordance with the procedures described.

5. Training Implications

It has been determined that there are no specific training requirements associated with this policy/procedure.

6. Documentation

No related documents within this policy.

7. Monitoring, Review and Archiving

7.1 **Monitoring**

The ICB Board will agree with the Senior Governance Manager CSU a method for monitoring the dissemination and implementation of this policy. Monitoring information will be recorded in the policy database.

7.2 **Review**

7.2.1 The ICB Board will ensure that this policy document is reviewed in accordance with the timescale specified at the time of approval. No policy or procedure will remain operational for a period exceeding three years without a review taking place.

7.2.2 Staff who become aware of any change which may affect a policy should advise their line manager as soon as possible. The Executive Director will then consider the need to review the policy or procedure outside of the agreed timescale for revision

7.2.3 For ease of reference for reviewers or approval bodies, changes should be noted in the 'document history' table on the front page of this document.

NB: If the review consists of a change to an appendix or procedure document, approval may be given by the Executive Director and a revised document may be issued. Review to the main body of the policy must always follow the original approval process.

7.3 **Archiving**

The ICB Board Governing Body will ensure that archived copies of superseded policy documents are retained in accordance with the NHS Records Management Code of Practice 2021.

Schedule of Duties and Responsibilities

ICB Board	The ICB Board has responsibility for setting the strategic context in which organisational process documents are developed, and for establishing a scheme of governance for the formal review and approval of such documents.
Chief Executive	The Chief Executive has overall responsibility for the strategic direction and operational management, including ensuring that ICB process documents comply with all legal, statutory and good practice guidance requirements.
Senior Governance Manager CSU	The Senior Governance Manager will advise on: • adaptions required to enable employees with a disability to commence/remain in employment, including any adaptations required for the safe use of equipment; • advising managers on any work adjustments required for the safe use of working equipment; • advise on manual handling risk assessments for the safe use of work equipment; • incidents relating to the use of work equipment.
ICB Responsibilities	The ICB will ensure that: • adequate resources are available to enable the organisation to comply with the statutory duties of the Health and Safety at Work etc. Act 1974, the Provision and Use of Work Equipment Regulations 1998, Lifting Operations and Lifting Equipment Regulations 1998; • adequate and suitable risk assessments are carried out for staff required under the Management of Health and Safety at Work Regulations 1999 and introduce control measures to eliminate or minimise the risks; • when selecting work equipment, the working conditions and the risks to the health and safety of persons which exist in the premises or how that work equipment is to be used and any additional risk posed by its use are considered; • that work equipment is so constructed installed or adapted as to be suitable for purpose for which it is used or provided; • the equipment is accompanied by suitable safety measures, e.g., protective devices, markings, warnings; • work equipment is used only for operations for which, and under conditions for which, it is suitable; • only people who have received the relevant information, instruction and training are permitted to use the equipment.

Is this meant to be a separate section or part of the above?	• work equipment is used only for operations for which, and under conditions for which, it is suitable; • only people who have received the relevant information, instruction and training are permitted to use the equipment. • An asset register of all equipment will be kept.
Managers# Responsibilities	All Managers are responsible for the health and safety of the staff, service users and workplaces. They must ensure when using equipment at work: • that appropriate training is provided; • adequate supervision is provided; • that testing, maintenance, inspection, service and calibration of equipment is in place; • all equipment is assessed to identify significant risks to employees and other persons; • control measures are implemented to eliminate or reduce risks to a minimum; • assessments and controls are recorded and reviewed; • safe working procedures are monitored and reviewed; • staff are competent to use equipment supplied for their workplace activities; • that staff are familiar with the equipment, and it's use; • appropriate statutory signs relevant to the equipment used are displayed; • Any faulty equipment is removed from service and reported.
Employee's Responsibility	All employees have a responsibility to: • only use equipment if they have had the appropriate training; • check workplace equipment prior to use; • report any defect, failure, hazard • ensure that they are familiar with any risk assessments; • use safe working procedures. • Co-operating with the development and implementation of policies and procedures and as part of their normal duties and responsibilities. • Identifying training needs in respect of policies and procedures and bringing them to the attention of their line manager. • Attending training / awareness sessions when provided. • It is the responsibility of all staff to report any defects of equipment which pose a risk to their manager.

Commissioning Support Staff.	Whilst working on behalf of the ICB CSU staff will be expected to comply with all policies, procedures and expected standards of behaviour within the ICB, however they will continue to be governed by all policies and procedures of their employing organisation.

Appendix A – Equality Impact Assessment

Initial Screening Assessment (STEP 1)

As a public body organisation, we need to ensure that all our current and proposed strategies, policies, services and functions, have given proper consideration to equality, diversity and inclusion, do not aid barriers to access or generate discrimination against any protected groups under the Equality Act 2010 (Age, Disability, Gender Reassignment, Pregnancy and Maternity, Race, Religion/Belief, Sex, Sexual Orientation, Marriage and Civil Partnership).

This screening determines relevance for all new and revised strategies, policies, projects, service reviews and functions.

Completed at the earliest opportunity it will help to determine:

- The relevance of proposals and decisions to equality, diversity, cohesion and integration.
- Whether or not equality and diversity is being/has already been considered for due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED).
- Whether or not it is necessary to carry out a full Equality Impact Assessment.

Name(s) and role(s) of person completing this assessment:

Name: Lee Crowe
Job Title: Governance Manager, H&S/Fire/Security
Organisation: NHS North of England CSU

Title of the service/project or policy: Provision of Use of Work Equipment

Is this a;
Strategy / Policy ☒Service Review ☐ Project ☐
Other Click here to enter text.

What are the aim(s) and objectives of the service, project or policy:
The aim of the policy is to ensure the ICB considers Health and Safety along with its other business objectives and to ensure that the ICB follows the details stipulated within H&S Regulations.

Who will the project/service /policy / decision impact?
(Consider the actual and potential impact)

- **Staff ☒**
- **Service User / Patients ☐**
- **Other Public Sector Organisations☐**
- **Voluntary / Community groups / Trade Unions ☐**
- **Others, please specify** Click here to enter text.

Questions	Yes	No
Could there be an existing or potential negative impact on any of the protected characteristic groups?	☒	☐
Has there been or likely to be any staff/patient/public concerns?	☐	☐

Could this piece of work affect how our services, commissioning or procurement activities are organised, provided, located and by whom?	☐	☐
Could this piece of work affect the workforce or employment practices?	☐	☐
Does the piece of work involve or have a negative impact on: • Eliminating unlawful discrimination, victimisation and harassment • Advancing quality of opportunity • Fostering good relations between protected and non-protected groups in either the workforce or community	☐	☐

If you have answered no to the above and conclude that there will not be a detrimental impact on any equality group caused by the proposed policy/project/service change, please state how you have reached that conclusion below:

Click here to enter text.

If you have answered yes to any of the above, please now complete the 'STEP 2 Equality Impact Assessment' document

Accessible Information Standard	Yes	No
Please acknowledge you have considered the requirements of the Accessible Information Standard when communicating with staff and patients. https://www.england.nhs.uk/wp-content/uploads/2017/10/accessible-info-standard-overview-2017-18.pdf	☐	☐

Governance, ownership and approval

Please state here who has approved the actions and outcomes of the screening		
Name	**Job title**	**Date**
Claire Riley	Director of Corporate Governance, Communications and Involvement	June 2022

Publishing

This screening document will act as evidence that due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED) has been given.

NHS
North East &
North Cumbria

Corporate	ICBP041 - Violence, Aggression and Abuse Management Policy

Version Number	Date Issued	Review Date
V1	July 2022	July 2024

Prepared By:	Senior Governance Manager, CSU North of England Commissioning Support Unit.
Consultation Process:	ICS Integrated Governance Workstream
Formally Approved:	July 2022
Approved By:	ICB Board

EQUALITY IMPACT ASSESSMENT

Date	Issues
March 2022	None identified.

POLICY VALIDITY STATEMENT

Policy users should ensure that they are consulting the currently valid version of the documentation. The policy will remain valid, including during its period of review. However, the policy must be reviewed at least once in every 3-year period.

ACCESSIBLE INFORMATION STANDARDS

If you require this document in an alternative format, such as easy read, large text, braille or an alternative language please contact NECSU.comms@nhs.net

Version Control

Version	Release Date	Author	Update comments
1.0	July 2022	Senior Governance Manager, NECS	First issue

Approval

Role	Name	Date
Approver	ICB Board	July 2022

Contents

1. Introduction

1.1 Scope

This policy is a corporate policy.

1.2 Purpose and Scope

1.2.1 For the purposes of this policy, the NHS Integrated Care Board will be referred to as “the ICB”.

1.2.2 The ICB aspires to the highest standards of corporate behaviour and clinical competence, to ensure that safe, fair and equitable procedures are applied to all organisational transactions, including relationships with staff and visitors and the use of public resources. In order to provide clear and consistent guidance, the ICB will develop documents to fulfil all statutory, organisational and best practice requirements and support the principles of equal opportunity for all.

1.2.3 The aim of this policy is to reduce the risks, so far as it is reasonably practicable, for staff.

1.2.4 This policy applies to all employees of the ICB and in particular deals with the issue of violence, aggression and abuse against a member of its staff by a member of the public (i.e., patient, member of the patient’s family, member of the public etc.). If a member of staff feels that they are experiencing any violence, aggression or abuse by another member of staff, they should refer to the appropriate HR policies.

1.2.5 All employees have a common law duty of care to co-operate with their employer to comply with the ICB policy.

2. Definitions

The following terms are used in this document:

2.1 Violence

The ICB define acts of violence as:
"Any incident in which a member of staff is verbally abused, threatened or assaulted by a patient or member of the public in circumstances relating to his or her employment." (Health and Safety Executive 1997)

This is a very broad definition of ‘violence’; however, it is important to acknowledge that violence can be either physical or non-physical and the two must be distinguished and recorded as different from one another.

The Counter Fraud and Security Management Service define physical assault "*the intentional or unintentional application of force to the person of another, without lawful justification, resulting in physical injury or personal discomfort*," and non-physical assault as *"the use of inappropriate words or behaviour causing distress and/or constituting harassment."*

2.2 Risk Assessment

Risk Assessment is a process of identifying what hazards exist in the workplace and how likely it is that they will cause harm to employees and others. It is the first step in deciding what prevention or control measures need to be taken to protect staff from harm.

3. Management of Violence, Aggression and Abuse

3.1 Action to Be Taken When Physical Assault Has Taken Place on a Member of Staff: (Counter Fraud and Security Management Service Guidance)

3.1.1 Line Manager and police to be contacted immediately by the person assaulted, or a relevant colleague.

3.1.2 The Director of Corporate Governance, Communications and Engagement as the nominated Executive Lead, is to be contacted as soon as practicable by the person assaulted, their line manager or a colleague, and inform the ICB Governance lead and CSU Senior Governance Manager

3.1.3 The Director of Corporate Governance, Communications and Engagement will:

- Contact, as soon as is reasonably practicable, the Senior Governance Manager CSU with specific information on the assault.
- Arrange for full co-operation to be given to police or the Senior Governance Manager CSU and any subsequent action.
- Ensure that details of the incident are recorded on the ICB's incident reporting system (SIRMS).
- Arrange for an acknowledgement of the report to be sent to the injured party and copied to the line manager to ensure that the necessary support arrangements, such as counselling and or occupational health are offered. The acknowledgement should state what action is being undertaken and the injured party should be kept informed of the progress and outcome.

- Ensure that all possible preventative action is taken to minimise the risk of a similar incident reoccurring.
- Keep the line manager appraised of situation

3.1.4 The line manager will:

- Contact the employee directly to offer support, e.g., ensure the employee is aware of the counselling facilities available and the services of the Local Security Management Specialist which is provided by a third party via the CSU.

- Offer support on an on-going basis as appropriate.

3.2 Security Management Service Action upon a physical incident occurring

3.2.1 The CSU Senior Governance will:

- Determine if the police are going to lead the investigation.

- If the police are handling the case, ensure that the case is regularly monitored as to progress, make sure the person assaulted and the ICB is kept updated, and ensure both are informed of any outcomes.

- The Crown Prosecution Service (CPS) should undertake any criminal prosecution if the police are handling the case.

- If the police are not handling the case, with the victim's consent carry out initial investigations.

- Progress the investigation, including recording all details relating to the investigation on a locally held file.

- Update the person affected by the physical assault and the nominated Executive Lead on a regular basis, as to progress and outcomes.

3.2.2 If the police are not handling the case or the Crown Prosecution Service are unwilling to undertake a criminal prosecution, CSU Senior Governance Manager will discuss with ICB, if appropriate to provide advice and guidance on viability of a private prosecution.

3.2.3 The CSU Senior Governance Manager, if appropriate, will advise on the viability of civil proceedings consultation with the ICB and the person(s) subjected to the assault.

The procedure(s) for implementing this policy document are as follows:

- Managers to follow advice and guidance provided in Appendix B-G

3.3 Action Following Acts of Violence

3.3.1 Members of staff carrying out the act of violence.

Where a member of staff is alleged to have carried out an act of violence, abuse or aggression this will be considered under the ICB Disciplinary policies and procedures.

Where the patient, member of the public or relative initiates the complaint then the ICB Complaints Policy may also be invoked.

3.3.2 Patients, relatives or members of the public who carry out the act of violence

Where a patient, relative or member of the public is alleged to have carried out an act of violence, abuse or aggression then the ICB reserves the right to respond to the alleged incident, as deemed necessary in light of the circumstances. The level of response will be dependent upon the seriousness of the incident. The potential responses or actions available to the ICB include:

- verbal warnings
- written warnings from the Chief Executive
- police presence at consultations
- criminal prosecution
- civil prosecution

4. Implementation

4.1 This policy will be available to all staff.

4.2 All managers are responsible for ensuring that relevant staff within the ICB have read and understood this document and are competent to carry out their duties in accordance with the procedures described.

5. Training Implications

The training required to comply with this policy are:

All Managers must ensure that staff attend necessary events e.g.

- Conflict Resolution Training where required

6. Related Documents

6.1 Other related policy documents

- Complaints Policy
- Incident Reporting and Management Policy
- Serious Incidents (SIs) Management Policy
- SOP Lone Worker
- Bullying and Harassment Policy
- Grievance Policy

6.2 Legislation and statutory requirements

- Cabinet Office (1974) *Health & Safety at Work Etc. Act 1974*. London. HMSO.
- Cabinet Office (1998) *Human Rights Act 1998*. London. HMSO.
- Cabinet Office (1999*) Management of Health & Safety at Work Regulations 1999*. London. HMSO.
- Cabinet Office (2001) *Freedom of Information Act 2001*. London. HMSO.
- Cabinet Office (2006) *Equality Act 2006*. London. HMSO.
- Cabinet Office (2007) *Corporate Manslaughter and Corporate Homicide Act 2007*. London. HMSO
- Cabinet Office (2008*) Health & Safety Offences Act 2008 Amends Section 33 (Prosecutions for criminal offences) of the Health and Safety at Work Act 1974.* London. HMSO.

7. Monitoring, Review and Archiving

7.1 Monitoring

The ICB Board will agree a method for monitoring the dissemination and implementation of this policy. Monitoring information will be recorded in the policy database.

7.2 Review

7.2.1 The ICB board will ensure that this policy document is reviewed in accordance with the timescale specified at the time of approval. No policy or procedure will remain operational for a period exceeding three years without a review taking place.

7.2.2 Staff who become aware of any change including legislative change which may affect a policy should advise their line manager as soon as possible. The Executive Director will then consider the need to review the policy or procedure outside of the agreed timescale for revision.

7.2.3 For ease of reference for reviewers or approval bodies, changes should be noted in the 'version control' table on the second page of this document.

NB: If the review consists of a change to an appendix or procedure document, approval may be given by the Executive Director and a revised document may be issued. Review to the main body of the policy must always follow the original approval process.

7.3 Archiving

The ICB Board will ensure that archived copies of superseded policy documents are retained in accordance with Records Management: NHS Code of Practice 2021.

8. Equality Impact Assessment

Initial Screening Assessment (STEP 1)

As a public body organisation, we need to ensure that all our current and proposed strategies, policies, services and functions, have given proper consideration to equality, diversity and inclusion, do not aid barriers to access or generate discrimination against any protected groups under the Equality Act 2010 (Age, Disability, Gender Reassignment, Pregnancy and Maternity, Race, Religion/Belief, Sex, Sexual Orientation, Marriage and Civil Partnership).

This screening determines relevance for all new and revised strategies, policies, projects, service reviews and functions.

Completed at the earliest opportunity it will help to determine:

- The relevance of proposals and decisions to equality, diversity, cohesion and integration.
- Whether or not equality and diversity is being/has already been considered for due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED).
- Whether or not it is necessary to carry out a full Equality Impact Assessment.

Name(s) and role(s) of person completing this assessment:

Name: Lee Crowe
Job Title: Governance Manager, H&S/Fire/Security
Organisation: NECS

Title of the service/project or policy: Violence Aggression and Abuse Management policy

Is this a;
Strategy / Policy ☒Service Review ☐ Project ☐
Other Click here to enter text.

What are the aim(s) and objectives of the service, project or policy:
The aim of the policy is to ensure ICB considers Health and Safety along with its other business objectives and to ensure that the ICB follows the details stipulated within H&S Regulations.

Who will the project/service /policy / decision impact?
(Consider the actual and potential impact)

- **Staff ☒**
- **Service User / Patients ☐**
- **Other Public Sector Organisations☐**
- **Voluntary / Community groups / Trade Unions ☐**
- **Others, please specify** Click here to enter text.

Questions	Yes	No
Could there be an existing or potential negative impact on any of the protected characteristic groups?	☐	☒
Has there been or likely to be any staff/patient/public concerns?	☐	☒
Could this piece of work affect how our services, commissioning or procurement activities are organised, provided, located and by whom?	☐	☒
Could this piece of work affect the workforce or employment practices?	☐	☒
Does the piece of work involve or have a negative impact on: • Eliminating unlawful discrimination, victimisation and harassment • Advancing quality of opportunity • Fostering good relations between protected and non-protected groups in either the workforce or community	☐	☒

If you have answered no to the above and conclude that there will not be a detrimental impact on any equality group caused by the proposed policy/project/service change, please state how you have reached that conclusion below:

The procedure is a review of an existing procedure and has received only minor updates. There is no fundamental change to the content therefore the previous EIA which concluded 'no impact' remains appropriate.

If you have answered yes to any of the above, please now complete the 'STEP 2 Equality Impact Assessment' document

Accessible Information Standard	Yes	No
Please acknowledge you have considered the requirements of the Accessible Information Standard when communicating with staff and patients. https://www.england.nhs.uk/wp-content/uploads/2017/10/accessible-info-standard-overview-2017-18.pdf	☒	☐

Governance, ownership and approval

Please state here who has approved the actions and outcomes of the screening		
Name	**Job title**	**Date**
Claire Riley	Executive Director of Corporate Governance, Communications & Involvement	June 2022

Publishing

This screening document will act as evidence that due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED) has been given.

Appendix A

Schedule of Duties and Responsibilities

ICB Board	The ICB Board has responsibility for setting the strategic context in which organisational process documents are developed, and for establishing a scheme of governance for the formal review and approval of such documents.
Executive Committee	The Executive Committee has delegated responsibility from the ICB Board for the development, review, approval and monitoring of organisational process documents (such as policies). It is responsible for monitoring compliance with the Violence, Aggression and Abuse policy. It will ensure that any issues of significant risk are actioned appropriately.
Chief Executive	The Chief Executive has overall responsibility for the strategic direction and operational management, including ensuring that ICB process documents comply with all legal, statutory and good practice guidance requirements.
Director of Corporate Governance, Communications and Engagement	The Director of Corporate Governance, Communications and Engagement as Executive Lead has responsibility for health and safety and will ensure that appropriate strategies and systems are in place to manage the ICB's health and safety risks and will act as the lead person on security management work in conjunctions with CSU Senior Governance Manager. • As soon as is reasonably practicable contact the CSU Senior Governance Manager with specific information on the assault. • Ensure that the actions described in Appendix A & B are carried out. • Ensure any necessary documentation in relation to incidents is carried out.

All Managers	All managers are responsible for: • Implementing this policy, the management of violence, aggression and abuse and reviewing them accordingly. • Ensuring that staff receive the necessary training, including conflict resolution training, relevant to the level of identified risk. • Managing any incidents or staff concerns that are reported to them. • Ensuring that violence and aggression hazards are adequately identified, and relevant control measures put in place. • Ensuring employees are involved in or aware of risk assessments. • Maintaining an awareness of advice and the support available to reduce the risk. • Ensuring that employees are aware of available means of advice and support. • Taking all reasonable steps to reduce the risk of both physical and non-physical assault. • Ensuring appropriate contact is maintained with the employee following an incident. • Ensuring that the employee is aware of counselling services available and refer the employee where appropriate. • Giving serious consideration to the concerns of employees. • Ensuring that all incidents of physical and non- physical assault are reported in line with the Counter Fraud and Security Management Service guidance, including notifying the Executive lead. See Appendix 2. • Ensuring that potential violent/aggressive visitors are highlighted to staff, other Team Managers and where appropriate, other partner agencies.
All Staff	All staff, including temporary and agency staff, are responsible for: • Compliance with relevant process documents such as lone working. Failure to comply may result in disciplinary action being taken. • Co-operating with the development and implementation of policies and procedures and as part of their normal duties and responsibilities. • Identifying the need for a change in policy or procedure as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and advising their line manager accordingly. • Identifying training needs in respect of policies and procedures and bringing them to the attention of their line manager. • Attending training / awareness sessions when provided.

Appendix B

Action to be taken when physical assault has taken place on a member of staff

1. Police to be contacted immediately by the person assaulted their manager or relevant colleague.

2. The nominated Executive lead for the ICB is to be contacted as soon as practicable by the person assaulted, their line manager or a colleague, and inform the ICB Risk Lead.

3. The nominated Executive lead will:

   - contact, as soon as is reasonably practicable the CSU Senior Governance Manager with specific information on the assault.

   - arrange for full co-operation to be given to police or the CSU Senior Governance Manager and any subsequent action.

   - ensure those details of the incident are recorded on the ICB's risk management recording system.

   - arrange for an acknowledgement of the report to be sent to the injured party and copied to the line manager to ensure that the necessary support arrangements, such as counselling and or occupational health are offered. The acknowledgement should state what action is being undertaken and the injured party should be kept informed of the progress and outcome.

   - ensure that all possible preventive action is taken to minimise the risk of a similar incident reoccurring.

   - keep the line manager informed of the on-going Local Security Management Specialist's situation.

4. The line manager will:

   - contact the employee directly to offer support, e.g., ensure the employee is aware of the counselling facilities available and the services of the Local Security Management Specialist.

   - offer support on an on-going basis as appropriate.

Security Management Service Action upon a physical incident occurring provided by CSU

The Local Security Management Specialist will:

- determine if the police are going to lead the investigation.

- if the police are handling the case, ensure that the case is regularly monitored as to progress, make sure the person assaulted and the ICB is kept updated, and ensure both are informed of any outcomes.

- The Crown Prosecution Service (CPS) should undertake any criminal prosecution if the police are handling the case.

- If the police are not handling the case, carry out initial investigations in conjunction with the Counter Fraud and Security Management Service's Legal Protection Unit.

- Progress the investigation with all speed, including recording all details relating to the investigation on a locally held file (using the standards in the CFSMS OS Manual of Guidance).

- Update the person affected by the physical assault and the nominated Executive lead of Security Management of the ICB on a regular basis, as to progress and outcomes.

If the police are not handling the case or the Crown Prosecution Service are unwilling to undertake a criminal prosecution, then the Counter Fraud and Security Management Service's Legal Protection Unit will, if appropriate, consider a private prosecution.

NHS Protect Legal Protection Unit, if appropriate, will consider civil proceedings consultation with the ICB and the person(s) subjected to the assault.

Appendix C

Action to be taken when a Non-Physical Assault has taken place

- where appropriate the police should be contacted, as soon as is practicable, by the person subject to the non-physical assault, their manager or relevant colleague.

- the seriousness of the incident should be taken into account in deciding whether the police should be involved, but where the incident is believed to fall into a racially or religious aggravated matter, then the incident should always be reported to the police.

- the police should be given information about the assailant's clinical condition (if known), if this could be seen as a contributory factor leading to the non-physical assault taking place, however, the presence of a clinical condition should not necessarily preclude appropriate action being taken. This should be a matter for the police and/or the ICB.

- the nominated Executive lead for the ICB must be contacted, as soon as practicable, by the person suffering the abuse, their manager or relevant colleague.

The nominated Executive lead the ICB will:

- liaise, co-operate with and monitor cases of non-physical assault that have been referred to and are being handled by the police.

- where the matter has been reported to the police and the police have decided not to pursue the matter, consider whether the ICB should consider/initiate private prosecution and/or civil proceedings via the ICB's Legal Service, where appropriate.

- ensure that details of the incident are recorded on the ICB's appropriate incident reporting system to comply with Health and Safety legislation.

- ensure that an acknowledgement of the report is sent to the injured party and ensure that any necessary support arrangements, such as counselling or occupational health are offered. The acknowledgement should state that the matter will be dealt with, that appropriate action will be taken and that the particular member of staff will be appraised of progress and outcome.

- ensure the person subject to the non-physical assault is informed of the outcome of any action taken

Appendix D

Advice/Guidance for Managers

This guide will not provide an answer to every situation, and your own experience will be a crucial factor along with following the Policy in deciding appropriate action. It will, however, hopefully increase awareness of the problem and provide practical advice.

Why Must I Take Action?

Legislation

- The Health and Safety at Work Etc. Act 1974 requires employers to take reasonable steps to ensure the health, safety and welfare of their employees while at work
- The Management of Health and Safety at Work Regulations 1999 specifically requires the assessment of risks to employees

Efficiency

The effects of violence can have serious operational costs and include: -

- Sickness absence
- Impaired performance
- De-motivation of other employees
- Negative effect on other stakeholders

Responsibility

- As a manager, you are the employer's representative and thereby charged with the execution of the employer's responsibilities within your area of control.

What Action Should I Take?

In considering what action to take, never accept violence as "part of the job".

Assess the Risk

- Ensure a personal/Team risk assessment has been carried out please refer to ICB H&S Risk Assessment SOP
- Consider the individual employee:
  - Perpetrators being reported to appropriate authorities i.e., police
  - Previous training/experience
  - Previous incidents
- Monitor and analyse reported incidents

Reduce the Risk

In reducing the risk, several factors need to be considered.

Employees

- Ensure that employees where applicable have provided with relevant training and have access to a copy of this policy and the employee guidance at Appendix D.
- Consider training needs in the light of the level of risk faced.
- Be willing always to offer support and advice and sources of advice (Health and Safety Team, Local Security Management Specialist, Police) and ensure that you communicate this to employees.
- Never dismiss or ignore signs of apprehension.
- Ensure that employees are aware that they are advised to leave dangerous situations even when their task is not completed.
- Encourage staff to adopt a “Customer First” approach, but never put themselves at risk.
- Assist employees in developing action plans (not necessarily a written document but an understanding of what to do in particular situations).
- Ensure that employees are aware of their responsibilities in supporting colleagues.
- Watch out for signs of bullying/intimidation.

Working Methods

- Arrange appointment times to minimise risk:
  - morning meetings where alcohol abuse is a potential problem
  - avoid overlong delays by providing sufficient interval between appointments
- Minimise staff isolation in dangerous situations:
  - limit visits to those, which are unavoidable
  - arrange for employees to work in pairs in potentially dangerous situations
- Ensure staff use the lone worker system in operation at the ICB and abide by any risk assessments and local procedures.

Location

- Arrange interview areas to provide an easy escape route and ready support/back-up
- Eliminate potential weapons wherever possible (any loose/moveable object is a potential weapon)
- Ensure that any reception/waiting areas are designed to minimise frustration e.g.:
  - comfortable seating
  - soothing colours
  - magazines etc.
- Ensure adequate lighting in and around buildings
- Restrict public access to necessary areas
- Provide door answering safeguards (e.g., viewers, chains, C.C.T.V.) where appropriate

- Utilise sources of advice on environmental issues e.g., Local Security Management Specialist
- Consider alternative locations for the provision of care where necessary

What Should I Do If an Incident Occurs?

Immediately

- In all cases the victim should be treated with sensitivity and offered support by managers and colleagues. Where particular anguish/trauma has been suffered, they should be advised of the availability of counselling from their General Practitioner or Occupational Health.
- Ensure that the victim is not blamed for contributing to the incident (self-blame is particularly common amongst victims of violence). Where you consider that the victim's actions may have contributed, this should be dealt with as a training and development issue and not through criticism.
- Call for professional medical help, if necessary.
- Follow the procedure laid down on the policy and where necessary contact the police if an assault has taken place.

Follow Up

- At the earliest opportunity, ensure that any incidents are reported on the ICB's Incident Reporting System (SIRMS)
- Ensure and check that the incident is investigated appropriately.
- In more serious cases, discuss with the individual whether he/she feels able to return to particular work situations and consider what, if any, support, advice or training might be beneficial.
- In cases of harassment at work. Advisors are available to provide counselling for the victim.

When an employee suffers actual physical injury, he/she might be entitled to compensation through the Criminal Injuries Compensation Authority. The employee can apply for such compensation by visiting www.gov.uk/claim-compenstation-criminal-injury

Appendix E

Advice/Guidance for Employees

Although this information cannot provide a precise answer to every situation, it should help to create a greater awareness of the problem as well as offering some practical advice.

Before the encounter

Assess the risk
Look for factors which might indicate a high level of risk and require specific action. Some “high risk” indicators are listed below:

The Client (the potential assailant)

- background unknown/authenticity unsure
- history of violence (the most important factor)
- history of alcohol/drug abuse
- previous threats (always take these seriously)
- perceived victimisation (feelings of having been let down during previous dealings)
- unrealistic expectations (likely to be severely disappointed by what you have to say)
- change/uncertainty
- high level of stress (e.g., the loss of a close family member, home, job etc.)

You (the potential victim)

- close ongoing relationship with the individual
- seen as the source of his/her frustration
- apprehension (this can increase the level of tension. Understanding the risk and taking steps to protect yourself can greatly reduce it)
- visits away from the work base
- male/female (both are vulnerable – women can be seen as easier targets - men more legitimate ones)
- Do not ignore your own signs of apprehension (instinct, intuition)

Absence of these signs does NOT guarantee your safety

Take Action
Take basic precautions and where the level of risk appears to be high, take specific preventative measures as identified in the risk assessment and use the lone worker SOP.

Basic precautions

- be sure that the customer/client is genuine before agreeing a visit
- when carrying out visits always leave a record of:
    - *Where* you’re going - details – address etc
    - *Who* you’re going to see
    - *Why* you’re going (purpose of the visit)

    - *When* you expect to return
- If you don't intend to return to base, arrange to contact someone and use and regularly update the lone worker system.
- consider your escape route
- consider the level of risk and decide whether specific action is necessary

Specific preventative measures

- discuss concerns with your manager
- request support/backup where necessary
- maintain contact on visits (by the lone worker system and phone)
- if risks are unacceptable, see the customer/client at work where support is more easily provided
- if meetings are likely to carry unacceptable risks, restrict/ control contact
- arrange morning meetings where there is a history of alcohol abuse.
- if a meeting takes place at work, ensure no loose objects can be used as weapons
- arrange seating to allow escape in cases of emergency

During the encounter

Assess the risk

Look for signs of high risk and watch out for danger signals.

High Risk Indicators

- any unexpected person
- effect of alcohol/drugs
- potential weapons (loose movable objects are potential weapons)
- frustration caused by circumstances immediately before the encounter e.g.
    - long delays
    - noisy/crowded waiting areas
    - re-direction from one place to another
- isolation - no colleagues nearby

Danger Signals (in the potential assailant)

These signals can be equally relevant whether given in a quiet, calm tone or shouted in an angry manner –

Appearance:

- tearful
- sweating
- restless
- staring - eyeball to eyeball confrontation
- pale skin
- obvious facial muscle tension

Posture:

- bodily nearness
- towering/threatening stance
- clenched hands
- folded arms

Speech:

- changed in tone, volume or pitch
- use of insults, threats or sarcasm, in particular, use of de-personalising language
- (sexist/racist abuse and foul language)
- repetition of the same word or phrase

Victim Support & Counselling

Support should be offered by your direct line manager. This can include signposting to counselling services and/or practical support such as help in seeking medical attention, contacting family or friends, providing an opportunity to discuss the incident and offering support during the investigation.

In cases where you have suffered particular anguish or trauma, your line manager may advise you to seek counselling from your General Practitioner, the Occupational Health service or an external counselling service.

Appendix F

Requirements for Reporting Incidents

All incidents, covered by the definition of violence, whether physical or non-physical, must be recorded on the ICB's Incident Reporting Management System.

They must also be reported to the Police, where appropriate.

The legal requirement for reporting incidents falls under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR). These incidents would be reported by the CSU Senior Governance Manager on behalf of the ICB

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995

There is a legal requirement under RIDDOR 1995 to report certain specified work- related incidents, either to the enforcing authority for the workplace or to a central HSE reporting centre.

Accident/Incident Reporting

RIDDOR requires the specified responsible person, usually employers, to report certain defined work-related accidents or incidents to the enforcing authority. In summary, the accidents or incidents that are required to be reported include:

- all fatalities
- accidents resulting in any of the specified "major injuries"
- certain defined work-related diseases
- accidents resulting in employees being off work for more than three days
- certain dangerous occurrences such as building collapses, gas explosions, etc.

The accidents have to be reported to the Health and Safety Executive by the quickest means within 10 days

How to make a report:

Guidance on how to report a RIDDOR incident can be obtained from the CSU Governance Team via necsu.healthandsafety@nhs.net

Reporting Death or Major Injury

In the event of an accident arising out of a work activity which results in:

- the death or major injury to an employee or self-employed person on work premises;
- the death of a member of the public; or
- a member of the public being taken to hospital

then a report must be made to the police and the HSE Incident Contact Centre further guidance would be provided by the CSU Senior Governance Manager/LSMS.

Where the nature and severity of an injury is not immediately apparent, the report required shall be submitted as soon as the nature of the condition is confirmed.

Deaths to be reported include those where an employee dies within one year as a result of an accident at work, whether or not this was reported at the time of the original accident.

Major injuries are defined by reference to schedule 1 of the regulations to include:

- fractures other than fingers, thumbs and toes
- amputation (including surgical amputation following and accident)
- dislocation of shoulder, hip, knee or spine
- eye injury resulting in temporary or permanent loss of sight, by chemical or hot metal burn, or penetrating injury
- unconsciousness caused by electric shock, exposure to a hazardous substance, biological agent, or asphyxia
- any acute condition or illness resulting in loss of consciousness or requiring resuscitation or admission to hospital for more than 24 hours
- illness requiring medical treatment related to exposure to a hazardous substance.

Reporting Lost Time Injuries (over 7 day absence)

In the event of an accident arising out of a work activity which results in the incapacity of an employee (or self-employed person working on the premises) for more than seven consecutive days, then a report must be made, by one of the methods described above, within ten days.

Three consecutive days does NOT include the day of the accident, but includes:

- any day on which the person was unable to fulfil his/her normal work duties
- weekends and days not normally worked when the injured person was incapacitated.

This includes any act of non-consensual physical violence done to a person at work. For full information on RIDDOR 1995 consult the guidance notes and regulations.

NHS
North East &
North Cumbria

Corporate	ICBP046 - Serious Incidents Management Policy

Version Number	Date Issued	Review Date
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Prepared By:	Senior Manager, Clinical Quality, NECS
Consultation Process:	Integrated Governance Workstream ICB Chief Nurse ICB Medical Director
Formally Approved:	July 2022
Approved By:	ICB Board

EQUALITY IMPACT ASSESSMENT

Date	Issues
March 2022	None

POLICY VALIDITY STATEMENT

Policy users should ensure that they are consulting the currently valid version of the documentation. The policy will remain valid, including during its period of review. However, the policy must be reviewed at least once in every 3-year period.

ACCESSIBLE INFORMATION STANDARDS

If you require this document in an alternative format, such as easy read, large text, braille or an alternative language please contact NECSU.Comms@nhs.net

Version Control

Version	Release Date	Author	Update comments
1	July 2022	Senior Manager, Clinical Quality, NECS	Not Applicable. First Issue

Approval

Role	Name	Date
Approver	ICB Board	July 2022

Contents

7. Introduction

The Integrated Care Board (ICB) aspires to the highest standards of corporate behaviour and clinical competence, to ensure that safe, fair and equitable procedures are applied to all organisational transactions, including relationships with patients their carers, public, staff, stakeholders and the use of public resources. In order to provide clear and consistent guidance, the ICB will develop documents to fulfil all statutory, organisational and best practice requirements and support the principles of equal opportunity for all.

The NHS treats over one million patients every single day. The vast majority of patients receive high standards of care however incidents do occur, and it is important they are reported and managed effectively.

The ICB as commissioners of care seek to assure that all services which may be commissioned meet nationally identified standards, which are managed through the local contracting process. Compliance with Serious Incident (SI) and Never Event (NE) reporting is a standard clause in all contracts and service level agreements as part of a quality schedule.

The role of the ICB as commissioners is to gain assurance that incidents are properly investigated, that action is taken to improve clinical quality, and that lessons are learned in order to minimise the risk of similar incidents occurring in the future. It is intended that intelligence gained from SIs will be used to influence quality and patient safety standards for care pathway development, service specifications and contract monitoring.

The revised policy is intended to reflect the responsibilities and actions for dealing with SIs and NEs and the tools available.

It outlines the process and procedures to ensure that SIs and NEs are identified, investigated and learned from as set out in the Serious Incident Framework 2015 and the revised Never Events policy and framework 2018.

7.1 Status

This policy is a corporate policy.

7.2 Purpose and scope

1.2.1 The purpose of this policy is to identify what is meant by a SI or NE and to describe the role of the ICB when a SI or NE occurs across a number of organisations.

This policy aims to ensure that the ICB in its commissioner role complies with current legislation and current national guidance from NHS England, in particular the reporting, notifying, managing and investigating SIs and NEs.

1.2.2 This policy applies to all employees of the ICB and is recommended for adoption by independent contractors e.g., GPs, Dental Practitioners, Optometrists and Pharmacists.

1.2.3 All NHS providers including Independent Healthcare Sector providers, where NHS services are commissioned, need to comply with the ICB reporting requirements within this policy, which reflects the Serious Incident Framework 2015 and the Never Events policy and framework 2018

8. Definitions

The following terms are used in this document:

2.1 Definition of a Serious Incident & Never Event

2.1.1 Serious incidents (SIs) are events in health care where the potential for learning is so great, or the consequences to patient, families and carers, staff or organisations are so significant that they warrant our particular attention to ensure these incidents are identified correctly, investigated thoroughly and most importantly, learned from to prevent the likelihood of similar incidents happening again. SIs can extend beyond incidents that affect patients directly and include incidents that may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare. SIs can be isolated, single events or multiple linked or unlinked events signalling systemic failures within a commissioning or health system. NHS England has produced an information resource to support the reporting and management of serious incidents which can be found in The SI Framework and supporting appendices (Appendix 1).

2.1.2 Whilst the definition of a SI is quite broad, the following criteria outline the type of incidents which should be included:

1. Unexpected or avoidable death of one or more people. This includes:
   - Suicide/self-inflicted death
   - Homicide by a person in receipt of mental health care within the recent past

2. Unexpected or avoidable injury to one or more people that has resulted in serious harm.

3. Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent:

- The death of the service user
- Serious harm
- Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment or acts of omissions which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery.

4. Never Events - all Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death. Further information can be found in Appendix 1
5. An incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following:

    - Failures in the security, integrity, accuracy or availability of information often described as data loss and/or information governance related issues (see Appendix 3 for further information);
    - Property damage
    - Security breach/concern, Article 4 (12) of the General Data Protection Regulations "Personal data breach" means a breach of security leading to the accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to, personal data transmitted, stored or otherwise processed.
    - Cyber incidents: The Security of Network and Information Systems Directive ("NIS Directive") requires reporting of relevant incidents to the Department of Health and Social Care (DHSC) as the competent authority from 10 May 2018.
    - Incidents in population-wide healthcare activities such as screening or immunisation programmes where the potential for harm may extend to a large population;
    - Inappropriate enforcement/care under the Mental Health Act (1983),the Mental Capacity Act (2005) and Mental Capacity (Amendment) Act 2019: including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS or Liberty Protection Safeguards (LPS) when these come into effect replacing DOLS in 2022
    - Systematic failure to provide an acceptable standard of safe care (this may include incidents, or series of incidents, which necessitate ward/ unit closure or suspension of services); or
    - Activation of Major Incident Plan (by provider, commissioner or relevant agency)

6. Major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or

an organisation.

All potential commissioner or independent contractor SIs should be reported on the Safeguard Incident & Risk Management System (SIRMS) in the first instance to be triaged for escalation via Strategic Executive Information System (StEIS), Data Security and Protection Toolkit, CareCERT etc

2.2 Working with other Organisations/Sectors

2.2.1 *Deaths in Custody*

People in custody, including those detained under the Mental Health Act (1983) or those detained under the police and justice system, are owed a duty of care by relevant authorities. The obligation on the authorities to account for the treatment of an individual is particularly stringent when that individual dies.

Any death in prison or police custody will be referred to the Prison and Probation Ombudsman (PPO) or the Independent Police Complaints Commission (IPCC) who are responsible for carrying out the relevant investigations. Healthcare providers must fully support these investigations where required to do so.

In NHS Mental Health services, providers must ensure that any death of a patient detained under the Mental Health Act (1983) is reported to the CQC without delay. However, providers are responsible for ensuring that there is an appropriate investigation into the death of a patient detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies. In circumstances where the cause of the death is unknown and/or where there is reason to believe the death may have been avoidable or unexpected then the death must be reported to the provider's commissioner(s) as an SI and investigated appropriately.

Where the deceased is subject to a Deprivation of Liberty Safeguards (DoLS) authorisation, the coroner must always be informed, whether the death was expected or not, a coroner's officer will attend.

2.2.2 *Serious Case Reviews and Safeguarding Adult Reviews*

The Local Safeguarding Children Partnerships have the statutory responsibility to commission a Child Safeguarding Practice Review when specific criteria are met. The Local Safeguarding Adult Board now has a statutory responsibility to commission a Safeguarding Adult Review in certain circumstances.

Healthcare providers must contribute towards safeguarding reviews as requested to do so by the Local Safeguarding Partnership/Board where it is indicated that a serious incident has occurred. ICB Safeguarding Designated Professionals will provide health leadership to review processes at a local 'Place' level.

The interface between the serious incident process and local safeguarding policies must therefore be articulated in the local multi-agency safeguarding policy and protocol.

Further details on the procedure for the reporting and management of safeguarding children/adults incidents can be found in Appendix 2.

2.2.3 Domestic Homicide Reviews

Where a Domestic Homicide is identified by the police, the Community Safety Partnership (CSP) will consider whether the case meets the criteria for a Domestic Homicide Review (DHR). Healthcare providers must co-operate in this process. ICB Safeguarding Designated Professionals will provide health leadership to review processes.

2.2.4 *Homicide by patients in receipt of mental health care*

Where patients in receipt of mental health services commit a homicide, NHS England will consider and, if appropriate, commission and investigation. This process is overseen by NHS England's Regional investigation teams.

2.2.5 *Serious Incidents in National Screening Programmes*

There are a number of immunisation or screening programmes which require a broader approach to handling incidents. NHS England is responsible for the commissioning of local NHS screening services and retain responsibility for the sign-off of any SIs reported by providers in this area.

Further details on resources and guidance the management of incidents within the screening programme can be found at:

https://www.gov.uk/government/publications/managing-safety-incidents-in-nhs-screening-programmes

2.3 Information Governance and Cyber Security Serious Incidents requiring Investigation

The General Data Protection Regulation (GDPR)/UK Data Protection Bill imposes legal obligations on controllers to comply with the requirement to report specific breaches to the Information Commissioner's Office (ICO) without undue delay and no later than 72 hours of becoming aware of such a breach, where the breach is likely to result in a risk to the rights and freedoms of individuals.

The GDPR/UK Data Protection Bill requires that a controller informs individuals affected by a breach of their personal data of the breach without undue delay,

where the breach is likely to result in a risk to the rights and freedoms of individuals.

Any incident involving the actual or potential loss of personal information that involves a high risk to the rights and freedoms of individuals should be considered as potentially serious and advice should be sought from the IG service.

Where an IG incident impacts upon a patient's rights and freedoms it must be reported to the Clinical Quality team so they can report it through the STEIS system as soon as possible (and no later than 24 hrs. after the incident during the working week). These must be categorised in STEIS using the "Confidential Information Leak/IG Breach" category. NHS England is responsible for notifying the Department of Health of any category 3-5 incident and will do this as soon as possible after they have been made aware of such an incident (either through STEIS or other means).

There is no simple definition of an information governance serious incident. The scope of an Information Governance Serious Incident may include:

- Breach of one of the principles of the Data Protection Act and/or the Common Law Duty of Confidentiality, or the General Data Protection Regulations.
- Unlawful disclosure or misuse of confidential data, recording or sharing of inaccurate data, information security breaches and inappropriate invasion of people's privacy.
- Personal data breaches which could lead to identity fraud or have other significant impact on individuals.

There are many possible definitions of what a Cyber incident is, for the purposes of reporting the definition is anything that could (or has) compromised information assets within Cyberspace. "Cyberspace is an interactive domain made up of digital networks that is used to store, modify and communicate information. It includes the internet, but also the other information systems that support a businesses, infrastructure and services."

These types of incidents could include:

- Phishing emails
- Denial of Service attacks
- Social Media Disclosures
- Web site defacement
- Malicious Internal damage
- Spoof website
- Cyber Bullying

NHS Digital has provided guidance for how SIs relating to information governance and cyber security should be dealt with and should be embedded within local process and procedures. The full guidance is accessible at https://www.dsptoolkit.nhs.uk/Help/29

Individual organisations are responsible for following NHS Digital's Guide to the notification of data security and protection incidents. Incidents which score Level 2 or above must be reported centrally via the Information Governance Toolkit. If a CCG is unsure of the level of the incident, further guidance can be sought from the Commissioning Support Unit's Information Governance Team.

Breach reporting is now mandatory for all organisations. Notification and subject communication requirements will include breaches that organisations might not have notified under the previous data protection regime. The traditional view that a data breach is only reportable when data falls into the wrong hands is now replaced by a concept of a risk to rights and freedoms of individuals under Article 33 of GDPR. Any security breach that creates a risk to the rights and freedoms of the individual is a personal data breach and could be notifiable to the ICO if it reaches a certain threshold. Any personal data breach that could create a significant risk to the rights and freedoms of an individual must be notified to the Information Commissioner via this reporting tool. All personal data breaches will involve a breach of security at some point in the processing and the additional use of this tool for NIS incident reporting will save the health and social care sector time and effort in reporting.

Any incident must be graded according to the significance of the breach and the likelihood of those serious consequences occurring. The incident must be graded according to the impact on the individual or groups of individuals and not the organisation. It is advisable that incidents are reviewed by the Data Protection Officer or Caldicott Guardian or the Senior Information Risk Owner when determining what the significance and likelihood a data breach will be. The significance is further graded rating the incident of a scale of 1-5. 1 being the lowest and 5 the highest. The likelihood of the consequences occurring are graded on a scale of 1-5, 1 being a non-occurrence and 5 indicating that it has occurred.

Where the personal data breach relates to vulnerable group in society, as defined below, the minimum score will be a 2 in either significance or likelihood unless the incident has been contained. This will have the effect of automatically informing the Information Commissioner if one of the other axes scores above a 3. Further guidance can be sought from the Commissioning Support Unit's information governance team.

Consideration should always be given to informing patients/service users when person identifiable information about them has been lost or inappropriately placed in the public domain.

Loss of encrypted media should not be reported as an SI unless the data controller has reason to believe that the encryption did not meet the Department of Health Standards that the protections had been broken or were improperly applied.

https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/data-security-and-protection-toolkit

2.4 Serious Incidents involving controlled drugs.

SIs that involve controlled drugs must also be notified to the North of England Commissioning Support Medicines Optimisation Team and the ICB Director of Medicines.

3. Reporting & Management of Serious Incidents

3.1 Independent Healthcare sector

3.1.1 The Independent Healthcare Sector (IHS) is subject to the same contractual obligations for the reporting of SIs as other providers of NHS services. The ICB should ensure that appropriate reporting arrangements are in place with the IHS in relation to SIs where the provider is unable to directly report an SI onto StEIS (Appendix 5).

3.1.2 The commissioner of the service should ensure that IHS SIs are reported via STEIS and investigated appropriately by the responsible provider.

3.2 Provider and Commissioner Responsibilities

3.2.1 Each Provider must nominate a single point of contact or lead officer for managing their SIs.

3.2.2 Organisations should ensure that mechanisms are in place to report all incidents meeting the criteria.

3.2.3 The SI lead officer must report a SI through STEIS within 2 working days of identification of the incident as a SI, completing all relevant sections. At this stage it is important that any immediate learning and actions are included in the initial report.

3.2.4 If appropriate, for example where a SI is likely to generate media interest, the SI lead officer must liaise with the organisation's communications team who will liaise directly NHS England Communications team. The ICB communications team should also be notified.

3.2.5 The organisation must then provide a 72hr report, which should be sent to the NECS clinical quality team responsible for the management of that provider SI caseload on behalf of the 'Place' commissioner. The report should include more information regarding the event, immediate learning and how the RCA will be conducted.

3.2.6 Under the Data Protection Act (2018) organisations need to be open and transparent with regards to investigation processes unless there are specific exceptions. Arrangements may need to be put in place to support patients and family members through the investigation process and sharing of the outcome of investigations. The appointment of a Family Liaison Officer may be appropriate.

3.2.7 If an incident involves more than one NHS organisation, **it is the responsibility of the organisation where the incident took place** to formally report it through STEIS and to lead the investigation process. All other additional organisations involved must contribute and fully cooperate with the process in line with the agreed timescales. Where there is doubt about who should report the incident then clarity must be sought through the North of England Commissioning Support Clinical Quality Team.

3.2.8 Commissioners should help to facilitate discussions relating to who is the most
appropriate organisation to take responsibility for co-ordinating the investigation
process. Commissioners themselves should provide support in complex circumstances. Where no one provider organisation is best placed to assume responsibility for co-ordinating an investigation, the commissioner may lead this
process. The Responsible Accountable Supporting Consulted and Informed (RASCI) model should be completed in order to assign accountability and ensure lines of communication are kept open and responsibilities are clear.

3.2.9 Where an incident involves the independent sector or contracted services, it is the role of the commissioner to report the SI onto StEIS on their behalf, however responsibility for investigation remains with the provider.

3.2.10 This guidance must not interfere with existing lines of accountability and does not replace the duty to inform the police and/or other organisations or agencies where appropriate. Further guidance can be obtained from the Department of Health publication *Memorandum of Understanding: Investigating Patient Safety Incidents* June 2004 and accompanying NHS guidance of December 2006. The need to involve outside agencies should not impede the retrieval of immediate learning.

3.2.10 Certain SIs may also be subject to independent investigations conducted by the Healthcare Safety Investigation Branch (HSIB), and this includes all patient safety investigations of maternity incidents occurring in the NHS which meet criteria for the Each Baby Counts programme.

3.2.11 Incidents in which the actions or omissions of a provider or its employees have impacted or have had potential to impact on children and/ or vulnerable adults must be investigated in conjunction with the identified safeguarding lead and in accordance with related guidance.

3.2.12 Where an incident is subject to the involvement of a coroner, an independent inquiry, serious case review or any safeguarding issues, this should be highlighted clearly within the STEIS report as this may affect closure date.

3.2.13 Organisations should undertake investigation procedures / root cause analysis (RCA) as per organisation policy and submit to the responsible body within the agreed timescales. An example for the contents of a report and action plan can be found in **Appendix 4.** To ensure confidentiality all reports submitted to the commissioners or NECS Clinical Quality Team should be anonymous and sent via the agreed STEIS NHS-net account. NECS will conduct a quality assurance check on all RCAs on behalf of the commissioner in order to ensure the 20 day deadline is met.

3.3 Commissioner (ICB) SIs

3.3.1 If a Serious Incident has been identified as occurring within the ICB, reporters should refer to the ICBs Incident Reporting and Management Policy.

3.4 Independent Contractors

3.4.1 Once an SI is identified, in a ICB commissioned service, the Independent Contractors Procedure for the Reporting and Management of Serious Incidents should be followed, or where applicable NHS England should be notified (appendix 5).

3.4.2 Where a SI raises professional concerns about a GP, local 'Place' arrangements for assuring high standards of professional performance should be invoked, where this is applicable, or NHS England notified.

3.4.3 Independent Contractors should have systems in place to ensure that staff are supported appropriately following the identification of a SI.

3.5 NHS Providers

3.5.1 Once an SI is identified, the Providers' Procedure for the Reporting and Management of Serious Incidents should be followed (appendix 6)

3.5.2 Providers should have systems in place to ensure that staff are supported appropriately following identification of a SI

3.6 Independent Healthcare Sector Providers

3.6.1 Once an SI is identified, the Procedure for the Reporting and Management of Independent Healthcare Sector Serious Incidents should be followed (Appendix 7).

3.7 Staff Involved in Serious Incidents

3.7.1 Serious incidents can be distressing for those involved.

3.7.2 The appropriate Director, Head of Service or Manager should ensure that staff are supported at all stages of a SI with reference to ICB HR policies.

3.7.3 The appropriate Director, Head of Service or Manager are responsible for ensuring that a de-briefing session occurs at an appropriate stage following a SI.

3.7.4 If, during the course of a SI investigation it becomes apparent that a member of staff may be subject to a disciplinary hearing, appropriate advice and support should be taken via Human Resources and the relevant policy followed.

3.8 Fair Blame

The ICB is committed to a policy of 'fair blame'. In particular, formal disciplinary procedures will only be invoked following an incident where:

- There are repeat occurrences involving the same person where their actions are considered to contribute towards the incident
- There has been a failure to report an incident in which a member of staff was either involved or about which they were aware (failure to comply with organisation's policy and procedure)
- In line with the organisation and/or professional regulatory body, the action causing the incident is removed from acceptable practice or standards, or where
- There is proven malice or intent

Fair blame means that the organisation:

- Operates its incident reporting policy in a culture of openness and transparency which fulfils the requirements for integrated governance
- Adopts a systematic approach to an incident when it is reported and does not rush to judge or 'blame' without understanding the facts surrounding it
- Encourages incident reporting in the spirit of wanting to learn from things that go wrong and improve services as a result

3.9 Information for Education and Training Organisations

3.8.1 In the event an incident involves a student or trainee, the relevant academic institution will be notified by the NHS Trust/ICB as appropriate.

3.8.2 Where a SI concerns the commissioning or provision of medical or dental education or training, or a medical or dental trainee or trainees, there will be appropriate communication between the ICB and Health Education England (North East).

3.9 ICB Management & Closure of Serious Incidents

3.9.1 The ICB is responsible for quality assuring the robustness of its providers' serious incident investigations and the action plan implementation undertaken by their providers.

3.9.2 The ICB is responsible for evaluating investigations and gaining assurance that the processes and outcomes of investigations include identification and implementation of improvements that will prevent recurrence of serious incidents.

3.9.3 In order to achieve this, the ICB has established the Serious Incident Panel and the terms of reference can be found in Appendix 8.

4. Implementation

4.1 This policy will be available to all Staff for use in the circumstances described on the title page.

4.2 ICB directors and managers are responsible for ensuring that relevant staff within the ICB have read and understood this document and are competent to carry out their duties in accordance with the procedures described.

4.3 The implementation of the detail of this policy is aligned into the full roll-out, development and implementation of the incident module of the SIRMS across the ICB and NECS.

4.4 This policy is reviewed at regular intervals to ensure that the implementation of the processes contained in the policy are in line with the practical experience of users of the SIRMS.

5. Training Implications

5.1 The sponsoring director will ensure that the necessary training or education needs, and methods required to implement the policy are identified and resourced or built into the delivery planning process. This may include identification of external training providers or development of an internal training process.

5.2 The level of training required in incident reporting and management varies depending on the level and responsibility of the individual employee.

5.3 The training required to comply with this policy is key to the successful implementation of the policy and embedding a culture of incident reporting and management in the organisation. Through a training and education programme, staff will have the opportunity to develop more detailed knowledge and appreciation of the role of incident reporting and management. Training and education will be offered through a rolling programme of incident reporting and management training.

6. Documentation

6.1 Other related policy documents.

- Serious Incident Framework (March 2015)
- Revised Never Events Policy and Framework (March 2015)

6.2 Best practice recommendations

- Managing Safety Incidents in National Screening Programmes (October 2015)
- Health and Social Care Information Centre; Checklist Guidance for Reporting, Managing and Investigating Information Governance and Cyber Security Serious Incidents Requiring Investigation

7. Monitoring, Review and Archiving

7.1 **Monitoring**

The ICB Board will agree with the Chief Executive a method for monitoring the dissemination and implementation of this policy. Monitoring information will be recorded in the policy database.

The Executive Director will ensure that each policy document is reviewed in accordance with the timescale specified at the time of approval. No policy or procedure will remain operational for a period exceeding three years without a review taking place.

7.2 **Review**

7.2.1 The ICB Board will ensure that this policy document is reviewed in accordance with the timescale specified at the time of approval. **No policy or procedure will remain operational for a period exceeding three years without a review taking place.**

7.2.2 Staff who become aware of any change which may affect a policy should advise their line manager as soon as possible. The Executive Director will then consider the need to review the policy or procedure outside of the agreed timescale for revision.

7.2.3 For ease of reference for reviewers or approval bodies, changes should be noted in the ‘document history’ table on the front page of this document. **(**

NB: If the review consists of a change to an appendix or procedure document, approval may be given by the sponsor director and a revised document may be issued. Review to the main body of the policy must always follow the original approval process.

7.3 Archiving

The ICB Board will ensure that archived copies of superseded policy documents are retained in accordance with the NHS Records Management Code of Practice 2021.

Annex A

Schedule of Duties and Responsibilities

Through day to day work, employees are in the best position to recognise any specific fraud risks within their own areas of responsibility. They also have a duty to ensure that those risks, however large or small, are identified and eliminated. Where it is believed fraud, bribery or corruption could occur, or has occurred, this should be reported to the CFS or the chief finance officer immediately.

ICB Board / ICB Quality/Governance/Safety Committee	Has delegated responsibility to the ICB Board for setting the strategic context in which organisational process documents are developed, and for establishing a scheme of governance for the formal review and approval of such documents.
Accountable Officer	The accountable officer has overall responsibility for the strategic direction and operational management, including ensuring that ICB process documents comply with all legal, statutory and good practice guidance requirements. The Chief Officer has responsibility for ensuring that the ICB has the necessary management systems in place to enable the effective management and implementation of all risk management and governance policies and delegates the responsibility for the management of SIs to the Executive Director of ?Nursing?
Senior Clinical Quality Manager	The *Senior Clinical Quality Manager, NECS,* will ensure that the policy is updated according to the agreed timetable for review, or whenever significant changes occur in the statutory frameworks governing it
Commissioning Support Staff.	Whilst working on behalf of the ICB NECS staff will be expected to comply with all policies, procedures and expected standards of behaviour within the ICB, however they will continue to be governed by all policies and procedures of their employing organisation
Clinical Quality Team (NECS)	Will ensure that the Serious Incident Policy is implemented operationally and according to the internal Standard Operating Procedures governing the use of StEIS, SIRMS and other systems and processes to enable the effective administration and management of all SIs.

All Staff	All staff, including temporary and agency staff, are responsible for: • Compliance with relevant process documents. Failure to comply may result in disciplinary action being taken. • Co-operating with the development and implementation of policies and procedures and as part of their normal duties and responsibilities. • Identifying the need for a change in policy or procedure as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and advising their line manager accordingly. • Identifying training needs in respect of policies and procedures and bringing them to the attention of their line manager. • Attending training / awareness sessions when provided.

Annex B

Equality Impact Assessment

Initial Screening Assessment (STEP 1)

As a public body organisation, we need to ensure that all our current and proposed strategies, policies, services and functions, have given proper consideration to equality, diversity and inclusion, do not aid barriers to access or generate discrimination against any protected groups under the Equality Act 2010 (Age, Disability, Gender Reassignment, Pregnancy and Maternity, Race, Religion/Belief, Sex, Sexual Orientation, Marriage and Civil Partnership).

This screening determines relevance for all new and revised strategies, policies, projects, service reviews and functions.

Completed at the earliest opportunity it will help to determine:

- The relevance of proposals and decisions to equality, diversity, cohesion and integration.
- Whether or not equality and diversity is being/has already been considered for due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED).
- Whether or not it is necessary to carry out a full Equality Impact Assessment.

Name(s) and role(s) of person completing this assessment:

Name: Gregor Miller
Job Title: Senior Clinical Quality Manager
Organisation: NECS

Title of the service/project or policy: ICB Serious Incident Policy

Is this a;
Strategy / Policy ☒Service Review ☐ Project ☐
Other Click here to enter text.

What are the aim(s) and objectives of the service, project or policy:
This policy aims to ensure that the ICB as Commissioners comply with current legislation as well as current national guidance, NHS England guidance and requirements with regard to accident/incident reporting generally, but in particular reporting, notifying, managing and investigating Serious Incidents and Never Events.

Who will the project/service /policy / decision impact?
(Consider the actual and potential impact)

- **Staff ☒**
- **Service User / Patients ☐**
- **Other Public Sector Organisations☒**
- **Voluntary / Community groups / Trade Unions ☐**

- **Others, please specify** Click here to enter text.

Questions	Yes	No
Could there be an existing or potential negative impact on any of the protected characteristic groups?	☐	☒
Has there been or likely to be any staff/patient/public concerns?	☐	☒
Could this piece of work affect how our services, commissioning or procurement activities are organised, provided, located and by whom?	☐	☒
Could this piece of work affect the workforce or employment practices?	☐	☒
Does the piece of work involve or have a negative impact on: • Eliminating unlawful discrimination, victimisation and harassment • Advancing quality of opportunity • Fostering good relations between protected and non-protected groups in either the workforce or community	☐	☒

If you have answered no to the above and conclude that there will not be a detrimental impact on any equality group caused by the proposed policy/project/service change, please state how you have reached that conclusion below:

No detrimental impact identified

If you have answered yes to any of the above, please now complete the 'STEP 2 Equality Impact Assessment' document

Accessible Information Standard	Yes	No
Please acknowledge you have considered the requirements of the Accessible Information Standard when communicating with staff and patients. https://www.england.nhs.uk/wp-content/uploads/2017/10/accessible-info-standard-overview-2017-18.pdf	☒	☐

Governance, ownership and approval

Please state here who has approved the actions and outcomes of the screening		
Name	**Job title**	**Date**
David Purdue	ICB Chief Nurse	June 2022

Publishing

This screening document will act as evidence that due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED) has been given.

Appendix 1

SERIOUS INCIDENT FRAMEWORK 2015/16 & FREQUENTLY ASKED QUESTIONS

Serious Incident Framework 2015
https://www.england.nhs.uk/patient-safety/serious-incident-framework/

Serious Incident Framework 2015 FAQs

Never Events Policy and Framework 2018
https://improvement.nhs.uk/documents/2265/Revised_Never_Events_policy_and_framework_FINAL.pdf

Never Events List 2018
https://improvement.nhs.uk/documents/2266/Never_Events_list_2018_FINAL_v5.pdf

Never Events Policy Framework FAQs

Appendix 2

PROCEDURE FOR THE REPORTING AND MANAGEMENT OF SAFEGUARDING CHILDREN/ADULTS INCIDENTS

Link to, or embedded policy/procedure document for ICB Safeguarding SOP

Appendix 3

Checklist Guidance for Reporting, Managing and Investigating Information Governance and Cyber Security Reportable Incidents

It is essential that all Information Governance reportable data security and protection incidents which occur in Health, Public Health and Adult Social Care services are reported appropriately and handled effectively.

The purpose of this guidance is to support Health, Public Health and Adult Social Care service commissioners, providers, suppliers and staff in ensuring that:

- The management of reportable IG incidents conforms to the processes and procedures set out for managing all Serious Incidents Requiring Investigation as well as the NHS Digital Guide to the Notification of Data Security and Protection Incidents;
- There is a consistent approach to evaluating IG reportable incidents;
- The ICO must be notified of all reportable Incidents within 24 hours of becoming aware of them;
- Any affected data subjects / individuals are appropriately informed;
- Early reports of reportable incidents are sufficient to decide appropriate escalation, notification and communication to interested parties;
- Appropriate action is taken to prevent damage to patients, staff and the reputation of Healthcare, Public Health or Adult Social Care;
- All aspects of a reportable incident are fully explored and ‘lessons learned’ are identified and communicated; and
- Appropriate corrective action is taken to prevent recurrence
- Caldicott 2 recommendations (accepted by the Government) are addressed.
- The National Data Guardian for Health and Care Review of Data Security, Consent and Opt-Outs standards are met;
- There is transparent reporting of incidents
- Contractual obligations are adhered to with regards to managing, investigating and reporting reportable incidents in a standardised and consistent manner, including reporting to Commissioners.

Appendix 4

EXAMPLE TEMPLATE

Guidance on Serious Incident Report and Action Plan

The report into Serious Incidents and the associated action plan should cover the following minimum information. Further work is under way with local organisations to develop and agree a common template

Report

- Introduction
- Constitution and investigation procedure
- Membership of the investigation team
- Terms of reference
- Background information
- Chronology
- Findings – to be identified against each of the terms of reference
- Conclusions
- Root cause(s)
- Lessons learnt
- Recommendations

Action Plan

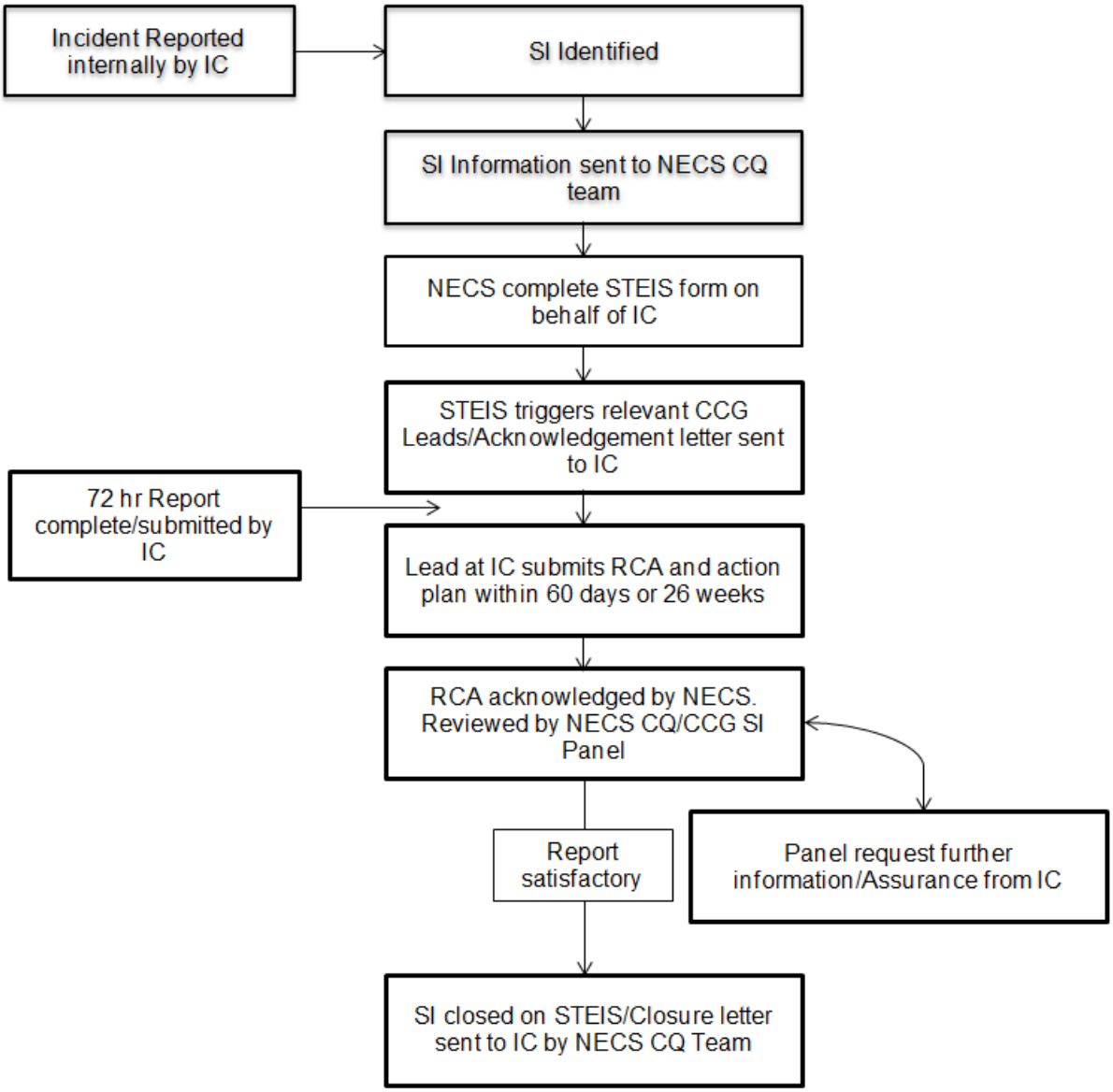
- Clearly set out which fall from the recommendations
- What needs to happen to achieve the outcome
- Identified title of who is responsible for the action
- Specific timescales on-going except where incorporated in to the Trust's everyday business for example the organisation's annual programme of audit.

Root cause analysis tools to assist organisations in their investigation can be found at:

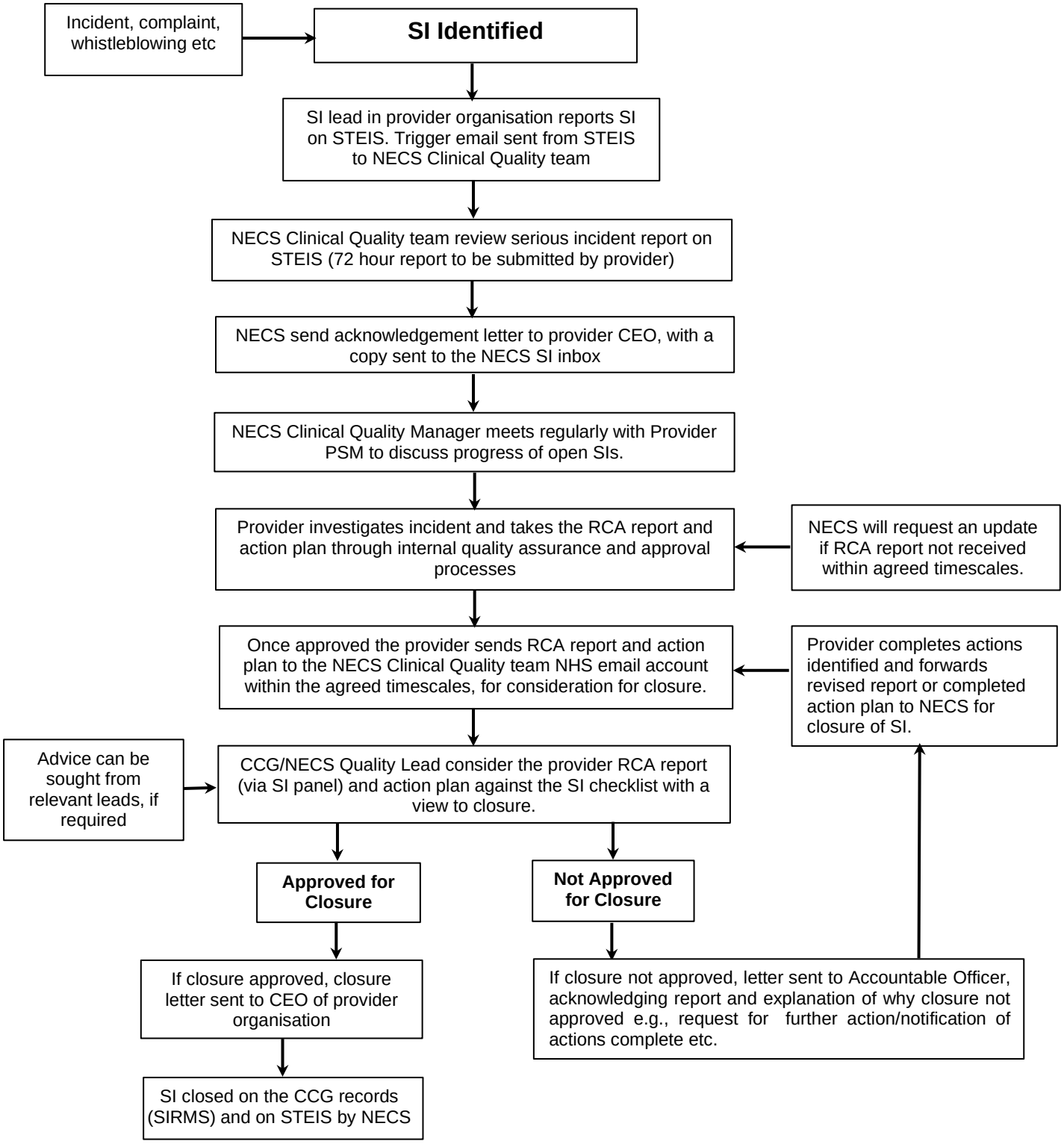
http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/

Appendix 5

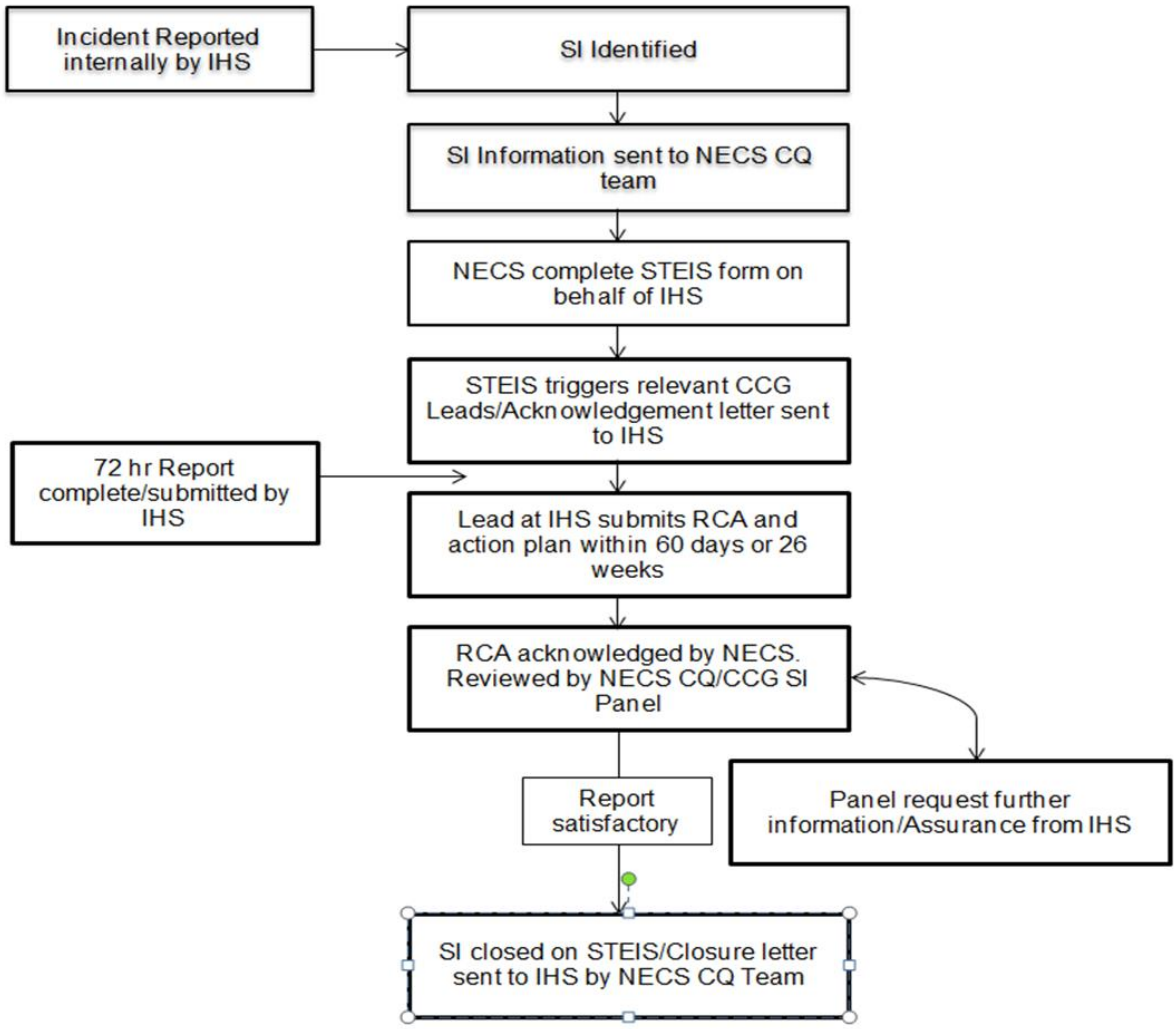
Procedure for the Reporting and Management of Independent Contractor/Commissioned Service SIs Only



Appendix 6
Procedure for the Reporting and Management of NHS Provider SIs Only



Appendix 7 Procedure for The Reporting and Management of Serious Incidents Independent Healthcare Sector (IHS) Providers



Appendix 8

Serious Incident Review Panel
Terms of Reference

To be determined

NHS
North East &
North Cumbria

Corporate	ICBP039 - Standards of Business Conduct and Declarations of Interest Policy

Version Number	Date Issued	Review Date
1	July 2022	July 2024

Prepared By:	CSU Governance Team, CSU. CCG Governance Leads
Consultation Process:	ICS Integrated Governance Workstream
Formally Approved:	July 2022
Approved By:	ICB Board

EQUALITY IMPACT ASSESSMENT

Date	Issues
May 2022	None identified.

POLICY VALIDITY STATEMENT

Policy users should ensure that they are consulting the currently valid version of the documentation. The policy will remain valid, including during its period of review. However, the policy must be reviewed at least once in every 3-year period.

ACCESSIBLE INFORMATION STANDARDS

If you require this document in an alternative format, such as easy read, large text, braille or an alternative language please contact necsu.comms@nhs.net

Version Control

Version	Release Date	Author	Update comments
1	July 2022	CSU Governance team.	First issue.

Approval

Role	Name	Date
Approver	ICB Board	July 2022

Contents

1. Introduction, Aims and Objectives

1.1 For the purposes of this policy, the North East and North Cumbria Integrated Care Board (NENCICB) will be referred to as “the ICB”, in relation to the 'corporate body'

In 2020/21 the Department for Health and Social Care spent £192 billion. This money is used to fund a wide range of health and care services, including GP services, ambulance, mental health, community and hospital services, which are commissioned by the NHS, and public health. It also funds some social care services, which are mainly commissioned by local authorities. £2.5 billion of the Department for Health and Social Care’s budget is spent on administration costs for the department and the health and care system, such as departmental running costs, regulatory costs, and business services, e.g., the NHS payroll. The total budget for 2020/21 was more than £50 billion higher than in 2019/20 because of the Covid-19 pandemic. The funds raised through the Health and Care Levy and other additional funding commitments will see the department’s budget reach more than £170 billion a year from 2022/23[1].

1.2 The purpose of this policy is to ensure exemplary standards of business conduct are adhered to by Board members, committee and sub-committee members and employees of the Integrated Care Board (ICB) (as well as individuals contracted to work on behalf of the Board or otherwise providing services or facilities to the ICB such as those within commissioning support services). Throughout this Policy individuals will be aware of their own responsibilities as well as the ICB's responsibilities as a corporate body. The Policy also sets out the responsibilities of the ICB as an employer, taking account of the individual and corporate obligations set out in the Bribery Act 2010.

1.3 The policy draws attention to the consequences of non-compliance with its requirements, which may include disciplinary action and/or legal action.

1.4 The production of this policy draws on the wide range of guidance issued over the years for NHS bodies.

1.5 This policy does not apply to independent and private sector organisations, general practices, social enterprises, community pharmacies, community dental practices, optical providers, local authorities – who are subject to different legislative and governance requirements. However, they would be required to comply with the requirements to declare interests should they be a member of the Board or any of its sub-committees or working groups.

[1] https://www.kingsfund.org.uk/audio-video/key-facts-figures-nhs#:~:text=In%202020%2F21%20the%20Department,the%20NHS%2C%20and%20public%20health.

2. Guidance and Legal Framework

2.1 The NHS Management Executive published guidance, “Standards of business conduct for NHS staff”, (HSG (93) 5), which remains extant and provides specific guidance on:

- The standards of conduct expected of all NHS staff where their private interests may conflict with their public duties; and
- The steps which NHS employers should take to safeguard themselves and the NHS against conflicts of interest.

Specifically, it makes it clear that it is the responsibility of staff to ensure that they are not placed in a position which risks, or appears to risk, conflict between their private interests and their NHS duties.

2.2 The Department of Health’s document, “Code of Conduct for NHS Managers”, (October 2002), provides guidance on core standards of conduct expected of NHS Managers to act in the best interests of the public and patients/clients to ensure that decisions are not improperly influenced by gifts or inducements. Professional Codes of Conduct governing health care professionals are also pertinent. Similarly, the General Medical Council’s guidance, “Leadership and management for all doctors” (March 2012), details the standards and expectations required of clinicians in leadership and management positions.

2.3 The ICB should observe the principles of good governance as set out in:

- The Nolan Principles on Conduct in Public Life
- The Good Governance Standards for Public Services (2004), Office for Public Management (OPM) and Chartered Institute of Public Finance and Accountancy (CIPFA) sets out the principles of good governance.
- The seven key principles of the NHS Constitution
- The Equality Act 2010
- The UK Corporate Governance Code
- NHS England: Managing Conflicts of Interest in the NHS: Guidance for staff and organisations (February 2017)

2.4 The Bribery Act 2010 came into force on 1 July 2011 and repeals previous corruption legislation. The Act has introduced the criminal offences of offering and receiving a bribe. It also places specific responsibility on organisations to have in place adequate procedures to prevent bribery and corruption taking place. This policy should be read in-conjunction with the ICB's Counter Fraud, Bribery and Corruption policy.

Bribery can generally be defined as offering, promising or giving a financial or other advantage to influence others to use their position in an improper way (i.e., to obtain a business advantage). A benefit can be money, gifts, rewards etc. and does not have to be of substantial financial value. No actual gain or loss has to be made.

A person has committed a criminal offence of offering a bribe even if the offer is declined, as does a person who accepts a bribe even if they don't receive it.

A bribe does not have to be in cash; it may be the awarding of a contract, provision of a gift, hospitality or sponsorship or another benefit.

Anyone found guilty of either offering or receiving a bribe could face a custodial sentence of up to 10 years imprisonment.

Corruption is generally considered as an umbrella term covering various activity and behaviour including bribery, kickbacks, favors, corrupt preferential treatment or cronyism. Corruption can be broadly defined as the offering or acceptance of inducements, gifts, favors, payment or benefit-in-kind which may influence the action of any person. Corruption does not always result in a loss. The corrupt person may not benefit directly from their deeds; however, they may be unreasonably using their position to give some advantage to another.

All staff are reminded that they should be transparent in respect of recording any gifts, hospitality or sponsorship, see section 5 of this policy.

Section 7 of the Bribery Act 2010 introduced a new corporate offence of 'failure of commercial organisations to prevent bribery'. The Board can be held liable when someone associated with it bribes another in order to obtain or retain business for the organisation and be subject to an unlimited fine. However, the Board will have a defence if it can demonstrate that it had adequate procedures in place designed to prevent bribery.

The Act applies to everyone associated with the ICB and who performs services on its behalf, or who provides the organisation with goods or services. This includes anyone working for or with the ICB, such as employees, agents, subsidiaries, contractors and suppliers.

Employees of the ICB must not request or receive a bribe from anybody, nor imply that such an act might be considered. This means they will not agree to receive or accept a financial or other advantage from a former, current or future client, business partner, contractor or supplier or any other person as an incentive or reward to perform improperly their function or activities.

More information on the Bribery Act 2010 can be found at the following website address: https://www.legislation.gov.uk/ukpga/2010/23/crossheading/general-bribery-offences

2.5 As required by section 14Z30 of the NHS Act 2006, the ICB has made arrangements (outlined in this policy) to manage any actual and potential conflicts of interest to ensure that decisions made by the ICB will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of the ICB's decision-making processes.

2.6 The ICB will abide by the following principles

- Safeguard system-led commissioning, whilst ensuring objective
- investment decisions.
- Act in a way that demonstrates that they are acting fairly and transparently and in the best interests of their patients and ICB population.
- Act in a way that upholds confidence and trust in the NHS and system partners.
- Recognition that the ICB requires a diversity of perspectives in order for it to make good decisions; therefore, interests will be managed sensibly and proportionately in line with NHSE guidance and the ICB's Standards of Business Conduct and Declarations of Interest Policy.
- Decision making will be made with a regard to the Triple Aim: considering the effects of the decisions on; the health and wellbeing of the people of England; the quality of services provided or arranged by both the ICB and other relevant bodies and the sustainable and efficient use of resources by the ICB and other relevant bodies.

2.7 This policy has been produced considering all of the current NHS managing conflict of interest guidance and legal framework.

2.8 Placing of orders and contracts

2.8.1 The ICB will procure in a fair, open, transparent and non-discriminatory manner between prospective contractors or suppliers for contracts (including where the ICB is commissioning a service through Any Qualified Provider) as is the requirement of NHS England and the ICB Standing Orders and the European procurement regulations – Public Contracts Regulations 2015 (PCR 2015). This means that:

- No private, public or voluntary organisation or company which may bid for ICB business should be given any advantage over its competitors, such as advance notice of the ICB's requirements. This applies to all potential contractors, whether or not there is a relationship between them and the ICB, such as a long-running series of previous contracts.

- Each new contract should be awarded solely on merit, taking into account the requirements of the ICB and the ability of the contractors to fulfil them.

- No special favor is to be shown to current or former employees or their close relatives or associates in awarding contracts to private or other businesses run by them or employing them in any capacity. Contracts may be awarded to such businesses when they are won in fair, open and transparent competition against other tenders, but scrupulous care must be taken to ensure that the selection process is conducted impartially, and that staff who are known to have a relevant interest play no part in the selection.

2.8.2 All staff, Board members, Committee members and individuals acting on behalf of the ICB, in contact with suppliers and contractors (including external consultants), and in particular those who are authorised to sign orders or place contracts for goods, materials or services, are expected to adhere to professional standards of a kind set out in the ethical code of the Institute of Purchasing and Supply are also required to declare any interest if they are participating in a specific procurement and tendering processes.

2.8.3 This policy should also be read in-conjunction with the ICB's Procurement policy.

2.9 Partnership Governance

The Board will ensure effective arrangements are in place for the governance of Integrated Care Partnerships (ICPs) (both at system and place level). The increasing development of partnership-based approaches to the commissioning and delivery of care place further emphasis on the necessity for strong governance and performance management in partnership working arrangements. In this respect, there needs to be a clear approach to ensure and demonstrate that investment in partnerships delivers effective and appropriate outcomes for the local population.

As part of an effective governance and assurance process the Board will satisfy itself that managing conflicts of interests and the principles of this policy are applied to ICPs (both at system and place level).

2.10 Private Transactions

Individual staff, Board members and Committee members and individuals acting on behalf of the ICB, will not seek or accept preferential rates or benefits in kind for private transactions carried out with companies with which they have had, or may have, official dealings on behalf of the ICB. (This does not apply to concessionary agreements negotiated with companies by NHS management, or by recognised staff interests, on behalf of all staff – for example, NHS staff benefits schemes).

3. Application of Public Service Values and Principles to the NHS

3.1 Public service values must be at the heart of the NHS. High standards of corporate and personal conduct, based on recognition that patients come first, have been a requirement throughout the NHS since its inception. Moreover, since the NHS is publicly funded it is accountable to Parliament for the services it provides and for the effective and economic use of taxpayers' money.

3.2 The Code of Conduct: Code of Accountability in the NHS (Appointments Commission/DOH - 2nd Rev: 2004) defines three crucial public service values which must underpin the work of the health service:

- **Accountability** – everything done by those who work in the NHS must be able to stand the test of parliamentary scrutiny, public judgements on propriety and professional codes of conduct.

- **Probity** – there should be an absolute standard of honesty in dealing with the assets of the NHS: integrity should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of NHS duties.

- **Openness** – there should be sufficient transparency about NHS activities to promote confidence between the NHS body and its staff, patients and the public.

3.3 Following the findings of the Nolan Committee in 1994, a set of recommendations was published by the government setting out 'Seven Principles of Public Life' which apply to all in the public service, and which are embodied within the ICB Constitution. These are attached in Appendix A.

4. Appointments and Roles and Responsibilities

4.1 NHS employers

The Board is responsible for ensuring that the requirements of this policy and supporting documents are brought to the attention of all employees and contractors and that mechanisms are put in place for ensuring that the guidelines are effectively implemented. These responsibilities are particularly important given the corporate responsibility set out in the Bribery Act for organisations to ensure that their anti-corruption procedures are robust.

Such awareness will be promoted through:

- A clause in written statements of terms and conditions of employment.
- Publication on the ICB's website for relevant staff.
- Regular reminders to staff of their obligations
- Requirements re mandatory training
- All staff required to complete declaration of interests returns, which will be collated and held centrally
- Induction processes
- Inclusion in Board and committee processes

In line with the Health and Social Care Act 2008 (Regulations 2014 (SI 2014/2936), the Chair of the Board is responsible for confirming that the fitness of all new Executive Directors has been assessed, and that they are satisfied those appointees are fit and proper individuals for their specific Executive Director role. The ICB is responsible for ensuring that all relevant assessments have taken place, as part of the recruitment process including assessing Executive Directors are:

- Of good character
- Have the necessary qualifications, skills and experience
- Are able to perform the work they are employed for
- Can supply information, such as certain checks and a full employment history.

NHS staff are expected to:

- Ensure that the interests of patients remain paramount at all times.
- Be impartial and honest in the conduct of their official business.
- Use the public funds entrusted to them to the best advantage of the service, always ensuring value for money.
- Register with the ICB any interest outside the workplace which could be construed as affecting any part of their work within the ICB e.g., outside / secondary employment.

It is also the responsibility of staff to ensure that they do not:

- Abuse their official position for personal gain or to benefit their family or friends.
- Seek to advantage or further private business or other interests, in the course of their official duties

It is the responsibility of all staff to raise any concerns regarding staff business conduct.

All NHS staff should ensure that they are not placed in a position that risks, or appears to risk, conflict between their private interests and their NHS duties.

4.2 Board and Committee/Sub-Committee Members and individuals acting on behalf of the ICB.

All Board, committee and sub-committee members, and employees of the ICB, will comply with this policy in line with their terms of office and/ or employment. This will include but not be limited to declaring all interests on a register that will be maintained by the ICB

Individuals acting on behalf of the ICB, must act in accordance with this policy in circumstances whether they are either employed fully by the ICB, hold appointments with the ICB, are employed on a sessional basis or on an honorary contract, or provide services under a service level agreement with the ICB.

4.3 CSU Staff

Whilst working on behalf of the ICB, CSU staff will be expected to adhere to the ICB's standards of behaviour, including observing and adhering to the Nolan Principles and openly declaring any conflict of interests to the ICB. CSU staff will continue to be governed by all policies and procedures issued by their employer.

4.4 Candidates for appointment

Candidates for any appointment with the Board must disclose in writing if they are related to or in a significant relationship with (e.g., spouse or partner) any Board member or employee of the ICB. The NHS Jobs application form requests this information and therefore must be disclosed before submission.

A member of an appointment panel which is to consider the employment of a person to whom they are related or have a significant relationship with, must declare the relationship before an interview is held.

Candidates for any appointment with the ICB shall, when applying, also disclose cases where they or their close relatives or associates have a controlling and/or significant financial interest in a business (including a private company, public sector organisation, other NHS employer and/or voluntary organisation), or in any other activity or pursuit, which may compete for an NHS contract to supply either goods or services to the Board. For appointments out- with NHS Jobs, through the local requirement procedures.

4.5 Canvassing for appointments

It is acknowledged that informal discussions concerning an advertised post can be part of the recruitment process. The canvassing or lobbying of ICB employees, Board members or any members of an appointments panel, either directly or indirectly, shall disqualify a candidate. This shall not preclude a ICB employee, Board member or any members of an appointments panel from giving a written reference or testimonial of a candidate's ability, experience or character for submission to an appointments panel. Jobs will be awarded on the merit of the individual candidate and not through any such canvassing or lobbying.

4.6 Appointing Board or committee members and senior e mployees

On appointing Board, committee or sub-committee members and senior staff, the ICB will, on a case by case basis, consider whether conflicts of interest should exclude individuals from being appointed to the relevant role. General principles are reflected in the ICB Constitution (section 6.2.1).

As outlined in section 4.1 of this policy, the Chair of the Board is responsible for confirming that the fitness of all new Executive Directors has been assessed, and that they are satisfied those appointees are fit and proper individuals for their specific Executive Director role. The ICB is responsible for ensuring that all relevant assessments have taken place, as part of the recruitment process including assessing Executive Directors are:

- Of good character
- Have the necessary qualifications, skills and experience
- Are able to perform the work they are employed for
- Can supply information, such as certain checks and a full employment history.

4.7 Conflicts of Interest Guardian

The ICB has appointed a Conflicts of Interest Guardian. This role is undertaken by the Audit Committee Chair. In collaboration with the ICB's governance lead, their role is to:

- Act as a conduit for members of the public and members of the partnership who have any concerns with regards to conflicts of interest.
- Be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest
- Support the rigorous application of conflict-of-interest principles and policies
- Provide independent advice and judgment to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation
- Provide advice on minimising the risks of conflicts of interest.

Whilst the Conflicts of Interest Guardian has an important role within the management of conflicts of interest, executive members of the Board have an on-going responsibility for ensuring the robust management of conflicts of interest, and all ICB employees, Board and committee members will continue to have individual responsibility in playing their part on an ongoing and daily basis.

4.8 Employees' outside employment

The standard contract used across the ICB sets out terms concerning outside employment. Your contract of employment does not preclude you from accepting other employment outside normal working hours. However, such other employment or business activity must not in any way hinder or conflict with the interests of your employment with the ICB. You should consult your manager before accepting other employment in the interests of your ICB employment and Working Time Regulations. The relevant documentation relating to this can be obtained from your manager".

Any employee who may be considering outside employment should discuss this in the first instance with their manager before undertaking the employment.

Employees must not engage in outside employment during any periods of sickness absence from the ICB. To do so may lead to a referral being made to the Local Counter Fraud Specialist for investigation which may lead to criminal and/or disciplinary action in accordance with the ICB's Counter-Fraud, Bribery and Corruption Policy.

The Board will take all reasonable steps to ensure that employees, committee members, contractors and others engaged under contract are aware of the requirement to inform the ICB if they are employed or engaged in, or wish to be employed or engage in, any employment or consultancy work in addition to their work with the ICB. The purpose of this is to ensure that the ICB is aware of any potential conflict of interest. Examples of work which might conflict with the business of the ICB, including part-time, temporary and fixed term contract work, including:

- Employment with another NHS body
- Employment with another organisation which might be in a position to supply goods/services to the ICB
- Directorship of a GP Federation or non-executive roles; and
- Self-employment, including private practice, charitable trustee roles, political roles and consultancy work in a capacity which might conflict with the work of the ICB, or which might be in a position to supply goods/services to the ICB.

These conflicts of interest should be identified as soon as possible, and appropriately managed and recorded on the ICB's Register of Interests. The position should also be reviewed whenever an individual's role, responsibility or circumstances change in a way that affects the individual's interests. For example, where an individual takes on a new role outside the ICB, or enters into a new business or relationship, these new interests should be promptly declared and appropriately managed in accordance with the statutory guidance.

Where an individual, including any individual directly involved with the business or decision-making of the ICB and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interest in the event of the ICB considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of the ICB Constitution, and this policy.

5. Gifts and Hospitality

5.1 Gifts

5.1.1 Overarching Principle

Employees of the ICB, individuals of the Board and Committee members and individuals acting on behalf of the ICB must not accept any fee or reward for work done whilst on ICB duty other than that agreed under their terms and conditions of employment.

Situations where the acceptance of gifts could give rise to conflicts of interest should be avoided. ICB staff and members 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.

ICB staff should not accept gifts that may affect, or be seen to affect, their professional judgement. This overarching principle should apply in all circumstances.

Any personal gift of cash or cash equivalents (e.g., vouchers, tokens, offers of remuneration to attend meetings whilst in a capacity working for or representing the ICB) must always be declined, whatever their value and whatever their source, and the offer which has been declined must be declared to the ICB governance lead who has designated responsibility for maintaining the register of gifts and hospitality and recorded on the register.

Any offers of gifts, hospitality or sponsorship shall be recorded in accordance with section 6.

5.1.2 Gifts

A 'gift' is defined as 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.

Gifts from suppliers or contractors doing business (or likely to do business) with the ICB should be declined, whatever their value (subject to this, low cost branded promotional aids may be accepted and not declared where they are under the value of a common industry standard of £6).

The person to whom the gifts were offered must declare the offer to the ICB governance lead with designated responsibility for maintaining the register of gifts and hospitality so the offer which has been declined can be recorded on the register.

Gifts offered from other sources (e.g., patients, families, service users) may be accepted if they are under a value of £50 and do not need to be declared to the ICB governance lead with designated responsibility for maintaining the register of gifts and hospitality, nor recorded on the register.

Gifts valued at over £50 should be treated with caution and only be accepted on behalf of an organisation (i.e., to an organisation's charitable funds), not in a personal capacity and must be declared to the ICB governance lead with designated responsibility for maintaining the register of gifts and hospitality and recorded on the register.

A common sense approach should be applied to the valuing of gifts (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).

Multiple gifts from the same source over a 12-month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds
£50.

In cases of doubt, advice should be sought from the line manager/Governance Lead or Executive Director for Corporate Governance, Communications and Involvement, or the gift should be politely declined, and declared.

5.2 Hospitality

Delivery of services across the NHS relies on working with a wide range of partners (including industry and academia) in different places and, sometimes, outside of 'traditional' working hours. As a result, ICB staff will sometimes appropriately receive hospitality. Staff receiving hospitality should always be prepared to justify why it has been accepted and be mindful that even hospitality of a small value may give rise to perceptions of impropriety and might influence behaviour.

Hospitality means offers of meals, refreshments, travel, accommodation and other expenses in relation to attendance at meetings, conferences, education and training events etc.

5.2.1 Overarching principles

- ICB staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement
- Hospitality must only be accepted when there is a legitimate business reason, and it is proportionate to the nature and purpose of the event
- Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors. These can be accepted if modest and reasonable, but individuals should always obtain approval from the Executive Director for Corporate Governance, Communications and Involvement or ICB governance lead and declare these.

5.2.2 Meals and Refreshments

Meals and refreshments under a value of £25 may be accepted and need not be declared. If they are of a value between £25 and £75, they may be accepted and must be declared.

Over a value of £75 should be refused unless (in exceptional circumstances) Executive Director for Corporate Governance, Communications and Involvement approval is given. A clear reason should be recorded on the ICB's Gifts and Hospitality register as to why it was permissible to accept. A common sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).

5.2.3 Travel and Accommodation

Modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared. Offers which go beyond modest or are of a type that the ICB itself might not usually offer, need approval by Executive Director for Corporate Governance, Communications and Involvement / ICB governance lead, should only be accepted in exceptional circumstances and must be declared. A clear reason should be recorded on the Gifts and Hospitality register as to why it was permissible to accept travel and accommodation of this type.

A non-exhaustive list of examples of 'beyond modest' offers includes:

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

5.3 Payment for speaking at a meeting/conference

Should a member of staff, Board or Committee member or individual acting on behalf of the ICB, be asked to speak at an event relating to ICB business for which a payment is offered, and it is delivered in working hours then there are two choices open to them, which must be agreed with their line manager:

- The payment should be credited to the ICB.

- The member of staff takes annual leave or unpaid leave, and the payment is made to the member of staff as a private matter between the organisation making the payment and the individual member of staff. The member of staff remains responsible for any tax liability which arises.

5.4 Commercial Sponsorship

5.4.1 ICB staff, Board and committee members, may be offered commercial sponsorship for courses, conferences, post/project funding, meetings and publications in connection with the activities that they carry out for, or on behalf of, the ICB

5.4.2 All such offers (whether accepted or declined) must be declared and recorded, and the ICB governance lead designated by the ICB to provide advice, support, and guidance on how conflicts of interest should be managed should provide advice on whether or not it would be appropriate to accept any such offers. If such offers are reasonably justifiable and otherwise in accordance with statutory guidance, then they may be accepted.

5.4.3 For the purpose of this policy, commercial sponsorship is defined as including *"[NHS funding] from an external source, including funding of all, or part of, the costs of a member of staff, NHS research, staff training, pharmaceuticals, equipment, meeting rooms, costs associated with meetings, meals, gifts, hospitality, hotel and transport costs (including trips abroad), provision of free services (speakers), buildings or premises".*

5.4.4 In all these cases, ICB employees, Board and Committee members and individuals acting on behalf of the ICB must declare sponsorship or any commercial relationship linked to the supply of goods or services and be prepared to be held to account for it. This should be recorded in the Gifts, Hospitality and Sponsorship Register (see section 6).

5.4.5 Where such collaborative partnerships involve a pharmaceutical company, the proposed arrangements must also comply fully with the relevant regulations and the ICB's Commercial Sponsorship and Joint Working with the Pharmaceutical Industry Policy.

5.4.6 As a general rule, sponsorship arrangements involving the ICB will be at a corporate organisational level, rather than Executive Director level.

5.4.7 Acceptance of commercial sponsorship must not in any way compromise commissioning decisions of the ICB or be dependent on the supply of goods or services. Sponsors should have no influence over the content of an event, meeting, seminar publication or training. The company logo can be displayed on materials, but no advertising or promotional information should be displayed. Materials should contain a disclaimer which states that sponsorship of the material does not imply that the ICB endorses any of the company's products or services. No information should be supplied to a company for their commercial gain unless there is a clear benefit to the NHS.

5.4.8 All ICB employees, Board and Committee members and individuals acting on behalf of the ICB should discuss the implications, with their manager/ Executive Director for Corporate Governance, Communications and Involvement, before accepting an invitation to speak at a meeting organised by a pharmaceutical company. The company should have no influence over the content of any presentation made by the ICB's employee/representative. It should be made clear that the ICB's presence does not imply that the ICB endorses any of the company's products or services.

5.4.9 Under no circumstances will the ICB agree to 'linked deals' whereby sponsorship is linked to future purchase of particular products or to supply from particular sources.

5.4.10 Sponsorship of ICB events by appropriate external bodies should only be approved if a reasonable person would conclude that the event will result in clear benefits of the ICB and NHS.

5.4.11 During dealings with sponsors there must be no breach of confidentiality or data protection legislation and, as a rule, information which is not in the public domain should not normally be supplied.

5.4.12 Organisations external to the ICB or NHS may also sponsor posts or research. 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, or if sponsored posts cause a conflict of interest between the aims of the sponsor and the aims of the organisation, particularly in relation to procurement and competition. There needs to be transparency and any conflicts of interest should be well managed. For further information, please see Managing Conflicts of Interest in the NHS: Guidance for staff and organisations.

5.11 Donations in relation to the organisation

5.11.1 Employees must check with their line manager or Executive Finance Director before making any requests for donations to clarify appropriateness and/or financial or contractual consequences of acquisition. Requests for equipment or services should not be made without the express permission of a senior manager.

5.11.2 Donations/gifts from individuals, charities, companies (as long as they are not associated with known health-damaging products) – often related to individual pieces of equipment or items – provide additional benefits to patients but may have resource implications for the ICB. Further guidance regarding charitable funds and gifts and donations can be requested from the Executive Finance Director.

5.11.3 Any gifts to the organisation should be receipted and a letter of thanks should be sent.

5.11.4 Any gifts to the organisation should be declared and registered onto the Gifts, Hospitality and Sponsorship register.

5.12 Donations to an individual

5.12.1 Personal monetary gifts to an employee or appointed member should be politely but firmly declined. Where a member of staff is a beneficiary of a Will of a patient who has been under their care, the member of staff must inform their line manager of the gift or gifts so that consideration can be given to whether or not it is appropriate in all the circumstances for that member of staff to retain the gift or gifts in order to avoid subsequent claims by the beneficiaries to the Estate of inducement, reward or corruption.

5.12.2 In order to determine whether the bequest should be accepted it may be necessary to have the gift valued and where the gift has a value over a certain amount for the gift to either be returned to the Estate or the gift to be donated to a Charity of the member of staff's choice. Where the gift is to be returned to the Estate and the Trustees of the Estate are of the view having regards to all the circumstances that the member of staff should retain the gift regardless of its value, it may be appropriate for the Trustees to provide a disclaimer for future claims against the gift to avoid subsequent claims on the gift or allegations of inducement or reward being made against the member of staff or the ICB at some point in the future.

5.13 Rewards for Initiative

5.13.1 The ICB will identify potential intellectual property rights (IPR), as and when they arise, so that they can protect and exploit them properly, and thereby ensure that they receive any rewards or benefits (such as royalties), in respect of work commissioned from third parties, or work carried out by individuals in the course of their NHS duties. Most IPR are protected by statute, e.g., patents are protected under the Patents Act 1977 and copyright (which includes software programmes) under the Copyright Designs and Patents Act 1988. To achieve this, NHS organisations and employers should build appropriate specifications and provisions into the contractual arrangements which they enter into before the work is commissioned or begins. They should always seek legal advice if in any doubt, in specific cases.

5.13.2 With regard to patents and inventions, in certain defined circumstances the Patents Act gives employees or individuals in the course of their duties a right to obtain some reward for their efforts, and the ICB will see that this is effected. Other rewards may be given voluntarily to employees or other individuals who, within the course of their employment or duties, have produced innovative work of outstanding benefit to the NHS.

5.13.3 In the case of collaborative research and evaluative exercises with manufacturers, the ICB will obtain a fair reward for the input it provides. If such an exercise involves additional work for an ICB employee or individual outside that paid for by the ICB under his or her contract of employment, or sessional arrangements, arrangements will be made for some share of any rewards or benefits to be passed on to the employee(s) or individuals concerned from the collaborating parties. Care will, however, be taken that involvement in this type of arrangement with a manufacturer does not influence the purchase of other supplies from that manufacturer.

5.13.4 The ICB Intellectual Property Policy should be adhered to.

6. Recording of gifts, hospitality and sponsorship

6.1 Gifts, hospitality and sponsorship will be recorded in a central register in accordance with the guidelines. The form at Appendix B should be completed and returned to the governance lead promptly so that the details can be recorded on the central Register. Failure to notify the ICB may lead to disciplinary action against a member of staff.

6.2 Where gifts, hospitality or sponsorship are offered, but declined, the offer should still be recorded using the form at Appendix B.

6.3 All hospitality or gifts declared must be transferred to the gifts, hospitality and sponsorship register.

6.4 It is acknowledged that there may be circumstances where hospitality may be offered by an organisation, as an integral element of a strategic partnership relationship. A fund should be established so that the ICB may meet the costs of that hospitality, thus enabling the benefits to the strategic relationship, but not compromising compliance with the Standards of Business Conduct. Acceptance of such hospitality and associated funding agreement will be authorised by the Executive Director for Corporate Governance, Communications and Involvement and recorded in the gifts, hospitality and sponsorship register.

7. Declaration of Interests

7.1 Identification and definition of conflicts of interest

7.1.1 A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role is, could be or is seen to be impaired or otherwise influenced by his or her involvement in another role or relationship. In some circumstances, it could be reasonably considered that a conflict exists even when there is no actual conflict. In these cases, it is important to manage these perceived conflicts in order to maintain public trust.

7.1.2 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.

7.1.3 Conflicts of interest can arise in many situations, environments and forms of commissioning, with an increased risk in primary care commissioning, out-of- hours commissioning and involvement with integrated care organisations and new care models such as Multi-specialty Community providers, Primary and Acute Care Systems or other arrangements of a similar scale and scope, may here find themselves in a position of being both commissioner and provider of services. Conflicts of interest can arise throughout the whole commissioning cycle from needs assessment to procurement exercises, to contract award & monitoring.

7.1.4 Where an individual, i.e., an employee, a member of the Board, or a member of its committees or sub-committees has an interest or becomes aware of an interest which could lead to a conflict of interest in the event of the ICB considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of the ICB Constitution and this Policy.

7.1.5 Interests can be captured in four different categories (see below and Appendix C):

i. **Financial interests:** This is where an individual may get direct financial benefits from the consequences of a commissioning decision. This could, for example, include being:

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

This could also include an individual being:

- In secondary employment
- In receipt of secondary income from a provider
- In receipt of a grant from a provider
- In receipt of any payments (for example honoraria, one-off payments, day allowances or travel or subsistence) from a provider
- In receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role; and
- Having a pension that is funded by a provider (where the value of this might be affected by the success or failure of the provider).

ii. **Non-financial professional interests:** This is where an individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their professional reputation or status or promoting their professional career. This may, for example, include situations where the individual is:

- An advocate for a particular group of patients
- A GP with special interests e.g., in dermatology, acupuncture etc.
- A member of a particular specialist professional body (although routine GP membership of the RCGP, British Medical Association (BMA) or a medical defence organisation would not usually by itself amount to an interest which needed to be declared)
- An advisor for the Care Quality Commission (CQC) or the National Institute for Health and Care Excellence (NICE)
- Engaged in a research role
- The development and holding of patents and other intellectual property rights which allow staff to protect something that they create, preventing unauthorised use of products or the copying of protected ideas; or

iii. **Non-financial personal interests:** This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is:

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

iv. Indirect interests: This is where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a commissioning decision (as those categories are described above) for example, a:

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

A declaration of interest for a "business partner" in a GP partnership should include all relevant collective interests of the partnership, and all interests of their fellow GP partners (which could be done by cross referring to the separate declarations made by those GP partners, rather than by repeating the same information verbatim).

Whether an interest held by another person gives rise to a conflict of interests will depend upon the nature of the relationship between that person and the individual, and the role of the individual within the ICB.

Note that the Declaration of Interest Form sets out the range of interests as a reminder of the types of interests which should be declared.

7.2 Questions to ask when declaring Interests

In determining what needs to be declared, individuals should ask themselves the following questions:

- Am I, or might I be, in a position where I or my family or associates gain from the connection between my private interests and my employment with the ICB?
- Do I have access to information which could influence purchasing decisions?
- Could my outside interest be in any way detrimental to the ICB or to patient's interests?
- Do I have any other reason to think I may be risking a conflict of interest?

If in doubt, the individual concerned should assume that a potential conflict of interest exists.

7.3 Declaring and Registering Interests

7.3.1 It is a requirement of the relevant legislation section 14Z30 of the 2006 Act, for the ICB to maintain registers of the interests of:

- **All ICB employees**, including:
- All full and part time staff
- Any staff on sessional or short term contracts
- Any students and trainees (including apprentices)
- Agency staff; and
- Seconded staff

In addition, any self-employed consultants or other individuals working for the ICB under a contract for services should make a declaration of interest in accordance with this policy, as if they were ICB employees.

Members of the Board: All members of the Board's committees, sub-committees/sub-groups, including:

- Co-opted members
- Appointed deputies; and
- Any members of committees/groups from other organisations.
- Partner members and Ordinary members
- Regular participants and observers.

7.3.2 The ICB will need to ensure that, as a matter of course, declarations of interest are made and regularly confirmed or updated. All persons referred to above must declare any interests as soon as reasonably practicable and by law within 28 days after the interest arises. Further opportunities include:

- **On appointment:**
  Applicants for any appointment to the ICB or its Board or any committees should be asked to declare any relevant interests. When an appointment is made, a formal declaration of interests should again be made and recorded. As part of the ICB's induction process, Line Managers are responsible for ensuring employees have completed a declaration of interest form.

- **Annually: When prompted by the ICB:**
  Because of their role in spending taxpayers' money, ICBs should ensure that, at least annually, staff are prompted to update their declarations of interest, or make a nil return where there are no interests or changes to declare.

- **At meetings:** All attendees are required to declare their interests as a standing agenda item for every Board, committee, sub-committee or working group meeting, before the item is discussed. Even if an interest is recorded in the register of interests, it should be declared in meetings where matters relating to that interest are discussed. Declarations of interest and action taken to manage that conflict of interest at the meeting should be recorded in minutes of meetings.
  In the case of Board and its Committees, any known interests should also be recorded on the Chair's sheet and be provided to the Chair before the meeting. They should also be included on the report's front cover sheet. (the Chair's sheet and Report Cover Sheet cover the requirements of the alternative indicative templates for recording interests during meetings, as provided in the 2017 Managing Conflicts of Interest Statutory Guidance)

  The chair of a meeting of the ICB's Board or any of its committees, sub-committees or groups has ultimate responsibility for deciding whether there is a conflict of interest and for taking the appropriate course of action in order to manage the conflict of interest.

- **On changing role, responsibility or circumstances:**
  Whenever an individual's role, responsibility or circumstances change in a way that affects the individual's interests (e.g., where an individual takes on a new role outside the ICB or enters into a new business or relationship), a further declaration should be made to reflect the change in circumstances as soon as possible, and in any event within 28 days. This could involve a conflict of interest ceasing to exist or a new one materialising.

7.3.5 Individuals will declare any interest that they have, in relation to a decision to be made in the exercise of the commissioning functions of the ICB, in writing to the Executive Director for Corporate Governance, Communications and Involvement as soon as they are aware of it and in any event no later than 28 days after becoming aware. The ICB must record the interest in the appropriate register as soon as the ICB becomes aware of it.

7.3.6 Where an individual is unable to provide a declaration in writing, for example, if a conflict becomes apparent in the course of a meeting, they will make an oral declaration, and provide a written declaration as soon as possible thereafter.

7.3.7 The Executive Director for Corporate Governance, Communications and Involvement will ensure that the registers of interest are reviewed annually and updated as necessary.

7.3.8 In addition, all ICB Board and Executive members' appointments are offered on the understanding that they subscribe to the "Codes of Conduct and Accountability in the NHS".

7.3.9 The Declaration of Interest proforma for completion by Board members, members of a committee or sub-committee and employees within the ICB is available at Appendix C.

7.3.10 Failure to notify the Board of a relevant conflict of interest, additional employment or business may lead to disciplinary action against the member of staff and/or criminal action (including prosecution) under the relevant legislation.

7.3.11 An interest should remain on the public register for a minimum of six months after the interest has expired and the ICB will retain a private record of historic interests for a minimum of 6 years after the date on which it expired. The published register will state that historic interests are retained by the ICB for the specified timeframe and details of whom to contact to request this information.

7.4 Managing Conflicts of Interest: general

7.4.1 Members of the Board, committees or sub-committees and employees will comply with the arrangements determined by the ICB for managing conflicts or potential conflicts of interest as set out in this Policy.

7.4.2 The ICB governance lead will ensure that for every interest declared, either in writing or by oral declaration, arrangements are in place manage the conflict of interests or potential conflict of interests, to ensure the integrity of the ICB's decision making processes.

7.4.3 Individuals are responsible for managing the specific conflict of interest or potential conflicts of interest, within 28 days of declaration. On review of the register the ICB's governance lead will confirm the following:

- when an individual should withdraw from a specified activity, on a temporary or permanent basis
- monitoring of the specified activity undertaken by the individual, either by a line manager, colleague or other designated individual.

7.4.4 Where an interest has been declared, either in writing or by oral declaration, the declarer will ensure, wherever possible, that before participating in any activity connected with the ICB's exercise of its commissioning functions, they have received confirmation of the arrangements to manage the conflict of interest or potential conflict of interest from the Executive Director for Corporate Governance, Communications and Innovation.

7.4.5 Declaration of Interests should be an agenda item on all Board and Committee agendas. Declarations should be made with regard to any specific agenda items. If a conflict of interest is established with regard to a specific agenda item, the conflict of interest should be recorded in the minutes, notified to the Conflicts of Interest ICB Governance Lead and published in the register. Similarly, any new offers of gifts or hospitality (whether accepted or not) which are declared at a meeting must be notified to the Conflicts of Interest ICB governance lead and included on the ICB's gifts, hospitality and sponsorship register to ensure it is up-to-date. The information provided to the ICB governance lead should include the relevant information as detailed on Appendices C and E.

7.4.6 Where an individual member, employee or person providing services to the ICB is aware of an interest which:

i. Has not been declared, either in the register or orally, they will declare this at the start of the meeting

ii. Has previously been declared, in relation to the scheduled or likely business of the meeting, the individual concerned will bring this to the attention of the chair of the meeting, together with details of arrangements that have been confirmed for the management of the conflict of interests or potential conflict of interests.

7.4.7 The chair of the meeting will then determine how this should be managed and inform the member of their decision. Where no arrangements have been confirmed, the chair of the meeting may require the individual to withdraw from the meeting or part of it. They will not be able to vote on the issue under any circumstances. Where a prejudicial interest is identified that person must leave the room during the discussion of the relevant item and cannot seek to improperly influence the decision in which they have a prejudicial interest. The Chair's decision will be final in the matter and the individual will then comply with these arrangements, which must be recorded in the minutes of the meeting.

7.4.8 Where the chair of any meeting of the ICB, including committees or sub-committees, or Board, has a personal interest, previously declared or otherwise, in relation to the scheduled or likely business of the meeting, they must make a declaration and the deputy chair will act as chair for the relevant part of the meeting. Where arrangements have been confirmed for the management of the conflict of interests or potential conflicts of interests in relation to the chair, the meeting must ensure these are followed. Where no arrangements have been confirmed, the deputy chair may require the chair to withdraw from the meeting or part of it. Where there is no deputy chair, the members of the meeting will select one in line with the provisions in the ICB's Constitution and Standing Orders.

7.4.9 Any declarations of interests, and arrangements agreed in any meeting of the ICB, including committees or sub-committees, or the Board, will be recorded in the minutes. The interest must be subsequently reported to the designated governance lead for recording in the Register.

7.4.10 Where members of a meeting are required to withdraw from a meeting or part of it, owing to the arrangements agreed for the management of conflicts of interests or potential conflicts of interests, the chair (or deputy) will determine whether or not the discussion can proceed in accordance with the provisions of the Constitution and Standing Orders or the terms of reference.

7.4.11 In making this decision the chair will consider whether the meeting is quorate, in accordance with the number and balance of membership set out in the ICB Constitution and Standing Orders or the terms of reference. Where the meeting is not quorate, owing to the absence of certain members, the decisions will be deferred until such time as a quorum can be convened. Where a quorum cannot be convened from the membership of the meeting, owing to the arrangements for managing conflicts of interest or potential conflicts of interests, the chair of the meeting shall consult with the Executive Director for Corporate Governance, Communications and Involvement on the action to be taken.

7.4.12 In any transaction undertaken in support of the ICB's exercise of its functions (including conversations between two or more individuals, e-mails, correspondence and other communications), individuals must ensure, where they are aware of an interest, that they conform to the arrangements confirmed for the management of that interest. Where an individual has not had confirmation of arrangements for managing the interest, they must declare their interest at the earliest possible opportunity in the course of that transaction and declare that interest as soon as possible thereafter. The individual must also inform either their line manager (in the case of employees), or the Executive Director for Corporate Governance, Communications and Involvement of the transaction.

7.4.13 The Executive Director for Corporate Governance, Communications and Involvement will take such steps as deemed appropriate, and request information deemed appropriate from individuals, to ensure that all conflicts of interest and potential conflicts of interest are declared.

7.5 Managing Conflicts of Interest throughout the commissioning cycle

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

7.5.2 In designing service requirements attention should be given to public and patient involvement throughout the commissioning cycle.

7.5.3 It is good practice to engage relevant providers, especially clinicians, in confirming that the design of service specifications will meet patient needs. This may include providers from the acute, primary, community, and mental health sectors, and may include NHS, third sector and private sector providers. Such engagement, done transparently and fairly, is entirely legal. However, conflicts of interest, as well as challenges to the fairness of the procurement process, can arise if a commissioner engages selectively with only certain providers (be they incumbent or potential new providers) in developing a service specification for a contract for which they may later bid.

7.5.4 Provider engagement should follow the three main principles of procurement law, namely equal treatment, non-discrimination and transparency. This includes ensuring that the same information is given to all at the same time and procedures are transparent. This mitigates the risk of potential legal challenge.

7.5.5 Specifications should be clear and transparent, reflecting the depth of engagement, and set out the basis on which any contract will be awarded.

7.5.6 Anyone seeking information in relation to procurement, or participating in a procurement, or otherwise engaging with the ICB in relation to the potential provision of services or facilities to the ICB, will be required to make a declaration of any relevant conflict / potential conflict of interest.

7.5.7 Anyone contracted to provide services or facilities directly to the ICB will be subject to the same provisions of the ICB's Constitution and this policy in relation to managing conflicts of interests. This requirement will be set out in the contract for their services.

7.5.8 The ICB must refer to the organisations Procurement Policy and comply with relevant Procurement legislation.

7.5.9 The procurement template (Appendix D) should be used to complete the register of procurement decisions and to provide evidence of the ICB's deliberations on conflicts of interest.

7.5.10 The ICB must maintain a register of procurement decisions taken, including.

- The details of the decision
- Who was involved in making the decision?
- A summary of any conflicts of interest in relation to the decision and how this was managed
- The award decision taken

7.5.11 The register should be updated whenever a procurement decision is taken and must be made publicly available by.

- Ensuring that the register is available in a prominent place on the web site and
- Making the register available upon request for inspection at the ICB's headquarters

7.5.12 The management of conflicts of interest applies to all aspects of the commissioning cycle, including contract management.

7.5.13 Any contract monitoring meeting needs to consider conflicts of interest as part of the process i.e., the chair of a contract management meeting should invite declarations of interests; record any declared interests in the minutes of the meeting; and manage any conflicts appropriately and in line with this guidance. This equally applies where a contract is held jointly with another organisation such as the Local Authority or with other ICBs under lead commissioner arrangements.

7.5.14 The individuals involved in the monitoring of a contract should not have any direct or indirect financial, professional or personal interest in the incumbent provider or in any other provider that could prevent them, or be perceived to prevent them, from carrying out their role in an impartial, fair and transparent manner.

7.6 Raising Concerns and breaches

Individuals, who have concerns regarding conflict of interest or ethical misconduct either in respect of themselves or colleagues, should raise it in the first instance with their manager. Alternatively, they can raise it as an issue using the Raising Concerns at Work Policy or contacting the Conflict of Interest Guardian. If the concern relates to any suspected fraudulent practice, staff should follow the advice given in section 10 of this document.

The ICB has agreed a process for managing breaches of this policy, summarised at Appendix E, which includes:

- How the breach is recorded
- How it is investigated
- The governance arrangements and reporting mechanisms
- Links to the Raising Concerns at Work Policy and HR policies
- Communications and management of any media interest
- When to notify NHS England and how
- Process for publishing the breach on the ICB web site

The ICB will publish anonymised details of breaches on its web site.

7.7 Publication of Registers

The ICB will publish the register(s) of interest and register(s) of gifts, hospitality and sponsorship, the register of Procurement Decisions in a prominent place on the ICB's website and will also be referenced in the ICB's Annual Report and Annual Governance Statement (in line with Annual Reporting requirements issued each year).

In exceptional circumstances, where the public disclosure of information could give rise to a real risk of harm or is prohibited by law, an individual's name and/or other information may be redacted from the publicly available register(s). Where an individual believes that substantial damage or distress may be caused, to him/herself or somebody else by the publication of information about them, they are entitled to submit a written request that the information is not published. Decisions must be made by the Conflicts of Interest Guardian for the ICB, who should seek appropriate legal advice where required, and the ICB should retain a confidential un-redacted version of the register(s).

8. Confidentiality

8.1 Employees, ICB members, members of the Board, or a member of a committee or a sub-committee of the ICB should be particularly careful using or making public, internal information of a confidential nature, particularly regarding details covered under the Data Protection Act 1998 or other legislation whether or not disclosure is prompted by the expectation of personal gain.

8.2 Disclosure of information which counts as “commercial in confidence” and which might prejudice the principle of a purchasing system based on fair competition may be subject to scrutiny and disciplinary or criminal action or both.

8.3 This does not affect the ICB's grievance or complaints procedures in terms of freedom of expression and is not intended to restrict any of the freedoms protected under Article 10 of the Human Rights Act 1998. It is designed to complement professional and ethical rules, guidelines and codes of conduct on an individual’s freedom of expression.

8.4 An employee or individual who has exhausted all the locally established procedures, including reference to the Raising Concerns at Work Policy, and who has taken account of advice that may have been given, may wish to consult their MP or the Secretary of State for Health in confidence. Extreme caution should be exercised by anyone considering contacting the media.

8.5 Section 43B (1) of the Public Interest Disclosure Act 1998 provides protection for disclosure of information where the reasonable belief of the worker making the disclosure, tends to show that:

a. A criminal offence has been committed, is being committed or is likely to be committed

b. That a person has failed, is failing or is likely to fail to comply with any legal obligation to which he is subject

c. That a miscarriage of justice has occurred, is occurring or is likely to occur

d. That the health or safety of any individual has been, is being or is likely to be endangered

e. That the environment has been, is being or is likely to be damaged, or

f. That information tending to show any matter falling within points a. to e. has been, is being or is likely to be deliberately concealed.

8.6 Protection from disclosure to the media is highly unlikely to be given if the person making the disclosure has not exhausted all internal and external avenues.

8.7 Any employee, member of the Board, or a member of a committee or a sub-committee of the Board making a disclosure to the media should be mindful that any information that they provide may be misinterpreted thus undermining their genuine concern and potentially wrongly threatening the reputation of colleagues and the ICB. In addition, if they choose to contact the media and the disclosure is not protected by the Public Interest Disclosure Act 1998 their actions might constitute misconduct and will be considered in accordance with the ICB Disciplinary Policy and Procedure.

9. Use of Resources

All managers are required (under the Code of Conduct for NHS Managers) to use the resources available to them in an effective, efficient and timely manner having proper regard to the best interests of the public and patients.

10. Fraud/Theft

If you suspect theft, fraud, or other untoward events taking place at work you should:

- Make a note of your concerns, and
- In the case of theft contact your Local Security Management Specialist
- In the case of fraud contact the Local Counter Fraud Specialist on or the Executive Director of Finance
- You can also report to the national NHS Fraud and Corruption Reporting Line on 0800 028 40 60 or www.reportnhsfraud.nhs.uk/

Staff should not be afraid of raising concerns and will not experience any blame or recrimination as a result of making any reasonably held suspicion known.

If staff have any concerns about any of the issues raised in this document, they should contact their manager or Human Resources Manager.

11. Non-compliance with Policy

Failure to notify the ICB of a relevant conflict of interest, additional employment or business may lead to disciplinary action against the individual including potential dismissal or removal from office in accordance with the ICB's Disciplinary Policy and procedure and/or criminal action (including prosecution) under the relevant legislation.

A review of lessons learned will be conducted by the Accountable Officer or nominated deputy following any incident of non-compliance with this policy and the report to be reviewed by the ICB's Audit Committee.

If conflicts of interest are not effectively managed, ICB's could face civil challenges to decisions they make. In extreme cases, staff and other individuals could face personal civil liability, for example a claim for misfeasance in public office.

Failure to manage conflicts of interest could lead to criminal proceedings including for offences such as fraud, bribery and corruption. This could have implications for ICBs and linked organisations, and the individuals who are engaged by them.

Concerns can be raised using the Raising Concerns at Work Policy or contacting the Conflict of Interest Guardian, of this policy. If the concern relates to any suspected fraudulent practice, staff should follow the advice given in section 10 of this document.

The ICB has agreed a process for managing breaches of this policy, outlined in Appendix E.

12. Internal Audit

It is recognised that there is no statutory requirement (at present), to undertake an annual audit of conflict of interest, however, an annual audit will be considered as part of the annual audit planning exercise.

13. Linked Policies/Guidance

- ICB Constitution
- NHS England: Standards of Business Conduct Policy 2017
- Standards for members of NHS Boards and Clinical Commissioning Group governing bodies in England published by the Professional Standards Authority for Health and Social Care 2012
- ABPI Code of Professional Conduct relating to hospitality/gifts from pharmaceutical/external industry
- Counter-Fraud, Bribery and Corruption Policy
- Raising Concerns at Work (Whistleblowing) policy
- Guidance to staff on travel expenses
- Travel and Expenses policy
- Intellectual Property Management and Revenue Sharing Policy
- Commercial Sponsorship and Joint Working with the Pharmaceutical Industry Policy
- Secondary Employment guidance
- Code of Conduct and Code of Accountability for NHS Boards 2013
- Institute of Purchasing and Supply
- Ethical code of the Institute of Purchasing and Supply

14. Further Information

If there are any queries on declaration of interests, acceptance or registering of gifts etc. the Executive Finance Director, Executive Director for Corporate Governance, Communications and Involvement, ICB governance Lead and Conflict of Interest Guardian can be contacted for further information.

15. Monitoring, Review and Archiving

15.1 **Monitoring**

The Board will ensure there is in place for monitoring the dissemination and implementation of this policy. Monitoring information will be recorded in the policy database.

15.2 **Review**

15.2.1 The Board will ensure that this policy document is reviewed in accordance with the timescale specified at the time of approval. No policy or procedure will remain operational for a period exceeding three years without a review taking place.

15.2.2 Staff who become aware of any change that may affect a policy should advise their line manager as soon as possible. The Executive Director will then consider the need to review the policy or procedure outside of the agreed timescale for revision.

15.2.3 For ease of reference for reviewers or approval bodies, changes should be noted in the 'version control' table on the second page of this document.

NB: If the review consists of a change to an appendix or procedure document, approval may be given by the sponsor director and a revised document may be issued. Review to the main body of the policy must always follow the original approval process.

15.3 **Archiving**

The Board will ensure that archived copies of superseded policy documents are retained in accordance with Records Management: NHS Code of Practice for Health and Social Care 2021.

16. Equality Impact Assessment

Initial Screening Assessment

As a public body organisation, we need to ensure that all our current and proposed strategies, policies, services and functions, have given proper consideration to equality, diversity and inclusion, do not aid barriers to access or generate discrimination against any protected groups under the Equality Act 2010 (Age, Disability, Gender Reassignment, Pregnancy and Maternity, Race, Religion/Belief, Sex, Sexual Orientation, Marriage and Civil Partnership).

This screening determines relevance for all new and revised strategies, policies, projects, service reviews and functions.

Completed at the earliest opportunity it will help to determine:

- The relevance of proposals and decisions to equality, diversity, cohesion and integration.
- Whether or not equality and diversity is being/has already been considered for due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED).
- Whether or not it is necessary to carry out a full Equality Impact Assessment.

Name(s) and role(s) of person completing this assessment:

Name: Aimee Tunney
Job Title: Governance & Assurance Manager
Organisation: North of England Commissioning Support Unit

Title of the service/project or policy: Standards of Business Conduct and Declaration of Interest policy

Is this a;
Strategy / Policy ☒Service Review ☐ Project ☐
Other N/A

What are the aim(s) and objectives of the service, project or policy:
The purpose of this policy is to ensure exemplary standards of business conduct are adhered to by Board members, committee and sub-committee members and employees of the Integrated Care Board (ICB) (as well as individuals contracted to work on behalf of the Board or otherwise providing services or facilities to the ICB such as those within commissioning support services). Throughout this Policy individuals will be aware of their own responsibilities as well as the ICB's responsibilities as a corporate body. The Policy also sets out the responsibilities of the ICB as an employer, taking account of the individual and corporate obligations set out in the Bribery Act 2010

Who will the project/service /policy / decision impact?
(Consider the actual and potential impact)

- **Staff ☒**
- **Service User / Patients ☐**
- **Other Public Sector Organisations☐**
- **Voluntary / Community groups / Trade Unions ☐**
- **Others, please specify** Click here to enter text.

Questions	Yes	No
Could there be an existing or potential negative impact on any of the protected characteristic groups?	☐	☒
Has there been or likely to be any staff/patient/public concerns?	☐	☒
Could this piece of work affect how our services, commissioning or procurement activities are organised, provided, located and by whom?	☒	☐
Could this piece of work affect the workforce or employment practices?	☒	☐
Does the piece of work involve or have a negative impact on: • Eliminating unlawful discrimination, victimisation and harassment • Advancing quality of opportunity • Fostering good relations between protected and non-protected groups in either the workforce or community	☐	☒

If you have answered no to the above and conclude that there will not be a detrimental impact on any equality group caused by the proposed policy/project/service change, please state how you have reached that conclusion below:

No detrimental impact on a protected equality group. However, breaches of conflict of interest could have an overall impact to service delivery, commissioning, and procurement.

Accessible Information Standard	Yes	No
Please acknowledge you have considered the requirements of the Accessible Information Standard when communicating with staff and patients. https://www.england.nhs.uk/wp-content/uploads/2017/10/accessible-info-standard-overview-2017-18.pdf	☒	☐

Governance, ownership and approval

Please state here who has approved the actions and outcomes of the screening		
Name	Job title	Date
Claire Riley	Executive Director of Corporate Governance, Communications & Involvement	June 2022
Presented to (Appropriate Committee)		Publication Date
ICB Board		July 2022

Publishing

This screening document will act as evidence that due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED) has been given.

Appendix A

The Nolan Principles on Standards in Public Life

The Nolan Committee was set up in 1994 to examine concerns about standards of conduct of all holders of public office, including arrangements relating to financial and commercial activities, and make recommendations as to any changes in arrangements which might be required to ensure the highest standards of propriety in public life. The committee published *"seven principles of Public Life"*, which it believes should apply to all those operating in the public sector. These principles should be adopted by ICB staff and are as follows:

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 their 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.

All staff will be expected to adopt these principles when conducting official business for and on behalf of the ICB so that appropriate ethical standards can be demonstrated at all times.

Appendix B

Template: Gifts, Hospitality and Sponsorship Form

Recipient Name	Position	Date of Offer	Date of Receipt (if applicable)	Details of Gift / Hospitality	Estimated Value	Supplier / Offer Name and Nature of Business	Details of Previous Offers or Acceptance by this Offeror/ Supplier	Details of the officer reviewing and approving the declaration made and date	Declined or Accepted?	Reason for Accepting or Declining	Other Comments

The information submitted will be held by the ICB for personnel or other reasons specified on this form and to comply with the organisation's policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 1998. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in registers that the ICB holds.

I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to the ICB as soon as practicable and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, professional regulatory or internal disciplinary action may result.

I **do / do not (delete as applicable)** give my consent for this information to published on registers that the ICB holds. If consent is NOT given, please give reasons:

Signed: **Date:**

Signed: **Position:** **Date: (Line Manager or a Senior ICB Manager)**

Please return to **<insert name/contact details for team or individual in CCG nominated to provide advice, support, and guidance on how conflicts of interest should be managed, and administer associated administrative processes>**

Appendix C

Template: Declaration of interests for ICB members and employees

Name:	
Position within, or relationship with, the ICB (or NHS England in the event of joint committees):	

Detail of interests held (complete all that are applicable):

Type of Interest* *See reverse of form for details	Description of Interest (including for indirect Interests, details of the relationship with the person who has the interest)	Date interest relates From & To		Actions to be taken to mitigate risk (to be agreed with line manager or a senior ICB manager)

The information submitted will be held by the ICB for personnel or other reasons specified on this form and to comply with the organisation's policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 1998. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in registers that the ICB holds.

I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to the ICB as soon as practicable and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, or internal disciplinary action may result.

I **do / do not [delete as applicable]** give my consent for this information to be published on registers that the ICB may publicly disclose. If consent is NOT given, please give reasons:

Signed: **Date**:

Signed: **Position:** **Date:**
(Line Manager or Senior ICB Manager)

Please return to *<insert name/contact details for team or individual in ICB nominated to provide advice, support, and guidance on how conflicts of interest should be managed, and administer associated administrative processes>*

Types of interest

Type of Interest	Description
Financial Interests	This is where an individual may get direct financial benefits from the consequences of a commissioning decision. This could, for example, include being: • A director, including a non-executive director, or senior employee in a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations; • A shareholder (or similar owner interests), a partner or owner of a private or not-for-profit company, business, partnership or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations. • A management consultant for a provider; • In secondary employment); • In receipt of secondary income from a provider; • In receipt of a grant from a provider; • In receipt of any payments (for example honoraria, one off payments, day allowances or travel or subsistence) from a provider • In receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role; and • Having a pension that is funded by a provider (where the value of this might be affected by the success or failure of the provider).
Non-Financial Professional Interests	This is where an individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their professional reputation or status or promoting their professional career. This may, for example, include situations where the individual is: • An advocate for a particular group of patients; • A GP with special interests e.g., in dermatology, acupuncture etc. • A member of a particular specialist professional body (although routine GP membership of the RCGP, BMA or a medical defence organisation would not usually by itself amount to an interest which needed to be declared); • An advisor for Care Quality Commission (CQC) or National Institute for Health and Care Excellence (NICE); • A medical researcher.
Non-Financial Personal Interests	This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is: • A voluntary sector champion for a provider; • A volunteer for a provider; • A member of a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation; • Suffering from a particular condition requiring individually funded treatment; • A member of a lobby or pressure groups with an interest in health.
Indirect Interests	This is where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a commissioning decision (as those categories are described above). For example, this should include: • Spouse / partner; • Close relative e.g., parent, grandparent, child, grandchild or sibling; • Close friend; • Business partner.

Appendix D

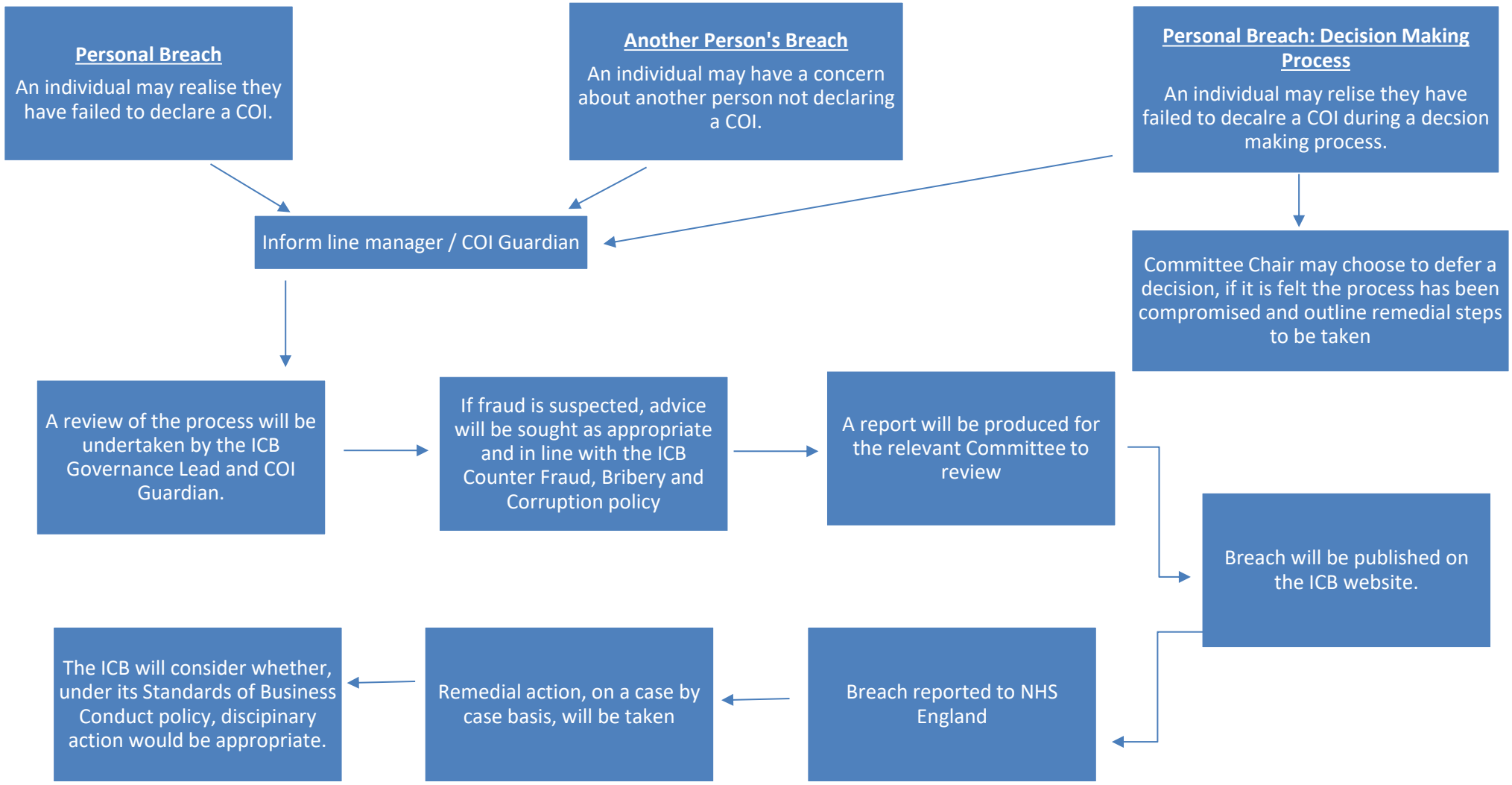
Procurement Template

Service:	
Question	**Comment/ Evidence**
1. How does the proposal deliver good or improved outcomes and value for money – what are the estimated costs and the estimated benefits? How does it reflect the ICB's proposed commissioning priorities? How does it comply with the ICB's commissioning obligations?	
2. How have you involved the public in the decision to commission this service?	
3. What range of health professionals have been involved in designing the proposed service?	
4. What range of potential providers have been involved in considering the proposals?	
5. How have you involved your Health and Wellbeing Board(s)? How does the proposal support the priorities in the relevant joint health and wellbeing strategy (or strategies)?	
6. What are the proposals for monitoring the quality of the service?	
7. What systems will there be to monitor and publish data on referral patterns?	
8. Have all conflicts and potential conflicts of interests been appropriately declared and entered in registers?	
9. In respect of every conflict or potential conflict, you must record how you have managed that conflict or potential conflict. Has the management of all conflicts been recorded with a brief explanation of how they have been managed?	
10. Why have you chosen this procurement route e.g., single action tender?	

11. What additional external involvement will there be in scrutinising the proposed decisions?	
12. How will the ICB make its final commissioning decision in ways that preserve the integrity of the decision-making process and award of any contract?	
Additional question when qualifying a provider on a list or framework or pre selection for tender (including but not limited to any qualified provider) or direct award (for services where national tariffs do not apply)	
13. How have you determined a fair price for the service?	
Additional questions when qualifying a provider on a list or framework or pre selection for tender (including but not limited to any qualified provider) where GP practices are likely to be qualified providers	
14. How will you ensure that patients are aware of the full range of qualified providers from whom they can choose?	
Additional questions for proposed direct awards to GP providers	
15. What steps have been taken to demonstrate that the services to which the contract relates are capable of being provided by only one provider?	
16. In what ways does the proposed service go above and beyond what GP practices should be expected to provide under the GP contract?	
17. What assurances will there be that a GP practice is providing high-quality services under the GP contract before it has the opportunity to provide any new services?	

Appendix E

Managing breaches and conflicts of interest process



Appendix F

Template declarations of interest checklist

There is a legal obligation to manage conflicts of interest appropriately. It is essential that declarations of interest and actions arising from the declarations are recorded formally and consistently across the board, committee and sub-committee meetings. This checklist has been developed with the intention of providing support in conflicts of interest management to the Chair of the meeting- prior to, during and following the meeting. It does not cover the requirements for declaring interests outside of the committee process.

Timing	Checklist for Chairs	Responsibility
In advance of the meeting	**1.** **The agenda** to include a standing item on declaration of interests to enable individuals to raise any issues and/or make a declaration at the meeting.	Meeting Chair and secretariat
	2. A **definition of conflicts of interest** should also be accompanied with each agenda to provide clarity for all recipients.	Meeting Chair and secretariat
	3. **Agenda** to be circulated to enable attendees (including visitors) to identify any interests relating specifically to the agenda items being considered.	Meeting Chair and secretariat
	4. **Members should contact the Chair** as soon as an actual or potential conflict is identified.	Meeting members
	5. Chair to review a **summary report (which could be included on the Chair's sheet) from preceding meetings** i.e., sub-committee, working group, etc., detailing any conflicts of interest declared and how this was managed.	Meeting Chair
	The Chair's sheet would include information relating to discussions at preceding meetings, e.g.,	Meeting Chair
	6. A **summary of the members' declared interests** is checked to establish any actual or potential conflicts of interest that may occur during the meeting.	

During the meeting	**7. Check and declare the meeting is quorate** and ensure that this is noted in the minutes of the meeting.	Meeting Chair
	8. Chair requests **members to declare any interests in agenda items**- which have not already been declared, including the nature of the conflict.	Meeting Chair
	9. Chair makes a decision as to how to manage each interest which has been declared, including whether / to what extent the individual member should continue to participate in the meeting, on a case by case basis, and this decision is recorded.	Meeting Chair and secretariat
	10. As minimum requirement, the following should be **recorded in the minutes of the meeting**: • Individual declaring the interest; • At what point the interest was declared; • The nature of the interest; • The Chair's decision and resulting action taken; • The point during the meeting at which any individuals retired from and returned to the meeting - even if an interest has not been declared; • **Visitors in attendance** who participate in the meeting must also follow the meeting protocol and declare any interests in a timely manner. **A template for recording any interests during meetings** is detailed below.	Secretariat
Following the meeting	**11.** All **new interests declared** at the meeting should be promptly updated onto the declaration of interest form;	Individual(s) declaring interest(s)
	12. All new completed declarations of interest should be **transferred onto the register of interests.**	Designated person responsible for registers of interest

Partners in improving local health

North of England Commissioning Support

Value Based Clinical Commissioning Policies

North East & North Cumbria

Integrated Care Board

Version 11

Implementation: 31st May 2022

Contents

Introduction

Across the country most, if not all, ICB'Ss have a set of policies and procedures for limiting the number of low clinical value interventions. The Audit Commission's report 'Reducing expenditure on low clinical value treatments'[2] analyses variation on approaches to this work. This approach was based on the 'Save to Invest' programme developed by the London Health Observatory[3] incorporating the 'Croydon List' of 34 low priority treatments.

In addition, the national Evidence-Based Interventions (EBI) programme was launched in 2018 in partnership with the Academy of Medical Royal Colleges, NHS Clinical Commissioners, the National Institute for Health & Excellence (NICE), NHS England & Improvement, Royal Colleges, specialist societies, ICB'Ss, providers and the public. The aim of the programme is to improve the quality of care and is designed to reduce the number of medical or surgical interventions as well as some other tests and treatments which the evidence tells us are inappropriate for some patients in some circumstances. It is also recognised that sometimes these interventions can do more harm than good.

As well as improving outcomes, a further aim of the national EBI Programme is to free up valuable resources so they can be put to better use elsewhere in the NHS. The EBI programme develop and publish national policy on a range of procedures / interventions, the first set of proposals being consulted on nationally during 2018 and published as national policy in April 2019. EBI is a rolling programme of work which is expected to evolve and expand the number of national policies over time.

How this Policy works

This policy sets out a consistent approach by ICB'Ss across the North East and North Cumbria to stop variation in access to NHS services and allow fair and equitable treatment for all local patients. Revisions to the policy are managed and co-ordinated by a clinically-led North East & North Cumbria Policy Development and Review Group.

For clarity there are two differing processes in place to apply for NHS funding for these procedures:

Check+ – This is a web-based system which incorporates specific modules for both aspects of this policy. The EBIcheck+ module enables primary and secondary care clinicians to obtain instant funding approval where the patient meets the clinical criteria for the procedure. A patient does not need to follow the Individual Funding Request

[2]Reducing expenditure on low clinical value treatments. Audit Commission, April 2011. https://www.audit-commission.gov.uk/nationalstudies/health/financialmanagement/lowclinicalvalue/Pages/Default.aspx

[3]Save to Invest: Developing criteria-based commissioning for planned health care in London. Malhotra N. Jacobson B. 2007. https://www.lho.org.uk/Download/Public/11334/1/Save%20To%20Invest%20-%20Commissioning%20for%20Equity.pdf

(IFR) process in these circumstances. The IFRcheck+ module manages IFR submissions.

Individual Funding Request (IFR) – The IFR process is to be used in circumstances when a patient does not meet the clinical criteria for a procedure as set out in this policy document but can demonstrate exceptionality in accordance with the definition.

Exceptionality is defined as:
'The patient or their circumstances are significantly different from the general population of patients with the condition in question ***and*** *the patient is likely to gain significantly more benefit from the intervention than might normally be expected for patients with that condition.'*

Where procedures do not require prior approval to be obtained for NHS funding before the treatment takes place, these are identified as 'Monitored Approval' within the policy document. Further information on this category of policy is included within the FAQ section.

Due to the expansion of this document through the inclusion of national EBI Policies, along with the nature of some of the procedures / interventions identified within the EBI programme being more related to pathways, the number of policies identified in the Monitored Approval category has significantly increased. In response to this, and specific feedback received about improving the usability of the policy, the document has been split into two sections for ease of use by end users:

- Section 1: IFR and Prior Approval Policies
    - *This section includes all policies which require approval to be confirmed prior to the treatment taking place*
- Section 2: Monitored Approval Policies
    - *This section includes all policies which do not need approval to be confirmed prior to the treatment taking place*

Frequently Asked Questions (FAQs)

Why do we need policies?

NHS resources come under ever greater pressures each year. Ensuring that treatment and care is focused where it can make the biggest difference is a key part of making best use of these resources. This is a key challenge for all NHS organisations, and a prime focus for commissioning among ICB'Ss. These policies help clinicians identify interventions with limited benefit, thereby providing potential for reinvesting elsewhere, where potential benefits are greater.

The alternative to having policies of this kind is to leave each decision to individual GPs, to manage individual dilemmas without guidance and without the context of the health needs of the wider population.

The Academy of Medical Royal Colleges has launched a Choosing Wisely campaign (https://www.choosingwisely.co.uk/) which is aligned to the North East and Cumbria approach to increasing value and improving population health.

At the heart of the Choosing Wisely initiative is a call to both doctors and patients to have a fully informed conversation about the risks and benefits of treatments and procedures. As well as releasing resources for other activities, it says patients should always ask five key questions when seeking treatment. They are:

1. Do I really need this test, treatment or procedure?
2. What are the risks or downsides?
3. What are the possible side effects?
4. Are there simpler, safer options?
5. What will happen if I do nothing?

In a study carried out last year, 82% of doctors said they had prescribed or carried out a treatment which they knew to be unnecessary. The vast majority of this group cited patient pressure or patient expectation as the main reason.

What do these policies cover?

These cover interventions where there is significant risk that patients undergoing them will gain little health benefit.

The procedures have low rather than no clinical value. Some may be effective but may have low value because other (medical) treatments could be tried first. Other effective procedures may provide large benefits for some patients but less to those with few symptoms, where risks and benefits are closely balanced. There are interventions which are effective in some but give no clinical value in others.

Finally, there are those interventions that whilst effective, are undertaken for primarily cosmetic reasons, which commissioners often consider as providing low clinical value.

Who are they for?

They are to assist clinicians in making referral decisions, where the principal reason for referral is for surgical intervention. They are also to assist providers of treatment and surgical services and are a statement about what the NHS will routinely pay for.

How has the policy been compiled and developed?

The policies have been compiled by a group of clinical decision-makers, GPs, and Public Health specialists, with advice and guidance from clinical specialists and regional networks. The group has used published evidence and guidance, alongside expert opinion to develop and refine this set of policies.

These policies are kept under constant review to ensure the policies are in-line with evidence and best practice. This process is managed and coordinated across the North East and Cumbria to ensure that there is consistency in the policies and their application.

How often will this policy be reviewed?

Commissioners plan to review policy content on an annual basis. However, there may be occasions whereby this is more frequent for example upon receipt of new national or local guidance from organisations such as NICE or NTAG.

Are the policies categorised in any way?

Yes - Procedures within this policy are categorised and identified into 3 cohorts.

The first two categories are those procedures / interventions which require approval to be confirmed prior to the treatment taking place. This will be either through an Individual Funding Request, which must be submitted for consideration by the relevant commissioner, or a Prior Approval which can be generated at the point of assessing the patient, provided that the patient clearly demonstrates meeting the relevant criteria. All procedures / interventions that fall into these two categories are contained within the first section of the policy.

The final category of policies is identified as 'Monitored Approval'. These are procedures / interventions that do not need any form of approval to be confirmed prior to the treatment taking place. These policies relate predominantly to treatments that have been identified as best practice pathways, rather than treatments that have limited clinical benefit. It can also include treatments that are very small in volumes

carried out. Whilst these policies do not require approval prior to treatment, the pathways are subject to review in relation to activity levels and any variation observed. Monitored Approval policies, whilst not requiring prior approval to be obtained prior to treatment, will be included in the regional EBIcheck+ tool to provide a complete suite of policies and be available as a point of reference. These policies are found in section 2.

The 3 cohorts of activity are specified below:

Category 1 (IFR): Interventions that are not routinely commissioned, with patients only able to access such treatments where an Individual Funding Request (IFR) is agreed.

Category 2 (Prior Approval): Interventions that should only be performed where specific criteria are met. These procedures should only be carried out where prior approval (PAT) is obtained from Commissioners to demonstrate compliance with the criteria.

Category 3 (Monitored Approval): Interventions that should only be performed where specific criteria are met. These procedures can take place without the need to first obtain prior approval from Commissioners, but it is the provider's responsibility to ensure that all clinicians are compliant with policy criteria and have appropriate monitoring mechanisms in place. Although a PAT is not necessarily required, the procedure/intervention will still be available to access and through EBIcheck+.

Is securing funding a guarantee of treatment?

Approval for NHS funding is NOT the same as a guarantee of treatment. Funding (the role of the commissioner for a whole population) is often requested before specialist assessment. The ultimate decision about safety and appropriateness of treatment is a clinical one which must be discussed with the patient.

What about treatments that have already started under private arrangements?

If treatments have already been started under private arrangements, the overarching assumption is that a whole package of care has been purchased and its potential complications taken account of and explained to the patient. Therefore, it would be unreasonable to expect the NHS to pick up the costs associated with private treatment unless there is a medical emergency, or some other exceptional circumstance – see specific policies for further details. Running out of funds, whilst unfortunate, is not exceptional.

Notwithstanding this point, it is recognised that an individual who has commenced treatment that would have been routinely commissioned by the NHS on a private basis

can, at any stage, request to transfer to complete the treatment within the NHS. However, at the point that the patient seeks to transfer back to NHS care, the patient would be required to be reassessed by an NHS clinician in line with the relevant current policy to ensure compliance with the latest criteria. In addition, where criteria is met, the patient will not be given any preferential treatment by virtue of having accessed part of their care privately and will be subject to standard NHS waiting times.

Likewise, if a device has been privately purchased and initiated, the NHS will not pick up the costs of consumables or maintenance, unless the patient meet NHS criteria. For example, a patient who has purchased a continuous glucose monitor would be expected to have sufficient funds to purchase consumables for the life of the device unless they meet the NHS criteria for the device.

What about treatments that have been started and completed under private arrangements?

Funding is not provided retrospectively. If treatment has been completed under private arrangements it is assumed that the patient has sufficient funds to cover this treatment.

What about the continuation of experimental treatments/loaned device trials?

The continuation of experimental treatments/loaned device trials will not be routinely funded. Initiating patients on treatments without clear evidence of safety, efficacy, effectiveness or cost-effectiveness raises patient expectations that the treatment will be continued. Where treatments are initiated by providers on a loan/ experimental basis this is done at the provider's own risk. The provider must be clear with the patient about the end point/ exit strategy for the trial and/ or continuing care.

This excludes formal clinical research trials for which there are separate arrangements between funders and providers.

What if surgeons undertake procedures outside the indications in these policies?

There is no guarantee of payment in accordance with the legally binding contract.

EBIcheck+ Frequently Asked Questions

What is EBIcheck+?

EBIcheck+ is a module contained within the Check+ system which enables primary and secondary care clinicians to obtain instant funding approval where the patient meets the clinical criteria for the procedure. EBIcheck+ was formally known as vbcchecker.

What should EBIcheck+ be used for?

EBIcheck+ should be used in the first instance for any patients being referred or treated for any procedures documented within this policy

Which part of the policy is governed by the EBIcheck+ process?

The whole policy document forms part of the EBIcheck+ requirements. There are no exclusions to this.

Who can make an application for funding through EBIcheck+?

EBIcheck+ is available to use by both primary and secondary care. If the procedure required is known at the point of referral it is expected that the prior approval ticket (PAT) will be generated by the GP. If the GP refers for an opinion and secondary care clinicians advise that a specific procedure is needed, then the PAT should be generated by secondary care.

What happens if the patient does not meet the criteria?

If the patient does not meet the specific policy criteria and the clinician believes that the patient can demonstrate exceptionality, then the Individual Funding Request (IFR) process should be followed. Those submitting an IFR (typically the patient's GP) will be able to do so using the IFRcheck+ module which is also contained within the Check+ system.

What if a GP makes a referral outside the criteria outlined in these policies?

Secondary Care have the option to reject the referral back to primary care for completion of the funding approval or complete the PAT themselves. Both options are supported by ICB'Ss.

Individual Funding Request (IFR) Frequently Asked Questions

When should we use the IFR Process?

The IFR process is to be used in circumstances when a patient does not meet the clinical criteria for a procedure as set out in this policy document but can demonstrate exceptionality in accordance with the definition.

Exceptionality is defined as:

'The patient or their circumstances are significantly different from the general population of patients with the condition in question ***and*** *the patient is likely to gain significantly more benefit from the intervention than might normally be expected for patients with that condition.'*

Can psychological considerations be taken into account within the definition of exceptionality?

Accounting for psychological factors in arriving at a decision about eligibility for NHS funding is hard to do in a clear and fair way. These considerations have been removed from this policy as psychological distress unfortunately does not constitute clinical exceptional circumstance.

NICE guidance indicates that clinicians should consider the possibility of Body Dysmorphic Syndrome when making referral for plastic surgery (NICE Guidance 31).

Should photographs be submitted with the IFR?

Photographs are not used in consideration of exceptionality - and handling them presents significant risks of compromising confidentiality. Please do **NOT** submit photographs. Any photographs received will be returned to sender upon receipt and an incident will be logged on Safeguard Incident and Risk Management System (SIRMS).

How can pain and significant functional impairments/ limitations to activities of daily living endured by patients be demonstrated in an IFR case?

Pain has been defined as an "unpleasant sensory and emotional experience arising from actual or potential tissue damage" with clinical pain being "whatever the person says he or she is experiencing whenever he or she says it occurs" and is therefore subjective.[4]

[4] Fink, R. (2000) Pain assessment: the cornerstone to optimal pain management, Baylor University Medical Centre Proceedings, 13(3): 236-239

There is insufficient evidence to use questionnaire derived scores to evidence pain in individuals. Therefore, in lieu of a standard assessment tool, alternative clear and objective evidence must be provided when demonstrating patient pain and significant functional impairments/ limitations to activities of daily living.

This evidence should include documented assessments and/ or patient history, including:

- A description of the pain and which daily activities are no longer achievable;
- Prescribing history;
- Recorded sickness/ absence due to pain/ functional impairment;
- Evidence from functional tests/ investigations, such as gait analysis, physiotherapy/ OT assessment;
- History of the pain/ impairment and the response to/ impact/ effect of conventional therapies available.

Significant functional impairment is defined as:

- Symptoms that result in a physical/ functional inability to sustain employment/ education despite reasonable occupational adjustment, or act as a barrier to employment or undertaking educational responsibilities;
- Symptoms preventing the patient carrying out routine domestic or carer activities;
- Symptoms preventing the patient carrying out self-care or maintaining independent living.

Cosmetic Procedures

Treatments or surgery are not eligible for NHS funding. A significant degree of exceptionality must be demonstrated before funding can be considered outside of these policies. Specifically, psychological factors are not routinely taken into consideration in determining NHS funding.

Whilst some degree of distress is usual among people who consider aspects of their physical appearance as undesirable, the degree of this will not routinely be taken into account in any funding decision. Further, it is expected clinicians consider the possibility of psychological problems including Body Dysmorphic Syndrome NICE Guidance CG31 assess for these and ensure appropriate management before considering any referral for plastic surgery.

This guidance applies to many of the following policies, in particular:

Abdominoplasty or Apronectomy	Circumcision
Breast asymmetry	Vaginoplasty, Labial Vulvoplasty and Vulvar
Breast augmentation (Breast enlargement)	Lipoplasty
Breast prosthesis removal or replacement	Hirsutism
Breast reduction	Removal of tattoos
Bunion surgery	Resurfacing procedures
Ganglion removal	Face lift or brow lift
Gynaecomastia	Liposuction
Inverted nipple correction	Removal of benign skin lesions
Mastopexy	Thigh lift, buttock lift and arm lift
Revision mammoplasty	Surgical Treatment for Hair Loss
Blepharoplasty	Oculoplastic Eye Problems
Pinnaplasty	Surgical Fillers
Repair of lobe of external ear	Varicose veins
Septorhinoplasty	

Commissioning Responsibility

The procedures contained within this policy document are the commissioning responsibility of Integrated Care Boards (ICB'Ss). There are a number of procedures / treatments that fall within the commissioning responsibility of NHS England (NHSE), and as such, providers should satisfy themselves that they are following the relevant policy prior to undertaking any interventions. Examples of such procedures that are NHSE commissioning responsibility include:

- Autologous Cartilage Transplantation
- Bone Morphogenetic Protein
- Cervical disc prosthesis

Section 1:

IFR & Prior Approval Policies

Policies which require approval to be confirmed prior to the treatment taking place

Breast Surgery

Breast – Asymmetry	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

This policy does not apply to breast reconstruction as part of the treatment for breast cancer.

Policy:

Surgical correction of breast asymmetry will not be routinely funded.

Please note: this policy does not apply to breast reconstruction or other surgery to obtain symmetry as part of the treatment for breast cancer

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Breast – Augmentation	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

This policy does not apply to breast reconstruction following mastectomy for treating breast cancer.

Policy:

Breast augmentation will not be routinely funded.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Breast – Inverted Nipple Correction	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

The term inverted nipple refers to a nipple that is tucked into the breast instead of sticking out or being flat. It can be unilateral or bilateral. It may cause functional and psychological disturbance. Nipple inversion may occur as a result of an underlying breast malignancy, and it is essential that this be excluded.

Policy:

Surgery for the correction of inverted nipple for cosmetic reasons will not be funded.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Breast – Mastopexy	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Breasts begin to sag and droop with age as a natural process. Pregnancy, lactation and substantial weight loss may escalate this process. This is sometimes complicated by the presence of a prosthesis which becomes separated from the main breast tissue leading to "double bubble" appearance.

This policy does not apply to breast reconstruction as part of the treatment for breast cancer.

Policy:

Mastopexy will not be routinely funded.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Breast – Prosthesis Replacement	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Breast prosthesis may have to be removed after some complications such as leakage of silicone gel or physical intolerance. This policy deals with the potential replacement of a prosthesis.

Policy:

Breast Prosthesis replacement will only be funded under the following circumstances:

- There is grade 4 capsule formation OR radiological evidence of implant failure OR the patient has a Poly Implant Prosthesis (PIP) implant

AND

- The original procedure was provided by the NHS

AND

- The original implant insertion was following cancer surgery, trauma, developmental asymmetry, or surgery for the alleviation of symptoms of gender dysphoria

AND

- The replacement of prosthesis (on a like-for-like basis) has been discussed with the patient and is agreed as the best course of action by the treating clinician

Please note – PIP Implants: If a patient has had Poly Implant Prostheses (PIP) breast implants originally fitted on the NHS, these may be removed and replaced. If a patient wishes to have replacement prosthesis following the removal of PIP implants, but the criteria above are not applicable, please follow the IFR process for these individual cases.

Please note: Replacement of both implants may occur where all criteria above are met for at least one implant being removed, and where the treating clinician and patient agreed the removal and replacement of both implants is the most appropriate outcome.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Breast – Reduction	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Excessively large breasts can cause physical and psychological problems. Breast reduction procedures involve removing excess breast tissue to reduce size and improve shape. As excess weight is likely to exacerbate symptoms associated with large breasts, it is assumed that patients going forward for surgery will be near normal weight.

Assessing eligibility for surgery is problematic not least because there are several recognised approaches to measuring bra size http://www.wikihow.com/Measure-Your-Bra-Size, some of which relate to historical manufacturing standards.

The following approach to calculating cup size is recommended for standardisation (extracted from Modern Sizing section of above reference): subtract band size (below the breast) from the bust size (at the widest point). The difference between the two numbers determines cup size:

Less than 1 inch difference = AA
1 inch difference= A
2 inches = B
3 inches = C
4 inches = D
5 inches = DD
6 inches = DDD (E in UK sizing)
7 inches = DDDD/F (F in UK sizing)
8 inches = G/H (FF in UK sizing)
9 inches = I/J (G in UK sizing)
10 inches = J (GG in UK sizing)

This policy does not apply to breast reconstruction as part of the treatment for breast cancer.

Policy:

Breast reduction will only be funded in accordance with ALL of the criteria specified below.
For women:

- The woman has received a full package of supportive care from their GP such as advice on weight loss and managing pain.

AND

- In cases of thoracic / shoulder girdle discomfort, a physiotherapy assessment has been provided

AND

- Breast size results in functional symptoms that require other treatments/interventions (e.g., intractable candidal intertrigo; thoracic backache/kyphosis where a professionally fitted bra has not helped with backache, soft tissue indentations at site of bra straps).

AND

- Breast reduction planned to be 500gms or more per breast or at least 4 cup sizes.

AND

- Body mass index (BMI) is <27 and stable for at least twelve months.

AND

- Woman must be provided with written information to allow her to balance the risks and benefits of breast surgery.

AND

- Women should be informed that smoking increases complications following breast reduction surgery and should be advised to stop smoking.

AND

- Women should be informed that breast surgery for hypermastia can cause permanent loss of lactation.

Surgery for primarily cosmetic reasons is not eligible for NHS funding.

Repeat surgeries will <u>not</u> be routinely commissioned.

Breast – Revisions of Breast Reduction Surgery & Repeated Courses of Nipple Tattooing	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Breast reconstruction is surgery to make a new breast after removal of the breast or part of the breast **due to cancer treatment or prevention**. The aim is to make a breast of similar size and shape to the original breast. Breast reconstruction can be done at the same time as the cancer surgery (immediate reconstruction), or after cancer surgery (delayed reconstruction) and may involve the use of implants to achieve the desired effect. Nipple tattooing is also a recognised procedure in relation to breast reconstruction surgery following treatment for breast cancer in order to improve the appearance of the breast.

Policy:

A full course of treatment will be funded for patients undergoing either immediate or delayed breast reconstruction surgery, to include all aspects of the reconstruction. This includes the provision of implant(s) for the reconstruction, and one course of treatment for Nipple Tattooing.

Revisions of reconstruction surgery for purely cosmetic reasons and further courses of Nipple Tattooing will not be funded.

Please Note: Breast Reconstruction Surgery Post Mastectomy does NOT require Prior Approval

Cardiology

Exercise ECG for Screening for Coronary Heart Disease	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Exercise electrocardiogram (ECG) is a type of cardiac stress test that should no longer be used to screen for coronary heart disease (CHD).

Exercise ECG has no role in the screening of asymptomatic and low risk patients for coronary heart disease because it has a very low pre-test probability of identifying pathology. Risk calculators, such as Systematic Coronary Risk Evaluation (SCORE), are instead recommended to identify patients who are at greater risk of CHD.

Under the guidance of cardiologists, the test has a limited role for diagnosis in selected patients with symptoms suggestive of CHD, and/or where CHD has been diagnosed to confirm functional capacity or severity.

This guidance applies to adults aged 19 years and over.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy:

ECG for Screening for Coronary Heart Disease will NOT be routinely funded.

Surgical Intervention for Benign Prostatic Hyperplasia	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Transurethral resection of prostate (TURP) is a therapeutic procedure involving removal of tissue from the inner aspect of the prostate using diathermy, via an endoscopic approach. It is commonly undertaken for voiding lower urinary tract symptoms (LUTS) presumed secondary to benign prostatic hyperplasia (BPH).

TURP is undertaken on an in-patient basis, with a catheter left in-situ for 24-48 hours post-op for the purpose of irrigation. TURP may be undertaken under either general or spinal anaesthesia.

TURP causes temporary discomfort, occasionally pain, haematuria and is associated with small risks of infection and acute urinary retention after removal of the catheter. There is also a risk of sexual dysfunction following TURP. There are small but significant risks of significant harm, including severe fluid and electrolyte imbalances associated with absorption of large volumes of irrigating fluid (TUR syndrome). TUR syndrome can be avoided by using bipolar diathermy, a variant of the standard technology.

TURP is the longest established of a range of endoscopic surgical procedures for benign enlargement of the prostate, with varying indications and potential complications. These include, among others:

- Transurethral incision of the prostate (TUIP) or Bladder Neck Incision (BNI)
- Holmium LASER enucleation of the prostate
- 532 nm ('Greenlight') laser vaporisation of the prostate
- UroLift
- Transurethral needle ablation of the prostate (TUNA)
- Transurethral vaporisation of the prostate (TUVP)
- Transurethral water vapour therapy (Rezum)

Open simple/benign prostatectomy is uncommonly undertaken in men with very large prostates and problematic symptoms. Newer ablative therapies are currently under evaluation and non-surgical procedures such as prostatic artery embolisation (PAE).

This guidance applies to male adults aged 19 years and over.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy: Only men with severe voiding symptoms, or in whom conservative management options and drug treatment have been unsuccessful, should be offered surgical intervention. Surgery is indicated (in healthy men) in complicated BPH i.e., chronic retention with renal impairment as evidenced by hydronephrosis and impaired GFR, and in most cases of acute retention secondary to BPH. The following criteria need to be met:

- The person is healthy and has complicated benign prostatic hyperplasia (i.e., chronic retention with renal impairment) as evidenced by hydronephrosis and impaired GFR

OR

- Other evidence of complicated BPH (e.g., urinary tract infections, bladder stones or acute urinary retention)

OR

- Bothersome LUTS persist alongside high, or unchanged International Prostate Symptom Scores despite optimal conservative and drug treatment

AND

- Shared Decision Making process has been carried out and the person has been counselled thoroughly regarding alternatives

Cardiovascular

Resperate Devices for Hypertension	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Resperate is a portable electronic device that promotes slow, deep breathing. Resperate is approved by the Food and Drug administration for reducing stress and lowering blood pressure.

Policy:

Resperate device for hypertension is not routinely commissioned owing to inadequate evidence of long term benefit over other relaxation techniques.

As such, clinicians should not routinely prescribe or recommend this product to patients either as monotherapy or an adjunct to pharmacological management because there is limited clinical evidence of effectiveness.

Complementary & Alternative Medicines

Complementary & Alternative Medicines	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Complementary and alternative medicines (CAMs) are treatments that fall outside of mainstream healthcare. These medicines and treatments range from acupuncture, massage and homeopathy to aromatherapy, meditation transcutaneous electrical nerve stimulation (TENS) and colonic irrigation.

Policy:

Complementary and alternative therapies, outside of existing ICB'S commissioned services and pathways, will not be routinely funded.

Dermatology

Hyperhidrosis - Referral	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Hyperhidrosis is a condition characterised by excessive sweating and can be generalised or focal. Generalised hyperhidrosis involves the entire body, and is usually part of an underlying condition, most often an infectious, endocrine or neurological disorder. Focal hyperhidrosis is an idiopathic disorder of excessive sweating that mainly affects the axillae, the palms, the soles of the feet, armpits and the face of otherwise healthy people. Depending on the severity of the hyperhidrosis, it can be managed in primary or secondary care.

Primary care: lifestyle management, such as regular night-time antiperspirant use (up to 20% aluminium chloride hexahydrate available OTC), avoiding tight clothing and manmade fabrics, wearing white or black clothing to minimize the signs of sweating, dress shields to absorb excess sweat, and avoiding stimuli such as caffeine, spicy foods or crowded areas. Underlying anxiety should be treated.

More patient information and support is available from Hyperhidrosis UK. http://hyperhidrosisuk.org/

References:

http://cks.nice.org.uk/hyperhidrosis#!scenario
http://www.bad.org.uk/
http://hyperhidrosisuk.org/

Policy:

Referral for Hyperhidrosis will only be funded in accordance with the criteria below:

- The search for an underlying cause has been exhausted

AND

- Any underlying anxiety has been identified and managed

AND

- Advice on lifestyle management has been followed for a minimum of 2 months (use an antiperspirant frequently, avoid tight clothing and manmade fabrics, wear white or black clothing to minimize the signs of sweating, consider dress shields to absorb excess sweat)

AND

- 20% aluminium chloride hexahydrate has failed or is contraindicated

AND

- Hyperhidrosis Disease Severity Scale (HDSS) 3 or 4

AND

- The patient has medical complications of hyperhidrosis (i.e., skin macerations and secondary infections).

Note: There must be a minimum of 6 months duration between Botulinum Toxin injections.

Hyperhidrosis - Thoracic Sympathectomy (Endoscopic or Open)	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Hyperhidrosis is a condition characterised by excessive sweating and can be generalised or focal. Generalised hyperhidrosis involves the entire body, and is usually part of an underlying condition, most often an infectious, endocrine or neurological disorder. Focal hyperhidrosis is an idiopathic disorder of excessive sweating that mainly affects the axillae, the palms, the soles of the feet, armpits and the face of otherwise healthy people. Depending on the severity of the hyperhidrosis, it can be managed in primary or secondary care.

Policy:

Thoracic Sympathectomy (Endoscopic or Open) for the treatment of hyperhidrosis is not routinely funded.

Hyperhidrosis Treatment with Botulinium Toxin	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Hyperhidrosis is a condition characterised by excessive sweating and can be generalised or focal. Generalised hyperhidrosis involves the entire body, and is usually part of an underlying condition, most often an infectious, endocrine or neurological disorder. Focal hyperhidrosis is an idiopathic disorder of excessive sweating that mainly affects the axillae, the palms, the soles of the feet, armpits and the face of otherwise healthy people. The principal management strategies for hyperhidrosis are medical https://cks.nice.org.uk/hyperhidrosis

Botulinum Toxin is only licensed for the treatment of severe axillary hyperhidrosis and its cost effectiveness compared to other treatment options is yet to be established.

Policy:

Botulinum Toxin will only be funded in the management of severe *axillary* hyperhidrosis in accordance with the criteria below:

- The search for an underlying cause has been exhausted

AND

- Any underlying anxiety has been identified and managed

AND

- Advice on lifestyle management has been followed for a minimum of 2 months (use an antiperspirant frequently, avoid tight clothing and manmade fabrics, wear white or black clothing to minimize the signs of sweating, consider dress shields to absorb excess sweat)

AND

- 20% aluminium chloride hexahydrate has failed or is contraindicated

AND

- Hyperhidrosis Disease Severity Scale (HDSS) 3 or 4

AND

- The patient has medical complications of hyperhidrosis (i.e., skin macerations and secondary infections).

AND

- In the opinion of an experienced dermatologist, other treatment options have been exhausted (including anticholinergics e.g.: propantheline)

AND

- The patient is 17 years or older

Note: There must be a minimum of 6 months duration between Botulin Toxin injections

Removal of Benign Skin Lesions	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Benign skin lesions (across the body including eyelids) include a wide range of skin disorders such as epidermoid and pilar cysts (sometimes referred to as sebaceous cysts) , dermoid cyst, lipoma(ta), skin tags (including anal skin tags), milia, molluscum contagiosum, seborrhoeic keratoses (basal cell papillomata), spider naevus (telangiectasia), non-genital viral warts in immunocompetent patients, sebaceous cysts, thread veins, xanthelasma, dermatofibromas, benign pigmented moles, neurofibromata, comedones and corn/callous.

Disfiguring scars and keloid or hypertrophic scars (including acne scarring), whether arising from prior injury or surgery, are also included in the scope of this policy.

Mostly these are removed on purely cosmetic grounds. The risks of surgical scarring must be balanced against the appearance of the lesion. Patients with multiple subcutaneous lipomata may need a biopsy to exclude neurofibromatosis.

Policy:

Removal, cryotherapy or treatment (in secondary care) of benign skin lesions will only be funded in accordance with the criteria specified below:

- There is well documented evidence of significant pain (see FAQs)

OR

- The lesion is unavoidably and significantly traumatised on a regular basis with evidence of this causing regular bleeding or resulting in infections such that the patient requires 2 or more courses of antibiotics (oral or intravenous) per year

OR

- there is impairment of visual fields

Where the lump is rapidly growing, abnormally located and/ or is displaying features suspicious of malignancy, specialist assessment should be sought using the 2 week wait pathway.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Note: If an IFR is obtained for the treatment of a keloid or hypertrophic scar, the number of treatments with intralesional triamcinolone will be limited to 3.

Rhinophyma	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Rhinophyma is the term used to describe the overgrowth and distortion of the soft tissues of the nose. This uncommon condition develops as an end point of chronic inflammatory processes within the rosacea spectrum. While the cosmetic impact is the most obvious consequence and may lead to social isolation and severe emotional distress, patients also commonly develop airflow obstruction, leading in some cases to complete nasal blockage.

The development of rosacea may be prevented or reduced by appropriate treatment of rosacea in the early stages, but once established there is rarely any benefit from medical management. The most effective surgical treatment for severe or symptomatic cases is a single local anaesthetic day case procedure to remove excess tissue and reshape the normal nasal contours using electrosurgery. The treatment site is left to heal naturally, with excellent results and high patient satisfaction in most cases.

Policy:

Surgical treatment for Rhinophyma is only offered as a treatment option for adults where the following criteria are met:

- There is significant phymatous change and where isotretinoin unlikely to be effective

AND

- There is clear evidence of significant airflow obstruction or blockage

AND

- Surgical treatment (including laser ablation when appropriate) has been recommended by a Consultant Dermatologist

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Diabetes

Continuous Glucose Monitoring	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Continuous Glucose Monitoring (CGM) is a device including a sensor self-inserted subcutaneously, which records blood glucose levels through the day and night. This can help individuals with variable and unpredictable glucose levels achieve safer and more stable overall control, improve metabolic control, reduce hypoglycaemia episodes and improve quality of life.

Policy:

Continuous Blood Glucose Monitors for Type 1 Diabetes will only be funded in accordance with the criteria specified below, and where requests are made by a Consultant Diabetologist :

- Disabling hypoglycaemia despite optimal self-management supported by a secondary care specialist team

OR

- Inability to recognise hypoglycaemia due to age or communicate about, symptoms of hypoglycaemia (for example, because of cognitive or neurological disabilities)

OR

- Dangerously erratic glucose levels leading to decompensated high glucose levels and diabetic ketoacidioosis

OR

- For pregnant women with labile blood glucose or dangerous hypoglycaemia

OR

- Transition from paediatric care where patients are already using CGM and having demonstrated significant clinical benefit justifying ongoing provision

OR

- Children and young people who undertake high levels of physical activity at a regional, national, or international level, that despite optimal management and education is leading to suboptimal diabetes control

OR

- Meets current NICE guidance on use of CGM for patients living with Type 1 Diabetes

All initial requests are made on the basis of a short term (maximum 6 months) trial of continuous monitoring. Where there have been successful results of the trial, a further request for long term funding should be made.

Continuous Glucose Monitoring should be discontinued after a six month trial if no improvement is demonstrated

Continuous Sub-Cutaneous Insulin Infusion for Adults and Children over 12 years	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

NICE technology appraisal TA151 on insulin pump therapy states that continuous subcutaneous insulin pump therapy is recommended as a treatment option for adults and children 12 years and older with type 1 diabetes mellitus to improve control of blood sugar and reduce the rate of hypoglycaemia (low blood sugar levels).

Policy:

Insulin Pumps and consumables are only offered as a treatment option for adults and Children 12 years and over where the following criteria are met:

- Attempts to reach target haemoglobin A1c (HbA1c) levels with multiple daily injections result in the person having disabling hypoglycaemia

OR

- HbA1c levels have remained high (8.5% or above) with multiple daily injections despite the person and/or their carer carefully trying to manage their diabetes

AND

- Patient has Type 1 diabetes mellitus

AND

- Treatment is only started by a secondary care multidisciplinary diabetes team including diabetes doctors, specialist nurses and dieticians

AND

- Provision will include the device (either new or renewal) and all relevant consumables and technical support requirements

Note: This policy includes the use of Patch Pumps. Where a patient meets the criteria, it is understood that Prior Approval remains in place for the period the patient requires the use of an insulin pump.

Continuous Sub-Cutaneous Insulin Infusion in Children under 12	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

The recommendations of NICE and other studies including the RCPCH NPDA technology audit demonstrate the potential benefits of the use of insulin pumps when clinically indicated for children under 12 years old.

Policy:

Insulin Pumps and consumables are only offered as a treatment option for Children less than 12 years old where the following criteria are met:

- Patient has Type 1 diabetes mellitus

AND

- MDI therapy is considered to be impractical or inappropriate as determined by a secondary care multidisciplinary diabetes team including diabetes doctors, specialist nurses and dieticians

AND

- The patient and their carer are aware that they will be expected to transition off the insulin pump and undergo a trial of MDI therapy between the ages of 12 and 25 years, the timing and appropriateness of which will be clinically determined.

AND

- Treatment is only started by a secondary care multidisciplinary diabetes team including diabetes doctors, specialist nurses and dieticians

AND

- Provision will include the device (either new or renewal) and all relevant consumables and technical support requirements

Note: This policy includes the use of Patch Pumps. Where a patient meets the criteria, it is understood that Prior Approval remains in place for the period the child requires the use of an insulin pump, noting the criteria that transition off the insulin pump between the ages of 12 and 25 years should be considered.

Please be aware this policy relates to children under 12 years old **only.** For children 12 years old and over, who have not yet commenced treatment, please refer to the policy for Continuous Sub-Cutaneous Insulin Infusion for Adults and Children over 12 years.

Flash Glucose Monitoring	Category: *(IFR / Prior Approval / Monitored Approval)*	Prior Approval
	Local or National EBI (Evidence Based Interventions) Policy:	Local

Background:

Flash Glucose Monitoring (for example, Freestyle Libre® devices) are classified as a red device and therefore can only be initiated and prescribed by specialist secondary care clinicians.

Consumables for this device should be prescribed for a period of time aligned to a patient's required routine outpatient appointments. Additional outpatient appointments should not be made purely for the purpose of obtaining repeat prescription for associated consumables. In these circumstances, the ICB'S will not pay for additional outpatient appointments.

In circumstances where a patient has bought their own device or has been provided with the device as part of a clinical trial, consumables will only be funded when prior approval has been obtained demonstrating that the patient meets the criteria.

Consumable costs will be reconciled using the routine reconciliation process associated with VBC data on the basis of 100% compliance. The cost of any consumables for this product which have been prescribed without prior funding approval will not be reimbursed by ICB'Ss to providers.

Policy:

Flash Glucose Monitoring (for example, Freestyle Libre® devices) should only be used for people aged four and above, attending specialist diabetes clinics (including Community based) and who have been assessed by the specialist clinician and deemed to meet one or more of the below requirements.

- Those with Type 1 diabetes and recurrent severe hypoglycaemia or impaired awareness of hypoglycaemia. (NICE recommend continuous glucose monitoring (CGM) with alarms as standard and that the Freestyle Libre 2 is inferior to CGM, however, if both the patient and clinician consider that a 6 month trial of Flash Glucose monitoring would more clinically appropriate then this can be considered).

OR

- Those with Type 1 diabetes AND have had 2 or more admissions with diabetic ketoacidosis or 2 or more episodes of hypoglycaemia requiring third party assistance (per year)

OR

- Those with Type 1 diabetes AND who meet the criteria for insulin pump therapy (HbA1c 69.4mmol/mol >8.5%) or disabling hypoglycaemia where a successful trial of Flash Glucose Monitoring may avoid the need for pump therapy

OR

- Those with any form of diabetes on haemodialysis AND on insulin treatment AND who are clinically indicated as requiring intensive monitoring

OR

- Patients with diabetes associated with cystic fibrosis on insulin treatment

OR

- Those with pre-existing diabetes (Type 1 or Type 2) on insulin who are actively trying to conceive or are currently pregnant

OR

- People with Type 1 diabetes who are unable to routinely self-monitor blood glucose due to disability who require carers to support glucose monitoring and insulin management

OR

- People with Type 1 diabetes for whom the specialist diabetes MDT determines have occupational or psychosocial circumstances that warrant a 6-month trial of Flash Glucose Monitoring with appropriate adjunct support

OR

- Previous self-funders of Flash Glucose Monitors with Type 1 diabetes where those with clinical responsibility for their diabetes care are satisfied that their clinical history suggests that they would have satisfied one or more of the criteria set out above prior to them commencing use of Flash Glucose Monitoring had these criteria been in place prior to April 2019; AND has shown improvement in HbA1c since self-funding

OR

- People with Type 1 diabetes or insulin treated Type 2 diabetes who are living with a learning disability and recorded on their GP Learning Disability Register

In addition;

- All patients (or carers) must be willing to undertake training in the use of Flash Glucose Monitoring devices (for example, Freestyle Libre® devices) and commit to on-going regular follow-up and monitoring (including remote follow-up where this is offered).
- All patients should have attended, or give due consideration to future attendance, at a Type 1 diabetes structured education programme (DAFNE or equivalent if available locally).
- For pregnant patients; Total duration of Flash Glucose monitoring will be for 12 months in total: inclusive of pregnancy and the immediate post-partum period. Thereafter, patients will be expected to return to their previous method of blood glucose testing. Patients developing Gestational Diabetes are excluded from this recommendation
- All patients agree to scan glucose levels no less than 3 times per day (minimum of every 8 hours) and use the sensor >70% of the time.

The hospital initiating any Flash Glucose Monitoring will supply a 7L Sharps Bin for the safe disposal of used Freestyle Libre® applicators and sensors, the monitoring device and a 28 day supply of sensors (i.e. two sensors, one of which is supplied free by Abbott) and write to patient's GP practice requesting that they continue to prescribe during the trial period.

At 6 months the patient will be reviewed by the diabetes specialist and will only continue to receive Flash Glucose Monitoring if they meet criteria as detailed within this policy. The specialist will be expected to communicate this to the patient's GP and carry out an annual assessment of continuing benefit thereafter.

NB: Previous self-funders are ONLY eligible for NHS funded treatment if they meet the criteria set out in this policy.

Flash Glucose Monitoring devices should be discontinued after a six-month trial if no improvement is demonstrated in one or more of the following areas:

1. Reductions in severe/non-severe hypoglycaemia
2. Improvement of impaired awareness of hypoglycaemia
3. Episodes of diabetic ketoacidosis
4. Admissions to hospital
5. Improvement in HbA1c
6. Testing strip usage
7. Quality of Life changes using validated rating scales.
8. Commitment to regular scans and their use in self-management.

Ongoing use should be assessed annually thereafter.

i-Port Advance for use in Children and Adults with Type 1 Diabetes	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

The i-Port Advance is a device that may offer an alternative option to pump therapy in patients with Type 1 diabetes. Clinical evidence for the use of i-Port Advance device is limited, however, based on problems associated with insulin administration by injection(s), such as pain, anxiety (needle phobia), lipohypertrophy, and risk of infection, there may be some degree of acceptability for the device which may assist in achieving optimal glycaemic control reducing admissions from diabetic ketoacidosis (DKA) and reducing the insulin doses required.

Policy: The use of the i-Port Advance device in children or adults will be offered as a treatment option where the following criteria are met:

- Patients in whom multiple daily injections are impractical and inappropriate where use of an injection port may avoid the need to move to insulin pump therapy

OR

- Patients with significant anxiety and needle phobia who are avoiding or missing injections

OR

- Patients with a raised HbA1 >69mmol/ l with poor compliance with treatment or who are injecting into lipohypertrophy despite support and advice to avoid these areas

AND

- Patient has Type 1 diabetes

AND

- Treatment is only started by a secondary care multidisciplinary diabetes team including diabetes doctors, specialist nurses and dieticians

Please note: Continued use of the i-Port Advance device should be reviewed every 3-6 months by an appropriate clinician. Where a patient meets the criteria, it is understood that Prior Approval remains in place for the period the patient requires the use of the device.

Ear, Nose and Throat (ENT)

Adult Snoring Surgery (in the absence of Obstructive Sleep Apnoea – OSA)	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Snoring is a noise that occurs during sleep that can be caused by vibration of tissues of the throat and palate. It is very common and as many as one in four adults snore, as long as it is not complicated by periods of apnoea (temporarily stopping breathing) it is not usually harmful to health, but can be disruptive, especially to a person's partner. A number of alternatives to surgery are available and include; weight loss, stopping smoking, reducing alcohol intake, medical treatment of nasal congestion and mouth splints.

Policy:

Due to the significant risks that patients could be exposed to and no evidence of longer term benefits; this procedure is not routinely commissioned in the management of uncomplicated snoring.

This policy relates to adults only.

Grommets (and other ventilation devices) in Children	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Otitis media with effusion (OME) has a good prognosis. It is a self-limiting condition and 90% of children will have complete resolution within 1 year. Active observation for at least 3 months (watchful waiting) rarely results in long-term complications. There is no proven benefit from treatment with any medication or complementary or alternative treatments.

Insertion of ventilation tubes, or grommets, is the most common surgical treatment. Evidence suggests that the benefit of grommets on children's hearing gradually decreases in first year of insertion.

The procedure improves hearing in the short term (up to 12 months after surgery) but has not been shown to improve language or speech development. Parents / cares should have the risks and benefits of treatment clearly discussed with them. There should be evidence that the risks and benefits of treatment options have been clearly discussed with the patient / carer and are documented in the patient notes. This may include the NHS Rightcare Shared Decision Making tool. Patient decision making aids are available to search through the following link: https://library.nhs.uk/knowledgehub/

Policy:

Referral for a Specialist opinion when:

- Persistence of bilateral otitis media with effusion (OME) and hearing loss over 3 months

OR

- If hearing loss of any level is associated with a significant impact on the child's developmental, social, or educational status.

OR

- If hearing loss is severe.

OR

- The hearing loss persists on two documented occasions (usually following repeat testing after 6–12 weeks).

OR

- The tympanic membrane is structurally abnormal (or there are other features suggesting an alternative diagnosis).

OR

- There is a persistent, foul-smelling discharge suggestive of a possible cholesteatoma.

OR

- The child has Down's syndrome or has a cleft palate.

OR

- The child has recurrent acute otitis media (defined as three or more episodes in 6 months, or four or more episodes in 12 months with at least one episode in the past 6 months) in whom conservative measures have been ineffective.

Ventilation tube (grommet) insertion will be funded in accordance with NICE guidance (CG60):

- There is evidence that the risks and benefits of treatment options have been clearly discussed with the patient / carer and are documented in the patient notes. This may include the NHS Rightcare Shared Decision Making tool. Patient decision making aids are available to search through the following link: https://library.nhs.uk/knowledgehub/.

AND EITHER

- Children with persistent bilateral OME documented over a period of 3 months with a hearing level in the better ear of 25–30 dBHL or worse, when averaged at 0.5, 1, 2 and 4 kHz (or equivalent dBA where dBHL not available).

OR

- Exceptionally in children with persistent bilateral OME with a hearing loss less than 25–30 dBHL where the impact of the hearing loss on a child's developmental, social or educational status is judged to be significant.

OR

- The ventilation tube is inserted for the diagnosis of underlying sensori-neural hearing loss

OR

- The treatment of recurrent acute otitis media (defined as three or more episodes in 6 months, or four or more episodes in 12 months with at least one episode in the past 6 months) in whom conservative measures have been ineffective

OR

- The treatment of chronic retraction of the tympanic membrane

OR

- Children who cannot undergo standard assessment of hearing thresholds where there is clinical and tympanographic evidence of persistent glue ear and where the impact of the hearing loss on a child's developmental, social or educational status is judged to be significant.

Removal of Adenoids for Treatment of Glue Ear	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Adenoids are lymphatic tissue that reside in the post nasal space and arise from the roof of the nasopharynx. Adenoids are only usually present in children and tend to grow from birth, reaching the largest size when a child is between 3 and 5 years of age, before slowly shrinking away by adulthood.

When the adenoids are enlarged or inflamed they may contribute to glue ear (otitis media with effusion), which can affect hearing. They can also cause symptoms of nasal blockage, mouth breathing, obstructive sleep and other upper respiratory tract symptoms (e.g., persistent runny nose)

When children have persistent glue ear that affects hearing, one option for treatment of the hearing loss is with grommet insertions (ventilation tubes) and guidance for this intervention is already set out in the EBI guidance published in November 2018 – 'grommets for glue ear in children'.

In some circumstances, when a child is undergoing surgery to insert grommets, the adenoids may also be partially resected at the same time. This is a short procedure performed via the mouth to remove excessive adenoidal tissue (adenoidectomy) and is most commonly performed either by electrocautery (monopolar suction diathermy), cold steel dissection (curettage), or coblation. The aim of adenoidectomy is to improve eustachian tube function and therefore reduce the recurrence of glue ear after grommets fall out.

This guidance applies to children aged 18 years and under

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy: Adenoidectomy should only be carried out when the following criteria are met:

- The child has persistent and / or frequent nasal obstruction which is contributed to by adenoidal hypertrophy (enlargement)

OR

- The child is undergoing surgery for re-insertion of grommets due to recurrence of previously surgically treated otitis media with effusion

OR

- The child is undergoing grommet surgery for treatment of recurrent acute otitis media

OR

- Adenoidectomy as part of treatment for obstructive sleep apnoea or sleep disordered breathing in children (e.g., as part of adenotonsillectomy)

OR

- Adenoidectomy as part of the treatment of chronic rhinosinusitis in children

OR

- Adenoidectomy for persistent nasal obstruction in children and adults with adenoidal hypertrophy

OR

- Adenoidectomy in preparation for speech surgery in conjunction with the cleft surgery team

Adjuvant adenoidectomy should not be routinely performed in children undergoing grommet insertion for the treatment of otitis media with effusion

Septorhinoplasty, Rhinoplasty, and Septoplasty for nasal deformities	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Septorhinoplasty, Rhinoplasty, and Septoplasty for nasal deformities are surgical procedures performed on the nose to change its size or shape or both. People usually ask for this procedure to improve self-image. The policy applies to all three procedures of Septorhinoplasty, Rhinoplasty, and Septoplasty.

Policy:

Rhinoplasty, Septoplasty, or Septorhinoplasty for nasal deformities will only be funded in accordance with the criteria specified below:

- Where conservative treatment has been exhausted;

AND

- Problems caused by obstruction of the nasal airway

OR

- Objective nasal deformity caused by direct trauma and the treatment is required at the time of, or soon after the acute episode and before permanent healing has occurred.

OR

- Correction of complex congenital conditions to improve function e.g., cleft lip and palate.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Surgery for Sinusitis - Referral for Specialist Secondary Care Assessment	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Chronic rhinosinusitis (CRS) is defined as inflammation (swelling) of the nasal sinuses that lasts longer than 12 weeks. The sinuses are mucus secreting, air filled cavities in the face and head that drain into the nose; their normal function may be disrupted by environmental, infectious or inflammatory conditions which damage the epithelial lining and disturb the balance of the natural microbial community. Patients report a number of symptoms including nasal blockage, discharge, alteration to smell, and facial pressure or pain. They often have a relapsing course, with recurrence after treatment commonplace. Absenteeism and presenteeism are widespread.

It is a common chronic condition that affects approximately 11% of adults and has a significant detrimental effect on the quality of life of those affected, thus creating a significant disease burden.

CRS as a term encompasses a wide range of phenotypes but can broadly be divided into two main types. Chronic rhinosinusitis with Nasal Polyposis (CRSwNP) and Chronic Rhinosinusitis without Nasal Polyposis (CRSsNP).

First-line treatment is with appropriate medical therapy, which should include intranasal steroids and nasal saline irrigation. In the case of CRSwNP a trial of a short course of oral steroids should also be considered.

Where first-line medical treatment has failed patients should be referred for diagnostic confirmation and they then may be considered for endoscopic sinus surgery. This involves surgery using a telescope via the nasal cavity to open the sinuses and, if present, remove nasal polyps, both improving the effectiveness of ongoing medical therapy and relieving obstruction. The surgery is usually undertaken under general anaesthetic as a day-case procedure in otherwise healthy individuals.

This guidance applies to Children and Adults.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy: Surgery for sinusitis will only be funded where the following criteria are met:

- A clinical diagnosis of CRS has been made (as set out in RCS/ENT-UK Commissioning guidance) in primary care and patient still has moderate / severe symptoms after a 3-month trial of intranasal steroids and nasal saline irrigation

AND

- In addition, for patients with bilateral nasal polyps there has been no improvement in symptoms 4 weeks after a trial of 5-10 days of oral steroids (0.5mg/kg to a max of 60 mg)

OR

- Patient has nasal symptoms with an unclear diagnosis in primary care

OR

- Any patient with unilateral symptoms or clinical findings, orbital, or neurological features should be referred urgently / via 2-week wait depending on local pathways.

Tonsillectomy for Recurrent Tonsillitis	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Tonsillectomy is one of the most common surgical procedures in the UK. There is good evidence for the effectiveness of tonsillectomy in children but only limited evidence in adults.

Policy:

Tonsillectomy will only be funded for adults or children in accordance with the criteria specified below:

- The sore throats are due to acute tonsilitis;

AND

- The episodes of sore throat are disabling and prevent normal functioning

AND EITHER

- Seven or more well documented, clinically significant episodes of sore throat in the previous year;

OR

- Five or more such episodes have occurred in each of the preceding two years

OR

- Three or more such episodes have occurred in each of the preceding three years

OR

- There is a suspicion of malignancy

OR

- Recurrent episodes of quinsy

This policy does not apply to Emergency Presentations (e.g., treatment of parapharyngeal abscess), tonsil bleeding or deep neck infection. It also does not apply to OSAS in children. These diagnoses will be funded.

There is no restriction on funding for tonsillectomy to treat adult obstructive sleep apnoea with tonsillar enlargement (if trials of continuous positive airway pressure (CPAP) and the use of mandibular advancement devices are unavailable or unsuccessful).

Tonsillectomy for the treatment of halitosis associated with tonsilloliths will not be routinely funded.

Fertility

Assisted Reproduction Treatments	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR & Prior Approval** ***(please see detail of policy)***
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

The Clinical Guideline on *fertility assessment and treatment* was published by NICE in February 2013 (NICE CG156, 2013) and covers all clinical procedures/pathways relating to fertility assessment and treatment.

This document provides a single specific commissioning policy for the NHS with the aim to ensure consistency in the application of the guideline across the North East & North Cumbria region.

Over 80% of couples in the general population will conceive within 1 year if:

- the woman is aged under 40 years

AND

- they do not use contraception and have regular sexual intercourse.

Of those who do not conceive in the first year, about half will do so in the second year (cumulative pregnancy rate over 90%). [NICE 2004, amended 2013].

The estimated prevalence of infertility is one in seven couples in the UK. A typical Integrated Care Board can expect about 230 new consultant referrals (couples) per 250,000 head of population per year (NICE CG11, 2004).

All couples are eligible for consultation and advice from the specialist service

Policy:

Investigations to determine fertility are routinely commissioned on the NHS.

IVF / ICSI carried out as part of pre-implantation genetic testing is commissioned directly by NHS England and is therefore not covered by this policy.

The NHS does <u>not</u> routinely commission the following:

- Any treatment requiring surrogacy (paid or altruistic).
- Intrauterine or other artificial insemination for an otherwise fertile woman.
- Treatment when sub fertility is due to previous sterilisation procedure.
- Treatment when any party to the pregnancy with proposed parental responsibility has living children.
- Treatment when any party to the pregnancy with proposed parental responsibility has not been registered with a ICB'S in the areas covered by the policy for at least 1 year.
- Treatment for patients who are not eligible for NHS treatment in line with the Overseas Visitors Charging Regulations.

- Fertility preservation for patients whose fertility has not been at risk from iatrogenic or other medical conditions.
- Gamete donation (noting that altruistically donated gametes may be used in treatment at the discretion of treatment providers).
- Treatment for women after their 43rd birthday.
- Treatment when the female hoping to become pregnant is a smoker
- Treatment when the female has a BMI <19 or >30.
- Treatment when the male party to the pregnancy has male factor infertility and is a smoker.

Policy: NHS funded fertility treatment is available to treat established infertility in the following circumstances:

Treatment for male factor infertility

Absolute or relative male factor infertility has been demonstrated on semenalysis.

In relative male factor sub fertility, there has been 2 years of regular vaginal intercourse* following health optimisation (i.e., BMI <30 and non-smoking for both parties).

*Regular vaginal intercourse is defined as 3 times per week.

Treatment of female factor infertility

Absolute or relative female factor infertility has been demonstrated on appropriate investigations.

In relative female factor sub fertility, if clinically appropriate, there has been either 2 years of regular heterosexual vaginal intercourse following health optimisation (BMI <30 & non-smoking for both parties) or 6 cycles of medically managed artificial insemination (by an HFEA licensed provider) with health optimisation (BMI <30 & non-smoking).

Treatment of unexplained infertility

There has been either 2 years of regular heterosexual vaginal intercourse following health optimisation (BMI <30 & non-smoking for both parties) or 6 cycles of medically managed artificial insemination (by an HFEA licensed provider) with health optimisation (BMI <30 & non-smoking).

Where the criteria for male factor, female factor or unexplained fertility have been met the NHS will fund IUI and/or IVF (inc ICSI) subject to the following criteria being met:

Ref	Policy	Access Criteria	Guidance Notes
1	**Fertility treatment female wishing to become pregnant under 40 years** 1. 12 cycles of artificial insemination using partner's sperm or 6 cycles of donor sperm (by an HFEA licensed provider). 2. Up to 3* full cycles of IVF, with or without intracytoplasmic sperm injection (ICSI).	Female: BMI greater than 19.0 and lower than or equal to 30.0 and non-smoker at the start of treatment. Male factor infertility: Non-smoker at the start of treatment. If the woman reaches the age of 40 during treatment, complete the current full cycle but do not offer further full cycles. *Refer to Guidance Notes	**3 full cycles of IVF** Inform people that normally a full cycle of IVF treatment, with or without ICSI should comprise 1 episode of ovarian stimulation and the associated episode transfer of the fresh and frozen embryo(s) relating to that cycle. Access to three cycles is not an automatic right – the outcome of any previous cycle will be taken into account. Treatment must be medically indicated at the start of each cycle. As IVF success rates decline significantly after 3 cycles, previous cycles received irrespective as to whether they were funded by the NHS or privately will be taken into account. If patients have funded 3 or more IVF cycles privately they will not be entitled to any NHS funded cycles. If patients have funded 2 cycles privately they will be entitled to 1 NHS cycle. If patients have funded 1 cycle privately they will be entitled to 2 NHS cycles.

Ref	Policy	Access Criteria	Guidance Notes
2	**Fertility treatment female wishing to become pregnant aged 40 to 42 years** 1. 12 cycles of artificial insemination using partner's sperm or 6 cycles of donor sperm (by an HFEA licensed provider). 2. Up to 1* full cycle of IVF, with or without intracytoplasmic sperm injection (ICSI). Treatment must start before the woman's 43rd birthday	Female: BMI greater than 19.0 and lower than or equal to 30.0 and non-smoker at the start of treatment Male factor infertility: Non-smoker at the start of treatment. Provided all the following 3 criteria are fulfilled: • They have never previously had IVF treatment **AND** • There is evidence of good ovarian reserve as identified by a specialist clinician **AND** • There has been a discussion of the additional implications of IVF and pregnancy at this age *Refer to Guidance Notes	**1 full cycle of IVF** Inform people that normally a full cycle of IVF treatment, with or without ICSI should comprise 1 episode of ovarian stimulation and the associated episode transfer of the fresh and frozen embryo(s) relating to that cycle. **Ovarian reserve testing** The aim is to select those with at least 10% chance of successful treatment. The criteria remain under review. At present use the following criteria to predict the likely ovarian response to gonadotrophin stimulation in women who are eligible for IVF treatment: • Total antral follicle count of more than or equal to 4 **AND** • Anti-Müllerian hormone of more than or equal to 5.4 pmol/l.

Fertility Preservation

Policy: The NHS will fund fertility preservation for anyone who is at high risk of premature infertility from iatrogenic or other medical conditions including women who are at high risk of idiopathic premature ovarian failure (POF).

Note: in the case of idiopathic POF, high risk is defined as having more than one affected direct family member.

Embryo / Gamete Harvesting & Storage

Policy: The NHS will fund embryo / gamete harvesting and storage for those patients who have had their fertility preservation funded by the NHS in accordance with the fertility preservation policy for:

- An initial period of one year (subject to clinical review at the end of the period)
- A further period of up to 10 years (subject to clinical review at the end of the period)
- For females up to a period for which the female remains eligible for NHS fertility treatment. Once the female has reached the maximum age for NHS fertility treatment the patient should have the option to privately fund storage should this be clinically appropriate.
- For males a period up to 55 years in total from fertility preservation.

Gametes stored by the NHS will not be preserved after the patient has deceased.

Patients who have had gamete storage funded by the NHS will be subject to the NHS fertility treatment policy at the time they wish to use the gametes.

Embryo Storage following NHS funded Assisted Reproduction Treatment

The NHS will fund embryo storage for embryos which have been funded by the NHS in line with the Fertility Policy. Embryos will be stored by the NHS up to the time that the female reaches the maximum age for fertility treatment on the NHS. Any embryos stored or created by the NHS will not be preserved after the patient has deceased.

Note: Any embryos stored before the woman's 43rd Birthday may be implanted within 12 months of the date storage commenced*.

* The rationale for this is that the embryo has been created while the female is compliant in line with the policy.

Gastroenterology

Appropriate Colonoscopy in the Management of Hereditary Colorectal Cancer (monoallelic MUTYH)	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Colorectal carcinoma (CRC) is one of the most common cancers in the UK with more than 40,000 new cases diagnosed each year. An estimated 35% of CRC is due to heritable factors.

While colonoscopy is a safe procedure, there is a small risk of complications – including pain, intestinal perforation or major haemorrhage as well as issues related to any sedative used. Colonoscopy should therefore be used appropriately in the management of CRC in people who have been identified with an increased lifetime risk of CRC due to hereditary factors.

This guidance applies to adults aged 19 years and over.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

NOTE: Colonoscopy in relation to specific conditions / interventions, should only be carried out where the specified criteria are met – see the appropriate policy under the Monitored Approval section.

Policy:

Appropriate colonoscopy in the management of hereditary colorectal cancer for monoallelic MUTYH pathogenic variant carriers

- **Colonoscopy in the management of hereditary colorectal cancer for monoallelic MUTYH pathogenic variant carriers is NOT routinely commissioned**

Cholecystectomy (for asymptomatic gallstones)	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Cholecystectomy is the surgical removal of the gall bladder. Prophylactic cholecystectomy is not indicated in most patients with asymptomatic gallstones. Possible exceptions include patients who are at increased risk for gallbladder carcinoma or gallstone complications, in which prophylactic cholecystectomy or incidental cholecystectomy at the time of another abdominal operation can be considered. Although patients with diabetes mellitus may have an increased risk of complications, the magnitude of the risk does not warrant prophylactic cholecystectomy.

Policy:

Cholecystectomy for asymptomatic gall stones will only be funded in exceptional clinical circumstances through an Individual Funding Request. Bile duct clearance and laparoscopic cholecystectomy will be funded for both symptomatic and asymptomatic stones in the common bile duct.

Note: The referrer should include evidence that there is evidence that the risks and benefits of treatment options have been clearly discussed with the patient / carer and are documented in the patient notes. This may include the NHS Rightcare Shared Decision Making tool. Patient decision making aids are available to search through the following link: https://library.nhs.uk/knowledgehub/

General Surgery

Anal Fissure (Surgery)	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

An anal fissure is a tear in the lining of the lower rectum (anal canal) that causes pain during bowel movements.

Policy:

For referral to secondary care the patient should meet at least one of the following criteria:

- Multiple, off the midline, large or irregular (atypical fissures) as these may be the manifestation of underlying disease

OR

- Children whose anal fissure has not healed after 2 weeks

OR

- Severe pain refractory to conservative therapy and impacting on patient wellbeing

OR

- Persisting anal fissure not healed after 8 weeks of conservative management

OR

- Symptoms suggestive of systemic disease e.g., inflammatory bowel disease

Consider referring an elderly person earlier to exclude an anal or low rectal malignancy.

A 2 week wait referral should be considered for patients aged 50 and over with unexplained rectal bleeding' or 'All ages (<50) with rectal bleeding **and** any of the following unexplained symptoms or findings: abdominal pain/change in bowel habit/weight loss/iron-deficiency anaemia'.

Bariatric Surgery	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

ICB'Ss took over the responsibility of commissioning bariatric surgery for patients (Adults only) from NHS England from 1st April 2017. As such, ICB'Ss adopted the same criteria as previously undertaken by NHSE Commissioning colleagues.

Policy:

Surgery will only be considered as a treatment option for adults with morbid obesity providing all of the following criteria are fulfilled:

- The individual is considered morbidly obese – classified as adults with a BMI of 40kg/m2 or more;

OR

- The individual is between 35 kg/m2 and 40kg/m2 in the presence of other significant diseases;

AND

- There must be formalised MDT led processes for the screening of co-morbidities and the detection of other significant diseases. These should include identification, diagnosis, severity / complexity assessment, risk stratification / scoring and appropriate specialist referral for medical management. Such medical evaluation is mandatory prior to entering a surgical pathway.

AND

- Morbid/severe obesity has been present for at least five years.

AND

- The individual has recently received and complied with a specialist obesity service weight loss programme (non-surgical Tier 3 / 4), as described below.

Weight Loss Programmes (non-surgical Tier 3 / 4)

- This will have been for a duration of 12-24 months. For patients with BMI > 50 attending a specialist bariatric service, this period may include the stabilisation and assessment period prior to bariatric surgery. The minimum acceptable period is six months. The specialist obesity weight loss programme and MDT should be decided locally. This will be led by a professional with a specialist interest in obesity and include a physician, specialist dietician, nurse, psychologist and physical exercise therapist, all of whom must also have a specialist interest in obesity. There are different models of local MDT structure.

- Important features are the multidisciplinary, structured and organised approach, lead professional, assessment of evidence that all suitable non-invasive options have been explored and trialled and individualised patient focus and targets. In addition to offering a programme of care, the service will select and refer appropriate patients for consideration for bariatric surgery.

Bariatric Surgery - Revisional Procedures	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Revisional surgery is an additional attempt to maintain or secure further improvements in weight loss, resolution and improvement of obesity-related co-morbidities and gains in quality of life.

Policy:

Revisional procedures will only be considered electively for clinical reasons due to complications where one of the following criteria has been met:

- Surgical complications including technical problems arising from the original bariatric surgical procedure. These may present as severe gastrointestinal symptoms such as reflux, nausea, vomiting, dysphagia or inability to tolerate solid foods.

OR

- Medical complications of the primary procedure including profound macro and micronutrient deficiencies; anaemia, malnutrition and metabolic abnormalities such as disabling intractable hypoglycaemia.

OR

- Failure of the primary operation to provide adequate, stable and durable weight loss with adequate resolution of weight related comorbidities, or to address significant weight regain, frequently with re- emergence of pre-operative comorbidities

Groin Hernia	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

An inguinal hernia **is the most common hernia** (about 70% of all hernias). Femoral hernias account for less than 10% of all groin hernias. However, they frequently become incarcerated or strangulated due to the small size of this space through which they protrude and hence present as emergencies in most cases[5] with 40% presenting as emergencies[6]. The incidence of femoral hernias is higher in women than men. In general, women have an increased risk of emergency procedure from groin hernias compared to men.

Policy:

Referral to secondary care and subsequent surgical treatment will be provided where patients meet one or more of the following criteria (NB: Policy only applies to Adults):

- History of incarceration, difficulty in reducing the hernia,

OR

- Increased risk of strangulation (high risk in female patients)

OR

- Inguino-scrotal hernia

OR

- Progressive increase in size of hernia (month-on-month)

OR

- Significant pain or discomfort sufficient to cause significant functional impairment (see FAQs)

AND

- There is evidence that the risks and benefits of treatment options have been clearly discussed with the patient / carer and are documented in the patient notes. This may include the NHS Rightcare Shared Decision Making tool. Patient decision making aids are available to search through the following link: https://library.nhs.uk/knowledgehub/

[5] https://www.hernia.org/types/femoral-hernia/

[6] McIntosh A, Hutchinson A, Roberts A and Withers H. Evidence-based management of groin hernia in primary care—a systematic review. Family Practice 2000; 17: 442–447.

Haemorrhoid Surgery	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

From the Banov et al paper 1985, grading of haemorrhoids is as follows:

- Grade I: The haemorrhoids do not prolapse.
- Grade II: The haemorrhoids prolapse upon defecation but spontaneously reduce.
- Grade III: The haemorrhoids prolapse upon defecation and must be manually reduced.
- Grade IV: The haemorrhoids are prolapsed and cannot be manually reduced.

Policy:

Haemorrhoidectomy will be funded in the following circumstances:

- Grade I or II haemorrhoids with severe symptoms which include bleeding, faecal soiling, itching or pain which have failed to respond to conservative management for 3 months, where banding or Haemorrhoidal Arterial Ligation (HAL) is inappropriate.

OR

- Grade III or IV haemorrhoids (i.e., prolapsed) where banding or Haemorrhoidal Arterial Ligation (HAL) is inappropriate and where there is persistent pain or bleeding

OR

- Irreducible and large external haemorrhoids

OR

- Symptoms suggestive of systemic disease e.g., inflammatory bowel disease

NB: Fast track referral - In patients aged 50 and over with unexplained rectal bleeding' or 'All ages (<50) with rectal bleeding and any of the following unexplained symptoms or findings: abdominal pain/change in bowel habit/weight loss/iron deficiency anaemia'.

Please note that perianal haematoma is not classified as haemorrhoidectomy and will require separate management.

All other circumstances require prior approval.

Sacral Nerve Stimulation for Bladder Symptoms	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Sacral nerve stimulation, also termed sacral neuromodulation, is a type of medical electrical stimulation therapy.

It typically involves the implantation of a programmable stimulator subcutaneously, which delivers low amplitude electrical stimulation via a lead to the sacral nerve, usually accessed via the S3 foramen.

In line with NICE recommendations this policy has separate eligibility criteria and care pathways for men and women.

Policy:

Women

SNS for urinary incontinence or urgency-frequency syndrome in women will only be funded in accordance with the criteria below:

- Symptoms are refractory to lifestyle modification (caffeine reduction, modification of fluid intake, weight loss if BMI >30)

AND

- Symptoms are refractory to behavioural interventions: a minimum of 6 weeks of bladder retraining OR 3 months of pelvic floor muscle training (in mixed UI only, where there is some stress incontinence as well as OAB)

AND

- Symptoms are refractory to 4 weeks of anticholinergic medication to a maximal tolerated dose (a number of drugs may be tried in accordance with NICE CG171) [OR Mirabegron, in people for whom anticholinergic drugs are contraindicated or clinically ineffective or have unacceptable side effects (NICE TA290)]

AND

- The woman has been referred to secondary care, reviewed by an MDT and a diagnosis of detrusor over activity has been confirmed by urodynamic assessment

AND

- Symptoms are refractory to injections of Botulinum Toxin Type A into the bladder wall unless the patient is unwilling or unable to perform clean intermittent catheterisation.

Men

SNS for men with overactive bladder (OAB) caused by detrusor over activity will only be funded in accordance with the criteria below:

- Symptoms are refractory to conservative management lifestyle advice, advice on fluid intake, supervised bladder training and use of containment products (pads, sheaths, etc.)

AND

- Symptoms are refractory to 4-6 weeks of anticholinergic medication [OR Mirabegron, in people for whom anticholinergic drugs are contraindicated or clinically ineffective, or have unacceptable side effects (NICE TA290)]

AND

- The man has been referred to secondary care for specialist assessment and a diagnosis of detrusor over activity has been confirmed

AND

- Symptoms are refractory to injections of Botulinum Toxin Type A into the bladder wall unless the patient is unwilling or unable to perform clean intermittent catheterisation.

Before a permanent SNS device is fitted, ALL prospective patients must have been approved for and have undergone a positive trial period (2-3 weeks) of temporary stimulation resulting in a 50% or greater improvement in voiding function based on the results of a voiding diary.

SNS will not be funded for patients with:

- Stress incontinence, the most common type of urinary dysfunction
- Urinary retention due to obstruction (e.g., from benign prostatic hypertrophy, cancer, or urethral stricture)
- Urge incontinence due to psychological or neurological conditions, such as diabetes with peripheral nerve involvement, MS, stroke or spinal cord injury (see NICE CG 148).

Sacral Neuromodulation (SNM) for Faecal Incontinence	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Sacral neuromodulation (SNM) is a surgical treatment option for selected patients with faecal incontinence. NICE published Interventional procedures guidance IPG99 November 2004 regarding usage of SNM. SNM is now considered the first line surgical treatment option for the majority of patients with faecal incontinence once conservative treatment has failed.

In patients with anal sphincter dysfunction or sensory dysfunction it may be possible to significantly improve symptoms and associated quality of life primarily from modulation of afferent nerve activity. It involves low-level electrical stimulation applied via electrodes through the sacral foramina to the sacral nerve supply of the lower bowel and sphincters. The procedure is done in two stages. First a temporary electrode (PNE) is inserted which is connected to an external stimulator. The test period lasts for 2 week period, during which the patient keeps a daily symptom diary. If significant benefit is achieved (>50% improvement from baseline symptoms) then a permanent implantable pulse generator is implanted. This is programmed and stimulation is continuous. It doesn't need to be switched off for defaecation.

Policy:

Sacral Neuromodulation (SNM) is only offered as a treatment option for adults where the following criteria are met:

- The patient has severe faecal incontinence, significantly affecting quality of life, not responding to standard conservative treatment and all first line treatments have been tried

AND

- Investigations have demonstrated and confirmed a deficient anal sphincter or sensory dysfunction

AND

- The patient's distress is such that otherwise surgical intervention or colostomy would be required

AND

- There has been a two week trial and a good response to sacral neuromodulation (> 50% reduction in episodes of FI)

Surgery for Divarication of Recti	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Divarication or diastasis of the rectus abdominus muscles (DRAM or DRA) is a condition where the abdominal muscles become separated in the midline of the abdomen (linea alba). This can cause the midline to "bulge" when intra-abdominal pressure is increased.

The condition is relatively common and asymptomatic, although patients may be unhappy with the appearance of their abdomen. Evidence suggests that divarication does not carry the same risks as that of actual herniation and therefore it does not normally lead to any complications that require intervention.

Policy:

Surgery for Divarication of Recti will NOT be routinely funded

Vasectomy under General Anaesthetic	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Vasectomy is a surgical procedure for male sterilization or permanent contraception. During the procedure, the male vas deferens are severed and then tied or sealed in a manner so as to prevent sperm from entering into the seminal stream (ejaculate) and thereby prevent fertilization.

Policy:

Vasectomies under General Anaesthetic (GA) in secondary care will only be funded in the following circumstances:

- There is previous documented allergy or absolute medical contra-indication to Local Anaesthetic

OR

- The patient has anatomic abnormalities, i.e., there is an inability to palpate and mobilize both vas deferens or large hydroceles or varicoceles

OR

- There is past trauma or surgery which has resulted in scarring of the scrotum which would require surgery in an in-patient setting.

OR

- The patient is taking anticoagulants or antiplatelet medications and risk of haemorrhage (bleeding) is high

Fear of the procedure, or patient choice are not adequate reasons for requesting vasectomy under GA.

Gynaecology

Dilatation and Curettage (D&C) for treatment of Heavy Menstrual Bleeding	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Dilatation and curettage (D&C) is a procedure performed under general anaesthetic in which the opening of the womb (cervix) is widened (dilation) and the lining of the womb is biopsied or removed by scraping (curettage).

NICE Guidelines (NG88) recommends D&C is not offered as a diagnostic or treatment option for heavy menstrual bleeding due to a lack of evidence. Ultrasound scans and camera tests can be used to investigate heavy periods.

Policy:

Dilatation and curettage (D&C) is NOT routinely commissioned as a therapeutic or diagnostic intervention for heavy menstrual bleeding or any other uterine bleeding disorder.

Hysterectomy for Heavy Menstrual Bleeding	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Hysterectomy should not be used as a first line treatment solely for heavy menstrual bleeding.

Policy:

For women diagnosed with heavy menstrual bleeding (menorrhagia), with or without fibroids, hysterectomy will not be commissioned unless ALL of the following criteria are met:

- Recommendations for the medical treatment of heavy menstrual bleeding (and/or symptomatic large or multiple fibroids) set out in NICE Clinical Guideline NG88 for Heavy Menstrual Bleeding (https://www.nice.org.uk/guidance/ng88) have failed, or are contraindicated, or has been declined by the woman. This includes the use of a progestogen-releasing intrauterine device (levonorgestrel releasing systems - LNG-IUS).

AND

- Uterine endometrial ablation methods have failed or are not clinically appropriate or has been declined by the woman.

AND

- The woman has been fully informed of the implications of surgery and does not wish to retain her uterus and fertility.

AND

- There is evidence that the risks and benefits of treatment options have been clearly discussed with the patient / carer and are documented in the patient notes. This may include the NHS Rightcare Shared Decision Making tool

Reversal of Female Sterilisation	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Reversal of sterilisation is a surgical procedure that involves the reconstruction of the fallopian tubes.

Policy:

Reversal of sterilisation will NOT be routinely funded.

Neurology

Vagal Nerve Stimulation (Non-Invasive) for Cluster Headache	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Non-invasive transcutaneous stimulation of the vagus nerve (nVNS) is a new treatment modality which aims to treat headache disorders while avoiding the need for an implanted device. The mechanism by which nVNS treats headache is poorly understood but may be due at least in part to inhibition of pain signalling by the neurotransmitter gamma amino butyric acid (GABA).

Cluster headache is a primary headache disorder characterised by recurrent attacks of unilateral pain, often in or around the eye or temple. Attacks usually last between 15 minutes and 3 hours and may be described by patients as the worst pain they have ever experienced. Attacks may be episodic (occur in clusters lasting weeks or months, separated by remission usually lasting months or years) or chronic (attacks occur for a year or more without remission, or remission is absent or lasts less than 1 month). The one-year prevalence of cluster headache is around 0.05%, while the lifetime prevalence is around 0.12%. Episodic cluster headache is the more common form, accounting for 80-90% of cases. The condition is at least 3 times more common in men than in women, for reasons which are not known.

Policy:

Non-invasive transcutaneous vagus nerve stimulation (e.g., gammaCore) for the treatment of cluster headache will only be funded if the following criteria are met:

- Patient suffers severe cluster headache interfering with lifestyle.

AND

- Treatment recommended by specialist

Ophthalmology

Autologous Serum Eye Drops	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Autologous serum eye drops treat severe keratoconjunctivitis sicca (dry eye). Dry eyes can be helped with intensive treatment with artificial teardrops; however, for some patients the symptoms are not completely relieved. The National Blood Service has developed an alternative to these artificial drops. Autologous serum eye drops are a last resort measure where all other conservative interventions have failed.

Policy:

Autologous serum eye drops will only be funded on a 5 month initial trial basis in accordance with the criteria specified below:

- Patients have been treated unsuccessfully with maximal tolerated conventional and NICE approved therapies (for example, Ciclosporin).

Note: Further funding will be subject to the submission of a progress report following a 5 month trial, outlining the improvements in objective measures.

Chalazia Removal	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Chalazia (meibomian cysts) are benign lesions on the eyelids due to blockage and swelling of an oil gland that normally change size over a few weeks. Many but not all resolve within six months with regular application of warm compresses and massage.

Policy:

Incision and curettage (or triamcinolone injection for suitable candidates) of Chalazia should only be undertaken in accordance with the criteria below:

- Has been present for more than 6 months and has been managed conservatively with warm compresses, lid cleaning and massage for 4 weeks

OR

- Interferes significantly with vision

OR

- Interferes with the protection of the eye by the eyelid due to altered lid closure or lid anatomy

OR

- Is a source of infection that has required medical attention twice or more within a six month time frame

OR

- Is a source of infection causing an abscess which requires drainage

Where the lump is rapidly growing, abnormally located and / or is displaying features suspicious of malignancy, specialist assessment should be sought using the 2 week wait pathway.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Oculoplastic Eye Problems – Ectropion	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Ectropion is a condition, typically a consequence of advanced age, in which the eyelid is turned outwards away from the eyeball.

Policy:

Surgery for Ectropia will only be funded in accordance with the criteria below:

- Conservative management has been exhausted and there is evidence of significant impairment of the punctum

AND

- There is recurrent infection in surrounding skin

OR

- There is significant impact on vision affecting functionality

OR

- In order to have safer intraocular procedures / so the patient can undergo another intraocular procedure.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Oculoplastic Eye Problems – Entropion	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

An entropion occurs where an eyelid turns inwards towards the eye. This causes the eyelashes to rub against the front of the eye (the cornea). The lower eyelid is most commonly affected.

Policy:

Surgery for Entropia will only be funded in accordance with the criteria below:

- There entropion is symptomatic causing ocular irritation, foreign body sensation, blepharospasm, tearing and redness and there is risk of corneal damage

OR

- There is significant impact on vision affecting functionality

OR

- In order to have safer intraocular procedures / so the patient can undergo another intraocular procedure.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Oculoplastic Eye Problems – Surgery for Minor Eyelid Lesions	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Minor eyelid lesions include eyelid papillomas or skin tags, cysts of moll, cysts of zeis, Meibomium cysts.

Policy:

Surgery or treatment for minor eyelid lesions will only be funded in accordance with criteria below:

- There is well documented evidence of significant pain (see FAQs)

OR

- Recurrent infection

OR

- Recurrent bleeding

OR

- Is subject to unavoidable recurrent trauma leading to bleeding

OR

- There is significant impact on vision affecting functionality

Where the lump is rapidly growing, abnormally located and / or is displaying features suspicious of malignancy, specialist assessment should be sought using the 2 week wait pathway.

Surgery for primarily cosmetic reasons is not eligible for NHS funding.

Orthopaedics

Arthroscopic shoulder decompression for subacromial shoulder pain	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Arthroscopic sub-acromial decompression is a surgical procedure that involves decompressing the sub-acromial space by removing bone spurs and soft tissue arthroscopically.

Policy:

Arthroscopic shoulder decompression for pure subacromial shoulder pain will be funded in the following circumstances:

- Pure subacromial impingement is not caused by associated diagnoses such as rotator cuff tears, acromio-clavicular joint pain or calcific tendinopathy

AND

- Physiotherapy and exercise programmes have been actively undertaken and found to be ineffective in resolving the shoulder pain

AND

- There is evidence that the risks and benefits of treatment options have been clearly discussed with the patient / carer and are documented in the patient notes. This may include the NHS Rightcare Shared Decision Making tool. Patient decision making aids are available to search through the following link: https://library.nhs.uk/knowledgehub/

It should be noted that when shoulder decompression is carried out as part of a wider set of procedures, then prior approval will not be required.

Bunions / Minor Foot Problems	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Degeneration of the small joints of the toes and feet is a common problem. It is often caused by inappropriate footwear. It can usually be managed conservatively by changing footwear. Surgery is sometimes sought to avoid the need to change footwear or for cosmetic purposes.

Policy:

Referral for surgery for minor foot problems will only be considered when the following criteria are met:

- The patient has been referred to a podiatrist and conservative management has failed (Including avoiding high heels, exercises, applying ice, non-surgical treatment)

AND

- The patient suffers from severe deformity that causes significant functional impairment (including inability to fit adequate footwear)

OR

- The patient suffers from severe pain that causes significant functional impairment

OR

- There is recurrent or chronic ulceration due to the deformity

OR

- There is recurrent or chronic bursitis or tendinitis at the first metatarsal head due to the deformity.

Exclusions: If the patient has diabetic peripheral neuropathy or suspected osteomyelitis and a foot lesion may lead to amputation of a toe or foot, there is no restriction and prompt referral using appropriate local pathways is required. This policy does not apply to surgery to correct deformity due to acute trauma.

Carpal Tunnel Syndrome Release	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Evidence from observational studies shows that symptoms resolve spontaneously in some people: good prognostic indicators are short duration of symptoms, a young age, and carpal tunnel syndrome due to pregnancy.

There is good evidence that surgical treatment relieves the symptoms of carpal tunnel syndrome (CTS) more effectively than splinting. However, splinting is effective in about 50% of people in the short term. Carpal tunnel surgery is a low priority procedure for patients with intermittent or mild to moderate symptoms. Mild cases with intermittent symptoms causing little or no interference with sleep or activities require no treatment.

Cases with intermittent symptoms which interfere with activities or sleep should first be treated with:

a. corticosteroid injection(s) (medication injected into the wrist: good evidence for short (8-12 weeks) term effectiveness); or

b. night splints (a support which prevents the wrist from moving during the night: not as effective as steroid injections)

Referral guidance: Consider referral for electromyography and nerve conduction studies if the diagnosis is uncertain.

Policy:

Carpal tunnel surgery will be funded if the following criteria are met:

There is evidence that the risks and benefits of treatment options have been clearly discussed with the patient / carer and are documented in the patient notes. This may include the NHS Rightcare Shared Decision Making tool. Patient decision making aids are available to search through the following link: https://library.nhs.uk/knowledgehub/

AND EITHER

Severe symptoms that significantly interfere with daily activities (see FAQ) persist or recur after at least 3 months of conservative therapy, including 8 weeks of nocturnal splinting and / or one local corticosteroid injections if clinically appropriate.

OR

- There is neurological deficit, for example sensory blunting, thenar muscle wasting or motor weakness (moving the thumb away from the hand).

Dupuytren's Contracture – Collagenase Clostridium Histolyticum (CCH) Injections	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Dupuytren's contracture is caused by fibrous bands in the palm of the hand which draw the finger(s) (and sometimes the thumb) into the palm and prevent them from straightening fully. Several treatments are available: needle fasciotomy, fasciectomy and dermofasciectomy. None is entirely satisfactory with some having slower recovery periods, higher complication rates or higher reoperation rates (for recurrence) than others.

In conjunction with NICE guidelines (TA459), Collagenase Clostridium Histolyticum (CCH) Injections is no longer recommended as an option for treating Dupuytren's contracture as the drug is no longer licensed.

Policy:

Collagenase Clostridium Histolyticum (CCH) Injections for Dupuytren's contracture is NOT routinely funded

Dupuytren's Contracture - Radiotherapy	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Dupuytren's contracture is caused by fibrous bands in the palm of the hand which draw the finger(s) (and sometimes the thumb) into the palm and prevent them from straightening fully. Several treatments are available: needle fasciotomy, fasciectomy and dermofasciectomy. None is entirely satisfactory with some having slower recovery periods, higher complication rates or higher reoperation rates (for recurrence) than others.

Policy:

Radiotherapy for Dupuytren's contracture is NOT routinely funded.

Dupuytren's Contracture - Referral for Secondary Care Opinion	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Dupuytren's contracture is caused by fibrous bands in the palm of the hand which draw the finger(s) (and sometimes the thumb) into the palm and prevent them from straightening fully. Several treatments are available: needle fasciotomy, fasciectomy and dermofasciectomy. None is entirely satisfactory with some having slower recovery periods, higher complication rates or higher reoperation rates (for recurrence) than others.

Policy:

Referral for Secondary Care Opinion of Dupuytren's contracture will only be funded in accordance with the criteria specified below:

- Flexion deformity >30° at the MCP Joint or 20° at the PIP Joint

OR

- severe thumb contractures which interfere with function

OR

- Rapidly progressive disease

AND

- Contracture interferes with lifestyle and/or occupation

NB: If the above criteria are fulfilled and a PAT obtained in primary care, then the specialist will not need to obtain a further PAT for surgery. However, for clarity, the same criteria above apply if there is a decision to proceed to surgery and a PAT must be obtained.

Extracorpreal Shockwave for MSK conditions	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Extracorporeal Shockwave Therapy or ESWT is a treatment that can be used in physical therapy, orthopaedics, urology and cardiology. The shockwaves are abrupt, high amplitude pulses of mechanical energy, similar to soundwaves, generated by an electromagnetic coil or a spark in water. Similar technology using focused higher energies is used to break up kidney and gallstones and is termed lithotripsy. "Extracorporeal" means that the shockwaves are generated externally to the body and transmitted from a pad through the skin.

Policy:

Extracorporeal Shockwave Therapy is NOT routinely funded for musculoskeletal conditions.

Extracorporeal Shock Wave Therapy for Plantar Fasciitis	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Extracorporeal Shockwave Therapy or ESWT is a treatment that can be used in physical therapy, orthopaedics, urology and cardiology. The shockwaves are abrupt, high amplitude pulses of mechanical energy, similar to soundwaves, generated by an electromagnetic coil or a spark in water. Similar technology using focused higher energies is used to break up kidney and gallstones and is termed lithotripsy. "Extracorporeal" means that the shockwaves are generated externally to the body and transmitted from a pad through the skin.

Policy:

Extracorporeal shock-wave therapy for plantar fasciitis is NOT routinely funded

Ganglion Excision	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Ganglia are benign fluid filled, firm and rubbery lumps attached to the adjacent underlying joint capsule, ligament, tendon or tendon sheath. They occur most commonly around the wrist, but also around fingers, ankles and the top of the foot. They are usually painless and completely harmless. Many resolve spontaneously especially in children (up to 80%). Reassurance should be the first therapeutic intervention. Aspiration alone can be successful, but recurrence rates are up to 70%. Surgical excision is the most invasive therapy but recurrence rates up to 40% have been reported. Complications of surgical excision include scar sensitivity, joint stiffness and distal numbness.

Referral guidance: Include reference to the degree of pain and restriction of normal activities caused by the ganglion.

Policy:

Surgical treatment for ganglia will only be funded in accordance with the criteria specified below:

- There is significant pain and / or a significant functional impairment affecting activities of daily living (see FAQs)

AND

- If aspiration fails to resolve the pain or tingling / numbness

OR

- Where there is recurrent spontaneous discharge of fluid or significant nail deformity (in relation to Myxoid / Mucous Cysts)

Hip Arthroscopy	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Hip arthroscopy refers to the viewing of the interior of the acetabulofemoral (hip) joint through an arthroscope and the treatment of hip pathology through a minimally invasive approach.

Policy:

Hip Arthroscopy will only be commissioned (from surgeons with specialist expertise in this type of surgery) in line with the requirements stipulated by NICE IPG 408 **and only for patients who fulfil ALL of the following criteria:**

- A definite diagnosis of hip impingement syndrome / femoro-acetabular impingement (FAI) has been made by appropriate investigations, X-rays, MRI and CT scans

AND

- An orthopaedic surgeon who specialises in young adult hip surgery has made the diagnosis in collaboration with a specialist musculoskeletal radiologist

AND

- The patient has had severe FAI symptoms (restriction of movement, pain and 'clicking') or significantly compromised functioning for at least 6 months

AND

- The symptoms have not responded to all available conservative treatment options including activity modification, drug therapy (NSAIDs) and specialist physiotherapy

If the patient does not meet all the criteria described above but the Specialist still recommends this treatment, an Individual Funding Request should be submitted for consideration.

Hip Arthroscopy is **NOT** routinely funded for patients where any of the following apply:

- Advanced osteoarthritis or severe cartilage injury
- A hip joint space on plain radiograph that is less than 2mm wide anywhere
- Candidates for total hip replacement
- Hip dysplasia
- Generalised joint laxity especially in diseases connected with hypermobility of the joints
- Osteogenesis imperfecta (brittle bone disease)

Hip Prostheses and Resurfacing	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

ODEP, the Orthopaedic Data Evaluation Panel was set up in 2002 to implement NICE guidance on primary hip implants. Hip resurfacing followed in 2004. Since 2002 manufacturers use ODEP to benchmark their Hip, Knee and now Shoulder prostheses, against agreed standards and at regular time points.

Policy:

Prostheses for total hip replacement and resurfacing arthroplasty will only be funded where the prosthesis to be used has a rate (or projected rate) of revision of 5% or less at 10 years (ODEP 10A* rating, or A* rating at less than 10 years).

• Hip Replacement Surgery	• Category: • *(IFR / Prior Approval / Monitored Approval)*	• Prior Approval
	• Local or National EBI (Evidence Based Interventions) Policy:	• Local

• Background:

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• Hip replacement surgery is usually necessary when the hip joint is worn or damaged so that your mobility is reduced, and you are in pain even while resting. The most common reason for hip replacement surgery is osteoarthritis, however, other conditions can cause hip joint damage such as rheumatoid arthritis. A hip replacement is major surgery, so it is usually only recommended in certain circumstances if other treatments, such as physiotherapy or steroid injections, have not helped reduce pain or improve mobility.

• Policy:

•

• Hip replacement surgery will only be funded in accordance with the criteria specified below:

- The patient has accessed core (non-surgical) treatment options for at least 3 months as part of their management plan:
  - Access to appropriate information as an ongoing, integral part of the management plan rather than a single event at time of presentation
  - Access to activity and exercise including aerobic fitness and local muscle strengthening appropriate to age, co-morbidity, pain severity or disability
  - Access to facilitated interventions to achieve weight loss if the patient is overweight or obese.

• AND

- The patient has moderate to severe persistent joint pain that is refractory to non-surgical treatment and may include joint injections and recommended use of non-steroidal anti-inflammatories and other analgesics and has a substantial impact on their quality of life.

• AND

- There is clinically significant moderate to severe functional limitation which is refractory to use of walking aids and other forms of physical therapies and results in diminished quality of life (see FAQs)

• AND

- There is evidence that the risks and benefits of treatment options have been clearly discussed with the patient / carer and are documented in the patient notes. This may include the NHS Rightcare Shared Decision Making tool. Patient decision making aids are available to search through the following link: https://library.nhs.uk/knowledgehub/.

•

• Note: referral for joint surgery should be considered before there is prolonged and established functional limitation and significant pain.

•

• Revision Surgery for Hip replacements is not currently included within the scope of this policy.

Knee Arthroscopy	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Knee arthroscopy is a surgical technique that can diagnose and treat problems in the knee joint. Arthroscopic washout of the knee is an operation where an arthroscope (camera) is inserted in to the knee along with fluid. Occasionally loose debris drains out with the fluid, or debridement, (surgical removal of damaged cartilage) is performed, but the procedure does not improve symptoms or function of the knee joint.

Policy:

Knee arthroscopy will only be funded in accordance with the criteria specified below:

- Clinical examination (or MRI scan) has demonstrated clear evidence of an internal joint derangement (meniscal tear, ligament rupture or loose body)

AND

- Conservative treatment has failed or where it is clear that conservative treatment will not be effective.

OR

- In exceptional cases, intractable knee pain considered likely to benefit from arthroscopic treatment according to assessment by a Consultant Knee Surgeon.

OR

- There is continuing diagnostic uncertainty following MRI, such that a Consultant Knee Surgeon recommends diagnostic arthroscopy.

Arthroscopy is not commissioned:

- For diagnostic purposes only (noting the exception above);

- To provide arthroscopic washout alone as a treatment for chronic knee pain due to osteoarthritis. This procedure may be appropriate in conditions such as septic arthritis

This policy restriction does not apply where there is an urgent need for investigation/treatment.

Knee Replacement Surgery (Total)	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Knee replacement surgery (arthroplasty) is a common operation that involves replacing a damaged, worn or diseased knee with an artificial joint. The most common reason for knee replacement surgery is osteoarthritis, however, other conditions can cause hip joint damage such as rheumatoid arthritis. A knee replacement is major surgery, so is normally only recommended in certain circumstances if other treatments, such as physiotherapy or steroid injections, have not reduced pain or improved mobility.

Policy:

Knee replacement surgery will only be funded in accordance with the criteria specified below:

- The person has been offered the core (non-surgical) treatment options for at least 3 months as part of their management plan:
    - Access to appropriate information as an ongoing, integral part of the management plan rather than a single event at time of presentation
    - Access to activity and exercise including aerobic fitness and local muscle strengthening appropriate to age, co-morbidity, pain severity or disability
    - Access to facilitated interventions to achieve weight loss if the patient is overweight or obese.

AND

- The patient has moderate to severe persistent joint pain that is refractory to non-surgical treatment and may include joint injections and recommended use of non-steroidal anti-inflammatories and other analgesics and has a substantial impact on their quality of life.

AND

- There is clinically significant moderate to severe functional limitation which is refractory to use of walking aids and other forms of physical therapies and results in diminished quality of life (see FAQs)

AND

- There is evidence that the risks and benefits of treatment options have been clearly discussed with the patient / carer and are documented in the patient notes. This may include the NHS Rightcare Shared Decision Making tool. Patient decision making aids are available to search through the following link: https://library.nhs.uk/knowledgehub/.

Note: referral for joint surgery should be considered before there is prolonged and established functional limitation and significant pain.

Revision Surgery for Knee replacements is not currently included within the scope of this policy.

Low (Lumbar) Back Pain and Sciatica (radicular pain)

This policy has been revised in the light of NICE guideline NG59 and the National Back Pain and Radicular Pain Pathway (NBPRPP). The policy applies to all patients who experience either new episodes or chronic persistent and unremitting symptoms of low back pain and sciatica.

The policy covers treatment procedures for the lumbar spine. It does not cover:

- non-lumbar regions of the spine, and
- serious spinal pathology and the potentially serious neurological sequelae of sciatica (progressive neurological deficit and Cauda Equina Syndrome)

The precise form and content of comprehensive non-surgical treatments including Combined Physical and Psychological Programmes (CPPP) may vary according to Integrated Care Board (ICB'S), the extent to which the NBPRPP has been implemented, and the individual needs of the patient.

Low Back Pain - Epidural and nerve root injections for <u>Acute</u> Radicular Leg Pain	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Policy:

Epidural and nerve root injections are not routinely funded for the treatment of non-specific low back pain.

Injections for <u>acute</u> radicular leg pain (caudal epidural, lumbar epidural, transforaminal epidural or nerve root injections) will only be funded in accordance with the criteria specified below:

- The patient has radicular leg pain (below the knee for lower lumbar herniation, into the anterior thigh for upper lumbar herniation) consistent with the level of spinal involvement

OR

- There is evidence of nerve-root irritation with a positive nerve-root tension sign (straight leg raise-positive between 30° and 70° or positive femoral tension sign)

AND

- The pain is not responding to analgesia

AND

- The patient is unable to tolerate rehabilitation and exercises

AND

- In the opinion of the clinician a nerve root injection is required in order for the patient to mobilise, exercise and engage with rehabilitation

AND

- The pain has been present for less than 8 weeks

Note: Nerve root injections should only be performed under imaging. Under these circumstances, a total of up to two injections will be funded per episode.

Epidural injections are not recommended or funded for neurogenic claudication caused by central spinal canal stenosis.

Nerve root injections for diagnostic purposes will be funded where Prior Approval is in place.

Low Back Pain - Epidural and nerve root injections for <u>Chronic</u> Radicular Leg Pain	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Policy:

Epidural and nerve root injections are not routinely funded for the treatment of non-specific low back pain.

Injections for <u>chronic</u> radicular leg pain (caudal epidural, lumbar epidural, transforaminal epidural or nerve root injections) will only be funded in accordance with the criteria specified below:

- The patient has radicular leg pain (below the knee for lower lumbar herniation, into the anterior thigh for upper lumbar herniation) consistent with the level of spinal involvement

OR

- There is evidence of nerve-root irritation with a positive nerve-root tension sign (straight leg raise-positive between 30° and 70° or positive femoral tension sign)

AND

- Comprehensive non-surgical treatment, including CPPP where available, or where not available, analgesia, psychologically informed rehabilitation and modified value based activity has not been successful

Note: Nerve root injections should only be performed under imaging. Under these circumstances, a total of up to two injections will be funded per episode. The interval between two injections must be at least 6 months.

Epidural injections are not recommended or funded for neurogenic claudication caused by central spinal canal stenosis.

Nerve root injections for diagnostic purposes will be funded where Prior Approval is in place.

Low Back Pain - Lumbar disc replacement	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Policy:

Lumbar disc replacement will not routinely be funded for patients with low back pain.

Low Back Pain - Medial Branch Block (MBB)	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Policy:

Prior to Radiofrequency denervation (Rhizolysis), medial branch block should first take place for diagnostic purposes only.

Medial Branch Block for chronic non-specific low back pain will only be funded in accordance with the criteria below:

- Comprehensive non-surgical treatment including CPPP where available, or where not available, analgesia, physiotherapy, and modified activity has not been successful

AND

- The main source of pain is thought to come from structures supplied by the medial branch nerve

AND

- Moderate or severe levels of localised back pain (rated as 5 or more on a visual analogue scale, or equivalent) at the time of referral

AND

- Where a patient has had a previous medial branch block followed by rhizolysis then the interval should be a minimum of 16 months

Low Back Pain - Radiofrequency denervation (rhizolysis)	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Policy:

Radiofrequency denervation for chronic non-specific low back pain will only be funded in accordance with the criteria below:

- Comprehensive non-surgical treatment including CPPP where available, or where not available, analgesia, physiotherapy, and modified activity has not been successful

AND

- The main source of pain is thought to come from structures supplied by the medial branch nerve

AND

- Moderate or severe levels of localised back pain (rated as 5 or more on a visual analogue scale, or equivalent) at the time of referral

AND

- Where a patient has had a previous rhizolysis then the interval should be a minimum of 16 months

AND

- Positive response to a diagnostic medial branch block (which also requires PAT funding)

Low Back Pain - Spinal decompression and discectomy	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Policy:

Spinal decompression (laminectomy) and discectomy will only be funded for patients with sciatica (radicular pain) in accordance with the following criteria:

- Magnetic resonance imaging shows compression of the neural elements consistent with the clinical symptoms

AND

- Radicular pain (below the knee for lower lumbar herniations, into the anterior thigh for upper lumbar herniations) and neurological deficit consistent with the level of spinal involvement

OR

- There is evidence of nerve-root irritation with a positive nerve-root tension sign (straight leg raise-positive between 30° and 70° or positive femoral tension sign)

AND

- Symptoms persist despite non-operative treatment for at least 6 weeks (e.g., analgesia, physiotherapy, modified activity, etc.) provided that analgesia is adequate and there is no significant neurological deficit.

Low Back Pain - Spinal Fusion	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBIcho**

Policy:

Spinal Fusions will only be funded for patients in accordance with the following criteria:

- Failed Conservative Treatment for at least 3 months (including targeted physiotherapy and appropriate analgesia)

AND

- Discussion and Agreement at Regional Spinal MDT

AND

- Symptomatic Instability (spondylolisthesis)

OR

- Destabilising Decompression

OR

- Revision of Non-Union (previous attempted fusion)

OR

- Revision discectomy

This policy excludes patients where there is evidence of Trauma, Tumour, Infection, Degenerative Scoliosis, or Progressive neurological deficit - including cord or cauda equine compression.

Low Back Pain - Spinal injections (Therapeutic)	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Policy:

Therapeutic spinal injections of local anaesthetic and steroid are not routinely funded for the treatment of non-specific low back pain.
Spinal injections include:

- Facet joint injections
- Therapeutic Medial branch blocks
- Intradiscal therapy
- Prolotherapy
- Trigger Point Injections

Paediatric Foot Problems	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Whilst minor foot or gait problems are relatively common presentations in children, referral directly for surgery is rarely needed. Referral for prophylactic or cosmetic reasons for minor foot problems should not be considered in children.

Policy:

Referral of children to orthopaedic surgery for minor foot problems should only be considered in the following circumstances:

- Metatarsus varus (also known as metatarsus adductus or "in-toeing") has been diagnosed clinically;

AND

- associated developmental dysplasia of the hips is suspected;

OR

- Child is ≥ 5 years of age and intoeing is still evident despite community podiatry review

OR

- Curly toes have been diagnosed clinically;

AND

- Severe deformity is present (as is shown by either deformity of the growing nail of the toe or pressure on the adjacent toe or corn formation on the dorsum of the toe.)

OR

- There is significant pain unmanageable by community podiatry services

Exclusions: The treatment of children with acute foot trauma or with neurodevelopmental problems or other complex conditions affecting the feet is not covered by this policy. This policy also does not apply when a foot or gait problem is considered to need further investigation by a paediatrician to determine its cause.

Surgery to treat Periprosthetic Infection	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Periprosthetic joint infection (PJI) is a serious complication after arthroplasty, which is associated with pain and functional incapacitation.

Policy:

Surgical treatment for periprosthetic joint infection will only be funded in accordance with the following criteria:

- This patient has been discussed and documented (or if urgent, will be within 10 days of surgery) in a Multidisciplinary Team (MDT) meeting, consisting of; at least 2 surgeons, and at least 1 microbiologist or infectious disease consultant

AND

- The case and subsequent related procedures will be recorded on the national Bone and Joint Infection Registry

Trigger Finger Release in Adults	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Trigger digit occurs when the tendons which bend the thumb/finger into the palm intermittently jam in the tight tunnel (flexor sheath) through which they run. It may occur in one or several fingers and causes the finger to "lock" in the palm of the hand. Mild triggering is a nuisance and causes infrequent locking episodes. Other cases cause pain and loss and unreliability of hand function. Mild cases require no treatment and may resolve spontaneously.

Policy:

Surgery for trigger finger will only be funded in accordance with the criteria specified below:

- The patient has co-morbidities associated with an increased risk of trigger finger (e.g., rheumatoid arthritis or diabetes mellitus) and the patient's symptoms have not improved with at least 4 months of conservative treatment (e.g., NSAIDs, splintage, physiotherapy of the affected finger).

OR

- The patient's symptoms have not resolved despite at least one steroid injection in the last 4 months.

OR

- The specialist opinion is that surgery is needed promptly to prevent the development of flexion contractures.

OR

- The finger is permanently locked in the palm

OR

- The patient has previously had 2 other trigger digits unsuccessfully treated with appropriate non-operative methods

This policy applies to adults only.

Unicompartmental Knee Replacement (medial, lateral and patello femoral)	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Unicompartmental knee replacement (arthroplasty) is a surgical procedure in which only the damaged parts of the knee are replaced.

Policy:

Unicompartmental Knee replacement surgery (medial & lateral and patella femoral) will only be funded in accordance with the criteria specified below:

- The person has been offered the core (non-surgical) treatment options for at least 3 months as part of their management plan:
    - Access to appropriate information as an ongoing, integral part of the management plan rather than a single event at time of presentation
    - Access to activity and exercise including aerobic fitness and local muscle strengthening appropriate to age, co-morbidity, pain severity or disability
    - Access to facilitated interventions to achieve weight loss if the patient is overweight or obese.

AND

- The patient has moderate to severe persistent joint pain that is refractory to non-surgical treatment and may include joint injections and recommended use of non-steroidal anti-inflammatories and other analgesics and has a substantial impact on their quality of life.

AND

- There is clinically significant moderate to severe functional limitation which is refractory to use of walking aids and other forms of physical therapies and results in diminished quality of life (see FAQs)

AND

- There is evidence that the risks and benefits of treatment options have been clearly discussed with the patient / carer and are documented in the patient notes. This may include the NHS Rightcare Shared Decision Making tool. Patient decision making aids are available to search through the following link: https://library.nhs.uk/knowledgehub/.

AND

- The treating surgeon has performed / supervised >10 medial or lateral unicompartmental knee replacements in the last 12 months and discussed their revision rate during appraisal

Note: referral for joint surgery should be considered before there is prolonged and established functional limitation and significant pain.

Other

Bobath Therapy	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Bobath therapy is an approach in neurological rehabilitation that is applied in patient assessment and treatment (such as with adults after stroke or children with cerebral palsy). The goal of applying the Bobath concept is to focus on handling skills to improve muscle tone, posture, movement skills and function. It aims to assess the patient's needs and adapt to individual requirements. The evidence base for the effectiveness of Bobath therapy in children and adults is poor and there are more effective treatments available.

Policy:

Bobath Therapy will NOT be routinely funded.

Continuous Positive Airway Pressure (CPAP) Device for patients with obstructive sleep apnoea	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

CPAP is recommended as a treatment option for adults with symptomatic obstructive sleep apnoea/hypopnoea syndrome (OSHAS) regardless of severity under certain circumstances.

Policy:

Continuous Positive Airway Pressure (CPAP) is only offered as a treatment option for adults with OSAHS, where the following criteria are met:

- The patient has symptoms that affect their quality of life and ability to go about their daily activities

AND

- Lifestyle advice and any other relevant treatment options have been unsuccessful or are considered inappropriate

AND

- Diagnosis and treatment of OSAHS, and the monitoring of the response, has been carried out by a specialist service with appropriately trained medical and support staff

Helmet Therapy for Treatment of Positional Plagiocephaly / Brachycephaly in Children	Category: *(IFR / Prior Approval / Monitored Approval)*	IFR
	Local or National EBI (Evidence Based Interventions) Policy:	National EBI

Background:

Non-synostotic/positional plagiocephaly and brachycephaly are distortions of the skull (flattening to the side or the back of the head) that most commonly become apparent in the first few months of life as a result of the amount of time a baby spends lying on their back. Non-synostotic/positional plagiocephaly and brachycephaly are very common, affecting up to 40% of infants (as opposed to synostotic conditions which are rare).

Cranial Moulding Orthosis – or 'helmet therapy' – is an intervention that claims to correct the shape of the head. A specially moulded solid helmet is created (with space to allow the flattened area to re-mould) that must be worn 23 hours a day. This helmet requires repeated adjustments as the baby grows.

This guidance applies to children aged 2 years and under.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy:

Helmet therapy for treatment of positional plagiocephaly / brachycephaly in children is NOT routinely commissioned

Lycra Garments (for Children)	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

The limited data which is inconclusive suggests that wearing Lycra garments may improve stability, movement and function in some children with cerebral palsy in the short term but are not conclusive. The limitations of the evidence make it difficult to characterise whether there are patient groups that may benefit more than others and which if any benefits are sustained in the long term.
Adverse effects reported in studies with various types of Lycra garments (full body suits, vests, shorts) include vomiting, cyanosis, hyperthermia, muscle weakness, inhibition of voluntary movement, respiratory compromise, constipation, friction sores and erythema. Long term safety is not known.

Policy:

Lycra Garments are only offered as a treatment option where the following criteria are met:

- Patient is <18 years old

AND

- The request is for a <u>new</u> patient, or where the request is for a replacement, there is sufficient evidence that the child has outgrown their previous garment, or there has been 12 months between requests

AND

- A Lycra garment is recommended by an appropriate paediatric health professional involved in the child's care

AND

- The family of the patient are aware that the funding is only available until age 18

Wigs & Hair Pieces	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Hair loss and hypotrichosis for men and women have many causes including androgenetic alopecia, fungal infection, trauma (e.g., due to (trichotillomania), radiotherapy, chemotherapy, nutritional deficiencies (e.g., iron deficiency), and autoimmune diseases (e.g., alopecia areata). Male pattern baldness is a common type of hair loss and for many men it is a normal process at whatever age it occurs. Almost all men have some baldness in their 60s. Treatment of hair loss can include hair transplantation or hair grafting, the 'Interlace' hair system, or Dermatography (tattooing).

Policy:

Requests for wigs to correct male pattern baldness or androgenic hair loss in women (at any age) or for any other reasons that are considered cosmetic are not routinely commissioned. Wigs & Hair Pieces will only be commissioned in the following circumstances:

- The patient has experienced total or severe hair loss resulting from one of the following; severe alopecia areata, alopecia totalis; scarring alopecia (including scleroderma, lichen planus, discoid lupus, folliculitis decalvans, frontal fibrosing alopecia); cancer treatment; severe trauma (including burns)

AND

- The patient is aware that they will be entitled to a maximum of 2 acrylic wigs per year

AND

- The patient is aware that human hair wigs are **not** prescribed on the NHS unless the patient is allergic to acrylic wigs or has a skin condition that will be made worse by an acrylic wig.

AND

- The patient is aware that the approval of a wig is not open ended, and they will need to return to their GP after 3 years for re-assessment in line with the relevant commissioned policy at that time.

NOTE: Patients who satisfy the criteria of this policy will be eligible for a maximum of 2 acrylic wigs per year (from the point of approval) **up to a maximum value** of £465.

Where prior approval is obtained, funding requests will be eligible for a 3-year period without needing to be re-referred. After this point, patients should return to their GP to be re-assessed and where appropriate (i.e.: they continue to meet the current policy in place at that time), generate a new Prior Approval / IFR.

Patients who do not meet policy criteria are not eligible for funding of wigs.

Plastics

Abdominoplasty or Apronectomy	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Abdominoplasty (also known as tummy tuck) is a surgical procedure performed to remove excess fat and skin from the mid and lower abdomen. Many people develop loose abdominal skin after pregnancy or substantial weight loss. However, surgery is not part of the usual response to these normal, physiological processes.

Policy:

Abdominoplasty or Apronectomy will not be routinely funded

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Blepharoplasty	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Blepharoplasty is a surgical procedure performed to correct puffy bags below the eyes and droopy upper eyelids. It can improve appearance and widen the field of peripheral vision. It is usually done for cosmetic reasons. Consideration should be given to whether blepharoplasty or brow lift is the more appropriate procedure, particularly in the case of obscured visual fields.

Policy:

Blepharoplasty will only be funded in accordance with the criteria specified below:

- Impairment of visual fields in the relaxed, non-compensated state

OR

- Clinical observation of poor eyelid function leading to discomfort, e.g., headache worsening towards end of day and/or evidence of chronic compensation through elevation of the brow.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Face Lift or Brow Lift	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

These surgical procedures are performed to lift the loose skin of the face and forehead to get a firm and smoother appearance of the face. These procedures will not be funded to treat the natural processes of ageing or to achieve a cosmetic outcome.

Policy:

Face lift or brow lift will only be funded in accordance with the criteria specified below.

These procedures will **only** be considered for treatment of the functional impairments arising from:

- Congenital facial abnormalities

OR

- Facial palsy (congenital or acquired paralysis)

OR

- As part of the treatment of specific conditions affecting the facial skin e.g., Cutis laxa, pseudoxanthoma elasticum, neurofibromatosis

OR

- To correct the functional consequences of trauma

OR

- To correct functional consequences of deformity following surgery

OR

- In some cases of impaired visual fields, where it may be a more appropriate primary procedure than blepharoplasty

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Gynaecomastia	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Gynaecomastia is benign enlargement of the male breast. Most cases are idiopathic. For others endocrinological disorders and certain drugs such as oestrogens, gonadotrophins, digoxin, spironolactone, cimetidine and proton pump inhibitors could be the primary cause. Obesity can also give the appearance of breast development as part of the wide distribution of excess adipose tissue. Early onset gynaecomastia is often tender, but this usually resolves in 3 to 4 months.

Full assessment of men with gynaecomastia should be undertaken, including screening for endocrinological and drug related causes and necessary treatment is given prior to request for NHS funding. It is important to exclude inappropriate use of anabolic steroids or cannabis.

Policy:

Surgery to correct gynaecomastia will not be routinely funded.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Liposuction	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Liposuction (also known as liposculpture), is a surgical procedure performed to improve body shape by removing unwanted fat from areas of the body such as abdomen, hips, thighs, calves, ankles, upper arms, chin, neck and back. Liposuction is sometimes done as an adjunct to other surgical procedures.

Policy:

Liposuction simply to correct the distribution of fat will not be funded.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Pinnaplasty	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Pinnaplasty is performed for the correction of prominent ears or bat ears. Prominent ears are a condition where one's ears stick out more than normal.

Correction is considered to be a primarily a cosmetic procedure. Surgery for primarily cosmetic reasons is not eligible for NHS funding.

The exception to this policy is procedures (***remodelling of external ear lobe***) in children with congenital abnormalities of the ear to improve hearing as this is covered by Specialised commissioning and should be managed through the specialised commissioning route.

Policy:

Pinnaplasty will NOT routinely be funded.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Removal of Tattoos	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

A tattoo is defined as a form of body modification, made by inserting indelible ink into the dermis layer of the skin to change the pigment.

Policy:

Tattoo removal will not be routinely funded.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Resurfacing Procedures: Dermabrasion, chemical peels and laser treatment	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Dermabrasion involves removing the top layer of the skin with an aim to make it look smoother and healthier. Scarring and permanent discolouration of skin are the rare complications. This policy includes all laser skin treatments, for example for Rhinophyma or Rosacea.

Policy:

Resurfacing procedures will not be routinely funded.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Surgical Fillers (for Treatment of wrinkles and skin ageing)	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Surgical Fillers are widely used in cosmetic surgery, for the treatment of wrinkles and skin aging, to improve the appearance of scars and for augmenting the volume of soft tissue such as in the lips.

Policy:

Surgical fillers for the treatment of wrinkles and skin ageing will not be routinely funded

This commissioning position applies to the use of both natural (e.g., fat, dermis) and synthetic fillers (temporary or permanent) including hyaluronic acid fillers and collagen. Please note; the treatment of complications arising from the cosmetic use of surgical fillers in private practice is not routinely funded.

Surgical Treatment for Hair Loss	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Hair loss and hypotrichosis for men and women have many causes including androgenetic alopecia, fungal infection, trauma (e.g., due to (trichotillomania), radiotherapy, chemotherapy, nutritional deficiencies (e.g., iron deficiency), and autoimmune diseases (e.g., alopecia areata). Male pattern baldness is a common type of hair loss and for many men it is a normal process at whatever age it occurs. Almost all men have some baldness in their 60s. Treatment of hair loss can include hair transplantation or hair grafting, the 'Interlace' hair system, or Dermatography (tattooing).

Policy:

Surgical Treatment for hair loss will not be routinely funded.

Thigh Lift, Buttock Lift and Arm Lift, Excision of Redundant Skin or Fat	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

These surgical procedures are performed to remove loose skin or excess fat to reshape body contours. As the patient groups seeking such procedures are similar to those seeking abdominoplasty (see above), the functional disturbance of skin excess in these sites tends to be less and so surgery is less likely to be indicated except for appearance, in which case it should not be available on the NHS.

Policy:

These procedures will not be routinely funded.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Vaginoplasty, Labial Vulvoplasty and Vulvar Lipoplasty	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Surgery for Vaginoplasty, Labial Vulvoplasty and Vulvar lipoplasty are all cosmetic procedures. This policy does not cover vaginal repair following delivery and is part of obstetric or gynaecological treatment. Clinicians should refer to the following guidance from the Royal College of Obstetricians and Gynaecologists : https://www.rcog.org.uk/en/news/joint-rcogbritspag-release-issues-surrounding-women-and-girls-undergoing-female-genital-cosmetic-surgery-explored/

Policy:

Vaginoplasty will not routinely be funded.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Radiology

Shoulder Radiology: Guided Injections	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

W1 Scans for Shoulder Pain

X-rays should be used routinely as the first line of radiological investigation for the diagnosis of most routine shoulder pathology. This practice should be followed in primary, intermediate and secondary care.

The use of Ultrasound, MRI and CT scanning should be restricted to those secondary care services that are responsible for the definitive treatment of such patients. The use of these investigations outside secondary care should only be allowed if referral pathways have been developed with the local secondary care specialist shoulder service.

Primary care patients that are deemed urgent or have red flags should be referred urgently to the appropriate secondary care team.

W2 Image Guided Injections for Shoulder Pain

Image guided subacromial injections are not recommended in primary, intermediate or secondary care.

Evidence does not support the use of guided subacromial injections over unguided subacromial injections in the treatment of subacromial shoulder pain. Other image guided shoulder injections should only be offered under the guidance of a secondary care shoulder service.

For patients who initially present with shoulder pain in primary or intermediate care, the first line of radiological investigation should be a plain x-ray. X-rays diagnose most routine shoulder problems such as osteoarthritis, calcium deposits, rotator cuff arthropathy, impingement, fractures and primary and secondary tumours.

This guidance applies to adults aged 19 years and over.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy: X-rays should be used routinely as the first line of radiological investigation for the diagnosis of most routine shoulder pathology. This practice should be followed in primary, intermediate and secondary care. Scans for Shoulder pain should only be carried out where the specified criteria are met – see the associated policy under the Monitored Approval section.

Guided Injections for Shoulder Pain

Evidence now indicates there is no additional benefit from a guided subacromial injection over an unguided landmark injection and so these are no longer recommended in primary, intermediate and secondary care during routine management of patients with subacromial shoulder pain.

Image guided subacromial injections are NOT routinely commissioned

NOTE: If shoulder RED FLAGS are present, an urgent referral to secondary care should be arranged for further investigation and management

Urology

Circumcision	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Circumcision is a surgical procedure that involves partial or complete removal of the foreskin of the penis. It is an effective procedure and confers benefit for a range of medical indications.

Policy:

Circumcision for both Adults and Children is not funded for social, cultural or religious reasons. Circumcision will only be funded for specific medical reasons in accordance with the criteria specified below.

Medical reasons for funding circumcision include:

- Carcinoma of the penis

OR

- Pathological phimosis: the commonest cause is lichen sclerosus – balanitis xerotica obliterans (BXO) is an old fashioned descriptive term

OR

- Recurrent episodes of balanoposthitis

OR

- Leukoplakia (suspicion of cancer)

Relative indications for circumcision or other foreskin surgery:

- Prevention of urinary tract infection in patients with an abnormal urinary tract

OR

- Recurrent paraphimosis

OR

- Traumatic (e.g., zipper injury)

OR

- Tight foreskin causing pain on arousal/ interfering with physical function

OR

- Congenital abnormalities

Reversal of Male Sterilisation	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Reversal of male sterilisation is a surgical procedure that involves the reconstruction of the vas deferens.

Sterilisation procedure is available on the NHS and couples seeking sterilisation should be fully advised and counselled (in accordance with RCOG guidelines) that the procedure is intended to be permanent.

Policy:

Reversal of sterilisation will NOT be routinely funded.

Vascular

Liposuction for Chronic Lymphoedema	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Lymphoedema is the abnormal accumulation of subcutaneous fat and fluid in body tissue. It leads to chronic swelling that can cause disability, pain and cosmetic issues. Any part of the body can be affected, but the condition is most common in the arms and legs. Lymphoedema can be complicated by recurrent infection (cellulitis), which further damages the lymphatic vessels and aggravates the condition. Liposuction for chronic lymphoedema is usually done under general anaesthesia, but regional nerve blockade is also possible. Current evidence on the safety and efficacy of liposuction for chronic lymphoedema is adequate to support the use of this procedure.

Policy:

Liposuction for Chronic Lymphoedema will only be funded where the following criteria are met:

- The procedure is non-cosmetic

AND

- The patient has failed conservative management in line with the current patient pathway for the treatment of lymphoedema

AND

- Treatment is recommended by, and only started by, a specialist lymphoedema multidisciplinary team as part of a lymphoedema service pathway

AND

- The patient is willing and able to adhere to lifelong self-management, including compression hosiery, skin care, healthy diet and exercise

AND

- Has no remaining movable oedema (i.e.: treatable with conservative management)

AND

- Has no active cancer, wounds or active infection

AND

- Has an oedema impacting on function / ability to carry out work or self-care as assessed using the validated LYMQOL tools, OR where their oedema has been replaced by large amounts of adipose tissue

AND

- A History of recurrent cellulitis

NOTE: Conservative treatments for lymphoedema include manual lymph drainage (MLD), and decongestive lymphatic therapy (DLT).

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Liposuction for the Management of Lipoedema	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Lipoedema is frequently confused with lymphoedema but is a separate condition with similar presentation. It is a disorder of fat distribution, which causes symmetrical and excessive deposition of adipose tissue in the limbs. Any part of the body can be affected, but the condition is most common in the arms and legs leading to chronic swelling that can cause disability, pain and cosmetic issues.

Policy:

Liposuction for the Management of Lipoedema will NOT be routinely funded

Varicose Veins Interventions	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Varicose veins are dilated, often palpable subcutaneous veins with reversed blood flow. They are most commonly found in the legs. Estimates of the prevalence of varicose veins vary. Visible varicose veins in the lower limbs are estimated to affect at least a third of the population. Risk factors for developing varicose veins are unclear, although prevalence rises with age, and they often develop during pregnancy.

In some people varicose veins are asymptomatic or cause only mild symptoms, but in others they cause pain, aching or itching and can have a significant effect on their quality of life. Varicose veins may become more severe over time and can lead to complications such as changes in skin pigmentation, bleeding or venous ulceration. It is not known which people will develop more severe disease, but it is estimated that 3–6% of people who have varicose veins in their lifetime will develop venous ulcers.

Policy:

Referral to a vascular service Guidance: Refer people with bleeding varicose veins to a vascular service[7] immediately.

Policy for Referral:

Refer people to a vascular service if they have any of the following:

- History of bleeding from a varicosity which are at risk of bleeding again

OR

- Ulceration which is progressive and/or causing significant pain despite treatment

OR

- Active or healed ulceration and/or progressive skin changes that may benefit from surgery

OR

- Recurrent superficial thrombophlebitis

OR

- Significant pain attributable to varicose veins having a severe impact on quality of life and interfering with actives of daily living (see FAQ).

[7] *A team of healthcare professionals who have the skills to undertake a full clinical and duplex ultrasound assessment and provide a full range of treatment.*

Assessment and treatment in a vascular service

Assessment: Use duplex ultrasound to confirm the diagnosis of varicose veins and the extent of truncal reflux, and to plan treatment for people with suspected primary or recurrent varicose veins.

Interventional treatment: For people with confirmed varicose veins and truncal reflux:

1. Offer endothermal ablation and Endovenous laser treatment of the long saphenous vein

2. If endothermal ablation is unsuitable, offer ultrasound-guided foam sclerotherapy

3. If ultrasound-guided foam sclerotherapy is unsuitable, offer surgery.

If incompetent varicose tributaries are to be treated, consider treating them at the same time.

Non-interventional treatment: Compression hosiery to treat varicose veins is not recommended unless interventional treatment is unsuitable for clinical reasons or patient choice.

Policy for Interventions:

Interventional treatments for varicose veins outlined above will only be funded in accordance with the criteria specified below.

- Persistent ulceration that is progressive or causing significant pain (see FAQs)

OR

- Recurrent superficial thrombophlebitis where there is significant pain and disability

OR

- Progressive skin changes that suggest potential ulceration due to venous insufficiency

OR

- Significant haemorrhage from a ruptured superficial varicosity

OR

- Patients with significant pain attributable to chronic venous insufficiency which is having a significant impact on quality of life and interfering with activities of daily living (see FAQs)

Patients whose primary concern is cosmetic will not be funded for surgical treatment.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Section 2:

Monitored Approval Policies

Policies that do not need approval to be confirmed prior to the treatment taking place

Breast Surgery

Breast – Prosthesis Removal	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Breast prosthesis may have to be removed after some complications such as leakage of silicone gel or physical intolerance.

Policy:

The removal of breast implants for any of the following in patients who have undergone cosmetic augmentation mammoplasty that was performed either in the NHS or privately will be funded for the following indications:

- Breast disease

OR

- Implants complicated by recurrent infections

OR

- Implants with capsule formation that is associated with severe pain

OR

- Implants with capsule formation that interferes with mammography

OR

- Intra or extra capsular rupture of silicone gel filled implants

OR

- Implants manufactured by Poly Implant Prostheses (PIP implants), where they were originally fitted by the NHS

This policy does not apply to breast reconstruction as part of the treatment for breast cancer; or following risk-reducing mastectomy for women with no personal history of breast cancer who meet the criteria detailed in NICE Clinical Guideline CG 164 (2017).

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Cardiology

Diagnostic Coronary Angiography for low risk, stable chest pain	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

NICE guidelines recommend that where a diagnosis of chest pain cannot, by clinical assessment alone, exclude stable angina, 64-slice (or above) CT coronary angiography should be offered as first-line. Invasive coronary angiography should only be offered to patients with significant findings on CT coronary angiogram or with inconclusive further imaging.

This guidance applies to adults aged 19 years and over.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy:

Invasive coronary angiography should only be offered for low risk, stable chest pain as third-line investigation when the results of non-invasive functional imaging are inconclusive:

- Patient has significant findings on CT coronary angiogram (Significant coronary artery disease (CAD) found during CT coronary angiography is ≥ 70% diameter stenosis of at least one major epicardial artery segment or ≥ 50% diameter stenosis in the left main coronary artery)

OR

- CT coronary angiography is inconclusive and further non-invasive functional imaging (either Stress echocardiography, OR first-pass contrast-enhanced magnetic resonance (MR) stress perfusion, OR MR imaging for stress-induced wall motion abnormalities, OR Fractional flow reserve CT (FFR-CT), OR Myocardial perfusion scintigraphy with single photon emission computed tomography (MPS with SPECT) is inconclusive

Troponin Test	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Troponin blood testing should be used to diagnose acute myocardial infarction. It should only be used in cases where a clinical diagnosis of acute coronary syndrome or myocarditis is suspected or for prognostic purposes when pulmonary embolism is confirmed.

This guidance applies to Adults and Children

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy:

- A clinical diagnosis of acute coronary syndrome is suspected

OR

- A clinical diagnosis of myocarditis is suspected or myocardial damage following chemotherapy

OR

- Test is for prognostic purposes when pulmonary embolism is confirmed

Gastroenterology

Appropriate Colonoscopy in the Management of Hereditary Colorectal Cancer	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Colorectal carcinoma (CRC) is one of the most common cancers in the UK with more than 40,000 new cases diagnosed each year. An estimated 35% of CRC is due to heritable factors.

While colonoscopy is a safe procedure, there is a small risk of complications – including pain, intestinal perforation or major haemorrhage as well as issues related to any sedative used. Colonoscopy should therefore be used appropriately in the management of CRC in people who have been identified with an increased lifetime risk of CRC due to hereditary factors.

This guidance applies to adults aged 19 years and over.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy: Colonoscopy in relation to the conditions / interventions listed, should only be carried out where the specified criteria are met.

Appropriate colonoscopy in the management of hereditary colorectal cancer - family history

- For individuals with moderate familial CRC risk a one-off colonoscopy at age 55 years

OR

- Subsequent colonoscopic surveillance should be performed as determined by post-polypectomy surveillance guidelines

OR

- One colonoscopy every 5 years from age 40 years to age 75 years for individuals that have high familial CRC risk (a cluster of 3x FDRs with CRC across >1 generation)

Appropriate colonoscopy in the management of hereditary colorectal cancer - for Lynch Syndrome (LS) and Lynch-like Syndrome

- The patient has Lynch Syndrome and is a MLH1 and MSH2 mutation carrier and therefore colonoscopic surveillance is in line with every 2 years from age 25 years to age 75 years

OR

- Patient has Lynch Syndrome and is a MSH6 and PMS2 mutation carrier and therefore colonoscopic surveillance is in line with every two years from age 35 years to age 75 years

OR

- Patient has Lynch-like Syndrome with deficient MMR tumours without hypermethylation/BRAF pathogenic variant and no pathogenic constitutional pathogenic variant in MMR genes (and their unaffected FDRs), and no evidence of biallelic somatic MMR gene inactivation, and therefore has colonoscopic surveillance every 2 years from age 25 years to age 75 years

Appropriate colonoscopy in the management of hereditary colorectal cancer for Early Onset CRC (EOCRC)

- Patient is diagnosed with CRC, under the age of 50 years and hereditary CRC symptoms have been excluded, colonoscopy surveillance to be carried out as standard post-CRC after 3 years

OR

- Patient is diagnosed with CRC, under the age of 50 years and hereditary CRC symptoms have been excluded and they have had their previous 3-year interval colonoscopy and is now having colonoscopic surveillance every 5 years until eligible for national screening

Appropriate colonoscopy in the management of hereditary colorectal cancer for Serrated Polyposis Syndrome (SPS)

- Patient has Serrated Polyposis Syndrome (SPS) and colonoscopic surveillance is every year from diagnosis once the colon has been cleared of all lesions >5mm in size

OR

- Patient has Serrated Polyposis Syndrome (SPS) and no polyps ≥ 10mm in size are identified at subsequent surveillance examinations, so colonoscopic surveillance interval is every 2 years

OR

- First degree relatives of patients with SPS undergoing an index colonoscopic screening examination at age 40 or ten years prior to the diagnosis of the index case will be carried out

OR

- Patient is a first degree relative of a patient with SPS who is undergoing surveillance colonoscopy every 5 years until age 75 years, unless polyp burden indicates an examination is required earlier according to post-polypectomy surveillance guidelines

Appropriate colonoscopy in the management of hereditary colorectal cancer for Multiple Colorectal Adenoma (MCRA)

- Patient has MCRA (defined as having 10 or more metachronous adenomas) and so is having annual colonoscopic surveillance from diagnosis to age 75 years after the colon has been cleared of all lesions >5mm in size

OR

- Patient has MCRA (defined as having 10 or more metachronous adenomas) and no polyps 10mm or greater in size are identified at subsequent surveillance examinations, colonoscopic surveillance will be carried out every two years

Appropriate colonoscopy in the management of hereditary colorectal cancer for Familial Adenomatous Polyposis (FAP)

- Patients are confirmed to have FAP on predictive genetic testing and so colonoscopic surveillance is to be carried out from 12-14 years (or every 1-3 years, personalised according to colonic phenotype)

OR

- Patient has a first degree relative with a clinical diagnosis of FAP (i.e., “at risk”) and in whom an APC mutation has not been identified (so colorectal surveillance is to be carried out from 12-14 years or every 5 years until either a clinical diagnosis is made, and they are managed as FAP, or the national screening age is reached)

Appropriate colonoscopy in the management of hereditary colorectal cancer for MUTYH-associated Polyposis (MAP)

- Patient has MUTYH-associated Polyposis (MAP) and so colorectal surveillance to be carried out from 18-20 years, and, if surgery has not been undertaken, is to be repeated annually

Appropriate colonoscopy in the management of hereditary colorectal cancer for Peutz-Jeghers Syndrome (PJS)

For symptomatic patients, investigate earlier.

- Patient is asymptomatic with PSJ then colorectal surveillance is to be carried out from 8 years

OR

- Patient is asymptomatic with PSJ if baseline colonoscopy is normal, repeat colonoscopy deferred until 18 years, however if polyps are found at baseline examination, repeat every 3 years

Colonoscopy in the management of hereditary colorectal cancer for Juvenile Polyposis Syndrome (JPS)

- Patient is asymptomatic with JPS offer colorectal surveillance from 15 years

OR

- Patient is asymptomatic with JPS then offer a surveillance colonoscopy every 1-3 years, personalised according to colorectal phenotype

ERCP in Acute Gallstone Pancreatitis without Cholangitis	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Early endoscopic retrograde cholangiopancreatography (ERCP) for acute gallstone pancreatitis without cholangitis is not recommended.

This guidance applies to adults aged 19 years and over.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy: Early ERCP in the treatment of acute gallstone pancreatitis, should only be performed if there is evidence of cholangitis or obstructive jaundice with imaging evidence of a stone in the common bile duct. Early ERCP refers to ERCP being performed on the same admission, ideally within 24 hours.

Not included in EBIcheck+ due to this intervention most often taking place as part of an Inpatient admission

Repeat Colonoscopy	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Colonoscopy can assist in the diagnosis of CRC and several other pathologies, including colonic polyps. Polyp removal (or polypectomy) can be performed endoscopically and is an effective way to treat pre-malignancy polyps (which includes both serrated polyps (excluding diminutive [1-5mm] rectal hyperplastic polyps) and adenomatous polyps.

Colonoscopy with or without polypectomy is a safe procedure however there is a small risk of complications - including pain, intestinal perforation or major haemorrhage as well as issues related to any sedative used. Colorectal carcinoma is often treated by surgical resection, especially for people with potentially curative disease. Individuals who have had treatment for colorectal carcinoma and adenomas are known to be at high-risk of recurrence.

While reducing colorectal mortality is an important aim of colonoscopic surveillance, the main aim is to prevent colorectal cancer by resecting premalignant polyps. Many patients benefit from this alone and do not require subsequent surveillance.

This guidance applies to adults aged 19 years and over.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy: Surveillance Colonoscopy in relation to the conditions / interventions listed should only be carried out where the specified criteria are met.

High Risk Classification:

Either of the following put individuals at high-risk for future colorectal cancer following polypectomy:

- 2 or more premalignant polyps including at least one advanced colorectal polyp (defined as a serrated polyp of at least 10mm in size or containing any grade of dysplasia, or an adenoma of at least 10mm in size or containing high-grade dysplasia);

OR

- 5 or more premalignant polyps

NOTE: Where there are no high-risk findings, colonoscopic surveillance should cease but individuals should be encouraged to participate in the national bowel screening programme when invited

Surveillance colonoscopy after polypectomy

- The patient is considered high risk, in line with the specified criteria

AND

- The patient is under the age of 75with a life-expectancy greater than 10 years

AND

- Has not had surveillance within the past 3 years.

Surveillance colonoscopy after potentially curative CRC resection

- The patient is considered high risk, in line with the specified criteria

AND

- The patient has not had a clearance colonoscopy within a year since initial resection or surveillance within 3 years of clearance colonoscopy

Surveillance after pathologically *en bloc* R0 EMR or ESD of LNPCPs or early polyp cancers:

- The patient is considered high risk, in line with the specified criteria

AND

- The patient has not had a surveillance colonoscopy within the last 3 years

Surveillance after piecemeal EMR or ESD of LNPCPs (large non-pedunculated colorectal polyps of at least 20mm in size)

- The patient is considered high risk, in line with the specified criteria

AND

- There has been confirmation of no reoccurrence following the original resection

AND

- The patient is undergoing a site check at either 2-6 months, or 18 months on from original resection, OR a surveillance colonoscopy at 3 years.

Surveillance where histological completeness of excision cannot be determined in patients

- The patient is considered high risk, in line with the specified criteria

AND

- The patient has non-pedunculated polyps of 10-19mm in size, OR an adenoma containing high-grade dysplasia, OR a serrated polyp containing any dysplasia

AND

- Site checks are being carried out between 2-6 months of surgery

Upper GI Endoscopy	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Endoscopy is an invasive procedure and is not always well tolerated. It carries significant risks and should not be used as a first-line indication in all patients.

This guidance applies to adults aged 19 years and over.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy: Upper GI Endoscopy in relation to the conditions / interventions listed, should only be carried out where the specified criteria are met.

NOTE: There should be separate consideration for those with symptoms that qualify for a 2WW, for which EBIcheck+ is not relevant and 2WW pathways should be followed.

Upper GI Endoscopy (for the investigations of symptoms)

- Gastro-oesophageal symptoms are non- responsive to treatment or unexplained

OR

- Suspected GORD who are thinking about surgery

OR

- H pylori that has not responded to second- line eradication (which can be confirmed with a urea breath test)

Upper GI endoscopy (H pylori and associated peptic ulcer)

- If there is a coexisting peptic ulcer, then repeat endoscopy should be considered 6-8 weeks after beginning treatment for H pylori and the associated peptic ulcer

Upper GI endoscopy (Barrett's oesophagus)

- The patient has GORD (endoscopically determined oesophagitis or endoscopy - negative reflux disease) so endoscopy is to be carried out to diagnose Barrett's oesophagus

OR

- Endoscopy surveillance for patient's diagnosed with Barrett's Oesophagus

Upper GI endoscopy (Coeliac Disease)

- Patient is aged 55 and under with suspected coeliac disease and anti-TTG >10x reference range should be treated for coeliac disease on the basis of positive serology and without endoscopy or biopsy

Upper GI endoscopy (Surveillance Endoscopy)

- Patient is fit enough for subsequent endoscopic or surgical intervention, should neoplasia be found. Senior clinician input has been provided before embarking on long term endoscopic surveillance

OR

- Patients diagnosed with extensive gastric atrophy (GA) or gastric intestinal metaplasia, (GIM) (defined as affecting the antrum and the body) should have endoscopy surveillance every three years

OR

- Patients diagnosed with GA or GIM just in the antrum with additional risk factors- such as strong family history of gastric cancer of persistent H pylori infection, should undergo endoscopy every three years

Upper GI endoscopy (Screening Endoscopy)

- Screening is to be performed in keeping with European expert guidelines (2015)

AND

- Individual is aged 50 and over, with multiple risk factors for gastric cancer (e.g., H. Pylori infection, family history of gastric cancer - particularly in first degree relative, pernicious anaemia, male, smokers)

Upper GI endoscopy (Post excision of adenoma)

- Following complete endoscopic excision of adenomas, gastroscopy is to be performed at 12 months or annually thereafter (when appropriate)

General Surgery

Appendicectomy without confirmation of Appendicitis	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Appendicitis is the most common cause of abdominal pain requiring surgical intervention.

In children appendicitis can often be diagnosed clinically, if there is diagnostic uncertainty, an ultrasound can confirm appendicitis. CT is not recommended in children given the risks of ionising radiation; MRI can be used in centres with appropriate expertise.

In adults negative appendicectomy can occur in up to 30% of cases where appendicitis is suspected on clinical grounds, but imaging is not performed. In patients with typical symptoms, diagnosis can generally be made based on history, physical examination and blood analysis. The 'triple-screen' (CRP <10, WCC <10.5 and a neutrophil percentage <75%) has a negative predictive value >99% in excluding appendicitis, and imaging for appendicitis is not recommended in this setting. Recent studies have shown there is a potential role for non-operative management of acute appendicitis, imaging can help identify which patients could be managed conservatively.

Where patients present with atypical or equivocal symptoms, imaging should be sought to reduce the negative appendicectomy rate. While both ultrasound and computed tomography (CT) are effective, ultrasound is preferred as a first-line investigation. This is particularly important in young patients or in female patients when there is a significant incidence of a gynaecological differential diagnosis (where US is superior to CT). CT may be more appropriate in obese patients where ultrasound is more challenging, or for older patients in whom the differential diagnosis may be broad and where CT is usually of more value.

The diagnostic accuracy of MRI to diagnose appendicitis is similar to CT. Where specialist MRI is available it can be considered if CT is contraindicated, it is particularly useful for pregnant patients.

This guidance applies to adults and children.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy: Imaging of patients should only take place where there is suspicion of acute appendicitis in a defined clinical pathway.

Where patients present with a high clinical suspicion of appendicitis, then imaging may not be necessary, but imaging can help identify which patients can be managed conservatively. If there is clinical doubt then imaging can reduce the negative appendicectomy rate. Most patients should have an ultrasound as the first-line investigation. If the diagnosis remains equivocal, a contrast-enhanced CT (CECT, preferably low dose) can be performed to give a definitive diagnosis prior to the patient returning to the surgical unit for a decision on management.

A pathway like this is dependent on the availability of an adequately skilled Radiologist (Consultant or Registrar) or Sonographer to perform the ultrasound assessment in a timely fashion. If this is not possible discretion should be used to proceed directly to limited dose CECT of the abdomen and pelvis.

Not included in the EBIcheck+ as the intervention is part of a clinically defined pathway

Neurology

Functional Electrical Stimulation for Drop Foot	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Functional electrical stimulation (FES) is a treatment that uses the application of small electrical charges to improve mobility. It is particularly used as a treatment for drop foot. Drop foot is caused by disruption in the nerve pathway to and from the brain, rather than in nerves within the leg muscles.

Policy:

Non-Implantable Devices:

Functional Electrical Stimulation for drop foot is routinely commissioned with the non-implantable device, in line with NICE IPG278, providing normal arrangements are in place for clinical governance, consent and audit, and provided ALL of the following criteria are met:

- Drop foot is impeding gait and in whom the use of all orthotics (AFO) has proven to be unsuccessful following specialist assessment;

AND

- The patient has demonstrable functional improvement from an individual trial of FES;

AND

- The intervention is recommended by a multidisciplinary team specialised in rehabilitation.

Implantable Devices:

The wireless or implantable device is NOT routinely commissioned. Funding will only be considered where there are exceptional clinical circumstances. The clinician needs to submit an application to the Individual Funding Request Panel.

Functional Electrical Stimulation for issues other than Drop Foot	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Functional electrical stimulation (FES) is a treatment that uses the application of small electrical charges to improve motor function in weak or flaccid muscles. It can be used in rehabilitation of the upper limb as part of a motor training programme.

Policy:

Functional Electrical Stimulation may be offered for issues other than drop foot to patients only where the following criteria are met:

- The request is being made for a patient following an upper limb, upper motor neurone impairment

AND

- The patient has demonstrable functional improvement from a trial of FES (within a 4 week period)

AND

- Where the recommendation for FES is made by a specialist rehabilitation team for the upper limb as part of a motor training programme

Spinal Cord Stimulation (Adults only)	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Spinal cord stimulation (or neuromodulation) involves implanting electrodes next to the spinal cord and modifies the perception of neuropathic pain by stimulating the dorsal column of the spinal cord. These treatments are well established for certain types of severe chronic neuropathic pain, with approval as outlined in the NICE guidelines (TA159) with a role in failed back surgery syndrome (FBSS) and chronic regional pain syndrome (CRPS) as an alternative to further surgery or increasing dose of opioids in FBSS or as an approach in CRPS after pharmacotherapy and nerve blocks have not provided adequate pain relief, in line with the British Pain Society (BPS). Spinal cord stimulation is not suitable for everyone with chronic pain, and that it should be used only as part of a multidisciplinary team approach alongside other therapies and a strategy for rehabilitation and only after a successful trial with a temporary external device.

Policy:

Spinal Cord Stimulation is only offered as a treatment option for adults where the following criteria are met:

- The patient continues to experience chronic pain of neuoropathic origin, (measuring at least 50 mm on a 0–100 mm visual analogue scale or alternative as appropriate) for at least 6 months despite appropriate conventional medical management

AND

- The patient has had a successful trial of spinal cord stimulation

AND

- Assessment has been made by a multidisciplinary team experienced in chronic pain and management of people with spinal cord stimulation devices, including experience in the provision of ongoing monitoring and support of the person assessed

Oculoplastics

Referral for Dry Eye Syndrome	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Dry eye syndrome, or dry eye disease, is a common condition that occurs when the eyes don't make enough tears, or the tears evaporate too quickly. The tear film covers the cornea and exposed conjunctiva. It contributes to the health of the cornea and conjunctiva by supplying nutrients, flushing away waste products and acting as a protective barrier.

Most cases of sore tired eyes resolve themselves. Mild to moderate cases of dry eye syndrome or sore tired eyes can usually be treated using lubricant eye treatments that consist of a range of drops, gels and ointments that can easily be purchased over the counter.

Patients should be encouraged to manage both dry eyes and sore eyes by implementing some self-care measures and avoidance of environmental factors alongside treatment.

Policy:

Referral for specialist assessment is only recommended in the following circumstances:

- An underlying systemic condition such as Sjogren's syndrome is suspected

OR

- Symptoms cannot be adequately controlled in primary care after 12 weeks of regular (at least 4 times daily) application of ocular lubricant

OR

- The person has abnormal lid anatomy or function

OR

- There is diagnostic uncertainty

Please note: A prescription for treatment of dry or sore eyes should not routinely be offered in primary care as the condition is appropriate for self-care.

Where a serious eye condition such as acute glaucoma, keratitis, iritis, or cornel ulcer is suspected, referral to a specialist should be made without delay.

Ophthalmology

Surgery for Refractive Error (including Excimer Laser following corneal transplant or cataract surgery)	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Refractive eye surgery is any eye surgery used to improve the refractive state of the eye and decrease or eliminate dependency on glasses or contact lenses. This can include various methods of surgical remodelling of the cornea or cataract surgery. The most common methods today use excimer lasers to reshape the curvature of the cornea. Successful refractive eye surgery can reduce or cure common vision disorders such as myopia, hyperopia and astigmatism, as well as degenerative disorders like keratoconus.

Excimer Laser for poor refraction after corneal transplant or cataract surgery is a last resort measure where all other conservative and surgical interventions have failed.

Policy:

Surgery for refractive error is only commissioned in the following circumstances;

- Where poor refraction after corneal transplant or cataract surgery is demonstrated;

AND

- Where all other conservative and surgical interventions have failed.

Orthopaedics

Arthroscopic Surgery for Meniscal Tears	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Arthroscopy of the knee is a surgical technique where a camera and instruments are inserted into the knee through small incisions, usually under general anaesthesia. Following a detailed systematic assessment of the important structures within the knee joint a surgical procedure is performed which can involve repair or resection of meniscal tissue, with or without other associated procedures such as ligament reconstruction or repair of articular cartilage lesions. The British Association for surgery of the Knee (BASK) recently published guidelines for the use of arthroscopic surgery to treat degenerate meniscal tears.

This guidance applies to Adults and Children

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy: Meniscal tears in the knee are a common finding and in many cases are not related to any significant symptoms, therefore arthroscopic surgery for meniscal tears should only take place when the following criteria are met:

- Non-operative treatments (including paracetamol and topical NSAIDS) have not settled symptoms after 3 months/persistent symptoms ongoing and an MRI has revealed an unstable meniscal tear

OR

- The patient has had an acute injury and an MRI scan reveals a potentially reparable meniscus tear

OR

- Patient has a locked knee and requires an urgent assessment, which showed a bucket handle tear of the meniscus to be present.

AND

- The patient has gone through a shared decision-making process and understands the risks of surgery.

Exogen Ultrasound Bone Healing	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Exogen Ultrasound Bone Healing delivers low-intensity pulsed ultrasound waves for healing non-union fractures and accelerating the healing of fresh fractures.

Policy:

Exogen ultrasound for bone healing only be funded in accordance with the criteria specified below:

- Where there is a long bone fracture with non-union (failure to heal after 9 months)

Ilizarov Technique	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

The Ilizarov apparatus is a type of external fixation used in orthopaedic surgery to lengthen or reshape limb bones; to treat complex and/or open bone fracture; and in cases of infected non-union of bones that are not amenable with other techniques.

Policy:

Ilizarov technique is commissioned for routine elective use in orthopaedics in individual carefully selected cases, where there is agreement by a local orthopaedic MDT that of all available treatments, Ilizarov/TSF is the best clinical option for the patient in terms of a favourable functional limb outcome (bone and functional outcomes are not always the same). Ideally, the MDT should comprise at least two consultant Orthopaedic surgeons, with input from specialist nursing, physiotherapy and musculoskeletal radiology.

Please note; this does not apply to emergency care.

Ring External Fixator / Hexapod External Fixator	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

External fixators used in orthopaedic surgery, such as a Taylor Spatial Frame (TSF), Ilizarov frames or Truelok frames (Orthofix), aid the healing process of complex fractures and bone deformities. These frames can be used in acute trauma settings but also in more "elective" / planned limb reconstruction cases. Both angular and translational deformities can be corrected with an external fixator. The correction of the bone deformity typically takes 3-4 weeks, but the frame will have to remain on the limb until bony union is achieved which can take months / years depending on the clinical situation.

Policy:

An external fixator (Ring or Hexapod) may be offered to patients only where the following criteria are met:

- Appropriate treatment options, including sequelae of non-operative management have been discussed with the patient / carer and documented in notes

AND

- It is considered to be the most clinically appropriate option as determined by a consultant orthopaedic surgeon with rationale for frame use documented and having undergone local MDT / discussion

AND

- The patient and or their carer must have the ability to carry out the daily adjustments to aid the healing process of complex fractures and / or angular and / or translational bone deformities

OR

- If patient or carer are unable to perform corrections then the hospital service should be able to facilitate the process

Vertebral Augmentation (vertebroplasty or kyphoplasty) for Painful Osteoporotic Vertebral Fractures	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Osteoporotic bones are of reduced density and are more susceptible to fractures. Vertebral compression fractures are a break in a bone of the spinal column that results in a reduction in height of that bone. Osteoporotic vertebral fractures can cause pain and potentially an associated reduction in mobility. The pain can often improve as healing occurs. Deformity and respiratory or gastrointestinal disturbance as a result of fractures may be permanent.

Vertebral augmentation, including vertebroplasty (VP) and kyphoplasty (KP), refers to spinal procedures which involve the injection of bone cement (typically polymethylmethacrylate (PMMA)) into the fractured vertebral body via a needle inserted through the skin, using image guidance). These procedures aim to increase stability and strengthen the bone with the intention of reducing pain and further collapse. The procedure can be performed under local anaesthetic with sedation, or general anaesthesia interventional radiologist, spinal surgeon or pain specialist. Decisions regarding the need for vertebral augmentation are made by the operator, in conjunction with metabolic and pain specialists, geriatricians and the patient.

The alternative to vertebral augmentation is conservative management. This consists of pain relief, bracing, and manual therapy. Bone healing can take place over 2-12 weeks. Hospitalisation, immobility and opioid pain medication often have significant side effects, particularly in older patients.

This guidance applies to adults aged 19 years and over.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy:

- Patient has severe (7/10 or greater on VAS scale) ongoing pain after a recent, unhealed vertebral fracture despite optimal pain management

AND

- The acute vertebral fracture has been proven on imaging and correlates with the site of maximal pain on clinical examination

AND

- Multidisciplinary team discussions have taken place

AND

- The procedure will take place at a facility with access to spinal surgery services

AND

- Processes for audit and clinical governance are in place

AND

- Vertebroplasty must be performed in conjunction with additional measures to improve bone health

NOTE: Older patients (>60 years old) with fractures at most 6 weeks old and with severe pain despite optimal pain management benefit most from the procedure.

Other

Blood Transfusion	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

A blood transfusion may be indicated if a patient has a shortage of red blood cells (RBC) causing haemodynamic instability or impeding oxygen delivery to tissues and organs. This can be for a variety of reasons including severe bleeding, cancer or a blood disorder. However, blood transfusion carries risks and only the minimum number of units should be transfused to avoid harm. It is recommended to use restrictive thresholds for transfusion, and to give only a single unit at a time, except where the patient has active bleeding.

This guidance applies to adults (or equivalent based on body weight for children or adults with low body weight) only.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy: Red Blood Cell transfusions for adults (or equivalent based on body weight for children or adults with low body weight) should only be administered where the following criteria is met:

- A single unit of blood is given to a patient with severe acute anemia (Hb <70g/litre) that is symptomatic and prevents rehabilitation or mobilization

NOTE: Blood transfusions should not be given to patients due to B12, folate or iron deficiency anaemia alone. Restrictive red blood cell transfusion should not be used for patients with major haemorrhage, acute active bleeding, acute coronary syndrome or who need regular transfusions for chronic anaemia.

• **Open / Wide-Bore / Upright Magnetic Resonance Imaging (MRI) Scanning**	• **Category:** • *(IFR / Prior Approval / Monitored Approval)*	• **Monitored Approval**
	• **Local or National EBI (Evidence Based Interventions) Policy:**	• **Local**

- **Background:**
-
- As the demand for MRI imaging increases so does the demand for different types of scanner. The main reasons for alternative scanners being requested are claustrophobia and obesity, with a few being requested for clinical reasons (usually upright scans) however, there is a need to manage access to alternative scanners in an equitable way based on need whilst managing a scarce resource. The majority of patients should be referred for a standard MRI scan in the normal way however, if they are unable to undergo scanning in this way due to claustrophobia or obesity, then they should be managed in line with this policy.

- **Policy:**
-
- **Upright MRI Scanning (standing, weight-bearing or positional MRI) are NOT routinely commissioned.**
-
- **Referral for open or wide-bore MRI scanning as an alternative to conventional MRI in secondary care is commissioned only for the specific anatomy requested where:**
-
    - The patient has an underlying condition that prevents them from properly lying in a conventional MRI scanner because of severe pain despite analgesia provision
    - **OR**
    - The patient is unable to tolerate conventional MRI due to claustrophobia, or cannot fit into a standard scanner due to obesity
- **AND**
    - It is considered essential for the clinical management of the patient and no alternative is available
- **AND**
    - All other options to attain a scan have been tried and failed (including standard scanning under oral sedation in the first instance, unless this is clinically contraindicated)
- **AND**
    - The patient is made aware of the limitations (e.g.: resolution of the resulting image impacting on the quality of the scan result) for the relevant type of scanner before being referred
-
- **Note:** Any conditions not described in the policy where the referrer believes there is a requirement for an open or wide-bore MRI scan to be undertaken should be submitted as an Individual Funding Request. Scans undertaken as part of an externally funded trial are excluded from this policy.
-

Pathology

Liver Function, Creatinine Kinase and Lipid Level Tests – (Lipid lowering therapy)	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Lipid modification therapies are a group of medicines which help to lower the level of low-density lipoprotein (LDL) cholesterol in the blood. High levels of LDL cholesterol are linked to the development of cardiovascular disease (CVD) which includes ischaemic heart disease and stroke. There is strong evidence that lipid modification therapy improves the mortality for people at high risk of cardiovascular diseases as well as those with established disease. Clinically significant side effects associated with lipid modification therapy include skeletal muscle and liver and toxicity.

Skeletal muscle toxicity related to lipid modification treatment may result in myopathy, myositis and rhabdomyolysis. Whilst these conditions are potentially serious, they occur rarely. The likelihood of muscle toxicity increases with higher lipid modification therapy doses and in patients with predisposing co-morbidities. Creatine kinase is a blood marker which becomes elevated in various skeletal muscle pathologies and is used, alongside signs and symptoms, to diagnose muscle toxicity related to lipid lowering treatment.

Adverse effects on the liver related to lipid modification treatment are very rare and include transaminitis (raised transaminase liver enzymes in the blood) as well as jaundice and liver failure. Liver function testing is used alongside signs and symptoms to diagnose liver toxicity.

This guidance applies to adults aged 19 years and over.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy: Liver Function Testing in relation to the conditions / interventions listed, should only be carried out where the specified criteria are met.

Liver Functioning Test

- Baseline liver function to be carried out before starting lipid modification therapy

OR

- Liver function is being measured (once) within 3 months of starting treatment

OR

- Liver function is being measured (once) at 12 months following treatment

Creatine Kinase Testing for Lipid Lowering Therapy

- Prior to lipid modification therapy initiation in patients who have experienced generalized, unexplained muscle pains or weakness (whether associated with previous lipid-monitoring therapy)

OR

- If a patient develops muscle pains or weakness whilst on lipid modification therapy.

Lipid Testing

- Measure full lipid profile by taking at least one lipid sample before starting lipid modification therapy. This should include measurement of total cholesterol, HDL cholesterol, non-HDL cholesterol and triglyceride concentrations. A fasting sample is not needed.

OR

- Total cholesterol, HDL cholesterol and non-HDL cholesterol should be measured in all people who have been started on high-intensity statin treatment (both primary and secondary prevention, including atorvastatin 20 mg for primary prevention) at 3 months of treatment and aim for a greater than 40% reduction in non-HDL cholesterol.

OR

- Consider an annual non-fasting blood test for non-HDL cholesterol to inform discussion at annual medication reviews.

NOTE: Further details are outlined in NICE guidance (CG181) and ESC guidance for the management of dyslipidaemias: lipid modification to reduce cardiovascular risk. Creatine kinase should not be routinely monitored in asymptomatic people who are taking lipid modification therapy.

Prostate-Specific Antigen (PSA) Test	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Prostate-specific antigen (PSA) is a protein produced by the prostate gland. Blood PSA levels can be elevated in prostate cancer as well as a number of other conditions including benign prostatic hypertrophy, prostatitis and urinary tract infection. The PSA test is the most commonly used test that can lead to the diagnosis of localised prostate cancer for which potentially curative treatment can be offered. Increased PSA levels may be associated with a raised probability of prostate cancer. However, many men have raised PSA levels without having prostate cancer and many men with prostate cancer don't have raised PSA levels.

Typically, men with persistently raised PSA levels are referred on for further evaluation and may be offered histological assessment by trans-rectal or trans-perineal biopsy. MRI is less likely than biopsy to detect clinically insignificant cancers and therefore reduces over-diagnosis. MRI also enables a more accurate diagnosis of clinically significant cancers because the MRI image can be used to target the biopsy.

Biopsies help to confirm the presence of cancer and allows an assessment of the cancer grade and stage. It is possible that biopsies not guided by MRI imaging can miss smaller areas of cancer or detect indolent disease of unclear clinical significance (which may subsequently require further investigation or treatment). There are a number of potential adverse effects of biopsies including pain, bleeding, urinary retention, infection (which may become serious sepsis) and sexual problems. It is also recognised this process has a significant psychological burden.

This guidance applies to male adults aged 19 years and over.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy: Prostate-Specific Antigen (PSA) Test should only be performed where the following criteria are met:

- The man is asymptomatic and over age 40 and at higher risk of prostate cancer (e.g., they are Black and/or have a family history of prostate cancer)

OR

- Symptomatic men with lower urinary tract symptoms (LUTS), such as nocturia, urinary frequency, hesitancy, urgency or retention, visible hematuria

OR

- erectile dysfunction

OR

- Symptoms that could be due to advanced prostate cancer (for example lower back pain, bone pain, weight loss).

AND

- A careful discussion about the potential risks and benefits of PSA testing has been held, allowing for shared decision

NOTE: PSA testing for prostate cancer should be avoided if the man has:

- An active or recent urinary infection (PSA may remain raised for many months).
- Had a prostate biopsy in the previous 6 weeks.

Both of the above are likely to raise PSA and give a false positive result.

Plastics

Hirsutism	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Laser treatment is increasingly being used as a cosmetic intervention to remove body hair. Patients with excessive body hair are described as having hirsutism. Hair depilation (for the management of hypertrichosis) involves permanent removal/reduction of hair from face, neck, legs, armpits and other areas of body usually for cosmetic reasons. Hair depilation is most effectively achieved by laser treatment.

Policy:

Hair depilation will only be funded in accordance with the criteria specified below.

One course of treatment will be funded for those patients:

- Who are undergoing treatment for pilonidal sinuses to reduce recurrence

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Repair of Lobe of External Ear	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

The external ear lobe can split partially or completely as result of trauma or wearing ear rings. Correction of split earlobes is not always successful, and the earlobe is a site where poor scar formation is a recognised risk.

Policy:

Repair of lobe of external ear will only be funded in accordance with the criteria specified below.

- If the totally split ear lobe is a result of direct trauma and the treatment is required at the time of, or soon after the acute episode and before permanent healing has occurred.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Radiology

Knee MRI for suspected Meniscal Tears	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Patients who have knee pain with persistent mechanical symptoms (locking, catching and intermittent sudden pain on movement) that has not responded to three months of initial non-operative care may have a symptomatic meniscal tear. These patients are referred to intermediate or secondary care and in these circumstances an MRI scan is the best investigation to determine the cause of symptoms.

Patients who have a clear history of a significant acute knee injury and mechanical symptoms or who have a locked knee require referral to intermediate or secondary care and should undergo MRI investigation.

The majority of patients who present to primary care with knee pain do not require initial investigation with an MRI scan once red flag symptoms and signs have been excluded.

This guidance applies to adults aged 19 years and over.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy:

Degenerate meniscal tears and OA are extremely common in the general population. MRI is not usually recommended for a suspected degenerative meniscal tear

- Clear history of a significant acute knee injury

AND

- Mechanical symptoms

OR

- Have a locked knee

Knee MRI when symptoms are suggestive of Osteoarthritis	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Osteoarthritis (OA), the most common form of arthritis, is characterised by joint pain accompanied by a varying degree of functional limitation and reduced quality of life. The most affected joints are the knees, hips and small hand joints with a poor link between changes visible on a radiograph and symptoms of osteoarthritis.

An initial diagnosis of OA can be made when clinical assessment is suggestive of this pathology. If imaging is required to confirm the diagnosis, then weight bearing radiographs are the first-line of investigation. Magnetic resonance imaging (MRI) for knees is not usually needed.

This guidance applies to adults aged 19 years and over.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy: An MRI of the knee is not usually needed for the diagnosis of Osteoarthritis. An MRI should only be offered where the following criteria are met:

- Patient has severe symptoms but relatively mild osteoarthritis on standard X-rays

OR

- Patient is working up for possible HTO (High Tibial Osteotomy) or partial knee replacement (to focus on the state of the anterior cruciate ligament and retained compartments)

Low Back Pain Imaging	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

The evaluation of low back pain by a medical provider should include a complete medical history and examination. It should be established if any "red flag" signs or symptoms are present that could indicate serious underlying pathology.

Serious underlying pathology includes but is not limited to:

- Infection
- Suspected cancer
- Spinal injury
- Spinal cord compression
- Inflammatory conditions
- Patients with cancer and symptoms suggestive of spinal metastases
- Spondyloarthritis in over 16s
- Cauda equina syndrome

This guidance applies to adults aged 19 years and over.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy: Imaging for Low Back Pain should only be offered if serious underlying pathology is suspected.

- Serious underlying pathology is suspected - this may include, but is not limited to, cancer, infection, trauma, spinal cord injury (full or partial loss of sensation and/or movement of part(s) of the body) or inflammatory disease. Please see the relevant NICE guideline for further information around these conditions.

AND

- A full history and medical examination of the patient has been carried out

NOTE: Do not routinely offer imaging in a non-specialist setting for people with low back pain with or without sciatica in the absence of red flags, or suspected serious underlying pathology following medical history and examination.

MRI scan of the hip for arthritis	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

When clinical assessment is suggestive of osteoarthritis (OA) and plain radiographs demonstrate typical OA features, the use of MRI for the investigation of hip pain is not usually needed.

Do not request a hip MRI when the clinical presentation (history and examination) and X-rays demonstrate typical features of OA. MRI scans rarely add useful information to guide diagnosis or treatment.

Requesting MRI scans further prolongs waiting times for patients. Importantly it can cause unnecessary anxiety while waiting for specialist consultation and can delay MRI scans for patients with diagnoses other than OA of the hip.

This guidance applies to adults aged 19 years and over.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy: Do not request a hip MRI when the clinical presentation (history and examination) and X-rays demonstrate typical features of OA. MRI of the hip for arthritis should only be requested where the following criteria are met:

- The patient is under 45
  AND
- The patient does not have activity-related joint pain
  AND
- The patient has morning stiffness lasting more than 30 minutes

OR

- Suggestions of infection, e.g., pyrexia, swollen and red joint, significant irritability, other risk factors of septic arthritis

OR

- Patient has suffered trauma

OR

- Patient has history or family history of an inflammatory arthropathy

OR

- Mechanical, impingement type symptoms

OR

- Prolonged and morning stiffness

OR

- History of cancer or corresponding risk factors

OR

- Suspected Osteonecrosis / Avascular necrosis of the hip

OR

- Suspected transient osteoporosis

OR

- Suspected periarticular soft tissue pathology e.g., abductor tendinopathy"

NOTE: It is important to exclude other diagnoses, especially when red flags are present. If imaging is necessary, the first-line investigation should be plain x-ray.

Pre-operative chest x-ray	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Chest radiographs in the pre-operative assessment of adult, elective surgical patients prior to routine surgery is not recommended.

This guidance applies to adults aged 19 years and over.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy: Pre-operative chest x-ray should only take place where the following criteria have been met:

- Patients undergoing cardiac or thoracic surgery

OR

- Patients undergoing organ transplantation or live organ donation

OR

- At the request of the anesthetist in those with suspected or established cardio-respiratory disease, who have not had a chest radiograph in the previous 12 months, and who are likely to go to critical care after surgery

OR

- At the request of the anesthetist in those with a recent history of chest trauma

OR

- At the request of the anesthetist in patients with a significant smoking history who have not had a chest radiograph in the previous 12 months, or those with malignancy and possible lung metastases

OR

- At the request of the anesthetist in those undergoing a major abdominal operation, who are at high risk of respiratory complications

NOTE: N**ICE recommend that chest radiographs should not be routinely offered before elective surgery.**

Pre-operative ECG	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Performance of a resting electrocardiogram (ECG) in asymptomatic adult patients undergoing low-risk, non-cardiac elective surgery during the pre-operative assessment is not necessary.

This guidance applies to adults aged 19 years and over.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy: Pre-operative ECG should only take place where the following criteria have been met:

- Patients with an American Society of Anesthesiologists (ASA) physical classification status of 3 or greater and no ECG results available for review in the last 12 months

OR

- Patients with a history of cardiovascular or renal disease, or diabetes

OR

- Patients with any history of potential cardiac symptoms (e.g., cardiac chest pain, palpitations, unexplained syncope or breathlessness) or a new murmur, that has not previously been investigated

OR

- Patients are over the age of 65 and attending for major surgery

NOTE: Pre-operative electrocardiograms should not be routinely performed in low risk, non-cardiac, adult elective surgical patients

Shoulder Radiology: Scans for Shoulder Pain	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

W1 Scans for Shoulder Pain

X-rays should be used routinely as the first line of radiological investigation for the diagnosis of most routine shoulder pathology. This practice should be followed in primary, intermediate and secondary care.

The use of Ultrasound, MRI and CT scanning should be restricted to those secondary care services that are responsible for the definitive treatment of such patients. The use of these investigations outside secondary care should only be allowed if referral pathways have been developed with the local secondary care specialist shoulder service.

Primary care patients that are deemed urgent or have red flags should be referred urgently to the appropriate secondary care team.

W2 Image Guided Injections for Shoulder Pain

Image guided subacromial injections are not recommended in primary, intermediate or secondary care.

Evidence does not support the use of guided subacromial injections over unguided subacromial injections in the treatment of subacromial shoulder pain. Other image guided shoulder injections should only be offered under the guidance of a secondary care shoulder service.

For patients who initially present with shoulder pain in primary or intermediate care, the first line of radiological investigation should be a plain x-ray. X-rays diagnose most routine shoulder problems such as osteoarthritis, calcium deposits, rotator cuff arthropathy, impingement, fractures and primary and secondary tumours.

This guidance applies to adults aged 19 years and over.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy: X-rays should be used routinely as the first line of radiological investigation for the diagnosis of most routine shoulder pathology. This practice should be followed in primary, intermediate and secondary care. Scans for Shoulder pain should only be carried out where the specified criteria are met.

Scans

- Ultrasound, MRI or CT scan has been requested by secondary care services that are responsible for the definitive treatment of the patient

OR

- Investigations are outside secondary care, and a referral pathway has been developed with the local secondary care specialist shoulder service

NOTE: If shoulder RED FLAGS are present, an urgent referral to secondary care should be arranged for further investigation and management

Urology

Cystoscopy for Men with uncomplicated Lower Urinary Tract Symptoms	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Cystoscopy is a diagnostic procedure used to examine the lining of the bladder and urethra. Either a rigid or flexible endoscope may be used, under general or local anaesthesia, respectively. Rigid cystoscopy is undertaken when flexible cystoscopy offers insufficiently clear views, or when biopsy is indicated.

Cystoscopy can cause temporary discomfort, occasionally pain and haematuria and is associated with a small risk of infection. In the context of male lower urinary tract symptoms (LUTS), cystoscopy may offer indirect evidence regarding an underlying cause (commonly prostatic enlargement, for example).

This guidance applies to male adults aged 19 years and over.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy: Cystoscopy should only be offered when clinically indicated and the patient has LUTS symptoms

- The patient has lower urinary tract symptoms (LUTS) and suffers recurrent urinary tract infections

OR

- The patient has lower urinary tract symptoms (LUTS) and has sterile pyuria (urine dip positive for leukocytes without bacterial growth)

OR

- The patient has lower urinary tract symptoms (LUTS) and haematuria

OR

- The patient has very significant/profound lower urinary tract symptoms (LUTS)

OR

- The patient has lower urinary tract symptoms (LUTS) with pain around urinary tract

OR

- The patient has lower urinary tract symptoms (LUTS) and risk factors such as long smoking history, travel or occupational history suggesting a high risk of malignancy, or previous urogenital surgery

Surgical Removal of Kidney Stones	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Urinary tract stones are amongst the most common condition dealt with by urologists with an estimated 6,000 patients admitted to hospital per year with the condition. Shockwave lithotripsy (SWL) is a non-surgical technique for treating these stones in the kidney or ureter. The technique uses high energy shockwaves to break the stones into smaller fragments which can then pass spontaneously.

Stones can be observed to see if they pass spontaneously, or treated with shockwave lithotripsy, or surgical techniques such as ureteroscopy (URS) and percutaneous stone surgery (PCNL), both of which may involve placing a stent.

The optimal management depends on the type, size and location of the stone as well as patient factors such as co-morbidity and pregnancy. For appropriate stones SWL is advantageous as it is non-invasive and so has fewer major adverse events than surgery.

This guidance applies to Adults aged 19 years and over

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy:

- Renal stones are 5-10mm and not suitable for watchful waiting, shockwave lithotripsy is to be offered as first-line treatment (unless contra-indicated or not targetable)

OR

- Renal Stones are 10-20mm shockwave lithotripsy can be considered as first-line treatment (if treatment can be given in a timely fashion)

OR

- Renal stones are 10-20mm and shockwave lithotripsy is contraindicated or ineffective, then ureteroscopy can be considered.

OR

Renal stones are over 20mm (including staghorn), percutaneous nephrolithotomy (PCNL) can be offered as first-line treatment

Document History

All amendments and updates to the Regional VBCC Policy prior to April 2019 have been archived and can be found in previous versions of the policy document. These can also be obtained upon request.

February 2019 – For Implementation from 1st April 2019		
Policy Area	**Notes**	**Contributors**
Bariatric Surgery – Revisional Procedures	Inclusion of policy relating to Revisional Bariatric Surgery following clarification queries. No change to previous NHSE policy – now ICB'S responsibility.	NE&C Clinical Leads and NHSE Commissioners
Breast – Prosthesis Replacement	Breast – Prosthesis Replacement previously not routinely commissioned will now be recognised as a commissioned procedure where a specific set of criteria are met, as detailed within the policy.	NE&C ICB'S Clinical Leads and Clinical Teams from Newcastle Hospitals FT
Vagal Nerve Stimulation (Non-invasive) for Cluster Headache	Inclusion of Policy following NTAG Guidance published.	NE&C Clinical Leads and NTAG
Adult Snoring Surgery (in the absence of OSA)	National EBI Policy for inclusion in Regional Policy from April 2019. Adopted EBI Policy Title. Not previously included in NE&C Policy.	National EBI Guidance
Dilatation and curettage (D&C) for heavy menstrual bleeding in women	Minor changes to wording based on new NICE Guidelines. No changes to basis of policy. Adopted EBI Policy Title. Previously 'Dilatation and curettage (D&C) for treatment of heavy menstrual bleeding'.	National EBI Guidance

Knee arthroscopy	No changes to policy but reviewed in line with EBI guidance. Maintained current NE&C Policy title.	National EBI Guidance
Low Back Pain - Spinal injections	Minor additions suggested to policy for Non-Specific LBP. Maintained current NE&C policy title.	National EBI Guidance
Breast reduction	Some changes to wording of existing policy criteria. No change to Policy title.	National EBI Guidance
Removal of benign skin lesions	Minor changes to policy criteria in first criteria point. Adopted EBI Policy Title. Previously 'Minor Skin Lesions'.	National EBI Guidance
Grommets (and other ventilation devices) in Children	Some minor additions to policy as suggested by EBI Guidance. Maintain current NE&C policy title.	National EBI Guidance
Tonsillectomy for Recurrent Tonsillitis	Very minor additions to criteria wording included. Adopted EBI Policy title. Previously 'Tonsillectomy'.	National EBI Guidance
Haemorrhoid surgery	Very minor additions to criteria wording included.	National EBI Guidance

	Adopted EBI Policy title. Previously 'Haemorrhoidectomy surgical'.	
Hysterectomy for heavy menstrual bleeding	Very minor additions to criteria wording included. No change to Policy Title.	National EBI Guidance
Chalazia removal	Wider policy of 'Surgery for Minor Eyelid Lesions' which includes Chalazia already exists in NE&C. Chalazia Removal separated out to become standalone policy. Wider NE&C policy for all other minor eyelid lesions remains in place. Adopted EBI policy title.	National EBI Guidance
Arthroscopic shoulder decompression for subacromial shoulder pain	National EBI Policy for inclusion in Regional Policy from April 2019. Adopted EBI Policy Title. Not previously included in NE&C Policy.	National EBI Guidance
Carpal tunnel syndrome release	Inclusion of additional Background: text and minor amends to policy criteria. Adopted EBI Policy Title. Previously 'Carpal Tunnel Surgery'.	National EBI Guidance
Dupuytren's Contracture – Referral for Secondary Care Opinion	Inclusion of additional Background: text and minor amends to policy criteria. No changes proposed to Collagenase or Radiotherapy policies. Maintained current NE&C policy title	National EBI Guidance

Ganglion excision	Very minor additions to criteria wording included. Adopted EBI Policy title. Previously 'Ganglia'.	National EBI Guidance
Trigger finger release in adults	Inclusion of additional Background: text and further amends to policy criteria as suggested by EBI Guidance. Adopted EBI Policy Title. Previously 'Trigger Finger.	National EBI Guidance
Varicose vein interventions	Very minor amendments to policy wording included. Adopted EBI Policy Title. Previously 'Varicose Veins in the Leg'.	National EBI Guidance

January 2020 – For Implementation from 1st April 2020		
Policy Area	**Notes**	**Contributors**
Functional Electrical Stimulation (FES)	The title of this existing policy has been updated to reflect that it is specifically FES for Drop Foot due to the inclusion of a new policy for 'FES for issues other than drop foot'	NE&C ICB'S Clinical Leads and Clinical Teams from Northumbria FT
Invitro Fertilisation (IVF) and Intracytlopasmic Sperm Injection (ICSI)	Rename the title of the policy to the following: 'Assisted Reproduction Treatments' Policy content has been re-drafted to ensure the detail of the policy is clearer to understand as well as addresses position on same sex couples as surrogacy is not funded for male or females and Fertility Preservation	NE&C ICB'S Clinical Leads and Clinical Teams from Newcastle Hospitals FT

Low Back Pain - Epidural and nerve root injections	Removed as a singular policy and replaced with the following two distinct policies, as recommended by local specialists; ○ Low Back Pain – Epidural and Nerve Root Injections for **Acute** Radicular Leg Pain ○ Low Back Pain – Epidural and Nerve Root Injections for **Chronic** Radicular Leg Pain	NE&C ICB'S Clinical Leads and Clinical Teams from Northumbria FT
Low Back Pain - Medial Branch Block (MBB) Low Back Pain - Radiofrequency Denervation (Rhizolysis)	Included a specific policy title for 'Medial Branch Block' and corresponding criteria that mirrors the criteria for Rhizolysis to clarify that a PAT can be obtained for this intervention, where criteria are satisfied. Minor update to Rhizolysis policy to add an additional criteria point to note that a positive response to MBB diagnostic is required and to highlight that the MBB requires a separate PAT.	NE&C ICB'S Clinical Leads and Clinical Teams from Northumbria FT
Breast – Revisions of Breast Reconstruction Surgery and Repeated Courses of Nipple Tattooing	Some minor additional words added to the Background: information with minor formatting change to emphasise the words 'due to cancer treatment or prevention' in the Background: information.	NE&C ICB'S Clinical Leads
Hyperhidrosis – Referral Hyperhidrosis – Treatment with Botulinum Toxin	Hyperhidrosis – Referral; Additional criteria added in line with the criteria required for the treatment of hyperhidrosis, specifically, that any underlying anxiety has been identified and managed, and that 20% aluminium chloride hexahydrate has failed or is contraindicated Hyperhidrosis – Treatment with Botulinum Toxin**;** Additional criteria added in line with the criteria required for the referral of a hyperhidrosis patient, specifically, that there must be evidence of medical complications such as skin macerations or secondary infections.	NE&C ICB'S Clinical Leads and Clinical Teams from Newcastle Hospitals FT
Flash Glucose Monitoring	Policy criteria updated as detailed below to reflect the NHS England policy as already adopted and reflected in VBC Checker (now EBIcheck+).	NE&C ICB'S Clinical Leads

Breast – Breast Prosthesis Replacement	Clarity added to ensure marked asymmetry is included within the policy, provided criteria are met. Additional clarity added to note that this procedure will only be considered when the original procedure was provided by the NHS.	NE&C ICB'S Clinical Leads
Knee Replacement Surgery	Policy title updated to read 'Knee Replacement Surgery (Total)'	NE&C ICB'S Clinical Leads and Orthopaedic Alliance
Wigs & Hair Pieces	Inclusion of new policy	NE&C ICB'S Clinical Leads
Lycra Garments (for Children)	Inclusion of new policy	NE&C ICB'S Clinical Leads
Rhinophyma	Inclusion of new policy	NE&C ICB'S Clinical Leads and Clinical Teams from Newcastle Hospitals FT
Continuous Positive Airway Pressure (CPAP) Device for Adults	Inclusion of new policy	NE&C ICB'S Clinical Leads and Clinical Teams from Newcastle Hospitals FT
Sacral Neuromodulation (SNM) for Faecal Incontinence	Inclusion of new policy	NE&C ICB'S Clinical Leads and Clinical Teams from South Tees FT
Spinal Cord Stimulation (Adults only)	Inclusion of new policy	NE&C ICB'S Clinical Leads and Clinical Teams from South Tees FT
Functional Electrical Stimulation (FES) for issues other than drop foot	Inclusion of new policy	NE&C ICB'S Clinical Leads and Clinical Teams from Northumbria FT
Open / Wide-Bore / Upright Magnetic Resonance Imaging (MRI) Scanning	Inclusion of new policy	NE&C ICB'S Clinical Leads
Ring External Fixator / Hexapod External Fixator	Inclusion of new policy	NE&C ICB'S Clinical Leads and Orthopaedic Alliance
Unicompartmental Knee Replacement (medial, lateral and patello femoral)	Inclusion of new policy	NE&C ICB'S Clinical Leads and Orthopaedic Alliance
Surgery to treat periprosthetic joint infection	Inclusion of new policy	NE&C ICB'S Clinical Leads and Orthopaedic Alliance

Continuous Sub-Cutaneous Insulin Infusion for Adults and Children over 12 years	Inclusion of new policy	NE&C ICB'S Clinical Leads and Gateshead Health FT
Continuous Sub-Cutaneous Insulin Infusion for Children under 12 years	Inclusion of new policy	NE&C ICB'S Clinical Leads and Gateshead Health FT

August 2021 – For Implementation from 1st October 2021		
Policy Area	**Notes**	**Contributors**
Gastric Neuromodulation	Removed from the policy document as confirmed as Specialised Commissioning responsibility.	NE&C ICB'S Clinical Leads
Continuous Sub-Cutaneous Insulin Infusion for Adults and Children over 12 years	Additional clarity to cover device, consumables, and any technical support requirements. Clarity added on the period a Prior Approval would be in place for. Change the word Omnipod to 'patch pumps'.	NE&C ICB'S Clinical Leads and Gateshead Health FT
Continuous Sub-Cutaneous Insulin Infusion in Children under 12	Additional criteria points added to bring in line with policy for Adults and Children > 12 yrs old. Clarity on the period a Prior Approval would be in place for. Clarity that patients should transition off an insulin pump to undergo a trial of MDI Therapy. MDI trial to be extended to age range 12-25 years. Additional clarity to ensure policy covers the device, consumables, and any technical support requirements. Change the word Omnipod to 'patch pumps'.	NE&C ICB'S Clinical Leads and Gateshead Health FT
Breast – Prosthesis Removal	Clarity that patients who have had PIP implants fitted on the NHS can have these removed.	NE&C ICB'S Clinical Leads

Breast – Prosthesis Replacement	Updated to take account of Gender Dysphoria patients and issues of PIP implants.	NE&C ICB'S Clinical Leads
Breast – Asymmetry	Clarification of policy to cover removal of a healthy breast to create symmetry following cancer treatment.	NE&C ICB'S Clinical Leads
Vasectomy under GA	Moved from an IFR based policy, to a criteria-led prior approval policy.	NE&C ICB'S Clinical Leads
Flash Glucose Monitoring	Updated policy criteria based on recent updates to national policy.	NE&C ICB'S Clinical Leads and South Tyneside & Sunderland FT
Assisted Reproduction Treatments	Clarification on policy to note IVF / ICSI carried out as part of pre-implantation genetic testing is commissioned directly by NHS England and therefore not covered by ICB'S commissioned policy.	NE&C ICB'S Clinical Leads
Various Policies as follows: - Groin Hernia - Low Back Pain – Spinal decompression & Discectomy - Low Back Pain - Radiofrequency denervation (rhizolysis) - Low Back Pain – Spinal Fusion - Cholecystectomy (for asymptomatic gallstones)	Policies all now fall under a National Evidence Based Interventions (EBI) Policy statement. Policies reviewed and no changes required to policy detail or criteria.	Updated due to National EBI Guidance
Bobath Therapy	Inclusion of new policy - Local	NE&C ICB'S Clinical Leads
Diabetes i-Ports	Inclusion of new policy - Local	NE&C ICB'S Clinical Leads and Gateshead Health FT
Diagnostic coronary angiography for low risk, stable chest pain	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
Surgery for sinusitis - referral for specialist secondary care assessment	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation

Removal of adenoids for treatment of glue ear	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
Arthroscopic surgery for meniscal tears	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
Troponin test	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
Surgical removal of kidney stones	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
Cystoscopy for men with uncomplicated lower urinary tract symptoms	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
Surgical intervention for benign prostatic hyperplasia	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
Exercise ECG for screening for coronary heart disease	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
Upper GI endoscopy	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
Appropriate colonoscopy in the management of hereditary colorectal cancer	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
Repeat Colonoscopy	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
ERCP in acute gallstone pancreatitis without cholangitis	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation

Appendicectomy without confirmation of appendicitis	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
Low back pain imaging	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
Knee MRI when symptoms are suggestive of osteoarthritis	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
Knee MRI for suspected meniscal tears	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
Vertebral augmentation (vertebroplasty or kyphoplasty) for painful osteoporotic vertebral fractures	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
Shoulder Radiology: Scans for Shoulder Pain and Guided Injections	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
MRI scan of the hip for arthritis	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
Helmet therapy for treatment of positional plagiocephaly/ brachycephaly in children	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
Pre-operative chest x-ray	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
Pre-operative ECG	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
Prostate-specific antigen (PSA) test	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation

Liver function, creatinine kinase and lipid level tests – (Lipid lowering therapy)	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
Blood transfusion	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation

January 2022 – For Implementation from 1st April 2022		
Policy Area	**Notes**	**Contributors**
Oculoplastic Eye Problems – Blepharitis	This policy has been agreed to be fully removed from the regional policy document.	NE&C ICB'S Clinical Leads
Dupuytren's Contracture – Collagenase Clostridium Histolyticum (CCH) Injections	Updated category of policy from Prior Approval to an IFR policy (i.e.: Not Routinely Funded) due to drug now being unlicensed. References to collagenase injections as a treatment option removed from linked policies, specifically: - Dupuytren's Contracture – Radiotherapy - Dupuytren's Contracture – Referral for Secondary Care Opinion	NE&C ICB'S Clinical Leads
Breast – Prosthesis Replacement	Additional criteria added to reflect a discussion has taken place between patient and treating clinician to confirm replacement of prosthesis is best outcome	NE&C ICB'S Clinical Leads
Wigs & Hair Pieces	Updated policy to move from Monitored Approval to Prior Approval to ensure suppliers have relevant documentation to back eligibility Foot note added to policy to clarify value of free wigs (when satisfying criteria) is £465 per annum and not expected to pay NHS prescription charge Allow funding requests for wigs to be eligible for a 3-year period, without needing to be re-referred	NE&C ICB'S Clinical Leads

Continuous Glucose Monitoring	Additional criteria added at request of Diabetes Clinical Network colleagues to take account of impending changes to NICE guidance on CGM.	Gateshead FT (Diabetes Clinical Network colleagues)
Liposuction for Chronic Lymphoedema	New Policy inclusion – In line with NTAG guidance	NE&C ICB'S Clinical Leads & regional NTAG colleagues
Liposuction for the Management of Lipoedema	New Policy inclusion	NE&C ICB'S Clinical Leads & regional NTAG colleagues
Surgery for Divarication of Recti	New Policy inclusion – In line with NTAG guidance	NE&C ICB'S Clinical Leads
Referral for Dry Eye Syndrome	New Policy inclusion - Local	NE&C ICB'S Clinical Leads and CDDFT Consultant colleagues.
General update made to policies which had a link to the NICE evidence search in relation to shared decision making.	Due to the closure of the NICE evidence search function on 31/03/22 NICE advised to utilise a different search function within the NHS Knowledge and Library Hub, as follows: https://library.nhs.uk/knowledgehub/ All previous references to the NICE search function have been updated throughout the VBC document with the above link.	NECS operational leads

NHS
North East &
North Cumbria

Corporate	ICBP013 Incident Response Plan

Version Number	Date Issued	Review Date
1	July 2022	July 2024

Prepared By:	ICS EPRR Operational Delivery Manager
Consultation Process:	EPRR Governance Group
Formally Approved:	July 2022
Approved By:	ICB Board

EQUALITY IMPACT ASSESSMENT

Date	Issues
June 2022	None identified

POLICY VALIDITY STATEMENT

Policy users should ensure that they are consulting the currently valid version of the documentation. The policy will remain valid, including during its period of review. However, the policy must be reviewed at least once in every 3-year period.

ACCESSIBLE INFORMATION STANDARDS

If you require this document in an alternative format, such as easy read, large text, braille or an alternative language please contact NECSU.comms@nhs.net

Version Control

Version	Release Date	Author	Update comments
1	July 2022	ICS EPRR Operational Delivery Manager	Not Applicable. First Issue

Approval

Role	Name	Date
Approver	ICB Board	July 2022

CONTENTS

1. Introduction

The NHS needs to be able to plan for, respond to and recover from a wide range of incidents, emergencies or disruptive challenges that could impact on health or patient care. These could range from extreme weather conditions to an outbreak of an infectious disease, or a major transport incident. An emergency may have an immediate impact on the whole organisation or only parts of the organisation however it is important that all staff are made aware of the plan and its contents.

Each Integrated Care Board (ICB) is a Category Responder 1 under the Civil Contingencies Act 2004 (CCA). Category 1 are organisations at the core of the response to most emergencies (the emergency services, local authorities, NHS bodies). Category 1 responders are subject to the full set of civil protection duties and are required to:

- assess the risk of emergencies occurring and use this to inform contingency planning
- put in place emergency plans
- put in place business continuity management arrangements
- put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- share information with other local responders to enhance co-ordination
- co-operate with other local responders to enhance co-ordination and efficiency

The plan applies to all staff within the North East and North Cumbria Integrated Care Board as well as external stakeholders. In the event of a major incident, it is likely that several organisations will respond therefore the plan includes the specific roles and responsibilities which will be supported by regular training and exercising to ensure all key personnel are competent. This is both a legislative, Civil Contingencies Act (CCA) 2004 and NHS Emergency Preparedness, Resilience and Response (EPRR) framework 2015 requirement.

Purpose

The purpose of this plan is to outline the process and response to be followed for an incident or emergency to ensure that the North East and North Cumbria (NENC) Integrated Care Board (ICB) response to an incident or emergency is patient focused and effectively managed.

The Incident Response Plan outlines the strategic and tactical requirements to ensure compliance with CCA 2004, NHS EPRR framework 2015 and associated guidance and governmental regulations.

NENC ICB will work in partnership with other agencies within North East and North Cumbria Health and Care Partnership and North East and Cumbria Local Resilience Forums: Northumbria, Cleveland, and County Durham and Darlington and Cumbria and the implementation of an on-call system provides a single point of access for these partners.

Objectives

In the event of an incident or emergency, the objectives of the NENC ICB will be to:

- Ensure that the ICB complies with the statutory duties under the Civil Contingencies Act (2004) as a Category 1 responder
- Ensure that ICB managers adopt principles of good practice and include elements of contingency planning and business continuity planning into their everyday processes
- Give clear guidance on the lines of responsibility for emergency preparedness, response and recovery within the ICB
- Provide information to staff to allow them to respond to an incident safely and effectively
- Reduce, control or mitigate as far as is practicably possible the effects of an emergency on the ICB and North East and North Cumbria areas
- Ensure that staff are aware of the command-and-control structure that will be implemented to manage the incident response
- Recognise that staff may require additional welfare provision to be implemented when responding to an emergency and to put in place a mechanism to deal with this
- Provide ICB staff with information to enable them to deal with incidents that have special circumstances
- Prepare emergency plans and participate in appropriate training and exercising

Incident Response Plan Activation

The ICB might be alerted to an incident via a number of sources or routes including:

- NHS Provider organisations (e.g., Trusts, Primary Care)
- North East Ambulance Service (NEAS)
- North West Ambulance Service (NWAS)
- NHS England
- Place / ICB colleagues
- Resilience Direct
- Media
- Multi-agency partners (including police, Local Authority, UK Health Security Agency)

The information received will need to be assessed and a decision made as to whether to activate this plan.

An initial risk assessment should be undertaken as soon as possible (Appendix 1). This will determine the next steps to be taken.

In making this assessment, it is important to distinguish between:

- Events that can be dealt with using normal day to day arrangements
- Events that can be dealt with within the resources and emergency planning arrangements of the ICB and local NHS commissioned services
- Events that require a joint coordinated response from the organisations across the North East and North Cumbria area
- Events that require a strategic level coordinated multi-agency response across the North East and North Cumbria (or wider) health community
- Events that need regional co-ordination

The decision to activate this plan must be made by the relevant personnel within the ICB authorised to do so. It is essential that all decisions and their rationale must be documented in relation to the decision whether to activate the plan and following the activation of this plan.

People authorised to activate the ICB Incident Response Plan are:

- ICB Executives
- ICB Director On Call (2nd On Call)
- Accountable Emergency Officer

If this plan is activated the Strategic Aim and Objectives of the ICB for the response must be agreed.

Definition of a Major Incident

The term 'major incident' is defined as:

"An event or situation with a range of consequences, which requires special arrangements to be implemented by one or more emergency responder agencies".

Incident Notifications

Incident notifications should be prefixed with one of the following however it should be noted that not all organisations receive these alerts and organisations should each make their own determination whether to stand by or stand up a major incident and when to stand down their response and move to recovery activities.

Major Incident Standby	This alerts the NHS that a major incident may need to be declared. It is likely to involve NHS organisations making preparatory arrangements appropriate to the incident
Major Incident Declared	This alerts NHS organisations that they need to activate their plan and mobilise additional resources
Major Incident Cancelled	This message cancels either of the first two messages at any time
Stand Down	All receiving hospitals are alerted as soon as all live casualties have been removed from the site. It is the responsibility of each NHS organisation to assess when it is appropriate for them to stand down their own response

ICB Action on being informed of an incident or standby declaration within the patch

In hours (Monday – Friday, 08:30 – 17:30hrs)
The contact point for NENC ICB will be via NEAS Emergency Operations Centre to the North of England Commissioning Support Unit (who will then contact the designated Tactical Health Commander on call from the ICB. In addition, NECSU will identify subject matter experts within the ICP area to provide support for the management of the incident.

A METHANE will be emailed to ngccg.NENCICBincident@nhs.net

Out of hours (17.30 to 08.30 Monday to Thursday and Friday 17.30 to 08.30 on Monday)
During out of hours period, an alert would be made to the designated Tactical Health Commander on call from the ICB on call rota via NEAS Emergency Operations Centre. This person would manage the incident in conjunction with the Strategic Health Commander (where appropriate) and then hand over to another Tactical Health Commander at 08:30hrs the next working day.

An alert may be raised to the Tactical Health Commander on-call via NHS England, or other organisations such as Local Authority, North East Ambulance Service, North West Ambulance Service or a local foundation trust when an incident has been declared or when such an organisation is on standby and preparing to declare a major incident.

A METHANE will be emailed to ngccg.NENCICBincident@nhs.net

Upon being informed of an incident, the Tactical Health Commander should take details using an Incident Notification Log (Appendix 2). The Tactical Health Commander on-call should consult with the informant any details to ensure the details and expectations of the NENC ICB have been recorded accurately.

Furthermore, in the event of such an incident the communication cascade mechanism should be via Tactical Health Commander who should ensure they also alert their Regional NHS England (NHSE) Team. In some instances, such alerts may also come directly from NHSE National.

The Regional NHSE Team will assist the ICB in implementing command and control mechanisms and the deployment of appropriate NHS resources should the response extend beyond the operational area of a single ICB. They are also available to advise and support the ICB command structure, in recognition that the ICB is a newly formed Category 1 responding organisation.

Incident Classification

Incidents are classified to support the planning, response and recovery from incidents that manifest from a range of hazards and threats.

For the NHS, incidents are classed as:

- Business Continuity Incident
- Critical Incident
- Major Incident

The following incident/emergency terms and definitions are common practice within NHS organisations and the terms are used to provide a sense of impact on healthcare services.

Used by	Term	Description	Example
Healthcare	**Business Continuity incident**	Disrupts, or might disrupt, an organisation's normal service delivery, below acceptable predefined levels, where special arrangements are required to be implemented until services can return to an acceptable level.	Surge in demand requiring resources to be temporarily redeployed
Healthcare	**Critical incident**	Disruption results in the temporary or permanent loss of critical service delivery. Patients may have been harmed or the environment is not safe requiring special measures and support from other agencies.	Loss of power in an acute hospital, community hospital or mental health inpatient unit.
Healthcare	**Major incident**	Any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties, as to require special arrangements to be implemented.	Terrorist incident
Multi-agency	**Major incident**	Event or situation requiring a response under one or more of the emergency services' major incident plans.	Road traffic collision
Multi-agency partners	**Emergency**	"(a) an event or situation which threatens serious damage to human welfare in a place in the United Kingdom; (b) an event or situation which threatens serious damage to the environment of a place in the United Kingdom; (c) war, or terrorism, which threatens serious damage to the security of the United Kingdom".	

Incident Levels

As an event evolves it may be described in terms of its level shown below. For clarity, these levels must be used by all organisations across the NHS when referring to incidents:

Incident Level	Description	Coordinating Organisation
1	An incident or event which impacts on a single organisation, and which can be managed within place or with ICB support	Led by affected organisation with support from their ICB (place)
2	An incident or event which impacts multiple organisations within an ICB footprint or requires mutual aid between providers within a single ICB. Managed by the ICB with regional EPRR support	Led by ICB with support from the regional EPRR team
3	An incident or event affecting multiple organisations across ICB footprints or of such a magnitude/specialism that it requires regional coordination. May require national support	Led by NHS England North East and Yorkshire regional team
4	An incident or event affecting multiple regions or of such a magnitude that it requires national involvement in order to lead the NHS response	Lead by NHS England national team

Key Areas for Response

Command, Control and Coordination

Incident Coordination Centre

The purpose of the Incident Coordination Centre (ICC) is to provide a place where the ICB can implement and co-ordinate the organisation-wide initial response and recovery operations; to provide a single point of contact for requests for assistance allowing the Incident Management Team an immediate overview of the organisation-wide response and to provide an area for information collation and preparation of any briefings.

Depending on the nature of the incident the ICC might be a physical location or virtual.

The main ICC will be the Boardroom, NENC ICB, Riverside House, Goldcrest Way, Newburn Riverside, Newcastle upon Tyne, NE15 8NY.

In the event that Riverside House is not available and the ICB has to operate from a secondary ICC there are four other local options available. These are:

- Ridley House, Regent Medical Centre, Gosforth, NE3 1DQ;
- Waterfront 4, Newburn Riverside;
- Newcastle Civic Centre;
- Gateshead Civic Centre.

However, depending upon the location of the incident, it may be more appropriate to establish the ICC in one of other ICB areas such as:

- North Ormesby Health Village, Middlesbrough, TS3 6AL
- Parkhouse, Baron Way, Cumbria, CA6 4SJ
- Pemberton House, Sunderland, SR5 3XB

Incident Management Team (Appendices 10 – 15)

In the event of the ICC being stood up, the following are suggested roles that may be present at the ICC when convened. However, this is dependent on the nature of the incident and decision taken by the Health Strategic Commander:

- Strategic Health Commander
  - This is the most senior person on duty, who takes charge. Their primary role is to formulate the overall strategic response. This role will represent the ICB at multi-agency strategic coordinating groups.

- Incident Coordination Centre Manager
  - The primary role of the ICC Manager is to manage the ICC and provide support to the Tactical and Strategic Health Commander roles.

- Tactical Health Commander
  - This role will provide senior managerial support to managing the incident, implementing the agreed strategic and actions, in conjunction with members of the incident management team (IMT). This role will represent the ICB at multi-agency tactical coordinating groups.
  - Depending on the size and/or location of the incident, there may be more than one Tactical Health Commander.

- Incident Management Team Member (Duty Officer)
  - These roles will provide support to the incident senior manager and will implement actions as directed to effectively manage the incident.
  - Depending on the size and/or location of the incident, there may be more than one Incident Team Member.

- Incident Management Support Officer
  - This role will provide administrative support to the incident management team.

    - Depending on the size and/or location of the incident, there may be more than one Incident Support Officer.

- Loggist
    - Comprehensive logging should be made of all events, decisions, rationale and actions taken.

Any other roles as designated by the senior manager (strategic commander) may be established to support the management of the incident.

Please note: Allow time for handover briefings during the incident (using standardised briefing tools, Appendix 3).

Action cards for specific incidents are available within appendices 6 – 9.

Command Roles

The management of emergency response and recovery is undertaken at one or more of three ascending levels: Operational, Tactical and Strategic which each defined below as per NHS England (2022):

Operational

Operational is the level at which the management of immediate 'hands on' work is undertaken. Operational commanders will concentrate their effort and resources on the specific tasks within their geographical or functional area of responsibility (place based).

The ICB operational commander will consider whether a tactical level is required and advise accordingly.

Operational structures will provide information on the incident, assist providers impacted by an incident and help coordinate and liaise with partners, services and other organisations during an incident.

Tactical

The purpose of the tactical level is to ensure that the actions taken by the operational level are coordinated, coherent and integrated in order to achieve maximum effectiveness, efficiency and desired outcomes. Where formal coordination is required at a tactical level then a Tactical Coordinating Group (TCG) may be convened with multi-agency partners within the area of operations. The tactical commanders will:

- Determine priorities for allocating available resources
- Plan and coordinate how and when tasks will be undertaken
- Obtain additional resources, if required
- Assess significant risks and use this to inform tasking of operational commanders

- Ensure the health and safety of the public and personnel

The aim of the ICB Tactical Health Commander will be to ensure that all health and care providers are coordinated through tactical coordination groups and are able to effectively manage any incidents. It may be necessary to invoke the strategic level of managements to take overall command and set the strategic direction when it becomes clear that resources, expertise and coordination are required beyond the capacity of the tactical level (although this is dependent on the severity or impact of the incident).

In general, critical and major incident situations will be able to be managed by the Tactical Health Commander as most emergencies and major incidents are geographically local and limited in time and are dealt with in an effective and efficient way through local capacity and capability.

Strategic

The purpose of the strategic level is to consider the incident in its wider context; determine the longer-term and wider impacts and risks with strategic implications; define and communication the overarching strategy and objectives for the response; establish the framework, policy and parameters for lower level tiers and monitor the context, risks, impacts and progress towards defined objectives.

When an event or situation has a particularly significant impact; substantial resource implications or lasts for an extended duration it may be necessary to convene a multi-agency coordinating group at the strategic level bringing together the strategic commanders from relevant organisations. This group is known as the Strategic Coordinating Group (SCG).

The ICB strategic health commander will be empowered to make executive decisions on behalf of the ICB.

Strategic Coordinating Group

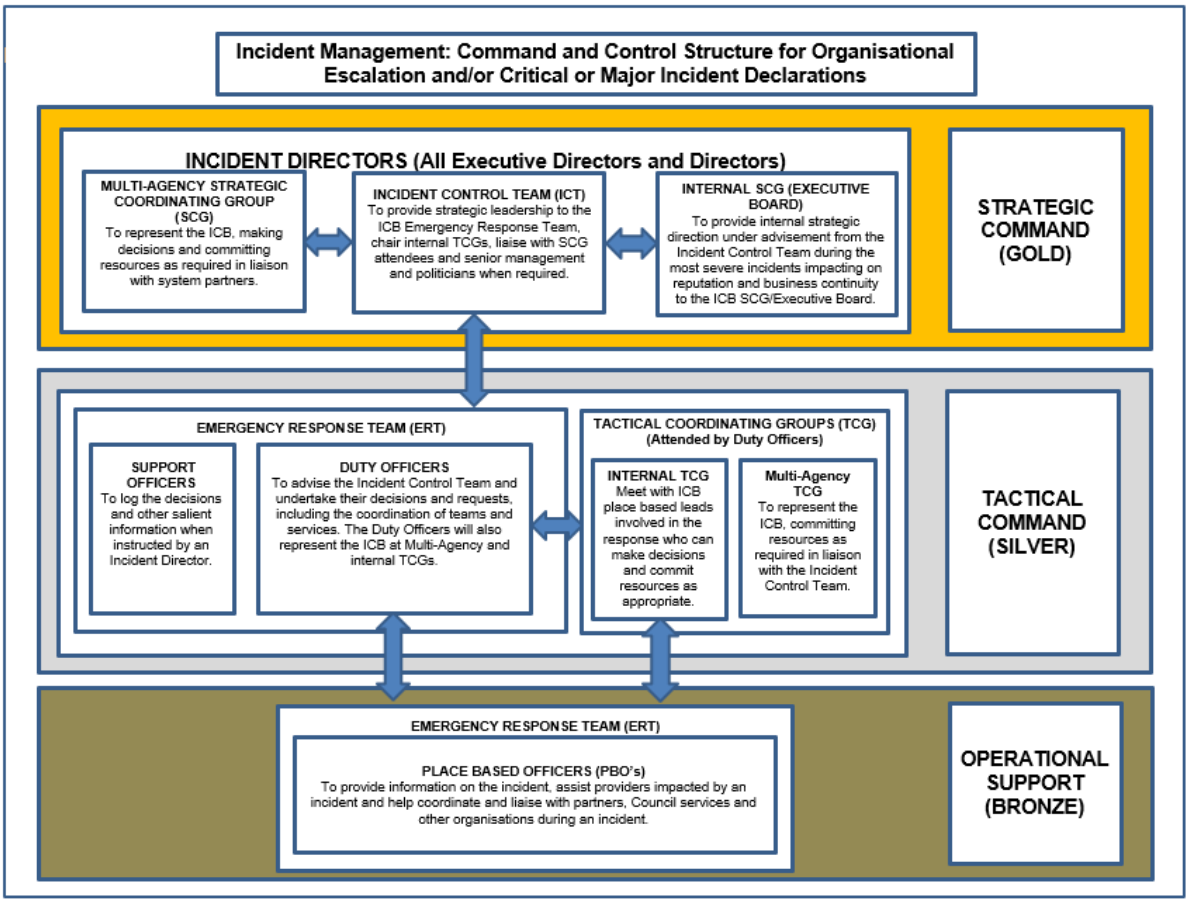
The purpose of the SCG is to take overall responsibility for the multi-agency management of the incident and to establish the policy and strategic framework within which lower tier command and coordinating groups will work. The SCG will:

- Determine and promulgate a clear strategic aim and objectives and review them regularly;
- Establish a policy framework for the overall management of the event or situation;
- Prioritise the requirements of the tactical tier and allocate personnel and resources accordingly;
- Formulate and implement media-handling and public communication plans;
- Direct planning and operations beyond the immediate response in order to facilitate the recovery process

For incidents across multiple SCG areas, then NHS England regional and national teams, as appropriate, will undertake command, control and coordination of the NHS and will be responsible for appropriate representation to regional and central coordination structures and groups.

Generic Tier of Command

The figure below shows the generic tier of command and basic responsibilities. In an incident there will be a clear and identifiable commander who is responsible for coordinating the activity of the ICB at each level of command:



Financing Incidents

In the event an incident declaration or event that requires the incident response plan to be activated it is expected that financial considerations should not impact on the speed or scale of the response required to immediately manage incident.

However, it is essential that financial expenditure incurred as a direct result of the incident is documented from the outset until the conclusion of the incident, including the recovery phase or until such time as the ICB Finance Director could reasonably consulted, whichever the earliest.

Planning Roles & Responsibilities

NENC ICB Executive Team

The Executive Team is responsible for, with the support of the ICB EPRR team, embedding and maintaining a culture of emergency preparedness, resilience and response within the organisation, ensuring that the organisation has a robust emergency response and management system in place, capable of dealing with a range of incident issues/scenarios and ensuring that effective arrangements are in place and are regularly reviewed, monitored, exercised, debriefed and updated.

NENC ICB Emergency Preparedness, Resilience and Response Team

The Emergency Preparedness, Resilience and Response (EPRR) team is responsible for:

- Ensuring that all staff likely to be involved in a major incident response have access to regular training and exercising sessions taking place both internally and externally with multi-agency partners;
- Ensuring that arrangements for responding to a major incident are maintained, monitored and reviewed;
- Ensuring that the organisations emergency plans are coordinated with those of other relevant organisations
- Ensuring that support is provided to the relevant areas by the North of England Commissioning Support Unit team
- Ensuring that the ICB develops a range of business continuity plans and specific scenario incident response plans to aid the management of the key risks identified on EPRR risk registers

All Staff

All staff within NENC ICB are responsible for ensuring that the principles outlined within this plan are universally applied to when responding to an incident or emergency.

All on-call commanders and staff with roles in a major incident are responsible for undertaking and following the training plan set out for the relevant particular staff group or EPRR role.

System and Partnership Working

System Cascade

In the event of an incident, the communication cascade mechanism should be via the Tactical Health Commander who should ensure that they alert their regional NHS England and Improvement (NHSEI) team. In some instances, such alerts may come directly from NHSEI national.

The regional NHSEI team will assist ICBs in implementing command and control mechanisms and the deployment of appropriate NHS resources should the response extend beyond the operational area of a single ICB.

Communication

Other ICS member organisations which are Category 1 responders (NHS provider organisations and Councils) have their own robust and effective on-call capacity and capability to manage incidents which affect them directly. The ICB will work in partnership with these organisations to respond to incidents in their place.

Where appropriate, NHS provider organisations will escalate issues to NENC ICB for support and leadership across a place or across North East and North Cumbria. Similarly, NENC ICB will escalate issues which require support from NHS England.

NENC ICB Tactical Health Commander (1st on-call) provides the single point of contact for local partners in North East and North Cumbria who may wish to contact the NHS to advise of an incident, emergency or formally declared major incident that requires a multi-agency response.

Effective communications are crucial. It is essential to disseminate accurate and timely information to staff, partners, stakeholders and where necessary the public during the response to a business interruption. The Incident Coordination Centre Coordinator will liaise with the communications lead as needed to ensure effective, on-going communications. Clear and consistent communication is an essential part of incident response. This involves internal ICB and health sector communication as well as with multi-agency partners and the public.

The ICB communications team must be involved in Incident response from the outset. They will work with the Strategic and Tactical Commander(s) to agree communications internally and externally

Contact details will be disseminated to relevant personnel and stakeholders to maintain effective channels of communication.

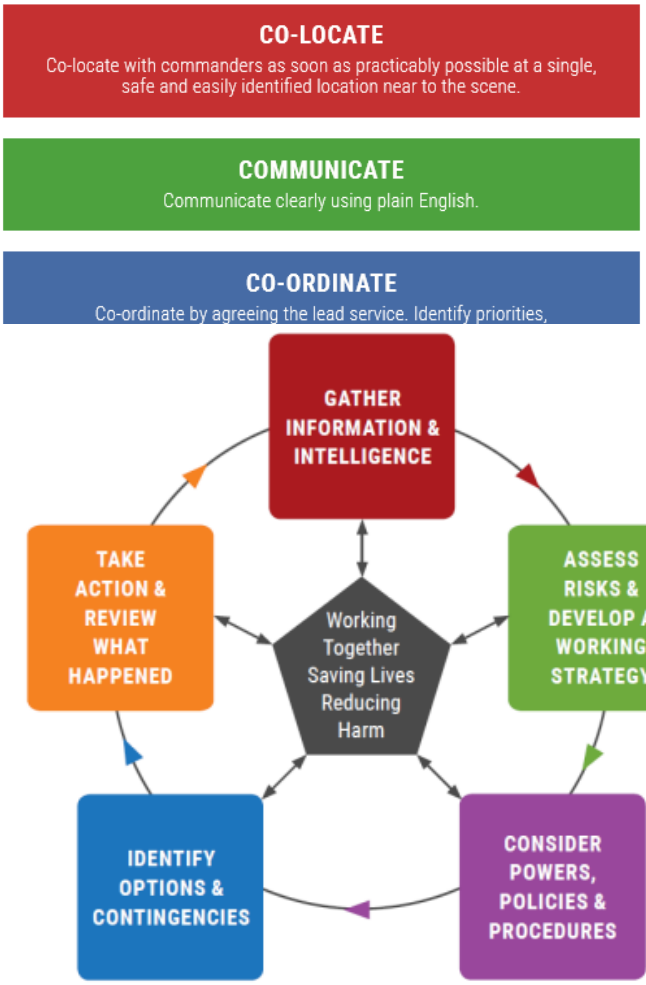
Joint Emergency Services Interoperability Principles

Principles for Joint Working

Effective communication between responders and responder agencies underpins effective joint working. Sharing and understanding information aids the development of shared situational awareness, which underpins the best possible outcomes of an incident. JESIP provides incident and emergency commanders/coordinators, at the scene and elsewhere, with generic guidance on the actions they should take when responding to multi-agency incidents of any scale.

The core principles under JESIP for joint working are as below:

Joint Decision Model



The Joint Decision Model (JDM) shown below, was developed to assist different agencies to bring together the available information, reconcile potentially differing priorities and make effective decisions together.

The JDM is to be applied to decision making at any emergency incident and it is suitable for use by commanders throughout the chain of command.

METHANE

During the early stages of an incident, it takes time for operational structures, resources and protocols to be put in place. In order to help all agencies, gather initial information about the incident in a consistent manner, METHANE should be used (see appendix 2). This brings structure and clarity to the initial stages of managing any multi-agency or major incident.

For incidents, following below the major incident threshold' METHANE' becomes an 'ETHANE' message.

M	MAJOR INCIDENT	Has a major incident or standby been declared? (Yes / No - if no, then complete ETHANE message)	*Include the date and time of any declaration.*
E	EXACT LOCATION	What is the exact location or geographical area of the incident?	*Be as precise as possible, using a system that will be understood by all responders.*
T	TYPE OF INCIDENT	What kind of incident is it?	*For example, flooding, fire, utility failure or disease outbreak.*
H	HAZARDS	What hazards or potential hazards can be identified?	*Consider the likelihood of a hazard and the potential severity of any impact.*
A	ACCESS	What are the best routes for access and egress?	*Include information on inaccessible routes and rendezvous points (RVPs). Remember that services need to be able to leave the scene as well as access it.*
N	NUMBER OF CASUALTIES	How many casualties are there, and what condition are they in?	*Use an agreed classification system such as 'P1', 'P2', 'P3' and 'dead'.*
E	EMERGENCY SERVICES	Which, and how many, emergency responder assets and personnel are required or are already on-scene?	*Consider whether the assets of wider emergency responders, such as local authorities or the voluntary sector, may be required.*

Record Keeping

Those on-call must keep a log of each time they are contacted or make contact in relation to their on-call activities. A new log must be started for each staff member on-call so that it is clear who is writing the log and what on-call position they hold.

Decisions must be recorded in a way that makes them auditable. Individual decision makers must be identified and accountable for decisions they make. Wherever

possible the rationale supporting the decision should be recorded along with the decision itself. All decisions should be proportionate, necessary, and legal.

The purpose of completing a log/record of on-call events is:

- to support staff in keeping a record of actions taken, conversations and decisions so that they can refer back during an ongoing incident;
- to protect staff and the decisions that they make when they are on-call. In an inquest or court of law, if it is not written down there is no evidence that any event or decision took place;
- to provide a learning tool for all on-call staff, so that others can learn from the situations faced and the decisions taken in response to them

A central repository of completed logs will be maintained, to aid learning and in case it needs to be referenced in the future.

Recovery

The Tactical Health Commander or Strategic Health Commander (where strategic command has been established) will determine when the incident response will be stood down. Please note, that whilst the incident has been stood down, this does not necessarily occur following the last admission etc.

Criteria for de-escalation would include:

- Reduction in internal resource requirements
- Reduced severity of the incident
- Reduced demands from government departments, the service and commissioned service
- Reduced public or media interest

Staff Welfare

Staff involved in the incident may have been exposed to the elements for some period of time, in difficult and often traumatic situations, so allowing them the comfort of shelter and ‘familiar’ surroundings will help in the ‘return to normality’. Appropriate referrals should be made i.e., occupational health via the commander to ensure support is provided where necessary.

It will be the responsibility of individual organisations to ensure that appropriate de-briefing arrangements and welfare support is in place for all persons within their employment or under their control. This also applies to the ICB and their staff or contractors.

Early consideration of the welfare of staff is essential. This includes ensuring adequate staffing resource to respond to the incident and planning staffing schedules.

The welfare and psycho-social support will vary according to the type of incident, duration of incident and individuals involved.

The offer and provision of psycho-social support needs to be available beyond the immediate response and recovery phase. Psycho-social impacts are likely to be a long-term issue and needs may not become apparent for a number of years.

Debrief

The Strategic Commander is responsible for ensuring that a debrief (Appendix 17) is held. There are different types of debrief:

- **Hot debrief** – immediately after the incident or period of duty
- **Cold/Structured/Organisational debrief** – within two weeks post incident
- **Multi-agency debrief** – within four weeks of the close of the incident

Hot debriefs should take place as soon as possible conducted by the commander after the incident has been stood down, normally held at a suitable venue.

The lessons identified will enable further resilience to be applied to the emergency plans of all organisations.

A structured debrief should be undertaken and will look at the following areas of a major incident response and recovery to provide some structure to the process:

- Systems and procedures – such as command and control
- Equipment – communication devices, resources
- Personnel – activation and mobilisation, welfare issues and numbers

An agreed and structured debrief process should involve representatives from all key departments involved and a de-brief report will be prepared to identify lessons from the incident. Further multi-agency structured debriefs will also take place.

Governance

The incident response plan will be subject to the governance of NENC ICB and will be subject to an annual review to reflect any lessons identified from major (and other) incidents, events or exercises as well as to comply with newly published guidance or legislation. The plan will undergo a **full** review within 6 months of its ratification and embedment, before moving into a three year cycle to embed learning from exercises, incidents, inquiries etc.

The incident response plan will be subject to both internal and multi-agency exercises which may take the form of;

- Communication Exercise – every 6 months *(minimum)*
- Table Top Exercise – every 12 months *(minimum)*
- Command Post Exercise (CPX) – every 3 years (*minimum)*
- Live Exercise – every 3 years *(minimum)* (NHS England, 2015)

Glossary

The following definitions and abbreviations are regularly used in the programme of work referred to as emergency preparedness, resilience and response (EPRR).

Activity	Processes or sets of processes undertaken by the ICB, or on behalf of the ICB, that supports the delivery of services.
Business as usual	Pre-defined acceptable levels of service delivery.
Business Continuity Management	Process to identify potential threats, assess the impact of those threats on the ICB and building a framework to support ICB resilience to those threats, including protecting patients and stakeholders' interests and achieving strategic objectives. Includes strategic and tactical capability of the ICB to plan for and respond to business interruptions in order to support continued delivery of 'business as usual'
COBR	Cabinet Office Briefing Rooms
CBRN	Chemical, Biological, Radiological and Nuclear
CCA	Civil Contingencies Act
COMAH	Control of Major Accident Hazards. Regulations applying to the chemical industry and to some storage sites where threshold quantities of dangerous substances, as identified in the regulations, are kept or used
Critical Activities	Those activities carried out by the NENC ICB which are most time sensitive and important for ensured continued delivery. These will be mainly those services essential for immediate life and death of patients. These activities will typically suffer if delayed by more than one hour
DHSC	Department of Health & Social Care
Desired Activities	Those activities carried out by the ICB which can be postponed or delayed most easily. These activities will begin to suffer if delayed by more than 7 days.
Disruption	Any event planned or unplanned, which causes an interruption to the ICB's ability to continue business as usual.
ED	Emergency Department
EPRR	Emergency, Preparedness, Resilience and Response
Essential Activities	Those activities carried out by the NENC ICB which are sensitive and important, but not critical to life and death of patients. These activities will normally suffer if delayed by more than one day
Incident Coordination Centre (ICC)	Operations centre from which the management and co-ordination of the response by is carried out.
Incident Management Team (IMT)	Team of staff with specific responsibilities for managing the incident.
Local Health Resilience Partnership (LHRP)	Group which provides a strategic forum for local organisations to facilitate health sector preparedness and planning for emergencies at LRF level.

Local Resilience Forum (LRF)	Process for bringing together all the category 1 and 2 responders within a police force area for the purpose of facilitating co-operation in fulfilment of their duties under the Civil Contingencies Act
Major Incident	An event classified as a major incident according to the ICB Incident Response Plan
NEAS	North East Ambulance Service NHS Foundation Trust
Necessary Activities	Those activities carried out by the NENC ICB which support business delivery on a daily basis and are not critical or essential. These activities will typically start to suffer if not restored within a week.
NHS	National Health Service
NHSE/I	NHS England & NHS Improvement
SAGE	Scientific Advice to Government in Emergencies provide advice to local Strategic Coordinating Groups (SCGs) which respond to the local consequences and manage local recovery efforts.
SCG	Strategic Coordinating Group
STAC	Scientific and Technical Advice Cell. Group of technical experts from those agencies involved in an emergency response that may provide scientific and technical advice to the Strategic Co-ordinating Group chair or single service gold commander

Appendix 1 – Risk Assessment

Appendix 2 - Incident Notification Log

INCIDENT NOTIFICATION LOG

Name of Caller:	
Originating Organisation:	
Date and Time of Call:	
Contact Number: (Mobile and Landline)	
Major Incident/Critical Incident:	**DECLARED / STANDBY** (circle)

Exact Location:

Type of Incident:

- Is the area and population likely to be affected widespread?
- Has the incident already occurred or is it likely to happen?
  - Is the incident
  - Under Control
  - Contained but possibility of escalation
  - Out of control and threatening
  - Unknown and undetermined

Hazards: (Present and potential)

- Level and immediacy of potential risk or danger (to public, response personnel or provider services)

Access: (Direction of approach/egress)

Number of Casualties: (Number, severity and type)
P1 (Casualties requiring immediate life-saving resuscitation and/or surgery).
P2 (Stabilised casualties needing early surgery but delay acceptable)
P3 (Casualties requiring treatment but a longer delay is acceptable)
Discharged
Dead

Emergency Services Activated and Responding:

☐ **Police** ☐ **Fire** ☐ **Ambulance**

Support Requested:

- Increased capacity (hospital, primary care, community)

• Treatment (serious casualties, minor casualties)
• Public Information
• Support for rest centres (evacuees, causalities)
• Expert Advice
• Is support required:
  - Immediately
  - Within a few hours
  - Standby situation

Number of persons displaced, evacuated or at risk:
Organisations affected or likely to be: (Is more than one organisation affected? List those effected)
What infrastructure affected: • On people involved, the surrounding area, • On property, the environment, transport, communications, • On external interests – media, relatives, adjacent areas and partner organisations.
Who has been informed (when and by whom, if known?)
What are the knock-on effects to other services and/or partner organisations?
What is the potential impact on NENC ICB (patients, staff or providers)?

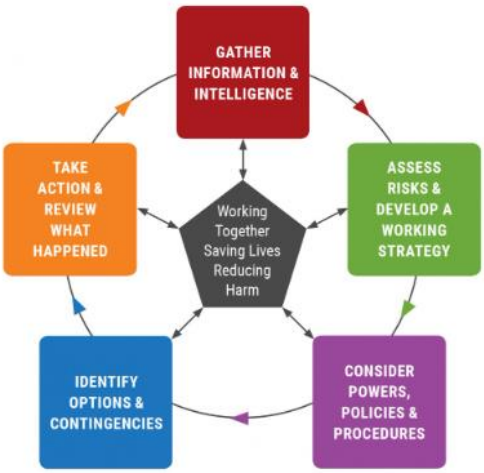
Completed by: (sign name)	
Completed by: (print name)	

Appendix 3 – Briefing and Handover Tool

Within the NHS **SBAR** is a commonly used tool. SBAR is an easy to use, structured form of communication that enables information to be transferred accurately between individuals.
SBAR consists of standardised prompt questions in four sections to ensure that staff are sharing concise and focused information.

(See blank template below)

SBAR Template

Date:		Time of handover:	
Role: (e.g., Strategic Health Commander/2nd on call)			
Name of Outgoing Health Commander:		Name of Incoming Health Commander:	
			
Situation Concise statement of the problem/ issue/ incident			
Background Pertinent and brief information related to the problem / issue/ incident			
Assessment Analysis and considerations of options – what you found / think			
Recommendation Action requested / recommended – what you want / actions that are required			
Signature of outgoing commander: (dated and timed		Signature of incoming commander: (dated and timed)	

Appendix 4 – Situation Report Template

MAJOR INCIDENT SITUATION REPORT - SITREP

Note: Please complete all fields. If there is nothing to report, or the information request is not applicable, please insert NIL or N/A.

Organisation:		**Date:**	
Name (completed by):		**Time:**	
Telephone number:			
Email address:			
Authorised for release by (name & title):			

Type of Incident (Name)	
Organisations reporting serious operational difficulties	
Impact/potential impact of incident on services / critical functions and patients	
Impact on other service providers	
Mitigating actions for the above impacts	

Impact of business continuity arrangements	
Media interest expected/received	
Mutual Aid Request Made (Y/N) and agreed with?	
Additional comments	
Other issues	
C&M ICB Incident Coordination Centre contact details: **Name:** **Telephone number:** **Email:**	

Appendix 5 – Infectious Disease Outbreak

General

- In the event of an infectious disease outbreak, the Incident Management Team will act as the ICB Outbreak Incident Management Team
- Undertake internal business continuity planning in the context of the pandemic or outbreak
- Enact business continuity arrangements as appropriate to the developing situation to ensure critical activities can be maintained
- Enable staff to work flexibly to balance the need to deliver key outputs, minimise staff illness and recognise family pressures
- Plan for staff absence in line with likely pandemic/outbreak impact and existing HR policy
- Consider the criteria to be met that might lead to the redeployment of staff either internally or to other parts of the system, ensuring that any redeployment of staff to a clinical role is signed off by appropriate senior management
- Make plans to ensure that the ICB Tactical Health Commander On Call rota is maintained
- Ensure the early engagement of communications professionals to devise, deliver and maintain internal, external and stakeholder/cross-partnership communications before, during and after a pandemic or outbreak
- Continue to support the deployment of Microsoft Teams, Zoom or similar to facilitate effective agile working

Across the System

- Make allowance for the likely burden of disease arising directly from the pandemic/outbreak and because of any changes to NHS priorities
- Consider any secondary impacts, both short and long term, on commissioning priorities and service delivery
- Consider the value of collaboration when commissioning services where there are similar health priorities
- Review the emerging trends referencing changes to the individual health behaviours of the population and consider the impacts on service requirements and delivery
- Determine at regular intervals the ability to access general health and social care services during the pandemic/outbreak
- Capture the learning from any changes in service access and provision to determine if they should remain in place post pandemic/outbreak

Capturing the Consequences of Ongoing Change

- Review regularly changes to service provision and delivery, determined nationally and/or locally, to understand the impact on commissioning intentions and budgets

- Consider the likely impacts on the provision of primary and secondary care services, including GP practices and community care, and the consequences on both the short term and the long-term health of the population served
- Determine the relationship between disrupted and changed services and the impact, both positive and negative, on health and well being

	Action	Completed
1	Ensure the ICB/Place is represented on the Outbreak Control Team (OCT) once it is convened if requested by UKHSA	
2	Ensure close links from the OCT to the System Resilience Group to manage system wide pressures	
3	Support the operational response under direction of the Pandemic IMT if requested, including providing a route of escalation 24/7	
4	Work closely with commissioned services to support timely responses to the emerging /developing situation	
5	Provide support to Primary Care to cope with increased demands, if necessary, as directed by NHS England	
6	Meet all monitoring requirements through, for example, timely responses to request for sit-reps and other reporting/surveillance monitoring requirements to support management of the outbreak	
7	Support proactive communications and engagement of key stakeholder to ensure timely access to accurate and consistent health and social care messages. The ICB communications manager will work closely all organisations involved to ensure access to appropriate spokespersons/media responses.	
8	Work closely to support care homes to manage outbreaks if required	
9	Contribute to any de-briefs/lessons learnt meetings	
10	Review ICB Infectious Disease Action Card post Outbreak	
11	Review Business Continuity plans with services following the infectious Disease to ensure lessons learnt are incorporated into future plans	

Appendix 6 – Adverse Weather

Severe weather conditions can be caused by rain, floods, snow and solar flare (see appendix 7 and 8 for heatwave and cold weather), that can have wide reaching effects on the NHS for example:

- Avoidable deaths related to heart and lung conditions, infectious diseases and weather-related conditions
- Increased health and social care demands
- Staffing pressures
- Disruptions to:
    - Travel
    - Logistics
    - Infrastructure including utilities
    - Resources

Upon receipt of advice and weather warning guidance from the Meteorological Office (Met Office), the ICB will risk assess the potential impact and, if necessary, undertake escalations that lead to the activation of a command and control structure to ensure a coordinated, risk assessed and informed response to on-going healthcare delivery.

This will include:

- Communication with staff
- Outlining the actions to prepare for, respond and recover from severe weather-related incidents (this may include the creation of an on-call rota during out-of-hours)
- Develop plans to mitigate risk
- Ensuring continuity of care
- Provide appropriate guidance and support to ICB employees to maintain health, well-being and safety
- Working in partnership with and providing mutual aid, to local responders, agencies and voluntary organisations

Appendix 7 - Heatwave

NHS England Regional and ICBs should work collaboratively to ensure that between them they have a cascade mechanism for heatwave alerts to all providers of NHS commissioned care both in business-as-usual hours and the out of hours period in their area. NHSE, in collaboration with ICBs, will ensure that local providers of NHS commissioned care have the capacity and capability to deliver their functions. NHS England will hold the providers of NHS commissioned care to account for implementation, in co-ordination with ICBs as appropriate.

The current version of Heatwave Plan for England - GOV.UK (www.gov.uk)

System Response:

	Action	Completed
1	Expect increased admissions	
2	Take steps to mitigate the effect of increased admissions on the system.	
3	Ensure staff are briefed on the affects and ways to reduce impact from Heatwave.	
4	Seek assurance that commissioned services are undertaking action to reduce impact from Heatwave.	
5	Ensure staff understand key messages	
6	Ensure safety of ICB staff	
7	Support to NHSE if necessary	
8	Work closely to support care homes to manage Heatwave if required	
9	Contribute to any de-briefs/lessons learnt meetings	
10	Review ICB Heatwave Action Card post incident	
11	Review Business Continuity plans with services following the Heatwave to ensure lessons learnt are incorporated into future plans	

ICB Response:

	Action
Office Environment	Workplace should be maintained at reasonable levels. A reasonable level can be assessed using the HSE Thermal Comfort Checklist http://www.hse.gov.uk/temperature/assets/docs/thermal-comfort-checklist.pdf
	Use Air conditioning if available.
	Close blinds/curtains.
	Use office fans to cool the air.
	Turn off any unnecessary artificial lighting or electrical devices.
	Identify cooler areas of the office and relocate staff if possible.
	Remind staff of the First aiders and where they are located. Advise First Aiders of heat related injury signs and symptoms.
	Consider flexible working arrangements to allow staff to work at cooler times of the day

Hydration	Provide water for staff and visitors. Staff are likely to require greater hydration in the event of a heatwave. Ensure staff and visitors have suitable drinking water to stay hydrated.
	Remind staff to drink regularly and not wait until they are thirsty.
Travelling	Hot temperatures may cause travel disruption, particularly on rail journeys.
	Plan journeys and seek alternative routes where possible.
	Check with train provider prior to journey.
	Take water with you on long car journeys.
Staff working outdoors	Consider flexible working arrangements to allow staff to work at cooler times of the day.
	Use sun block
	Wear clothing that covers areas likely to exposed for prolonged periods of time.
Dress Code	Consider relaxing the organisation dress code.
Individuals at increased risk	Consider any staff, visitors or service users that may be at an increased risk from hot weather. UK Health Security Agency (UKHSA) identifies Elderly, pregnant and those with ongoing medical conditions or taking medication.
	Ask staff to consider consulting with their GP regarding effect of hot weather thermoregulation and the fluid balance on those taking medicine

Heatwave Alert levels

Level 0	Long term planning - All year
Level 1	Heatwave and Summer preparedness programme - 1 June to 15 September
Level 2	Heatwave is forecast - Alert and readiness - 60% risk of heatwave in the next 2 to 3 days
Level 3	Heatwave Action - Temperature reached in one or more Met Office National Severe Weather Warning Service regions
Level 4	Major Incident - Emergency response - Central government will declare a Level 4 alert in the event of severe or prolonged heatwave affecting sections other than health

Appendix 8 – Cold Weather

NHS England Regional and ICBs should work collaboratively to ensure that between them they have a cascade mechanism for Cold Weather alerts to all providers of NHS commissioned care both in business as usual hours and the out of hours period in their area.

The current version of Cold weather plan for England - GOV.UK (www.gov.uk)

System Response:

	Action	Completed
1	Expect increased admissions	
2	Take steps to mitigate the effect of increased admissions on the system.	
3	Ensure staff are briefed on the affects and ways to reduce impact from Cold/Severe weather.	
4	Seek assurance that commissioned services are undertaking action to reduce impact from Cold Weather.	
5	Ensure staff understand key messages	
6	Ensure safety of ICB staff	
7	Support to NHSE if necessary	
8	Work closely to support care homes to manage Cold Weather if required	
9	Contribute to any de-briefs/lessons learnt meetings	
10	Review ICB Cold Weather Action Card post Incident	
11	Review Business Continuity plans with services following the Cold Weather to ensure lessons learnt are incorporated into future plans	

ICB Response:

	Action
Office Environment	Workplace should be maintained at reasonable levels. A reasonable level can be assessed using the HSE Thermal Comfort Checklist http://www.hse.gov.uk/temperature/assets/docs/thermal-comfort-checklist.pdf
	Raise heating levels in the offices.
	Identify warmers areas of the office and relocate staff if possible.
	Consider access into buildings and making safe an areas where heavy footfall is present
Travelling	Cold Weather may cause travel disruption.
	Plan journeys and seek alternative routes where possible.
	Check with train provider prior to journey.
Staff working outdoors	Consider flexible working arrangements to allow staff to travel less
	Consider accessibility of those visiting patients or partners.
	Wear clothing suitable for cold weather.
Dress Code	Consider relaxing the organisation dress code.

Individuals at increased risk	Consider any staff, visitors or service users that may be at an increased risk from cold Weather. UKHSA identifies Elderly and those with ongoing medical conditions or taking medication.
	Ask staff to consider consulting with their GP regarding effect of Cold Weather for those taking medication or with any medical conditions affected by cold weather.

Cold Weather Alert levels

Level 0	**Year-round planning** *All year*
Level 1	**Winter preparedness and action programme** *1 November to 31 March*
Level 2	**Severe winter weather is forecast – Alert and readiness** *mean temperature of 2°C or less for a period of at least 48 hours and/or widespread ice and heavy snow are predicted, with 60% confidence*
Level 3	**Response to severe winter weather – Severe weather action** *Severe winter weather is now occurring: mean temperature of 2°C or less and/or widespread ice and heavy snow.*
Level 4	**Major incident – Emergency response** *Central Government will declare a Level 4 alert in the event of severe or prolonged cold weather affecting sectors other than health*

Appendix 9 – Evacuation & Shelter

The decision to shelter or evacuate should only be taken following a dynamic risk assessment, (A template with this is provided below) where the risk to life whilst remaining in-situ has been assessed had deemed a greater risk than evacuation. In certain circumstances, it will be safer to remain in-situ or to invacuate, rather than to evacuate.

Current guidance NHS England » Evacuation and shelter guidance for the NHS in England

In the event of an incident for the ICB, they should follow the evacuation plan outlined within the Business Continuity plan.

Appendix 10 – ICB Tactical Health Commander Action Card

	Action Card - ICB Tactical Health Commander	
	Accountable to: ICB Strategic Health Commander	**Date/Time Completed**
	Responsibilities • To ensure that the NHS within the ICB area continues to deliver its core functions during the response and recovery phase of any incident(s) • Deliver the ICB incident response strategy through the development of a tactical plan • To coordinate the ICB resources • To liaise with NHS England Regional colleagues as required	
	Initial Actions	
1	Obtain as much information about the incident as possible, completing the Incident Notification Log (Appendix 2)	
2	If necessary, verify the information received by contacting the initial caller, the police, the local authority or other appropriate partner agencies as well as advising them of your contact details and the ICB Incident email address: ngccg.NENCICBincident@nhs.net Regularly check this inbox	
3	Commence decision log (where appropriate contact your loggist and make appropriate arrangements for them to attend in person or remotely as required)	
4	Start a personal log of actions using the incident log book	
5	In light of the information received so far, assess the severity of the situation, undertake service impact analysis and take/direct any immediate remedial actions (Appendix 1). Consider the potential impact of the incident on local health economy, using the NHS England Incident Alert levels to determine initial responses (page 10)	
6	If multi-agency coordination is required, attend any teleconference and/or meetings that you are requested to attend and maintain regular communication as	

	appropriate. It may be necessary that you request that a TCG (health or multi-agency) is stood up	
7	Assume command of the initial ICB response and manage the impact on healthcare services and patient safety/quality and coordinate the response in collaboration with staff and healthcare providers.	
8	If appropriate inform the ICB Communications Team of the incident and ensure comms colleagues are involved in any communication cells.	
9	In general, critical and major incident situations will be able to be managed by the Tactical Health Commander therefore the ICB IRP should therefore be activated (Appendix 3) and a strategy set (Appendix 19). However, and where appropriate, it may be necessary to escalate to the Strategic Health Commander where there are longer-term and/or wider impacts, risks with strategic implications or potential reputational damage. If it is not escalated to the Strategic Health Commander, then a SitRep (Appendix 4) should be completed and cascaded when alerted to the incident and at regular intervals	
10	Agree plan / Battle Rhythm with the Incident Management Team (and with the Strategic Health Commander if escalated) regarding how you will keep each other updated (frequency, communication method etc.)	
11	When the ICB Incident Response Plan is activated ensure that relevant ICB staff and other stakeholders are informed	
12	Depending on the nature/type of incident, it may be necessary to activate the Incident Coordination Centre arrangements and establish an Incident Management Team	
13	If the Incident Response Plan is activated, the Tactical Health Commander on call should move into the ICC briefing the relevant personnel, including: - Specified ICB Incident Management Team members (consider whether the IT lead needs to be contacted) - On-call managers of provider units/teams (where appropriate) specifying that the ICC is now operational, providing phone numbers and ICC email address: ngccg.NENCICBincident@nhs.net	
14	Establish shared situational awareness (Appendix 3)	
15	Confirm what is required to assist the local health economy,	

	this may include: - Mobilising resources from locally commissioned services - Providing local NHS leadership, if required liaise with relevant partner organisations - Cascading information to relevant service level providers - Informing and maintaining dialogue with neighbouring ICBs when appropriate Supporting ICB commissioned organisations with any local demand, capacity and system resilience issues.	
16	Ensure situation reports are created regularly and shared (Appendix 4) in line with the frequency agreed within the strategic aims of the response	
17	Establish command structure with appropriate representation from the ICB (e.g., with Place) – in order to establish shared situational awareness and promote subsidiarity	
18	Ensure that a log of any financial expenditure relating to the incident is commenced	
19	Depending upon the scale or type of incident, anticipate requests from the Local Authority to support reception or rest centres if established. Clarify the location of the centres and type of assistance required (clinical, administrative or general support)	
20	When the tactical health commander stands down from their shift, ensure a full briefing and handover is provided to the new tactical health commander. Ensure the briefing and handover is logged	
21	**Post Incident** • Attend debriefs • Ensure that incident records are retained according to records management policies and retention schedules	

Appendix 11 – ICB Strategic Health Commander Action Card

	Action Card - ICB Strategic Health Commander	
	Accountable to: ICB Chief Executive	**Date/Time Completed**
	Responsibilities • To ensure that the NHS within the ICB area continues to deliver its core functions during the response and recovery phase of any incident(s) • Overall responsibility for the command and control of the ICB response to an incident • To liaise with NHS England Regional colleagues as required • Ensure Strategic & Tactical Command responsibilities are appropriately maintained through an enduring incident	
	Initial Actions	
1	After strategic level representation has been requested by the ICB Tactical Health Commander, commence decision log (contact your loggist and make appropriate arrangements for them to attend in person or remotely as required)	
2	Ensure that relevant ICB staff and other stakeholders are informed that the ICB Incident Response Plan has been activated	
3	Identify a flow of communications (battle rhythm) dependent upon: - SCG meetings (if called) - NHS External meetings/teleconferences - Reporting requirements	
4	Establish shared situational awareness (Appendix 3)	
5	Deliver initial brief at executive level (to ensure situational awareness)	
6	Agree ICB Strategic Aim and Objectives for the incident response	
7	Establish a plan to support the SCG if one is established,	

	including the reporting needed, as defined by NHS England. If required, nominate a senior ICB representative to attend the SCG	
8	If multi-agency coordination is required, attend any teleconference and/or meetings that you are requested to attend and maintain regular communication as appropriate. It may be necessary that you request that a SCG (health or multi-agency) is stood up	
9	Assume command of the ICB response and manage the impact on healthcare services and patient safety/quality and coordinate the response in collaboration with NHS England on call staff and healthcare providers.	
10	In conjunction with ICB Communications Team and in consultation with NHS England and/or local partners (for level 3 or 4 incidents), develop and agree media strategy (which may need to be agreed by the SCG)	
11	Plan ahead for the coming hours not just the immediate requirements	
12	Consider staff welfare – shifts/handover	
13	Ensure SitReps are collated regularly and shared as required (Appendix 4)	
14	Plan to maintain enduring Strategic Command presence (at executive level) as necessary	
15	Consider recovery arrangements for the incident as early as possible	
16	Establish liaison with the appropriate personnel from NHS England, UKHSA, NHS Trusts and partner agencies	
17	Confirm the relevant command and control structures that have been implemented across the local health economy	
18	Confirm that all relevant internal personnel have been informed	
19	Confirm what is required to assist the local health economy, this may include: - Mobilising resources from locally commissioned services - Providing local NHS leadership, if required liaise with relevant partner organisations - Cascading information to relevant service level providers - Informing and maintaining dialogue with neighbouring ICBs when appropriate - Supporting ICB commissioned organisations with any local demand, capacity and system resilience issues.	

20	When indicated by the type of incident, establish a broader membership of the Incident Management Team consisting of all responding organisations, in agreement with NHS England or local partners	
21	When the strategic health commander stands down from their shift, ensure a full briefing and handover is provided to the new strategic health commander. Ensure the briefing and handover is logged	
22	**Post Incident** • Ensure that debriefs take place (hot debrief, cold/structured/organisational, ensure appropriate representative attends multi-agency debrief) • Ensure that incident records are retained according to records management policies and retention schedules	

Appendix 12 – Incident Coordination Centre Manager

ACTION CARD: Incident Coordination Centre Manager		
Responsible for: Managing the NENC ICB Incident Coordination Centre.		
No	**Action**	**Date and Time Completed**
1	Respond as requested by the Tactical Health Commander	
2	Start a personal log of actions using the Incident Log Book.	
3	Record all instructions received, actions taken and other incidents which may enable the ICB to assess the success of the Incident Response Plan and provide evidence to any inquiry which may follow. All entries noted must be timed, dated, signed and made in ink.	
4	Establish document control.	
5	Establish rotas and call in staff as indicated to provide cover and continuity.	
6	Ensure adequate handover arrangements are in place (Appendix 3)	
7	Gather information and assess relevance.	
8	Action decisions and process as requested.	
9	Assist in the preparation of time critical documents.	
10	Ensure all evidence both written and electronic is saved and secured.	
11	On stand down, ensure that all original documentation (including notes, flip charts, emails) are kept.	

Appendix 13 – Communications Lead

ACTION CARD: Communications Lead		
Responsible for: Communications and Media		
No	**Action**	**Date and Time Completed**
1	Set up communications log and media monitoring service	
2	On-call communications representative to dial into initial conference call	
3	On activation, contact the Strategic health commander on-call	
4	Draft initial holding media statement	
5	Liaise with relevant partners communications lead to confirm statements, briefing key internal and external stakeholders	
6	Seek approval of media statement from the Strategic Health Commander	
7	Distribute approved statement to media as requested	
8	Alert communications leads at NHS England	
9	If virtual media cell is initially established, consider requirement to establish permanent media cell depending on the likely length and nature of the incident	
10	If required, draft an internal message for staff to be circulated by email with approval from Strategic Health Commander	
11	Establish mutual aid arrangements	

Appendix 14 – Incident Management Team Member

ACTION CARD: Incident Team Member		
Responsible for: Providing operational support to the Incident Strategic or Tactical Health Commander working in the Incident Coordination Centre.		
No	**Action**	**Date and Time Completed**
1	Familiarise yourself with the layout of the ICC.	
2	Carry out duties as directed by members of the Incident Management Team e.g., responsibility for managing a response cell.	
3	Maintain a personal log of all calls/conversations/actions/events and decisions taken using the action log provided. All entries in the log book must be dated, signed and made in ink.	
4	Maintain a list of key contacts and update appropriate lists.	
5	Maintain a list of other contacts appropriate to your function.	
6	Maintain a record of queries and responses as well as documents produced.	
6	Undertake general duties, as directed	
7	Ensure that the action logs and all other information relating to the incident is retained and passed to the appropriate Strategic or Tactical Health Commander (or other IMT members) during handover or at the end of the incident (Appendix 3)	

Appendix 15 – Loggist

ACTION CARD: Loggist		
Responsible for: Recording and documenting all issues/actions/decisions made by the Senior Manager in Charge.		
No	**Action**	**Date and Time Completed**
1	The Loggist must use the Incident Log Book provided.	
2	On arrival all staff to the ICC must wear ID badges. If the badges are unclear the Loggist must ask for clarification of who is present within the room and their title.	
3	The log must be clearly written, dated and initialed by the Loggist at the start of shift and include any location.	
4	All persons in attendance to be recorded in the log Book.	
5	The log must be a complete and continuous record of all issues/actions/decisions made by the Tactical Health Commander or Strategic Health Commander.	
6	Timings have to be accurate and recorded each time information is received or transmitted. If individuals are tasked with a function or role this must be documented and when the task is completed this must also be documented.	
7	If notes or maps are utilised these must be noted within the log.	
8	At the end of each session in the log a score and signature is to be added underneath the documentation so no alterations can be made at a later date.	
9	All documentation is to be kept safe and retained as evidence for any future proceedings.	
10	When something is written in error changes must be made by a single line scored through the word and the amendment made.	
11	Participate in ICB and multi-agency debriefs.	

Appendix 16 – Incident Management Team Support Officer

	Action Card - ICB Incident Management Team Support Officer	
	Accountable to: ICB Strategic Commander	**Date/Time Completed**
	Responsibilities • Providing administrative support to the Incident Management Team working in the ICC.	
	Initial Actions	
1	Familiairise yourself with the layout of the ICC	
2	Carry out duties as directed by the members of the IMT	
3	Minute any meetings or teleconferences	
4	Maintain a telephone log of all calls/events and decisions taken using the action log provided. All entries in the log book must be dated, signed and made in ink.	
5	Maintain a list of key contacts and update appropriate lists	
6	Maintain a list of other contacts appropriate to your function	
7	Maintain a record of queries and responses as well as documents produced	
8	Undertake general duties, as directed, e.g., faxing, copying etc.	
9	Act as a runner to deliver messages within the ICB offices	
10	Ensure that all completed action logs of events and actions taken are maintained and signed by the appropriate manager	
11	Ensure that the action logs and all other information relating to the incident is retained and passed to the on-call senior manager at the end of the incident	

Appendix 17 – Generic Debrief Template

GENERIC DEBRIEF TEMPLATE

INCIDENT DATE	
OUTLINE	

This debrief template provides the framework for undertaking a structured De-brief and will assist in the development of the post incident report which will cover:

- What was supposed to happen?
- What actually happened?
- Why were there differences?
- What lessons were identified?

Issue	Response
How prepared were we?	
What went well?	
What did not go well?	
What can we do better in the future?	
Is there a need to modify the plan/training?	

Other issues	
Communications	
Equipment	
Human resources	
Planning and briefing	
IT	
Other issues	

Completed by - ……..Role - ……..

Appendix 18 – ICB Reception Action Card

ACTION CARD: ICB Reception		
Responsible for: Acting as first point of contact for the ICB and ensuring that the Tactical Health Commander on Call is notified immediately should a potential or actual business continuity issue or major/critical incident be reported.		
No	**Action**	**Date and Time Completed**
1	Be aware of the daily ICB on call rota and how to contact the Tactical Health Commander on Call (particularly if the ICB Tactical Health Commander on Call is off-site).	
2	If a call is received for the Tactical Health Commander on Call, log the name of the caller, contact number (and alternative) and organisation in case contact is lost. Clarify the reason for the call.	
3	Contact the Tactical Health Commander on call clearly specifying that the caller needs to speak urgently to them about ‘a potential or actual business continuity issue or major incident’.	
4	Log the date and time of the call and the time the Tactical Health Commander on call was advised.	

Appendix 19 – Setting a Strategy

Being 'S T R A T E G I C' aide memoire		
S	**Strategy**	what is the plan for now/the next few hours/days?
T	**Tactical**	have you got all you need in place to achieve your objectives? Any gaps?
R	**Resources**	do you have everything you need now an in the near future (people, assets, mutual aid)?
A	**Anticipate**	what is the extent or length of the emergency? When will you transition to recovery?
T	**Truth**	be honest about any problems and issues and try to suggest solutions to problems. Use plain English.
E	**Experts**	have access to knowledgeable staff/ organisations to support you
G	**Geography**	– be cognisant of your geographical boundaries
I	**Information**	establish key facts for situational awareness
C	**Costs and Communications**	record costs. What are the implications? What needs to be communicated to responders, the public and into Government?

NHS
North East &
North Cumbria

Corporate	ICBP014 Emergency Preparedness, Resilience and Response Policy

Version Number	Date Issued	Review Date
1	July 2022	July 2024

Prepared By:	ICS EPRR Operational Delivery Manager
Consultation Process:	Relevant ICS workstreams and Task and Finish Groups.
Formally Approved:	July 2022
Approved By:	ICB Board

EQUALITY IMPACT ASSESSMENT

Date	Issues
June 2022	None identified.

POLICY VALIDITY STATEMENT

Policy users should ensure that they are consulting the currently valid version of the documentation. The policy will remain valid, including during its period of review. However, the policy must be reviewed at least once in every 3-year period.

ACCESSIBLE INFORMATION STANDARDS

If you require this document in an alternative format, such as easy read, large text, braille or an alternative language please contact necsu.comms@nhs.net

Version Control

Version	Release Date	Author	Update comments
1	July 2022	ICS EPRR Operational Delivery Manager	Not applicable. First Issue

Approval

Role	Name	Date
Approval	ICB Board	July 2022

Contents

1. Introduction

The North East and North Cumbria Integrated Care Board (NENC ICB) is committed to developing and maintaining prepared and resilience services' by taking a proactive approach to Emergency Preparedness, Resilience and Response (EPRR).

NENC ICB will lead integration within the NHS, bringing together all those involved in planning and providing NHS services to take a collaborative approach to agreeing and delivering ambitions for the health of their population.

The NHS England core standards for EPRR requires NHS organisations and providers of NHS funded care to have an overarching EPRR policy for building resilience across the organisation to enable a response to major incidents and business disruptions, regardless of source, whilst continuing to deliver the core critical services that its stakeholders and community rely upon.

As part of the ICB's on-going programme to increase resilience, the ICB will continue to maintain its statutory duties as a Category 1 responder under the Civil Contingencies Act (CCA) 2004, and NHS England EPRR core standards.

2. Aim/Scope

The aim of this policy is to outline how the NENC ICB will develop and maintain prepared and resilient services that meet the statutory and mandatory duties as set out in the Civil Contingencies Act 2004 and the NHS England EPRR Framework 2015.

3. Objectives

This policy will achieve the stated aim by ensuring the following objectives are met:

- An integrated emergency planning process is in place across the ICB that is built on the principles of integrated emergency management (IEM) as well as risk assessment, cooperation with multi-agency partners, emergency planning, communicating with the public and information sharing
- An incident response plan, associated plans and guidance are in place, kept up to date, accessible, tested regularly and specifically addresses any potential causes of a major incident for which the ICB is at particular risk
- A business continuity policy and associated plans for business continuity disruptions are in place, kept up to date, accessible and tested regularly
- The needs of vulnerable persons, including children, are considered in all resilience arrangements
- Appropriate arrangements are in place to provide and receive mutual aid locally, regionally and nationally
- Systems and facilities are in place to ensure health, safety and welfare of all staff in a major incident or business continuity incident
- Suitable and sufficient training arrangements are in place to ensure the competence of staff in performing emergency planning and major incident roles

- The ICB's EPRR arrangements are mutually compatible with and fully support other EPRR arrangements within the wider health economy and that it actively participates in Local Health Resilience Partnerships (LHRP) and Local Resilience Forums (LRFs)
- A culture of EPRR is adopted within and across the ICB that makes EPRR an intrinsic element of management and operation

4. Duties - Roles & Responsibilities

4.1 Integrated Care Board

The responsibilities of the NENC ICB as a Category One responder will be subject to the full range of civil protection duties (pending the CCA 2004 amendment which will formally legislate ICB's as Category One responders) and will maintain a requirement to:

- assess the risk of emergencies occurring and use this to inform contingency planning
- put in place emergency plans
- put in place business continuity management arrangements
- put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- share information with other local responders to enhance co-ordination
- co-operate with other local responders to enhance co-ordination and efficiency

4.2 Executive Lead for EPRR and nominated Accountable Emergency Officer (AEO)

The Executive Lead for EPRR is ultimately responsible for emergency preparedness and is accountable to the ICB for ensuring that systems are in place to facilitate an effective major incident response ensuring that:

- A designated officer is nominated to perform the role of Head of EPRR to support the ICB in preparing for potential emergencies

- Robust ICB major incident response plans and procedures in place;

- Resilient ICB business continuity procedures and detailed business continuity plans developed by each directorate/service area for essential services;

- Agreed action and capability arrangements that outlines roles and responsibilities in the event of a major incident or disruptive challenge;

- All staff who participates in the ICB on-call system are trained in emergency and contingency response and ensure their on-call officer competencies are annually monitored and adequate CPD is maintained under the National Occupational Standards by their line managers

- Publicised and readily available training programme for all levels of the ICB;
- Ensure exercise arrangements are implemented:
    - Live exercises at least every three years as a minimum;
    - Table top exercises annually as a minimum;
    - Communication cascade tests or command post exercises every six months as a minimum which includes external stakeholders
- Detailed EPRR self-assessment / audit tools with subsequent evidence identified to ensure compliance and preparedness; and,
- Systems for regular reporting and review across the ICB

4.3 Head of EPRR

The ICB has in place a designated full time Head of EPRR to support the Executive lead for EPRR, they are responsible for:

- Supporting the Executive lead for EPRR in implementing the ICB EPRR framework;
- Ensuring the ICB remains compliant with the CCA 2004, NHS EPRR guidance and other appropriate legislation, statutory and non-statutory guidance;
- Developing an EPRR annual work programme agreed with the AEO;
- Developing, disseminating and maintaining the ICB's EPRR arrangements;
- Arranging and delivering EPRR training, as required;
- Coordinating testing and exercising of the ICB's emergency arrangements; and
- Deputising for the Accountable Emergency Officer at LHRP meetings
- Deputising for the Accountable Emergency Officer at all LRF meetings

4.4 EPRR Central Team

The EPRR central team are responsible for supporting the Head of EPRR to:

- Deliver the ICB's EPRR framework on a day-to-day basis;
- Ensure that all staff are appropriately trained in major incident management
- Ensure strategic, tactical and operational health commanders maintain their core competencies and attend appropriate training/exercising in line with the relevant standards, including Joint Emergency Services Interoperability Principles (JESIP);
- Arrange and deliver EPRR training, as required;
- Deliver testing and exercising of the ICB's emergency arrangements, plans and procedures etc.;
- Manage, produce and update specific plans in accordance with national and statutory requirements; and
- Ensure the ICB remains compliant with the CCA 2004, NHS EPRR guidance 2015, and other appropriate legislation, statutory and non-statutory guidance

4.5 ICB Health Commanders (Strategic and Tactical)

The ICB recognises that EPRR should be a consideration for all staff either directly or indirectly employed by the ICB Through induction training and regular awareness training, the ICB ensures all staff are:

- Familiar with the arrangements detailed in the ICB's incident response plan, and business continuity plan, including the expectation of all ICB staff to be able and willing to perform roles outside of their usual duties/locations in the response to a major incident or serious business disruption
- Familiar with the roles and responsibilities as listed in the incident response plan, all associated documentation and business continuity plans;
- Aware of and attend, as necessary, the training available to support them in their emergency response role (where applicable); and

5. Governance/Groups with ICB responsibilities

NHS England expects all NHS funded organisations to have an AEO with regard to EPRR. Chief Executives of organisations commissioning or providing care on behalf of the NHS will designate the responsibility for EPRR as a core part of the organisation's governance and its operational delivery programme.

The NENC ICB governance arrangements for EPRR are as follows:

5.1 Executive Team

The ICB Executive team promote and oversee the implementation of the EPRR framework, plans, policy and guidance. This involves:

- Ensuring they are aware of their role and responsibilities as detailed in both the ICB incident response plan and business continuity arrangements;
- Supporting the development and implementation of EPRR capabilities in preparation for an emergency incident;
- Ensuring that departments and services under their control all have suitable and up to date procedures and plans in order to comply with this policy;
- Disseminating the EPRR framework to services

The Executive team is responsible for scrutiny and endorsement of the EPRR framework and all associated EPRR plans, guidance and will receive appropriate papers and reports in relation to EPRR.

Furthermore, the Executive Team has the responsibility of reviewing and agreeing the compliance levels in relation to the annual NHS England EPRR self-assessment process against the national NHS England EPRR core standards and framework.

5.2 EPRR Governance Group

Chaired by the AEO, this group will receive verbal and/or written reports on a regular basis with regards to the EPRR workstreams, and business continuity matters e.g., compliance, approval of policy, risk to operational services, new initiatives, regional and national updates etc.

6. Training & Exercising

6.1 Training expectations for staff

The ICB will detail all training available internally, externally and via multi-agency partners as well as exercises scheduled for the year in the annual EPRR training and exercise calendar.

This calendar will contain a mixture of formal and informal training session to ensure it remains flexible and able to adapt to the changing risks, priorities and needs of the organisation. Competent individuals will carry out all EPRR training.

The ICB will also provide bespoke training and exercises upon request and advertise all relevant training available to appropriate teams and individuals. The ICB EPRR team will retain records of training and delegates and will ensure that they attend meetings or individual briefings to explain the ICB's EPRR arrangements (compulsory for all new members to the on-call rota).

6.2 Exercising

To consolidate learning and provide an opportunity to develop staff competencies and practice carrying out their roles (as well as validating and testing the associated plans/procedures) the annual training programme is supported by an exercise schedule.

Exercise arrangements are in line with NHS England requirements and entail:

- a six-monthly communication test
- annual table-top exercise
- live exercise at least once every three years

Exercises are carried out in both single and multi-agency environments with lessons identified incorporated in to future planning and training

7. Legal Framework

Following a significant incident or emergency event that has generated high profile media interest several legal investigations and challenge can and will be made. These may include coroners' inquests, public enquiries, and criminal investigations and civil action.

NENC ICB will ensure that following an incident that all associated documentation will be securely stored for up to 25 years to facilitate any future internal or external investigations.

Should legal advice related to emergency preparedness incident be required this will be sought from the ICB and/or NHS England & Improvement.

8. Collaborative Working

Strategic Forums are in place and responsible for delivering joint health planning, known as Health Resilience Partnerships (HRPs) of which the ICB will form part of the membership (Appendix 1).

8.1 Regional Health Resilience Partnership (RHRP)

The RHRP acts as the Strategic Forum across the North East and Cumbria ICB footprint and provides a single collaborative forum between National EPRR work programmes and work and planning undertaken at a locality level.

8.2 Local Health Resilience Partnerships (LHRPs)

The Local Health Resilience Partnership (LHRP) is chaired by the ICB AEO and acts as a Strategic forum across health and care (NHS Health, Public Health and Social Care) to deliver the ICB's EPRR Strategy and effect the coordination of National, Regional and ICB level workstreams with terms of reference in place to ensure that the NHS the Integrated Care Board footprint can respond to significant incidents or emergencies of any scale in a way that delivers:

- optimum care and assistance to the victims and their families,
- that minimises the consequential disruption to healthcare services and
- that brings about a speedy return to normal levels of functioning

Members of the LHRP comprise of Strategic Health Leaders from across the NENC ICB footprint, in the event that the designated representative is unable to attend the meeting the expectation is that any deputy must have:

- the authority to take decisions on behalf of their organisation
- the authority to approve plans and policies and
- the authority to commit resources on behalf of their organisations/systems

8.2.1. Format & Frequency of meetings

The North East and North Cumbria LHRP will meet, as a minimum, quarterly and align the meeting schedule with the Regional Health Resilience Partnership. Meeting structures may vary to meet the needs of the locality and will be directed by the Accountable Emergency Officer

All meetings will be formally documented, and minutes shared with all relevant health organisations within the LHRP area and will be brought to the LRF by the co-chairs. These minutes will be publicly available on request, subject to appropriate consideration of any restricted/sensitive items.

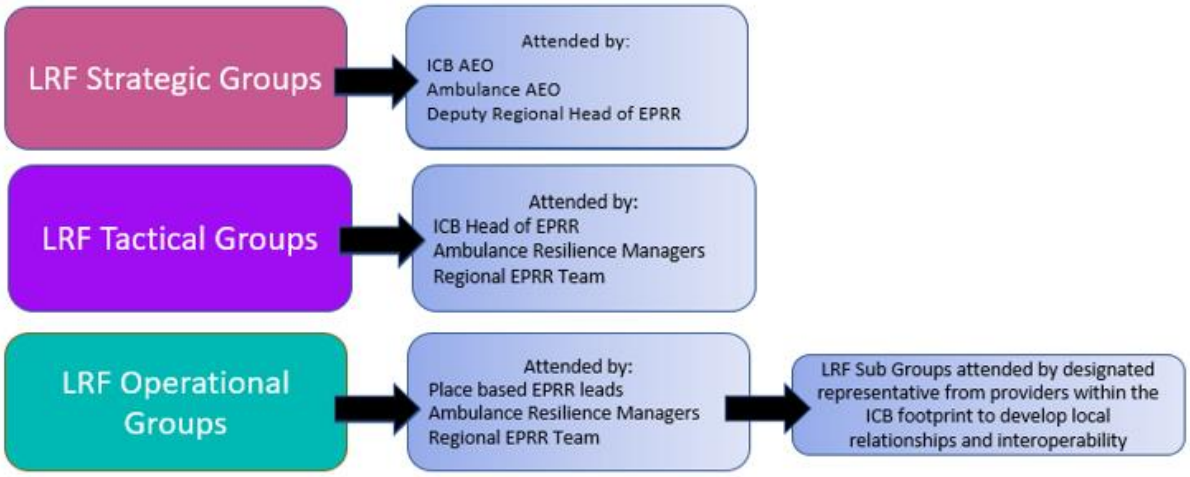
Any reports or items to be tabled must be submitted a minimum of ten working days prior to the next LHRP meeting and subsequent papers and minutes will be circulated to LHRP members a minimum of seven working days before the next meeting.

8.3 Health Resilience Sub-Group

The Health Resilience Sub-Group will feed jointly into the NENC LHRP and LRF whereby the local health organisations will come together to collaborate and deliver the strategic aim and objectives. This group will be chaired by the Head of EPRR.

8.4 Local Resilience Fora

Representation at the LRF's



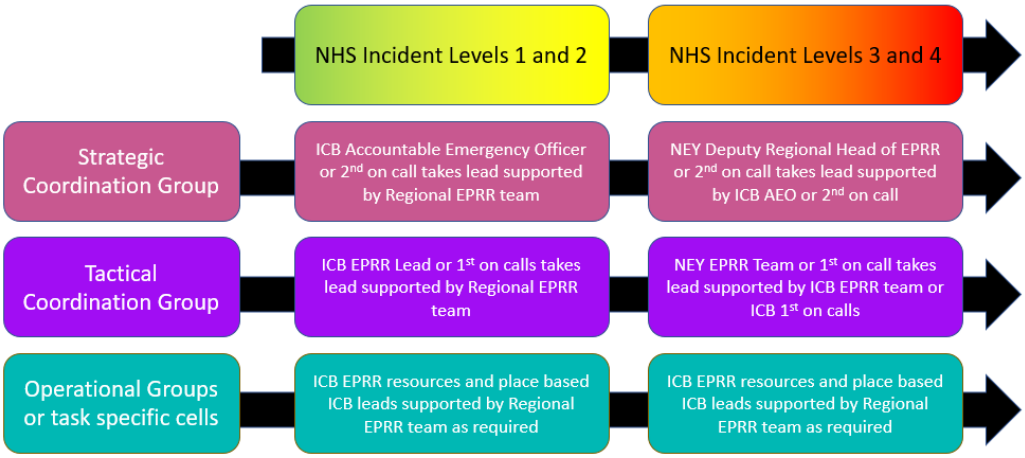
It is critical that as part of our Health Resilience and Local Resilience Forum partnerships that we maintain a consistent and interoperable engagement with fosters sharing of information and joint working.

9. Response and Recovery

Incident Response Arrangements with Multi-agency partners

In responding to a health specific incident which requires support from multi-agency partners, or where an incident or event is one that automatically triggers a multiagency response the coordination and leadership of the NHS will vary depending on what level of NHS Incident Level the incident falls into.

The below table details at what level the leadership and coordination responsibility sit when responding to an incident where either a Strategic Coordination Group (SCG) or Tactical Coordination Group (TCG) is called:



10. On Call Arrangements

The NENC ICB is responsible for ensuring appropriate leadership during emergencies and other times of pressure. Incidents, emergencies, and peaks in demand can occur at any time of day or night, the NENC ICB has an appropriate out of hours on-call system with the ability to represent and lead at both Strategic and Tactical levels.

Details of the on-call arrangements can be found in the NENC ICB On Call Policy.

11. Training & Exercising

Training and Exercising is a critical component of delivering NENC ICB statutory responsibilities.

11.1 Training

Training those staff who have a response role for incidents is of fundamental importance. Whilst familiar to responding to routine everyday challenges by following usual business practices, very few respond to incidents on a frequent basis.

These individuals who have been identified as having a role to play in either response (commanders) or planning for incidents are required to undertake an ongoing programme of training which is aligned to the level of responsibility –

- Strategic
- Tactical
- Operational

Training will be focussed on the specific roles and requirements assigned to the individual, and the wider organisational and multi-agency response structures they may be called to work within in order to ensure that they hold current qualifications and competence to effectively fulfil that role.

Before commencing on-call activities, staff should have undertaken mandatory training required for their role, and also training which familiarises staff with the specific arrangements for their own team, including:

- Expectations of all on-call staff (including the principles outlined in this guidance)
- Familiarisation with response plans including any specific plans, such as pandemic influenza, business continuity, pressure and escalation etc. This should include a particular focus on key elements such as action cards, incident reporting forms and logs, escalation arrangements and contact details
- Familiarisation of local EPRR arrangements, geographies, key risks outlined on the Community Risk Register(s),
- Familiarisation of terminology and structures, especially Strategic Co-ordination Group (SCG) arrangements in multi-agency response to major incidents
- Access, purpose and use of all documentation and resources provided to on-call staff
- Principles of setting up and running a local Incident Coordination Centre.
- How to maintain personal logs during an incident, along with working with a dedicated Loggist (especially for First and Second on-call managers)

It should be noted that other senior leaders at an SCG or other formal multi-agency response setting will have undertaken a wide range of courses and exercises as part of their response role, so it is expected that on-call staff will work with the EPRR staff to ensure that they undertake as wide a range of further training as possible. EPRR staff will be able to advise further depending on staff requirements, particular local risks, and training resources which may be available through local resilience partnerships.

11.2 Formal Training (Mandatory & Supplemental)

First and second on-call staff need to receive formal training in Principles in Health Command (PHC). This will include the dynamic risk assessment process which will need to be applied in any incident scenario, to ensure they have the skills and knowledge to undertake this role effectively, as well as ensuring that the appropriate competencies of its on-call staff are developed and maintained in line with the Civil Contingencies Act 2004 and mandatory elements of the National Occupational Standards (NOS (Skills for Justice)) for responding to emergencies.

Formal training must also be undertaken in the legal implications of incidents afterwards if public inquiries are held, and the importance of effective record-keeping and management. This training is mandatory for Second on-call staff.

Formal training is further required to understand the media implications of incidents and prepare Second on-call staff for fronting media interviews. This is mandatory for Second on-call staff.

All ICB Executives will undergo legal CPD training in relation to on-call competencies in alignment with the NHS England and NHS Improvement Contract Standards. This is mandatory for ICB Executives.

In the event of a protracted or different incident arising which requires new, specialised response plans to be put in place, all on-call staff must ensure they complete any dedicated training which may be put in place for these events.

Staff undertaking such training as outlined above should include this in their Personal Development Review and subsequent plan, and also include it in their job description if possible.

Individuals who have undertaken their formal training will be required to undertake an ongoing programme of Continual Professional Development (CPD) which is logged and evidenced within a Professional Development Portfolio (PDP) as outlined in the minimum occupational standards and national EPRR Framework.

12. Exercising

As emergencies by their very nature are unpredictable, the best way to regularly evaluate the effectiveness of response plans and the competence of staff using those plans, is to take part in regular exercises. Plans which are developed to allow the NENC ICB to respond efficiently and effectively will be exercised to ensure they are fit for purpose and encapsulate all necessary functions and actions to be carried out in an incident as part of our continuous improvement principles and should ensure wider health engagement and the inclusion of multi-agency partners on a regular basis in order to ensure a collaborative and interoperable response.

NHS organisations are required to undertake communications tests every six months, desktop exercises annually, and a live exercise once every three years.

To ensure all on-call staff continue to meet competencies, remain up to date on their local response arrangements, and also meet external compliance requirements, on-call staff should be involved in at least one exercise annually. This should be formally recorded in a PDP and a formal debriefing undertaken.

It is recommended that all on-call staff take part in both internal exercises wherever possible. NENC ICB share the NE LRF exercise programme with colleagues and identify suitable exercises for this purpose.

Taking part in an incident response also fulfils some of the requirements of exercising.

Communications exercises are conducted regularly as part of the maintenance and management of the on-call arrangements. Staff on-call are expected to respond should they be contacted for these purposes.

12.1 Exercising Requirements

12.1.1 Training & Exercising Requirements of NHS Organisations

Each NHS funded organisation has a set of minimum requirements identified in regard to training and exercising (detailed in the NHS England EPRR Framework and EPRR Core Standards).

As a minimum, the NENC ICB is required to undertake the following:

Type of exercise	Minimum frequency	Overview
Communications exercise	every six months	To test the ability of the organisation to contact key staff, other NHS, and partner organisations. This should include any communications methods or technology used as part of their response and be conducted both in-hours out-of-hours on a rotational basis and should be unannounced
Table-top exercise	every 12 months	The table-top exercise brings together relevant staff, and partners as required, to discuss the response, or specific element of a response, to an incident. They work through a particular scenario and can provide validation to a new or revised plan. Participants are able to interact and gain knowledge of their own, and partner organisations' roles and responsibilities
Command post exercise	every 3 years	The command post exercise (CPX) tests the operational element of command and control and requires the setting up of the Incident Coordination Centre (ICC). This provides a practical test of equipment, facilities and processes and provides familiarity to those undertaking roles within the ICC. It can be incorporated into other types of

		exercise, such as the communications or live play exercises
Live play exercise	every three years	The live play exercise is a live test of arrangements and includes the operational and practical elements of an incident response. For example: simulated casualties being brought to an emergency department or the setting up of a mass countermeasure centre, or mass evacuation.

It is to be noted that is the NENC ICB activates the incident response plan for response to a live incident or activates the ICC this replaces the need to run an exercise, providing lessons are identified and logged and an action plan developed.

Lessons identified from training and exercising

Lessons identified from both training and exercising within the NENC ICB will be shared through the Local Health Partnership arrangements as part of our continual improvement process.

Details of logging the learning from the exercise, the actions taken to implement or address that learning and what has changed as a result will be detailed within the training programme.

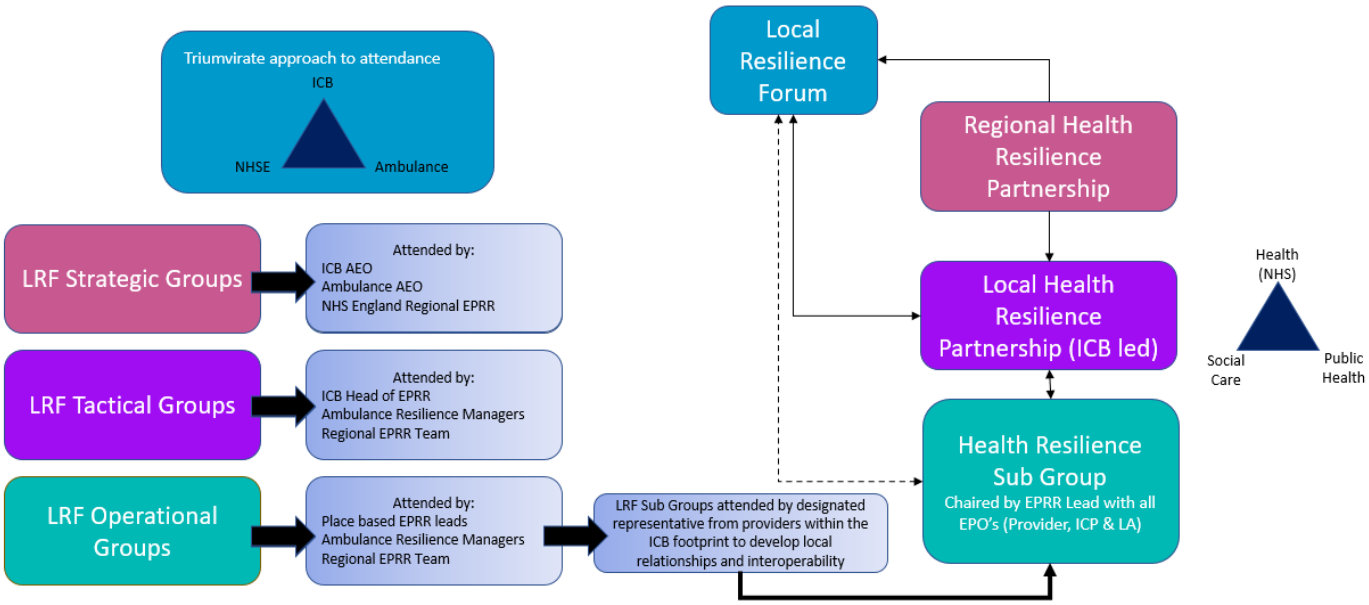
13. Assurance

The minimum requirements which NHS funded organisations must meet are set out in the Core Standards.

These standards are in accordance with the CCA 2004, the NHS Act 2006 (as amended) and the Cabinet Office Expectations and Indicators of Good Practice set for Category 1 and 2 Responders.

Annually the NENC ICB is required to undertake a self-assessment against this set of minimum standards concluding at the Executive Team to issue a Statement of EPRR Conformity which will be published in the annual report.

Appendix 1 – Local Resilience Forum & Health Resilience Partnership Engagement



(NHS England NEY, 2022)

Appendix 2 Compliance and Effectiveness Monitoring for this Policy

Process in the policy	Monitoring and audit				
	Key Performance Indicators (KPI)/ Criteria	**Method**	**Who By**	**Committee**	**Learning/ Action Plan**
Response	Compliance with NHS EPRR Core Standards, the Civil Contingencies Act 2004 and its associated statutory/non-statutory guidance	The AEO will review the EPRR Policy and the following documents: • ICB Risk Register • Incident Response Plan • Business Continuity Plans and Procedures (including business impact analysis); • Training and Exercise Plan; The Head of EPRR will also ensure that any appropriate external	EPRR Governance Group Executive Team Accountable Emergency Officer	EPRR Governance Group Executive Team Accountable Emergency Officer	The results of all reviews, audits and self-assessments both internally or externally will be clearly documented and maintained with corrective and preventative actions identified to ensure continual improvement across the organisation. Post-incidents single agency and multi-agency debriefings will be used to inform learning from live incidents, training events and exercises to ensure all plans, procedures and Standard Operating Procedures reflect best practice.

Process in the policy	Monitoring and audit				
	Key Performance Indicators (KPI)/ Criteria	**Method**	**Who By**	**Committee**	**Learning/ Action Plan**
		audits tools and assurance processes are conducted on a regular basis, examples of external audit tools include: • Provision of assurance to NHS England; • Separately, or through the LHRP			
Ensure the ICB is fully compliant with Emergency Preparedness standards	Compliance measured against recognised performance indicators: Compliance to best practice identified in Civil Contingencies Act 2004 guidance	External auditing, NHS assurance process and process of peer review of ICB progress with Emergency Preparedness. Annual assurance submission of EPRR	External/Internal	EPRR Governance Group Executive Team	

Process in the policy	Monitoring and audit				
	Key Performance Indicators (KPI)/ Criteria	**Method**	**Who By**	**Committee**	**Learning/ Action Plan**
	Emergency Preparedness Compliance to Civil Contingencies Act 2004 guidance *Emergency Response and Recovery* Compliance to NHS Core Standards for EPRR	capability through NHS England Cumbria and North East			

Appendix 4 Equality Impact Assessment

Initial Screening Assessment (STEP 1)

As a public body organisation, we need to ensure that all our current and proposed strategies, policies, services and functions, have given proper consideration to equality, diversity and inclusion, do not aid barriers to access or generate discrimination against any protected groups under the Equality Act 2010 (Age, Disability, Gender Reassignment, Pregnancy and Maternity, Race, Religion/Belief, Sex, Sexual Orientation, Marriage and Civil Partnership).

This screening determines relevance for all new and revised strategies, policies, projects, service reviews and functions.

Completed at the earliest opportunity it will help to determine:

- The relevance of proposals and decisions to equality, diversity, cohesion and integration.
- Whether or not equality and diversity is being/has already been considered for due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED).
- Whether or not it is necessary to carry out a full Equality Impact Assessment.

Name(s) and role(s) of person completing this assessment:

Name: Marc Hopkinson
Job Title: Associate Director
Organisation: Newcastle Gateshead CCG

Title of the service/project or policy: NENC ICB EPRR Policy

Is this a;
Strategy / Policy ☒Service Review ☐ Project ☐
Other Click here to enter text.

What are the aim(s) and objectives of the service, project or policy:
The aim of the policy statement and the supporting Incident Response Plan is to demonstrate how North East and North Cumbria Integrated Care board (the ICB) will meet its obligations with regard to Emergency Preparedness, Resilience and Response (EPRR).

Who will the project/service /policy / decision impact?
(Consider the actual and potential impact)

- **Staff ☒**
- **Service User / Patients ☐**
- **Other Public Sector Organisations☐**
- **Voluntary / Community groups / Trade Unions ☐**
- **Others, please specify**

Questions	Yes	No
Could there be an existing or potential negative impact on any of the protected characteristic groups?	☐	☒
Has there been or likely to be any staff/patient/public concerns?	☐	☒
Could this piece of work affect how our services, commissioning or procurement activities are organised, provided, located and by whom?	☐	☒
Could this piece of work affect the workforce or employment practices?	☐	☒
Does the piece of work involve or have a negative impact on: • Eliminating unlawful discrimination, victimisation and harassment • Advancing quality of opportunity • Fostering good relations between protected and non-protected groups in either the workforce or community	☐	☒

If you have answered no to the above and conclude that there will not be a detrimental impact on any equality group caused by the proposed policy/project/service change, please state how you have reached that conclusion below:

There is no significant/material impact or change to the working practices of staff who would support the EPRR workstream.

If you have answered yes to any of the above, please now complete the 'STEP 2 Equality Impact Assessment' document

Accessible Information Standard	Yes	No
Please acknowledge you have considered the requirements of the Accessible Information Standard when communicating with staff and patients. https://www.england.nhs.uk/wp-content/uploads/2017/10/accessible-info-standard-overview-2017-18.pdf	☒	☐

Governance, ownership and approval

Please state here who has approved the actions and outcomes of the screening		
Name	**Job title**	**Date**
Jacqueline Myers	Director of Systems Oversight	July 2022
Presented to (Appropriate Committee)		**Publication Date**
ICB Board		July 2022

Publishing

This screening document will act as evidence that due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED) has been given.

NHS
North East &
North Cumbria

Corporate	ICBP015 Emergency Preparedness, Resilience and Response on call policy

Version Number	Date Issued	Review Date
1	July 2022	July 2024

Prepared By:	ICS EPRR Operational Delivery Manager
Consultation Process:	Relevant ICS workstreams and Task and Finish Groups.
Formally Approved:	July 2022
Approved By:	ICB Board

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ACCESSIBLE INFORMATION STANDARDS

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Version Control

Version	Release Date	Author	Update comments
1	July 2022	ICS EPRR Operational Delivery Manager	Initial draft of North East and North Cumbria Integrated Care Board On-Call Policy

Approval

Role	Name	Date
Approval	ICB Board	July 2022

Contents

1. Introduction

The purpose of this policy sets out the arrangements for individuals on-call for North East and North Cumbria Integrated Care Board (NENC ICB). It confirms the competencies and minimum standards expected of NENC ICB on-call staff, in line with the requirements of the following legislation and statutory duties:

- Civil Contingencies Act 2004
- Health and Care Act 2022
- NHS England Emergency Preparedness Resilience and Response Core Standards
- NHS Command and Control Framework

2. Purpose

As a Category 1 responder under the Civil Contingencies Act 2004, it is essential that NENC ICB maintains the ability to provide leadership of the NHS at both a strategic and tactical level and effect a response to an incident or emergency as required, both in and out of hours.

NENC ICB is responsible for leading the mobilisation of the NHS in the event of an incident or emergency in the North East and North Cumbria. In addition, the ICB is responsible for ensuring that it has the capability for NHS command, control, communication and co-ordination of commissioners and providers of NHS funded care, during incidents, emergencies, or periods of significant operational challenge. This is achieved via a two-tier on-call system, consisting of a first and second on-call.

NENC ICB works in partnership with other agencies within North East and North Cumbria Health and Care Partnership and North East Local Resilience Forums: Northumbria, Cleveland, and County Durham and Darlington and the on-call system provides a single point of access for these partners.

3. Roles, Responsibilities & Competencies

First on-call (Tactical Commander) will be contacted first as part of on-call notification or escalation processes and decides upon any initial actions that may be required. This aligns with the National Occupational Standards (NOS) for Tactical Commanders, sometimes referred to as Silver command.

The second on-call (Strategic Commander) role is held by an Executive Director and aligns with the NOS for Strategic Commanders, sometimes referred to as Gold command. The second on-call should only be contacted by the first on-call for matters which require further action and/or authorisation or for information. The second on-call should not routinely be contacted directly by other parties, except by second on-call peers in other systems or unless a Strategic Coordinating Group (SCG) has been convened.

All on-call staff should have the necessary skills commensurate with their function. The key skills should be matched to the National Occupational Standards for Civil Contingencies and additional skills e.g., Incident Coordination Centre (ICC) operating procedures should be acquired through both internal and external training and exercising.

Whilst the frequency that staff undertake on-call activities is dependent on the number and skill level of staff available, rotas need to strike a balance between not being overly demanding and activities being undertaken sufficiently regularly to maintain the skills of the individuals.

To prevent deterioration in competency levels staff should ensure they maintain these key skills through training which must then form part of their annual personal development review (PDR). Staff on-call are responsible for ensuring they can meet minimum competency standards and that they highlight any requirements for training and/or exercising to their line manager. This is also assessed for the purposes of the annual EPRR assurance process.

On-call activities can, on occasion, be challenging. Those undertaking such duties must understand the on-call commitment and attend any necessary training, exercising and incident review processes to ensure both the currency of their knowledge and their competence to carry out their assigned role.

On-call responsibilities apply both in and out of office hours. In some cases, there may be a point in which it is appropriate to formally hand over the management of an incident or emergency to another more appropriate manager or director. However, the responsibility remains a 24-hour activity.

Staff undertaking on-call responsibilities must ensure that they remain fit for work for the duration of their on-call period. They must ensure that they are not under the influence of alcohol, medication or other substance that may impair their ability to make decisions or manage an incident or emergency.

Some incidents or emergencies may require staffing for prolonged periods. During these times it is imperative that all managers and staff follow NENC ICB Health and Safety policy & Corporate procedures to ensure that the health, safety and welfare of staff remains a key focal point throughout the response. As part of the incident response a duty rota and cover arrangements will be implemented to relieve on-call staff to support their wellbeing and to ensure continued effective decision making.

4. System and Partnership Working

Other ICS member organisations which are Category 1 responders (NHS provider organisations and Councils) have their own robust and effective on-call capacity and capability to manage incidents which affect them directly. The ICB will work in partnership with these organisations to respond to incidents in their place.

Where appropriate, NHS provider organisations will escalate issues to NENC ICB for support and leadership across a place or across North East and North Cumbria. Similarly, NENC ICB will escalate issues which require support from NHS England.
NENC ICB provides the single point of contact for local partners in North East and North Cumbria who may wish to contact the NHS to advise of an incident, emergency or formally declared major incident that requires a multi-agency response.

5. On-Call Roles

a. Role of First on-call (Tactical Commander)

The first on-call is designated to act as the gateway to NENC ICB both in and out of hours and provide an initial risk assessment to the issues as they present. Staff operating on this rota should be at senior manager level with experience of the NHS. These individuals must be prepared to undergo ongoing training and exercising. They should be able to demonstrate a level and competency to make dynamic assessments of operational issues, and act with authority and credibility as a representative of NHS England.

Staff operating on the first on-call rota are commonly Agenda for Change (AFC) Bands 8 – 9. Irrespective of the AFC banding, the first on-call should be empowered to undertake the most appropriate action on the initial information received. These actions commonly fall into three broad categories:

- **Note the information**: Establish any need to continue to receive further information and updates but defer any action until the situation escalates or is resolved.
- **Recognition that the occurrence requires further action,**

management, intervention, or support: These can be safely managed through the provision of advice, guidance, signposting or facilitating a resolution between appropriate agencies. This generally does not require the actions of the second on-call; however, details may be shared for information.

- **The occurrence is of such magnitude, complexity, or reputational risk that second on-call level involvement is required**.

When the first on-call has identified issues that are for NENC ICB to deal with and are of such complexity or risk to reputation that they require involvement of more senior staff, these will be escalated to the Second on-call. Where appropriate they will also be escalated to the NHS Regional Team for information.

In the event of a declared major incident, the first on-call will take up the role of the ICB's Tactical Commander and enact its Incident response plan and immediately alert the second on-call.

b. Role of Second on-call (Strategic Commander)

The second on-call is designated to provide senior level decision making and leadership when required. Staff operating on the Second on-call rota are traditionally at Very Senior Manager (VSM) or AFC Band 9 level.

In the event of a declared major incident, the second on-call will take up the role of Strategic Commander and implement their Incident Response Plan and must be prepared to represent the NHS at any strategic coordination groups (SCG) that are established. It is expected that the second on-call will become the NHS Strategic Command representative at these meetings.

For incidents defined as levels 1 or 2 in the NHS EPRR framework the ICB will provide the strategic leadership for the NHS response, supported by the NHS England North East and Yorkshire (NEY) Regional team. For incidents defined as levels 3 or 4 the NEY Region team will provide the strategic leadership, supported by the ICB strategic commander.

As part of this role the second on-call is required to establish and maintain an excellent understanding of the roles and responsibilities of all responding organisations in the event of an incident or emergency.

Staff on the second on-call rota are likely to have the relevant understanding and skills required to fulfil this function as part of their substantive role. However significant issues and incidents are likely to place staff under periods of high pressure, where the situation can change very quickly and decisions are based on limited, and sometimes imperfect, information. As such it is important that all staff engaged on such rotas are fully committed to ongoing training and development to maintain their effectiveness and experience.

c. Subject Matter Experts

There may be occasions when the nature of an incident or emergency requires specialised input from a Subject Matter Expert (SME). Internally such advice could be sought from:

- EPRR team, as owners of the Incident Response and Incident Coordination Centre Plans
- Administrative staff (to support an Incident Coordination Centre (ICC))
- Finance
- Human Resources
- Clinical and Professional
- Primary Care Commissioning
- Legal
- Business Continuity
- Communications

Certain teams such as EPRR and Communications, may decide a separate formal on-call rota be established. It is unlikely that other specific functions will need to be on-call. However, a system will be in place for use *in-extremis* and incident documentation will reflect how this additional support can be accessed.

Outside of NENC ICB SMEs are available from a number of other sources including but not limited to:

- NHS England
- Emergency Services
- UK Health Security Agency
- Local Authorities
- NENC Local Resilience Forums

Each of these agencies will have their own on-call systems in place. An on-call pack will be maintained and made available to NENC ICB on-call staff, including information on how these services can be accessed.

6. Protocols for Escalation

A wide range of possible incidents or emergencies could occur within the NHS and wider communities. There are occasions that require the escalation of an incident or emergencies to other levels of the NHS for information or for action. Messages should follow the following format and be clear if the message is for:

INFORMATION:	No action required, but information needs to be shared.
ALERT:	No immediate action required; however, information is important, and the situation may develop

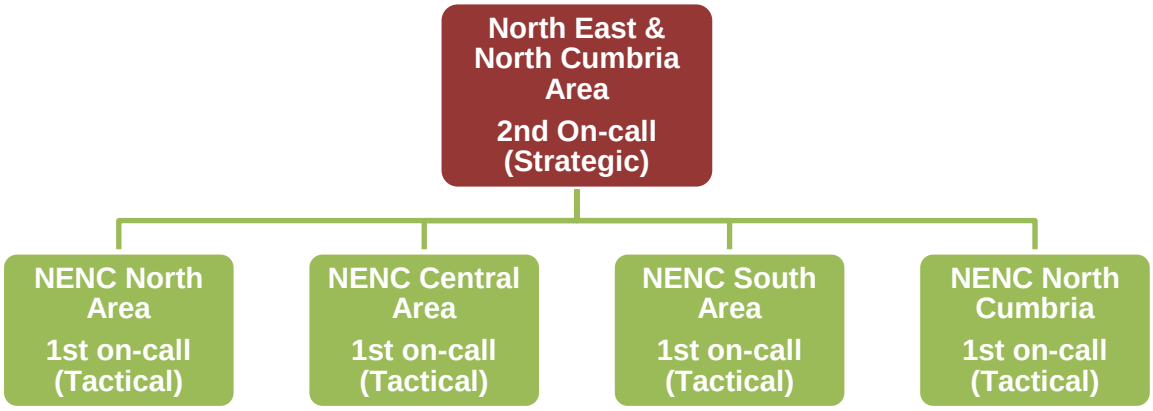
FOR ACTION:	Action necessary, an incident has occurred, or a request has been made that requires a response
FOR EXERCISE:	This is part of an exercise however it requires a response

7. On-call Rota

a. Structure

The on-call rota for NENC ICB will consist of:

- One first on-call (Tactical) in each of the four ICB place teams, and
- One second on-call (Strategic) for the whole of North East & Cumbria



The first on-call rota in each place will consist of around 10 staff who are VSM or AfC bands 8-9, drawn from the ICB place team (or members of the ICB central team). Participation in the First on-call rota will be voluntary, and subject to the remuneration and support outlined in Annex 1.

The second on-call rota for North East and North Cumbria will consist of all Executive Directors of the ICB and those place leaders who do not have a dual role with another partner body. (Place leaders with a dual role can opt to be a member of the ICB rota or their partner body rota).

b. On-call Arrangements and How They Operate

The Accountable Emergency Officer will ensure that there is a named post responsible for the administration of the on-call rota. The rotas should be produced at least one month before the start of the quarter to which they relate. Any staff member who cannot be on-call for any week allocated to them should swap that week with an appropriately trained colleague. It is the individual's responsibility to ensure that they make any arrangements to swap days/weeks, that the rota is updated accordingly, and that relevant colleagues and partners informed.

If a staff member falls sick or is unable to fulfil their responsibilities whilst on-call for any other emergency reason, they (or their office support) should first try to find their own replacement before contacting the other member of staff on-call who should then take responsibility to seek a swap/find cover with other colleagues.

Personal Development Reviews (PDRs) for on-call staff should include competencies relating to their on-call activities as well as their substantive role.

Processes will be put in place to ensure that those administering the rota, providing training for competencies etc. are notified in a timely manner of:

- Any new member of staff who would be required to join the on-call rota
- Any departing member of staff who was on the on-call rota
- Any staff member who is increasing or decreasing their working hours

The rota will be stored in a central folder/area. All members of staff on the on-call rotas should ensure that they are available / contactable for the whole time they are on-call and avoid geographical areas where there is no mobile phone coverage (or make alternative arrangements to maintain cover).

Individuals are normally on-call for a set amount of time. This will typically be for a period of one week, starting on Monday at 09:00hrs. At popular holiday times, particularly Christmas, shorter periods of on-call may be arranged.

On-call staff contacted are expected to respond within 15 minutes of the initial alert. It is expected that those on-call will initiate any responding actions and alert notification cascades immediately on receipt on an emergency alert.

In the event that a physical ICC needs to be established, if circumstances such as travel disruption mean that those on-call are unable to attend in person then, in consultation with colleagues, they should contact a colleague who is also on their rota and arrange for them to take over the management of the response on their behalf.

c. Documentation, Accessibility & Information Technology

NENC ICB will ensure that on-call staff have the appropriate equipment to be contacted while out of the office; this could include a range of mobile devices including pagers, smartphones, tablets, laptops etc. Staff leaving their on-call responsibilities must return all equipment and documents that have been given to them for this purpose.

Information for on-call teams will be kept in a central folder/area with appropriate access restrictions placed upon it. All those on-call should be able to access this folder in and out of usual business hours. The access and folder will be managed by a named post.

The ICB on-call resource pack will hold key information including contact lists, current policies e.g., Demand Management Policies, and operating procedures such as the Incident Response Plan, the ICC Standard Operating Procedure and alerting protocols.

The on-call pack will also include an incident/event notification log, a decision log, a communications record (phone calls made and received, text and e-mail messages) and a briefing template that records key facts which form the basis for decision making i.e., escalation to the next level of readiness or response.

It is incumbent on on-call staff to ensure that they maintain access to the latest copies of these documents, whether electronic or in hard copy, and that this is maintained at all times. Staff should be cognisant of the security markings of documents and manage them in line with NENC ICB Document and Records Management Policy and the Cabinet Office Government Security Classifications document. This approach extends to the management and handling of on-call rotas and contact lists that hold personal information.

NENC ICB works in partnership with other agencies within North East and North Cumbria Local Health and Care Partnership and North East and North Cumbria Local Resilience Forums must be advised of the detail of the single point of access to on-call staff and be kept updated if there are any changes to these arrangements.

d. On-call Handover/Briefing

Those on-call should proactively arrange handover of on-call duties using the following procedure:

- Outgoing on-call health commander – at changeover – contact the next on-call health commander to report any incidents from the previous period that may need further action, and to confirm any other handover processes

- Following an actual incident, the outgoing on-call team should ensure they remain contactable for a period of 1 hour to address any handover queries that may arise

- In the event the on-call team is required to take a command role in an incident, those individuals should undergo a ‘hot’ de-brief prior to going off duty to ensure that any lessons or issues can be captured and to ensure wellbeing support is considered

8. Record Keeping

Those on-call must keep a log of each time they are contacted or make contact in relation to their on-call activities. A new log must be started for each staff member on-call so that it is clear who is writing the log and what on-call position they hold.

Decisions must be recorded in a way that makes them auditable. Individual decision makers must be identified and accountable for decisions they make. Wherever possible the rationale supporting the decision should be recorded along with the decision itself. All decisions should be proportionate, necessary, and legal.

The purpose of completing a log/record of on-call events is:

- to support staff in keeping a record of actions taken, conversations and decisions so that they can refer back during an ongoing incident

- to protect staff and the decisions that they make when they are on-call. In an inquest or court of law, if it is not written down there is no evidence that any event or decision took place

- to provide a learning tool for all on-call staff, so that others can learn from the situations faced and the decisions taken in response to them

A central repository of completed logs will be maintained, to aid learning and in case it needs to be referenced in the future.

9. Training

a. Overview

Suitable training will be given to any member of staff who is expected to undertake on-call activities, to enable them to be confident in what is expected of them.

Before commencing on-call activities, staff should have undertaken mandatory training required for their role, and also training which familiarises staff with the specific arrangements for their own team, including:

- Expectations of all on-call staff (including the principles outlined in this guidance)
- Familiarisation with response plans including any specific plans, such as pandemic influenza, business continuity, pressure and escalation etc. This should include a particular focus on key elements such as action cards, incident reporting forms and logs, escalation arrangements and contact details
- Familiarisation of local EPRR arrangements, geographies, key risks outlined on the Community Risk Register(s),
- Familiarisation of terminology and structures, especially Strategic Co-ordination Group (SCG) arrangements in multi-agency response to major incidents
- Access, purpose and use of all documentation and resources provided to on-call staff
- Principles of setting up and running a local Incident Coordination Centre.
- How to maintain personal logs during an incident, along with working with a dedicated Loggist (especially for First and Second on-call managers)

It should be noted that other senior leaders at an SCG or other formal multi-agency response setting will have undertaken a wide range of courses and exercises as part of their response role, so it is expected that on-call staff should work with their EPRR staff to ensure that they undertake as wide a range of further training as possible. EPRR staff will be able to advise further depending on staff requirements, particular local risks, and training resources which may be available through local resilience partnerships.

b. Formal Training (Mandatory & Supplemental)

First and second on-call staff need to receive formal training in Principles in Health Command (PHC). This will include the dynamic risk assessment process which will need to be applied in any incident scenario, to ensure they have the skills and knowledge to undertake this role effectively, as well as ensuring that the appropriate competencies of its on-call staff are developed and maintained in line with the Civil Contingencies Act 2004 and mandatory elements of the National Occupational Standards (NOS (Skills for Justice)) for responding to emergencies.

Formal training must also be undertaken in the legal implications of incidents afterwards if public inquiries are held, and the importance of effective record-keeping and management. This training is mandatory for Second on-call staff.

Formal training is further required to understand the media implications of incidents and prepare Second on-call staff for fronting media interviews. This is mandatory for Second on-call staff.

All ICB Executives will undergo legal CPD training in relation to on-call competencies in alignment with the NHS England and NHS Improvement Contract Standards. This is mandatory for ICB Executives.

In the event of a protracted or different incident arising which requires new, specialised response plans to be put in place, all on-call staff must ensure they complete any dedicated training which may be put in place for these events.

Staff undertaking such training as outlined above should include this in their Personal Development Review and subsequent plan, and also include it in their job description if possible.

Individuals who have undertaken their formal training will be required to undertake an ongoing programme of Continual Professional Development (CPD) which is logged and evidenced within a Professional Development Portfolio (PDP) as outlined in the minimum occupational standards and national EPRR Framework.

10. Exercising

As emergencies by their very nature are unpredictable, the best way to regularly evaluate the effectiveness of response plans and the competence of staff using those plans, is to take part in regular exercises.

NHS organisations are required to undertake communications tests every six months, desktop exercises annually, and a live exercise once every three years.

To ensure all on-call staff continue to meet competencies, remain up to date on their local response arrangements, and also meet external compliance requirements, on-call staff should be involved in at least one exercise annually. This should be formally recorded in a PDP and a formal debriefing undertaken.

It is recommended that all on-call staff take part in both internal exercises wherever possible. NENC ICB share the NE LRF exercise programme with colleagues and identify suitable exercises for this purpose.

Taking part in an incident response also fulfils some of the requirements of exercising.

Communications exercises are conducted regularly as part of the maintenance and management of the on-call arrangements. Staff on-call are expected to respond should they be contacted for these purposes.

11. Records of Training & Exercising

On-call staff must keep an annual record of all training and exercising undertaken, as part of a PDP, to ensure they achieve and maintain the required competencies. They should keep their EPRR lead updated on such activities.

12. Debriefing & Lessons Learned

An essential part of planning for, and responding to, incidents and emergencies is reviewing the response and ensuring all important information is captured.

A formal process will be in place within the ICB to ensure that formal debriefing processes are undertaken after any response to an exercise, test or incident, so that lessons can be learned, and plans revised as required.

Debriefing will also help to identify any training needs which may need addressing, either at an individual level or a new element for which training needs to be provided.

Annex 1: Remuneration and Support

On-Call Remuneration and Support

Terms and conditions for remuneration for staff undertaking on-call activities are governed by Agenda for Change (AFC) and the VSM contract as appropriate.

AFC conditions are set out in the NHS Terms and Conditions of Service Handbook4 - this is subject to national review periodically, which may result in changes to the clauses below.

This annex seeks to place all the relevant aspects of the above documents into one place for ease of reference for staff undertaking on-call activities.

Pay enhancements for AFC staff undertaking on-call responsibilities

Staff that are required to be available to provide on-call cover outside their normal working hours are entitled to receive a pay enhancement. This includes staff in AFC pay bands up to and including band 9. This enhancement recognises both the availability to provide cover and any advice given by telephone during periods of on-call availability. This enhancement is based on the proportion of on-call periods in the rota when on-call cover is required: For current guidance on pay enhancements see the NHS Employers website (see Appendix C).

Annual leave

Staff required to work or to be on-call on a general public holiday are entitled to equivalent time to be taken off in lieu at plain time rates, in addition to the appropriate enhancements for staff undertaking on-call responsibilities.

Employees called into work during an on-call period

Employees who are called into work during a period of on-call will receive payment for the period they are required to attend, including any travel time. Alternatively, staff may choose to take time off in lieu. However, if for operational reasons time off in lieu cannot be taken within three months, the hours worked must be paid for.

For work (including travel time) as a result of being called out the employee will receive a payment at time and a half, with the exception of work on general public holidays which will be at double time. Time off in lieu should be at plain time. There is no disqualification from this payment for bands 8 and 9, as a result of being called out8.

Activity generated though on-call activities out of working hours can be claimed for if it is equivalent to an hour or more. Therefore, if activities

such as participating in teleconferences or preparing situation reports over a weekend period that equates to an hour or more can be claimed. Claims can then be made for each hour after in hourly timeframes and applies to bands 8 and 9.

Overtime payments

Staff that are not formally on-call nor scheduled to be on-call during an incident or emergency but are requested to provide additional support to the on-call team out of working hours, are entitled to claim overtime payments.

Staff in pay bands 1 to 7 that work additional to their contracted hours in support of on-call activities, whether in or outside the office location are eligible for overtime payments. There is a single harmonised rate of time-and–a-half for all overtime, with the exception of work on general public holidays, which will be paid at double time.

Senior staff paid in pay bands 8 or 9 will not be entitled to overtime payments however they are entitled to claim back time off in lieu of activity at plain time rates.

Activity generated though support to on-call staff beyond normal working hours can be claimed for if it is equivalent to an hour or more. Therefore, if activities such as participating in teleconferences or preparing situation reports over a weekend period equates to an hour or more then the relevant hours of activity can be claimed. Claims can then be made for each hour after in hourly timeframes.

Very Senior Managers (VSM) undertaking on-call responsibilities

VSM terms and conditions regarding hours of work outline that the standard working week is 37.5 hours over five days. Given the seniority of VSM roles, however, VSM staff are expected to work such hours as necessary – this includes participation in a senior managers' on-call rota.

Whilst the contract position notes VSM postholders will not be entitled to remuneration for being on-call, as with any staff engaged with on-call activities consideration should still be given to the hours VSMs may have worked on top of normal working hours. This should ensure that staff of all levels adhere to the Working Time Regulations.

Maximum working hours of staff responding to an incident or emergency

The Working Time Regulations determine maximum periods that staff can be required to work; this applies both in normal business and in the event of staffing an ICC out of hours – and must be borne in mind for all staffing arrangements and rotas to ensure staff do not work longer than these periods and become exhausted.

In essence, this means:

- a limit (over a reference period of several months) of an average 48 hours a week on the hours a worker can be required to work, though individuals may choose to work longer by "opting out"
- 5.6 weeks paid leave a year
- 11 consecutive hours' rest in any 24-hour period
- a 20-minute rest break if the working day is longer than six hours
- one day off each week.

Appendix 1

Equality Impact Assessment
Initial Screening Assessment (STEP 1)

As a public body organisation, we need to ensure that all our current and proposed strategies, policies, services and functions, have given proper consideration to equality, diversity and inclusion, do not aid barriers to access or generate discrimination against any protected groups under the Equality Act 2010 (Age, Disability, Gender Reassignment, Pregnancy and Maternity, Race, Religion/Belief, Sex, Sexual Orientation, Marriage and Civil Partnership).

This screening determines relevance for all new and revised strategies, policies, projects, service reviews and functions.

Completed at the earliest opportunity it will help to determine:

- The relevance of proposals and decisions to equality, diversity, cohesion and integration.
- Whether or not equality and diversity is being/has already been considered for due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED).
- Whether or not it is necessary to carry out a full Equality Impact Assessment.

Name(s) and role(s) of person completing this assessment:

Name: Marc Hopkinson
Job Title: Associate Director
Organisation: Newcastle Gateshead CCG

Title of the service/project or policy: NENC ICB On Call Policy

Is this a;
Strategy / Policy ☒Service Review ☐ Project ☐
Other Click here to enter text.

What are the aim(s) and objectives of the service, project or policy:
The aim of the policy is to ensure that there are adequate arrangements in place to provide an on-call arrangement covering time outside normal rostered duties and if necessary to attend or work remotely outside normal working hours to help manage any incident.

Who will the project/service /policy / decision impact?
(Consider the actual and potential impact)

- **Staff ☒**
- **Service User / Patients ☐**
- **Other Public Sector Organisations☐**
- **Voluntary / Community groups / Trade Unions ☐**
- **Others, please specify** Click here to enter text.

Questions	Yes	No
Could there be an existing or potential negative impact on any of the protected characteristic groups?	☐	☒
Has there been or likely to be any staff/patient/public concerns?	☐	☒
Could this piece of work affect how our services, commissioning or procurement activities are organised, provided, located and by whom?	☐	☒
Could this piece of work affect the workforce or employment practices?	☐	☒
Does the piece of work involve or have a negative impact on: • Eliminating unlawful discrimination, victimisation and harassment • Advancing quality of opportunity • Fostering good relations between protected and non-protected groups in either the workforce or community	☐	☒

If you have answered no to the above and conclude that there will not be a detrimental impact on any equality group caused by the proposed policy/project/service change, please state how you have reached that conclusion below:

There is no significant/material impact or change to the working practices of staff who would support the on call rota.

If you have answered yes to any of the above, please now complete the 'STEP 2 Equality Impact Assessment' document

Accessible Information Standard	Yes	No
Please acknowledge you have considered the requirements of the Accessible Information Standard when communicating with staff and patients. https://www.england.nhs.uk/wp-content/uploads/2017/10/accessible-info-standard-overview-2017-18.pdf	☒	☐

Governance, ownership and approval

Please state here who has approved the actions and outcomes of the screening		
Name	**Job title**	**Date**
Jacqueline Myers	Executive Director of System Oversight	June 2022

Presented to (Appropriate Committee)	**Publication Date**
ICB Board	July 2022

Publishing

This screening document will act as evidence that due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED) has been given.