Sheffield Teaching Hospitals
NHS Foundation Trust

Executive Summary
Report to the Board of Directors
Being Held on 24 September 2024

Subject	Approval of Trust Controlled Documents
Supporting TEG Member	Sandi Carman, Assistant Chief Executive
Author	Judith Green, Head of Corporate Governance and Lucy Middleton, Business Manager
Status	To Approve

PURPOSE OF THE REPORT

Following approval by the Trust Executive Group on 11 September 2024, the Board of Directors is requested to approve the following:

- Trust Controlled Documents Policy
- Standards of Business Conduct Policy (including Declarations of Interest, Gifts, and Hospitality)

KEY POINTS

The Trust's Reservation of Powers to the Board and Delegation of Powers outlines a number of areas where the approval of the Foundation Trust's policies and procedures is reserved to the Board. These include the following policies:

- Trust Controlled Documents Policy
- Standards of Business Conduct Policy (including Declarations of Interest, Gifts, and Hospitality)

In line with Trust practice for all corporate policies to be reviewed at a minimum every three years, a review of each has been undertaken to identify the need for any changes to be made to align with latest guidance, legislation, policy or practice.

Changes to each policy, with corresponding rationale are outlined in the appended tables (Appendix A)

IMPLICATIONS

Aim of the STHFT Corporate Strategy		✓ **Tick as appropriate**
1	Deliver the Best Clinical Outcomes	✓
2	Provide Patient Centred Services	✓
3	Employ Caring and Cared for Staff	✓
4	Spend Public Money Wisely	✓
5	Create a Sustainable Organisation	✓
6	Deliver Excellent Research, Education and Innovation	✓

RECOMMENDATIONS

The Board of Directors is asked to **APPROVE** the revised versions of the Trust Controlled Documents Policy and the Standards of Business Conduct Policy.

APPROVAL PROCESS

Meeting	**Date**	**Approved Y/N**
Trust Executive Group	11/09/2024	Y
Board of Directors	24/09/2024	

Trust Controlled Documents Policy

1. Introduction

An important element of the Trust's governance framework is the provision of a robust mechanism for the development, approval, management and dissemination of policy and procedural documents to ensure achievement of the organisation's objectives and the promotion of its values.

Documents are 'controlled' when their development, any revisions to their content or their removal from circulation are subject to a defined approval process, and their revision status, approval body and date of approval is evident within the document.

Trust Controlled Documents include strategies, policies, terms of reference, procedures, protocols and guidelines providing direction to staff. These types of documents have been categorised by the Trust under the main classification headings of:

- policies,
- guidelines and protocols,
- procedural / guidance documents; and
- terms of reference.

Patient Information Leaflets (PILs) are also classed as 'controlled'. The standards and procedure that should be followed in the production, development and management of patient information in the Trust are outlined separately in the Patient Information Policy.

Where subsets of Trust Controlled Documents need to be governed within a defined legal framework, for example Patient Group Directions (PGD), the process for managing these are set out within associated Trust policies signposted from this policy.

2. Purpose

The purpose of this policy and its associated documents is to ensure that Sheffield Teaching Hospitals NHS Foundation Trust (the Trust) has in place policies, guidelines and procedural documents which are controlled and implemented appropriately.

It outlines a structured and systematic approach for the development, approval, management and dissemination of Trust Controlled Documents which ensures that such documents are:

(i) consistently delivered to a high standard and in accordance with statutory and mandatory requirements

(ii) version controlled and previous versions removed from circulation with a copy archived for reference / legal reasons

(iii) written clearly and succinctly, using plain language appropriate to the intended audience

(iv) easily accessible to all staff and published in accordance with the Trust's Freedom of Information Act Publication Scheme

(v) implemented effectively by ensuring adequate awareness and providing appropriate training and support

(vi) assessed for training needs, resource implications and equality / human rights impact

(vii) systematically reviewed and revised regularly, responding to changes in legislation, standards and good practice; and compliant with Information Governance requirements.

3. Scope and exceptions

This policy applies to:

Setting	Trust-wide
Individuals	All staff
Speciality	All

4. Policy details

This section describes the overarching framework for the development and management of Trust Controlled Documents.

Detailed instructions for the practical application of this structured and systematic approach are provided in the following standard operating procedures; Development of a New Controlled Document and Review of a Controlled Document. Templates are available for different types of Controlled Documents including policies, guidelines, procedural documents, Standard Operating Procedures and terms of reference documents.

In general, Trust Controlled Documents have a Trust-wide application. Documents that do not have a Trust-wide application shall be managed locally by the relevant department, directorate, care group or staff group.

Arrangements for the development, approval, management and dissemination of such locally managed documents should follow the good practice principles outlined in this policy and associated standard operating procedures. Locally managed documents do not require ratification by TEG or the Board of Directors but should follow a local approval process and only be accessible from a controlled document library.

These procedures and templates may be amended from time to time by authority of the Assistant Chief Executive, provided that such amendments are compliant with this framework.

4.1 Principles

The development and management of Trust Controlled Documents must adhere to the following principles:

4.1.1 Decision to develop a Trust Controlled Document / Concept approval

Controlled Document Sponsor

All Trust Controlled Documents must have a Sponsor as defined within Section 5 of this framework. For corporate policies this must be a member of the Trust Executive Group (TEG).

Responsibilities of the Controlled Document Sponsor are outlined in section 5 of this framework and include the responsibility of approving the development of the Trust Controlled Document.

4.1.2 Developing a draft Trust Controlled Document

Controlled Document Lead

This is the identified lead professional, nominated by the Controlled Document Sponsor, responsible for the development and review of the Trust Controlled Document. Details of the responsibilities of the Controlled Document Lead are set out in Section 5 of this framework.

In some cases, the drafting of a Trust Controlled Document may be assigned to a nominated Author. In these cases, the Controlled Document Lead retains responsibility for ensuring that the development, review and management of the Trust Controlled Document is in accordance with this policy.

Stakeholder consultation

The Controlled Document Lead should identify all relevant stakeholders who should be involved in the development or consultation phases of the document.

Persons and groups consulted with during the development or review of a Trust Controlled Document must be listed in the *Groups / Persons Consulted* section of the template document.

As appropriate, patients and the public may be involved in the development or consultation phases. If a decision is made to involve patients or the public, please contact the Deputy Head of Quality Governance for further advice and support.

Style and format

Trust Controlled Documents should be written in a style which is concise and clear using unambiguous terms and language. All abbreviations should be written in full in the first instance of use, followed by the abbreviation in brackets.

To ensure compliance with NHS England guidance on implementation of the Accessible Information Standard all policies, procedural documents, clinical guidelines/protocols and terms of reference must be developed using the most recently approved relevant template. The formatting of the template must not be amended. When reviewing and updating a Trust Controlled Document, a check should be made as to whether a more recent template is available.

Templates are available for standingard operating procedures/, and guidance documents, but their use is not prescribed.

All Trust Controlled Documents must have a footer ~~on all pages which includes the document title, version number and~~ with page number of total page count.

Data Protection Legislation 2018

If a Trust Controlled Document contains information relating to the handling of or entries into health or corporate records (usually patient confidential data), then consideration must be given to the UK Data Protection Act 2018 (DPA18) and the EU General Data Protection Regulation (GDPR) and its application within the document.

Further guidance on DPA18 and the GDPR is available from the Trust's Data Protection Officer. See also information on the Information Governance intranet site.

Equality Impact Assessment

All ~~Controlled~~ corporate policies ~~and clinical guidelines~~ must be equality impact assessed before they are submitted to the relevant approval body.

As a public body, the Trust has a legal responsibility under the Human Rights Act not to breach human rights. Controlled Document Leads must consider if a Trust Controlled Document has the potential to impact on human rights. Further guidance on human rights is available on the Equality, Diversity and Inclusion (EDI) Intranet pages.

Similarly, the Trust has a legal responsibility under the 2010 Equality Act to comply with the Public Sector Equality Duty which requires the Trust to have *due regard* to:

- eliminate discrimination, harassment and victimisation
- advance equality of opportunity between people who share a relevant protected characteristic (Age, Race, Religion and belief, Disability, Sex, Gender Reassignment, Sexual Orientation, Pregnancy ~~&~~ and Maternity, Marriage ~~&~~ and Civil Partnership) and people who do not
- foster good relations between people who share a relevant protected characteristic and people who do not.

Having *due regard* means equality issues must be consciously considered in the process of decision-making by the Trust. This requirement is met through Equality Impact Analysis (EIA) which aims to identify and address real or potential inequalities and discrimination resulting from the development and implementation of Trust Controlled Documents and/or identify how equality can be promoted.

An EIA must be undertaken as part of the development of Trust Controlled Documents in accordance with the Guide to Rapid Equality Impact Assessment Process.

An EIA is a mandated section within ~~both~~ the ~~Controlled Document~~ corporate policy template ~~and guideline template~~ and must be completed. The Controlled Document Lead is responsible for the validity of any statement made. ~~Controlled Documents~~ Corporate

policies that do not have this section completed ~~may~~ will not be ratified.

Further guidance on the ~~R~~EIA process is available on the Equality, Diversity and Inclusion (EDI) Intranet pages and further advice sought from the EDI Department.

Other impacts

As part of the development of a ~~Controlled Document~~ corporate policy, consideration must be given to its impacts in terms of financial implications, sustainability implications and training implications.

It is the responsibility of the Controlled Document Lead to undertake a *Training Needs Outline* which considers the training required to implement the ~~Controlled Document~~ corporate policy.

This must be summarised in the *Training implications* section of the ~~Controlled Document~~ corporate policy template. It should highlight if the training has been approved by the Trust Executive Group (TEG) as mandatory training, the regularity of the training, implications for new employees and whether it affects all staff or specific staff groups only.

The need for additional resources (including training costs) to implement the ~~Controlled Document~~ corporate policy must be assessed and the *Financial implications* section of the template (within *Other impacts*) must be completed to confirm that:

(i) implementation is achievable within existing resources **or**
(ii) additional resources have been secured, (giving brief details).

4.1.3 Approval and ratification

Controlled Document Approval Body

The content of the Trust Controlled Document should be reviewed and approved by an expert group confirmed by the Controlled Document Sponsor. The responsibilities of the Controlled Document Approval Body, as outlined in section 5 of this policy, include ensuring that the development of the document complies with this framework.

All Controlled Documents must follow a ratification process. A summary of approval and ratification bodies is outlined on page 7.

All ~~Controlled Documents~~ corporate policies and controlled documents with a Trust-wide application~~, including all Trust policies~~, must follow the following ~~principals~~ principles:

- They must be sponsored by the appropriate Trust Executive Group (TEG) Director as noted in 4.1.1 above.
- The Approval Body as confirmed by the TEG Director Sponsor should review and approve the Controlled Document.
- ~~Trust~~ Corporate policies that have been approved by the designated Approval Body must be ratified by ~~the~~ ~~(~~TEG~~)~~, with the exception of those policies ~~specified~~ determined by the Assistant Chief Executive and recorded on the Board's workplan ~~in the Scheme of Reservation and Delegation~~ as requiring Board approval or Controlled Documents that TEG choose to escalate on an *ad hoc* basis to the Board for approval and ratification.

All other Controlled Documents must be approved, and where applicable, ratified by an appropriate body:

~~A summary of approval and ratification bodies is outlined in the table below:~~

Controlled Document classification	Approval body	Ratification body
Corporate Policies including framework documents, strategies and codes of conduct / practice	Expert group confirmed by the ~~relevant TEG Director in their capacity as~~ Controlled Document Sponsor	Trust Executive Group (TEG)
Local policies	Expert group confirmed by the Controlled Document Sponsor	N/A (the Controlled Document Sponsor should authorise the document for issue following approval by the relevant approval body).
Reserved corporate policies	TEG	Board of Directors
Guidelines and protocols Including clinical	Relevant professional forum or subject specialist(s)	Directorate Management Team or Directorate Governance

guidelines, **clinical protocols** and ~~**patient record forms**~~ **healthcare record forms***	confirmed by the Controlled Document Sponsor ** prior to developing or updating a healthcare record form, approval must be sought from the Connect24 programme team using this link.*	Group (or equivalent)
Procedural documents **Including standard operating procedures (SOPs) and procedural / guidance documents**	Relevant directorate / professional forum such as Directorate Management Team or Directorate Governance Group [or equivalent] confirmed by the Controlled Document Sponsor	• Where these support the implementation of a ~~Trust~~ Corporate Policy or have cross-directorate application ~~and included as an appendix~~, these should be ratified by a relevant oversight group or committee according to the subject matter ~~TEG ratification is required~~ • Local procedural documents – N/A (the Controlled Document Sponsor should authorise the document for issue following approval by the relevant approval body).
Terms of Reference (ToR)	The committee/group itself	The committee/group listed within the ToR as the '*accountable to*' group

Some documents are developed outside the Trust, for example national, regional or place-based guidelines/policies. In order to be adopted as Controlled Documents for implementation within the Trust they should be approved and ratified in accordance with this framework.

In these circumstances the *Document control* section of the template should still be completed in full, but the status will be changed to *adopted* and an *operational sponsor* will be identified in place of the Controlled Document Lead.

Full consideration should be given to how revisions to guidelines/policies developed externally are identified and disseminated within the Trust and the need to adopt a robust governance mechanism to ensure a full audit trail of changes.

In circumstances where a Controlled Document includes an appendix ~~which is 'controlled' or 'locally managed'~~ it is the responsibility of the Controlled Document Lead to ensure that the appendix is included in the ~~has been through the appropriate~~ approval process.

4.1.4 Dissemination

New and reissued Trust Controlled Documents are disseminated to staff via the Trust~~'s intranet site~~ Controlled Documents Library.

The Chief Executive's Office is responsible for maintaining access to Trust Controlled Documents on the ~~intranet site~~ Trust Controlled Documents Library and managing alerts to new and reissued Trust Controlled Documents.

~~It is the responsibility of the Controlled Document Lead to identify the target audience in the *Intended Recipients* section of the Controlled Document template.~~

~~Register / Library of~~ Trust Controlled Documents Library

The Chief Executive's Office will maintain ~~an up-to-date and controlled electronic~~ library of all Trust Controlled Documents ~~with a Trust-wide application and associated documentation, which.~~ This will be made accessible via the intranet site.

All new and updated Trust Controlled Documents are made available to staff electronically via the Trust's intranet site.

The Chief Executive's Office is responsible for publishing new and updated corporate policies and procedural documents / appendices associated with corporate policies on the intranet.

The Chief Executive's Office is also responsible for publishing terms of reference on the intranet.

The Software and Interface Team in the Informatics Directorate is responsible for publishing new and updated clinical guidelines on the intranet.

With the exception of corporate policies which are disseminated centrally, it is the responsibility of the Controlled Document Lead to identify the target audience in the *Intended Recipients* section of the Controlled Document template and to liaise with those identified to disseminate the new / revised documents.

The Chief Executive's Office liaises with the Communications Team to disseminate new and materially revised policies to all staff via a regular 'New and Updated Policies' email bulletin.

4.1.5 Review

Formal review

With the exception of Terms of Reference which require annual review, Trust Controlled Documents must be reviewed as a minimum every three years to ascertain whether they:

- are still required
- remain accurate
- continue to comply with the appropriate template
- align with latest guidance, legislation, policy or practice
- comply with any associated Trust Controlled Documents

Trust Controlled Documents should be reviewed immediately; irrespective of the review date, in response to:

- a recommendation following a Serious Incident or other governance findings
- changes in partnership working
- changes in legislation or national guidance

Minor revisions

It is sometimes necessary to make minor revisions to corporate policies outside the approved review dates (for example, to update changed organisational arrangements, job titles, etc., or to correct spelling mistakes). All requests to revise policies outside the approved review dates should be forwarded to the ~~Business Manager, Board of Directors~~ Patient and Staff Information Team for consideration by the Assistant Chief Executive.

If the suggested revision is not considered material, the Assistant Chief Executive is authorised to approve the revision on behalf of TEG / the Board of Directors without recourse to the standard Approval and ratification processes.

Minor amends to other types of Trust Controlled Documents should ~~be undertaken according to~~ follow the same procedure as ~~for~~ developing new Trust Controlled Document~~s~~ ~~development~~.

Urgent material amends

Under exceptional circumstances such as safety alerts about drugs or equipment, the Chair of the approval body can authorise an amendment to the Trust Controlled Document ~~through a Chair's action~~ to allow the updated version to be circulated immediately (through a Chair's action).

The Chair should notify the approval body of this by email at the time. This should be retrospectively reported at the next meeting of the approval body and recorded in the minutes. If this is a Trust Controlled Document that requires TEG / Board of Directors ratification the usual governance process should then be followed to secure ratification.

Trust Controlled Documents past their review date

Existing Trust Controlled Documents will remain in force until updated on the intranet or withdrawn, **even if the review date has been passed.**

Obsolete documents

If the Controlled Document Lead undertaking the review concludes that a Trust Controlled Document is obsolete (for example, in response to changes in legislation, service provision, etc) they may request that the Trust Controlled Document be removed from view from the ~~electronic library of Trust~~ Controlled Documents Library.

This decision must be approved by the Controlled Document Approval Body. In the case of corporate policies, the Assistant Chief Executive is authorised to approve this on behalf of TEG / the Board of Directors but may seek the wider view of TEG members as appropriate. The Controlled Document Lead is responsible for informing ~~*Controlled Document Support*~~ the Patient and Staff Information Team who will arrange for its archiving.

Archiving

Superseded and obsolete Trust-~~wide~~ Controlled Documents are retained and managed ~~electronically~~ on the Trust Controlled Documents Library by ~~*Controlled Document Support*~~ the Patient and Staff Information Team and are available internally on request.

Process for managing external requests for archived Trust Controlled Documents

- External requests for copies of archived Trust Controlled Documents should be sent to the Patient and Staff Information Team, who will seek approval from the Assistant Chief Executive to release the requested archived document.

- Any external requests for archived Trust Controlled Documents under the terms of the Freedom of Information Act will be processed in accordance with the Trust's Freedom of Information Policy.

4.1.6 Monitoring compliance and effectiveness of Trust Controlled Documents

The Trust is committed to ensuring compliance with all Trust Controlled Documents and will actively monitor the effectiveness of such documents through routine audit practices as part of the internal audit programme and clinical audit plan.

Should it become evident, through the monitoring process, that the document is not being followed or that staff are unaware of its existence, the Controlled Document Sponsor is responsible for implementing appropriate measures to address the situation.

Monitoring arrangements and Key Performance Indicators (or standards) to demonstrate compliance and effectiveness **must** be detailed in the *Monitoring* section of the Controlled Document template.

5. Roles and responsibilities

Role	Responsibility
Assistant Chief Executive	TEG Sponsor for this policy document. Also has specific responsibility for approving minor amendments and determining the Controlled Document Sponsor arrangements for a particular Trust Controlled Document where there is any uncertainty.
Board of Directors	Responsible for all Trust Controlled Documents, (including this policy). ~~but~~ W~~w~~ith the exception of a number of corporate policies defined as *Reserved Corporate Policies*, the Board h~~H~~as delegated responsibility to the Trust Executive Group.
Controlled Document Approval Body	It is the responsibility of the Controlled Document Approval Body to: (i) confirm it is the most appropriate Approval Body in terms of resident expertise to properly challenge and scrutinise the Trust Controlled Document. (ii) review the content of the Trust Controlled Document as the expert group. (iii) ensure that the development of the document complies with this policy. (iv) approve the document / approve the document for ratification* or recommend the author(s) to undertake additional work. **In line with the summary of approval and ratification bodies outlined in section 4.1.3, documents requiring TEG ratification include corporate policies, procedural documents with a Trust-wide application and terms of reference where TEG is the 'accountable to' group.*
Controlled Document Author	In many cases this will be the same individual as the Controlled Document Lead. Where another individual is nominated to draft the content of the Trust Controlled Document the wider responsibilities of the Controlled Document Lead (below) are retained by the Controlled Document Lead.
Controlled Document Lead	The Controlled Document Lead is the identified lead professional, nominated by the Controlled Document Sponsor, responsible for the development and review of the

	Trust Controlled Document. It is the responsibility of the Controlled Document Lead to ensure that the document is developed in accordance with this policy. In doing so they must: (i) ensure that a new Trust Controlled Document is not duplicating other work, either locally or nationally (ii) secure any necessary outline support for developing a new Trust Controlled Document, including sponsorship by the appropriate Director, noting that for corporate policies this must be a TEG Director (iii) identify and confirm with the Controlled Document Sponsor the Approval Body (for corporate policies Controlled Document Leads should contact the ~~Business Manager, Board of Directors~~ Patient and Staff Information Team and/or the sponsoring TEG Director for guidance concerning an appropriate Approval Body) (iv) ensure a new Trust Controlled Document is consistent with corporate and relevant directorate strategies, service priorities and other existing Trust Controlled Documents (v) ensure that the Trust Controlled Document is up-to-date and fit for purpose and should consider the impact of changes in legislation, guidance and organisational structure since the document was developed or last reviewed. (vi) ensure that the Trust Controlled Document is in the correct and most recently issued template format. (vii) confirm that any 'controlled' or 'locally managed' appendices have been through the appropriate approval process. (viii) Develop an implementation plan (ix) confirm that implementation is achievable within existing resources or that enabling resources have been secured. (x) identify the target audience in the *Intended Recipients* section of the template document Control Pages. *Where drafting of a Trust Controlled Document is assigned to a nominated Author the Controlled Document Lead retains these responsibilities.*
Controlled Document Sponsor	The Controlled Document Sponsor is the identified Director, or person to whom such responsibilities have been

	delegated, who has responsibility for approving the development of the Trust Controlled Document. • Corporate policies: Development of any corporate policy must be approved by the member of TEG who heads the area of the Trust to which the corporate policy most relates • For clinical guidelines the Controlled Document Sponsor is the Clinical Director Where there is any uncertainty as to the identity of a Controlled Document Sponsor for a particular Trust Controlled Document, the Assistant Chief Executive shall determine the Controlled Document Sponsor.
Controlled Document Stakeholder	A stakeholder is anyone with an interest in a Trust Controlled Document and includes staff (at all levels), staff side organisations, governors, departments, directorates, committees, patients and the public, external stakeholders and/or people with specialist skills or knowledge such as the Local Counter Fraud Specialist. Stakeholders can contribute to or comment on the content of a document and may recommend additional stakeholders.
Line Managers	It is the responsibility of line managers to: (i) ensure that their staff are aware of and have access to Trust Controlled Documents that are relevant to their working environment. (ii) ensure staff have access to any training identified as necessary for effective implementation of the Trust Controlled Document. (iii) ensure that current and/or superseded or withdrawn Trust Controlled Documents stored as hard copy or on shared drives or websites within their areas are removed. Only under exceptional circumstances (e.g. when staff do not have access to the intranet) can hard copy Trust Controlled Documents be stored locally and in such circumstances the line manager is responsible for ensuring the hard copy Trust Controlled Documents are current.
Staff	It is the responsibility of staff (including contractors and agency staff) to be aware of and to comply with relevant Trust Controlled Documents. Please note: (i) information regarding the failure to comply with a Trust

	Controlled Document, for example because of lack of training or inadequate equipment, must be reported to the Line Manager and the incident reported according to the Incident Management Policy. (ii) failure to comply with relevant Trust Controlled Documents that are mandatory will be dealt with in accordance with the Trust Disciplinary Procedure.
~~**Controlled Document Support (CDS)**~~ **The Patient and Staff Information Team**	Responsible for: (i) providing advice and support on aspects of this policy (ii) administering the development and approval process in line with this policy (iii) completing or updating relevant information within the *Document control* section of the Controlled Document template prior to publication / issue of the Controlled Document ~~(iv) maintaining access to Trust Controlled Documents on the electronic library of Trust Controlled Documents.~~ (v) maintaining associated databases / content management systems in relation to Trust Controlled Documents (vi) maintaining an archive of superseded or withdrawn Trust Controlled Documentss (vii) monitoring and supporting the effective and timely review of Trust Controlled Documents (viii) liaising with the Communications Department to issue a regular ~~'What's New'~~ New and updated policies' email bulletin ~~listing of new and revised Trust Controlled Documents for Trust-wide e-mail circulation.~~
Trust Executive Group (TEG)	Responsible for ratifying all corporate policies ~~Controlled Documents that have been approved by the designated Approval Body as requiring TEG ratification*.~~ Where TEG reserve responsibility as the Approval Body itself, the Trust Controlled Document must be ratified by the Board of Directors. ~~** In line with the summary of approval and ratification bodies outlined in section 4.1.3, documents requiring TEG ratification include policies, procedural documents with a Trust-wide application and terms of reference where TEG is the 'accountable to' group.*~~

6. Monitoring

Standard, process or issue to be monitored	Monitoring method	Monitored by	Reported to	Frequency
All Trust Controlled Documents in date	KPI Report	CEO Office	TEG	Bi - monthly
Corporate policies in date	KPI Report	CEO Office	Audit Committee	Quarterly

7. Definitions

For more guidance on developing a Trust Controlled Document in line with the defined classifications outlined below please refer to the following standard operating procedures, Development of a New Controlled Document and Review of a Controlled Document.

Term	Description
Clinical protocol	A detailed plan of clinical practice prescribing exactly what must be done and documented in a specific situation. It provides an agreed approach and / or description of roles and responsibilities. It may apply only to particular divisions or be applicable Trust-wide. **Clinical protocols do not allow deviation from the agreed practice.**
Controlled document	Documents which provide a framework for safe, effective and acceptable practice. Documents are 'controlled' when their development, any revisions to their content or their removal from circulation are subject to a defined approval process, and their revision status, approval body and date of approval is evident within the document. Controlled Documents include strategies, policies, procedures, protocols and guidelines which aim to provide direction to staff.
Trust Controlled Document	*In general, Trust Controlled Documents have a Trust-wide application.*
Locally Controlled Document	*Controlled documents that do not have a Trust-wide application shall be managed locally by the relevant department, directorate, care group or staff group.*

Code of conduct or practice	Describe desired staff behaviour in a specific context. For the purposes of this Policy, a code of conduct/practice is considered a policy document (see Policy definition).
Framework document	A number of the Trust's policies are designated as Frameworks. These set out a structured and systematic approach to a specific area of practice, outline roles and responsibilities and standards of delivery and are underpinned by detailed procedural guidance documents. For the purposes of this Policy, a framework is considered a policy document (see Policy definition).
Guideline (including Clinical Guideline)	Contain recommendations on the appropriate course of action. In the case of application to the treatment and care of patients with specific diseases and conditions, these are based on evidence-based recommendations they guide professionals and allow individuals to use their professional judgment and decision-making skills. **Guidelines are flexible and act as a support and guide, they are not prescriptive**. They do not include Patient group directions (see separate definition below).
Patient group direction (PGD)	A written instruction for the supply and / or administration of named medicines in an identified clinical situation. It applies to groups of patients who may not be individually identified before presenting for treatment. Separate governance arrangements are in place for these documents. (see Patient Group Directions Policy).
Patient record form / Healthcare record form	(Also referred to as a PRC or HRC, these are~~) is a~~ standardised template/forms used to record information relating to the physical or mental health or condition of an individual which has been made by or on behalf of a health professional in connection with the care of that individual, and is part of the patient record. The implementation of Connect24 requires all requests for new and updated templates/forms to be approved by the Trust.
Policy	A statement of intent and principles, explicitly stating

	individuals' responsibilities and accountabilities. It provides the basis for consistent decision making, actions and resource allocation. For the purposes of this Policy, Codes of conduct / practice are to be regarded as policies. **A policy is not open to interpretation or professional judgment and compliance is mandatory.**
Corporate policy	*A corporate policy may result from national policy or directives and provides a framework within which individuals or specific groups must work.*
Local policy	*Local policies can be used to outline the local implementation of a corporate policy.*
Procedural document	**Is a description of operational tasks to be undertaken to implement, or support, a policy.** Procedural documents apply across the Trust to all relevant sites and services.
Reserved policies	Those approved by TEG but ratified by the Board of Directors ~~in line with the Reservation and Delegation of Powers.~~
Standard operating procedure (SOP)	A written set of instructions that staff must follow to complete a job safely and compliantly, with no adverse effect on the personal health of the patient and staff or the environment, or on statutory requirements, and in a way that maximises operational efficiency. **Local SOPs are those which affect a very small number of people, are agreed within a team/small department and are not published centrally.*
Strategy	A medium or long-term plan of action designed to achieve a particular goal. The content of strategy documents will tend to be high level and concise, presenting a vision of what it is intended to achieve and why, what benefits are intended to accrue from the strategy and how it is to be achieved over a defined period – usually three to five years.

Terms of reference (ToR)	A document which details the specific authority that a board, committee or group has to oversee a delegated area of responsibility. It describes the committee's purpose, contains clear and specific information on how it is organised, what it is trying to achieve, who the members are, and when they meet.

8. References / standards and statutory legal requirements

Accessible Information Standard - Making health and social care information accessible
Human Rights Act 1998
Freedom of Information Act 2000
EU General Data Protection Regulation (GDPR) 2018
UK Data Protection Act 2018 (DPA18)

9. Associated Trust and external documents

Patient Information Policy
Guide to Rapid Equality Impact Assessment Process
Freedom of Information Policy
Incident Management Policy
Patient Group Directions Policy
Reservation and Delegation of Powers
Accessible Information Standard Policy
Standard Operating Procedure for the Development of a New Controlled Document
Standard Operating Procedure for the Review of an Existing Controlled Document
Policy Template
Procedural Template
Terms of Reference Template
Standard Operating Procedure Template
Guideline Template

10. Appendices

None

11. Document Control

Ref	55
Version	11
Status	Current
TEG Director Sponsor	Sandi Carman, Assistant Chief Executive
Author	Eleanor Rose, Patient and Staff Information Manager
Approval body	Trust Executive Group
Date approved	11 September 2024
Ratification body	Board of Directors
Date ratified	TBC
Issue date	TBC
Review date	30 September 2027

12. Version history

Version	Date issued	Brief summary of changes	Author
10	01/10/2021	New policy to replace Policy for the Development, Approval, Management and Dissemination of Trust Controlled Documents (Ref 55)	Judith Green, Corporate Governance Manager
10.1	03/10/2023	Minor amendments to remove links to obsolete documents to update to relevant current documents	Judith Green, Corporate Governance Manager
11	TBC	Addition of points of clarification, specifically around categorisation of documents, approval processes and roles and responsibilities. Updating of links and minor amendments to address formatting issues.	Eleanor Rose, Patient and Staff Information Manager

13. Consultation and review

Groups / persons consulted	Date
Associate Director of Equality, Diversity and Inclusion	23/08/21
Head of Quality Governance	23/08/21
Trust Controlled Documents Project oversight group members	06/08/24

14. Intended recipients

Essential reading for	Governance leads, All Trust Managers, MBB, TEG
Information for	All staff

15. Rapid equality impact assessment

What relevant quantitative and qualitative information (data) do you have? This may include national or local research, surveys, reports or research; workforce / patient data; complaints and patient experience data, etc.						
	Positive Impact This will actively promote or improve equality of opportunity or address unfairness or tackle discrimination	**Negative Impact** This will have a negative or adverse impact which will cause disadvantage or exclusion	**Neutral Impact** There is no likely impact on any of the protected groups	Does it advance equality of opportunity? (Y/N)	Does it eliminate unlawful discrimination? (Y/N)	Does it foster good relations between people? (Y/N)
Race (including nationality)	✓	×	×	**Y**	**Y**	**Y**
Religion/belief and non-belief	✓	×	×	**Y**	**Y**	**Y**
Disability	✓	×	×	**Y**	**Y**	**Y**
Sex	✓	×	×	**Y**	**Y**	**Y**
Gender Reassignment	✓	×	×	**Y**	**Y**	**Y**
Sexual Orientation	✓	×	×	**Y**	**Y**	**Y**
Age	✓	×	×	**Y**	**Y**	**Y**
Pregnancy and Maternity	✓	×	×	**Y**	**Y**	**Y**

Marriage and Civil Partnership	✓	×	×	Y	Y	Y
Human Rights (FREDA principles)	✓	×	×	Y	Y	Y
Carers	✓	×	×	Y	Y	Y
Other groups e.g. Gypsy, Roma, Travellers, vulnerable adults or children (e.g. homeless, care leavers, asylum seekers or refugees)	✓	×	×	Y	Y	Y

List any specific equality issues and information gaps that may need to be addressed through engagement and/or further research

15.1 Analysing the equality information

In this section record your assessment and analysis of the evidence. This is a key element of the EIA process as it explains how you reached your conclusions, decided on priorities, identified actions and any necessary mitigation

Analysis of the effects and outcomes
By ensuring that the process and systems in place for the development, approval, management and review of Controlled Documents aligns to EDI legislation this policy will have a positive impact on all above groups.

15.2 Outcome of equality impact assessment

No major change needed	Adjust Policy / proposal	Adverse impact but continue	Stop and remove policy / proposal
✓	×	×	×

15.3 Action plan

Action to address negative impact	By whom	By when	Resource implication
N/A			

15.4 Monitoring, review and publication

Manager signing off EIA (please enter name below)	**Date of next review** (please enter date below)
Eleanor Rose, Patient and Staff Information Manager	September 2027
Approved by (please enter name of Committee and date approved below)	**Date sent to EDI Team** sth.equalityanddiversity@nhs.net: (please enter date below)
Trust Executive Group	
	Date published (if applicable) (please enter date below)

16. Other impacts

Financial implications	None identified
Training implications	None identified
Sustainabilty implications	None identified
Other	None identified

17. Document imprint

Standards of Business Conduct (Declarations of Interest, Gifts and Hospitality) Policy

1. Introduction – Section content abridged

Sheffield Teaching Hospitals NHS Foundation Trust (the Trust), and the people who work with and for us, collaborate closely with other organisations, delivering high quality care for our patients. These partnerships have many benefits and should help ensure that public money is spent efficiently and wisely but there is a risk that conflicts of interest may arise.

It is the responsibility of all staff to ensure that they are not placed in a position which risks, or appears to risk, conflict between private interests and duties. In support of this transparent process, the Trust has an electronic register on which details are recorded of all declared interests and gifts and hospitality received by or offered to staff. This electronic register of interests is publicly available via the Trust's website. It is subject to audit inspection and the arrangements in place to support its management are reviewed via an annual report to the Audit Committee.

Adhering to this policy will help to ensure that we use NHS money wisely, providing best value for taxpayers and accountability to our patients for the decisions we take.

As a member of staff you should…	As an organisation we will…
Familiarise yourself with this policy which is based on national guidance and follow it. Use your common sense and judgement to consider whether the interests you have could affect the way taxpayers' money is spent. Regularly consider what interests you have and declare these as they arise. If in doubt, declare. **NOT** misuse your position to further your own interests or those close to you. **NOT** be influenced or give the impression that you have been influenced by outside interests. **NOT** allow outside interests you have to inappropriately affect the decisions you make when using taxpayers' money.	Ensure that this policy and supporting processes are clear and help staff understand what they need to do. Identify a team or individual with responsibility for: − Keeping this policy under review − Providing advice, training and support for staff on how interests should be managed. − Maintaining a register of interests. − Audit this policy and its associated processes and procedures at least once every three years. **NOT** avoid managing conflicts of interest. **NOT** interpret this policy in a way which stifles collaboration and innovation with our partners.

Contents – New section

2. Purpose

The Trust has a legal duty to prevent bribery, corruption and fraud and all staff are required to demonstrate the highest standards of probity and transparency, in line with the Trust's contracts of employment.

The purpose of this policy is to ensure that all staff maintain the highest standards of public accountability and are open and transparent in their business conduct by:

- Ensuring awareness of the correct declaration procedure in the event of being offered sponsorship, gifts, hospitality, or outside monies;
- Providing guidance to staff when they are required to provide professional advice and/or services, for a fee, to a non-NHS organisation;
- Ensuring the Trust maintains an accurate record of all the above interests; and
- Encouraging openness and transparency in the declaration process.

This policy will help our staff manage conflicts of interest risks effectively by:

- Introducing consistent principles and rules;
- Providing simple advice about what to do in common situations; and
- Supporting good judgement about how to approach and manage interests.

Further guidance on the implementation of this policy can be sought from the Head of Corporate Governance who, if necessary, will escalate the query to the Assistant Chief Executive.

3. Scope and exceptions

Setting	Trust-wide
Individuals	• All Trust staff (including full and part-time), seconded staff, those covered by a letter of authority / honorary contract, apprentices, students, trainees and those on work experience; • Directors, including Executive and Non-Executive Directors; • Trust Governors; • ~~Contractors, sub-contractors and External Consultants;~~ • Agency staff; • Volunteers~~; and~~ • ~~Committee, sub-committee and advisory group members (who may not be directly employed or engaged by the Trust).~~
Speciality	All

4. Policy details – Rewrite of section content

This section of the policy describes the systems operated by the Trust to allow public accountability and openness in relation to the declaration of interests.

A procedural flowchart has been developed to support the practical implementation of this policy (Appendix A), together with a series of frequently asked questions which are available via the Trust Intranet. The narrative elements of the policy should be read in full for a detailed explanation of requirements and reporting guidance.

If any member of staff has any doubt about the relevance or materiality of an interest, advice should be sought from their line manager, who may in turn seek guidance from the Head of Corporate Governance if required.

Disciplinary action may be taken if staff fail to declare a relevant and material interest, including failure to declare in a timely manner, or is found to have abused their position or knowledge for their own interest or that of close relatives or associates. Criminal actions may also be taken.

This policy also applies to the Board of Directors including Non-Executive Directors and to Governors.

4.1 General principles - identification and declaration of interests

4.1.1 Declarations of interest

All staff must identify and declare any interests outlined in this policy at the earliest opportunity (and in any event within 28 days of becoming aware of the conflict). If staff are in any doubt as to whether an interest should be declared then they should declare it, so that it can be considered. Declarations should be made:

- On appointment with the organisation
- When staff move to a new role or their responsibilities change significantly
- At the beginning of a new project/piece of work
- As soon as circumstances change and new interests arise (for instance, in a meeting when interests staff hold are relevant to the matters in discussion).

After expiry, an interest will remain on the register for a minimum of six months and historic interests will be retained in an archive file for a minimum of six years.

4.1.2 Proactive review of interests

The Assistant Chief Executive will prompt decision-making staff at least annually to review declarations they have made and, as appropriate, update them or make a nil return.

4.1.3 Records

The Trust will maintain an electronic register of interests (via the Chief Executive's Office).

4.1.4 Publication

The Trust will:

- Publish the interests declared by decision-making staff on the electronic register;
- Refresh this information at least annually; and
- Make this information available via the Trust website.

If an individual decision maker has substantial grounds for believing that publication of their interests should not take place then they should contact the Assistant Chief Executive to explain why.

In exceptional circumstances, for instance where publication of information might put a member of staff at risk of harm, information may be withheld or redacted on public registers. However, this would be the exception and information will not be withheld or redacted merely because of a personal preference. The Assistant Chief Executive's decision will be final.

4.1.5 Wider transparency initiatives

The Trust fully supports wider transparency initiatives in healthcare and encourages staff to engage actively with these.

Staff should give their consent for payments they receive from the pharmaceutical industry to be disclosed as part of the Association of British Pharmaceutical Industry (ABPI) Disclosure UK initiative[1]. These *transfers of value* include payments relating to:

- Speaking at and chairing meetings
- Training services
- Advisory board meetings
- Fees and expenses paid to healthcare professionals
- Sponsorship of attendance at meetings, which includes registration fees and the costs of accommodation and travel, both inside and outside the UK
- Donations, grants and benefits in kind provided to healthcare organisations.

[1] Further information about the scheme can be found on the ABPI website: http://www.abpi.org.uk/ethics/ethical-responsibility/disclosure-uk/about-disclosure-uk/

2 The ABPI public record (Disclosure UK) can be accessed on the ABPI website: https://www.abpi.org.uk/reputation/disclosure-uk/

The public ABPI record[2] will be subject to checking by the Trust for cross matching against the electronic register to identify where employees are failing to formally declare such relationships to the Trust.

4.2 General principles - management of interests

If an interest is declared but there is no risk of a conflict arising then no action is warranted. However, if a material interest is declared then the general management actions that could be applied include:

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

Each case will be different and context-specific, and the Trust will always clarify the circumstances and issues with the individuals involved. Staff should maintain a written audit trail of information considered and actions taken.

Staff who declare material interests should make their line manager or the person(s) they working for aware of their existence.

4.3 Categories of interests – common situations

4.3.1 Loyalty interests

All staff must declare all instances where they, a close relative or associate, has a controlling and/or significant personal interest (including friendships) in any business, or any other activity or pursuit, which may compete for an NHS contract to supply goods or services.

Additionally, the Trust expects staff to similarly declare personal interests (including directorship or other appointments) in any business venture or activity that could be perceived to have a connection to any healthcare provision or in any way be linked to their main employment with the Trust (e.g. provision of private treatment, private nursing or residential home).

Conflicts of interest can arise when decision-making is influenced subjectively through association with colleagues or organisations out of loyalty to the relationship they have, rather than through an objective process. The scope of locality interests is potentially huge so judgement is required for making declarations. Some examples are as follows:

- Hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role.
- Sit on advisory groups or other paid or unpaid decision-making forums that can influence how an organisation spends taxpayers' money.
- Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners.
- Are aware that their organisation does business with an organisation in which close family members and relatives, close friends and associates, and business partners have decision-making responsibilities.

All staff therefore have to declare such interests to the Trust, either on starting employment or on acquisition of the interest. Where holding loyalty interests gives rise to a conflict of interest then the guidance in this policy should be applied to mitigate risks and the loyalty interest should be recorded by logging onto the Trust's online register, selecting the *'Loyalty Interest'* menu option under the *New Declarations* link and populating the required fields.

4.3.2 Hospitality

Staff must not, under any circumstances, accept any hospitality from existing or potential suppliers which may, or be capable of being construed as, being able to influence a purchasing decision or cast doubts on the integrity of such decisions. This includes site visits to inspect equipment at the expense of the supplier. The Trust should meet the costs of an inspection visit so as to avoid putting in jeopardy the integrity of subsequent purchasing decisions. In short staff should:

- Not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement; and
- Only accept hospitality when there is a legitimate business reason and it is proportionate to the nature and purpose of the event.

Modest hospitality, provided it is normal and reasonable in the circumstances, e.g. lunches in the course of working visits, may be acceptable, though it should be similar to the scale of hospitality which the NHS as an employer would be likely to offer. The following apply:

Meals and refreshments:

- **Under** a value of **£25** – may be accepted and need not be declared
- Of a value **between £25 and £75**[3] – may be accepted and must be declared
- **Over** a value of **£75** – should be refused unless (in exceptional circumstances) line manager approval is given. A clear reason should be recorded on the organisation's register of interest 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 a reasonable estimate).

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 organisation itself might not usually offer, need approval by senior staff, should only be accepted in exceptional circumstances, and must be declared. A clear reason should be recorded on the Trust's register of interest as to why it was permissible to accept travel and accommodation of this type.

  A non-exhaustive list of examples includes:

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

All hospitality will be recorded in the electronic register to ensure probity, openness and transparency. Staff should decline all <u>other</u> offers of hospitality or entertainment and record all offers (whether accepted or declined) by logging onto the Trust's register, selecting the *Hospitality* menu option under the *New Declarations* link and populating the required fields.

Any potential hospitality which falls outside the scope of this policy, and which is linked to an unconditional desired benefit for the Trust (such as staff training) should be agreed with the member of staff's director in advance and notified, where appropriate, through the

[3] The £75 value has been selected with reference to existing industry guidance issued by the ABPI https://www.pmcpa.org.uk/media/3406/2021-abpi-code-of-practice.pdf

Assistant Chief Executive in accordance with the usual arrangements for declarations of hospitality.

4.3.3 Gifts

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

Gifts from suppliers or contractors:

- Gifts from suppliers or contractors doing business (or likely to do business) with the organisation should be declined unless they are low cost, branded and promotional aids such as pens or post it notes and under a value of £6 in total.
- All gift offers from suppliers or contractors should be declared regardless of whether they are accepted or not.
- Gifts of low-cost, branded and promotional aids do not need to be declared.

Gifts from other sources (e.g. patients, families, service users):

- Gifts of cash and vouchers (e.g. tokens, gift vouchers and lottery tickets) to individuals should always be declined;
- Staff should not ask for any gifts;
- Gifts valued at £50 or over should be treated with caution and only be accepted on behalf of the Trust (i.e. charitable funds[4]) and not in a personal capacity. These should be declared by staff;
- Modest gifts (including seasonal gifts) accepted under a value of £50 do not need to be declared;
- 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); and
- 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, staff should consult their line manager in the first instance.

All gifts received or offered above the £50 threshold (or where doubt exists) must be declared by logging onto the Trust's online register, selecting the *Gifts* menu option under the *New Declarations* link and populating the required fields.

[4] Any gifts accepted on behalf of the Trust should be donated to Sheffield Hospitals Charity. Arrangements can be made by contacting charity@shct.nhs.uk.

Where possible the declaration should be completed and approved in advance of receiving any gift.

The following need **not** be declared:

- Income generation schemes, which are managed and logged separately
- Discounts on pharmaceuticals, which are managed and logged separately

Where staff have any concern as to the potentially excessive value of a gift offered or the pressure to accept any gift is particularly high or where refusal might cause offence they should seek advice from the Assistant Chief Executive.

Staff should at all times be aware that NHSE Guidance on Managing Conflicts of Interest in the NHS seeks to ensure that the best interests of the public and patients/clients are upheld in decision making and that decisions are not improperly influenced by gifts or inducements.

Gifts which have been received without approval will be returned to the donor by the Trust. Where the donor cannot be traced the gift will be donated to an appropriate charity.

4.3.4 Donations

A donation is a charitable financial payment, which can be in the form of direct cash payment or through the application of a will or similar directive. Charitable giving and other donations are often used to support the provision of health and care services. As a major public sector employer the NHS holds formal and informal partnerships with national and local charities. Staff will, in their private lives, undertake voluntary work or fundraising activities for charity. A supportive environment across the NHS and charitable sector should be promoted. However, conflicts of interest can arise, therefore the following applies:

- Donations made by suppliers or bodies seeking to do business with the organisation should be treated with caution and not routinely accepted. In exceptional circumstances they may be accepted but should always be declared. A clear reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value.
- Staff should not actively solicit charitable donations unless this is a prescribed or expected part of their duties for the Trust or is being

pursued on behalf of Sheffield Hospitals Charity or other charitable body and is not for their own personal gain.

- Staff must refer to the Trust's Fundraising Policy if in their professional role they intend to undertake fundraising activities.
- Donations, when received, should be made to a specific charitable fund (never to an individual) and a receipt should be issued.
- Staff wishing to make a donation to a charitable fund in lieu of receiving a professional fee may do so, subject to ensuring that they take personal responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.

Gifts in the form of a donation of money to the Trust should be communicated immediately to the Chief Finance Officer. Such donations will be deposited in the Trust's charitable fund. Advice in regard to donations must be sought from the Sheffield Hospitals Charitable Funds department and records will be maintained in line with obligations under the charity law, in line with the above principles and rules.

4.3.5 Wills and legacies

Where a member of staff is a beneficiary to a Will of a patient who has been under their care, the member of staff must make their line manager aware as soon as possible. This must also be declared by logging onto the Trust's online register, selecting the *Donations* menu option under the *New Declarations* link and populating the required fields.

Staff should be guided by their accountabilities for professional conduct, and as such legacy bequests should not be accepted in a personal capacity. There is also a requirement to inform the Assistant Chief Executive, through their line manager so that any further considerations can be managed appropriately.

In accordance with the Trust's policy for Witnessing Wills staff should not be involved in making a will for a patient. It is the responsibility of all staff to ensure they are not put in a position which risks or appears to risk a conflict between their private interests and the interests of the Trust and the NHS.

4.3.6 Prizes

Where staff are entered, by virtue of their representation of, association with, or employment by the Trust, into raffle draws or competitions, the following rules apply:

- Prizes with an estimated value below £50 may be accepted without declaring to the Trust;
- Prizes with an estimated value of £50 and above shall be declared as a gift using the electronic system;
- The prize should only be accepted if it is offered without conditions. Photographs or publicity associated with the winning might constitute conditions. The recipient of the prize is responsible for ensuring that any photographic record of the prize award, or other form of publicity associated with the prize award is not to be used by the organisation that sponsors or provides the prize to imply any level of endorsement, by the Trust, of the sponsoring organisation, or its products. If there is any uncertainty, the prize winner should report any potential implications to their line manager, before the prize is accepted.

Raffles and lotteries run by the Trust and Sheffield Hospitals Charity, designed for staff involvement, and award and rewards made by the Trust to specific members of staff are specifically excluded from these requirements.

4.3.7 Sponsorship

Sponsorship - general

In general, Trust business should be funded from within the Trust's budget. However, industry and commerce often wish for a close involvement with the NHS. Whilst this can be to mutual benefit, there may be hidden benefits to commercial partners and costs to the NHS. Care must be taken to ensure there is no commercial advantage to a sponsor.

Where a sponsorship involves a pharmaceutical company then the arrangements must comply fully with the Association of the British Pharmaceutical Industry (ABPI) Code of Practice and the Medicines (Advertising) Regulations 1994. More information about pharmaceutical sponsorship is included at the end of this section.

Should there be any doubt about the appropriateness of accepting sponsorship staff should seek advice from their line manager or the Head of Corporate Governance.

Any member of staff covered by this policy who receives an approach regarding any form of sponsorship not described below should request that the details be put in writing; upon receipt this should be recorded by logging onto the Trust's online register, selecting the *Sponsorship* menu option under the *New Declarations* link and populating the required fields.

For regular sponsorship i.e. not a one-off event, a written Sponsorship Agreement will also be required.

All sponsorship will be recorded in to the electronic register to ensure probity, openness and transparency.

Sponsored events

Sponsorship of events by external bodies should only be approved if it can be demonstrated that the event will result in clear benefits for the Trust and the wider NHS. Sponsorship should not in any way compromise any decisions of the Trust or be dependent on the purchase or supply of goods or services. Sponsorship should not have any influence over the content of the event, meeting, seminar, publication or training event. The Trust will not endorse individual companies or their products or services as a result of the sponsorship.

During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection (or other) legislation. As a general rule, information which is not in the public domain should not be supplied and no information should be supplied to a company for its commercial gain.

At the Trust's discretion, sponsors or their representatives may attend or take part in the event, but they should not have a dominant influence over the content or the main purpose of the event.

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

When a member of staff gets paid to attend a conference or write an article in their professional capacity (and possibly during work time) the money should be paid to the Trust, not to the individual. Details of this payment should be declared by logging onto the Trust's register, selecting the *Sponsored Event* menu option under the *New Declarations* link and populating the required fields.

All staff must declare any sponsorship in accordance with the guidance in this section.

Sponsored research

Funding sources for research purposes must be transparent.

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

The requirement for staff to declare involvement in sponsored research conducted at the Trust is managed by the Clinical Research and Innovation Office. Details are recorded in compliance with NHS England policy, within the Trust's Integra Research Database.

The Trust's Clinical Research and Innovation Office (CRIO) will ensure that all sponsored research is recorded in the Integra Research Database. Staff involved in, or planning to conduct, sponsored research must ensure that the CRIO are fully informed of all sponsored research activity in compliance with the UK Policy Framework for Health and Social Care Research.

Sponsored posts

Staff who are considering entering in to an agreement regarding the external sponsorship of a post within the Trust must seek formal approval from the relevant Director and the Trust Executive Group (TEG) for final approval. Staff will be required to demonstrate acceptance of a sponsored post is transparent and does not stifle competition.

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

There should be written confirmation that the sponsorship agreements will have no effect on any management decisions over the duration of the sponsorship and auditing arrangements should be established to ensure that this is the case. These written arrangements should set out the circumstances under which the Trust may exit the sponsorship arrangements if conflicts of interest arise which cannot be mitigated.

Holders of sponsored posts must not promote or favour the sponsor's specific products or organisation and information about alternative suppliers must be provided.

Sponsors must not have any influence over the duties of the post or have any preferential access to services, materials or intellectual property relative to or developed in connection with the sponsored post.

Sponsored posts must be declared by logging onto the Trust's online register, selecting the *Sponsored Posts* option under the *New Declarations* link and populating the required fields.

Pharmaceutical Sponsorship

All Pharmaceutical companies entering into sponsorship agreements must comply with the Association of the British Pharmaceutical Industry (ABPI) Code of Practice and must pay due regard to the requirements of the Human Medicines Regulations 2012 in relation to inducements and hospitality. In all cases:

- Any sponsorship agreements with pharmaceutical companies will require the advice of the Chief Pharmacist before authorisation by the Assistant Chief Executive.
- All collaborative partnerships between the Trust and the pharmaceutical industry, charitable sector or non-NHS organisation must comply with current legislative and regulatory guidance.
- Participation in a collaborative pharmaceutical partnership does not in any way suggest the Trust endorsement of any product, only that the product is in line with the Trust's prescribing policy at the time.

4.3.8 Outside employment

The NHS relies on staff with good skills, broad knowledge and diverse experience. Many staff bring expertise from sectors outside the NHS, such as industry, business, education and beyond. The involvement of staff in these outside roles alongside their NHS roles can therefore be of benefit, but the existence of these should be well known so that conflicts can be either managed or avoided.

All Trust staff wishing to undertake outside employment should seek approval from their line manager prior to commencing any outside employment or on appointment at the Trust. Details of the outcome of this discussion should be provided as part of the declaration.

A declaration on the Trust's register of interests should be made where there is any potential for a conflict of interest to arise, for example if the outside employment is with an organisation/ body likely to do business with the Trust.

Where a potential conflict of interest is identified a judgement must be made as to appropriate action. Actions to manage a conflict of interest may include:

- Declining permission to take up outside employment
- Amending an employee's duties to remove the risk of conflict of interest
- Putting in place additional safeguards to mitigate the risk of conflict of interest e.g. absenting the employee from any decisions relating to their outside employer or competitor organisations
- Where no conflict of interest is established this should be recorded to ensure that it is in line with their terms and conditions of employment.

The above principle does not relate to trade union duties or activities carried out by a recognised trade union in line with existing arrangements.

Details of outside employment deemed relevant to be declared should be recorded by logging onto the Trust's online register, selecting the *Outside Employment*' menu option under the *New Declarations* link and populating the required fields.

Where an employee is currently engaged in outside employment without Trust approval, they must disclose the matter and seek retrospective approval, as soon as possible. The employee may be asked to cease their secondary employment.

Consent will not be unreasonably withheld provided that such secondary employment:

- Is not undertaken at times when the employee's Trust contract of employment is considered to be in operation
- Does not have an adverse impact upon the employee's Trust contractual duties
- Is not considered to be in competition with the Trust for the provision of goods and services
- In the case of medico-legal work, this work is completely unrelated to the activities of the Trust and there could be no linkage to any future legal claims against the Trust

- Does not have any health and safety implications such as contravening Working Time Regulations
- Is not contrary to the values of the Trust, that is its purpose as described in the Trust's Constitution and the Seven Principles of Public Life (Appendix B)
- Does not adversely impact on the reputation of the Trust
- Does not use Trust resources including premises, equipment, materials or staff.

The decision of the line manager to approve or refuse permission should be based on their assessment of the actual or potential conflict(s) of interest that such secondary employment presents and, following discussion with the employee, whether the conflict(s) can be satisfactorily managed. The line manager may seek further advice and guidance from the Assistant Chief Executive, as appropriate.

If a request to undertake secondary employment is refused, the employee may appeal the decision to the Assistant Chief Executive, whose decision is final.

Staff who are permitted to undertake secondary employment must:

- Consider the appropriateness of declaring it as an interest
- Identify and manage any actual or potential conflict of interest
- Keep their line manager directly informed of any material changes in secondary working practices or working hours.

Where approved secondary employment at the Trust is on the basis of part-time or ad-hoc hours, such as NHS Professionals, approval should cover the range of their external bank/part-time employment. This will prevent the need for separate authorisation for each period of employment.

Staff absent from work due to sickness ~~on sick leave from the Trust~~ must not undertake secondary employment without the prior agreement of the Trust who will decide if the work is considered therapeutic to their recovery. Similarly, if staff are absent from work due to other types of paid leave e.g. Study Leave, Special Leave, Parental Leave etc, any work undertaken ~~from~~ for another employer during agreed paid/unpaid time off~~Work undertaken without permission would~~ may be seen as fraudulent and considered in accordance with the Trust's Anti-Fraud, Bribery and Corruption Policy ~~and referred to the Trust's Counter-Fraud Specialist for further investigation and appropriate action taken, including the consideration of prosecution and civil recovery proceedings~~.

4.3.9 Clinical private practice

Clinical staff should declare all private practice on appointment, and/or any new private practice when it arises[5] including:

- Where they practise (name of private facility)
- What they practise (specialty, major procedures)
- When they practise (identified sessions/time commitment).

Clinical staff should (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed):

- Seek prior approval of the Trust before taking up private practice.
- Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work[6].
- Not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority guidelines (Private Healthcare Market Investigation Order 2014).

Consultants (and associate specialists) employed under the Terms and Conditions of Service (TCS) of Hospital Medical and Dental Staff are permitted to carry out private practice subject to conditions. Those on the new consultant contract must include their regular private sessions in their agreed job plan.

Staff employed by suppliers of insourcing providers supporting elective activity delivery should register this as an interest.

Clinicians should not initiate discussions about providing their Private Professional Services to NHS patients, nor should they ask other staff to initiate such discussions on their behalf.

4.3.10 Preferential treatment in private transactions

Individual staff must 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 Trust. This does not apply to concessionary agreements negotiated with

[5] Hospital Consultants are already required to provide their employer with this information by virtue of Para.3 Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.nhsemployers.org/sites/default/files/2021-09/Terms-and-Conditions-consultants-v11-Sept21.pdf

[6] These provisions already apply to Hospital Consultants by virtue of Paras.5 and 20, Sch. 9 of the Terms and Conditions – Consultants (England) 2003 https://www.nhsemployers.org/sites/default/files/2021-09/Terms-and-Conditions-consultants-v11-Sept21.pdf

companies by NHS management, or by recognised employees' interests, on behalf of all employees – for example, NHS employee benefits schemes.

Goods should not normally be delivered to the Trust for personal use, except for those employees and their family members who reside onsite in Trust premises.

4.3.11 Contracts and procurement

All staff who are in contact with suppliers and contractors (including external consultants) and in particular those employees who are authorised to sign Purchase Orders, or place contracts for goods, materials or services, are expected to adhere to professional standards of the kind set out in the Chartered Institute of Purchasing and Supply's Professional Code of Ethics, and the Trust's Standing Orders/Standing Financial Instructions.

The Trust will ensure that all invitations to potential Contractors and Suppliers to tender or quote for business include a notice warning them of the consequences of engaging in any corrupt practices involving employees of public bodies. For tenders to be considered they must be received with a declaration of bona fide tendering.

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

Those involved in the procurement exercises for an on behalf of the organisation should keep records that show a clear audit trail of how conflicts of interest have been identified and managed as part of procurement processes. At every stage of procurement steps should be taken to identify and manage conflicts of interest to ensure and to protect the integrity of the process.

When the Trust considers it necessary for staff advising on the purchase of equipment to inspect such equipment in operation in other parts of the country (or exceptionally overseas), the relevant Director, Assistant Chief Executive or Chief Medical Officer should be advised in advance and the Trust will consider meeting the cost so as to avoid putting in jeopardy the integrity of subsequent purchasing decisions.

4.3.12 Favouritism in awarding contracts

Fair and open competition between prospective contractors or suppliers for NHS contracts is a requirement of NHS Standing Orders and procurement rules. This means that:

- No private, public or voluntary organisation or company which may bid for NHS business should be given any advantage over its competitors, such as advance notice of NHS requirements. This applies to all potential contractors, whether or not there is a relationship between them and the NHS employer, 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 NHS and the ability of the contractors to fulfil them.

Staff must ensure that no special favour is shown to current or former employees or their close relatives or associates in award contracts to private or other businesses run by them or employing them in a senior or relevant managerial capacity. Contracts may be awarded to such businesses where they are won in fair competition, but scrupulous care must be taken to ensure that the selection process is conducted impartially, and that employees who are known to have a relevant interest play no part in the selection.

4.3.13 Patents

Staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are on-going, which are, or might be reasonably expected to be, related to items to be procured or used by the Trust, the NHS or NHS funded organisations:

- Staff should seek prior permission from the Trust before entering into any agreement with bodies regarding product development, research, work on pathways etc., where this impacts on the organisation’s own time, or uses its equipment, resources or intellectual property.
- Where holding of patents and other intellectual property rights give rise to a conflict of interest then the actions outlined in this policy should be considered and applied to mitigate risks.

4.3.14 Shareholding and other ownership issues

All staff are required to ensure that if they, their close relatives (i.e. partners/spouse and children) or their associated hold a "relevant or material interest" in an organisation that has commercial dealings with the Trust or whose principal business/activity is healthcare, that they declare such interest.

The Trust's Constitution describes separately the policy for declaring interests for members of the Council of Governors and the Board of Directors. The Code of Conduct for Governors describes the procedure for declaring and reporting interests of the Council and the Code of Conduct for the Board describes the procedure for declaring and reporting interests of the Board.

Interests should be declared via the Trust's online register.

Interests which should be regarded as "relevant and material" and should be declared are:

(i) **Directorships** –including Non-Executive directorships held in private companies or public limited companies (with the exception of those of dormant companies).

(ii) **Ownership** – including part-ownership or directorship of private companies, business or consultancies likely or possibly seeking to do business with the NHS (including suppliers of insourcing services supporting elective activity delivery).

(iii) **Shareholdings** – in organisations likely or possibly seeking to do business with the NHS:

- All shareholdings in private companies (including interests in partnerships and limited liability partnerships) where there is any potential conflict of interest must be declared
- Shareholdings in publicly listed companies held in blind trusts need not be declared
- Shareholdings in public listed companies with which the individual is aware or should be aware that the employing organisation contracts, or is considering contracting with, must be declared if the holding exceeds £5,000 market value or more than 1/100th of the nominal value of the issued share capital, whichever is less. In this circumstance the individual should declare the existence of the shareholding and the name of the company but need not declare the size of the interest.
- **Financial arrangement with the Trust** – any connection with an organisation, entity or company considering entering

into or having entered into a financial arrangement with the Trust, including but not limited to lenders or banks.

This section does not preclude the declaration of shareholdings of less value than the threshold described above where the owner recognises that a conflict of interest could be perceived.

If you hold a position of authority in a charity or voluntary organisation in the field of health and social care which contracts for or commissions NHS services you should also declare them.

4.3.15 System working – joint roles – New section

The new NHS landscape introduced by the Health and Care Act 2022 has facilitated greater integration and collaborative ways of working between NHS, independent sector and third sector organisations, including between NHS Foundation Trusts (FTs), NHS Trusts and Integrated Care Boards (ICBs).

As such there may be instances where directors may have multiple roles. For example, a director of an FT may also be a partner member of an ICB. In such an instance, the director will owe duties as director to the relevant FT and, at the same time, to the ICB. Where duties owed by the director to the FT do not align with the duties owed to the ICB, conflicts or potential conflicts of interest will apply separately to each organisation and the individual director's capacity to be involved in any board discussions will need to be assessed on an individual basis[7].

These instances are distinct from individuals undertaking positions / roles on external or system-wide forums / meetings to represent the Trust in the capacity of their substantive employment with the Trust.

4.4 Identifying and reporting breaches

4.4.1 Identifying breaches

There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate actions of staff or other organisations. For the purposes of this policy these situations are referred to as "breaches".

[7] Further guidance for conflicts of interest for Foundation Trust and NHS Trust Directors on Integrated Care Boards can be found here: conflicts-of-interest-nhsp-advice-from-mwe-jun23.pdf (nhsproviders.org)

4.4.2 Reporting breaches

Staff who are aware of actual breaches of this policy, or who are concerned that there has been, or may be, a breach, should report these concerns to the Assistant Chief Executive.

To ensure that interests are effectively managed staff are encouraged to speak up about actual or suspected breaches. Every individual has a responsibility to do this. For further information about how concerns should be raised refer to the Freedom to Speak Up Policy and Procedures. Where fraud is suspected, then refer to the Counter Fraud, Bribery and Corruption Policy.

The Trust will investigate each reported breach according to its own specific facts and merits and give relevant parties the opportunity to explain and clarify any relevant circumstances.

Following investigation the Trust will:

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

4.4.3 Taking action in response to reporting breaches

Action taken in response to breaches of this policy will be in accordance with Trust's disciplinary procedures and could involve organisational leads for staff support (e.g. HR), fraud (e.g. Local Counter Fraud Specialists), members of the management or executive teams and the Trust's auditors.

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

- Clarification or strengthening of existing policy, process and procedures.
- Consideration as to whether HR/employment law/contractual action should be taken against staff or others. This might include informal action, for example reprimand, or formal disciplinary action, for example formal warning.
- Consideration being given to escalation to external parties. This might include referral of matters to external auditors, NHS Counter

Fraud Authority, the Police, statutory health bodies (such as NHS England or the CQC), and/or health professional regulatory bodies.

- Contractual action, such as exercise of remedies or sanctions against the body or staff which caused the breach.
- Legal action, such as investigation and prosecution under fraud, bribery and corruption legislation.

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

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

4.4.4 Fraud and probity

Where the allegation is serious the matter should be referred appropriately to the Local Counter Fraud Specialist or by calling the confidential NHS Fraud and Corruption Reporting Line on: 0800 028 40 60 or by completing the online NHS fraud reporting tool.

4.4.5 Learning and transparency concerning breaches

Reports on breaches, the impact of these, and action taken will be reported to the Audit Committee for review.

To ensure that lessons are learnt and management of interests can continually improve, anonymised information on breaches, the impact of these, and action taken will be prepared and made available for inspection by the public upon request.

The Assistant Chief Executive will commission reviews of compliance with this policy. As a minimum, this will comprise:

- Annual review of the consolidated register of interests, gifts and hospitality and reasonableness check on the completeness of record keeping
- Annual review of investigations carried out at the Trust by the Local Counter Fraud Specialist, for evidence of non-compliance with this policy

- Ad hoc audit by Internal Audit services of the implementation of the code at an interval not greater than three years
- A review of managing conflicts of interest at meetings, including Board of Director meetings, committees of the Board of Directors and Council of Governors.

The reviews will be reported to the Audit Committee.

4.5 Legislation and guidance

4.5.1 Fraud, bribery and corruption

The Trust has a responsibility to ensure that all staff are made aware of their duties and responsibilities arising from the Bribery Act 2010. Under this Act there are four offences:

- Bribing, or offering to bribe another person;
- Requesting, agreeing to receive, or accepting a bribe;
- Bribing, or offering to bribe, a foreign public officer; and
- Failing to prevent bribery.

It is an offence under the Bribery Act 2010 both for anyone to receive, or to offer any financial or other advantage to another person in order to induce a person to perform improperly or reward any person for improper performance of a function or activity. This includes breaches in expected performance. It is also an offence under Section 3 of the Fraud Act 2006 for an employee to fail to disclose information to an employer to make a gain for themselves or another or to cause a loss or expose the Trust to the risk of loss.

Additionally, Section 4 of the same Act provides that it is also an offence for an employee who occupies a position in which they are expected to safeguard or not act against the financial interests of the Trust, to abuse that position to cause a loss or expose the Trust to the risk of loss. A breach of either Act renders employees liable to prosecution and may also lead to loss of their employment.

All staff should be aware of the requirements of the Bribery Act 2010 and should:

- Refer to the Trust's Anti-Fraud, Bribery and Corruption Policy;
- Report any suspicions of bribery, fraud and corruption to the Trust's Counter Fraud Specialist or NHS Counter Fraud Authority on 0800 028 4060 or www.reportnhsfraud.nhs.uk; and
- Be aware of the Trust's Freedom to Speak Up Policy and Procedures.

4.5.2 Guidance relating to the pharmaceutical industry – abridged content

In addition to the requirement for NHS staff to declare gifts and hospitality etc. to their NHS employer, a national database is publicly available by the Association of British Pharmaceutical Industry (ABPI)

This searchable database shows details of benefits given in cash or in kind (termed “transfers of value”) by pharmaceutical companies to healthcare organisations and individual healthcare professionals. The public ABPI record can be cross matched against the Trust’s own records of declarations of gifts and hospitality etc. and will identify where employees are failing to formally declare such relationships to the Trust.

5. Roles and responsibilities

In regard to this policy, the following have definitive roles in providing strategic leadership and advice.

Role	Responsibility
Chief Executive	The Chief Executive is ultimately responsible for ensuring there is an effective system in place for staff to declare sponsorship, gifts, hospitality, outside employment and any other interests.
Assistant Chief Executive	The Assistant Chief Executive has the following designated responsibility: • Ensuring a fit for purpose policy is in place and is made available to staff • Maintaining the Hospitality, Sponsorship and Gifts Register and ensuring appropriate oversight by the Audit Committee • Maintaining an up-to-date and publicly available Register of Interests for staff, Directors and Governors and ensuring appropriate oversight by the Audit Committee • Ensuring adequate records are kept for audit requirements; and • Provision of advice and information relating to hospitality, sponsorship, gifts, declarations of interest and professional advice and services to staff.
Head of Corporate Governance	The Assistant Chief Executive will be supported in this task by

	the Head of Corporate Governance.

Other roles and responsibilities in regard to the implementation of this policy

All Managers	All Managers have the responsibility of processing their staff's declarations of gifts, hospitality, interests and declarations of secondary employment in line with the procedures contained within this policy, and for the retention of such documents as contained herein.
All Staff	All Staff have the responsibility to comply with this policy. All staff must be aware of how and to whom declarations should be made, declaring material interests at the earliest opportunity (and in any event within 28 days) via a positive declaration to their organisation. Where applicable, staff must also adhere to their own professional Codes of Conduct in this area (e.g. GMC, NMC, HCPC, etc.). Staff who fail to disclose any relevant interests or who otherwise breach the organisation's rules and policies relating to the management of conflicts of interest are subject to investigation and, where appropriate, to disciplinary action/criminal action. No one acting on behalf of the Trust has the authority to approve any action that is contrary to the Trust's Standards of Business Conduct Policy.
Decision Making Staff	The business decisions made by the Trust must be ethical and in full compliance with legal requirements. These Standards of Business Conduct reflect our continued commitment to ethical business practices and regulatory compliance. By following the standards provided in this document, we are acknowledging our responsibilities to manage our activities with integrity. Some staff are more likely than others to have a decision-making influence on the use of taxpayers' money, because of the requirements of their role. For the purposes of this guidance these people are referred to as "decision-making staff": • Executive and Non-Executive Directors; • Medical Staff – Consultants and Associated Specialists; • Those at Agenda for Change Band 8d, equivalent or above; • All Clinical Directors, Nursing Directors and Operational

	Directors; • Members of Advisory Groups; • Trust Governors; • All staff within Pharmacy, IT, Estates and Procurement teams who have the power to enter into contracts on behalf of their organisation and are involved in decision-making concerning the commissioning of services, purchasing of goods, medicines, medical devices or equipment, and formulary decisions; and • NHS contractor professions, e.g. pharmacists, dentists and optometrists etc. All decision-making staff must make a declaration on starting employment and any new interests should be declared within a reasonable time of becoming aware of the interest and no later than 28 days after the interest becoming known. Decision-making staff are required to make at least an annual declaration of interest.
Meeting Chairs	The Chair of formal meetings including the Board and its Committees must ensure that a standing agenda item is included at the beginning of each meeting to determine if anyone has a conflict of interest in relation to the business to be transacted at the meeting. In the event that the Chair has a conflict, the Vice Chair is responsible for deciding the appropriate course of action. The Chair or Vice Chair or other non-conflicted member for the meeting must decide how to manage the conflict. The appropriate course of action will depend on the particular circumstances, but could include, not attending the meeting, not receiving supporting papers, leaving the meeting for the item to be discussed, allowing the individual to participate in some discussion but not the decision or vote etc. All decisions and actions takes must be recorded in the minutes by the Secretary to the meeting.

6. Monitoring

Standard, process or issue to be monitored	Monitoring method	Monitored by	Reported to	Frequency
Declaration of interests	Review of the electronic	Assistant Chief	N/A	Monthly

	register of interests	Executive		
Systems of Control	Review of arrangements in place under the policy	Internal Audit	Audit Committee	Three-yearly
Policy implementation	Annual Report	External Audit	Audit Committee	Annually

7. Definitions

Term	Description
Conflict of interest	A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold. A conflict of interest may be: • **Actual** – there is a material conflict between one or more interests; • **Potential** – there is the possibility of a material conflict between one or more interests in the future. Staff may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see it differently and perceived conflicts of interest can be damaging. All interests should be declared where there is a risk of perceived improper conduct.
Financial interest	Where an individual may get direct financial benefit[8] from the consequences of a decision they are involved in making.
Non-financial professional interests:	Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.
Non-financial personal interests:	Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are

[8] This may be a financial gain, or avoidance of a loss

	involved in making in their professional career.
Indirect interests:	Where an individual has a close association[9] with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.
Gifts	Any item of cash or goods, or any service, which is provided for personal benefit at less than its commercial value.
Hospitality	Meals and or drinks, visits, entertainment, lecture courses organised etc. provided or offered by suppliers/potential suppliers.
Secondary employment	Any paid employment outside the Trust; − Self-employment; − Bank/locum agency work either within or outside the Trust; − An extra job/work within the Trust; and − Voluntary work (whether paid or not).
Staff	Any individual or group covered within the scope of this code as detailed in Section 3 of this policy.
Decision-making staff	Decision-making staff as defined in Section 5 of this Policy.
Bribery and corruption	Involves offering, promising or giving someone a payment or benefit-in-kind to influence others to use their position or perform their function or activities improperly or to regard that person for having already done so.
Fraud	An intentional act to make a gain for themselves or another, or to have an intention to inflict a loss, or risk of loss on another.
Outside employment	Employment and other engagements, outside formal employment arrangements. This can include directorships, Non-Executive roles, self-employed, consultancy work, charitable trustee roles, political roles and roles within not-for-profit organisations, paid advisory positions and paid honorariums which relate to bodies likely to do business with the Trust. (Clinical private practice is considered in a separate

[9] A common sense approach should be applied to the term "close association". Such an association might arise, depending on the circumstances, through relationships with close family members and relatives, close friends and associates, and business partners.

	section).
Clinical private practice	Where clinical staff provide private practice work either for an external company, in their own right via a hosting arrangement on a private provider's premises, or through a corporate vehicle established by themselves.
Sponsorship (including sponsored events, sponsored research and sponsored posts)	NHS funding from an external source, including funding of all or part of the cost of a member of staff, NHS research, staff, training, pharmaceuticals, equipment, meeting rooms, costs associated with meetings, meals, gifts, hospitality, hotel and transport costs (including trips abroad), provision of free services (speakers), buildings or premises.
Register of interests	This is a publicly available up-to-date register containing full and accurate details of all such gifts, hospitality, inducements and actual or potential conflicts of interest. It will be available on the Trust website.
Breach	A situation when interests are not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate actions of staff or other organisations.

8. References

Freedom of Information Act 2000
Fraud Act 2006
The Bribery Act 2010
Sunshine Rule 2015
NHSE Guidance on Managing Conflicts of Interest in the NHS

9. Associated Trust and external documents – updated

Trust Controlled Documents

Trust Constitution (including the Standing Orders of the Council of Governors)
Use of Insourcing to Support Elective Activity Delivery (Policy)
Procurement Policy
Standing Orders for the Practice and Procedure of the Board of Directors
Standing Financial Instructions Policy
Reservation of Powers to the Board of Directors and Scheme of Delegation Policy
Code of Conduct for Council of Governors Policy
Freedom to Speak Up Policy and Procedures
Duty of Candour Policy

Confidentiality – Staff Code of Conduct
Counter Fraud, Bribery and Corruption Policy
Fundraising Policy
Witnessing of Wills Policy

External Documentation

Code of Governance for NHS provider trusts Standards matter: a review of best practice in promoting good behaviour in public life NHS Standard Contract
Commercial Sponsorship Ethical Standards for the NHS (2000)
Disclosure UK: Commercial ABPI Database of Industry Payments to Healthcare Professionals
Joint Statement from the Chief Executives of statutory regulators of health and care professionals

10. Appendices

Appendix A - Guidance Flowchart
Appendix B - Nolan Principles

11. Document control

Ref	9
Version	5
Status	Current
TEG Sponsor	Sandi Carman, Assistant Chief Executive
Author	Judith Green, Head of Corporate Governance
Approval body	Trust Executive Group
Date approved	11 September 2024
Ratification body	Board of Directors
Date ratified	24 September 2024
Issue date	TBC
Review date	24 September 2027

12. Version history

Version	Date issued	Brief summary of changes	Author
1	29.9.04		David Baldwin
2	October 2007	Refresh of Code of Conduct reflecting foundation trust status	Assistant Chief Executive

3	15.02.2019	To update and incorporate the Standards of Business Conduct Policy and the Procedure Relating to the Offer and Acceptance of Gifts and Hospitality ensuring compliance with NHSE and associated process for staff to make declarations	Jill Dentith, Management Consultant
4	28/10/2021	Updating of policy title to reflect content to facilitate easier identification by staff General updates with respect of operation of processes following implementation of electronic register Transfer into new Trust policy template format and associated re-ordering of content Addition of principles around medico legal work and also legacy bequests Clarification of principles around other common types of declaration	Judith Green, Corporate Governance Manager
5	31/07/2024	General formatting updates including creation of a contents page and streamlining of content General updates with respect of reference, associated Trust and external documents Addition of principles around conflicts of interest relating to system working	Judith Green, Head of Corporate Governance

13. Consultation and review

Groups / persons consulted	Date
Previously – Safety and Risk Management Board / Medical Director / Staffside	2019
Business Manager – Board of Directors	Oct 2021
Business Manager, CEO Office	July 2024
Head of Operational HR	August 2024

14. Intended recipients

All staff who should:

Essential reading for	All Decision-making staff as defined in section 5
Information for	All staff and individuals covered by the scope of the policy

15. Rapid equality impact assessment

What relevant quantitative and qualitative information (data) do you have? This may include national or local research, surveys, reports or research; workforce / patient data; complaints and patient experience data, etc.						
	Positive Impact This will actively promote or improve equality of opportunity or address unfairness or tackle discrimination	**Negative Impact** This will have a negative or adverse impact which will cause disadvantage or exclusion	**Neutral Impact** There is no likely impact on any of the protected groups	**Does it advance equality of opportunity? (Y/N)**	**Does it eliminate unlawful discrimination ? (Y/N)**	**Does it foster good relations between people? (Y/N)**
Race (including nationality)			✓			
Religion/belief and non-belief			✓			
Disability			✓			
Sex			✓			
Gender Reassignment			✓			
Sexual Orientation			✓			
Age			✓			
Pregnancy and Maternity			✓			
Marriage and Civil Partnership			✓			

Human Rights (FREDA principles)			✓			
Carers			✓			
Other groups e.g. Gypsy, Roma, Travellers, vulnerable adults or children (e.g. homeless, care leavers, asylum seekers or refugees)			✓			

List any specific equality issues and information gaps that may need to be addressed through engagement and/or further research

15.1 Analysing the equality information

In this section record your assessment and analysis of the evidence. This is a key element of the EIA process as it explains how you reached your conclusions, decided on priorities, identified actions and any necessary mitigation

Analysis of the effects and outcomes
Record your assessment and analysis of the evidence

15.2 Outcome of equality impact assessment

No major change needed	Adjust Policy / proposal	Adverse impact but continue	Stop and remove policy / proposal
✓ ✖	✓ ✖	✓ ✖	✓ ✖

15.3 Action plan

Action to address negative impact	By whom	By when	Resource implication

15.4 Monitoring, review and publication

Manager signing off EIA (please enter name below)	**Date of next review** (please enter date below)
Sandi Carman, Assistant Chief Executive	September 2027
Approved by (please enter name of Committee and date approved below)	**Date sent to EDI Team** sth.equalityanddiversity@nhs.net: (please enter date below)
TEG	
	Date published (if applicable) (please enter date below)

16 Other impacts

Financial implications	Ongoing resources to support the implementation of the policy across the Trust (Support contract for Declare online declarations of interest software)
Training implications	There are no specific training needs in relation to this policy, but all staff need to be aware of the key points that the policy covered.
Sustainabilty implications	None
Other	None

17 Document imprint

Commencement of Employment / New Interest

All staff are required to declare any interests on commencement of employment or within 28 days of a new interest.

Category of interests include loyalty interests, hospitality, gifts, donations, wills and legacies, prizes, sponsorship, outside employment, clinical private practice and shareholding

Discussion with STH Senior Manager

Any potential interests should be discussed with your line manager to identify any conflicts of interest and agree any necessary mitigations.

Make a Declaration of Interest

Once this discussion has taken place you must make a declaration of interest using the Declare system.

Details of any interests should be recorded along with the job title of the approving senior manager and any mitigations put in place. Examples of mitigations include:

"Declaration made under relevant agenda item"
"Recusal from any decision making that may be perceived as a conflict of interest"

Annual Review

All decision making staff must review existing declarations at the end of the financial year and update as required, either by:

- Adding new declarations previously not declared
- Confirming that there are no changes to existing declarations
- Making a "nil declaration" if there are no interests to declare

Accessing Support: If you are in any doubt about what should be declared or require support accessing the system please contact lucymiddleton@nhs.net

Seven principles of public life

The principles underpinning this Code are drawn from the Seven Principles of Public Life (adapted from the Nolan Report). All staff are expected to abide by them.

- Selflessness

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

- Integrity

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

- Objectivity

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

- Accountability

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

- Openness

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

- Honesty

  Holders of public office should be truthful.

- Leadership

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

APPENDIX A

Table I: Table of Changes following review of Trust Controlled Documents Policy – Sept 2024

Ref	Section	Description of proposed change	Rationale
1	*Policy name and throughout*	Re-adoption of terminology **Trust** Controlled Documents.	To confirm scope of policy as documents that have a Trust-wide application, while also promoting use of these principles to documents that are locally controlled.
2	Section 4 Policy details (p2) / Section 4.1.2 Style and format (p4)	Addition of reference to template for Standard Operating Procedures.	To reflect addition of template for procedural templates.
3	Section 4 Policy details (p3)	Addition of content to confirm that locally managed documents should follow a local approval process and only be accessible from a controlled document library.	Need to ensure that access to locally managed documents is controlled.
4	Section 4.1 Principles (p3) *and throughout*	Addition of word 'Corporate' before policies.	To distinguish between Trust-wide policies and local policies in line with scope of this policy.
5	Section 4.1.2 Developing a draft Trust Controlled Document (p4)	Change of job tile from Deputy Head of Patient and Healthcare Governance to Deputy Head of Quality Governance.	To reflect changes to department name / job titles.
6	Section 4.1.2 Style and format (p4)	Amendment to read 'Stand**ard** Operating Procedure'.	Correction of terminology.
7	Section 4.1.2 Style and format (p4)	Removal of reference to all pages needing a defined detail in footer.	Duplicated information within document control table of template.
8	Section 4.1.2 Equality Impact Assessment (p5)	Removal of reference to clinical guidelines and clarification of process for corporate policies.	To reflect only the corporate policy template includes an EIA form.
9	Section 4.1.2 Other Impacts (p6)	Replacement of references to 'Controlled Document' with 'corporate policy'.	Reflects fact that only corporate policy template includes 'other impacts' section within document control table.
10	Section 4.1.3 Approval and ratification (p6 / p7)	Clarification of ratification process for controlled documents with Trust-wide application.	To reflect Trust process.
11	Section 4.1.3 Approval and ratification (p7)	Removal of reference to individual policies being specified in Scheme of Delegation (SoD).	To reflect the fact that individual polices are not listed in the SoD.
12	Section 4.1.3 Approval and ratification (p7) - table	Addition within table of Local policies.	Addition of / redefinition of process for categories of documents.
13	Section 4.1.3 Approval and ratification (p8) - table	Replacement of 'patient record forms' with 'healthcare record forms'.	Change in nomenclature.

Ref	Section	Description of proposed change	Rationale
14	Section 4.1.3 Approval and ratification (p8) - table	Reference to need to seek approval for developing / updating paper healthcare record form.	To reflect new practice.
15	Section 4.1.3 Approval and ratification (p8) - table	Procedural documents ratification steps confirmed as being oversight / subject expert group.	Clarification of responsibility and to distinguish these from policy documents requiring TEG ratification.
16	Section 4.1.3 Approval and ratification (p9)	Addition of content regarding adoption of other Trust's documents.	To prompt consideration to governance of such documents.
17	Section 4.1.3 Approval and ratification (p9)	Confirmation that all appendices should be included with the controlled document at approval stage.	Clarification of process / responsibility.
18	Section 4.1.4 Dissemination (p9 / p10)	Addition of content to describe dissemination of documents according to classification.	To reflect / clarify current arrangements.
19	Section 4.1.4 Dissemination (p9) and *throughout*	Reference to Trust Controlled Documents Library to replace '*Intranet'* and '*Register of Controlled Documents*'.	Consistency of reference / nomenclature.
20	Section 4.1.5 Review – Formal review (p10)	Terms of Reference – annual review.	Confirmation that ToR require annual review.
21	Section 4.1.5 Review – Minor revisions (p10) / Obsolete Documents (p11) / Archiving (p12)	Change in individual roles referenced and other minor wording edits.	To reflect change in responsibilities within CEO Office team.
22	Section 4.1.5 Review – Archiving (p12)	Addition of content relating to process for requesting archived documents.	To reflect / clarify current arrangements.
23	Section 4.1.6 Monitoring compliance (p12)	Addition of content to reference audit practice.	Clarification of arrangements.
24	Section 5 – Roles and Responsibilities (table) (p14 / p15)	Minor wording edits / reflection of changes to roles within CEO Office.	Clarification of arrangements.
25	Section 6 Monitoring (p17)	Addition of row to reflect new reporting to Audit Committee re policy compliance.	To reflect new oversight arrangements.
26	Section 7 Definitions (p17 and p18)	Updating of table including subdivision of categorisation of policies into corporate and local and wording editing.	Housekeeping / to abridge content.
27	Associated Trust and external documents	External and Trust document references and hyperlinks updated / documents previously listed as appendices listed here.	Housekeeping.
28	Document Control	Updating of dates and other relevant fields.	Routine review process.
29	*Throughout*	Replacement of '&' with 'and'.	Typographical correction in line with Trust Style.

Table II: Table of Changes following review of the Standards of Business Conduct Policy – Sep 2024

Ref	Section	Description of proposed changes	Rationale
1	Section 1, Introduction (p1)	Rewrite of introduction.	Wording simplified for ease of understanding / reference.
2	Section 1, Introduction (p2)	Creation of a contents page and use of bookmarks.	Ease of navigation.
3	Section 3, Scope and expectations (p4)	Removal of reference to specific groups / individuals previously listed in scope (ie those not directly employed by the Trust).	To reflect the practical application of the policy.
4	Section 4, Policy Details (p4/5)	Rewrite of content referring to access to other sources of related information and to also remove content which the introduction of a table of contents has replaced.	To reflect changes in arrangements and to remove duplication of content.
5	Section 4.3.3, Gifts (p10)	Addition of Sheffield Hospitals Charity contact details.	Clarification of arrangements for donation of gifts.
6	Section 4.3.8, Outside Employment (p16)	Addition of reference to process for recording key discussions.	To promote requirement following analysis of breaches relating to this requirement.
7	Section 4.3.8, Outside Employment (p18)	Inclusion of content regarding undertaking secondary employment work during periods of sickness absence.	Added following stakeholder consultation with HR to align with HR policy.
8	Section 4.3.8, Outside Employment (p18)	Removal of reference to referral to the Trust's Counter-Fraud Specialist.	Process described within the Anti-Fraud, Bribery and Corruption Policy which is cross referenced in this section.
9	Section 4.3.9, Clinical private practice (p19) / Section 4.3.14, Shareholding and other ownership issues (p22)	Inclusion of content relating to secondary employment with suppliers of insourcing providers / shareholding in such.	Added to align with new Insourcing Policy.
10	Section 4.3.15, System working – joint roles (p23)	Addition of principles around system working.	To align with context of wider system governance changes since last policy review.
11	Section 4.4.2, Reporting breaches (p24) / (p26)	Replacement of "Raising Concerns at Work Policy" with "Freedom to Speak Up Policy and Procedures".	To reflect change in name of policy since last review of this policy.
12	Section 4.4.4, Fraud and Probity (p25)	Update of the procedure for referring cases to the Local Counter Fraud Specialist.	To reflect new reporting procedure.
13	Section 4.5.2, Guidance relating to the pharma industry (p27)	Content abridged.	Deletion of reference to 'new' context that was contemporary at time of last review.
14	*Throughout*	External and Trust document references and hyperlinks updated and new links added as and where appropriate.	Housekeeping
15	Section 10, Appendices / Appendix A (p39)	Removal of several flow charts from Appendix A / replacement with singular flowchart.	Individual flowchart superseded by other forms of procedural guidance (signposted in Introduction to policy).

16	Section 11, Document Control (p33)	Dates and other relevant fields updated.	Routine review process.
17	Section 12, Version history (p33/34)	Table updated to include proposed changes in this version 9 of the policy.	Routine review process.
18	Section 13, Consultation and Review (p35)	Table updated to reflect groups / persons consulted.	Routine review process.
19	*Throughout*	Footnote numbering updated.	Housekeeping.
20	*Throughout*	Changes of job titles / organisation names.	To reflect changes since last review.