Hertfordshire Community NHS Trust

TRUST BOARD

Meeting **5th October 2021**

Date: Title: **Supporting Papers**
Available electronically on the website at https://www.hct.nhs.uk/about-us/our-board/meeting-papers/

Executive Lead: **Various**
Author(s): **Various**
For: **Noting**

The Board is requested to note the following supporting papers which are for information only and which are referenced in reports within the main agenda.

Lead	Agenda Link	Title & Category	Attachment
Strategy, Planning and Engagement			
EHJ	**C1**	Emergency Preparedness Resilience and Response Core Standards – Compliance Statement and Policy 2021	(J1)
Clinical Services and Quality			
EK	**D1**	Pharmacy Annual Report	(J2)
Board Governance and Leadership			
DB	**F2**	The NHS Constitution	(J3)
		The NHS Code of Conduct and Accountability	(J4)
		The NHS Code of Openness	(J5)
		The "Nolan" Principles of Governance.	(J6)
		HCT Principles of Board Etiquette	(J7)
		The Code of Conduct for NHS Managers (Only applicable to Executive Directors)	(J8)

Hertfordshire Community NHS Trust

Jim McManus and Victoria Woodhatch
LHRP Co-chairs
Performance and Improvement
Directorate
NHS England and NHS Improvement
East of England
Charter House
Parkway
Welwyn Garden City
AL8 6JL

03 September 2021

Dear Jim and Victoria,

Emergency Planning Resilience and Response Core Standards
Statement of compliance

The Core Standards self-assessment has been presented to and approved by the HCT Executive meeting on 18 August 2021 and will be presented to the HCT Board meeting on 05 October 2021.

The Trust meets the requirements of all 37 applicable standards across the ten domains:

- Governance
- Duty to risk assess
- Duty to maintain plans
- Command and control
- Training and exercising
- Response
- Warning and informing
- Co-operation
- Business continuity
- CBRN

The 'Medical Gases Deep Dive' does not apply to the Trust as we have no piped gases as an organisation. Additionally, the 'Interoperable Capabilities' section is not applicable to us.

Hertfordshire Community NHS Trust therefore considers its overall level of compliance with the core standards to be **fully compliant**.

Yours sincerely,

Elliott Howard-Jones
Chief Executive, Hertfordshire Community NHS Trust

Emergency Preparedness, Resilience and Response Policy Statement - 2021

Contents

Foreword by the Chief Executive

The Civil Contingencies Act 2004 is the national legislation which places the highest priority on all organisations to ensure adequate emergency planning and preparedness, as well as robust business continuity planning.

Hertfordshire Community NHS Trust (HCT), under the Civil Contingencies Act 2004 is required to respond during an incident to support category 1 responders, and has a duty to protect and promote the health economy in partnership with the wider NHS, the emergency services and local authorities and through the Local Resilience Forum (LRF). We have a central role in planning for and responding to any incident with major consequences for health or health services.

Every member of staff has a vital role to play in ensuring there is a professional NHS response in a crisis. As such, it is essential that staff are familiar with how the Trust operates during such an event, what role staff may play, and what other organisations the Trust will be working with.

An emergency, by its nature, is a stressful and uncertain situation. As such it is vital that staff feel supported by an effective emergency management team, who will work with them to coordinate the response. There may be a need for staff to be flexible, work for extended periods and/or in unfamiliar environments, and we rely on staff cooperation and support in order to manage any crisis effectively.

This Policy Statement sets out the framework for the Trust's approach to Emergency Preparedness, Resilience and Response (EPRR).

It is vital that the Trust is prepared and can respond to any major incident, providing a coordinated range of emergency, mid and long-term services to those involved, including patients, carers, relatives and friends, and our own staff. As such, robust and comprehensive emergency planning is a priority for the Trust.

The success of this approach by the Trust has been evidenced during the Covid-19 pandemic over the last 18 months. As part of our response we put in place a 24/7 incident command centre (ICC) which, as well as a physical and remote presence at our head office, was further supported by our robust on-call process.

Elliot Howard-Jones
Chief Executive
Date

1. Overview

In order to comply with the Civil Contingencies Act 2004, the Health and Social Care Act 2012, NHS England Core Standards and EPRR framework, the Trust is committed to:

- A 24/7 Director/Senior manager on call rota to provide strategic leadership for the trust
- Expert advice, training and exercising to strategic, tactical and operational level will be provided for EPRR and business continuity as appropriate
- The Trust emergency planning and resilience manager will ensure that the Trust discharges its responsibilities under the Civil Contingencies Act 2004, the Health and Social Care Act 2012, and the NHS EPRR framework

2. Training and exercising

To enable these duties to be carried out HCT will:

Commit to facilitating the attendance of Directors/ Senior Managers on call to attend courses required to meet appropriate competencies. These include:

- JESIP awareness
- Director/Senior manager on call training
- Strategic leadership in a crisis
- Defensible decision making
- Trust, NHSE/I and LRF exercises as appropriate
- Media training

The Trust encourages staff to attend and participate in multi-agency training and exercising. Not only does this provide opportunities for wider learning, but also embeds the culture of joined up working and system-wide understanding of emergency preparedness and business continuity needs.

HCT will also commit to training members of staff to undertake the role of loggist and other positions within the Incident Command Centre (ICC) and carry out the duties as described within the Trust Major Incident Plan, Business Continuity Plan and other emergency response plans.

The Emergency planning and resilience manager, supported by the emergency planning group, will maintain oversight of the training needs of staff in relation to EPRR rolls. A register will be maintained of training undertaken.

HCT will ensure all staff undertaking any role within an incident are properly supported to undertake their role both during and after an incident.

The trust remains committed to exercising as required under the Civil Contingencies Act 2004. As a minimum this will include:

- A table-top exercise annually
- Communications exercise twice yearly
- A live exercise every three years

Where a live incident has occurred, this will negate the requirement for additional exercising provided all relevant aspects are covered and a review of any live incidents will ensure that any learning is embedded in future responses.

3. Funding

HCT will support the Local Health Resilience Partnership (LHRP) and LRF training budgets as appropriate, facilitating the training of staff on a system wide basis.

Under the Civil Contingencies Act requirements, the Trust will ensure appropriate funding for emergency preparedness and business continuity posts as well as for a local security management specialist (LSMS).

The trust will remain committed to the mutual aid agreements in place within the LHRP and LRF.

When responding to an incident it is acknowledged that costs will be met where they fall across the healthcare community.

4. Planning

HCT takes an active role within the LHRP via the Accountable Emergency Officer (AEO), and the LHRP sub-group is attended by the Emergency planning and resilience manager. HCT EPRR work is directly linked to the LHRP work plan and is overseen by the Emergency Planning Group which reports directly to the Trust executive committee. During 2020/21 HCT has taken an active role at the Hertfordshire Emergency Tactical Coordination Group (HETCG) as part of the pandemic response.

HCT will work with the LRF to ensure they take into account the needs of the wider health economy in terms of plans and the community risk register. Should any specific risks arise that affect HCT, these will be added to the corporate risk registers as appropriate.

The EPRR manager will maintain the plans and procedures for HCT with the support of the AEO and relevant departments as required. These will be reviewed in line with the emergency planning cycle where required.

5. Business Continuity Management Systems

HCT maintains robust business continuity plans (BCP) to ensure the continuation of critical services. Departmental and service BCPs are based on comprehensive Business Impact Analysis, and align with ISO Standards and Business Continuity Institute good practice guidelines.

6. Continuous Improvement

HCT recognises that to continue to improve services lessons should be identified and learned.

Lessons will be identified via:

- Internal debriefs following incidents and/or exercises
- External multi-agency debriefs following incidents and/or exercises

- Shared learning from other healthcare trusts and NHSE/I briefings

This has been demonstrated through the pandemic response through reflective surveys to incident leaders and all staff on two separate occasions with learning applied to future planning.

This statement will be reviewed annually as part of the EPRR assurance process to ensure it meets the needs of Hertfordshire community NHS Trust

7. EPRR Structure and personnel

Chief Executive	Elliot Howard-Jones
Accountable Emergency Officer	Marion Dunstone
EPRR manager	Jackie Davenport

For Incident Management

Strategic - Gold Command	Executive director (Director on call)
Tactical - Incident Coordination Centre/Silver Command	Associate/Deputy director (Senior manager on call)
Operational - Bronze Command	Service leads/heads of department

Hertfordshire Community NHS Trust

Pharmacy Annual Report 2020/2021

1.0 Executive Summary

1.1 This annual report provides an overview of work done by the Pharmacy Department on medicines optimisation and the governance on the use of medicines in Hertfordshire Community NHS Trust (HCT) for the period 1st April 2020 to 31st March 2021. It provides assurance that HCT complies with the regulations set out in:

- Care Quality Commission (CQC) (2020)
- Regulation 12 (1) & (2) (g) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to the proper and safe management of medicines
- The Medicines Act 1968
- The Human Medicines Regulation 2012
- The Misuse of Drugs Act 1971
- The Misuse of Drugs Regulations 2001
- The Misuse of Drugs (safe custody) Regulations 1973, amended 2007 and
- The Controlled Drugs (supervision of management and use) Regulations 2013

It also provides assurance of actions and improvements made by HCT in response to audit and incident findings.

1.2 Much of the focus of Pharmacy work this year has been with supporting the Trust's COVID-19 Pandemic response and the COVID-19 Mass Vaccination Programme.

1.3 New Pharmacy services continue to develop such as the anti-coagulation clinics and additional contracts for Primary Care Network (PCN) Pharmacy services.

1.4 The Electronic Prescribing and Medicines Administration (EPMA) Capital Business Case was approved this financial year and work on the implementation of EPMA started in the final quarter of the year.

2.0 COVID-19 Pandemic Response and Mass Vaccination

2.1 During the Trust's COVID-19 Pandemic response, initiated in April 2020, a number of innovative new services were developed to support the national and regional efforts to combat the virus. This includes the Prevention of Admission (POA) Service, COVID Virtual ward and Enhanced Care Home services.

Pharmacies provided support to the development and operation of these new services. The focus was threefold;

1) to ensure easy access to medication by patients and clinicians,
2) to ensure that clinicians and patients, especially those at high risk have easy access to clinical pharmacy guidance and receive proactive medicines optimisation input and
3) to support system-wide work to ensure the health system is working as planned, more seamlessly and no particular sector is over-stressed.

To this end, Pharmacy has developed a number of innovative solutions which have been very well received. These include:

- Developed a system for 24 hour access to End of Life Medicines in HCT locations,
- Facilitated the development of new clinical pathways for oral and intravenous antibiotic treatments, Deep Venous Thrombosis (DVT) and Subcutaneous Fluids,
- Developed new Patient Group Directions and pre-packed medicines to expand our treatment portfolio,
- Set up Electronic Prescribing Systems in certain services such as the Prevention of admission Hub,
- Provision of a new pharmacy on-call rota for out-of-hours medicines guidance,
- Provision of new pharmacy roles to support the Prevention of Admission Hub, COVID virtual wards and care home-based COVID rehabilitation wards with specialist medicine advice,
- Increased pharmacy presence in services with re-deployed nursing staff to support medicines use, attend Consultant ward rounds and discharge planning,
- Acting as named pharmacists for a number of care homes in the region as part of the Enhanced Care Home Services COVID response, providing medicine expertise to high risk areas.

- Working with system partners at regular COVID Outbreak meetings for all East and North Herts care homes and POA, supporting recent hospital discharges and review of new residents
- The Integrated Care Team pharmacist in the Lower Lea Valley locality provided extra support to the GPs by taking over the prescribing of catheters, dressings, ancillaries and authorisations and just in case medications. (data collection in Lower Lea Valley over a 10 month period recorded over 800 pharmacist interventions made, equivalent to 300 GP Hours saved and 38 prevented HUC/Ambulance call outs or hospital overnight stays attributed to prescribing antibiotics and preventing delirium, falls and acute kidney injury by medication reviews.)

2.2 The work achieved was truly an example of joint-up system working. The Pharmacy leaders from HCT, acute Trusts, Clinical Commissioning Group and retail Pharmacy met on a weekly basis to share information, discuss pressures in each sector and how we can support each other by collaborative working and increasing efficiency by reducing duplication. To support some of the services described above, two members of staff from E&N Herts CCG Pharmacy team were redeployed into HCT through mutual aid.

2.3 HCT was selected as the provider for COVID Mass Vaccination in East and North Hertfordshire, West Essex, Bedfordshire, Luton and Milton Keynes areas. Since December 2020, the Pharmacy Team has been providing substantial support to the programme including

- Providing assurance to the Regional Chief Pharmacist on Medicines Management in the vaccination centres
- Support on the use of Patient Group Directions and the National Protocol
- Training of staff on vaccine administration
- Training of staff on cold chain management
- Clinical support on the use of the vaccines, including a dedicated Pharmacy clinical support line Monday to Sunday, 8am to 8pm
- Support on vaccine transport and handling on site
- Regular visits to vaccination centres to support staff on medicines management and clinical vaccine queries
- Educating staff and patients about COVID-19 vaccination through on-line webinars and chats to improve their knowledge and increase uptake

3.0 Progress of the Medicines Optimisation and Pharmacy Plan 2019/ 2021

3.1 To provide a robust and sufficient response to the Pandemic efforts, a number of work streams originally planned for 2020/21 have been re-prioritised and rescheduled for a later date.

Of note, the exploration of use of Electronic Prescribing and Medicines Administration (EPMA), the transformation of Integrated Care Team (ICT) Pharmacy work and the development of an in-house ward pharmacist service were delayed by up to three quarters.

3.2 The business case for EPMA implementation was approved in Q3. The business case was developed by the Chief Pharmacist with support from the Head of Clinical Systems, the Assistant Director Integrated Community Services and the Lead Nurse for In-patients.

By the end of Q4, the recruitment process for the EPMA Project team was completed with some roles started. An EPMA Task and Finish Group consisting of representation from adult services, children's services, in-patient services, community services was formed to support and oversee the work of the Project Team.

The EPMA project consists of three phases- 1) EPMA in wards, 2) electronic prescribing in community services and 3) electronic medicines administration chart in community services. Active implementation will take place in 2021/22.

3.3 The transformation of the ICT Pharmacy work started in Q4 and will continue in 2021/22. Overall ICT work for the Trust during the Pandemic was reduced as some have been absorbed into the POA service, where Pharmacy have put in extra resources to support.

3.4 The development of an-in-house ward pharmacist service has been deferred to 2021/22. We continue to support the wards with clinical pharmacist through Service Level Agreements (SLAs) with our acute partners in the region.

4.0 Medicines Management & Safety

4.1 <u>Analysis of Medicines Incidents</u>

During 2020/21 our staff reported 340 medicines-related incidents, of which 211 (62%) were attributable to care delivered by HCT. The overall total is a 7% decrease compared to the number of incidents reported during 2019/20.

The total number of incidents resulting in harm in 2020/21 is 27, which represents a 1% increase compared to the previous year.

Due to the COVID-19 pandemic, there has been an increased number of patient contacts and use of medicines which are more novel to staff and more agency staff (due to redeployment) resulting in more “harm” medication incidents.

4.2 Trends and Themes

All medicines-related incidents are reviewed by our Pharmacy team. Almost all incidents are multi-factorial involving multiple professional and staffing groups. Therefore, all investigations have input from these groups to ensure actions and learning have the appropriate ownership and buy-in from relevant leads, in order that actions are successfully implemented.

Of the 27 HCT incidents resulting in harm, 24 resulted in low harm and 3 resulted in moderate harm. The 24 incidents were classified as low harm because further monitoring of the patient was required following the medication incident.

The 3 incidents resulting in moderate harm were further investigated using a Root cause analysis (RCA) as the patient had to be re-admitted to acute hospital for closer monitoring of their condition. These incidents identified a need for further prescribing support and more robust self-checks required by staff before administering medicines.

In 2020/21, we successfully continued the trend to reduce omitted doses of insulin in the Integrated Care Team service. Omitted insulin doses were first noted to be an issue in 2018/19, where there were 60 incidents. In 2019/20 this has reduced to 40 and this year, it was further reduced to 30.

The ICT pharmacists met extensively with the operations teams, with particular focus on learning from medication incidents. Substantial efforts were made to mitigate identified risks, including the development of junior members of the operations team. This work will be continued into the next financial year. The reduction in insulin omitted doses is a result of joint work between the Pharmacy, Quality and Operational teams.

It’s important that there is a robust process to help review incidents and the root cause.

As discussed above, insulin issues continue to be monitored despite the improvement. There has been an increased use of intravenous drugs in the Trust and with that, an increased proportion of incidents involving them. As part of the post COVID recovery phrase, Pharmacy has been reviewing and tackling areas of high risks with each locality, to ensure we can prevent similar incidents from happening again. Education and training in prescribing is an area of focus.

As part of medicines use and safety in our service, all moderate to severe medication incidents are investigated and lessons learnt produced. The lessons learnt from the incidents are shared with the staff via a Shared Lessons in Practice (SLiP) to help prevent incidents occurring again. All affected policies and SOP's are updated and shared with staff.

4.3 The Pharmacy Team continues to have a robust system to manage all medicines safety alerts and works closely with Risk Team. Each month clinical teams are sent safety alerts and supporting information to ensure that recommendations have been assessed and actioned.

5.0 Controlled Drugs

5.1 Controlled Drugs (CDs) in the Trust continue to be managed by the Chief Pharmacist and the Controlled Drug Accountable Officer to ensure its safe and effective use as well as to prevent misuse and diversion.

5.2 HCT takes part in the Local Intelligence Network in the England and East region to monitor for the occurrence of CD concerns. Quarterly reports of CD incidents are submitted centrally. In 2020/21, HCT reported no incidents classified as High risk or Extreme risk.

6.0 Medicines Management and Clinical Audits

6.1 Pharmacy continues to conduct a range of medicines management and clinical audits in our in-patient areas to provide assurance that medicines are managed correctly and its use is clinically appropriate.

6.2 During the first wave of the COVID-19 Pandemic, Pharmacy provided extra support in our wards. This was a top up service (in addition to the regular weekly visit by the clinical pharmacist) to provide twice weekly visits to conduct medication reviews, reconciliation and robust medicines management. This resulted in a reduction in medication incidents, less omitted doses and greater staff reassurance with regular pharmacy support.

In Q1, the regular quarterly medicines management audits were not completed due to re-prioritisation of work. The mitigation to this was the increased pharmacy presence and support delivered to these ward during this time. The quarterly audits were re-instated from Q2 onwards.

One area which is audited as part of the quarterly medicines audits are missed doses. Results have shown consistent improvement Quarter on Quarter. The table below shows the results for the Q4 audit at all three units.

Q4 Omitted Doses Audit over 1 week at Herts and Essex (HEH), Queen Victoria Memorial (QVM) and Danesbury
HEH- of the 1721 doses prescribed, 0.75% of doses were omitted
Danesbury- of the 1511 doses prescribed, 0.3% of doses were omitted
QVM hospital, of the 1189 doses prescribed, 0.3% of doses were omitted

6.3 The other findings from the Medicines Storage and Controlled Drugs audits which look at the safe and secure handling of medication have shown a consistent score in 'Green' across the various audited criteria.

6.4 As part of the robust governance and Pharmacy oversight, all reports are reviewed at Medicines Management Forum and further training is delivered to those units that score "red" in any audit criteria.

6.5 Monthly Dip tests, as a "quick" way to audit the ward on medicines management and missed doses were introduced last year. However, due to constraints in resources in the Pharmacy team bought on by the COVID-19 pandemic, these were paused this year, with only one DIP test performed. The "green" and improving results in the Quarterly audits and increased pharmacy presence on the wards provided assurance that standard of practice in medicines management and prescribing across the inpatients units were adhered to.

7.0 New Pharmacy Services

7.1 In September 2021, HCT took over a warfarin anticoagulation service from another provider. This is a pharmacist – led service with one Band 8a pharmacist working with a multi-disciplinary team of nurses and health care assistants to patients in North Hertfordshire with their warfarin.

As well as taking over the old service, HCT have made several improvements to it including improving accessibility by patients in the community and increased liaison with the anti-coagulation services at East and North Herts Trust and local GPs to streamline care.

There are approximately 550 patients on the caseload. Approximately 60% attend clinic appointments and the remaining 40% are visited at home by a nurse or HCA with pharmacist oversight and support virtually.

The service is running smoothly. Competencies and training programmes are being developed to improve the quality and consistency of the service and for succession planning.

7.2 The Primary Care Network (PCN) Pharmacy services continue to grow, with three new PCNs buying our services. This has added three PCN pharmacists, one PCN care home pharmacist and the first PCN pharmacy technician in our region to the HCT Pharmacy team.

Pharmacy has worked closely with the Contracts Team to strengthen our contracts with PCNs, to ensure income generation and standardisation of the service.

Author: Chi Kai Tam

Deputy Director of Medicines Optimisation, Chief Pharmacist

July 2021

THE NHS CONSTITUTION

the NHS belongs to us all

for England
27 July 2015

The NHS belongs to the people.

It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health.
It touches our lives at times of basic human need, when care and compassion are what matter most.

The NHS is founded on a common set of principles and values that bind together the communities and people it serves – patients and public – and the staff who work for it.

This Constitution establishes the **principles** and **values** of the NHS in England. It sets out **rights** to which patients, public and staff are entitled, and **pledges** which the NHS is committed to achieve, together with **responsibilities**, which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. The Secretary of State for Health, all NHS bodies, private and voluntary sector providers supplying NHS services, and local authorities in the exercise of their public health functions are required by law to take account of this Constitution in their decisions and actions. References in this document to the NHS and NHS services include local authority public health services, but references to NHS bodies do not include local authorities. Where there are differences of detail these are explained in the Handbook to the Constitution.

The Constitution will be renewed every 10 years, with the involvement of the public, patients and staff. It is accompanied by the Handbook to the NHS Constitution, to be renewed at least every three years, setting out current guidance on the rights, pledges, duties and responsibilities established by the Constitution. These requirements for renewal are legally binding. They guarantee that the principles and values which underpin the NHS are subject to regular review and recommitment; and that any government which seeks to alter the principles or values of the NHS, or the rights, pledges, duties and responsibilities set out in this Constitution, will have to engage in a full and transparent debate with the public, patients and staff.

1. Principles that guide the NHS

Seven key principles guide the NHS in all it does. They are underpinned by core NHS values which have been derived from extensive discussions with staff, patients and the public. These values are set out in the next section of this document.

1. The NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status. The service is designed to improve, prevent, diagnose and treat both physical and mental health problems with equal regard. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.

2. Access to NHS services is based on clinical need, not an individual's ability to pay. NHS services are free of charge, except in limited circumstances sanctioned by Parliament.

3. The NHS aspires to the highest standards of excellence and professionalism – in the provision of high quality care that is safe, effective and focused on patient experience; in the people it employs, and in the support, education, training and development they receive; in the leadership and management of its organisations; and through its commitment to innovation and to the promotion, conduct and use of research to improve the current and future health and care of the population. Respect, dignity, compassion and care should be at the core of how patients and staff are treated not only because that is the right thing to do but because patient safety, experience and outcomes are all improved when staff are valued, empowered and supported.

4. The patient will be at the heart of everything the NHS does. It should support individuals to promote and manage their own health. NHS services must reflect, and should be coordinated around and tailored to, the needs and preferences of patients, their families and their carers. As part of this, the NHS will ensure that in line with the Armed Forces Covenant, those in the armed forces, reservists, their families and veterans are not disadvantaged

in accessing health services in the area they reside. Patients, with their families and carers, where appropriate, will be involved in and consulted on all decisions about their care and treatment. The NHS will actively encourage feedback from the public, patients and staff, welcome it and use it to improve its services.

5. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population. The NHS is an integrated system of organisations and services bound together by the principles and values reflected in the Constitution. The NHS is committed to working jointly with other local authority services, other public sector organisations and a wide range of private and voluntary sector organisations to provide and deliver improvements in health and wellbeing.

6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources. Public funds for healthcare will be devoted solely to the benefit of the people that the NHS serves.

7. The NHS is accountable to the public, communities and patients that it serves. The NHS is a national service funded through national taxation, and it is the Government which sets the framework for the NHS and which is accountable to Parliament for its operation. However, most decisions in the NHS, especially those about the treatment of individuals and the detailed organisation of services, are rightly taken by the local NHS and by patients with their clinicians. The system of responsibility and accountability for taking decisions in the NHS should be transparent and clear to the public, patients and staff. The Government will ensure that there is always a clear and up-to-date statement of NHS accountability for this purpose.

2. NHS values

Patients, public and staff have helped develop this expression of values that inspire passion in the NHS and that should underpin everything it does. Individual organisations will develop and build upon these values, tailoring them to their local needs. The NHS values provide common ground for co-operation to achieve shared aspirations, at all levels of the NHS.

Working together for patients. Patients come first in everything we do. We fully involve patients, staff, families, carers, communities, and professionals inside and outside the NHS. We put the needs of patients and communities before organisational boundaries. We speak up when things go wrong.

Respect and dignity. We value every person – whether patient, their families or carers, or staff – as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits. We take what others have to say seriously. We are honest and open about our point of view and what we can and cannot do.

Commitment to quality of care. We earn the trust placed in us by insisting on quality and striving to get the basics of quality of care – safety, effectiveness and patient experience – right every time. We encourage and welcome feedback from patients, families, carers, staff and the public. We use this to improve the care we provide and build on our successes.

Compassion. We ensure that compassion is central to the care we provide and respond with humanity and kindness to each person's pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering. We find time for patients, their families and carers, as well as those we work alongside. We do not wait to be asked, because we care.

Improving lives. We strive to improve health and wellbeing and people's experiences of the NHS. We cherish excellence and professionalism wherever we find it – in the everyday things that make people's lives better as much as in clinical practice, service improvements and innovation. We recognise that all have a part to play in making ourselves, patients and our communities healthier.

Everyone counts. We maximise our resources for the benefit of the whole community, and make sure nobody is excluded, discriminated against or left behind. We accept that some people need more help, that difficult decisions have to be taken – and that when we waste resources we waste opportunities for others.

3a. Patients and the public – your rights and NHS pledges to you

Everyone who uses the NHS should understand what legal rights they have. For this reason, important legal rights are summarised in this Constitution and explained in more detail in the Handbook to the NHS Constitution, which also explains what you can do if you think you have not received what is rightfully yours. This summary does not alter your legal rights.

The Constitution also contains pledges that the NHS is committed to achieve. Pledges go above and beyond legal rights. This means that pledges are not legally binding but represent a commitment by the NHS to provide comprehensive high quality services.

Access to health services:

You have the right to receive NHS services free of charge, apart from certain limited exceptions sanctioned by Parliament.

You have the right to access NHS services. You will not be refused access on unreasonable grounds.

You have the right to receive care and treatment that is appropriate to you, meets your needs and reflects your preferences.

You have the right to expect your NHS to assess the health requirements of your community and to commission and put in place the services to meet those needs as considered necessary, and in the case of public health services commissioned by local authorities, to take steps to improve the health of the local community.

You have the right, in certain circumstances, to go to other European Economic Area countries or Switzerland for treatment which would be available to you through your NHS commissioner.

You have the right not to be unlawfully discriminated against in the provision of NHS services including on grounds of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status.

You have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible. The waiting times are described in the Handbook to the NHS Constitution.

The NHS also commits:

- to provide convenient, easy access to services within the waiting times set out in the Handbook to the NHS Constitution (pledge);
- to make decisions in a clear and transparent way, so that patients and the public can understand how services are planned and delivered (pledge); and
- to make the transition as smooth as possible when you are referred between services, and to put you, your family and carers at the centre of decisions that affect you or them (pledge).

Quality of care and environment:

You have the right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality.

You have the right to be cared for in a clean, safe, secure and suitable environment.

You have the right to receive suitable and nutritious food and hydration to sustain good health and wellbeing.

You have the right to expect NHS bodies to monitor, and make efforts to improve continuously, the quality of healthcare they commission or provide. This includes improvements to the safety, effectiveness and experience of services.

The NHS also commits:

- to identify and share best practice in quality of care and treatments (pledge).

Nationally approved treatments, drugs and programmes:

You have the right to drugs and treatments that have been recommended by NICE[1] for use in the NHS, if your doctor says they are clinically appropriate for you.

You have the right to expect local decisions on funding of other drugs and treatments to be made rationally following a proper consideration of the evidence. If the local NHS decides not to fund a drug or treatment you and your doctor feel would be right for you, they will explain that decision to you.

You have the right to receive the vaccinations that the Joint Committee on Vaccination and Immunisation recommends that you should receive under an NHS-provided national immunisation programme.

1 NICE (the National Institute for Health and Care Excellence) is an independent organisation producing guidance on drugs and treatments. 'Recommended for use by NICE' refers to a type of NICE recommendation set out in legislation. The relevant health body is obliged to fund specified NICE recommendations from a date no longer than three months from the publication of the recommendation unless, in certain limited circumstances, a longer period is specified.

The NHS also commits:

- to provide screening programmes as recommended by the UK National Screening Committee (pledge).

Respect, consent and confidentiality:

You have the right to be treated with dignity and respect, in accordance with your human rights.

You have the right to be protected from abuse and neglect, and care and treatment that is degrading.

You have the right to accept or refuse treatment that is offered to you, and not to be given any physical examination or treatment unless you have given valid consent. If you do not have the capacity to do so, consent must be obtained from a person legally able to act on your behalf, or the treatment must be in your best interests.[2]

You have the right to be given information about the test and treatment options available to you, what they involve and their risks and benefits.

You have the right of access to your own health records and to have any factual inaccuracies corrected.

You have the right to privacy and confidentiality and to expect the NHS to keep your confidential information safe and secure.

You have the right to be informed about how your information is used.

You have the right to request that your confidential information is not used beyond your own care and treatment and to have your objections considered, and where your wishes cannot be followed, to be told the reasons including the legal basis.

The NHS also commits:

- to ensure those involved in your care and treatment have access to your health information so they can care for you safely and effectively (pledge);
- that if you are admitted to hospital, you will not have to share sleeping accommodation with patients of the opposite sex, except where appropriate, in line with details set out in the Handbook to the NHS Constitution (pledge);
- to anonymise the information collected during the course of your treatment and use it to support research and improve care for others (pledge);
- where identifiable information has to be used, to give you the chance to object wherever possible (pledge);
- to inform you of research studies in which you may be eligible to participate (pledge); and

2 If you are detained in hospital or on supervised community treatment under the Mental Health Act 1983 different rules may apply to treatment for your mental disorder. These rules will be explained to you at the time. They may mean that you can be given treatment for your mental disorder even though you do not consent.

- to share with you any correspondence sent between clinicians about your care (pledge).

Informed choice:

You have the right to choose your GP practice, and to be accepted by that practice unless there are reasonable grounds to refuse, in which case you will be informed of those reasons.

You have the right to express a preference for using a particular doctor within your GP practice, and for the practice to try to comply.

You have the right to transparent, accessible and comparable data on the quality of local healthcare providers, and on outcomes, as compared to others nationally.

You have the right to make choices about the services commissioned by NHS bodies and to information to support these choices. The options available to you will develop over time and depend on your individual needs. Details are set out in the Handbook to the NHS Constitution.

The NHS also commits:

- to inform you about the healthcare services available to you, locally and nationally (pledge); and
- to offer you easily accessible, reliable and relevant information in a form you can understand, and support to use it. This will enable you to participate fully in your own healthcare decisions and to support you in making choices. This will include information on the range and quality of clinical services where there is robust and accurate information available (pledge).

Involvement in your healthcare and in the NHS:

You have the right to be involved in planning and making decisions about your health and care with your care provider or providers, including your end of life care, and to be given information and support to enable you to do this. Where appropriate, this right includes your family and carers. This includes being given the chance to manage your own care and treatment, if appropriate.

You have the right to an open and transparent relationship with the organisation providing your care. You must be told about any safety incident relating to your care which, in the opinion of a healthcare professional, has caused, or could still cause, significant harm or death. You must be given the facts, an apology, and any reasonable support you need.

You have the right to be involved, directly or through representatives, in the planning of healthcare services commissioned by NHS bodies, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.

The NHS also commits:

- to provide you with the information and support you need to influence and scrutinise the planning and delivery of NHS services (pledge);
- to work in partnership with you, your family, carers and representatives (pledge);
- to involve you in discussions about planning your care and to offer you a written record of what is agreed if you want one (pledge); and
- to encourage and welcome feedback on your health and care experiences and use this to improve services (pledge).

Complaint and redress:

You have the right to have any complaint you make about NHS services acknowledged within three working days and to have it properly investigated.

You have the right to discuss the manner in which the complaint is to be handled, and to know the period within which the investigation is likely to be completed and the response sent.

You have the right to be kept informed of progress and to know the outcome of any investigation into your complaint, including an explanation of the conclusions and confirmation that any action needed in consequence of the complaint has been taken or is proposed to be taken.

You have the right to take your complaint to the independent Parliamentary and Health Service Ombudsman or Local Government Ombudsman, if you are not satisfied with the way your complaint has been dealt with by the NHS.

You have the right to make a claim for judicial review if you think you have been directly affected by an unlawful act or decision of an NHS body or local authority.

You have the right to compensation where you have been harmed by negligent treatment.

The NHS also commits:

- to ensure that you are treated with courtesy and you receive appropriate support throughout the handling of a complaint; and that the fact that you have complained will not adversely affect your future treatment (pledge);
- to ensure that when mistakes happen or if you are harmed while receiving health care you receive an appropriate explanation and apology, delivered with sensitivity and recognition of the trauma you have experienced, and know that lessons will be learned to help avoid a similar incident occurring again (pledge); and
- to ensure that the organisation learns lessons from complaints and claims and uses these to improve NHS services (pledge).

3b. Patients and the public – your responsibilities

The NHS belongs to all of us. There are things that we can all do for ourselves and for one another to help it work effectively, and to ensure resources are used responsibly.

Please recognise that you can make a significant contribution to your own, and your family's, good health and wellbeing, and take personal responsibility for it.

Please register with a GP practice – the main point of access to NHS care as commissioned by NHS bodies.

Please treat NHS staff and other patients with respect and recognise that violence, or the causing of nuisance or disturbance on NHS premises, could result in prosecution. You should recognise that abusive and violent behaviour could result in you being refused access to NHS services.

Please provide accurate information about your health, condition and status.

Please keep appointments, or cancel within reasonable time. Receiving treatment within the maximum waiting times may be compromised unless you do.

Please follow the course of treatment which you have agreed, and talk to your clinician if you find this difficult.

Please participate in important public health programmes such as vaccination.

Please ensure that those closest to you are aware of your wishes about organ donation.

Please give feedback – both positive and negative – about your experiences and the treatment and care you have received, including any adverse reactions you may have had. You can often provide feedback anonymously and giving feedback will not affect adversely your care or how you are treated. If a family member or someone you are a carer for is a patient and unable to provide feedback, you are encouraged to give feedback about their experiences on their behalf. Feedback will help to improve NHS services for all.

4a. Staff – your rights and NHS pledges to you

It is the commitment, professionalism and dedication of staff working for the benefit of the people the NHS serves which really make the difference. High-quality care requires high-quality workplaces, with commissioners and providers aiming to be employers of choice.

All staff should have rewarding and worthwhile jobs, with the freedom and confidence to act in the interest of patients. To do this, they need to be trusted, actively listened to and provided with meaningful feedback. They must be treated with respect at work, have the tools, training and support to deliver compassionate care, and opportunities to develop and progress. Care professionals should be supported to maximise the time they spend directly contributing to the care of patients.

The Constitution applies to all staff, doing clinical or non-clinical NHS work – including public health – and their employers. It covers staff wherever they are working, whether in public, private or voluntary sector organisations.

Staff have extensive **legal rights**, embodied in general employment and discrimination law. These are summarised in the Handbook to the NHS Constitution. In addition, individual contracts of employment contain terms and conditions giving staff further rights.

The rights are there to help ensure that staff:

- have a good working environment with flexible working opportunities, consistent with the needs of patients and with the way that people live their lives;
- have a fair pay and contract framework;
- can be involved and represented in the workplace;
- have healthy and safe working conditions and an environment free from harassment, bullying or violence;
- are treated fairly, equally and free from discrimination;
- can in certain circumstances take a complaint about their employer to an Employment Tribunal; and
- can raise any concern with their employer, whether it is about safety, malpractice or other risk, in the public interest.

In addition to these legal rights, there are a number of **pledges**, which the NHS is committed to achieve. Pledges go above and beyond your legal rights. This means that they are not

legally binding but represent a commitment by the NHS to provide high-quality working environments for staff.

The NHS commits:

- to provide a positive working environment for staff and to promote supportive, open cultures that help staff do their job to the best of their ability (pledge);
- to provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities (pledge);
- to provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential (pledge);
- to provide support and opportunities for staff to maintain their health, wellbeing and safety (pledge);
- to engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families (pledge);
- to have a process for staff to raise an internal grievance (pledge); and
- to encourage and support all staff in raising concerns at the earliest reasonable opportunity about safety, malpractice or wrongdoing at work, responding to and, where necessary, investigating the concerns raised and acting consistently with the Employment Rights Act 1996 (pledge).

4b. Staff – your responsibilities

All staff have responsibilities to the public, their patients and colleagues.

Important legal duties are summarised below.

You have a duty to accept professional accountability and maintain the standards of professional practice as set by the appropriate regulatory body applicable to your profession or role.

You have a duty to take reasonable care of health and safety at work for you, your team and others, and to co-operate with employers to ensure compliance with health and safety requirements.

You have a duty to act in accordance with the express and implied terms of your contract of employment.

You have a duty not to discriminate against patients or staff and to adhere to equal opportunities and equality and human rights legislation.

You have a duty to protect the confidentiality of personal information that you hold.

You have a duty to be honest and truthful in applying for a job and in carrying out that job.

The Constitution also includes **expectations** that reflect how staff should play their part in ensuring the success of the NHS and delivering high-quality care.

You should aim:

- to provide all patients with safe care, and to do all you can to protect patients from avoidable harm;
- to follow all guidance, standards and codes relevant to your role, subject to any more specific requirements of your employers;
- to maintain the highest standards of care and service, treating every individual with compassion, dignity and respect, taking responsibility not only for the care you personally provide, but also for your wider contribution to the aims of your team and the NHS as a whole;
- to find alternative sources of care or assistance for patients, when you are unable to provide this

(including for those patients who are not receiving basic care to meet their needs);

- to take up training and development opportunities provided over and above those legally required of your post;
- to play your part in sustainably improving services by working in partnership with patients, the public and communities;
- to raise any genuine concern you may have about a risk, malpractice or wrongdoing at work (such as a risk to patient safety, fraud or breaches of patient confidentiality), which may affect patients, the public, other staff[3] or the organisation itself, at the earliest reasonable opportunity;
- to involve patients, their families, carers or representatives fully in decisions about prevention, diagnosis, and their individual care and treatment;
- to be open with patients, their families, carers or representatives, including if anything goes wrong; welcoming and listening to feedback and addressing concerns promptly and in a spirit of co-operation;
- to contribute to a climate where the truth can be heard, the reporting of, and learning from, errors is encouraged and colleagues are supported where errors are made;
- to view the services you provide from the standpoint of a patient, and involve patients, their families and carers in the services you provide, working with them, their communities and other organisations, and making it clear who is responsible for their care;
- to take every appropriate opportunity to encourage and support patients and colleagues to improve their health and wellbeing;
- to contribute towards providing fair and equitable services for all and play your part, wherever possible, in helping to reduce inequalities in experience, access or outcomes between differing groups or sections of society requiring health care;
- to inform patients about the use of their confidential information and to record their objections, consent or dissent; and
- to provide access to a patient's information to other relevant professionals, always doing so securely, and only where there is a legal and appropriate basis to do so.

3 The term 'staff' is used to include employees, workers, and, for the purposes of the Employment Rights Act 1996 (the ERA) (as amended by the Public Interest Disclosure Act), agency workers, general practitioners (e.g. those performing general medical services under General Medical Services Contracts), student nurses and student midwives, who meet the wider ERA definition of being a 'worker'. Whilst volunteers are not covered by the provisions of the ERA, guidance to employers makes clear that it is good practice to include volunteers within the scope of organisations' local whistleblowing policies.

© Crown copyright 2015
2904149 2p 5k 27th July 2015 (ESP)
Produced by Williams Lea for the Department of Health
For further copies of this title visit www.orderline.dh.gov.uk
and quote 2900013 The NHS Constitution.
Tel: 0300 123 1002
Fax: 01623 724 524
Minicom: 0300 123 1003 (8am to 6pm, Monday to Friday)

CODE OF CONDUCT
CODE OF ACCOUNTABILITY
IN THE NHS

CODE OF CONDUCT

Public Service Values

General Principles

Openness and Public Responsibilities

Public Service Values in Management

Public Business and Private Gain

Hospitality and Other Expenditure

Relations with Suppliers

Staff

Compliance

CODE OF ACCOUNTABILITY

Status

Code of Conduct

Statutory Accountability

The Board of Directors

The Role of the Chair

Non-Executive Directors

Reporting and Controls

Declaration of Interests

Employee Relations

NHS Appointments Commission

DH Department of Health

CODE OF CONDUCT FOR NHS BOARDS

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

There are three crucial public service values which must underpin the work of the health service.

Accountability – everything done by those who work in the NHS must be able to stand the test of parliamentary scrutiny, public judgements on propriety and professional codes of conduct.

Probity – there should be an absolute standard of honesty in dealing with the assets of the NHS: integrity should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of NHS duties.

Openness – there should be sufficient transparency about NHS activities to promote confidence between the NHS organisation and its staff, patients and the public.

General Principles

Public service values matter in the NHS and those who work in it have a duty to conduct NHS business with probity. They have a responsibility to respond to staff, patients and suppliers impartially, to achieve value for money from the public funds with which they are entrusted and to demonstrate high ethical standards of personal conduct.

The success of this Code depends on a vigorous and visible example from boards and the consequential influence on the behaviour of all those who work within the organisation. Boards have a clear responsibility for corporate standards of conduct and acceptance of the Code should inform and govern the decisions and conduct of all board directors.

Openness and Public Responsibilities

Health needs and patterns of provision of health care do not stand still. There should be a willingness to be open with the public, patients and with staff as the need for change emerges. It is a requirement that major changes are consulted upon before decisions are reached. Information supporting those decisions should be made available, in a way that is understandable, and positive responses should be given to reasonable requests for information and in accordance with the Freedom of Information Act 2000.

NHS business should be conducted in a way that is socially responsible. As a large employer in the local community, NHS organisations should forge an open and positive relationship with the local community and should work with staff and partners to set out a vision for the organisation in line with the expectations of patients and the public. NHS organisations should demonstrate to the public that they are concerned with the wider health of the population including the impact of the organisation's activities on the environment.

The confidentiality of personal and individual patient information must, of course, be respected at all times.

Public Service Values in Management

It is unacceptable for the board of any NHS organisation, or any individual within the organisation for which the board is responsible, to ignore public service values in achieving results. Chairs and board directors have a duty to ensure that public funds are properly safeguarded and that at all times the board conducts its business as efficiently and effectively as possible. Proper stewardship of public monies requires value for money to be high on the agenda of all NHS boards.

Accounting, tendering and employment practices within the NHS must reflect the highest professional standards. Public statements and reports issued by the board should be clear, comprehensive and balanced, and should fully represent the facts. Annual and other key reports should be issued in good time to all individuals and groups in the community who have a legitimate interest in health issues to allow full consideration by those wishing to attend public meetings on local health issues.

Public Business and Private Gain

Chairs and board directors should act impartially and should not be influenced by social or business relationships. No one should use their public position to further their private interests. Where there is a potential for private interests to be material and relevant to NHS business, the relevant interests should be declared and recorded in the board minutes, and entered into a register which is available to the public. When a conflict of interest is established, the board director should withdraw and play no part in the relevant discussion or decision.

Hospitality and Other Expenditure

Board directors should set an example to their organisation in the use of public funds and the need for good value in incurring public expenditure. The use of NHS monies for hospitality and entertainment, including hospitality at conferences or seminars, should be carefully considered. All expenditure on these items should be capable of justification as reasonable in the light of the general practice in the public sector. NHS boards should be aware that expenditure on hospitality or entertainment is the responsibility of management and is open to be challenged by the internal and external auditors and that ill-considered actions can damage respect for the NHS in the eyes of the community.

Relations with Suppliers

NHS boards should have an explicit procedure for the declaration of hospitality and sponsorship offered by, for example, suppliers. Their authorisation should be carefully considered and the decision should be recorded. NHS boards should be aware of the risks in incurring obligations to suppliers at any stage of a contracting relationship. Suppliers should be selected on the basis of quality, suitability, reliability and value for money. The Department of Health has issued guidance to NHS organisations about standards of business conduct (ref: HSG(93)5).

Staff

NHS boards should ensure that staff have a proper and widely publicised procedure for voicing complaints or concerns about maladministration, malpractice, breaches of this code and other concerns of an ethical nature. The board must establish a climate:

- that enables staff who have concerns to raise these reasonably and responsibly with the right parties;

- that gives a clear commitment that staff concerns will be taken seriously and investigated; and

- where there is an unequivocal guarantee that staff who raise concerns responsibly and reasonably will be protected against victimisation.

(Ref: Whistleblowing in the NHS, letter dated 25 July 2003 from the Director of HR in the NHS)

Compliance

Board directors should satisfy themselves that the actions of the board and its directors in conducting board business fully reflect the values in this Code and, as far as is reasonably practicable, that concerns expressed by staff or others are fully investigated and acted upon. All board directors of NHS organisations are required, on appointment, to subscribe to the Code of Conduct.

Originally published April 1994
First revision April 2002
Second revision July 2004

CODE OF ACCOUNTABILITY FOR NHS BOARDS

This Code of Practice is the basis on which NHS organisations should seek to fulfil the duties and responsibilities conferred upon them by the Secretary of State for Health.

Status

NHS organisations, such as NHS trusts, primary care trusts, strategic health authorities and special health authorities, are established under statute as corporate bodies so ensuring that they have separate legal personality. Statutes and regulations prescribe the structure, functions and responsibilities of the boards of these bodies and prescribe the way chairs and directors of boards are to be appointed.

Code of Conduct

All board directors of NHS organisations are required, on appointment, to subscribe to the Code of Conduct. Breaches of this Code of Conduct by the chair or a non-executive director of the board should be drawn to the attention of the appropriate Regional Commissioner of the NHS Appointments Commission.

NHS managers are required to take all reasonable steps to comply with the requirements set out in the Code of Conduct for NHS Managers. Chairs and non-executive directors of NHS boards are responsible for taking firm, prompt and fair disciplinary action against any executive director in breach of the Code of Conduct for NHS Managers.

Statutory Accountability

The Secretary of State for Health has statutory responsibility for the health of the population of England and uses statutory powers to delegate functions to NHS organisations who are thus accountable to the Secretary of State and to Parliament. The Department of Health is responsible for directing the NHS, ensuring national policies are implemented and for the effective stewardship of NHS resources.

NHS trusts provide services to patients (these may be acute services, ambulance services, mental health or other special services, e.g. for children). Other main functions are to:

- ensure services are of high quality and accessible;

- lead the development of new ways of working to fully engage patients and ensure a patient-centred service;

Primary care trusts are expected to identify the health needs of the population, to work to improve the health of the community and to secure the provision of a full range of services. Other main functions are to:

- maintain an effective public health function;

- lead local planning;

- manage and develop primary healthcare services;

- develop and improve local services;

- lead the integration of health and social care; and

- deliver services within their remit.

Strategic health authorities provide strategic leadership to ensure the maintenance of provision and the delivery of improvements in local health and health services by primary care trusts and NHS trusts, within the national framework of developing a patient-centred NHS and supported by effective controls and clinical governance systems. Other main functions for which the Strategic Health Authority is responsible are to:

- lead the development and empowerment of uniformly excellent frontline NHS organisations committed to innovation and improvement;

- consider the overall needs of the health economy across primary, community, secondary and tertiary care, and working with primary care trusts and NHS trusts to deliver a programme to meet these needs;

- performance manage and ensure accountability of local primary care trusts and NHS trusts;

- lead on the creation and development of clinical and public health networks;

- create capacity through the preparation and delivery of strategies for capital investment, information management and workforce development;

- ensure effective networks and joint working exists between NHS organisations for the provision of health and social care; and

- ensure the development and training of an adequate workforce of competent clinical personnel.

NHS trust, primary care trust and strategic health authority finances are subject to external audit by the Audit Commission and, for the value for money element, by the Healthcare Commission.

NHS boards must co-operate fully with the Department of Health, the Audit Commission and the Healthcare Commission when required to account for the use they have made of public funds, the delivery of patient care and other services, and compliance with statutes, directions, guidance and policies of the Secretary of State. The Chief Executive/ Permanent Secretary of the Department of Health, as Accounting Officer for the NHS, is accountable to Parliament. The work of the Department of Health and its associated bodies is examined by the House of Commons Health Committee. Its remit is to examine the expenditure, administration and policy of the Department of Health. Two other Parliamentary Committees, the Public Accounts Committee and the Public Administration Select Committee, scrutinise the work of the Department of Health and the health service.

The Board of Directors

NHS boards comprise executive directors together with non-executive directors and a chair who are appointed by the NHS Appointments Commission on behalf of the Secretary of State. Together they share corporate responsibility for all decisions of the board. There is a clear division of responsibility between the chair and the chief executive; the chair's role and board functions are set out below; the chief executive is directly accountable to the board for meeting their objectives, and as Accountable Officer, to the Chief Executive of the NHS for the performance of the organisation. Boards are required to meet regularly and to retain full and effective control over the organisation; the chair and non-executive directors are responsible for monitoring the executive management of the organisation and are responsible to the Secretary of State for the discharge of these responsibilities. Strategic health authorities generally provide the line of accountability from local NHS organisations to the Secretary of State for the performance of the organisation. Regional Commissioners of the NHS Appointments Commission will always be available to chairs and non-executive directors on matters of concern to them relating to the personal effectiveness of individual chairs and non-executives.

The duty of an NHS board is to add value to the organisation, enabling it to deliver healthcare and health improvement within the law and without causing harm. It does this by providing a framework of good governance within which the organisation can thrive and grow. Good governance is not restrictive but an enabling ingredient to underpin change and modernisation.

The role of an NHS board is to:

- be collectively responsible for adding value to the organisation, for promoting the success of the organisation by directing and supervising the organisation's affairs

- provide active leadership of the organisation within a framework of prudent and effective controls which enable risk to be assessed and managed

- set the organisation's strategic aims, ensure that the necessary financial and human resources are in place for the organisation to meet its objectives, and review management performance

- set the organisation's values and standards and ensure that its obligations to patients, the local community and the Secretary of State are understood and met.

Further details may be obtained from *Governing the NHS: A Guide for NHS Boards* at www.dh.gov.uk

The Role of the Chair

The overall role of the chair is one of enabling and leading so that the attributes and specific roles of the executive team and the non-executives are brought together in a constructive partnership to take forward the business of the organisation.

The key responsibilities of the chair are:

- leadership of the board, ensuring its effectiveness on all aspects of its role and setting its agenda;

- ensuring the provision of accurate, timely and clear information to directors;

- ensuring effective communication with staff, patients and the public;

- arranging the regular evaluation of the performance of the board, its committees and individual directors; and

- facilitating the effective contribution of non-executive directors and ensuring constructive relations between executive and non-executive directors.

A complementary relationship between the chair and chief executive is important. The chief executive is accountable to the chair and non-executive directors of the board for ensuring that the board is empowered to govern the organisation and that the objectives it sets are accomplished through effective and

properly controlled executive action. The chief executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the board.

Further details may be obtained from *Governing the NHS: A Guide for NHS Boards* at www.dh.gov.uk.

Non-Executive Directors

Non-executive directors are appointed by the NHS Appointments Commission on behalf of the Secretary of State to bring an independent judgement to bear on issues of strategy, performance, key appointments and accountability through the Department of Health to Ministers and to the local community.

The duties of non-executive directors are to:

- constructively challenge and contribute to the development of strategy;

- scrutinise the performance of management in meeting agreed goals and objectives and monitor the reporting of performance;

- satisfy themselves that financial information is accurate and that financial controls and systems of risk management are robust and defensible;

- determine appropriate levels of remuneration of executive directors and have a prime role in appointing, and where necessary, removing senior management and in succession planning; and

- ensure the board acts in the best interests of the public and is fully accountable to the public for the services provided by the organisation and the public funds it uses.

Non-executive directors also have a key role in a small number of permanent board committees such as the Audit Committee, Remuneration and Terms of Service Committee, the Clinical Governance Committee and Risk Management Committee.

Further details may be obtained from *Governing the NHS: A Guide for NHS Boards* at www.dh.gov.uk.

Reporting and Controls

It is the board's duty to present through the timely publication of an annual report, annual accounts and other means, a balanced and readily-understood assessment of the organisation's performance to:

- the Department of Health, on behalf of the Secretary of State

- the Audit Commission and its appointed auditors, and

- the local community.

Detailed financial guidance, including the role of internal and external auditors, issued by the Department of Health must be observed. (Ref: the *NHS Finance Manual* at www.info.doh.gov.uk/doh/finman).The Standing Orders of boards should prescribe the terms on which committees and sub-committees of the board may be delegated functions, and should include the schedule of decisions reserved for the board.

Declaration of Interests

It is a requirement that chairs and all board directors should declare any conflict of interest that arises in the course of conducting NHS business. All NHS organisations maintain a register of member's interests to avoid any danger of board directors being influenced, or appearing to be influenced, by their private interests in the exercise of their public duties. All board members are therefore expected to declare any personal or business interest which may influence, or may be *perceived* to influence, their judgement. This should include, as a minimum, personal direct and indirect financial interests, and should normally also include such interests of close family members. Indirect financial interests arise from connections with bodies which have a direct financial interest, or from being a business partner of, or being employed by, a person with such an interest.

Employee Relations

NHS boards must comply with legislation and guidance from the Department of Health on behalf of the Secretary of State, respect agreements entered into by themselves or on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money. Fair and open competition should be the basis for appointment to posts in the NHS.

The terms and conditions agreed by the board for senior staff should take full account of the need to obtain maximum value for money for the funds available for patient care. The board should ensure through the appointment of a remuneration and terms of service committee that executive board directors' remuneration can be justified as reasonable. Board directors' remuneration for the NHS organisation should be published in its annual report.

Originally published April 1994
First revision April 2002
Second revision July 2004

Code of Practice on Openness in the NHS

Contents

Code of Practice on Openness in the NHS

1. Introduction

This Code of Practice sets out the basic principles underlying public access to information about the NHS. It reflects the Government's intention to ensure greater access by the public to information about public services and complements the Code of Access to Information which applies to the Department of Health.

Because the NHS is a public service, it should be open about its activities and plans. So, information about how it is run, who is in charge and how it performs should be widely available. Greater sharing of information will also help to foster mutual confidence between the NHS and the public.

The basic principle of this Code is that the NHS should respond positively to requests for information, except in certain circumstances identified in the Code. For example, patients' records must be kept safe and confidential.

2. Scope

The Code of Practice covers the following NHS organisations in England: Health Authorities, Special Health Authorities, NHS Trusts, Primary Care Trusts, the Mental Health Act Commission and Community Health Councils. It also covers family doctors, dentists, optometrists (opticians) and community pharmacists.

Specific requirements for most of these organisations are detailed in separate annexes. Organisations not covered in the annexes must apply the general principles of the Code in their dealings with the public.

3. Aims

The aims of the Code are to ensure that people:

- have access to available information about the services provided by the NHS, the cost of those services, quality standards and performance against targets;

- are provided with explanations about proposed service changes and have an opportunity to influence decisions on such changes;

- are aware of the reasons for decisions and actions affecting their own treatment;

- known what information is available and where they can get it.

4. General Principles

In implementing the Code, the NHS must:

- respond positively to requests for information (except in the circumstances identified in paragraph 9);

- answer requests for information quickly and helpfully, and give reasons for not providing information where this is not possible;

- help the public to know what information is available, so that they can decide what they wish to see, and whom they should ask;

- ensure that there are clear and effective arrangements to deal with complaints and concerns about local services and access to information, and that these arrangements are widely publicised and effectively monitored.

5. Information Which Must be provided

Apart from the exemptions set out in paragraph 9 below, NHS Trusts, Primary Care Trusts and Health Authorities must publish or otherwise make available the following information (further details are given in Annexes A, B, C and D):

- information about what services are provided, the targets and standards set and results achieved, and the costs and effectiveness of the service;

- details about important proposals on health policies or proposed changes in the way services are delivered, including the reasons for those proposals. This information will normally be made available when proposals are announced and before decisions are made;

■ details about important decisions on health policies and decisions on changes to the delivery of services. This information, and the reasons for the decisions, will normally be made available when the decisions are announced;

■ information about the way in which health services are managed and provided and who is responsible;

■ information about how the NHS communicates with the public, such as details of public meetings, consultation procedures, suggestion and complaints systems:

■ information about how to contact Community Health Councils and the Health Service Commissioner (Ombudsman);

■ information about how people can have access to their own personal health records.

6. Response to Requests for Information

Requests for information, whether made in person or in writing, must be answered promptly. An acknowledgement must be sent within 4 working days and, where possible, the information should follow within 20 working days.

NHS organisations are not required to make available:

i) copies of the documents or records containing the information (although in some cases it may be simpler to do so if they contain nothing but the information requested);

ii) information which the organisation does not possess (eg comparable data with other organisations);

iii) individual copies of documents or other forms of information which are already widely publicly available.
If the information is not to be provided under the terms of the Code, an explanation must be provided within 20 working days of receipt of the request.

Each NHS organisation must publish the name of an individual who has responsibility for the operation of this Code of Practice. This should be a senior officer directly accountable to the Chief Executive of the organisation. Details of how to request information through this individual must also be publicised locally.

7. Charging for Information

NHS Trusts, Primary Care Trusts and Health Authorities may make a charge for providing information but are not required to do so. It is recommended that charging should be exceptional but that where charges are made the following ground rules should be observed:

a) no charge for individuals enquiring about services or treatment available to them; press and other media; Community Health Councils; MPs; Local Authorities; Citizen's Advice Bureaux;

b) for requests from people not listed above, no charge for the first hour and a charge not exceeding £20 per hour for each hour thereafter.

8. Personal Health Records

The NHS must keep patients' personal details confidential but people normally have a right to see their own health records. Depending on who made the records, patients can obtain access through the relevant Trust, Health Authority, family doctor or dentist. Access must be given within the timetable in the Access to Health Records Act 1990 (or, for records held on computer, the Data Protection Act 1984). Under these Acts patients may be charged for access to their records

9. Information Which May be Withheld

NHS Trusts and Authorities must provide the information requested unless it falls within one of the following exempt categories:

i) Personal information. People have a right of access to their own health records but not normally to information about other people.

ii) Requests for information which are manifestly unreasonable, far too general, or would require unreasonable resources to answer.

iii) Information about internal discussion and advice, where disclosure would harm frank internal debate, except where this disclosure would be outweighed by the public interest.

iv) Management information, where disclosure would harm the proper and effective operation of the NHS organisation.

v) Information about legal matters and proceedings, where disclosure would prejudice the administration of justice and the law.

vi) Information which could prejudice negotiations or the effective conduct of personnel management or commercial or contractual activities. This does not cover information about internal NHS contracts.

vii) Information given in confidence. The NHS has a common law duty to respect confidences except when it is clearly outweighed by the public interest.

viii) Information which will soon be published or where disclosure would be premature in relation to a planned announcement or publication.

ix) Information relating to incomplete analysis, research or statistics where disclosure could be misleading or prevent the holder from publishing it first.

10. Complaining About the Provision of Information

People may wish to complain about a decision to refuse to provide information, a delay in providing information or levels of charges. In the first instance, complaints should be made within 3 months to the local individual responsible for the operation of the Code (see paragraph 6 above). If the complainant remains dissatisfied, a complaint should be made to the Chief Executive of the organisation, or the Chief Executive of the Health Authority in the case of family doctors, dentists, pharmacists and optometrists (opticians). Community Health Councils may be able to help people to pursue their complaint. NHS Trusts and Authorities must acknowledge complaints within 4 working days and reply within 20 working days.

The NHS Trust or Authority will provide people with information about how to take their complaint further to the Health Service Ombudsman if they remain dissatisfied. However, the Ombudsman does not investigate complaints about the withholding of information by family doctors, dentists, pharmacists, optometrists (opticians) or Community Health Councils.

ANNEX A - NHS Trusts and Primary Care Trusts (PCTs)

1. Introduction

This annex describes the information which NHS Trusts and PCTs must publish or make available. It also lists examples of information which it is recommended should be made available as a matter of good practice, either through publication or on request.

2. Information Which Must be Published

The following are the documents which Trusts must publish by given dates:

■ an annual report describing the Trust's performance over the previous financial year, and including details of board members' remuneration; the report should be written and presented in a way that can be readily understood by the general public:

■ an annual summary of the Trust's business plan, describing the Trust's planned activity for the coming year;

■ a summary strategic direction document (not published annually), setting out the Trust's longer term plans for the delivery of health care services over a five year period; and

■ audited accounts published annually.

In addition to the documents described above, NHS Trusts and PCTs must also make available, on request:

■ the register of board members' private interests required under the Code of Accountability for NHS boards:

2.1 Public Meetings - NHS Trusts and PCTs are required to hold their board meetings in public. An agenda, papers, the accounts and the annual report must be publicly available at least 7 days in advance of the meeting. Provision must be made for questions and comments to be put by the public. Public meetings must be held in readily accessible venues and at times when the public are able to attend.

3. Good Practice in Providing Information

3.1 Examples of Additional Information Which May be Published

■ quarterly board reports (financial, activity, quality and contract information);

■ information on service changes;

■ agenda and papers relating to other meetings held in public in addition to the Annual Public Meeting.

3.2 Examples of Information Which May be Available on Request

The following list is a guide to some of the information which is routinely held by most NHS Trusts. Much of the information will be detailed in the previous year's annual report. Where more up-to-date information is available, this may be given:

■ patient information leaflets; ■ description of facilities (numbers of beds, operating theatres etc.); ■ waiting times by specialty; ■ detailed information on activity; ■ broad conclusions of clinical audit; ■ number and percentage of operations cancelled, by specialty; ■ price lists for extra-contractual referrals;

■ information about clinicians (including qualifications, areas of special interest, waiting times for appointment); ■ areas which have been market-tested, with details of decisions reached; ■ tenders received by value, but not by name of tenderer; ■ information on manpower and staffing levels and staff salaries by broad bandings; ■ policies for Trust staff, eg equal opportunities, standards of conduct; ■ environmental items, eg fuel usage; ■ volume and categories of complaints and letters of appreciation (without identifying individuals), and performance in handling complaints; ■ results of user surveys and action to be taken; ■ standing orders and waivers of standing orders; ■ standing financial instructions; ■ external audit management letter, and Trust response, time when response is made: ■ details of administrative costs; ■ funds held on trust, such as bequests and donations; ■ performance against quality standards in contracts; ■ clinical performance, by specialty, eg proportion of surgery done on day surgery basis, by condition; ■ performance against national and local targets for inpatient and day case waiting times; ■ names and contact (office) numbers of board members and senior officers; ■ basic salaries, ie excluding PRP and distinction awards, of staff, by bandings and in anonymised form; ■ response times for ambulances; ■ information about the use of outside management consultants, including expenditure

4. Procedures for Obtaining Information
Trusts must ensure that people know whom to ask for information. They must publish the name of the person responsible, along with full details of how to go about obtaining information and how to complain if the information is not provided. The person responsible should be a senior officer who is directly accountable to the Chief Executive of the Trust.

ANNEX B - Health Authorities

1. Introduction

1.1 Health Authorities have an essential role in the successful development of local services and achieving a strategic balance of care. (Annexes C and D give complementary advice for General Practitioners.)

1.2 This Annex describes the information which they must publish or make available. It also lists examples of information which it is recommended is made available as a matter of good practice, either through publication or on request.

2. Information Which Must be Published

2.1 Health Authorities

The following are the documents which Authorities must publish by given dates:

■ an annual report, describing the performance over the previous financial year, and including details of board members' remuneration; the report should be in a form that can be readily understood by the general public; ■ an annual report by the Director of Public Health; ■a full list of General Medical Practitioners, General Dental Practitioners, pharmacists and optometrists in their locality; ■ papers, agendas and minutes of board meetings held in public; ■audited accounts published annually; ■ a strategy document (not published annually) setting out the heath authority's plans over a five year period. They must consult with the public before and after developing the strategy.

In addition to the documents described above, authorities must also make available, on request:

■ annual purchasing plans; ■ contracts with providers, both NHS and non-NHS; ■ the register of board members' private interests required under the Code of Accountability for NHS boards.

2.2 Public Meetings - Health Authorities must hold all their board meetings in public, though there is provision of certain issues (eg personnel and commercial matters) to be taken in a private part of the meeting. The agenda for these meetings must always be provided to the press and on request to members of the public. Public meetings must be held in easily accessible venues, and at times when the public are able to attend.

Consultation - Health Authorities must consult with Community Health Council and other interested parties on any plans to change the services which they purchase or plan for their residents. They must publish well in advance a timetable to enable the public to know when and how they can influence to commissioning process.

3. Good Practice in Providing Information

3.1 Examples of Additional Information Which May be Published

■ information on services purchased by the Authority ;■ information about consultation exercises undertaken and outcomes; ■ full reports of any user or attitude surveys and action to be taken; ■ total available financial resources; ■ Health Authority allocation; ■proposed and actual expenditure on services, analysed by: ■ providers; ■ contracts (including by speciality, if available); ■treatments purchased separately from contracts (extra

contractual referrals); ■ changes in providers and contracts from previous years; ■ performance against quality standards in contracts; ■ clinical performance by speciality, of providers contracted with, eg proportion of surgery done on day surgery basis, by condition; ■ performance against national and local targets for in-patient and day case waiting times; ■ numbers of complaints dealt with and response times; ■ names and contact (office) numbers of Authority board members and senior officers; ■ basic salaries, ie excluding PRP and distinction awards, of staff, by bandings and in anonymised form; ■ information about the use of outside management consultants, including expenditure

3.2 Examples of Information Which May be Available on Request

■ future year resource plans; ■ information about expenditure on different types of health care, such a primary, secondary or community care; ■ price comparisons of all providers used by the purchaser; ■ total expenditure per head of population; ■ costs of authority administration; ■ standing orders and waivers of standing orders; ■ standing financial instructions ■ external audit management letter, and response, at the time when the response is made.

4. Procedures for Obtaining Information

Authorities must ensure that people know whom to ask for information. They must publish the name of the person responsible, along with full details of how to go about obtaining information and how to complain if the information is not provided. The person responsible should be a senior officer who is directly accountable to the Chief Executive of the Authority.

1.1 This annex describes the information which General Medical Practitioners, General Dental Practitioners, Community Pharmacists and Optometrists must publish or make available.

1.2 General Medical Practitioners, General Dental Practitioners, Community Pharmacists and Optometrists provide services to the public which are paid for by the NHS. The public should therefore have access to information about the services they provide. Although they are self-employed independent contractors, and cannot therefore be required to publish sensitive information about their businesses, their contracts for services specify information that is important to patients and which must be made available.

2. Information Which Must be Published

The following are the statutorily required documents which must be published.

2.1 General Medical Practitioners

Practice Leaflets - Essential information for patients about individual doctors' practices is published in practice leaflets which can be obtained from the practice. These must contain the following information:

■ name, sex, medical qualifications and date and first place of registration of the General Practitioner; ■ details of availability (including arrangements for cover when the General Practitioner is not available), appointments system and how to obtain an urgent appointment or home visit; ■ arrangements for obtaining repeat prescriptions and dispensing arrangements; ■ frequency, duration and purpose of clinics; ■ numbers and roles of other staff employed by the practice, and information about whether the General Practitioner works alone, part-time or in partnership; ■ details of services available - for example, child health surveillance, contraception, maternity, medical, minor surgery, counselling and physiotherapy; ■ details of arrangements for receiving and responding to patients' comments and complaints; ■ geographical boundary of the practice area; ■ details of access for the disabled.

In addition, some leaflets also:

■ contain information detailing any other professional staff employed by the practice, including their registration status; ■ are available in languages other than English which are commonly used locally.

2.2 General Dental Practitioners

Practice Leaflets - Essential information for patients about individual dental practices is published in practice leaflets which can be obtained from the practice. These contain:

■ name, sex and date of registration as a dental practitioner; ■ address, opening hours and details of partners/associates; ■ whether a dental hygienist is employed; ■ details of access to the premises; ■ whether only orthodontic treatment is available; ■ with consent, whether the dentist speaks any languages in addition to English; ■ General Dental Practitioners are required to inform patients of any emergency arrangements in place.

Charges

■ General Dental Practitioners must provide patients with individual costed treatment plans. They must display a notice of the scale of NHS charges and information about entitlement to exemption from or remission of charges.

It is good practice:

■ to provide information about their cross-infection control procedures, giving examples as appropriate.

2.3 Community Pharmacists

Practice Leaflets - Pharmacists are not obliged to produce practice leaflets but those dispensing more than 1500 prescriptions a month normally do so. These leaflets detail the range of services available to the public and, if produced, must contain the following information:

■ a list of services provided by the pharmacist; ■ name, address and telephone number of the pharmacy; ■ normal opening hours and arrangements for out of hours services and emergencies; ■ procedures for receiving comments on services provided.

As good practice:

■ an increasing number of Community Pharmacists make health promotion leaflets available to the public.

2.4 Optometrists

Optometrists are not currently required to produce practice leaflets, but many do so as a matter of good practice.

Results of Eye-Tests

Optometrists must provide patients with a copy of the results of their eye-tests (ie their prescription) or a statement that no prescription is required.

5. Procedures for Obtaining Information

3.1 Information about individual General Medical Practitioners, General Dental Practitioners, Pharmacists and Optometrists and their practice leaflets must be available from the practice. Health Authorities must ensure that people know whom to ask for additional information. The Authority should publish the name of the person responsible. This should be a senior officer who is directly accountable to the Chief Executive of the Authority.

5.2 Complaints about failure to obtain information should be dealt with as far as possible by the practice. If the complainant remains dissatisfied, he/she should be directed to the Family Health Services Authority. The assistance of the Community Health Council may also be sought. At present the Health Service Ombudsman does not investigate complaints against family doctors, dentists, optometrists (opticians) or pharmacists.

General Practitioners

ANNEX D - General Practitioners

1 Introduction

This Annex extends Annex C and describes the additional information which General Practitioners must publish or make available.

2. Information Which Should be Published

The following are the documents which General Practitioners should publish or make available by given dates:

■ plans for major shifts in purchasing; ■ annual practice plan describing how the practice intends to use its fund and management allowances over the coming year and demonstrating the practice's contribution to national targets and priorities as well as any locally-agreed objectives. The plan should include an outline longer term view and may optionally include the practice's primary health care team charter (Practice Charter) and plans for the practice's general medical services (GMS) activity; ■ Practice Charter (if available and not included above); ■ annual performance report; ■ audited annual accounts.

Consultation

General Practitioners must ensure that a copy (or a summary) of their major shifts in purchasing intentions, annual plans, Practice Charter (if separate) and performance reports is available at their practice for consultation by patients. A copy of the above documents should be sent to the Health Authority and a copy (or a summary) to the local Community Health Council.

In addition, General Practitioners are required to produce annual accounts for audit. Once audited, these are public documents and are available for inspection at the Health Authority.

3. Procedures for Obtaining Information

3.1 Information about individual practices should be requested direct from the practice. Complaints about failure to provide information should be dealt with as far as possible by the practice.

3.2 If the complainant remains dissatisfied he/she should be directed to the Health Authority. The assistance of the Community Health Council may also be sought. At present the Health Service Ombudsman does not investigate complaints against family doctors, dentists, optometrists opticians) or pharmacists.

3.3 Requests for information which is not about an individual practice should be directed to the Health Authority. They must ensure that they publicise the

name of the officer within the HA who is responsible for providing this information and for the operation of the Code of Practice. This should be a senior officer who is directly accountable to the Chief Executive of the Authority.

The Department of Health will be pleased to respond to any queries on this Code of Practice on Openness in the NHS. Please contact Jerry Bird, Room 2N21, Quarry House, Quarry Hill, LEEDS LS2 7UE.

Hertfordshire Community NHS Trust

The Board and Executive Team of Hertfordshire Community NHS Trust Subscribe to the "NOLAN" Principles of Public Life

These are:

Selflessness

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

Integrity

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

Objectivity

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

Accountability

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

Openness

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

Honesty

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

Leadership

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

Hertfordshire Community NHS Trust

The Board and Executive Team of Hertfordshire NHS Trust Subscribe to the "Principles of Board Etiquette"
(Adapted from the Integrated Governance Handbook, DoH 2006

	We Will	We Will Not
1	Respect one another as possessing individual and corporate skills, knowledge and responsibilities	Refer to past systems or mistakes as being responsible for today's situation.
2	Show determination, tolerance and sensitivity - rigorous and challenging questioning, tempered by respect	Act as 'stoppers' or 'blockers'
3	Show group support and loyalty towards • The Trust • each other • the Executive Team	Regard any arrangements as unchangeable or unchallengeable
4	Listen carefully to all ideas and comments and be tolerant to other points of view – be sensitive to colleagues' needs for support when challenging or being challenged	Adopt territorial attitudes – any members of the team has the right to challenge/question another
5	Be honest, open and constructive	Give offence – and be ready to apologise
6	Be courteous and respect freedom to speak, disagree or remain silent	Take offence – and shall stay open to discussion
7	Regard challenge as a test of the robustness of arguments – ensure no one becomes isolated in expressing their view. Treat all ideas with respect.	Regard papers presented as being 'rubberstamped' without discussion and agreement
8	Read all papers before the meeting and clarify any points of detail with the relevant author before the meeting, arrive on time and participate wholeheartedly	Act in an attacking, crushing or dismissive manner
9	Focus discussion on material issues and on the resolution of issues, allow differences to be forgotten	Become obsessed by detail and lose the strategic picture
10	Make the most of time – support the Chair, colleagues and guests in maximising scope and variety of viewpoints heard. Individual points are relevant and short.	Breach confidentiality – will be candid not secret

Code of Conduct for NHS Managers

October 2002

Code of Conduct for NHS Managers

© Crown Copyright 2002
Produced by Department of Health
29495 1p 1k Oct 02 (CWP)
CHLORINE FREE PAPER

The text of this document may be reproduced without formal permission
or charge for personal or in-house use.

First published October 2002

29495/*Code of Conduct for NHS Managers* can also be made available on request in braille,
on audio cassette tape, on disk, in large print, and in other languages on request.

Introduction

1. As part of the response to the Kennedy Report, the attached *Code of Conduct for NHS Managers* has been produced by a Working Group chaired by Ken Jarrold CBE.

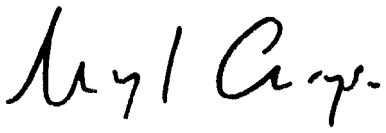
2. The Code sets out the core standards of conduct expected of NHS managers. It will serve two purposes:

   - to guide NHS managers and employing health bodies in the work they do and the decisions and choices they have to make.

   - to reassure the public that these important decisions are being made against a background of professional standards and accountability.

3. The environment in which the Code will operate is a complex one. NHS managers have very important jobs to do and work in a very public and demanding environment. The management of the NHS calls for difficult decisions and complicated choices. The interests of individual patients have to be balanced with the interests of groups of patients and of the community as a whole. The interests of patients and staff do not always coincide. Managerial and clinical imperatives do not always suggest the same priorities. A balance has to be maintained between national and local priorities.

4. The Code should apply to all managers and should be incorporated in the contracts of senior managers at the earliest possible opportunity. A document on implementation is attached.



NIGEL CRISP **9 October 2002**
NHS Chief Executive

Code of Conduct for NHS Managers

As an NHS manager, I will observe the following principles:

- make the care and safety of patients my first concern and act to protect them from risk;
- respect the public, patients, relatives, carers, NHS staff and partners in other agencies;
- be honest and act with integrity;
- accept responsibility for my own work and the proper performance of the people I manage;
- show my commitment to working as a team member by working with all my colleagues in the NHS and the wider community;
- take responsibility for my own learning and development.

This means in particular that:

1 I will:

- respect patient confidentiality;
- use the resources available to me in an effective, efficient and timely manner having proper regard to the best interests of the public and patients;

- be guided by the interests of the patients while ensuring a safe working environment;
- act to protect patients from risk by putting into practice appropriate support and disciplinary procedures for staff; and
- seek to ensure that anyone with a genuine concern is treated reasonably and fairly.

2 I will respect and treat with dignity and fairness, the public, patients, relatives, carers, NHS staff and partners in other agencies. In my capacity as a senior manager within the NHS I will seek to ensure that no one is unlawfully discriminated against because of their religion, belief, race, colour, gender, marital status, disability, sexual orientation, age, social and economic status or national origin. I will also seek to ensure that:

- the public are properly informed and are able to influence services;
- patients are involved in and informed about their own care, their experience is valued, and they are involved in decisions;
- relatives and carers are, with the informed consent of patients, involved in the care of patients;
- partners in other agencies are invited to make their contribution to improving health and health services; and
- NHS staff are:
  - valued as colleagues;
  - properly informed about the management of the NHS;
  - given appropriate opportunities to take part in decision-making.
  - given all reasonable protection from harassment and bullying;
  - provided with a safe working environment;
  - helped to maintain and improve their knowledge and skills and achieve their potential; and
  - helped to achieve a reasonable balance between their working and personal lives.

3 I will be honest and will act with integrity and probity at all times. I will not make, permit or knowingly allow to be made, any untrue or misleading statement relating to my own duties or the functions of my employer.

I will seek 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;
- NHS resources are protected from fraud and corruption and that any incident of this kind is reported to the NHS Counter Fraud Services;
- judgements about colleagues (including appraisals and references) are consistent, fair and unbiased and are properly founded; and
- open and learning organisations are created in which concerns about people breaking the Code can be raised without fear.

4 I will accept responsibility for my own work and the proper performance of the people I manage. I will seek to ensure that those I manage accept that they are responsible for their actions to:

- the public and their representatives by providing a reasonable and reasoned explanation of the use of resources and performance;
- patients, relatives and carers by answering questions and complaints in an open, honest and well researched way and in a manner which provides a full explanation of what has happened, and of what will be done to deal with any poor performance and, where appropriate giving an apology; and
- NHS staff and partners in other agencies by explaining and justifying decisions on the use of resources and give due and proper consideration to suggestions for improving performance, the use of resources and service delivery.

I will support and assist the Accountable Officer of my organisation in his or her responsibility to answer to Parliament, Ministers and the Department of Health in terms of fully and faithfully declaring and explaining the use of resources and the performance of the local NHS in putting national policy into practice and delivering targets.

For the avoidance of doubt, nothing in paragraphs two to four of this Code requires or authorises an NHS manager to whom this Code applies to:

- make, commit or knowingly allow to be made any unlawful disclosure;
- make, permit or knowingly allow to be made any disclosure in breach of his or her duties and obligations to his or her employer, save as permitted by law.

If there is any conflict between the above duties and obligations and this Code, the former shall prevail.

5 I will show my commitment to working as a team by working to create an environment in which:

- teams of frontline staff are able to work together in the best interests of patients;
- leadership is encouraged and developed at all levels and in all staff groups; and
- the NHS plays its full part in community development.

6 I will take responsibility for my own learning and development. I will seek to:

- take full advantage of the opportunities provided;
- keep up to date with best practice; and
- share my learning and development with others.

Department of Health **October 2002**

Implementing the Code

IMPLEMENTING THE CODE

1. The Code should be seen in a wider context that NHS managers must follow the 'Nolan Principles on Conduct in Public Life', the 'Corporate Governance Codes of Conduct and Accountability', the 'Standards of Business Conduct', the 'Code of Practice on Openness in the NHS' and standards of good employment practice.

2 In addition many NHS managers come from professional backgrounds and must follow the code of conduct of their own professions as well as this Code.

In order to maintain consistent standards, NHS bodies need to consider suitable measures to ensure that managers who are not their employees but who

(i) manage their staff or services; *or*

(ii) manage units which are primarily providing services to their patients

also observe the Code.

3 It is important to respect both the rights and responsibilities of managers. To help managers to carry out the requirements of the Code, employers must provide reasonable learning and development opportunities and seek

to establish and maintain an organisational culture that values the role of managers. NHS managers have the right to be:

- treated with respect and not be unlawfully discriminated against for any reason;
- given clear, achievable targets;
- judged consistently and fairly through appraisal;
- given reasonable assistance to maintain and improve their knowledge and skills and achieve their potential through learning and development; and
- reasonably protected from harassment and bullying and helped to achieve a reasonable balance between their working and personal lives.

Breaching the Code

4 Alleged breaches of the Code of Conduct should be promptly considered and fairly and reasonably investigated. Individuals must be held to account for their own performance, responsibilities and conduct where employers form a reasonable and genuinely held judgement that the allegations have foundation. Investigators should consider whether there are wider system failures and organisational issues that have contributed to the problems. Activity, the purpose of which is to learn from and prevent breaches of the Code, needs to look at their wider causes.

5 Local employers should decide whether to investigate alleged breaches informally or under the terms of local disciplinary procedures. It is essential however that both forms of investigation should be, and be seen to be, reasonable, fair and impartial. If Chief Executives or Directors are to be investigated, the employing authority should use individuals who are employed elsewhere to conduct the investigation. The NHS Confederation, the Institute of Healthcare Management and the Healthcare Financial Management Association are among the organisations who maintain lists of people who are willing to undertake such a role.

Application of Code

6 This Code codifies and articulates certain important contractual obligations that apply to everyone holding management positions. These include Chief Executives and Directors who as part of their duties are personally accountable for achieving high quality patient care. The Department of Health will in the next few months issue a proposed new framework of pay and contractual arrangements for the most senior NHS managers. Under this framework the job evaluation scheme being developed as part of the 'Agenda for Change' negotiations is likely to be

used as the basis for identifying which other managerial posts (in addition to Chief Executives and Directors) should be automatically covered by the Code. The new framework will also specify compliance with the Code as one of the core contractual provisions that should apply to all senior managers.

7 For all posts at Chief Executive/Director level and all other posts identified as in paragraph 6 above, acting consistently with the Code of Conduct for NHS Managers Directions 2002, employers should:

- include the Code in new employment contracts;
- incorporate the Code into the employment contracts of existing postholders at the earliest practicable opportunity.

Action

8 Employers are asked to:

(i) incorporate the Code into the employment contracts of Chief Executives and Directors at the earliest practicable opportunity *and* include the Code in the employment contracts of new appointments to that group;

(ii) identify any other senior managerial posts, i.e. with levels of responsibility and accountability similar to those of Director-level posts, to which they consider the Code should apply. (The new framework for pay and contractual arrangements will help more tightly define this group in due course.)

(iii) investigate alleged breaches of the Code by those to whom the Code applies promptly and reasonably as at paragraphs four to five;

(iv) provide a supportive environment to managers (see paragraph three above).

October 2002

NATIONAL HEALTH SERVICE ACT 1977
NATIONAL HEALTH SERVICE AND COMMUNITY CARE ACT 1990

The Code of Conduct for NHS Managers Directions 2002

The Secretary of State for Health, in exercise of the powers conferred by section 17(**a**), paragraph 10(1) of Schedule 5(b) and paragraph 8(3) of Schedule 5A(c) to the National Health Service Act 1977, and paragraph 16(5) of Schedule 2 to the National Health Service and Community Care Act 1990(**b**), hereby gives the following Directions:

Application, commencement, interpretation

1.-(1) These Directions apply to all NHS bodies in England and shall come into force on 9 October 2002.

(2) These Directions shall be referred to as The Code of Conduct for NHS Managers Directions 2002.

(3) In these Directions "NHS bodies" means:

(i) Strategic Health Authorities

(ii) Special Health Authorities

(iii) NHS Trusts

(iv) Primary Care Trusts

Implementation of Code of Conduct for NHS Managers

2. NHS bodies shall take all reasonable steps to comply with the requirements set out in the *Code of Conduct for NHS Managers* appended to these Directions.

Effect of Direction 2

3. The fact of compliance or non-compliance with Direction 2 shall in itself have no effect on the validity or enforceability of a contract entered into by an NHS body to which these Directions apply.

Signed by authority of the Secretary of State for Health

M G Sturges

Martin Sturges

4 October 2002 Department of Health

(**a**) 1977 c. 49. Section 17 was substituted by section 12(1) of the Health Act 1999 (c.8) and was amended by Schedule 5, Part 1, paragraph 5(1) and (3), to the Health and Social Care Act 2001 (c.15) and by Schedule 1, paragraph 7 to the NHS Reform and Health Care Professions Act 2002 (c.17).

(**b**) Paragraph 10(1) of Schedule 5(b) and paragraph 8(3) of Schedule 5A(c) to the National Health Service Act 1977 (1977 c.49), and paragraph 16(5) of Schedule 2 to the National Health Service and Community Care Act 1990 were amended by section 6 of the Health and Social Care Act 2001 (c.15).

Working Group Members

Ken Jarrold CBE

Chief Executive
County Durham and Tees Strategic Health Authority

Dr Gill Morgan

Chief Executive
NHS Confederation

Stuart Marples

Chief Executive
Institute of Healthcare Management

Professor Jenny Simpson OBE

Chief Executive
British Association of Medical Managers

John Flook

Chairman
Healthcare Financial Management Association

Penny Humphris

Director
NHS Leadership Centre