UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 24 OCTOBER 2019

Title:	**APPROVAL OF POLICIES**
Responsible Director:	David Burbridge, Director of Corporate Affairs
Contact:	Berit Reglar, Deputy Foundation Secretary, Ext 14324

Purpose:	To ask the Board to make an informed decision based on the information presented to them in this report and consider the following policies for approval: • Policy for the Approval of Non-Audit and Additional Services by the Trust's External Auditors • Security Policy (including the Prevention and Control of Violence and Aggression) • Policy for the Development and Management of Controlled Documents • Policy for Research Governance • Patient Relations Policy
Confidentiality Level & Reason:	None
Strategy Implementation Plan Ref:	#1 Increase alignment of corporate and clinical services across UHB #4 Meet regulatory requirements and operational performance standards, in line with agreed trajectories
Key Issues Summary:	• These policies have undergone a review in line with the Policy for the Development and Management of Controlled Documents. • Following the Trust transaction, all policies have been or are being aligned and reviewed by the Policy Review Group.
Recommendations:	The Board of Directors is asked to consider and, if thought fit, approve the following policies for publication: • Policy for the Approval of Non-Audit and Additional Services by the Trust's External Auditors • Security Policy (including the Prevention and Control of Violence and Aggression) • Policy for the Development and Management of Controlled Documents • Policy for Research Governance • Patient Relations Policy

Signed: David Burbridge	**Date:** 24 October 2019

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS

24 OCTOBER 2019

APPROVAL OF POLICY FOR THE APPROVAL OF NON-AUDIT AND ADDITIONAL SERVICES BY THE TRUST'S EXTERNAL AUDITORS, SECURITY POLICY, POLICY FOR THE DEVELOPMENT AND MANAGEMENT OF CONTROLLED DOCUMENTS, POLICY FOR RESEARCH GOVERNANCE AND PATIENT RELATIONS POLICY

PRESENTED BY DIRECTOR OF CORPORATE AFFAIRS

1. Policy For The Approval of Non-Audit And Additional Services By The Trust's External Auditors

1.1 The revised and aligned Approval of Non-Audit Services Policy sets out the framework for the approval of non-audit expenditure within University Hospitals Birmingham NHS Foundation Trust (the 'Trust').

1.2 The purpose of this policy is to ensure compliance with the Revised Ethical Standard of 2016 for Audit and Assurance ('the standard') as issued by the Financial Reporting Council (FRC).

1.3 <u>The key changes to this policy are the following:</u>

a) Inclusion of key bodies: section 2 (Scope).

b) Clarification of the definition of non-audit work to exclude LCFS services - section 3 (Framework).

c) Increase in prior approval threshold from £25,000 to £100,000 - section 4.2 (Chief Financial Officer Duties).

d) Requirement to report all non-audit work to the Audit Committee and to the Council of Governors: section 4.2 (Chief Financial Officer Duties).

e) Provision of non-audit services must be included in the Audit Committee section of the Annual Report: section 4.2 (Chief Financial Officer Duties).

f) Updated references to NAO Guidance: section 6 (References).

2. Security Policy (including the Prevention and Control of Violence and Aggression)

2.1 The revised and aligned Security Policy sets out the framework for the management of security across the Trust.

2.2 The purpose of this policy is to ensure the Trust is a safe and secure environment with regards to persons, functionality and physical assets; There is a unified, structured and proactive approach to the management of security, violence and aggression within the Trust with all due consideration of legislative, regulatory and mandatory obligations; and that all persons are aware of their roles, responsibilities and obligations with regards to security matters;

2.3 <u>The key changes are the following:</u>

a) Policy mainly based on QE policy pre-merger.

b) References to named contractors removed.

c) References to named incident management systems removed.

3. Policy for the Development and Management of Controlled Documents

3.1 The revised policy sets out the principles and framework for the development, approval and monitoring of all Controlled Documents throughout the Trust.

3.2 The aims of this policy are to ensure the Trust has in place policies and procedural documents which are developed, approved, implemented and monitored through a clear and consistent process.

3.3 <u>The key changes are the following:</u>

a) Sponsor for Clinical Guidelines changed from Clinical Guidelines Group to Service Lead (or a nominated colleague) – Section 3.2 (Definitions).

b) Added requirement of Policy Assurance Officer to request and review policy compliance evidence from Document Leads – Section 4.7 (Duties).

c) Added Corporate Compliance Manager regarding the oversight and provision of assurance of monitoring compliance of Controlled Documents – Section 4.9 (Duties).

4. Policy for Research Governance

4.1 The revised and aligned policy sets out the overarching standards for research governance in the Trust.

4.2 The aims of this policy are to ensure that all research undertaken within the Trust is supported by quality assurance systems which remove or minimise risks for patients, patient data and/or tissue, and staff, equipment and facilities.

4.3 <u>The key changes introduced include the following:</u>

a) Requirement for research studies to be registered with the Trust's Research and Development Offices has been added – Section 4.4.1, (Framework).

b) References to named incident management systems removed – Section 4.4.3, (Framework).

c) Research activity undertaken within the Trust to be monitored and audited by the Research and Development Offices – Section 6.1.3, (Implementation).

5. Patient Relations Policy

5.1 The revised and aligned policy sets out the Trust's framework for the management of comments, enquiries, concerns and complaints. The policy merges two existing QEHB policies (the Complaints Policy and the Policy for the Patient Advice and Liaison Service, PALS).

5.2 The main objective of this policy is to ensure that positive patient experience is enhanced at all times through continuous sharing of learning amongst Trust staff, and that all contacts are investigated and resolved in an appropriate and timely manner.

5.3 <u>The key changes to this policy are the following:</u>

a) In cases where a complaint investigation may prejudice a legal investigation, the decision to suspend the complaint investigation shall be taken by the Chief Nurse, following receipt of advice from relevant staff – Section 3.15, (Framework).

b) Implementation and monitoring controls with regards to policy compliance and quality assurance have been updated – Appendix A, (Monitoring Matrix).

6. Recommendation

6.1 The Board of Directors is asked to consider, and if thought fit, approve the above policies. **Please note that by approving the Approval of Non-Audit Services Policy, the Board also approves the corresponding changes in thresholds in the Standing Financial Instructions.**

David Burbridge
Director of Corporate Affairs
24 October 2019