The Newcastle Upon Tyne Hospitals NHS Foundation Trust

Policies A-L

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Adoption Leave and Pay Policy

Version No.:	9.0
Effective Date:	14 April 2022
Expiry Date:	14 April 2025
Date Ratified:	14 February 2022
Ratified by:	Heads of HR

GENERAL POLICY STATEMENT

It is recognised that the needs of adoptive parents are at least as great as those of natural parents in establishing a relationship with the child and in developing new routines. The needs can be greater when, as frequently happens, the adoptive parents have only a few days' notice of a child's arrival or where the child is older and may have a difficult family background as well as several changes of foster parents and children's homes.

Statutory Adoption Leave is 52 weeks made up of 26 weeks of Ordinary Adoption Leave and 26 weeks of Additional Adoption Leave. Adoption leave is available to a single person who is adopting a child or to one person in a couple (including same sex) who jointly adopt a child under the age of 18. The couple may choose which partner takes the adoption leave. Where the Trust employs both parents, one parent should be identified as the primary carer and be entitled to the majority of the leave. The partner of the primary carer is entitled to occupational maternity support leave and pay (equivalent to paternity leave and pay) providing they satisfy the eligibility criteria – see 5 below - and may qualify for shared parental leave and/or pay in accordance with the Shared Parental Leave Policy. Shared Parental Leave enables eligible parents to choose how to share the care of their child during the first year of adoption, providing parents with additional flexibility.

1 Scope

1.1 The policy applies to employees adopting children below the age of 18.

1.2 Parents who have a child through a surrogacy arrangement (see section 17), are able to apply for adoption leave, providing they meet the eligibility criteria as set out in section 5.

1.3 Employees are not entitled to Statutory Adoption Leave or Pay if they:

- arrange a private adoption
- become a special guardian or kinship carer
- adopt a stepchild

- adopt a family member or stepchild

1.4 **Fostering to adopt:** Each year a small number of children are placed with local authority foster parents, in accordance with section 22C of the Children Act 1989 with the expectation that they will adopt that child. The dual approved prospective adopter is eligible for adoption leave and pay (subject to the eligibility criteria in section 5 or 10, as appropriate) and can take this from up to 2 weeks before the child is placed with the family in accordance with section 22C (i.e. when the child joins the family, initially for fostering). The leave and pay must be taken within 52 weeks of this placement.

2 Aims

This policy enables an employee who will be the main carer and who wishes to adopt a child to take a period of leave to help the child settle into the family and adjust to new circumstances.

3 Duties – roles and responsibilities

3.1 The Executive Team is accountable to the Trust Board for ensuring Trust-wide compliance with policy.

3.2 Directorate managers and heads of service are responsible to the Executive Team for ensuring policy implementation.

3.3 Managers are responsible for ensuring policy implementation and compliance in their area(s).

3.4 Staff are responsible for complying with policy.

4 Contractual adoption leave and pay

4.1 Eligibility

All employees are entitled to 52 weeks' adoption leave.

a) An employee working full or part-time is entitled to adoption pay (see section 6 below) under the NHS contractual adoption pay scheme if the employee:

- has been matched with a child for adoption by an adoption agency or
- has a statutory declaration to confirm they've applied or will apply for a parental order in the 6 months after the child's birth (in the case of surrogacy arrangements) or
- has been sent official notification that the relevant UK Authority has issued a Certificate of Eligibility to the overseas authority involved in adoption that

they are eligible to adopt a child from overseas (in the case of overseas adoption).

b) has twelve months' continuous NHS service ending with the week in which they are notified of being matched with the child for adoption, or for those adopting from overseas, when the adopter has been sent official notification that the relevant UK Authority has issued a Certificate of Eligibility to the overseas authority involved in adoption that they are eligible to adopt a child from overseas. This will cover the circumstances where the employee is newly matched with the child by an adoption agency.

c) gives the correct notice, as per section 11.

d) provides the Human Resources Department with the required evidence, as per section 11.

e) has expressed an intention to return to work with the Trust or another relevant NHS employer for a minimum period of three calendar months after the adoption leave has ended.

5 Employee who notifies of an intention to return to work

5.1 An employee with twelve months' continuous service with the Trust and who intends to return to work with the Trust or another relevant NHS employer for a minimum period of three calendar months is entitled to 39 consecutive weeks' leave of absence with pay as follows:

- 8 weeks at full pay, less any Statutory Adoption Pay (SAP)
- 18 weeks at half pay, plus any SAP receivable, providing the total receivable does not exceed full pay
- for the following 13 weeks: SAP only

5.2 The employee may remain absent on unpaid leave for a further consecutive period of up to 13 weeks. The total amount of paid and unpaid leave will not exceed 52 weeks.

5.3 An employee who has notified an intention to return to work at the end of full adoption leave (i.e. after 52 weeks) or whose expected return date has been based on 52 weeks' paid and unpaid leave entitlement, is not required to give any further notification of return unless the employee wishes to return early, in which case eight weeks' notice should be given (at the manager's discretion the notice required may be reduced following discussion and agreement with the Human Resources Department).

5.4 By prior agreement, OAP can be paid in a different way, for example a fixed amount spread equally over the paid adoption leave period (i.e. a maximum of 39 weeks).

5.5 An employee has the right to return to their job under their original contract and on no less favourable terms and conditions unless a redundancy situation arose during the period of adoption absence or there is some other reason why it is not reasonably practicable to return to the original job.

6 Employee not returning to work

An employee who does not intend to return to work, either for the Trust or another NHS employer for a minimum period of three calendar months after adoption leave has ended, will not be entitled to Occupational Adoption Pay but may be entitled to pay equivalent to Statutory Adoption Pay (SAP).

7 Employee undecided whether to return to work

7.1 An employee who is undecided whether they will return to work after adoption leave can opt to receive SAP only. This decision can only be taken prior to the start of the adoption leave.

7.2 If the employee chooses not to receive OAP during adoption leave, the employee will receive their entitlement to OAP (less SAP) only after the employee has returned to work for the Trust or another NHS employer for a minimum period of three calendar months within 15 months of the beginning of the adoption leave.

7.3 If the employee subsequently decides not to return and gives due notice (as defined in the contract of employment), there will be no liability to refund OAP as only SAP was paid.

8 Calculation of adoption pay

Full pay will be calculated on the basis of the employee's average weekly earnings for eight weeks prior to the date of commencement of adoption leave, subject to the following qualifications:

a) in the event of a pay award or annual increment being implemented before the paid adoption leave period begins, the adoption pay will be calculated as though the pay award or annual increment had effect throughout the entire SAP calculation period. If such a pay award is agreed retrospectively, the adoption pay should be re-calculated on the same basis.

b) in the event of a pay award or annual increment being implemented during the paid adoption leave period, the adoption pay due from the date of the pay award

or annual increment will be increased accordingly. If such a pay award is agreed retrospectively, the adoption pay should be re-calculated on the same basis.

c) in the case of an employee on unpaid sickness absence, or on sickness absence attracting half pay during the whole part of the period used for calculating average weekly earnings, in accordance with the earnings rules for SAP purposes, average weekly earnings for the period of sickness absence shall be calculated on the basis of notional full sick pay.

d) in the case of an employee currently on adoption leave who intends to take a second period of adoption leave, either concurrently or in close succession to the first, who is in receipt of:

- half of full pay (plus any Statutory Adoption Pay receivable), or
- Statutory Adoption Pay, or
- no pay

during the whole or part of the period used for calculating average weekly earnings, in accordance with the earnings rules for Statutory Adoption Pay purposes, average weekly earnings for the second period of adoption leave shall be calculated based on notional full pay.

9 Statutory adoption pay

9.1 An employee who does not satisfy the conditions for contractual adoption pay and leave may be entitled to Statutory Adoption Pay (SAP).

9.2 An employee is entitled to a maximum of 39 weeks' SAP if the employee satisfies the following conditions:

a) has been matched with a child for adoption by an adoption agency

b) been employed by the Trust continuously for at least 26 weeks before the beginning of the week when the adoption agency confirmed the employee had been matched with a child for adoption, or has been continuously employed for at least 26 weeks continuing into the week in which the employee is sent Official Notification from the relevant UK Authority or by the time the employee wishes to start adoption leave for overseas adoptions, and

c) has average weekly earnings of at least equal to the lower earnings limit for national insurance contributions

d) gives the correct notice, as per section 12.

e) provides the required evidence, as per section 12.

9.3 SAP is paid at the rate of 90% of an employee's average weekly earnings for 6 weeks followed by 33 weeks at a flat rate set by the government or 90% of the employee's weekly earnings (whichever is lower).

10 Commencement and duration of adoption leave

10.1 An employee can commence adoption leave from;

a) up to 14 days before the date that the child is expected to start living with the employee (UK adoptions only)
b) when the child arrives in the UK or within 28 days of that date (overseas adoptions)
c) the day the child is born or the day after (for surrogacy arrangements)
d) leave can commence on any day of the week

10.2 If the placement is delayed and adoption leave has commenced, adoption leave cannot be stopped and resumed again at a later date.

11 Notification of adoption leave

11.1 Employees are advised to notify their manager and the Human Resources Department in writing of their intention to take adoption leave within seven days of being notified by their adoption agency that they have been matched with a child for adoption (or 28 days if adopting form overseas), unless this is reasonably not practicable. Employees should give 28 days' notice of the date they'd like their adoption leave and pay to commence, where this is possible.

11.2 If the individual's right to work is via a Certificate of Sponsorship they must also notify the Human Resources Department of this in order that they can ensure compliance with UKVI regulations during any period of adoption leave.

11.3 Appendix 1 includes the application for adoption leave for completion by the applicant, this will notify their manager and the Human Resources Department that:

a) you intend to take adoption leave
b) when the child is expected to be placed with you
c) when you wish to commence adoption leave

11.4 When notified the Human Resources Department will arrange to:

a) contact the employee to discuss the application and available options

b) receive the required evidence as follows;

i) All adoptions

- The original matching certificate or a letter from the adoption agency confirming that they have been matched with a child **OR** the 'Statutory Declaration' (signed in the presence of a legal professional) to confirm the employee has applied or will apply for a parental order in the 6 months after the child's birth **OR** the original official notification from the relevant UK authority that they have agreed the employee is eligible to adopt a child from overseas and has been assessed and approved as being a suitable adoptive parent (overseas adoptions)
- Name and address of the adoption agency (The adoption agency must be one which is recognised in UK Law)
- Employee's name and address
- Date the child is expected to be placed for adoption, or the date the child was placed for adoption

ii) For overseas adoptions; all of the above plus;

- The estimated date of the child arriving in the UK, within 28 days of this date (overseas adoption)
- The date the child arrived in the UK within 28 days of this date (overseas adoption)

c) within 28 days, give written confirmation of the;

- paid and unpaid leave entitlement under this policy (or statutory entitlements if the employee does not qualify)
- return date: unless an earlier return date has been given, the employee's expected return date, based upon 52 weeks' paid and unpaid leave entitlement under this policy
- length of any period of accrued annual leave/public holidays which it has been agreed may be taken following the end of the formal adoption leave period
- need for the employee to give at least eight weeks' notice of the revised date if they wish to return to work before the expected return date

If the employee has been unable to provide the usual amount of notice to the HR department (e.g. if an adoption process is expedited), they should ring the HR department to arrange prompt delivery of all required documentation and to agree a timescale for processing the application. Where adjustments to salary for adoption leave cannot be processed within payroll timescales, an adjustment will be made to salary the following month.

d) ensure UKVI are notified of the individual's adoption leave as per UKVI regulations for those employees whose right to work is via a Certificate of Sponsorship

12 Keeping in touch

12.1 Subject to agreement with their manager, an employee can work up to ten 'keeping in touch' (KIT days) (i.e. equivalent to two working weeks in total) during paid and/or unpaid adoption leave without losing entitlement to adoption pay and without bringing their adoption leave to an end. Any days of work will not extend the adoption leave period.

12.2 Before going on adoption leave, the manager and the employee should discuss and agree any voluntary arrangements for keeping in touch during the employee's adoption leave including:

a) any voluntary arrangements that the employee may find helpful to help keep in touch with developments at work and, nearer the time of their return, to help facilitate a return to work
b) keeping the manager in touch with any developments that may affect the intended date of return

12.3 To facilitate the process of KIT days it is important that the manager and employee have an early discussion to plan and make arrangements for KIT days before the employee's adoption leave takes place.

12.4 To enable employees to take up the opportunity to work KIT days, the Trust will consider the scope for reimbursement of reasonable childcare costs or the provision of childcare facilities where necessary.

12.5 The KIT days worked can be consecutive days or not, and can include training (including the completion of mandatory training) or other activities which enable the employee to keep in touch with their workplace.

12.6 Any such work must be by agreement, and neither the Trust nor the employee can insist on it.

12.7 The employee will be paid a proportion of their basic daily rate, for the actual hours worked less appropriate adoption leave payment for KIT days worked. Working for part of any day will count as one KITday.

13 Time off to attend adoption meetings

13.1 **Pre- adoption meetings:** In addition to the statutory rights identified below, an employee who is the adopter or is the partner (including same-sex partner) of the adopter (when adopting jointly) may take up to 5 days' paid leave (pro rata for

part time staff) for attendance at pre-adoption assessment training and any required official meetings in the pre-adoption process. In addition to this reasonable time off (without pay) or annual leave may be granted, subject to approval and exigencies of the service. The adopter and/or partner of the adopter should give reasonable notice and provide evidence of all appointments to the line manager or head of department.

13.2 Adoptive parents who have been matched with a child are entitled to time off to attend appointments arranged by, or at the request of, the adoption agency, for the purposes of having contact with that child or for any other purpose connected with the adoption process, prior to the date of the child's placement for adoption.

13.3 A single person who is adopting a child or the 'primary adopter' in a couple who jointly adopt a child has the right to paid time off if this occurs within the employee's normal working hours. An employee is entitled to take time off up to a maximum of five occasions and each occasion should not exceed six and a half hours.

13.4 The 'secondary adopter' in a couple who jointly adopt a child has the right to unpaid time off. An employee is entitled to take time off up to a maximum of two occasions and each occasion should not exceed six and a half hours.

13.5 All requests for time-off for pre-adoption meetings are subject to the prior approval of the manager who should not unreasonably refuse such a request. An employee wishing to exercise the right to take time off must complete the declaration at Appendix 2.

13.6 An employee should provide as much notice as possible and all requests must be supported by evidence that the appointment has been made at the request of the adoption agency.

13.7 It should be noted that if an employee has exercised the right to paid time off as the 'secondary adopter' they cannot then apply for other entitlements as the 'primary adopter.' Likewise, an employee who has exercised their right to paid pre-adoption leave will not be entitled to Maternity Support (Paternity) leave.

14 Disrupted/failed adoption

If an adoption arrangement fails, this can be a traumatic time for an employee. In the event of this occurring and depending on the individual circumstances, the following will apply:

a) If the employee is on paid adoption leave, adoption pay and adoption leave will cease eight weeks after the end of the week in which the employee is notified that the child will not be placed or the child is returned, or at the end of the additional adoption leave period, even where this is less than 8 weeks' away. The

manager will need to discuss and agree with the employee what arrangements can be made for their return to work.

b) If the child dies whilst the employee is on paid adoption leave, adoption pay and adoption leave will cease eight weeks after the end of the week in which the child dies, or at the end of the additional adoption leave period, even where this is less than 8 weeks' away.

c) For this purpose, a week is defined as seven days, beginning with a Sunday.

d) If the adopter was originally undecided on whether to return to work after the period of adoption leave (as per paragraph 8), but subsequently returns to work in the event of the adoption being disrupted, then the employee is entitled to the amount of occupational adoption pay that was deferred during the period the adoption existed (providing they met the eligibility for OAP prior to commencement of adoption leave).

e) If the employee is on adoption leave, the manager will need to discuss and agree with the employee what arrangements can be made for their return to work, or continued absence in the short-term.

f) If an employee has resigned to adopt a child, the employee will have no entitlement to return to employment with the Trust. Managers should at all times seek advice from the Human Resources Department before handling any matters under this section.

g) It is the employee's responsibility to inform their manager if the child will not be placed.

h) In the case of those adopting from abroad the employee cannot start their adoption leave or pay until the child has entered the UK. They should inform their manager as soon as they know they will not be adopting the child after all.

15 Failure to return to work

If an employee has notified an intention to return to work for the Trust or another NHS employer in accordance with paragraph 6 above fails to do so within 15 months of the beginning of the adoption leave, the employee will be liable to refund the whole of the adoption pay, less any SAP received. Repayment must be made within one month of notification.

16 Surrogacy

The Children and Families Act 2014 permits parents who have a child through a surrogacy arrangement to take ordinary paternity leave and pay, adoption leave and pay and shared parental leave and pay, provided that they meet the eligibility criteria.

Both parents in a surrogacy arrangement are also entitled to take unpaid time off work to attend two antenatal appointments with the woman carrying the child.

17 Shared Parental Leave

Shared parental leave will be available to adoptive parents t. Please refer the Shared Parental Leave Policy for further information.

Shared Parental Leave enables eligible parents to choose how to share the care of their child during the first year of birth or adoption, providing parents with additional flexibility.

18 Returning on flexible working arrangements

18.1 There is no legal right to return to a job on a part time basis, however, an employee may apply for flexible working, all requests will be considered – see 'Flexible Working Arrangements' policy.

18.2 If agreed the employee can return to work on a flexible basis, including changed or reduced hours, for an agreed temporary period, this must be clearly confirmed via the Human Resources Department. This will not affect the employee's right to return to their job under their original contract at the end of the agreed period.

18.3 An employee who returns to work whilst breastfeeding should refer to the Supporting Staff who are Breastfeeding Policy for details of support available.

19 Returning late from adoption leave

19.1 If an employee wishes to return to work later than their expected return to work date they can request parental leave (see 'Special Leave' policy) or unpaid leave (at manager's discretion). The employee should give at least 21 days' notice before the end of adoption leave and all leave is subject to approval in advance by the line manager.

19.2 If an employee is unable to return to work on the expected date due to illness or injury, this will be regarded as sickness absence and will be dealt with in accordance with the 'Employee Wellbeing' policy.

20 Sickness following the end of adoption leave

In the event of illness following the date the employee was due to return to work, normal sick leave provisions will apply as necessary.

21 Fixed term contracts or training contracts

21.1 An employee subject to a fixed-term or training contract which expires 14 days before the expected date of placement (they must have been notified by an adoption agency that they have been matched), will have their contract extended so as to allow the employee to receive the 52 weeks' adoption leave. Should they satisfy the conditions in section 5, this will include paid contractual leave, SAP and a remaining 13 weeks' unpaid leave as set out in paragraph 6.1 c).

21.2 Absence on adoption leave (paid and unpaid) up to 52 weeks before a further NHS appointment will not constitute a break in service.

21.3 If there is no right of return to be exercised because the contract would have ended if adoption had not occurred, the repayment provisions set out in paragraph 16. above will not apply

21.4 An employee on a fixed-term contract who does not meet the twelve months' continuous service condition set out in paragraph 5. a) above, may still be entitled to SAP – paragraph 10.

22 Rotational training contracts

22.1 Where an employee is on a planned rotation of appointments with one or more NHS employers as part of an agreed programme of training, they shall have the right to return to work in the same post, or in the next planned post, irrespective of whether the contract would otherwise have ended if adoption had not occurred.

22.2 In such circumstances, the employee's contract will be extended to enable the practitioner to complete the agreed programme of training.

23 Increments

Adoption leave whether paid or unpaid, will count as service for annual increments.

24 Accrual of annual leave/public holidays

24.1 Annual leave/public holidays will continue to accrue during adoption leave, whether paid or unpaid, and where possible should be taken during the relevant holiday year.

24.2 The amount of accrued annual leave an employee can carry over to the next annual leave year should not normally exceed five days i.e. one working week (pro-rata for part-time employees and full time employees who work their shifts over less than five shifts per week). The amount of annual leave/public holidays an employee wishes to carry over must be approved by the line manager before the adoption leave period starts.

24.3 Where a change in contracted hours is agreed, reference should be made to the Trust's policy: 'Calculation of Annual Leave and Public Holidays Entitlements' to resolve how any annual leave/public holidays outstanding/overtaken at the date of change should be managed.

24.4 Adoption leave, whether paid or unpaid, will count as service for the purposes of any service qualification period for additional annual leave.

25 Pension

25.1 Pension rights and contributions will be dealt with in accordance with the provisions of the NHS Pension Scheme.

25.2 Pension contributions accrue, but are not payable, during periods of unpaid adoption leave. As a result, the amount of accrued contributions will be deducted from salary when the employee returns to work over a period equivalent to the amount of unpaid leave taken. For example, three months' unpaid leave will amount to deductions from salary over the first three months following the employee's return to work.

25.3 These pension contributions are calculated from the pay received on the last day of paid leave before unpaid leave commenced.

25.4 The above deductions are in addition to the contributions payable by the employee from the date they return to work.

25.5 Any queries should be dealt with by a Pensions Officer in Payroll.

26 Continuous Service

26.1 For the purposes of calculating continuous service with one or more NHS employers the following applies:

a) NHS employers include health authorities, NHS Boards, NHS Trusts, Primary Care Trusts and the Northern Ireland Health Service
b) a break in service of three months or less will be disregarded (though not count as service)

26.2 The following breaks in service will also be disregarded (though not count as service):

a) employment under the terms of an honorary contract

b) employment as a locum with a general practitioner for a period not exceeding twelve months

c) a period of up to twelve months spent abroad as part of a definite programme of postgraduate training on the advice of the Postgraduate Dean or College or Faculty Advisor in the specialty concerned

d) a period of voluntary service overseas with a recognised international relief organisation for a period of twelve months which may exceptionally be extended for twelve months at the discretion of the Trust, or the employer which recruits the employee on their return

e) absence on an employment break scheme – see Flexible Working Arrangements policy

f) absence on maternity/adoption leave (paid or unpaid) as provided for under Trust policy

g) Employment as a trainee with a General Medical Practitioner in accordance with the provisions of the Trainee Practitioner Scheme will be disregarded and count as service.

27 Salary sacrifice schemes

27.1 There can be implications for an employee participating in a salary sacrifice scheme. These implications can include: effect on calculation for adoption pay; and eligibility to remain in the scheme during adoption leave when in reduced pay and/or on unpaid adoption leave.

27.2 An employee should check the terms of their salary sacrifice arrangements for further details and the Staff Benefits team for advice and information.

27.3 Employees who have a salary sacrifice arrangement(s) remain responsible for payments during periods of unpaid leave. The employee should contact the Staff Benefits team for advice and information on how to setup payments, if they are approaching a period of unpaid leave.

28 Professional Registration

An employee is responsible for ensuring that they maintain their competence and professional registration (where applicable) at all times during their paid and unpaid adoption leave.

29 Working whilst on adoption leave

Any employee considering undertaking **any** paid work whilst on adoption leave, excluding KIT days (in accordance with paragraph 13 above) should contact Payroll to ascertain what impact this may have on the adoption pay they receive.

30 Training

Training will be provided by the Human Resources Department to key staff following implementation of the policy.

31 Equality and Diversity

The Trust is committed to ensuring that, the way services are provided to the public and the staff are treated reflects their individual needs and does not unlawfully discriminate against individuals or groups on any grounds. This policy has been assessed accordingly.

32 Monitoring compliance with the policy

Standard / Process / Issue	Monitoring and Audit			
	Method	**By**	**Committee**	**Frequency**
Monitor applications for adoption leave and outcomes, in partnership with local staff representatives	Reporting of information from ESR and personal files	Director of Human Resources	EPF	Annually

33 Consultation and review of this agreement

This agreement has been reviewed in consultation with the Employment Policies and Procedures Consultative Group

34 Implementation of the policy (including raising awareness)

A summary of the key changes will be notified to managers following implementation. Further advice and guidance will be available from the Human Resources Department.

35 Additional documents

- Annual Leave and General Public Holidays Policy
- Disciplinary Policy and Procedure
- Employee Wellbeing Policy Incorporating Absence Management Procedure
- Flexible Working Arrangements Policy
- Shared Parental Leave Policy
- Special Leave Policy
- Supporting staff who are breastfeeding policy

Author: Employment Policies and Procedures Consultative Group

Appendix 1

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Application for Adoption Leave/Pay

Surname:	
Forename(s):	
Hospital / Department:	
Assignment number:	
Post:	
Date of appointment:	
Date of continuous service (please ask your manager to confirm the date)	
UK or overseas adoption	
Date of matching certificate:	
Expected date of placement:	
Adoption leave requested:	
From and to (paid):	
From and to (unpaid):	
Do you currently hold a Certificate of Sponsorship?	

If you have an existing salary sacrifice arrangement, you will be responsible for continuing those payments during leave. Please contact the Staff Benefits team for advice and information. By signing the declarations below, you are also confirming you have taken advice from the Staff Benefits Team

(Please sign section A, B, C or D below as appropriate)

Section A

I wish to apply for contractual adoption pay and intend to continue working in the NHS for a minimum period of three calendar months after the expiry of my adoption leave. I enclose a matching certificate.

If I fail to return to work in the NHS for three months after the expiry of my adoption leave, I agree to repay on demand the whole of the contractual adoption pay, less any SAP, I receive. I also agree to

reimburse the Trust the full amount of employer's national insurance contributions for the period of paid leave.

Signed: …………………………………………… Date: ………………………………….

Section B

I wish to apply for Statutory Adoption Pay only and wish to retain the right to return to my post. In the event of returning to my post within the stated time limits after the date of placement for a minimum period of three calendar months, I understand that the Trust will pay to me any contractual adoption pay I am entitled to under the Adoption Leave policy. I enclose a matching certificate.

Signed: ……………………………………………. Date: ……………………………..

Section C

I have no entitlement to Statutory Adoption Pay, but wish to apply for adoption leave in accordance with the Trust's Adoption Leave policy. I enclose a matching certificate.

Signed: ………………………………………… Date: …………………………………..

Section D - Adoption Pay (where there is no intention of returning to work)

I do not intend to return to work after the adoption and wish to apply for Statutory Adoption Pay. I enclose a matching certificate.

Signed: ………………………………… Date: …………………………………..

I would like request 'average equal monthly payments' Yes □ No □

For Human Resources Department Use Only

Authorised

Signed: ……………………………………………… Date: …………………………………..

Print Name: ……………………………………………………………………………………

Designation: …………………………………………………………………………………...

Date application and matching certificate sent to Payroll:
……………………………………………………….

Appendix 2

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Declaration to take time off work for adoption meetings

Surname:	
Forename(s):	
Hospital / Department:	
Assignment Number:	
Post:	
Expected / actual date of placement for adoption:	
Are you the:	Primary adopter ☐ Secondary adopter ☐
Date, time and location of appointment	
Dates requested for time off to attend adoption appointment	Date Time from: Time to:
Please state number of previous requests for time of to attend adoption appointments for this particular adoption	

I wish to apply for time off work to attend adoption appointments and declare that;

☐ the appointment in question was made on the request of the adoption agency, and
☐ the date and time of the appointment is as given above.

Signed: ……………………………………………. Date: ………………………………….

For Management Use Only - Authorised

Signed: …………………………………………….…. Date: ……………………….……….

Print Name: ……………………………………Designation: ……………………………….

Details entered onto ERA/ESR through Manager Self Service Arrangements using the relevant absence code and copy form sent to HR for personal file ☐

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Equality Analysis Form A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

PART 1

1. **Assessment Date:** [ ]

2. **Name of policy / strategy / service**:

Adoption Leave and Pay Policy

3. **Name and designation of Author:**

Ms K Pearce, Senior HR Manager (Projects)

4. **Names & designations of those involved in the impact analysis screening process:**

Employment Policies and Procedures Consultative Group

5.

Is this a:	Policy	x	Strategy		Service	
Is this:	New		Revised	x		
Who is affected	Employees	x	Service Users		Wider Community	

6. **What are the main aims, objectives of the policy, strategy, or service and the intended outcomes?** (*These can be cut and pasted from your policy*)

This policy enables an employee who will be the main carer and who wishes to adopt a child to take a period of leave to help the child settle into the family and adjust to new circumstances.

7. **Does this policy, strategy, or service have any equality implications?** **Yes** [ ] **No** [x]

If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:

[ ]

8. Summary of evidence related to protected characteristics

Protected Characteristic	Evidence, i.e. What evidence do you have that the Trust is meeting the needs of people in various protected Groups	Does evidence/engagement highlight areas of direct or indirect discrimination? If yes describe steps to be taken to address *(by whom, completion date and review date)*	Does the evidence highlight any areas to advance opportunities or foster good relations. If yes what steps will be taken? *(by whom, completion date and review date)*
Race / Ethnic origin (including gypsies and travellers)	The Trust is committed to ensuring that, the way services are provided to the public and the staff are treated reflects their individual needs and does not unlawfully discriminate against individuals or groups on any grounds. This statement equally applies to all protected characteristics	There is no evidence to suggested indirect/direct discrimination for any protected characteristic	No
Sex (male/ female)	Adoption leave is available to a single person who is adopting a child or to one person in a couple (including same sex) who jointly adopt a child under the age of 18. The couple may choose which partner takes the adoption leave.		No
Religion and Belief			No
Sexual orientation including lesbian, gay and bisexual people	Adoption leave is available to a single person who is adopting a child or to one person in a couple (including same sex) who jointly adopt a child under the age of 18. The couple may choose which partner takes the adoption leave. Trust has previously ran sessions and shared information for staff who identify as LGBT on the provisions of Trust family friendly policies Parents who have a child through a surrogacy arrangement (see section 17), are able to apply for adoption leave, providing they meet the eligibility criteria		No
Age			No
Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the			No

needs of carers in this section			
Gender Re-assignment	The policy uses gender neutral pronouns throughout		No
Marriage and Civil Partnership	The policy confirms that adoption leave is available to a single person who is adopting a child or to a partner (including civil partner) of a couple who jointly adopt a child under the age of 18		No
Maternity / Pregnancy			n/a

9. Are there any gaps in the evidence outlined above? If 'yes' how will these be rectified?

No member of staff has been refused leave on the basis of a protected characteristic

10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.

Do you require further engagement? Yes [ ] No [x]

11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?

No

PART 2

Name:

Date of completion:

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Employment Policies & Procedures

Maintaining Services During Adverse Weather Conditions and Public Transport Disruption Policy

Version No.:	5
Effective Date:	16 June 2023
Expiry Date:	16 June 2026
Date Ratified:	12 June 2023
Ratified by:	Heads of HR

1 GENERAL POLICY STATEMENT

1.1 The Trust will maintain services as much as possible during adverse weather conditions, whilst properly discharging its duty of care to staff and patients. This policy is based on the clear principle that in accordance with their contract of employment staff are required to attend work in order to receive payment of salary.

1.2 In rare or exceptional circumstances, it may be necessary for the Trust to close buildings or reduce service provision. On such occasions, full instructions will be given on how this time should be reflected. All staff will be made aware of these arrangements.

1.3 In all other circumstances, staff are expected to present themselves for work at the start of their shift. This may mean, with management approval, at an alternative work base.

2 Scope

This policy applies to all staff and anyone else engaged to work on behalf of the Trust.

3 Aims

This policy is intended to provide guidance to managers to ensure the circumstances referred to in section 1.3 are dealt with effectively and consistently by the Trust.

4 Duties – roles and responsibilities

4.1 The Executive Team is accountable to the Trust Board for ensuring Trust wide compliance with policy.

4.2 Director of Operations and heads of service are responsible to the Executive Team for ensuring policy implementation.

4.3 Managers are responsible for ensuring policy implementation and compliance in their area(s).

4.4 Staff are responsible for complying with policy.

5 Responsibilities of the employee

5.1 It is the responsibility of staff to make every effort to attend for duty at the start of their shift at their normal place of work. Where adverse weather conditions are forecast, staff are expected to plan ahead accordingly for situations such as school closures (see 6.7) and travel disruption.

5.2 In the event of adverse weather conditions/public transport disruption which renders staff unable to attend work, they should take all reasonably practicable steps to inform their manager directly (or nominated person in charge) at the earliest opportunity and no later than the time they are due to start work. Staff should ensure that they give details of any urgent work and/or deadlines that require attention in their absence.

5.3 Staff shall not unreasonably refuse to comply with temporary redeployment to an alternative base or undertake other duties.

5.4 Should weather conditions and or public transport improve during the day staff are expected to attend work.

6 Responsibilities of the manager

6.1 The manager should consider a range of factors impacting upon a staff member's ability to attend for duty including:

a) the requirements of the service
b) the weather conditions and their anticipated duration
c) their normal mode of transport
d) reasonable alternative methods of transport available to facilitate attendance
e) hours of work e.g., night shifts, weekend working and on-call arrangements
f) health & safety (a risk assessment may be needed)
g) health condition or disability that may present an additional barrier to attend work in bad weather conditions. Advice may be necessary from Occupational Health Service and Human Resources.
h) caring responsibilities that may present an additional barrier to attendance
i) distance to travel to work
j) capacity to work from home
k) capacity for redeployment to a more accessible or appropriate base
l) provision of alternative duties
m) use of alternative communication methods
n) use of existing on-call arrangements in order to establish contingency arrangements where adverse weather conditions are foreseeable

6.2 Where staff are unable to attend for duty, a number of options should be considered and discussed including:

a) use of any accrued lieu time
b) use of annual leave
c) unpaid leave
d) working any lost time back
e) time off for dependents leave
f) agile working
g) a combination of the above

All options are subject to agreement by the manager. Further details of the above may be found in the Annual Leave Policy ,Special Leave Policy and Working Flexibly Policy.

6.3 Where non-attendance is for a prolonged period (e.g. stranded abroad due to a significant and unforeseen disruption to flights) the manager shall discuss with staff how the time lost will be repaid.

6.4 It may be reasonably practicable for staff to work from home where this would be considered appropriate having regard to their normal duties and responsibilities. Such arrangements are subject to prior agreement by the manager with due consideration of health and safety, confidentiality and risk assessment.

6.5 Staff who fail to notify their manager of their inability to attend work shall be recorded as unauthorised unpaid absence and their pay will be deducted for the hours lost.

6.6 Where staff arrive late for duty and this was entirely due to adverse conditions their pay shall not normally be withheld for the time lost provided the manager has agreed how that time will be made up.

6.7 Where an emergency situation arises during a shift/working day, the manager shall exercise discretion regarding whether staff are able to leave early or perhaps be redeployed to an alternative base. Agile working may also be considered as set out above. Consideration should be given to service needs and advice should be obtained from an officer of appropriate senior authority. Any time lost shall be made up by staff at a time to be agreed with their manager.

6.8 Where an emergency situation occurs and staff request time off to collect and/or care for a child and/or dependent, managers should refer to the provisions set out in the Trust's Special Leave Policy.

6.9 For jobs where staff are required to drive and/or work outdoors in adverse weather conditions, managers should ensure individuals have appropriate equipment and safe systems of work in place and shall undertake regular risk assessments. Alternative duties or temporary redeployment to another base should be considered.

6.10 Where appropriate the Trust may make arrangements to provide staff with on-site accommodation if they anticipate difficulties travelling to or from work.

This can include arrangements for sleeping on site. There will be no charge for this.

7 Equality and Diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. This policy has been properly assessed.

8 Monitoring compliance with the policy

Standard / Process / Issue	**Monitoring and Audit**			
	Method	**By**	**Committee**	**Frequency**
a) The number of disciplinaries as a result of non-adherence to this policy b) The number of grievances as a result of the misapplication of this policy	Reporting of information from ESR	Chief People Officer	Heads of Human Resources Meeting	Annually

9 Consultation and review of this policy

This policy has been reviewed in consultation with the Employment Policies and Procedures Consultative Group

10 Implementation of the policy (including raising awareness)

A summary of the key changes will be notified to managers following implementation. Further advice and guidance will be available from the Human Resources Department.

11 Additional documents

Special Leave Policy
Annual Leave Policy
Working Flexibly

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Equality Analysis Form A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

PART 1

1. **Assessment Date:** 13th March 2023

2. **Name of policy / guidance/ strategy / service development / Investment plan/Board Paper**:

Adverse Weather Conditions and Public Transport Disruption

3. **Name and designation of author:**

4. **Names & Designations of those involved in the impact analysis screening process:**

HR Rep TBC, HR Heads, EPPCG

5. **Is this a:** Policy X Strategy ☐ Service ☐ Board Paper ☐

   Is this: New ☐ Revised X

   Who is affected: Employees X Service Users ☐ Wider Community ☐

6. **What are the main aims, objectives of the document you are reviewing and what are the intended outcomes?**
   (These can be cut and pasted from your policy)

Maintaining services during adverse weather conditions and transport disruptions and taking steps to ensure the duty of care to its employees is discharged. The policy also sets out considerations for managers and employees, and a process to follow in the event of a disruption.

7. Does this policy, strategy, or service have any equality implications? Yes ☐ No X

If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:

8. Summary of evidence related to protected characteristics

Protected Characteristic	**Evidence** **What evidence do you have that the Trust is meeting the needs of people in all protected Groups related to the document you are reviewing–** please refer to the Equality Evidence within the resources section at the link below: http://nuth-vintranet1:8080/cms/SupportServices/EqualityDiversityHumanRights.aspx	**Does evidence/engagement highlight areas of direct or indirect discrimination?** For example differences in access or outcomes for people with protected characteristics	**Are there any opportunities to advance equality of opportunity or foster good relations**? If yes what steps will be taken? (by whom, completion date and review date)
Race / Ethnic origin (including gypsies and travellers)	The aim of policy is to ensure consistency in maintaining services during adverse weather conditions and public transport disruption. The policy is clear that the Trust is committed to ensuring that the way staff are treated reflects their individual needs and does not unlawfully discriminate against individuals or groups. The Trust has a duty of care to all staff and where a member of staff has specific needs this will be carefully looked at and considered.	N/A	N/A
Sex (male/ female)	As above	N/A	N/A
Religion and Belief	As above	N/A	N/A
Sexual orientation including lesbian, gay and bisexual people	As above	N/A	N/A
Age	As above	N/A	N/A

Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section	As above, however in addition, the policy confirms that where staff have a disability or health condition which presents an additional barrier, consideration would be given to this and reasonable adjustments can be made to support staff. Staff who care for others or those with a disability will be signposted appropriately and to the relevant policy.	N/A	Other HR policies would provide additional means of support to staff who require reasonable adjustments or time off for dependents.
Gender Re-assignment	As race above	N/A	N/A
Marriage and Civil Partnership	As above	N/A	N/A
Maternity / Pregnancy	As above	N/A	N/A

9. Are there any gaps in the evidence outlined above? If 'yes' how will these be rectified?

No

10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.

Do you require further engagement Yes No X

11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?)

No, no negative impact is envisaged.

PART 2

Name of author:

TBC ?

Date of completion

13/03/23

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)

The Newcastle Upon Tyne Hospitals NHS Foundation Trust

Employment Policies and Procedures

Policy Regarding Alcohol, Drugs & Other Substances Which Could Affect Performance at Work

Version No.:	8.0
Effective From:	10 November 2021
Expiry Date:	10 November 2024
Date Ratified:	06 September 2021
Ratified By:	Executive Group

General Policy Statement

It is our commitment to provide a safe and secure environment for all staff, patients and visitors.

This policy is intended to support staff to carry out their duties whilst ensuring health, safety and wellbeing is maintained. It provides a guide for managers to handle concerns of alcohol and substance misuse.

Employees with alcohol, drug or other substance related problems will be supported sensitively.

1 Scope

1.1 This policy applies to all staff, and includes contractors, agency workers, volunteers, those engaged on clinical access/observer status placements and anyone else engaged to work in the Trust.

1.2 The policy will apply regardless of age, disability, race, nationality, ethnic origin, sex, sexual orientation, religion and belief, gender identity/expression, marriage and civil partnership or pregnancy and maternity.

1.3 In some circumstances it may be appropriate support staff in accordance with the Trust's Employee Wellbeing Policy.

1.4 This policy also provides guidance on situations where an employee is not fit for duty but does not have an alcohol, drug or other substance related problem, for example, consuming alcohol or drugs at times when this may have an effect on their performance at work.

1.5 Testing for alcohol, drugs and other substances will not be requested for individuals who are not employees of the Trust. The Trust reserves the right to contact the individual's employer where concerns arise, explain those concerns and, where appropriate, seek to remove an individual from Trust premises.

1.6 Consideration of referral to the Trust's Disciplinary Procedure may sometimes be necessary.

2 Duties (roles and responsibilities)

2.1 The Executive Team is accountable to the Trust Board for ensuring Trust-wide compliance with policy.

2.2 Directorate managers and heads of service are responsible to the Executive Team for ensuring policy implementation.

2.3 Managers are responsible for ensuring policy implementation and promoting awareness of this policy amongst their staff.

A manager may feel that work problems occur because of alcohol, drug or other substance abuse. It is important that managers do not attempt to diagnose or treat problems. Managers should act sensitively and supportively and where appropriate, staff should be encouraged to seek skilled help and advice.

2.4 Staff are responsible for complying with this policy. Staff should seek advice and help where they have concerns over their own or a colleague's health related to an alcohol, drug and/or other substance abuse problem.

All staff have a duty of care to ensure that the confidence of patients and colleagues is not affected by the consumption of alcohol.

2.5 The Newcastle Occupational Health Service is responsible for promoting awareness of alcohol and other substance abuse problems and encourage early identification. They will provide advice and guidance to individual staff and managers and refer individual staff for more specialist help if appropriate. They should be closely involved in any recovery programme and provide effective communication between the staff, manager, GP, and any specialist agency.

2.6 Trained Sample Collection Officers are responsible for collecting and testing, using mobile test units, for the presence of certain drugs of abuse and/or their metabolites in oral fluid and undertaking a Breath Alcohol Test which will detect the level of alcohol in the donor's sample. Collection Officers are also responsible for providing testing outcome data regarding a sample to the relevant member of the directorate management team and/or Human Resources.

They will maintain strict confidentiality at all times in respect of any sample.

They will manage all samples in accordance with national guidance published by the Royal College of Pathologists 'Guidelines for Handling Medico-legal Specimens and Preserving the Chain of Evidence.'

2.7 The external (UKAS) accredited laboratory (Alere Toxicology) is responsible for receiving, analysing and returning results to the Trust for the second stage drugs testing confirmation samples. They will manage all samples in accordance with national guidance published by the Royal College of Pathologists 'Guidelines for Handling Medicolegal Specimens and Preserving the Chain of Evidence'.

Alere Toxicology is also responsible for adequately training testing Collection Officers and maintaining the education on an ongoing basis.

2.8 Trade unions/staff organisation representatives have a responsibility to encourage staff to seek advice and assistance through this policy.

2.9 The Human Resources department is available to advise and support both staff and line managers in the application of this policy and to monitor its effectiveness. The Human Resources department will also assist managers in conducting any required investigations.

2.10 The Patient Services Coordinators are responsible for conducting testing out of hours. They will administer the test and make a decision on whether it is appropriate for the individual to remain at work for the remainder of their shift but will play no further part in any subsequent investigation or hearing, other than as a witness (if appropriate). Their role is to undertake testing, discuss with the Senior Manager on Call (if out of hours) and report the result to a member of the Directorate Management Team or equivalent when normal working hours resume.

3 General principles

3.1 Alcohol, drugs and other substances must not be consumed during working hours, including breaks.

3.2 Staff must not work, including when on-call and/or stand-by whilst under the influence of alcohol, drugs or any other substances.

3.3 Staff called in unexpectedly (i.e. not on duty, on-call and/or standby) who have consumed alcohol, drugs or other substances should declare this when their attendance at work is requested. Staff should not attend for duty in these circumstances.

4 Alcohol

4.1 It is important to promote awareness amongst staff of the limits of safe and sensible drinking and to create a working environment that discourages inappropriate drinking. It is also important to help and support staff in a consistent, sensitive and confidential manner.

4.2 It is not acceptable for the smell of alcohol to be present on staff.

5 Drugs and other substances

5.1 It is important to promote awareness amongst staff of the dangers of drug and other substance misuse and/or abuse.

5.2 Drug and other substances misuse and/or abuse refers to the use of illegal/legal drugs and the misuse, whether deliberate or unintentional, of legal prescription drugs, such as tranquillisers and solvents.

5.3 The Misuse of Drugs Act 1971 (MDA) is the principal legislation in the UK for preventing misuse of controlled drugs.

Under the MDA, if you knowingly permit the unauthorised and/or unlawful use, production or supply of any controlled drugs on Trust premises you could be committing an offence.

5.4 Misuse of drugs can seriously harm the user's health. For example, ecstasy has been linked to liver and kidney problems; cocaine causes damage to the lungs and LSD can trigger psychological problems. Other effects that may be potentially harmful include hallucinations, poor concentration and impaired coordination. These effects can create the greatest problems in the workplace as they increase the risk of accidents/incidents to users and/or others. Additionally, staff who misuse drugs and/or other substances may have impaired performance when at work or it may impact on their attendance.

6 Procedure for responding to an incident arising from potential alcohol, drug or other substance abuse

6.1 When an incident arising from potential alcohol, drug or other substance abuse occurs, i.e. there are concerns that a staff member is acting unusually and may be under the influence of such substances or is smelling of alcohol, the manager must respond immediately.

6.2 Management should take steps to assess the situation themselves, or nominate a deputy to do so.

6.3 In the case of medical and dental staff, the Medical Director on-call should be contacted to inform them of an incident.

6.4 If they have a reasonable belief that the staff member is not fit for duty, they should undertake an individual assessment (appendix 3). This is a legal requirement under the Management of Health & Safety at Work Regulations 1999. Knowingly allowing staff to continue working if affected by alcohol, drugs or other substances could render the Trust liable to prosecution.

6.3 When an incident/accident or 'near miss' occurs at work, the Trust reserves the right at its absolute discretion to ascertain whether alcohol, drugs or substance abuse was a contributory factor, and is a relevant consideration, and if so, to

consider whether to conduct testing on staff. Further information on the procedure for testing is available at appendix 4.

6.4 The individual assessment is likely to result in a request that the member of staff returns home. The manager should take steps to ensure the safety of the staff member; for example, booking a taxi to ensure the individual is not in charge of a vehicle.

6.5 When the staff member returns to work, the manager should hold a meeting with the individual to discuss the concerns, and make use of the guidance in appendix 2. The individual assessment should be reviewed and updated with appropriate steps, for example, monitoring, temporary redeployment, referral to Occupational Health. Managers should refer to appendix 1 and be mindful of determining whether this is a one off isolated incident, or whether behaviour and performance is characteristic of an underlying problem related to alcohol, drug or substance abuse. In the case of the latter, the manager should refer to 7.1b) of this policy.

6.6 If it is determined that the member of staff was under the influence of alcohol, drugs or other substances and this was not related to an underlying health problem, the manager may consider, in conjunction with their Senior HR advisor, whether to refer the matter via the disciplinary procedure.

7 Procedure for supporting staff with alcohol, drug and other substance related problems

Should staff be found to have a problem with alcohol, drugs or other substances that could affect performance at work, the Trust is committed to offer assistance in accordance with the provisions in this policy. The procedural arrangements are as follows:

7.1 Procedure to seek help and advice

a) Staff

i) When a staff member believes that they have an alcohol or other substance use problem, information and advice should be sought as soon as possible. It is important to state that the earlier the help is sought, the greater the possibility of recovery and the less detrimental the effect on the individual in their home life, and on their performance in the workplace.

ii) Ideally staff should discuss concerns with their line manager (because of the likely effect on work performance or behaviour). The manager should deal with any problems related to dependency in a non-judgemental & supportive manner.

iii) There may, however, be some cases where staff would prefer to seek information and advice outside the department. In such cases staff can contact the Newcastle Occupational Health Service and/or

the Human Resources department directly.

iv) If, for some reason, the individual does not wish to take any advice from the Newcastle Occupational Health service and/or the Human Resources department, they should be encouraged to go direct to their GP or a voluntary agency, such as the North East Council on Addictions (www.neca.co.uk) , a local alcohol or drug treatment advisory service, Change, Grow, Live (www.changegrowlive.org) or Doctors, Dentists and Medical Students can use the Sick Doctors Trust (http://sick-doctors-trust.co.uk/).

b) The manager

i) If the manager is concerned - normally because of deteriorating work performance, or attendance, or other signs (see Appendix 1); or if a colleague or staff member draws the attention of the manager to problems, then they should discuss these with the individual. Before any discussion takes place, the manager should seek further advice from the Human Resources department, and/or the Newcastle Occupational Health Service.

ii) There may be a need for more than one discussion, but it is important that the discussion is conducted in a strictly confidential manner. The opportunity should be given for staff to seek more skilled help and advice (guidance to assist managers in these discussions is detailed in Appendix 2).

iii) If the individual accepts that further skilled help and advice is needed, the manager should refer them to the Newcastle Occupational Health Service in the normal way.

iv) In the event of the individual denying there is a problem, the manager should offer the opportunity to seek further advice and strongly advise referral to the Newcastle Occupational Health Service. Whatever the outcome of the discussion the manager must document their concerns and actions, continue to monitor the situation and be prepared to take further action if necessary.

v) If the staff member states that help is to be sought or is actually being received, but the manager has continuing concerns about the individual's work performance and there is no evidence of help being received or having an appropriate effect, the individual should be referred to the Newcastle Occupational Health Service.

vi) If the Newcastle Occupational Health Service assesses that there is no alcohol, drug or other substance problem evident, the manager will then need to reassess the situation and deal with the individual's performance/behaviour in accordance with the Trust's appropriate policy/procedure.

c) The Newcastle Occupational Health Service

i) Where the Newcastle Occupational Health Service believes that the individual has an alcohol or drug abuse problem they will recommend whether it is appropriate for the individual and/or the Newcastle Occupational Health Service to contact one of the voluntary agencies available.

ii) The confidentiality of individuals will be respected. There may, however, in exceptional circumstances be an ethical duty incumbent on the Newcastle Occupational Health Service to breach a confidence where there is a clear risk to the health and safety of others. Should such a situation arise, it will be managed sensitively and every effort will be made to find a solution that ensures that the individual retains the confidence of both the Newcastle Occupational Health Service and the Trust.

d) The recovery programme

i) If it is decided that a recovery programme should be introduced and the employee accepts it, any elements that require the co-operation of the individual's manager will be discussed with that line manager.

ii) If an individual has gone directly to a voluntary agency or their GP, the manager can only help if they are aware of the need for such support.

iii) If an individual has to refrain from work during the recovery programme this will be treated as sickness absence and normal occupational and/or statutory sick pay arrangements in accordance with the Trust's Employee Wellbeing Policy will apply.

iv) If an individual accepts the programme and it is recommended they return to work during the programme, the individual's manager must be consulted regarding this.

v) If a return to work during the recovery programme will carry with it a risk of recurrence, or risk of jeopardising the welfare and safety of patients and staff this would normally be agreed jointly between the Newcastle Occupational Health Service, the Human Resources department and the manager concerned. The assistance of the Human Resources department should be sought to look for suitable alternative employment if this is considered appropriate. If no such alternative is available the individual will be medically suspended by the Newcastle Occupational Health Service who will review the situation at regular intervals.

vi) On completion of the programme, the voluntary agency involved may contact the Newcastle Occupational Health Service who will

discuss with the individual their fitness to return to their contracted post.

vii) When an individual does return, if behavioural or performance problems recur, the manager will need to contact Human Resources department for advice, to determine what action is necessary.

viii) If, at the end of the programme, a different post or role is suggested, the Human Resources department should be involved. It may be appropriate in certain circumstances to consider redeploying the individual under the terms of the Trust's Employee Wellbeing Policy.

8 Training

Further advice and guidance will be available from the HR Department. Awareness training can be delivered upon request.

The external test providers (Alere Toxicology) will be responsible for training collection officers in safe and appropriate use of the testing equipment and associated processes. Collections officers must be trained before administering any test and updates to training are required periodically to ensure competence.

9 Equality and Diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way services are provided and the way staff are treated reflects their individual needs and does not unlawfully discriminate against individuals or groups. This policy has been properly assessed.

10 Monitoring Compliance with the Policy

Standard / Process / Issue	Monitoring and Audit			
	Method	**By**	**Committee**	**Frequency**
Reporting of information held on Electronic Staff Record for the purpose of: ▪ The number of staff subject to disciplinary investigation/action as a result of alcohol, drug and/or other substance abuse. ▪ The number of staff whose reason for sickness absence from work was as a result alcohol, drug and/or other substance abuse/dependency.	Reports will be generated from the ESR system	Director of Human Resources	Heads of Human Resources Meeting	Annually

11 Consultation and Review of this Policy

This policy has been reviewed in consultation with the Employment Policies and Procedures Consultative Group.

12 Implementation of the Policy (including raising awareness)

A summary of the key changes will be notified to managers following implementation. Further advice and guidance will be available from the Human Resources department.

13 References

1) Royal College of Pathologists 'Guidelines for Handling Medicolegal Specimens and Preserving the Chain of Evidence' available at www.ibms.org/includes/act_download.php?download=chainofevidence
2) Management of Health and Safety at Work Regulations 1999 available at http://www.legislation.gov.uk/uksi/1999/3242/contents/made
3) Misuse of Drugs Act 1971 available at http://www.legislation.gov.uk/ukpga/1971/38/contents
4) North East Council on Addictions available at http://www.neca.co.uk/
5) Change, Grow, Live available at www.changegrowlive.org
6) Sick Doctors Trust available at http://sick-doctors-trust.co.uk/

14 Additional documents

- Disciplinary Policy and Procedure
- Employee Wellbeing Policy Incorporating Absence Management Procedure
- Speak up We're Listening Policy

Author: Employment Policies and Procedures Consultative Group

Appendix 1

Guidance on the signs of alcohol, drug abuse or other substance misuse

Alcohol or drug abuse is not concerned with isolated instances of absenteeism or poor work performance, but with a pattern of deteriorating work performance over a period of time:

1. Evidence of inadequate or deteriorating work performance

a) Frequent lateness, repeated brief periods of absence for trivial or inadequate reasons.
b) Impaired concentration and memory.
c) Absenteeism, particularly related to weekends, and high absenteeism rates for colds, 'flu', gastro-enteritis, depression etc.
d) Accident proneness, minor accidents at work and accidents off duty.
e) Mistakes, errors of judgment.
f) Improbable excuses for poor job performance.
g) Increasing general unreliability and unpredictability.

2. Observation of behaviour and appearance

a) Smelling of drink.
b) Under the influence of drink, drugs or other substances during working hours.
c) Mood changes, irritability, lethargy.
d) Deterioration in working relationships.
e) Borrowing money.
f) A combination of hand tremor, slurred speech, facial flushing, bleary eyes, poor personal hygiene, unkempt appearance.

3. Relationships with colleagues

a) Over-reaction to real or imagined criticism.
b) Unreasonable resentment.
c) Uncharacteristic irritability.
d) Complaints from colleagues.
e) Avoidance of manager or other senior staff
f) Borrowing from colleagues.

It should be emphasised that some of the above features may have other causes, such as staff who have health conditions that may give the appearance and/or impression of an alcohol, drug or other substance misuse problem. On these occasions, refer to the Employee Wellbeing policy and seek advice from Occupational Health and/or Human Resources.

Appendix 2

Guidance concerning discussions with staff regarding problems related to alcohol, drugs & other substances misuse

'DO'

1. Take advice from the Human Resources department first.
2. Prepare for the discussion - allow plenty of time & find a confidential space where you are unlikely to be disturbed
3. Focus on work performance/attendance/relationship with colleagues.
4. Be objective and factual.
5. Be concrete and specific.
6. Be non-judgmental and use non-emotive language.
7. Acknowledge the individual's positive contributions, past or present.
8. Show your concern for the individual. Listen to what they say about their personal problem.
9. Explain exactly what the individual must do to improve performance/attendance.
10. Be firm and consistent with the individual.
11. Adopt the same general stance, and follow the same procedure in every case.
12. Offer the opportunity of skilled help and advice - if you feel there is a need.
13. Explain that a test may be required and highlight to the individual the process involved and their rights in respect of this.
14. Treat members of your staff consistently.

'DON'T'

1. Comment on the individual's private life.
2. Rely on subjective impressions or rumour for which documented evidence is lacking.
3. Make vague accusations.
4. Convey verbally or by your manner that you are judging the individual's morals.
5. Ignore past or present achievements; doing so might invite an accusation of unfairness.
6. Argue with the individual about their problems, or attempt to give advice.
7. Leave any room for uncertainty about the individual's situation, and what needs to be done to rectify it.
8. Make exceptions.

Appendix 3

Individual Assessment

This individual assessment pro forma should be used to support the design of a relevant individual assessment to identify if an individual is unfit for duty at work, due to being under the influence of alcohol or other substances, and to determine next steps. This should be a live document under regular review. Each individual's circumstances will be different and varied and therefore this pro-forma forms a basis for assessment only and is not exhaustive.

Department			
Assessor			
Date			
Staff member			
Consideration	Details of considerations given/evidence available	Action to be taken	Review (comment, date and signature of manager and staff member)
When there's a concern the individual may be unfit for duty			
Do you have a reasonable belief that the staff member unfit for duty? Please give reasons for this – e.g. consider appendix 1, statements from colleagues or members of the public			
Can the member of staff remain at work? (if the individual is unfit for duty the cannot remain at work)			
If the staff member cannot remain at work, what arrangements will be made for their return home? (driving should not be agreed and alternatives should be offered)			
Is the staff member under the care of their GP or other health professional?			
Are you aware of any underlying health conditions including anxiety/depression, which may need to be taken into consideration to ensure the safety and wellbeing of the staff member?			
Are you aware of any safeguarding concerns relating to the staff member?			
Will anybody else be present when the staff member returns home?			
Does the staff member require any immediate mental health support?			

Next steps			
Is this incident a one off or may there be an underlying dependency? Please detail your considerations including, for example, OH/GP/Healthcare professional advice and guidance, are there any previous instances, how long has behaviour documented above been noticed?			
What support can be offered/signposted/referred?			
On what basis can the staff member return to work/continue to work? Consider phased return, working pattern, adjustment to duties			
Will testing be required? On what basis?			
What will colleagues be told about the staff member's absence/adjustments? (this should be agreed with the staff member)			
Do any other procedures need to be referred to? E.g. capability, employee wellbeing, disciplinary			
Signed – Manager			
Signed – Staff member			
Signed – companion/representative (if applies)			

Appendix 4

Testing for alcohol, drugs and other substances

1.1 The Trust may conduct 'for cause' testing for alcohol, drugs and other substances. 'Post incident' screening is useful for safety critical workplaces like the Trust and can be used to establish whether drugs, alcohol or other substances were a causal factor in an accident, incident or 'near miss'. This type of screening may also be considered where the Trust has reasonable suspicion that an individual may be under the influence of alcohol, drugs or other substances whilst at work.

1.2 'For cause' testing will be applied as follows:

a) following an individual's involvement in a workplace accident, incident or 'near miss' that has caused or could have caused a danger to health and safety **or**

b) where the Trust has reasonable grounds to believe or suspect that an individual is or may be under the influence of alcohol, drugs and/or other substances.

1.3 Immediately following such an incident or observation, as part of the investigation, consideration will be given to the requirement for the individual to provide an oral fluid sample (to screen for the presence of certain drugs) and/or undertake a breath alcohol test to detect the level of alcohol in the breath.

1.4 Upon identification of the need to undergo testing, the line manager (or other appropriate individual) will record any observations and will contact a member of the directorate management team (during normal working hours) or the Patient Services Co-ordinators and Senior Manager on Call (out of hours) but will not themselves be involved in the testing process.

1.4.1 The request for testing will normally be made by a member of the Directorate Management team, who should seek prior advice from the Human Resources department (during normal working hours). A Collection Officer can be requested via Human Resources (during normal working hours) or the Patient Services Coordinators (out of hours), after the requester has completed a testing agreement form including signatures (see Appendix 4 for testing agreement form - requestor). The Collection Officer will oversee the overall testing process and also obtain the agreement of the individual subject to testing (see Appendix 5 for testing agreement form – collection officer) prior to undertaking the test(s) but will have no involvement in the management of the individual following the outcome of the test(s).

1.5 Unreasonable refusal to agree to testing may result in suspension without pay whilst an investigation is conducted.

1.6 The staff member will be entitled to have a witness present e.g. trade union/staff organisation representative or work colleague.

1.7 The staff member must be accompanied and escorted to the venue where they will undergo the test(s). An appropriate (safe, private, discrete, hygienic) venue must be identified by a member of the Directorate Management team or the Patient Services Coordinator.

1.8 The staff member will be asked to voluntarily sign a written statement agreeing to undergo the test(s) (See Appendix 5 for agreement form). Following this, the individual undergoing testing is required to be nil by mouth (where safe to do so) for 20 minutes in order to restore near normal pH levels and ensure food debris is removed from the mouth.

1.9 The initial sample(s) will provide an immediate result with a hard copy printout. All samples will be managed in accordance with national guidance published by the Royal College of Pathologists 'Guidelines for Handling Medico legal Specimens and Preserving the Chain of Evidence'.

1.9.1 Following the initial screening on-site, a result will be provided as 'negative' (no presence of drugs or alcohol) or 'non-negative' (test result indicates evidence of particular groups of drugs or medications or alcohol).

Drugs:
A 'non-negative' result from an oral fluid drugs test will be followed up by a second 'split sample' collection test in which two samples are taken (A and B sample) and sent to an independent laboratory for analysis. Sample A is analysed (confirmation testing). If sample A is positive at confirmation stage, sample B is kept unopened for twelve months in the laboratory which provides the donor with a route through which to challenge the analysis of Sample A.

Alcohol:
A 'non-negative' result from a breath alcohol sample will be followed up with an identical test 20 minutes later in order to determine if alcohol levels are changing and to confirm the initial result.

1.9.2 The outcome of the testing at this stage should be communicated to the Directorate Management Team.

1.9.3 Following confirmation of a 'non-negative' sample, and where the individual has indicated they are currently using particular medication, it is advised to request a Medical Officer Review (MRO). An MRO will be performed by an identified Trust Clinician(s) in Occupational Health following receipt of a positive test result after confirmation analysis. This is to enable medication to be accounted for, and could mean an initial positive result may be declared negative by the review, and therefore in line with the named medication.

1.10 If either the drug or alcohol test shows a ‘non-negative’ result, the individual may be suspended or excluded immediately pending further investigation (see Disciplinary Policy/Procedure) (and further testing in the case of an oral fluid sample) and a referral to the Newcastle Occupational Health Service strongly advised. Referral to the Disclosure and Barring Service and/or the individual’s professional body may also be appropriate.

1.10.1 During the investigation the individual will be asked if they have a problem with alcohol, drug or other substance abuse. If they confirm they have and that they wish to address it, they will be offered support to resolve their issue through referral to the Newcastle Occupational Health Service and for assessment and support. The investigation will continue until conclusion.

1.10.2 If the individual states they do not have a problem with alcohol, drugs or other substance abuse, they will be informed that the test result may be considered as a contributory factor in an accident/incident or ‘near miss’ investigation (where relevant) and may result in disciplinary action being taken against the individual. Referral to the Disclosure and Barring Service and/or the individual’s professional body may be appropriate also.

1.11 If the drug or alcohol test shows a ‘negative’ result, the result will be recorded and any incident or accident investigation will continue, where appropriate. Subsequently, the individual may be invited to attend a meeting to discuss the incident/accident or ‘near miss’ (where appropriate) and the reasons for the action having been instigated.

Appendix 5

Alcohol, Drugs & Other Substances
Testing Agreement Form (Requestor)

Employee's Name:

____

Assignment No: ______________________ Date: _________________________

Manager's Name:

____

Manager's Job Title: ____

Requestor Name: ____

Requestor job title: ____

Reason for Testing request:____

____

____

Observations recorded: ____

____

Signature of Requestor:_______________________Date:___________________

EMPLOYEE'S STATEMENT:

I hereby agree to provide an oral fluid sample and/or breath test for the detection of alcohol, drugs or other substances. I am fully aware of the Trust's Policy regarding Alcohol, Drugs & Other Substances which could affect performance at work. I understand that a non negative result may be detected. I understand that my results will be communicated with my manager.

Signed: _____________________________ Dated: ________________________

Appendix 6

Alcohol, Drugs & Other Substances
Testing Agreement Form (Collection Officer)

Employee's Name: ____

Assignment No: ________________ Date of Sample: _________________

Collection Officer's Name: ____________________________________

Position: ___________________________________

EMPLOYEE'S STATEMENT:

I hereby agree to provide an oral fluid sample and/or breath test for the detection of alcohol, drugs or other substances. I am fully aware of the Trust's Policy regarding Alcohol, Drugs & Other Substances which could affect performance at work. I understand that a non negative result may be detected. I understand that my results will be communicated with my manager.

Signed: ____________________________ Dated: ______________________

Test Time: _________________________ Test Date: ____________________

Reason for Test:
……………………………………………………………………………………………

Signature of Collection Officer:

Signature of Witness (if applicable)

Test(s) conducted: Drugs ☐ Alcohol ☐

Result: ____

____

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Equality Analysis Form A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

PART 1

1. **Assessment Date:** 25/9/2020

2. **Name of policy / strategy / service**:

Policy Regarding Alcohol, Drugs & Other Substances Which Could Affect Performance at Work

3. **Name and designation of Author:**

Karen Pearce, Senior HR Manager (Projects)

4. **Names & designations of those involved in the impact analysis screening process:**

Natalie Cowan, HR Manager; Heads of HR, EPPCG

5.

Is this a:	Policy	√	Strategy		Service	
Is this:	New		Revised	√		
Who is affected	Employees	√	Service Users		Wider Community	

6. **What are the main aims, objectives of the policy, strategy, or service and the intended outcomes?** (*These can be cut and pasted from your policy*)

The purpose of this policy is to ensure that employees with alcohol, drug or other substance related problems are dealt with sensitively and in a way that is intended to help and support them to overcome these problems. As a result, it may be appropriate to deal with certain dependency cases in accordance with the Trust's Employee Wellbeing Policy.
This policy also provides guidance on situations where an employee is not fit for duty but does not have an alcohol, drug or other substance related problem, for example, consuming alcohol or drugs at times when this may have an effect on their performance at work. In such circumstances, it may be appropriate to deal with the matter in accordance with the Trust's Disciplinary policy/procedure.

7. **Does this policy, strategy, or service have any equality implications?** **Yes** √ **No** ☐

If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:

No

8. Summary of evidence related to protected characteristics

Protected Characteristic	Evidence, i.e. What evidence do you have that the Trust is meeting the needs of people in various protected Groups	Does evidence/engagement highlight areas of direct or indirect discrimination? If yes describe steps to be taken to address *(by whom, completion date and review date)*	Does the evidence highlight any areas to advance opportunities or foster good relations. If yes what steps will be taken? *(by whom, completion date and review date)*
Race / Ethnic origin (including gypsies and travellers)	The policy makes it clear that it applies to all groups regardless of age, disability, race, nationality, ethnic origin, sex, sexual orientation, religion and belief, gender identity/expression, marriage and civil partnership or pregnancy and maternity. A number of collection officers, from a range of backgrounds will be trained to undertake any required tests and will administer the tests only. No judgements will be made. The next steps will be dependent on whether an individual feels a non negative test is an indication of a problem or not, and not because of who they are. Specifically for race, the Trust will engage a cultural ambassador for any disciplinary investigation, where the member of staff under investigation identifies as BAME.	White men and women are most likely to be drinkers whilst Asian men and women were least likely to be, according to the Health and Social Care Information Centre, 2016. In the last 3 years, 7 cases were escalated to a disciplinary investigation. These all applied to White staff, and so it was not possible to ascertain if outcomes would be different for different ethnicities.	n/a
Sex (male/ female)	As above.	Statistics on Hospital admissions with a primary diagnosis of drug-related mental and behavioral disorders 2016 show a significant skew towards male (74% versus 26% female) Statistics on hospital related admissions for alcohol related problems were again skewed towards men but to a lesser extent (65% versus 35% female). In the last 3 years, 7 cases were escalated to a disciplinary investigation; 4 men and 3 women. The two cases relating to female staff (one is uncomplete), resulted in 'formal action; other' which usually refers to counselling. The male members of staff were either summarily dismissed or received a final written warning (one resigned). Overall, male members of staff have received more severe outcomes than female members of	n/a

		staff, albeit it's recognized that the numbers involved are very small and so not possible to draw a conclusion. This will continue to be monitored as part of the EA process.	
Religion and Belief	As above	In the last 3 years, 7 cases were escalated to a disciplinary investigation. Religion/belief was not recorded on ESR.	n/a
Sexual orientation including lesbian, gay and bisexual people	As above	In the last 3 years, 7 cases were escalated to a disciplinary investigation. Sexual orientation was not recorded on ESR.	n/a
Age	As above	In the last 3 years, 7 cases were escalated to a disciplinary investigation. There was a small age range and so no conclusions could be drawn to suggest treatment was different amongst different age groups. 32% of patients (hospital admissions with a primary diagnosis of drug-related mental health and behavioral disorders 2016) were aged between 25 and 34 with the majority of cases being aged between 16 and 44. 44% of patients admitted to hospital for alcohol related issues (2016) were aged between 55 and 74.	n/a
Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section	As above. The Trust offers support to individuals with mental health problems, such as mental health first aiders, occupational health services (including staff counsellors and psychologists), stress awareness information and the Trust has a Disability Staff network.	No particular statistics were found but it is widely recognised that substance abuse is often linked with poor mental health.	n/a
Gender Re-assignment	As above		n/a
Marriage and Civil Partnership	As above		n/a
Maternity / Pregnancy	As above		n/a

9. Are there any gaps in the evidence outlined above? If 'yes' how will these be rectified?

10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.

Do you require further engagement? Yes ☐ No √

11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?

No.

PART 2

Name:

Natalie Cowan

Date of completion:

25/9/2020

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)

The Newcastle Upon Tyne Hospitals NHS Foundation Trust

Human Resources Policies & Procedures

Annual Leave & General Public Holidays

Version No.:	12.0
Effective From:	18 October 2022
Expiry Date:	18 October 2025
Date Ratified:	17 October 2022
Ratified By:	Heads of HR

GENERAL POLICY STATEMENT

This document sets out the Trust's policy for the calculation of annual leave and general public holiday entitlements for all employees.

Staff should refer to their 'Statement of Main Terms and Conditions Of Employment: Further Particulars' for specific details of their individual entitlement, and further general information can be found in the NHS Terms & Conditions of Service Handbook which is available via the HR website on the Trust's intranet.

This policy shall apply to all staff employed by the Trust, including those who are seconded out to another organisation. It does not apply to employees seconded into the Trust (those employees are the responsibility of their substantive employer), or other individuals engaged to undertake activities within the Trust, for instance, contractors and agency workers.

1 Aims

The policy provides advice to managers and employees on the calculation, recording and management of annual leave.

2 Duties (Roles and Responsibilities)

2.1 The Executive Team is accountable to the Trust Board for ensuring Trust-wide compliance with policy.

2.2 Directorate managers and heads of service are responsible to the Executive Team for ensuring policy implementation.

2.3 Managers are responsible for ensuring policy implementation and compliance in their area(s).

2.4 Staff are responsible for complying with policy.

3 General Principles

3.1 Under the Working Time Regulations 1998, workers are entitled to a statutory minimum of 5.6 weeks annual leave per year. For a full time worker working five days a week, this equates to 28 days' annual leave (inclusive of eight Public Holidays).3.2 Under NHS Terms and Conditions of Service (Agenda for Change), the above statutory entitlement is included within the Trust's provisions for contractual annual leave which is detailed in Section 5 below.

3.2 The annual leave year is 1 April to 31 March each year.Employees are advised not to book any holiday until their leave request has been approved. Managers must review service need when considering whether a request can be approved.

3.3 The Trust expects all employees to take all of their annual leave entitlement within the current annual leave year. Carry over from one year to the next is discouraged. Where employees have been unable to take their entitlement due to maternity leave, adoption leave, paternity leave, shared parental leave, parental leave or sickness absence (as per the respective policies), the amount of annual leave an employee wishes to carry over must be approved in advance by the line manager/Clinical Director.

3.4 With the exception of the above and extenuating circumstances, the amount of accrued annual leave/public holidays staff can carry over to the next annual leave year should not normally exceed 5 days i.e. one working week (pro-rata for part-time staff and full time staff who work less than 5 days per week). Where annual leave is carried over, the first amount(s) of leave taken will be deemed to be carry over until the total amount of carry-over is exhausted. Where the carry-over of statutory annual leave is appropriate, the amount which may be carried over to a new leave year is four weeks (i.e. the entitlement under the European Working Time Directive) - the additional 1.6 weeks' annual leave under Regulation 13A of the Working Time Regulations does not carry over.

3.5 The Trust will not make payment in lieu of any untaken annual leave/public holidays. Payment will be made for untaken annual leave if staff terminate their employment with the Trust and are unable to utilise accrued annual leave during their notice period due to service need.

3.6 All staff can sell up to a maximum of 5 days of their annual leave entitlement in any one leave year (equivalent to one week's contractual hours). The number of days sold will be deducted from entitlement thereby reducing the amount of leave a staff member has remaining to take before the end of the leave year. Payment will be based on basic pay and the amount of annual leave hours assigned. The amount is non-pensionable and will be subject to deduction of tax and National Insurance. Subject to appropriate authorisation and payroll deadline, payment will be made on the next available payday following confirmation by the manager.

To request to sell annual leave entitlement, staff must complete the form here and submit it to their Directorate Manager/Head of Department/Head of

Service for authorisation. For Consultants and Trust Employed Doctors and Dentists (SAS doctors, specialty doctors, specialists, associate specialists, clinical trainer grades), the Directorate Manager and Clinical Director will need to authorise and process the request for payment.

Once authorised, managers should refer to the following guidance to administer and amend staff records in Allocate:

3.7 If an employee is unwell whilst on a period of annual leave, they should refer to the Employee Wellbeing policy for information on conditions in order to receive replacement holiday on their return to work.

3.8 If an employee is unwell before the start of a period of planned annual leave , they should refer to the Employee Wellbeing policy for information on how to postpone their leave.

4 Recording of Annual Leave

4.1 Annual leave is recorded centrally via the ERA system and in the case of Medical and Dental staffing, annual leave is managed centrally within departments.

4.2 Managers should record their staff's annual leave on the ERA system in a timely manner. In relation to medical and dental staff, managers should continue to record their annual leave on the ESR system.

4.3 Managers must keep a central record of any annual leave carried over by their staff to the next annual leave year. This must be available for scrutiny by Finance and external audit as and when required.

5 Calculation of Entitlement to Annual Leave and Bank Holidays

5.1 General Principles Non-Medical Employees

a) Annual leave entitlements for non-medical employees are as follows:

Length of Service	Annual Leave Entitlement
On appointment	27 days (202.5 Hours)
After 5 years' service	29 days (217.5 Hours)
After 10 years' service	33 days (247.5 Hours)

b) In addition to the above, there is normally a total of *eight general public holidays in a leave year. Entitlement is dependent on the number of hours/days normally worked per week.

(* Easter falls on a different date each year – either March or April.

When Easter falls both in April and the following March there will be more public holidays in one annual leave year than the next. This will not affect employees who generally work Monday to Friday and take public holidays when they fall. For other employees, managers will need to be vigilant of the calendar and ensure calculations are based on the actual number of public holidays in the period. This also applies to individuals who join or leave the Trust partway through a leave year).

c) Annual leave and general public holiday entitlement is calculated in hours. To calculate leave and/or public holiday entitlements, please refer to the annual leave calculator available here.

d) Employees who work part-time or job share shall receive entitlement to annual leave and public holidays on a pro-rata basis according to the number of hours worked. This is regardless of whether or not an employee works fixed days, or normally works on a roster basis on days that are not public holidays (e.g. weekends).

e) Where staff work standard shifts other than 7½ hours excluding meal breaks, annual leave and public holiday entitlements should be calculated on an hourly basis to prevent staff on these shifts receiving greater or less leave than colleagues on standard shifts.

f) Calculations in hours shall be rounded up or down to the nearest half hour (e.g. 1.7 = 1½ hours, 1.8 = 2 hours).

5.2 Starters, Leavers, Temporary/Fixed Term Contracts and Changes

a) Annual leave entitlement for all staff covered by this policy is calculated in hours using a '365-day' calculation. The calculation is applied as follows:

- When staff are appointed – entitlement in the first year (if not a full year) is the relevant full year entitlement (202½, 217½ or 247½ hours pro-rata for part-time) divided by 365-days multiplied by the number of calendar days in the leave year starting from the date of appointment and ending on 31 March. The amount will need to be recalculated if staff change their job and/or leave in the first year.

- When staff change their job (e.g. hours) – entitlement in the leave year should be calculated separately before and after the change. The calculation for each separate entitlement is:

    - Before the date of change – the relevant full year entitlement (202½, 217½ or 247½ hours pro-rata for part-time) divided by 365-days multiplied by the number of calendar days employed in the leave year before the date of chang

- From the date of change – the relevant full year entitlement (202½, 217½ or 247½ hours pro-rata for part-time) divided by 365-days multiplied by the number of calendar days of employment remaining in the leave year

  The amount will need to be recalculated if staff change their job more than once and/or leave in the same leave year.

- When staff leave the Trust – entitlement in the year of leaving (if not a full year) is the relevant full year entitlement (202½, 217½ or 247½ hours pro-rata for part-time) divided by 365-days multiplied by the number of calendar days they have been employed in that year. The amount will need to take account of the employee's start date and/or any job change(s) if they occurred in the year of leaving.

The annual leave calculator is available here.

5.3 Employees on Term Time Contracts

Annual Leave entitlement for a term-time employee is calculated based on contracted [actual working hours] and not paid hours. Annual leave is recorded in ERA based on an employees contracted hours and not their paid hours.

Staff on a term-time contract should request from their manager (via electronic annual leave requests in EmployeeOnline) which of the school holidays will be taken as annual leave rather than as 'days off' in line with their annual leave entitlement. Requests should be actioned by the manager in ERA. Incorrect recording of annual leave for term-timers who work unsocial hours is likely to result in under or over payments detailed guidance can be found in the ERA Policy.

5.4 Additional Annual Leave for Long Service

Additional annual leave entitlement is accrued after 5 and 10 years' service in accordance with the NHS Terms & Conditions of Service Handbook – see paragraph 6.1 above.

5.4 Unpaid Leave & Contractual Annual Leave Accrual

a) Contractual annual leave shall not accrue during periods of continuous unpaid leave (with the exception of unpaid maternity leave, adoption leave, paternity leave and Shared Parental Leave); I.e. leave that is 2 weeks or longer. In the event of any continuous unpaid leave, annual leave entitlement will be recalculated.

Deduction from contractual annual leave will be applied without detriment to

statutory entitlement.

b) General public holidays shall not accrue during periods of unpaid leave (with the exception of unpaid maternity leave, adoption leave, paternity leave and Shared Parental Leave). If a general public holiday falls during unpaid leave (other than the exceptions identified above) it shall be deducted from entitlement.

c) Periods of unpaid leave continue to be pensionable. It is an employee's responsibility to contact their pension's officer prior to any period of unpaid leave, to ensure they fully understand the pension implications and make any necessary arrangements regarding contributions during the unpaid period

d)Where an employee holds a Certificate of Sponsorship the employee and/or the line manager must contact the Human Resources Department to discuss any request for unpaid leave prior to the request being agreed, to ensure the employee fully understands any potential implications on their sponsorship.

6 Bank Nurses

Bank nurses' entitlement to statutory annual leave will be met by a payment on a quarterly basis in arrears. In addition to the basic rate of pay, a bank nurse will be paid an amount based on an average of earnings paid in the previous 12 weeks multiplied by 1.4 (a quarter of the full year's statutory annual leave entitlement), this will be clearly shown on the payslip.

7 Manager's Responsibilities

Managers must ensure that employees receive their correct entitlement to annual leave and public holidays.

8 Changes

8.1 When employees change:

- the number of contracted hours they work, or
- their shifts in any way that affects their annual leave entitlement (e.g. change from long shifts to short shifts, or from 2 days per week to 4 days, etc.), or
- their job within the Trust

Managers must ensure that the leave entitlement accrued before the date of change is taken in full before the change is affected. The following rules will apply:

8.2 Reduction in Hours

Example (undertaken leave):

A full timer (37½ hours) changing to half-time (18¾ hours) has one

week remaining of full time annual leave entitlement before the change. This must be cleared before part-time hours commence. The employee's start date for part-time hours must be deferred by one week.

Example (overtaken leave):

A full timer (37½ hours) changing to half-time (18¾ hours) has overtaken one week of full time annual leave entitlement before the change. The following options are available:

- the overtaken full time leave can be deducted from the part-time entitlement. This must be calculated in actual terms e.g. one week at full time is equivalent to two weeks at half-time, or
- a deduction from salary can be made equivalent to the actual amount of overtaken leave , or
- the actual number of overtaken hours can be made up by the employee either before or after their change to part-time hours.

All of the above options are subject to agreement by the relevant manager.

8.3 Increase in Hours

Example (undertaken leave):

A part-timer (18¾ hours) changing to full time (37½ hours) has one week remaining of part-time annual leave entitlement before the change. This must be cleared before full time hours commence. The employee's start date for full time hours must be deferred by one week.

Example (overtaken leave)

A part-timer (18¾ hours) changing to full time (37½ hours) has overtaken one week of part-time annual leave entitlement before the change. The following options are available:

- the overtaken part-time time leave can be deducted from the full time entitlement. This must be calculated in actual terms e.g. one week at part-time is equivalent to half a week at full time, or
- a deduction from salary can be made equivalent to the actual amount of overtaken leave , or
- the actual number of overtaken hours can be made up by the employee either before or after their change to full time hours

All of the above options are subject to agreement by the relevant manager.

9 Leavers

Managers must notify the Human Resources Department of all employee resignations immediately to avoid any overpayment. This can be done by email, telephone or via the 'Human Resources - Leavers' mailbox on the Trust's global email address. See 'Staff Leaving the Trust' Policy for further details.The Leaver's Checklist's notify's Payroll of any annual leave outstanding/overtaken and other payments due or to be paid or recovered.

10 Medical & Dental Staff

10.1 Senior Medical and Dental staff job plans are made up of Programmed Activities (PAs), each PA being 4 hours. A standard full time contract is 10 PAs per week, typically worked 2 PAs per day, Monday to Friday. Staff working 'long days' (eg 2.5 PAs) over a shorter week should seek guidance on calculating annual leave entitlement from the Clinical Director in the first instance.

10.2 A medical/dental employee who in the course of their duty is required to be present in hospital or other place of work between the hours of midnight and 9.00am on a public holiday should receive a day off in lieu.

10.3 Consultants

10.3.1 Consultants are entitled to annual leave at the following rates per year:

Number of Years Completed Service as a Consultant	
Up to Seven Years	**Seven or More Years**
32 days	34 days

10.3.2 Annual leave should be discussed at the annual Job Plan review. Dates for annual leave and the arrangements for the medical and dental employee's work to be done in thier absence should be incorporated into the agreed Job Plan, or alternatively agreed six weeks in advance.

10.4 Associate Specialists

10.4.1 Associate specialists are entitled to 32 days' annual leave per year:

10.4.2 Annual leave should be discussed at the annual Job Plan review otherwise Associate Specialists shall provide a minimum of six weeks' notice of annual leave.

10.5 Speciality Doctors

10.5.1 Speciality Doctors are entitled to annual leave at the following rates per year:

- Doctors who have completed a minimum of two years' service in the specialty doctor and/or in equivalent grades or who had an

entitlement to six weeks' annual leave a year or more in their immediately previous appointments shall be entitled to annual leave at the rate of 32 days a year.

- Specialty doctors other than those mentioned above shall be entitled to leave at the rate of 27 days a year.

10.6 Junior Doctors

10.6.1 2002 Junior Doctor Contract

Grade	Entitlement
Foundation Year 1 or equivalent	27 Days
Foundation Year 2 or equivalent	27 Days
SpR, ST (on the minimum, 1st and 2nd incremental points)	27 Days
SpR, ST (on the 3rd or higher incremental points)	32 Days

10.6.2 2016 Junior Doctor Contract

NHS Service	Entitlement
On first appointment to NHS	27 Days
After five years' completed NHS Service	32 Days

11 Training

A summary of the key changes will be notified to managers following implementation. Further advice and guidance will be available from the Human Resources Department.

12 Equality and Diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way services are provided and the way staff are treated reflects their individual needs and does not unlawfully discriminate against individuals or groups. This policy has been properly assessed.

13 Monitoring Compliance with the Policy

Standard / Process / Issue	Monitoring and Audit			
	Method	By	Committee	Frequency
• Management of overpayments	Review of overpayments	Director of Human Resources	HR/Finance/ Payroll/ Audit Group	Bi-Monthly

14 Consultation and Review of this Policy

This policy has been reviewed in consultation with the Employment Policies and Procedures Consultative Group.

15 Implementation of the Policy (including raising awareness)

A summary of the key changes will be notified to managers following implementation. Further advice and guidance will be available from the Human Resources Department.

16 Additional Documents

- Adoption Leave and Pay Policy
- Annual Leave Calculator
- Electronic Rostering and Attendance (ERA)
- Employee Wellbeing Policy – incorporating absence management
- Maternity Leave and Pay Policy
- Paternity Leave and Pay Policy
- Shared Parental Leave Policy

Author: Employment Policies and Procedures Consultative Group

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Equality Analysis Form A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

PART 1

1. **Assessment Date:**

2. **Name of policy / guidance/ strategy / service development / Investment plan/Board Paper**:

Annual Leave & General Public Holidays

3. **Name and designation of author:**

Karen Pearce, Head of Equality, Diversity & Inclusion - People

4. **Names & Designations of those involved in the impact analysis screening process:**

EPPCG

5. **Is this a:** Policy X Strategy ☐ Service ☐ Board Paper ☐

Is this: New ☐ Revised X

Who is affected: Employees X Service Users ☐ Wider Community ☐

6. **What are the main aims, objectives of the document you are reviewing and what are the intended outcomes?** *(These can be cut and pasted from your policy)*

The policy provides advice to managers and employees on the calculation, recording and management of annual leave.

7. **Does this policy, strategy, or service have any equality implications? Yes ☐ No X**

If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:

See below

8. **Summary of evidence related to protected characteristics**

Protected Characteristic	**Evidence** **What evidence do you have that the Trust is meeting the needs of people in all protected Groups related to the document you are reviewing–** please refer to the Equality Evidence within the resources section at the link below: http://nuth-vintranet1:8080/cms/SupportServices/EqualityDiversityHumanRights.aspx	**Does evidence/engagement highlight areas of direct or indirect discrimination?** For example differences in access or outcomes for people with protected characteristics	**Are there any opportunities to advance equality of opportunity or foster good relations**? If yes what steps will be taken? (by whom, completion date and review date)
Race / Ethnic origin (including gypsies and travellers)	This policy applies to all staff. Annual Leave is recorded on ERA, which shows that annual leave entitlement is taken by all staff members. The Trust is committed to ensuring that no employee should be treated less favourably on the grounds of their age, disability, race, nationality, ethnic origin, sex, sexual orientation, religion and belief, gender identity / expression, marriage and civil partnership or pregnancy and maternity.		
Sex (male/ female)	As above		
Religion and Belief	As above		
Sexual orientation including lesbian, gay and bisexual people	As above		

Age	As above		
Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section	As above Annual leave may be converted into sick leave, if the employee becomes unwell whilst on annual leave. Annual leave and general public holidays will accrue and statutory leave may be carried over into the next leave year, if the employee is unable to take their annual leave due to sick leave.		
Gender Identity / Expression	As above Leave provisions for those undergoing Gender Reassignment are covered in the Trusts Employee Wellbeing Policy and Gender Identity Policy.		
Marriage and Civil Partnership	As above		
Maternity / Pregnancy	As above Annual leave/public holidays will continue to accrue during maternity leave and where possible should be taken during the relevant holiday year	EA for Maternity policy holds further information	

9. Are there any gaps in the evidence outlined above. If 'yes' how will these be rectified ?

Data is not available to show where requests have not been approved.

10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.

Do you require further engagement Yes No X

11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?

No

PART 2

Signature of Author

K.Pearce

Print name

Karen Pearce

Date of completion

16th July 2019

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Employment Policies and Procedures

Appraisal for Revalidation Policy – Senior Medical and Dental Staff

Version No.:	5.0
Effective Date:	27 January 2023
Expiry Date:	27 January 2026
Date Ratified:	04 January 2023
Ratified by:	Clinical Policy Group

GENERAL STATEMENT

This document sets outs the Trust's policy for the conduct of annual appraisal and personal development planning for Consultant, Staff Grade, Specialty Doctor and Associate Specialist (SAS) Medical and Dental Staff including locum and honorary staff who have their primary clinical commitment with the Trust.

1 Aim of the Policy

The aim of the policy is to ensure that for all senior medical and dental staff annual appraisal is completed in keeping with stipulated time limits and informs the Revalidation process.

2 Duties – roles and responsibilities

2.1 The Medical Director (Responsible Officer) is accountable to the Trust Board for ensuring Trust-wide compliance with policy. The Deputy Medical Director is also the Deputy Responsible Officer and can deputise on behalf of the Responsible Officer.

2.2 The Trust is responsible for ensuring adequate resources are available for the processes of appraisal and Revalidation, including the provision of elements of supporting information such as but not exclusively activity figures and outcome data. NuTH appraisers act on behalf of the Trust in carrying out appraisal and their actions as an appraiser are therefore indemnified by the Trust.

2.3 The Trust will use medical appraisal outcomes to further improve patient care and staff wellbeing. This includes the provision of adequate support and remediation at an early stage when potential problems are identified.

2.4 Clinical Directors are responsible to the Executive Team for ensuring policy implementation and compliance in their directorates. The Clinical Director is responsible for ensuring that adequate resources made available to both the appraisee and appraiser for this purpose.

2.5 The Clinical Director should assist in providing information as required by appraiser and appraisee to inform their appraisal discussion. This will normally comprise items of supporting information, information about the Trust's

business plan and strategy in the appraisee's area of practice, and may include additional information specific to the individual appraisee and his/her practice.

2.6 The Clinical Director is responsible for taking the appraisal outcomes into account in the development of the Directorate's strategy and business plan, while supporting individual development congruent with the Directorate's needs.

2.7 The individual appraisee is responsible for the collation of adequate supporting information to allow useful, meaningful appraisal to occur. However, the Clinical Director and the Trust itself have a responsibility to contribute those elements of this information which it is reasonable to expect them to provide (see below). The appraisee is then required to participate fully in the appraisal discussion and the formulation of appraisal outputs including a personal development plan (PDP).

2.8 Subsequently both the appraisee and appraiser have a responsibility to engage in the completion of PDP and appraisal documentation within 28 days of their appraisal service constraints. By this process the appraisee's professional development should be maximised to the ultimate benefit of patients as well as the individual doctor and the Trust.

3 Background

3.1 Appraisal centres around a discussion about the appraisee's professional, educational and personal development, including behaviours. The content of this discussion is confidential. However the appraiser is governed by the Duties of a Doctor as laid down by the GMC with regard to patient safety issues should these arise as part of the appraisal discussion. Appraisal has the dual aims of ensuring high quality patient care and assisting the individual to achieve his or her full professional potential.

3.2 Annual appraisal of medical and dental staff is a professional responsibility and a mandated contractual obligation, as well as a key component of medical revalidation. Employees of other organisations e.g. Newcastle University, who hold an honorary contract with the Trust, should have an appraisal under the policies of their substantive NHS employer, in addition to any annual performance or appraisal process (e.g. university PDR) conducted by that process. No appraisee need undergo more than one annual NHS appraisal even if they are employed by more than one NHS organisation. As such appraisees should use whole of scope of practice documentation as required to provide appraisal/performance information to the Trust. The appraisal should cover work undertaken for the Trust. Any appraisal must comply with GMC and Trust standards in order to be accepted by both as fulfilling the obligation to undergo annual appraisal and so inform a revalidation recommendation.

3.3 In order to facilitate the Responsible Officer in making a positive recommendation for Revalidation, the doctor must provide evidence of active engagement with the appraisal process including annual appraisal.

3.4 Incremental pay progression implementation is dependent on the satisfactory completion of appraisal and job planning. The Trust reserves the right to apply Schedule 15 of the Consultant TCS and defer the award of the appropriate pay threshold for one year beyond the date on which the individual would otherwise have received the threshold in cases where appraisal and job planning have not been completed.

3.5 Eligibility for Clinical Excellence Awards (CEAs) is also dependent on the satisfactory completion of appraisal and job planning. The Trust reserves the right to withhold an award or payment in cases where appraisal and job planning have not been completed.

3.6 Appraisal is an opportunity for the individual to reflect upon his/her role within the Trust and to discuss future opportunities as well as to communicate ideas and concerns. Annual appraisal and personal development planning form part of the performance management, personal and professional development framework within the Trust. Career planning discussions will include future aims and aspirations; contribution to the Trust; and short or medium term plans about retirement.

3.7 The appraisal discussion must include a review of the previous PDP(s), including an assessment of the degree to which objectives have been met and/or reasons for their non-attainment. It should be informed by valid and verifiable supporting information, reflecting the breadth of the appraisee's practice and result in the following outputs:

a) a new or revised PDP prioritising development needs for the coming year.
b) a completed summary of appraisal
c) statements regarding revalidation as required by the GMC

3.8 Following successful completion of the process the agreed appraisal outcomes will inform the job planning process and the Trust's future planning.

3.9 Any discussion/review of the Trust's updated behaviours framework "Our Newcastle Way" undertaken by the Head of Department and/or Clinical Director may inform the personal development plan of an individual where appropriate.

4 Appraisal for Revalidation

4.1 Medical revalidation is the process by which all doctors practising in the UK are required to demonstrate that they are up to date, fit to practise and compliant with relevant professional standards. Annual appraisal plays a major role in informing a recommendation for revalidation by the Responsible Officer of the Trust to the GMC.

4.2 At appraisal, the appraisee will present supporting information, some of which will be provided by the Trust, including data demonstrating activity and outcomes. Where possible this should be benchmarked by the appraisee against information from the appraisee's specialty area of practice provided by the relevant Royal College(s) and specialist societies.

4.3 Supporting information should provide evidence relevant to the four domains of good medical practice, including information on scope of practice, continued professional development, quality improvement activity, significant events, complaints and compliments, and colleague and patient feedback.

4.4 A discussion about the progress an individual is making towards Revalidation, and the identification of any difficulties encountered should form part of the appraisal discussion and inform the development of the individual's PDP.

4.5 The appraiser will be required to complete statements regarding progress towards Revalidation as required by the GMC.

4.6 Concerns arising from appraisal (including lack of progress towards Revalidation) should be integrated with existing governance processes for remediation. Further information can be found in the Remediation Guidance Document provided on the Medical Revalidation pages on the Trust intranet.

5 Personal Development Planning (PDP)

5.1 A key output of the appraisal process is a PDP, with objectives which can realistically be achieved by the individual and the organisation.

5.2 A PDP for the coming year generated from the appraisal discussion should be agreed. This should include objectives which reflect the expectations and priorities of both the Trust and the individual. Specific resources required to meet the agreed objectives should be identified (where possible), and included within the development plan.

6 Appraisal and Job Planning

The information gathered during appraisal should inform the job planning process. Objectives agreed in the PDP should be considered during the annual job planning process.

Appraisal Timetable

Pre-Appraisal

Appraisal is by law, an annual mandated obligation. **This should be held in the same calendar month each year**, other than in agreed circumstances (e.g. illness or, maternity leave). Medical and dental staff subject to annual appraisal with the Trust should expect to receive timely reminders of this obligation. Newly appointed staff are advised to consider relatively early appraisal at 9-12 months following the take-up of their post to allow early discussion of their role and practice.

3 months before: Appraisees will receive an automated email prompt reminding them their appraisal is due and to start making arrangements.

2 months before: Appraisees will receive an automated email urgently reminding them their appraisal is due and that they should make arrangements.

1 month before: Appraisee should prepare documentation and gather supporting information.

Appraisee to inform Clinical Director of appraisal date and request any additional information that needs discussing to be sent to both parties.

Appraisees will also receive an automated email urgently reminding them their appraisal is due and if they had not yet arranged their appraisal, they must contact the Deputy Responsible Officer.

2 weeks before: Complete appraisal documentation and release to appraiser

.

Reflect on key issues you would like to discuss and consider at appraisal.

Appraisee suggest key topics for discussion.

At Appraisal: Ensure no interruptions.

Confirm key topics for discussion.

Agree development/training needs etc.

Outline the conclusions at the end of meeting.

If the appraisal is not held within the 12 month timescale, the matter will be escalated to the Appraisal Lead and the Trust for their input and a warning of potential non-engagement may be issued.

Post-Appraisal

Within 4 weeks: Appraisee and appraiser to agree final version of appraisal form and submit electronically.

Appraisee to complete confidential feedback on their appraisal and appraiser.

Directorate Completed Appraisal Outcomes:

Clinical Director to use appraisal information to formulate Directorate report and to inform business planning.

7 Appraisers

7.1 Appraisers will undergo formal, once only, appraisal training to ensure they are familiar with, and have an understanding of the Trust's appraisal process and requirements for Medical Revalidation. Further refresher training and updates will be provided as and when needed. Ongoing advice and support on all aspects of appraisal are available from the Deputy Medical Director and the Medical Trust Appraisal Lead.

7.2 Clinical Directors will provide the names of two potential appraisers to each appraisee. The doctor should select one appraiser and then make contact to arrange the appraisal. No appraisee should undergo appraisal with a colleague who is their immediate line manager (e.g. with their CD).

7.3 On occasions where the proposed appraisers are unacceptable to the appraisee, this should be discussed with his/her Clinical Director. If unresolved the choice of appraiser should be referred to the Deputy Medical Director.

7.4 In most cases appraisal will be with a Trust approved appraiser within the appraisee's directorate or specialty. However, in some circumstances and with the full support of the Trust and appraisal service it may be appropriate for the appraiser to be from a different specialty or directorate. As with any appraiser/appraisee pairing, this should be agreed in advance with the appraisee's Clinical Director. Such so-called "out of directorate" appraisal offers a new and refreshing perspective on appraisal.

7.5 Although some degree of continuity is encouraged, appraiser/appraisee pairings must vary over the 5 year cycle of appraisal and revalidation, where (unless agreed with CD/Appraisal Service) it is advised that no more than 3 successive appraisals be conducted by the same appraiser. Nonetheless, some continuity of appraisal pairings serves a useful function in monitoring progress against agreed PDP targets. It is advised that a minimum of 2 appraisals within a 5 year Revalidation cycle are with the same appraiser.

7.6 For further information on conflicts of interest, objectivity and raising complaints against appraisers please see the intranet section on medical revalidation -

8 Equality and Diversity

The Trust is committed to ensuring that the way services are provided to the public and the way staff are treated reflects individual needs and does not unlawfully discriminate against individuals or groups on any grounds. This policy has been properly assessed.

9 Monitoring Compliance with the Policy

Standard/ Process/ Issue	Monitoring and Audit			
	Method	By	Committee	Frequency
To ensure compliance with the policy appraisal completion rates will be monitored.	Reporting via the e-Revalidation system.	Medical Director	Appraisal and Revalidation Group.	Quarterly

10 Consultation and review of this policy

This policy has been reviewed in consultation with the Employment Policies and Procedures Consultative Group.

11 Implementation of the policy (including raising awareness)

A summary of the key changes will be notified to Clinical Directors and Directorate Managers following implementation.

12 References and associated documents

Further guidance and information for appraisees is available on the Trust Intranet together with current Trust recommended documentation. The Trust Intranet also hosts further information on appraiser training and related information regarding Revalidation and Remediation (including Mentors; Occupational Health & Wellbeing support). This Policy also links to the Training in the Safe Use of Medical Devices Policy.

Author: Employment Policies and Procedures Consultative Group

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Equality Analysis Form A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

PART 1

1. **Assessment Date:** 22.12.22

2. **Name of policy / strategy / service**:
Appraisal Policy – Senior Medical and Dental Staff

3. **Name and designation of Author:**
Tracy Mitchell, Head of Medical Staffing

4. **Names & designations of those involved in the impact analysis screening process:**
EPPCG, HR Heads

5.

Is this a:	Policy	x	Strategy		Service	
Is this:	New		Revised	x		
Who is affected	Employees	x	Service Users		Wider Community	

6. **What are the main aims, objectives of the policy, strategy, or service and the intended outcomes?** (*These can be cut and pasted from your policy*)
The aim of the policy is to ensure all for Senior Medical and Dental staff that annual appraisal is completed and informs the Revalidation process.

7. **Does this policy, strategy, or service have any equality implications?** **Yes** [ ] **No** [x]

If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:
Local data on all staff appraisal has been reviewed and identifies no areas of concern in relation to any of the Protected characteristics.

8. Summary of evidence related to protected characteristics

Protected Characteristic	Evidence, i.e. What evidence do you have that the Trust is meeting the needs of people in various protected Groups	Does evidence/engagement highlight areas of direct or indirect discrimination? If yes describe steps to be taken to address *(by whom, completion date and review date)*	Does the evidence highlight any areas to advance opportunities or foster good relations. If yes what steps will be taken? *(by whom, completion date and review date)*
Race / Ethnic origin (including gypsies and travellers)	The Trust is committed to ensuring that, as far as is reasonably practicable, the way it provides services to the public and the way it treats staff reflects their individual needs and does not unlawfully discriminate against individuals or groups. This policy has been assessed accordingly.	As at March 2022 74.52% of staff who identified as BME had completed an appraisal compared to 71.53% of white staff.	
Sex (male/ female)		As at March 2022 71.93% of staff who identified as female had completed an appraisal compared to 71.90% of white staff.	
Religion and Belief		As at March 2022 percentage completion rates were as follows; – Christianity 71.71% – Islam 69.54% – No belief 70.87% – Other 71.01% – Not recorded 73.62%	Increased declaration rates.
Sexual orientation including lesbian, gay and bisexual people		As at March 2022 percentage completion rates were as follows; – Heterosexual 71.44% – LGB 71.62% – Not recorded 73.86%	Increased declaration rates.
Age			
Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section	In the event of prolonged absence, either planned (e.g., maternity leave) or unplanned (e.g., sickness absence), managers should take reasonable steps to enable them to give consideration to an employee's pay progression on the relevant date.	As at March 2022 percentage completion rates were as follows; – Declared a disability 69.79% – No disability 71.70% – Not recorded 73.19%	Increased declaration rates.
Gender Re-assignment			
Marriage and Civil Partnership			
Maternity / Pregnancy	In the event of prolonged absence, either planned		

	(e.g., maternity leave) or unplanned (e.g., sickness absence), managers should take reasonable steps to enable them to give consideration to an employee's pay progression on the relevant date.		

9. Are there any gaps in the evidence outlined above? If 'yes' how will these be rectified?

Local data on appraisal outcomes are analysed on an annual basis. Information relating to April 20121 – March 2022 was reviewed as part of the completion of the Equality Analysis documentation.

10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.

Do you require further engagement? Yes [ ] No [x]

11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?

No

PART 2

Name:

Tracy Mitchell

Date of completion:

22 December 2022

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Employment Policies and Procedures

Appraisal Review and Development Policy

Version No.:	12.1
Effective From:	18 July 2023
Expiry Date:	25 January 2026
Date Ratified:	17 July 2023
Ratified By:	EPPCG

1. Introduction

This policy sets out the Trust's arrangements for the annual appraisal and development review meeting.

The success of the Trust depends greatly on the skills, ability of its staff; and is committed to developing staff attain their full potential. To do this, it is essential to ensure staff:

- Are supported to develop the ability to deliver optimal performance
- Have a clear understanding of what is expected of them
- Feel valued
- Agree individual objectives which are aligned to the overall aims, strategic framework, objectives, core values and behaviours of the Trust
- Have opportunities to discuss their contribution to their department and organisational goals
- Are provided with the opportunity to learn new skills, develop and enhance their existing skills

Underpinning current individual appraisal and development review is the Trust's Professional and Leadership Behaviours (PLBs) framework. This outlines the minimum standards of behaviour required of all staff at all levels. They are consistent with the NHS Constitution.

All staff should be provided with support to enable them to maximise their performance and development within the framework, and it is used as a measure in assessing whether requirements have been acheived, including for the purposes of pay progression.

The purpose of assessment is to provide a system enabling employees to demonstrate that their focus, efforts and achievements are aligned with requirements, and to support appraisers to make an informed assessment both in terms of looking back over past performance and going forward in jointly agreeing new objectives together with a personal development plan.

This process of reflection also facilitates an important opportunity to consider how current and future leaders are aligned to the leadership pathway.

As of September 2022, an updated behaviours framework “Our Newcastle Way” is being launched, tested and consulted across the organisation.

This framework has been developed in response to feedback from the “What Matters to You?” and Strategic Leaders Programme processes undertaken across the Trust and includes a self-assessment tool. Behaviours are grouped according to the three key themes of Autonomy and Control, Physical and Psychological Safety and Participative Management.

These will be integrated into appraisal processes within the next 12 months, subject to robust consultation and stakeholder engagement. Appraisers are encouraged to incorporate these into appraisal conversations to support and test the implementation process.

2. Policy scope

This policy applies to staff when they have satisfactorily completed their probationary period. Separate arrangements are in place for Medical and Dental Staff, see:

- Appraisal for Revalidation Policy – Senior Medical and Dental Staff
- Supervision and Revalidation of Junior Medical and Dental Staff Policy
- Procedure for Managing Probationary Periods respectively.

For staff employed on NHS Terms and Conditions of Service (Agenda for Change), eligibility for pay progression is subject to this policy and the relevant provisions of the NHS Terms and Conditions of Service Handbook. In addition, Nursing and Midwifery staff are subject to revalidation and this will be incorporated into the appraisal process – Appendix A outlines the ‘Nursing and Midwifery Revalidation as part of Appraisal’ procedure.

3. Aim of policy

The aim of this policy is to ensure that an annual appraisal review discussion is completed, and individual performance is evaluated in respect of objectives and the PLB framework.

4. Duties (Roles and Responsibilities)

4.1 The Executive Team is accountable to the Trust Board for ensuring Trust-wide compliance with policy.

4.2 Directorate Managers, Associate Directors and Heads of Service are responsible to the Executive Team for ensuring policy implementation and compliance in their areas

4.3 Staff are responsible for complying with policy and participating in the annual appraisal review process.

4.4 All staff are expected to make the care and safety of patients their first concern in everything they do in discharging their duties and responsibilities.

4.5 All staff are expected to aspire to the highest standards of performance and professionalism in the provision of high-quality care that is safe, effective and focussed on patient experience.

4.6 An appraiser's own successful appraisal outcome is dependent on them ensuring that staff in their department have completed an appraisal in accordance with this policy within the preceding 12 months. The minimum level of acceptable compliance with this requirement is as follows:

- From 31st March 2020 – 95%

5. Definitions

5.1 The annual appraisal and development review is the process of two-way discussion in which staff and managers have a formal, structured opportunity to reflect their strengths and development needs, and their contribution to meeting service aims and objectives.

5.2 Performance, capability and effectiveness are discussed with the purpose of ensuring these are maintained and/or developed to facilitate a process of continuous personal/professional (and organisational) improvement.

6. Principles

6.1 General principles

6.1.1 All staff covered by this policy must be appraised on an annual basis.

6.1.2 Pay progression and annually earned pay (see section 6.5.1 d) below) is subject to satisfactory annual appraisal and the relevant provisions of NHS Terms and Conditions of Service – see section 6.3 below.

6.1.3 The appraisal process should be completed in good time to ensure any change in pay can be carried out for payroll purposes before the due date.

6.1.4 The appraisal review and development process is based on an open and joint discussion in a formal appraisal meeting, a review of behaviours against the Trust PLB Framework (see section 6.5.3 below) and the production of a personal development plan (PDP).

6.1.5 The appraiser and appraise should agree a mutually convenient time to meet for the review to enable sufficient time to prepare.

6.1.6 Staff should receive regular feedback from their manager as part of their day-to-day monitoring/supervision/management.

6.1.7 There should be ‘no surprises’ at the annual appraisal review meeting when it comes to evaluating performance, development and behaviour against requirements. Appraisal should take place at the required time regardless of whether all mandatory training has or has not been completed at that time. If mandatory training requirements have not been achieved when the appraisal takes place, see paragraph 6.5.2 below.

6.1.8 Individual objectives may be set against short and/or long-term requirements. Where they refer to performance standards, these should be clearly defined to ensure individuals understand what the expectations are. All objectives, behaviours and PDPs should be subject to review and change where necessary during the year to ensure they are aligned to business/service need and the Trust’s PLBs.

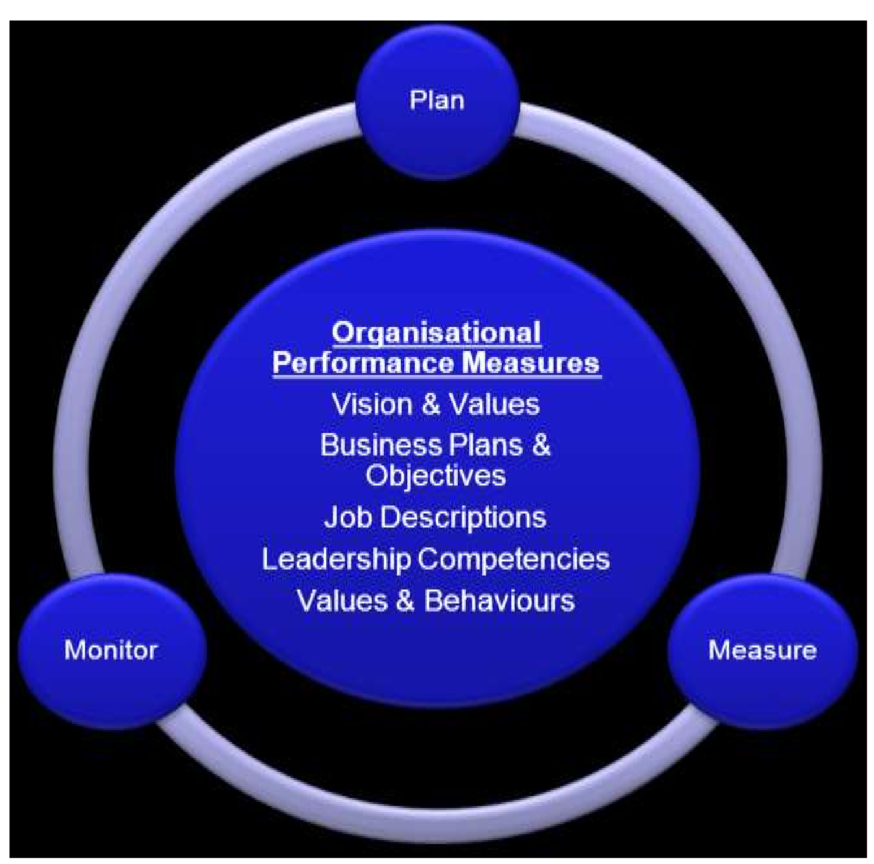
6.2 Performance management cycle

6.2.1 All line managers should ensure they are familiar with the Performance Management Cycle. The cycle demonstrates how the principles of Organisational Performance Measures (including appraisal) are integrated into the on-going performance management of staff throughout the year.

6.2.2 Other related HR policies and procedures which link to the Performance Management Cycle and are particularly related to appraisal include the following:

a) Capability Procedure
b) Flexible Working Arrangements Policy
c) Retirement Policy, Procedure and Guidance
d) Employee Wellbeing Policy Incorporating Absence Management
e) Recruitment and Selection (all disciplines)
f) Discipline Policy and Procedure
g) Grievance Policy and Procedure
h) Working Time Directive Policy

6.2.3 Performance management cycle:


Plan
Organisational Performance Measures
Vision & Values
Business Plans & Objectives
Job Descriptions
Leadership Competencies
Values & Behaviours
Monitor
Measure

6.2.4 Appraisal process:

Appraisal Process	Discussion Areas
Plan	Both parties complete Appraisal Conversation form • Review of previous year's Appraisal and PDP • Future objectives/targets/development areas
Measure	Joint discussion including the below main areas • Review of previous year's Appraisal and PDP • Future objectives/targets/development areas • Apply PLB performance rating (All discussions should include reference to the main supporting documents highlighted above)
Monitor	Plans to monitor performance in the future • One to ones • Mid Year Review • Feedback

(Appraisal conversation form is at Appendix 1).

6.3 Timing and frequency

6.3.1 Managers (or a nominated deputy) are required to individually appraise all staff covered by this policy on an annual basis. Staff are required to participate in the process. The appraisal must take place before the employee's pay step date.

6.3.2 New starters or staff new in to post should participate in an initial meeting to establish their role, responsibilities and initial objectives.

6.3.3 Appraisers and appraisees should use the Trust's Appraisal Good Practice Guide to support the appraisal process.

6.3.4 The 2018 national framework agreement on the reform of NHS Terms and Conditions of Service introduced provisions to move to a new pay system. Under the new system:

a) pay progression is no longer implemented on an annual basis

b) annual appraisal is mandated
c) time spent in-between pay step points in all bands is longer
d) fewer pay steps mean progress to the top of a band is quicker

(See Appendix B for further details).

6.3.5 For staff on a Trust Senior Staff Contract (equivalent to bands 8c, 8d, and 9), appraisals should be completed by 30 September annually. The performance rating discussed at appraisal will be considered a recommendation until ratings for all senior staff have been reviewed, quality assured and consistency checked by the Executive Team. Where there is any concern about a rating, the responsible Executive Director will review the relevant individual appraisal documentation and the rating may be subject to change. Only after this process has been completed will Executive Directors confirm a performance rating. The information resulting from appraisal discussions will be used:

- to inform the Trust's Leadership Development Strategy, including succession planning for future roles and 'mission critical' leadership posts, and
- if necessary, to identify and address issues of performance and capability by clarifying expectations and requirements, setting objectives, providing support, and resolving development needs. (As a last resort and/or in cases where formal action is necessary, the Capability Procedure or the Disciplinary Policy and Procedure should be used).

6.4 Discussion

6.4.1 The discussion should focus on the work of the appraisee, progress against the objectives agreed following the last appraisal, and consideration of whether or not the objectives have been achieved. If they were changed, the reason for the change should be acknowledged. The discussion should include any changes to the appraisee's job (either over the last year or anticipated in the coming year), a review of workload and working arrangements. The appraiser and appraise should be mindful of the Trust's Employee Health and Wellbeing arrangements, ensuring any areas of unacceptable stress are identified.

6.4.2 Before agreeing objectives and the standards of behaviour expected/required under the Trust's PLBs, managers and staff should familiarise themselves with the Trust's vision, strategic framework, core values aims and objectives. Appraisers may also integrate the emergent 'Our Newcastle Way' Framework for enhancement.

6.4.3 There should be discussion around these to:

a) inform the appraisal discussion

b) ensure employees understand how they contribute to overall aims, objectives and standards of behaviour
c) ensure the agreed objectives are aligned to those of the Trust and are sufficiently specific to be measurable (either qualitatively or quantitatively), relevant to the appraisee's work, and achievable within an agreed time period.
d) ensure their standards of behaviour are aligned to those the Trust expects/requires

6.4.4 The appraiser and the appraisee should agree when setting objectives which category of the PLBs is applicable to role and it is only that category which should be assessed. The intention is to ensure a clear, shared understanding about the expectations/requirements of the role. The discussion should also include the core behaviours which are expected from all staff. The agreed category of PLB's should be recorded in ESR (as a competency) as part of the appraisal process.

6.4.5 Following discussion, an assessment rating against the Trust's PLB's and achievement of objectives must be recorded using the tables below:

Rating	Attitude/professional behaviour
1	Exceeded expectations/exemplar
2	Achieved expectations
3	Partially achieved expectations, development identified where appropriate
4	Not achieved expectations, not acceptable (coach/ mentoring for behaviours improvement)

Rating	Objectives – Performance and Delivery
1	Exceeded requirements/expectations
2	achieved requirements/expectations
3	Partially achieved requirements/expectations, development identified where appropriate
4	Not achieved requirements/expectations, not acceptable (formal performance management identified)

Each objective should be reviewed and an overall rating determined so that the manager can map the outcome in the matrix at Appendix 4 and record it in ESR. The overall rating should be reflective of total performance and delivery, and take account of any 'weighting' and/or particular significance attached to the delivery of any particular objective(s). The ESR Manual provides guidance regarding how to record the outcomes.

6.4.6 Evaluation of job performance may be evidenced from a number of sources, including documentation provided by the individual; discussion between the appraiser and appraisee; observations by the manager.

6.4.7 In addition to the information outlined in the appraisal process diagram, discussion (and the written appraisal record) must also include:

a) Appraisee's career aspirations and plans/retirement intentions, contribution to the Trust, short or medium term plans. Staff who are considering retirement are encouraged to discuss their plans as early as possible to aid future workforce planning. It may also be helpful to discuss retirement options, including any wish to work in a more flexible way or flexible retirement. If the staff member doesn't want to discuss retirement, appraisers should be respectful of these wishes. In regard to career aspirations or future plans, it may be helpful to consider opportunities and development needs to support achievement of those aspirations. The outcome of this part of the discussion should be recorded in ESR as follows:

Retirement plans have been discussed and the appraisee is considering retirement:

- Within the next 12 months
- Within the next 12-24 months
- Within the next 2-5 years
- Within the next 5-10 years
- Greater than 10 years' time

Aspirations regarding leadership or managerial progression have been discussed and the appraisee:

- Has no immediate aspiration to progress to a leadership or managerial post
- Is not yet ready to progress into a further managerial post
- Has potential to progress - development required over next 12 months
- Has the skills and attributes to progress into a further leadership or managerial post

b) Review of mandatory training requirements and achievement. All annual mandatory training requirements are contained in the Training Needs Analysis in the Mandatory Training Policy available here.

c) Review of night worker health assessment – the frequency of a night worker assessment offer under the Working Time Policy is to be determined by the manager as part of the annual appraisal discussion.

d) Review of disciplinary record – pay progression and annually earned pay is not payable if an employee has a formal disciplinary sanction live on file. Pay progression or annually earned pay is payable from the day after the live sanction expires.

(Disciplinary sanction refers to formal warnings issued in relation to conduct under the Trust's Disciplinary Policy. It does not include investigations, informal warnings, counselling or other informal activities under the policy; nor does it include warnings applied in relation to absence due to ill health).).

e) Review of capability record – pay progression and annually earned pay is not payable if an employee has formal capability procedures in process. Pay progression or annually earned pay is payable from the day after the formal process ends.

(Capability process refers to formal action under the Trust's Capability Procedure to deal with lack of competence, including professional and clinical competence, and clear failure by an employee to achieve a satisfactory standard of work through lack of knowledge, ability or consistently poor performance. 'Process' means that there has been an outcome placing the employee in a formal stage of the procedure. It does not include investigations, informal stages and processes for dealing with absence due to ill health).

6.4.8 It is important that the appraisal review meeting closes with both parties having a mutual understanding of what is expected in the upcoming review period, and any follow up action required. Having completed the appraisal and development review and agreed the rating for the performance and delivery of the relevant PLBs and objectives, the next stage is to determine the overall outcome in the matrix at Appendix 4. This also includes whether any change in pay is required.

6.5 Pay

6.5.1 Pay progression

a) Pay progression is subject to satisfactory annual appraisal, at which the following must have been assessed and the outcome agreed:

i. Demonstration of core, professional and/or leadership behaviours (use assessment criteria in paragraph 6.4.5 above)

ii. Achievement of individual objectives, including performance of duties and responsibilities within role/job description; delivery of knowledge, skills and competencies (use assessment criteria in paragraph 6.4.6 above); and completion of all mandatory training requirements. If an employee has not acheived their mandatory training requirements, see paragraph 6.5.2 below.

b) The outcome of appraisal for PLBs, objectives and the overall rating must be recorded by the Manager using the Appraisal Outcome e-form in the HR Portal or directly in ESR using Manager Self Service.

c) The HR Department will produce a monthly report from ESR and action changes in pay where applicable.

d) Senior staff in pay bands 8c, 8d and 9

i. Pay progression to the last two points on the pay band is subject to being annually earned. Once earned, retention is conditional on the employee demonstrating annually that they have:

- continued satisfactory achievement of individual objectives
- completed all mandatory training requirements
- demonstrated core professional and/or leadership behaviours
- continued satisfactory performance of duties and responsibilities within role/job description
- demonstrated requisite knowledge, skills and competencies to meet agreed performance standards
- no formal disciplinary sanction live on file (see paragraph 6.4.8 d) above)
- no formal capability procedures in process (see paragraph 6.4.8 e) above)

ii. Annually earned pay is not subject to pay protection.

iii. From 1 April 2021, in the year after a senior staff member has reached the top of band 8c, 8d or 9, 5% or 10% of their basic salary will become re-earnable. Where standards are achieved, salary is retained at the top of the band. If standards are not achieved, salary may be reduced by 5% or 10% from the pay step date. The individual will be able to restore their salary to the top of

the band at the end of the following year by meeting the required standards.

iv. For senior staff appointed on a Trust contract, pay progression will be conditional on meeting agreed objectives and performance standards – see section 6.4 above.

6.5.2 <u>Withholding pay progression</u>

a) Ordinarily, staff should receive pay progression when it is due. However, pay progression may not occur in the following circumstances:

i. Failure to complete all mandatory training requirements and the reason is down to the employee. In such cases, the manager shall:

- record the employee as a '4' for their Objectives and Behaviours (overall outcome: 'Red')
- ensure support and an appropriate action plan to complete mandatory training is in place
- set a timescale for requirements to be achieved
- withhold pay progression until requirements have been achieved

ii. Failure to meet requirements in terms of performance and delivery of objectives, including performance of duties and responsibilities within role/job description and delivery of knowledge, skills and competencies.

iii. Failure to meet requirements in terms of core, professional and/or leadership behaviours.

iv. Employee has a live disciplinary sanction on their record at the time they are due to progress.

v. Employee has a formal capability process underway at the time they are due to progress.

b) In all cases where pay progression is withheld:

- the pay step date will remain the same
- pay progression will not be paid or back-dated
- a timescale for requirements to be achieved will be set
- support and an action plan for improvement will be put in place as necessary

c) Managers may give consideration to formal action under the Disciplinary policy if under-performance gives cause for concern and

the manager considers this is a conduct rather than a capability issue.

d) The outcome of appraisal for PLBs, objectives and the overall rating must be recorded by the Manager in ESR using Manager Self Service.

e) The HR Department will produce a monthly report and withhold pay progression where applicable.

f) Pay progression that is withheld under 6.5.2 i. a) will not occur until the manager records the outcome of appraisal in ESR as 'green'. This is to show the employee has achieved requirements. Pay progression is payable from the day after requirements were achieved, so it is the date of the day after requirements were achieved which managers must record in ESR. If this date is after the pay step date, the increase in pay will not be backdated and the pay step date will remain the same. Where pay progression is withheld due to a live disciplinary sanction, or because formal capability procedures are in process, the manager should initiate a meeting to review pay progression before the expiry of the sanction or capability process. The meeting should be used to confirm that all other requirements have been achieved and to ensure that the employee receives pay progression effective from the day after the sanction, or capability process ends.

g) The HR Department will arrange for pay progression to be paid from the date notified by the manager and will raise any query as necessary.

h) If it is identified and discussed that there are significant weaknesses in the job performance of the employee and these have not been resolved despite appropriate opportunities for training and/or support, pay progression should be deferred until those issues have been resolved formally in accordance with the relevant Trust policy/procedure.

6.5.2 Annual appraisal is mandatory for all staff under NHS Terms and Conditions of Service regardless of whether pay progression is due. Managers (and staff) must ensure appraisal takes place each year and that the outcome is recorded accurately and timely in accordance with paragraphs 6.4.5 and 6.5.6 above so that compliance can be monitored and reported.

6.5.3 In the event of prolonged absence, either planned (e.g. maternity leave) or unplanned (e.g. sickness absence), managers should take reasonable steps to enable them to give consideration to an employee's pay progression on the relevant date. This may include a review of:

- previous records
- progress towards meeting their PDP
- notes of any relevant meetings between the manager and the employee

- performance and development before planned absence starts

  the practicality of the employee achieving objectives if they are absent

6.5.4 A disciplinary sanction or formal capability process will not be applied retrospectively to delay a pay step if the sanction or process comes into effect after the pay step date.

6.5.5 If a disciplinary sanction in place at the time of the pay step date is subsequently repealed, for example as a result of a successful appeal, the pay step will be backdated to the pay step date if all other requirements have been achieved.

6.6 Requesting a review

6.6.1 If it is deemed that an appraisee has not achievedthe required level of performance and/or standards of behaviour and the appraisee does not agree, the appraisee has the right of review to an officer of higher authority. The appraiser shall inform the appraisee of the officer's name, designation and contact details.

6.6.2 The appraisee must submit their right of review (using the Appraisal Review form) to the relevant person within five working days of the appraisal. It must provide details of the reason for review and may refer to evidence that was provided at appraisal which demonstrates the required level of performance and/or standards of behaviour have been achieved.

6.6.2 The reviewer will arrange for a meeting to be held without unreasonable delay to consider the appraisee's case. The appraisee has the right to be accompanied by a trade union representative, or a work colleague if they wish. The appraiser will also be invited to the meeting.

6.6.3 The reviewer's decision will be final and will be communicated in writing to the appraisee and appraiser within five working days of the meeting.

6.7 Record Keeping

6.7.1 The line manager is responsible for authorising the outcome of an individual's appraisal, recording the outcome on both the Appraisal Conversation Form and also on ESR.

6.7.2 If the appraisal is carried out after the pay step date (NB this should only occur in exceptional circumstances), the manager should record the pay step date rather than the appraisal date in ESR and ensure that all future appraisals are undertaken before the individual's next pay step date.

6.7.3 Managers are responsible for recording the overall performance rating in ESR and taking appropriate action where a performance rating of 'Amber' or 'Red' is determined.

6.7.4 The Trust's standard appraisal documentation should be completed and a copy held by the appraiser and the appraisee. All working copies of documentation needed for appraisal can be accessed here.

Appendix 1	Appraisal conversation
Appendix 2	Core Professional Behaviours expected of all staff
Appendix 2a	First Level Leaders
Appendix 2b	Leading through Others (including Leaders)
Appendix 2c	Service & Corporate Leaders
Appendix 3	Performance objectives and development plan
Appendix 4	Performance and Behaviour Matrix
Appendix 5	Appraisal Review Form

7. Training

7.1 Appraisers are responsible for ensuring they are competent to carry out an annual appraisal.

7.2 It is recommended that appraisers undergo formal, once only, appraisal training to ensure they are familiar with, and have an understanding of the Trusts appraisal and development review process and requirements.

7.3 Appraisal skills training is featured in the Trust Training Directory. Ongoing advice and support on all aspects of appraisal are available from Education and Workforce Development and HR.

8. Equality and diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way services are provided, and the way staff are treated reflects their individual needs and does not unlawfully discriminate against individuals or groups. This Agreement has been properly assessed.

9. Monitoring compliance with the policy

Standard / process / issue	***Monitoring and audit***			
	Method	***By***	***Committee***	***Frequency***
To ensure compliance with the policy annual appraisal completion rates will be monitored	Performance Management Framework	Director of Human Resources	Performance Management Framework	Quarterly

10. Consultation and review

This policy has been reviewed in consultation with the Employment Policies and Procedures Consultation Group.

11. Implementation of policy (including raising awareness)

12. A summary of the key changes will be notified to managers as part of publishing this policy References

13. Associated documentation

- Employee Wellbeing Policy Incorporating Absence Management
- Recruitment and Selection Policies
- Disciplinary Policy and Procedure
- Capability Procedure
- Grievance Policy and Procedure
- Preceptorship Policy in accordance with the NHS Terms and Conditions of Service
- Procedure for Managing Probationary Periods
- Training in the Safe Use of Medical Devices Policy
- Leadership Development and Talent Management Strategy
- “Our Newcastle Way” – Behaviours Framework and Self Assessment Tool

Author: Employment Policies and Procedures Consultation Group

Appendix A
Registered Nurses, Nurse Associates and Midwives Revalidation as part of Appraisal

1. Introduction

The Nursing and Midwifery Council implemented a system of Revalidation for all Registered Nurses, Nurse Associates and Midwives from April 2016. Individual Registrants have a personal responsibility to compile a portfolio of evidence, mapped against the NMC Code of Conduct, to demonstrate that the requirements of revalidation have been achieved and to maintain their registration with the Nursing and Midwifery Council (NMC).
The requirements for Revalidation are;

- 450 practice hours or 900 if revalidating as both a Nurse and Midwife
- 35 hours CPD including 20 hours participatory learning
- Five pieces of practice related feedback
- Five written reflective accounts
- Reflective discussion
- Confirmation of all of the above by a designated confirmer

2. Scope

This policy applies to all Registered Nurses, Nurse Associates and Midwives. .

3. Aims

The Revalidation process is designed so that it can be undertaken as part of (a regular) appraisal and the NMC strongly recommend that, where possible, the confirmation discussion forms part of the Registered Nurses, Nurse Associates and Midwives annual appraisal. This policy outlines responsibilities of all participants and provides guidance to support the process.

Line managers, who provide confirmation as part of an annual appraisal, will find it helpful to have a revalidation discussion with the Registered Nurse, Nurse Associates or Midwife at each annual appraisal where they will be able to monitor progress and which may be combined with a Confirmation discussion during the twelve month period leading to the Revalidation date.

4. Duties (Roles and responsibilities)

The Executive Chief Nurse is responsible for ensuring systems are in place to support Nursing and Midwifery Revalidation.

Directorate Managers are responsible for ensuring appraisals are carried out in their areas.

Matrons and Sisters are responsible for ensuring a system of appraisal is in place and that Revalidation progress is discussed as part of annual appraisal. This will involve a review of the evidence in a Registrant's portfolio and confirmation that the registrant

has answered the six key questions relating to revalidation in the Electronic Staff Record (ESR). Matrons and Sisters will take on the role of Confirmer as part of the appraisal of Nurses and Midwives working for them.

Registered Nurses, Nurse Associates and Midwives are the owners of their own revalidation process. Completing the revalidation process is the responsibility of individual Registered Nurses, Nurse Associates and Midwives who are expected to;

- Maintain a portfolio of evidence to show they are meeting the NMC requirements for Revalidation.
- Provide evidence of their progress towards Revalidation at each annual appraisal.
- Discuss with their Line Manager where any issues arise which may impact on the Revalidation process.

5. Definitions

Revalidation - is the process that all Registered Nurses, Nurse Associates and Midwives in the UK need to follow to maintain their registration with the NMC. This process replaces the PREP requirements. Registered Nurses, Nurse Associates and Midwives are required to revalidate every three years to renew their registration.

Revalidation Date - this is the first day of the month that a Registered Nurse, Nurse Associate or Midwifes registration expires. For example, if the registration expires on 30 June, their revalidation application, and fee, is due by 1 June that same year.

Reflective Partner – this is a Registered Nurse or Midwife with whom a Registrant seeking revalidation will discuss their five reflective accounts.

Reflective Discussion – a formal discussion of five written reflective accounts which takes place between two NMC Registrants. The discussion is designed to encourage a culture of sharing, reflection and improvement amongst Registered Nurses, Nurse Associates and Midwives .

Confirmer - Registered Nurses, Nurse Associates and Midwives will be asked to declare that they have received confirmation from an appropriate person in support of their revalidation application. An appropriate person is a line manager or the person who undertakes a Registered Nurses, Nurse Associates or Midwives appraisal with delegated responsibility of their line manager (e.g. a band 6 Sister who undertakes appraisal on behalf of a band 7 Sister). This confirmer does not need to be a Registered Nurse or Midwife.

Confirmation Discussion – a discussion where the Registered Nurses, Nurse Associates or Midwife has demonstrated to their Confirmer that they have achieved the revalidation requirements. This is a key part of revalidation.

6. The Revalidation Process

Registered Nurses, Nurse Associates and Midwives have to Revalidate every three years to maintain their registration. In the first and second years, as part of the appraisal process, they should be asked to demonstrate that they are making progress with their Revalidation Portfolio. The evidence that a Registered Nurses, Nurse Associates or Midwife gathers as part of this portfolio may also be evidence that they are meeting the Trust's Professional Leadership Behaviours (PLB's).

Prior to annual appraisal, Registered Nurses, Nurse Associates and Midwives are requested to log onto ESR Self Service and answer six mandatory questions relating to their progress as this will enable managers to maintain an overview of all of their staff.

In the final year of the three year registration period, appraisal should also include a Confirmation discussion and if the manager is also an NMC Registrant, this may include a Reflective discussion. Where the manager is not an NMC Registrant, the Reflective discussion must take place first.

The NMC has provided a form which must be used by Confirmers, this is available on the NMC website. Confirmers are expected to;

- Make themselves available to have the Confirmation discussion in sufficient time to allow Registered Nurses, Nurse Associates and Midwives to Revalidate.
- Provide their name, job title, email address, professional address and professional registration number (where applicable) on the Confirmation form so that Nurses and Midwives can give this information to the NMC as part of the online Revalidation process.
- Have read the NMC Information for Confirmers.

Registered Nurses, Nurse Associates and Midwives must retain their portfolio and the completed Reflective Discussion form and Confirmer form securely until their Revalidation application is made. These forms contain personal data about both the Reflective Partner and Confirmer, and must be held securely in a way that upholds confidentiality and data protection for all those concerned e.g. electronically as a scanned document in a personal (not shared) drive or in a locked cupboard.

As a Confirmer, you must keep a record of those Registered Nurses, Nurse Associates and Midwives you confirm, particularly if you are acting as a Confirmer for multiple Registrants.

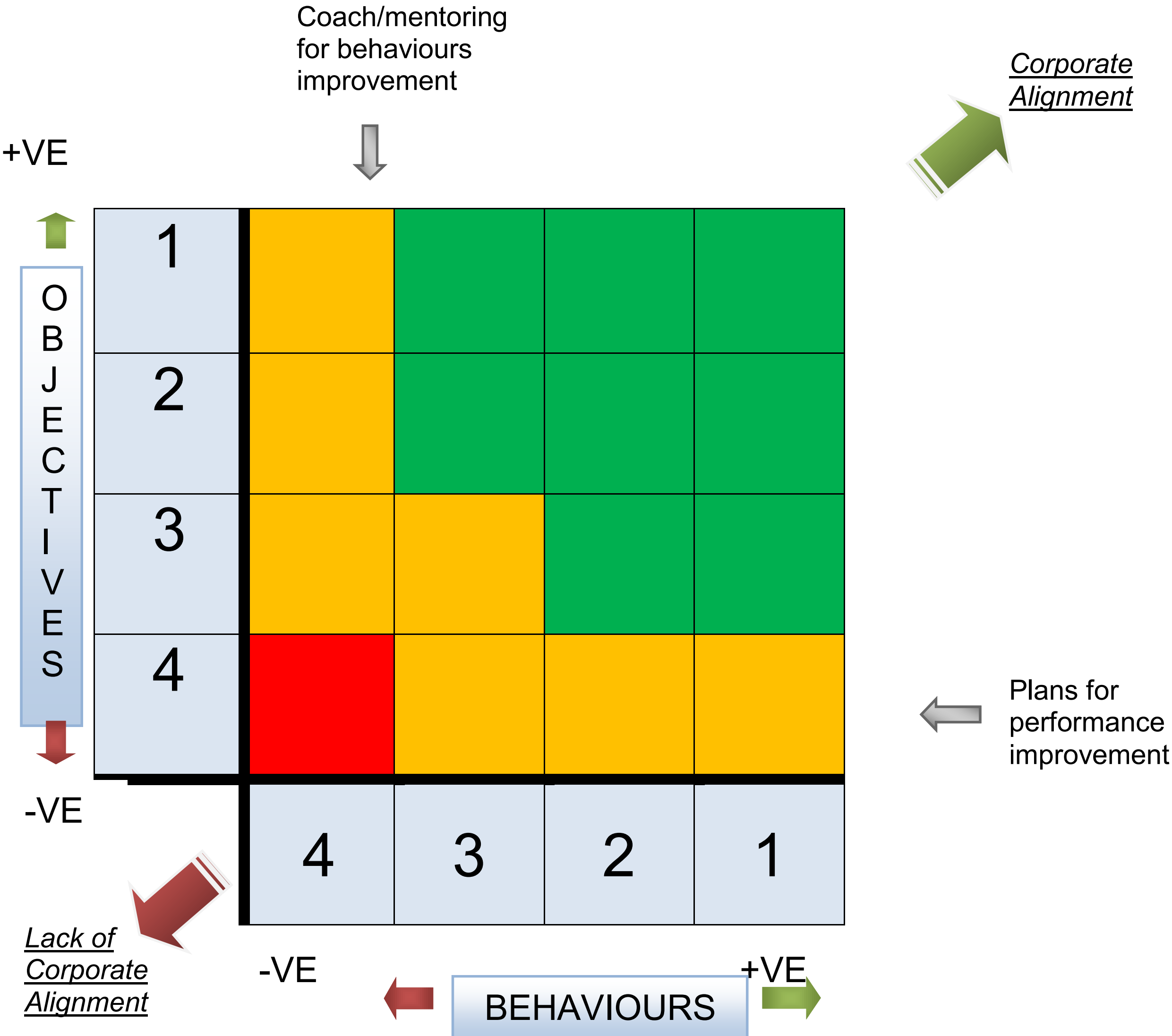
7. Supporting Documents

- Nursing and Midwifery Council (2015) *Information for confirmers*, London, NMC https://www.nmc.org.uk/globalassets/sitedocuments/revalidation/information-for-confirmers.pdf
- Nursing and Midwifery Council (2015) *Employers' guide to revalidation,* London, NMC http://revalidation.nmc.org.uk/information-for-employers/
- Nursing and Midwifery Council (2015) *How to revalidate with the NMC*, London, NMC http://revalidation.nmc.org.uk/

- Nursing and Midwifery Council (2015) *The Code: Professional standards of practice and behaviour for nurses and midwives,* London, NMC https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf

Appendix 4 - Performance and Review Matrix

PERFORMANCE AND BEHAVIOUR MATRIX



Overall Assessment - Objectives	Overall Assessment - Behaviours
1 - Exceeded (Exemplar)	1 - Exceeded (Exemplar)
2 - Achieved	2 – Achieved
3 - Partially achieved, performance improvement plan identified where appropriate	3 - Partiallyachieved, development identified where appropriate
4 – Not achieved, unacceptable (formal action)	4 – Not achieved , unacceptable (formal action)

Matrix Outcome:

Matrix Ref	Outcome	Performance Description	Action
1:1	Green	Overall performance outstanding/exemplar	Pay progression payable
All in green excl 1:1	Green	Overall performance achieved	Pay progression payable
All in Amber	Amber	Overall performance unsatisfactory (partially achieved/plan for development and/or improvement identified) – *see paragraph 6.5*	Pay progression not payable if formal capability procedure in process. Pay progression not payable formal process ended.
4:4	Red	Overall performance is unacceptable (formal disciplinary sanction live on file and/or formal capability procedure in process) – *see paragraphs 6.4.8 d) and e)v*	• Sanction: Pay progression not payable until sanction expired • Capability: Pay progression not payable until formal process ended
n/a	n/a	Mandatory training requirements not achieved – *see paragraph 6.5.2*	Increment not payable until requirements achieved

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Equality Analysis Form A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

PART 1

1. **Assessment Date:** December 2022

2. **Name of policy / strategy / service**:
   Appraisal Policy (non-medical staff)

3. **Name and designation of Author:**
   Ms K Pearce, Head of EDI (People)

4. **Names & designations of those involved in the impact analysis screening process:**
   EPPCG, HR Heads

5. **Is this a:** Policy [x] Strategy [ ] Service [ ]

   Is this: New [ ] Revised [x]

   Who is affected Employees [x] Service Users [ ] Wider Community [ ]

6. **What are the main aims, objectives of the policy, strategy, or service and the intended outcomes?** (*These can be cut and pasted from your policy*)
   The aim of this policy is to ensure for all non-Medical and Dental staff that annual appraisal is completed and individual performance is assessed in respect of objectives and professional and leadership behaviours.

7. **Does this policy, strategy, or service have any equality implications?** **Yes** [ ] **No** [x]

   If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:
   Local Staff Data on staff appraisal has been reviewed and identifies no areas for concern in relation to any of the Protected characteristics

8. Summary of evidence related to protected characteristics

Protected Characteristic	Evidence, i.e. What evidence do you have that the Trust is meeting the needs of people in various protected Groups	Does evidence/engagement highlight areas of direct or indirect discrimination? If yes describe steps to be taken to address *(by whom, completion date and review date)*	Does the evidence highlight any areas to advance opportunities or foster good relations. If yes what steps will be taken? *(by whom, completion date and review date)*
Race / Ethnic origin (including gypsies and travellers)	The Trust is committed to ensuring that, as far as is reasonably practicable, the way it provides services to the public and the way it treats staff reflects their individual needs and does not unlawfully discriminate against individuals or groups. This policy has been assessed accordingly. The Trust's PLBs specify the standards of behaviour required by all staff. Individual objectives should be linked to these core behaviours and there should be a clear, shared understanding between the appraiser and the appraisee of expectations/requirements in relation to role.	As at March 2022 74.52% of staff who identified as BME had completed an appraisal compared to 71.53% of white staff	All staff will be given direction and support to enable them to maximise their performance and development within the framework
Sex (male/ female)		As at March 2022 71.93% of staff who identified as female had completed an appraisal compared to 71.90% of white staff	
Religion and Belief		As at March 2022 percentage completion rates were as follows; – Christianity 71.71% – Islam 69.54% – No belief 70.87% – Other 71.01% – Not recorded 73.62%	Increased declaration rates
Sexual orientation including lesbian, gay and bisexual people		As at March 2022 percentage completion rates were as follows; – Heterosexual 71.44% – LGB 71.62% – Not recorded 73.86%	Increased declaration rates
Age			
Disability – learning difficulties, physical disability, sensory impairment and mental	In the event of prolonged absence, either planned (e.g. maternity leave) or unplanned (e.g. sickness absence), managers should take reasonable steps to enable them to give consideration to an employee's pay progression	As at March 2022 percentage completion rates were as follows; – Declared a disability 69.79%	Increased declaration rates

health. Consider the needs of carers in this section	on the relevant date. This may include a review of: a) Previous records b) Progress towards meeting their PDP c) Notes of any relevant meetings between the manager and the employee Performance and development before planned absence starts	– No disability 71.70% – Not recorded 73.19%	
Gender Re-assignment			
Marriage and Civil Partnership			
Maternity / Pregnancy	In the event of prolonged absence, either planned (e.g. maternity leave) or unplanned (e.g. sickness absence), managers should take reasonable steps to enable them to give consideration to an employee's pay progression on the relevant date. This may include a review of: d) Previous records e) Progress towards meeting their PDP f) Notes of any relevant meetings between the manager and the employee Performance and development before planned absence starts		

9. Are there any gaps in the evidence outlined above? If 'yes' how will these be rectified?

Local data on appraisal outcomes are analysed on an annual basis. Information relating to April 20121 – March 2022 was reviewed as part of the completion of the Equality Analysis documentation.

10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.

Do you require further engagement? Yes [ ] No [x]

11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?

No

PART 2

Name:

Karen Pearce

Date of completion:

December 2022

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Employment Policies and Procedures

Apprenticeship Policy

Version No.:	3
Effective From:	25 September 2020
Expiry Date:	25 September 2023
Date Ratified:	05 August 2020
Ratified By:	HR Heads

1 General Policy Statement

1.1 The Trust is committed to the national apprenticeship agenda and is in support of the NHS Talent for Care Strategy. It aims to provide high quality apprenticeships, underpinned by strong governance, for both new recruits and existing staff.

1.2 This policy complies with the Education and Skills Funding Agency (ESFA) and current Department for Education (DfE) funding rules. The Trust will review this policy and its practice as these rules change to ensure continued compliance.

1.3 This policy applies to all Trust Apprenticeship posts and Agenda for Change Band 2 to 4 vacancies. Sections 10, 11 and 12 do not apply to apprentices on the regional Pharmacy, Dental and Estates programmes.

1.4 This policy outlines the Trust's approach to apprenticeships as an integral part of its workforce plans, and aims to ensure:

1.4.1 The delivery of high quality apprenticeships.
1.4.2 Fair remuneration of the Trust's apprentices.
1.4.3 Effective use of the apprenticeship levy.
1.4.4 That the Trust has regard for the public body apprenticeship target.
1.4.5 ESFA and DfE apprenticeship rules are adhered to at all times.

1.5 This policy supports the 'Reducing Health Inequalities' agenda in that, where possible and aligned to the organisational strategy, the Trust will utilise apprenticeships to provide good quality training and employment to people in the local population.

2 Duties (roles and responsibilities)

Staff Group	Duties
The Executive Team	Accountable to the Trust Board for ensuring Trust-wide compliance with the policy.
Directorate managers and heads of service	Responsible to the Executive Team for ensuring implementation of the policy.
Managers	Responsible for ensuring policy implementation and compliance in their area(s).

Staff	Responsible for complying with the policy
Workforce Development.	• Will provide professional advice and guidance on apprenticeships to the Board, Executive Team and appointing managers • Responsible for monitoring the implementation of and compliance with the policy, reporting and providing assurance to the Trust's Learning and Education Group (LEG).

3 Definitions

3.1 Appendix 1 includes a list of definitions related to the content of this policy.

4 Apprenticeship eligibility

4.1 To be eligible for an apprenticeship, the individual must be:
- Training for a new job role, or
- Training in an existing job role, but requiring significant new knowledge and skills.

4.2 An individual may undertake any apprenticeship at a higher level than a qualification they already hold, including a previous apprenticeship. An individual may also undertake an apprenticeship at the same or lower level than a qualification they already hold if:
- The apprenticeship will allow the individual to acquire substantial new skills and knowledge, and
- The Trust can evidence that the content is materially different from any prior qualification or apprenticeship.

5 Contracting

5.1 For 'Employer Only' apprentices, a contract for delivery of the relevant apprenticeship will be in place with a main provider from the start of the apprenticeship.

6 Paying for apprenticeships

6.1 The Trust will use its apprenticeship levy funds to pay for apprenticeships undertaken by its employees. This means new recruit apprentices and existing post-holder apprentices, either of which may be 'Employer Provider' or 'Employer Only' apprentices.

6.2 For Employer Provider apprentices, the Trust will claim the full cost of training and assessment, including end point assessment for each apprentice from its Apprenticeship Service account.

6.3 For Employer Only apprentices, the Trust will negotiate a price for the total cost of each apprenticeship with the main provider. The price will include all training costs including end point assessment and where possible the cost of one resit/retake. The Trust will expect the main provider to reduce the content, duration and price of an apprenticeship to account for any prior learning.

6.4 In certain circumstances, where agreed at Executive level, the Trust may consider transferring Levy funds to support a partner organisation in providing apprenticeship training opportunities where these align to the Trust ambitions of being an anchor organisation and a full civic partner contributing to the health, wealth and wellbeing of the city and system.

7 Additional apprenticeship conditions (statutory or ESFA/DfE rules)

7.1 An apprentice cannot contribute financially to the direct cost of learning or assessment for any element of their apprenticeship. Therefore no bonding arrangement can be in place in relation to an apprenticeship.

7.2 All apprentices must have:

- An Apprenticeship Agreement, as defined by the 2009 Act
- A Commitment Statement
- Off the job training of 20% of the apprentice's normal working hours over the planned duration of the training period (known as the practical period in apprenticeship Standards) These hours will be recorded on the ILR, Apprenticeship Agreement and Commitment Statement, in accordance with ESFA funding rules. These hours will not include Maths and English which must be delivered in addition to the minimum requirement.
- An Initial Assessment designed specifically for their Framework or Standard as part of their induction to the apprenticeship.
- In addition all Employer Provider apprentices must have an Evidence Pack, which will be maintained and held by Workforce Development. The Evidence Pack must contain evidence to support the funding claimed, provide assurance that the apprentice exists, and must be made available to ESFA on demand.

8 Employment Conditions

8.1 The minimum duration of an apprenticeship is based on the apprentice working at least 30 hours per week, including any off-the-job training they undertake. Where an apprentice works fewer than 30 hours per week, the expected duration must be extended on a pro–rata basis using the following formula:

- (12 x 30) / average weekly hours = new minimum duration in months.

8.2 For apprentices who are under 18, the Trust has the same responsibilities as for other young workers, including additional requirements under the European Working Time Directive (EWTD). Managers seeking to appoint any young person, including an apprentice, should refer to the Trust's Young Persons and Work Experience Students Under 18 Years of Age Policy for more information, including risk assessment requirements, and the Trust's Working Time Regulations Policy.

8.3 In accordance with the Trust's Organisational Change and Redundancy Policy, the Trust would wish to avoid redundancies wherever possible. In circumstances where

an apprentice may be considered for redundancy, in addition to applying the Organisational Change and Redundancy Policy, the Trust would liaise with the ESFA to support the apprentice in finding an alternative employer and training provider to facilitate the completion of their apprenticeship.

9 Apprenticeship status

Unless specified within their contract of employment or within this policy, all Trust policies and procedures apply to apprentices as they would to any other employee.

10 Trust Apprenticeship recruitment requirements (applies to Bands 2 to 4 only)

10.1 In meeting the statutory requirement to ‘have regard’ for the public body apprenticeship target, the Trust expects that:

10.1.1 All Agenda for Change Band 2 posts will be appointed as apprenticeships, although it is recognised that there may be occasions when service need determines that a ‘role ready’ individual is required.

10.1.2 All Agenda for Change Band 3 and 4 vacancies must be considered for an apprenticeship unless any of the exemptions in Section 10.2 apply.

10.2 Only the following exemptions apply to section 10.1:

10.2.1 There is not an appropriate apprenticeship Framework or Standard available for the vacancy. To be considered available, there should be a registered training provider available to commence delivery of the apprenticeship at a location and within a timescale acceptable to the Trust and/or recruiting manager.

10.2.2 There will not be a post available on completion of the apprenticeship (not applicable to regional programme apprentices). The vacancy being recruited to must have a minimum contract length of 6 months longer than the planned duration of the apprenticeship, or the recruiting manager must confirm that another role, appropriate to the apprenticeship, would be available.

10.2.3 The role is in an area where professional staffing leads (Heads of Department/Directorate Managers) deem:

- The role or work area to be inappropriate for an inexperienced member of staff (even when well supervised), or
- It is appropriate to enforce a maximum number of new recruit apprentices in any one area.

10.2.4 The role is designed primarily or to significantly cover nights, whereby supervision and learning opportunities would be significantly reduced, or it is a role designed for a lone worker, or where the worker will carry out a significant amount of their duties

in the absence of colleagues or supervision. Recruiting managers should consider an apprentice's progress and available support before rostering them at night.

10.2.5 Where national staffing rules (profession specific) dictate that apprentices are classified as supernumerary in any staffing ratios/hours calculations, and as such they cannot be employed within budgeted establishment.

11 Trust apprenticeship backfill rules (applies to Band 2 to 4 clinical roles only)

11.1 For newly recruited and existing post holder apprentices training for Band 2 posts, backfill is permitted for clinical apprenticeships only. Clinical is defined as:

- Nursing & Midwifery Support roles.
- Healthcare Science Support roles.
- Allied Health Professional Support roles including Psychology.
- Pharmacy Support roles.

In the case of new recruit apprentices and in support of the Trust's Cost Improvement Programme, on a non-recurrent basis (until the apprentice completes and transfers into the role they were training for) the difference between the apprenticeship salary and the Agenda for Change salary will be removed from staffing budgets. If a clinical post, backfill funding will remain in budgets to cover the off the job learning element.

11.2 Backfill is permitted if affordable within existing budgets for:

- Existing post holder apprentices in clinical Band 2 posts,
- Apprentices training for or occupying Band 3 and 4 posts

11.3 Any other cases for backfill will be reviewed on an individual basis and will be approved in exceptional circumstances only.

11.4 It is expected that backfill will usually be achieved through the most financially efficient arrangement.

12 Apprenticeship remuneration structure

12.1 For apprentices training for Agenda for Change posts at Band 5 or higher, recruiting managers can appoint either on Annex 21 of the band the apprentice is training for or one band lower.

12.2 Regional apprenticeship programmes (currently Pharmacy, Dental and Estates) for which HEE sets the remuneration packages are outside the scope of this section of the policy.

12.3 For new recruit apprentices training for Agenda for Change Band 2 to 4 posts, the following basic pay rates apply:

Apprenticeship role description	Basic pay scale description
Apprentice appointed to a vacancy, training for an AfC Band 2 post.	Paid the National Minimum Wage at the 25+ rate, regardless of the age of the apprentice.
Apprentice appointed to a vacancy, training for an AfC Band 3 post.	Paid a salary equivalent to Band 2, progressing through increments as per NHS Terms and Conditions.
Apprentice appointed to a vacancy, training for an AfC Band 4 post.	Paid a salary equivalent to Band 3, progressing through increments as per NHS Terms and Conditions.

12.4 For new recruit apprentices training for Bands 2 to 4 posts, enhancement rates will be as outlined in the NHS Terms and Conditions of Service Handbook.

12.5 There will be no change to the salaries of existing staff who are appointed to an apprenticeship leading to a post at the same pay band as their current post.

12.6 For existing staff who apply for, and are appointed to an apprenticeship leading to a post lower than their current post, paragraphs 12.3 and 12.4 will apply (they will become a new recruit apprentice).

12.7 For existing staff undertaking an apprenticeship to support development in their own role (defined in Section 5 as an existing post-holder apprentice), their remuneration will be unchanged.

13 Apprenticeship complaints

13.1 Apprentices have the right to make a complaint about the apprenticeship training they receive. Employer Provider apprentices will be within in the scope of the Trust's Apprenticeship Complaints Protocol and will be provided with a copy at the start of their apprenticeship. Employer Only apprentices will be within the scope of their training provider's complaints process.

13.2 All apprentices have the right to raise a concern or make a complaint about their training via the Apprenticeship Helpline, who can be contacted at:

- 0800 015 0400, or nationalhelpdesk@apprenticeships.gov.uk

14 Apprentice mentors/buddies

14.1 Each apprentice will have a named mentor/buddy, who will be a member of staff working at least at the level of the post the apprentice is training for, as well as working in the same or a similar occupational area.

14.2 The mentor/buddy's role will be to provide support and guidance to the apprentice as part of their on-the-job training and ongoing support. The mentor/buddy may also be involved in delivery of the apprentice's off-the-job training.

15 Existing apprentices applying for non-apprenticeship posts

15.1 A manager may only consider shortlisting an application from a current apprentice where the application clearly meets all the essential criteria for the non-apprenticeship post. Where apprenticeship experience is being relied upon, that experience should only be considered sufficient where the apprenticeship has been or will be completed before the non-apprenticeship post commences.

15.2 Should a manager wish to appoint an existing apprentice into a non-apprenticeship post, they will be expected to support the appointee to complete the apprenticeship within their new post.

16 Training and guidance

Training and/or guidance on the content and implementation of this policy will be provided by Workforce Development, usually the Apprenticeship Team.

17 Equality and diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, services are provided and staff are treated in ways which reflect their individual needs, and do not unlawfully discriminate against individuals or groups. This policy has been properly assessed.

18 Monitoring compliance with the policy

Standard/process/ issue	**Monitoring and audit**			
	Methods	**By**	**Committee**	**Frequency**
• Monitoring whether all sections of the policy are adhered to. • Monitoring of apprentice mentor allocation. • Monitoring of apprenticeship complaints. • Identification of areas which can be improved.	Annual Self-Assessment. Monitoring of performance reports. Random sampling of Evidence Packs, Individual Learner Records (ILRs) and personal files.	Senior Workforce Development Officer. Workforce Development Manager. Head of Education and Workforce Development.	Learning and Education Group (LEG).	Continuous review with an annual report submitted to the Learning and Education Group.

19 Consultation and review

This policy has been reviewed in consultation with the Apprenticeship Delivery Board and the Employment Policies and Procedures Consultative Group.

20 Implementation

The updated policy will be included in the Trust policy database and will be highlighted to all members of the Apprenticeship Delivery Board and Apprenticeship Delivery Team. Recruiting managers will be made aware of the policy during the recruitment process. Advice and guidance on the policy will be provided by the Apprenticeship Team, either at advertised events or in response to individual enquiries.

Appendix 1 - Definitions

'Apprenticeship' refers to an 'approved English Apprenticeship' as outlined in the Apprenticeships, Skills, Children and Learning Act 2009. The term 'apprenticeship' is legally protected and can only be used to describe a statutory apprenticeship. An apprenticeship is a job with training. The job must have a productive purpose and should provide the apprentice with the opportunity to embed and consolidate the knowledge, skills and behaviours learned through the apprenticeship.

An **'Apprenticeship Agreement'** is an agreement between the apprentice and their employer, which must be signed and dated by both parties at the start of the apprenticeship. It is use to confirm the arrangements to be in place for the duration of the apprenticeship.

A **'Commitment Statement'** is a statement which outlines the commitments of the apprentice, their employer and the training provider. It must be signed and dated by all parties at the start of the apprenticeship. The Commitment Statement must include:

- The planned content and schedule for training.
- What is expected and offered by the employer, training provider and apprentice.
- How to resolve queries or complaints.

'Apprenticeship Frameworks' are primarily qualification-focused. The main aim at the end of a Framework is to have achieved a competency-based qualification, such as an NVQ, and a technical qualification, such as a BTEC. In a Framework, apprentices are assessed throughout the apprenticeship. All apprenticeship Frameworks are expected to be phased out and replaced by 'Apprenticeship Standards' by 31 July 2020.

An **'Apprenticeship Standard'** contains a list of the skills, knowledge and behaviours an apprentice will need to have learned by the end of their apprenticeship. Standards are occupation-focused; they are not qualification-led. The learning happens throughout the apprenticeship and the apprentice is assessed at the end, a process known as End Point Assessment (EPA). There are some apprenticeship Standards which do include a formal qualification: this is often, though not always, where a professional registration is required to work in the relevant occupation.

A **'new recruit apprentice'** is an individual who has applied for and been appointed to an advertised apprenticeship vacancy. This would include an existing member of staff who applies for such a post.

An **'existing post holder apprentice'** refers to a member of Trust staff who is undertaking an apprenticeship to support development in their current role. They were not initially appointed to an apprenticeship and have not been appointed to a new post to undertake the apprenticeship.

A **'regional programme apprentice'** is an apprentice undertaking an apprenticeship on one of the Health Education England (HEE)-funded or part-funded regional programmes, and where HEE may be the training provider. These programmes are currently:

- Pharmacy Technician Level 3.
- Dental Nursing Level 3.
- Estates apprenticeships, including Engineering and Construction.

An **'on programme apprentice'** describes any individual on an apprenticeship, at any point in the apprenticeship.

'Employer Provider' is a status awarded by the ESFA to employers who have successfully applied to be included on the Register of Apprenticeship Training Providers (RoATP). Employer Provider status allows an employer to use levy funds for delivery of apprenticeship training and assessment to their own staff only; they may not deliver any part of an apprenticeship to anyone other than their own employees.

An **'Employer Provider apprentice'** is an apprentice for whom the Trust is both employer and training provider. These are apprenticeships delivered by the Trust under its 'Employer Provider' agreement with the ESFA. The Trust will be in scope for Ofsted inspection in relation to these apprentices.

An **'Employer Only apprentice'** is an apprentice who is employed by the Trust, but whose apprenticeship is contracted to a university, college or training provider (known as a 'main provider'). These apprentices will not be in scope for the Trust's Ofsted inspection, but will be in scope for their main provider's inspection.

Appendix 2: ESFA requirements for Employer Providers to evidence the cost of apprenticeship delivery.

Appendix 3: ESFA definitions of eligible and ineligible costs.

Appendix 4: ESFA definition of what constitutes off-the-job training.

Appendix 5: ESFA requirements for Evidence Pack contents.

All of the above information can be found within the Funding Rules and Guidance Document at: https://www.gov.uk/guidance/apprenticeship-funding-rules-for-employer-providers/evidence-requirements

Alternatively please contact the Apprenticeship Team for advice and guidance.

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Equality Analysis Form A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

PART 1

1. **Assessment Date:** [ ]

2. **Name of policy / strategy / service**:

   Apprenticeship Policy

3. **Name and designation of Author:**

   Alan Weightman – Senior Workforce Development Officer

4. **Names & designations of those involved in the impact analysis screening process:**

   Alan Weightman – Senior Workforce Development Officer

5.

Is this a:	Policy	x	Strategy		Service	
Is this:	New		Revised	x		
Who is affected	Employees	x	Service Users		Wider Community	

6. **What are the main aims, objectives of the policy, strategy, or service and the intended outcomes?** (*These can be cut and pasted from your policy*)

   - ESFA and DfE apprenticeship rules are adhered to at all times.
   - Effective use of the apprenticeship levy to support the launch of new careers and the development of existing staff.
   - That the Trust has regard for the public body apprenticeship target.
   - The delivery of high quality apprenticeships.
   - The fair remuneration of the Trust's apprentices.

7. **Does this policy, strategy, or service have any equality implications?** **Yes** [x] **No** [ ]

   If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:

8. Summary of evidence related to protected characteristics

Protected Characteristic	Evidence, i.e. What evidence do you have that the Trust is meeting the needs of people in various protected Groups	Does evidence/engagement highlight areas of direct or indirect discrimination? If yes describe steps to be taken to address *(by whom, completion date and review date)*	Does the evidence highlight any areas to advance opportunities or foster good relations. If yes what steps will be taken? *(by whom, completion date and review date)*
Race / Ethnic origin (including gypsies and travellers)	**Note: The Trust is committed to creating an organisation that actively promotes equality of opportunity for all and ensuring that no-one receives less favourable treatment in any aspect of their employment in relation to any of the protected characteristics. (Equality, Diversity and Inclusion Policy, March 2019).** Apprenticeship performance data, such as achievement and retention rates, includes monitoring of ethnicity as a measure. All apprentices are provided with information on the Trust's BAME Staff Network at Induction.	No. Apprenticeship numbers and therefore achievements are still low. While it is still difficult to establish themes or trends, the evidence to date does not highlight any areas of discrimination. The data will become more robust as numbers grow. This will apply to all protected characteristics.	
Sex (male/ female)	Apprenticeship performance data, such as achievement and retention rates, includes monitoring of sex as a measure.	No. Of 353 apprentice starts since April 2017, 275 (78%) have been female and 78 (22%) male.	
Religion and Belief			
Sexual orientation including lesbian, gay and bisexual people	All apprentices are provided with information on the Trust's LGBT Staff Network at Induction.		
Age	Apprenticeship performance data, such as achievement and retention rates, includes monitoring of age as a measure.	No. The age range of NuTH apprentices is 16 to 63.	
Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section	The Initial Assessment process is used to identify additional learning and support needs or barriers to learning that may impact on the apprentice's ability to progress. This is in addition to the standard checks carried out at recruitment. Apprenticeship performance data, such as achievement and retention rates, includes monitoring of disability/learning difficulty as a measure. All apprentices are provided with information on the	No. Of the 340 apprentices who provided the information, 28 (8%) declared that they had a disability or learning difficulty.	

	Trust's Disability Staff Network at Induction.		
Gender Re-assignment	Gender Transition at Work Policy.		
Marriage and Civil Partnership			
Maternity / Pregnancy	Breaks in learning due to maternity/pregnancy are supported according to Trust policy, which applies equally to apprentices as to other staff.		

9. Are there any gaps in the evidence outlined above? If 'yes' how will these be rectified?

10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.

Do you require further engagement? Yes [ ] No [x]

11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?

No

PART 2

Name:

Alan Weightman

Date of completion:

6 April 2020

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Employment Policies and Procedures

Banding of Posts Procedure

Version No.:	7.0
Effective From:	19 May 2021
Expiry Date:	19 May 2024
Date Ratified:	10 May 2021
Ratified By:	Executive Group

General Policy Statement

This policy applies to all requests for the banding of posts covered by the NHS Terms and Conditions of Service Handbook excluding Medical and Dental Staff. It should also ensure consistency of approach in handling requests for the banding of posts under Job Evaluation.

For the purposes of this policy, banding issues fall into the following categories:

a) a rebanding request initiated by an employee
b) a rebanding request initiated by a manager, including rebanding following a workforce re-profiling exercise
c) bandings initiated externally (as a result of national directives binding on the Trust)
d) banding of new posts

1 Duties (Roles and responsibilities)

1.1 The Executive Team is accountable to the Trust Board for ensuring Trust-wide compliance with policy.

1.2 Directorate managers and heads of service are responsible to the Executive Team for ensuring policy implementation.

1.3 Managers are responsible for ensuring policy implementation and compliance in their area(s).

1.4 Staff are responsible for complying with policy.

2 General Principles

2.1 Job descriptions should clarify the duties and responsibilities inherent in a job. They should not contain value judgements about the nature of the job.

2.2 Job descriptions should be prepared and submitted using the standard template available here.

2.3 It is the responsibility of the Line Manager and/or Directorate Manager/Head of Department, in conjunction with their Human Resources Officer to ensure that a job description has been written correctly and that the content is relevant and accurate, before submission for evaluation.

2.4 The request for evaluation must go through the Recruitment Control Group (RCG) prior to the job description being evaluated. The RCG form should have a provisional banding and “banding to be confirmed via Job Evaluation” written clearly on it.

2.5 The job matching panel will not consider any job description unless written, supporting documentation from the appropriate Line Manager and/or Directorate Manager/Head of Department has also been submitted. The supporting information required is noted in the appropriate section below.

2.6 The pay band of a particular position will be determined by the outcome of the job matching process. It is not related to the capability of the individual performing the job.

3 Procedure

3.1 Rebanding Request Initiated by Employee

a) The post holder(s) and line manager and/or Directorate Manager/Head of Department (with advice from their Senior Human Resources Advisor) will agree a new job description and complete the rebanding request form available here , which should include details of how any potential increase in band will be funded.

b) The rebanding request form and job description should be submitted to the
Recruitment Control Group (RCG).

c) Any recommendation by the RCG to refer the job for matching will be forwarded to the Executive Team.

d) If further information is required (by either the RCG or Executive Team) this will be requested from the Directorate Manager/Head of Department. Where such information concerns the content of the job description, the Directorate Manager/Head of Department will agree it with the post holder.

e) If the request is approved, the job description will be referred for matching.

f) If the request is not approved, the Directorate Manager/Head of Department will be informed. They should then inform the post holder.

g) All outcomes of panel matching/evaluation are subject to approval by the Head of HR Services

h) If the outcome of matching is a change in band, it will be submitted to the RCG for consideration. The RCG will then make a recommendation to the Executive Team. The Directorate Manager/Head of Department will be advised of the outcome accordingly and they will inform the post holder. The change of band will be effective from the date the banding was confirmed or the date the duties became effective, if later.

i) A new job description will not be accepted for consideration unless agreed by the employee, the line manager and/or Directorate Manager/Head of Department. The current band of the post should not be identified to the matching panel.

j) Should the post holder or line manager require the assistance of a Job Analyst to produce a new job description, this will be arranged by their Human Resources Officer on request

3.2 Review and/or Redesign Request Initiated by Manager

a) Where a line manager initiates a request to review and/or redesign post(s), for instance, in relation to organisational change, workforce re-profiling, or where the original requirements for the post have changed, a new job description will be submitted for banding by the manager. The process will follow the core principles outlined in Annex 24 of the NHS Terms and Conditions of Service Handbook and the NHS Job Evaluation Handbook . Where agreement cannot be reached on a revised job description the Trust's 'Failure to Agree' process should be initiated.

b) The line manager and/or Directorate Manager/Head of Department and the post holder(s) (with advice where necessary from their Human Resources Officer) will aim to agree a new job description in partnership. Once finalised the line manager and/or Directorate Manager/Head of Department will complete the rebanding request form here. The request should include details of how any potential increase in band would be funded.

c) The rebanding request form and job description should be submitted to the
Recruitment Control Group (RCG).

d) Any recommendation by the RCG to refer the job for matching will be forwarded to the Executive Team.

e) If further information is required (by either the RCG or Executive Team) this will be requested from the Directorate Manager/Head of Department. Where such information concerns the content of the job description, the Directorate Manager/Head of Department will aim to agree it with the line manager and the employee.

f) If the request is approved, the job description will be referred for matching.

g) If the request is not approved, the Directorate Manager/Head of Department will be informed.

h) All outcomes of panel matching/evaluation are subject to approval by the Head of HR Services

i) A newly banded post should not be advertised or filled until approval from the Executive Team is received.

j) If the outcome of matching is a change in band, it will be submitted to the RCG for consideration. The RCG will then make a recommendation to the Executive Team. The Directorate Manager/Head of Department will be advised of the outcome accordingly and they will inform the post holder. The change of band will be effective from the date the banding was confirmed or the date the duties became effective, if later. Re-banding as a consequence of workforce re-profiling and/or organisational change and redundancy may attract pay protection in accordance with the Trust's Organisational Change and Redundancy Policy. Pay will not be protected in any other circumstance.

k) The current band of the post should not be identified to the matching panel.

l) Should the line manager require the assistance of a Job Analyst to produce a new job description, this will be arranged by their Senior Human Resources Advisor on request.

3.3 Rebanding Request Initiated Externally

a) The Director of Human Resources is the focal point for receipt of all conditions of service advice from national level including revised national pay agreements and banding criteria/guidelines.

b) On receipt of documentation which has implications for the revision of pay structures, the Director of Human Resources will:

   i. inform the Executive Team and seek direction on implementation
   ii. communicate with managers and Staff Representatives on any method and timescale for implementation
   iii. inform affected staff/staff groups of the relevant change(s)

c) Where appropriate, individuals affected by nationally determined pay and conditions changes shall be notified in writing. This will include information concerning the new band, salary scale and salary point to be applied together with the date on which the new provisions take effect. Arrangements for individual reviews, should there be a right of review, will also be referred to.

3.4 Banding of New Posts

a) The line manager and Directorate Manager/Head of Department will agree a new job description which should include details of how any potential increase in band will be funded.

b) The job description should be submitted to the Recruitment Control Group (RCG).

c) Any recommendation by the RCG to refer the job for matching will be forwarded to the Executive Team.

d) If further information is required (by either the RCG or Executive Team) this will be requested from the Directorate Manager/Head of Department. Where such information concerns the content of the job description, the Directorate Manager/Head of Department will agree it with the staff side representatives involved.

e) If the request is approved, the job description will be referred for matching.

f) If the request is not approved, the Directorate Manager/Head of Department will be informed. They should then inform the line manager and staff side representatives involved.

g) The remainder of the process in respect of the banding of new posts marries with that identified for rebanding requests initiated by the line manager as detailed in section 6.2 h of this policy.

h) A new post should not be advertised or filled until approval from the Executive Team is received.

4 Operation of Matching/Evaluation Panel

4.1 All members of a job matching/evaluation panel will have completed appropriate training in the NHS Job Evaluation Scheme.

4.2 The panel will consist of a minimum three members comprising of Management and Staff representatives.

4.3 Panel members should not be from the same work area as the post holder.

4.4 Should panel members have a query on a job description being evaluated, they will contact the appropriate manager by telephone.

4.5 The employee and their Directorate Manager/Head of Department may be asked to attend the panel and the panel may seek 'specialist' advice from within or out with the Trust to assist in reaching a matching outcome, however, neither is a requirement.

If the job description cannot be matched against a national profile, the manager, in conjunction with the Head of HR Services (or as delegated), can decide to review the job description and submit a new one. Exceptionally, the job may be referred for local evaluation (Job Analysis Questionnaire [JAQ]). A JAQ must be agreed and signed by the line manager and/or Directorate Manager/Head of Department. The JAQ will be evaluated by a job evaluation panel in accordance with the NHS Job Evaluation Handbook.

4.6 The job matching/evaluation panel will forward their decision to the Head of HR Services for approval. This will then be submitted to the RCG followed by the Executive Team for consideration.

4.7 The decision of the Executive Team will be notified in writing (via email) to the relevant manager and RCG Panel within 4 weeks of the date on which the job description was matched/evaluated.

4.8 The Directorate Manager/Head of Department should inform the post holder.

4.9 The Workforce Services team will be responsible for ensuring the administration of any change to the post holder's contract of employment and ESR.

4.10 For rebanding requests, the Directorate Manager/Head of Department will receive a copy of the job match report and the post holder will be advised of their right to seek a review of their job description. (See Section 8 for further details of the review procedure).

4.11 The date of implementation of a rebanding will normally be the date the job description band is confirmed or the date the duties become effective if later.

4.12 Rebanding to a higher band will be dealt with in accordance with the provisions for promotion contained in the NHS Terms and Conditions of Service Handbook.

4.13 If a post is rebanded, it may no longer be eligible for certain additional payments to salary. For example, overtime is not payable at band 8 and above. Any overpayment that occurs as a result of rebanding will be repayable in accordance with the Trust's Overpayment procedure.

4.14 In the event of rebanding to a lower band, pay protection will not normally apply. Any overpayment of salary for the period between the date the former band was effective from and the date the lower band was effective from, will be repayable by the post holder. The length of the repayment period will be the same as the period over which the overpayment was paid. Re-banding as a consequence of workforce re-profiling and/or organisational change and redundancy may attract pay protection in accordance with the Trust's Organisational Change and Redundancy Policy.

5 Review Requests

5.1 A post holder can seek a review of their new/changed job description if new or changed information relating to the responsibilities of the post was not available to the matching/evaluation panel. The post holder may also include information which they feel may not have been fully taken into account by the panel.

5.2 A review request must be received within 28 calendar days of notification of the job matching/evaluation panel's decision and must be submitted using the form available here.

5.3 The preliminary stage of the review will consist of an informal meeting between the post holder and a nominated Senior Human Resource Advisor and Staff Representative.

5.4 If requested by the post holder the post holder's own Staff Representative and/or line manager may be present.

5.5 The outcome of the preliminary stage can be one of the following:

a) the post holder withdraws their review request because they better understand and accept the original outcome. There should be no pressure on the post holder to withdraw their review request

b) the post holder better understands what information will be required by the panel in order to consider the review request

c) the post holder is better able to focus on those JES factors which are relevant to a review in their particular circumstances

5.6 Following the preliminary stage the job description submitted to the first panel and the review form will be submitted to another panel for a fresh look at all of the job factors. The second panel will not have access to the outcome of the first panel and the majority of its members will be different.

5.7 The outcome of a review panel can be one of the following:

a) Job Matching

i. The job description is matched to the same national profile at the same band
ii. The job description is matched to the same national profile at a different band (higher or lower)
iii. The job description is matched to a different national profile at the same band
iv. The job description is matched to a different national profile at a different band (higher or lower)
v. The job description is not matched to a national profile. In these circumstances, the manager in conjunction with the Head of HR Services, can decide to review the job description and submit a new one. Exceptionally, the job may be referred for local evaluation (Job Analysis Questionnaire [JAQ])

b) Local Evaluation

i. The job description is evaluated at the same or a different band (higher or lower)

5.8 Rebanding to a higher band will be dealt with in accordance with the provisions for promotion contained in the NHS Terms and Conditions of Service Handbook and be effective from the date of the original job matching decision.

5.9 Where a job description is banded lower the same rules apply as in section 4.14 above.

5.10 The review procedure –is final; there is no further right of appeal.

6 Misapplication of Process

6.1 In the event that a post holder can demonstrate that the process for banding their
job description was misapplied, they can raise a complaint.

6.2 The complaint must relate to process and not against the matching or pay banding decision.

6.3 The complaint must be made in writing to the Head of HR Services and be received within 28 calendar days of receiving the notification of the decision of the matching/evaluation/review panel.

6.4 The Head of HR Services will arrange for the complaint to be investigated and will inform the post holder of the outcome.

6.5 Where a complaint is upheld, the job description will be referred to a new matching/evaluation panel consisting of members who have not previously been involved in matching/evaluating the post. The outcome of this panel will be final.

6.6 There will be no recourse to the Trust's Grievance Procedure on matters related to the process for the banding of posts and/or the outcome.

7 Consistency Check

All posts banded under this procedure will be subject to consistency check by a panel trained in the NHS Job Evaluation Scheme which will consist of a minimum of one Management and one Staff representative.

8 Training

Training will be provided where requested by the Human Resources Department to managers following implementation of the procedure.

9 Equality and Diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way services are provided and the way staff are treated reflects their individual needs and does not unlawfully discriminate against individuals or groups. This policy has been properly assessed.

10 Monitoring Compliance with the Policy

Standard / Process / Issue	Monitoring and Audit			
	Method	By	Committee	Frequency
Monitoring to identify that banding of posts is conducted fairly and consistently	Reporting of information on ESR	Director of Human Resources	Heads of Human Resources Meeting	Annually

11 Consultation and Review of this Policy

This policy has been reviewed in consultation with the Employment Policies and Procedures Consultative Group

12 Implementation of the Policy (including raising awareness)

A summary of the key changes will be notified to managers following implementation. Further advice and guidance will be available from the Human Resources Department.

13 References

1. Agenda for Change Handbook

2. NHS Job Evaluation Scheme Handbook

14. Additional Documents

- Organisational Change and Redundancy Policy
- Overpayment Procedure
- Banding of Posts Forms (Intranet)

Author: Employment Policies and Procedures Consultative Group

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Equality Analysis Form A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

PART 1

1. **Assessment Date:**

2. **Name of policy / guidance/ strategy / service development / Investment plan/Board Paper**:

   Banding of Posts

3. **Name and designation of author:**

   Victoria Usher; HR Manager.

4. **Names & Designations of those involved in the impact analysis screening process:**

   HR Heads, EPPCG

5. **Is this a:** Policy × Strategy ☐ Service ☐ Board Paper ☐

   Is this: New ☐ Revised ×

   Who is affected: Employees × Service Users ☐ Wider Community ☐

6. **What are the main aims, objectives of the document you are reviewing and what are the intended outcomes?** *(These can be cut and pasted from your policy)*

   The policy sets out a framework for requests for the banding of posts covered by the NHS Terms and Conditions of Service Handbook excluding Medical and Dental Staff. It also ensures consistency of approach in handling requests for the banding of posts under Job Evaluation.

7. **Does this policy, strategy, or service have any equality implications? Yes ☐ No ×**

If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:

The policy sets out the process given under the NHS Terms and Conditions of Service

8. **Summary of evidence related to protected characteristics**

Protected Characteristic	**Evidence** **What evidence do you have that the Trust is meeting the needs of people in all protected Groups related to the document you are reviewing–** please refer to the Equality Evidence within the resources section at the link below: http://nuth-vintranet1:8080/cms/SupportServices/EqualityDiversityHumanRights.aspx	**Does evidence/engagement highlight areas of direct or indirect discrimination?** For example differences in access or outcomes for people with protected characteristics	**Are there any opportunities to advance equality of opportunity or foster good relations**? If yes what steps will be taken? (by whom, completion date and review date)
Race / Ethnic origin (including gypsies and travellers)	The trust has the following provisions; ▪ Provision of Interpreters ▪ Information available in other formats on request ▪ Mandatory EDHR Training ▪ Trust partnership work with 3rd sector organisations ▪ BAME Staff Network	No, EDI monitoring should take place however	EDI monitoring should take place on a recurrent basis
Sex (male/ female)	▪ Mandatory EDHR Training ▪ Women's Health and Sexual Health Services available for advice and support ▪ Trust partnership work with 3rd sector organisations	As above	As above
Religion and Belief	▪ Chaplaincy Team available for advice and support. ▪ Religion, Belief and Cultural Practices	As Above	As above

	Policy and Guidance		
Sexual orientation including lesbian, gay and bisexual people	▪ Mandatory EDHR Training ▪ Trust partnership work with 3rd sector organisations ▪ Trust activities at Northern Pride ▪ LBGBT Staff Network	As above	As above
Age	▪ Mandatory EDHR Training ▪ Trust partnership work with 3rd sector organisations	As above	As above
Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section	▪ Occupational Health ▪ Psychological and Mental Health Services ▪ Rehabilitation Services ▪ Professions Allied to Medicine services ▪ Accessible Information Standard ▪ Provision of BSL Signers and Deaf Blind Guides ▪ LD Liaison Nurse, flagging of learning disability and patient passport. ▪ Trust work to support Carers ▪ Mandatory EDHR Training ▪ Trust partnership work with 3rd sector organisations ▪ Disability Staff Network	As above	As above
Gender Identity / Expression	▪ Trust Gender Identity Working Group ▪ Mandatory EDHR Training ▪ Trust partnership work with 3rd sector organisations	As above	As above
Marriage and Civil Partnership	▪ Mandatory EDHR Training	As above	As above
Maternity / Pregnancy	▪ Maternity Services available for advice and support. ▪ Breast Feeding Policy and signage	As above	As above

	▪ Mandatory EDHR Training ▪ Trust partnership work with 3rd sector organisations		

9. Are there any gaps in the evidence outlined above. If 'yes' how will these be rectified?

Gathering information will help identify and address any issues.

10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.

Do you require further engagement Yes No x

11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?

No impact envisaged

PART 2

Signature of Author

Victoria Usher

Print name

Victoria Usher

Date of completion

14/01/2021

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)

The Newcastle Upon Tyne Hospitals NHS Foundation Trust

Employment Policies and Procedures

Capability: Dealing with Concerns Regarding Medical and Dental Practitioners

Version No.:	9.0
Effective Date:	10 February 2023
Expiry Date:	10 February 2026
Date Ratified:	06 February 2023
Ratified by:	Heads of HR

GENERAL POLICY STATEMENT

The Newcastle upon Tyne Hospitals NHS Foundation Trust recognises the value of its workforce and is committed to supporting staff to provide high quality patient care.

The efficiency and effectiveness by which the Trust discharges its responsibilities depends to a large extent on the ability of all its employees to achieve and maintain high standards of personal job performance.

In order to achieve the necessary standards, practitioners must be aware of what is expected of them & clinical managers have a personal responsibility to ensure that this is communicated. Open communication is encouraged to ensure understanding of those expectations.

Wherever possible, the Trust will aim to resolve issues of capability (including clinical competence and health) through ongoing assessment and support at local level. Early identification of problems is essential to reduce the risk of harm to patients.

However sometimes concerns are sufficiently serious that the Medical Director determines a more formal route is appropriate and that a formal investigation should be undertaken.

1 Policy Statement

The purpose of this policy is to ensure there are mechanisms in place to:

- identify concerns about Medical and Dental practitioners
- provide help and support to practitioners to achieve acceptable levels of performance
- resolve concerns without resorting to formal procedures where appropriate
- manage cases which require more formal investigation

2 Aim of Policy

The aim of this policy is to provide guidance to Clinical Directors and Medical and Dental practitioners. The policy sets out guidance on:

- Rights and responsibilities
- Acting on concerns
- Categorisation of concerns
- Management of concerns, including the procedures for restricting practice, exclusion from the workplace, Capability and Appeal Hearings.

3 Scope

3.1 The procedure applies to all Medical and Dental practitioners employed and working within the Trust. It outlines the procedures to be followed when a concern is raised about a doctor or a dentist.

3.2 If it is considered that failure to achieve the required standard of job performance is because of carelessness, lack of effort or negligence by the individual, then the matter will be dealt with as a conduct issue.

3.3 Ill health issues will be taken into account. Arrangements for handling concerns about a practitioner's health are described in Appendix 1.

3.4 Concerns about the capability of doctors and dentists in training should be considered initially as training issues and the postgraduate dean should be involved from the outset. Any allegation of misconduct against a doctor or dentist in recognised training grades may be considered initially as a training issue and dealt with via the educational supervisor and college or clinical tutor with close involvement of the postgraduate dean from the outset.

3.5 The Trust has developed strong co-partnership relations and there is a joint protocol between Newcastle University and the Trust which includes arrangements for dealing with any concerns about practitioners with honorary contracts.

4 Roles and responsibilities

4.1 The Executive Team is accountable to the Trust Board for ensuring Trust-wide compliance with policy.

4.2 The Medical Director and Clinical Directors are responsible to the Executive Team for ensuring policy implementation.

4.3 Medical and Dental practitioners are responsible for complying with this policy.

5 Action When a Concern Arises

5.1. The management of performance is a continuous process. Concerns about a practitioner's conduct and/or capability can come to light in a wide variety of ways:

- Concerns expressed by other NHS professionals, health care managers, students and non-clinical staff. Any concerns raised verbally should wherever possible subsequently be confirmed in writing.

- Review of performance against job plans, annual appraisal, revalidation.
- Monitoring of performance data / quality of care.
- Clinical governance, clinical audit and other quality improvement activities.
- Patient Complaints.
- Information from the regulatory bodies.
- Litigation following allegations of negligence.
- Information from the police or coroner.
- Court judgements.

5.2 Concerns about the capability of a practitioner may arise from a single incident or a series of events, reports or poor clinical outcomes. The Trust will consider whether the matter raises questions about the practitioner's capability as an individual (health problems, behavioural difficulties or lack of clinical competence) or whether there are other matters that need to be addressed.

5.3 Once identified remedial and supportive action should be taken quickly by clinical managers to ensure identified problems do not become serious or lead to patient harm.

5.4 Not all actions will require formal investigation or recourse to formal procedures. An assessment should be made on a case by case basis.

6 Categorisation of concerns

6.1 It is for the Medical Director to determine whether a case should be categorised as Level 1 or Level 2. HR will provide advice and support.

6.1.1 Level 1 Capability Concerns

May include, but not limited to, less serious concerns around non clinical skills which have the potential to be managed and resolved without resorting to formal procedures.

Examples may include but not limited to:

- ineffective clinical team working skills
- inability to communicate effectively
- inappropriate delegation of clinical responsibility
- inadequate supervision of delegated clinical tasks
- poor overall organisation in the job
- targets or deadlines not being met

6.1.2 Level 2 Capability Concerns

May include, but not limited to, more serious concerns about clinical practice for which formal investigation under this procedure is appropriate, or issues previously identified as Level 1 which have not improved. These are concerns which, if proven, may result in a final written warning or termination of contract.

Examples may include but not limited to:

- clinical practice which has the potential to put patients at risk or does cause actual harm to patients arising from a lack of knowledge, aptitude, experience or skills
- issues previously identified as Level 1 have not improved to the required standard despite local interventions.

6.2 For concerns identified as Level 2, the Medical Director will usually determine a more formal route is appropriate and that a formal investigation should be undertaken. HR will provide advice and support. The procedure is outlined in the Formal Capability Procedure to Address Concerns Regarding Competence of Medical and Dental Practitioners.

7 Managing Level 1 Capability Concerns

7.1 The Medical Director will determine how the case should be managed. HR will provide advice and support. This may involve but is not limited to:

- retraining
- performance review
- counselling
- coaching
- mentoring; and/or
- formal mediation.

7.2 Where issues may be resolved in this way the Medical Director will nominate an appropriate senior clinician to draw up, agree and oversee an action plan with the practitioner designed to enable the practitioner to remedy any lack of capability that has been identified. The Trust will facilitate the agreed action plan. The action plan will identify:

- a clear description of the issue(s)
- details of the improvement(s) required
- what needs to be achieved to demonstrate satisfactory performance
- what further support will be provided,
- monitoring, review and variance of the workload as required, including timescales
- method of reviewing and monitoring standards of performance in respect of the agreed objectives and requirements of the job, including timescales
- review and monitoring of any supervision levels, including timescales
- confirmation that in the event of insufficient improvement, formal action may be taken

7.3 Frequently, in Level 1 cases, it is anticipated that the Practitioner will recognise and accept the need to address capability issues, therefore a formal investigation is unlikely. However an individual always retains the right to challenge allegations and the Medical Director always has the right to

commission a formal investigation. In such cases, any investigation will be carried out by adopting the same processes as in Level 2 cases.

Training

Opportunities for training will be provided by the Human Resources Department.

Equality and Diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way services are provided and the way staff are treated reflects their individual needs and does not unlawfully discriminate against individuals or groups. This policy has been properly assessed.

Monitoring Compliance with the Policy

Standard / Process / Issue	Monitoring and Audit			
	Method	**By**	**Committee**	**Frequency**
Monitoring will include Identifying the number of employees subject to formal action Monitoring the timeliness of process start and end dates	Reporting of information on the Electronic Staff Record	Director of Human Resources	Heads of Human Resources Meeting	Annually

Consultation and Review of this Policy

This policy has been reviewed in consultation with the Employment Policies and Procedures Consultative Group

Implementation of the Policy (including raising awareness)

A summary of the key changes will be notified to managers following implementation. Further advice and guidance will be available from the Human Resources Department.

References

Practitioner Performance Advice (formerly NCAS) found at:
https://resolution.nhs.uk/services/practitioner-performance-advice/

Additional Documents

Health, Wellbeing and Attendance Management

Appendix 1

Handling Concerns about a Practitioner's Health

1 Introduction

1.1 A wide variety of health problems can have an impact on an individual's clinical performance. These conditions may arise spontaneously or be as a consequence of work place factors such as stress.

1.2 The principle for dealing with individuals with health problems is that, wherever possible and consistent with reasonable public protection, they should be treated, rehabilitated or re-trained and kept in employment, rather than be lost from the NHS.

2 Retaining the services of individuals with health problems

2.1 Wherever possible the Trust will seek to continue to employ the practitioner provided this does not place patients or colleagues at risk. The Trust will consider the following actions for practitioners with health problems

- Sickness absence during which the practitioner will be managed under the Trust's Employee Wellbeing Policy

- Where a condition is considered likely to be a disability, the Trust is required under the Equality Act to consider reasonable adjustments. These are many accommodations, modifications or provisions made in the workplace to allow a person with disability to work effectively. Reasonable adjustments can be made on a temporary or permanent basis depending on the situation i.e. removal of the practitioner from certain duties or reassignment to a different area of work, re-training, consideration of Ill-health retirement.

3 Handling Health Issues

3.1 Where there is an incident that points to a problem with the practitioner's health, the incident may need to be investigated to determine whether a health problem exists. If the report recommends Occupational Health involvement, the nominated manager must immediately refer the practitioner to the Occupational Health Service.

3.2 The Occupational Health Service will agree a course of action with the practitioner and send their recommendations to the Medical Director. A meeting should be convened with HR, the Medical Director or Case Manager, the practitioner and an Occupational Health Physician to agree a timetable of action and rehabilitation (where appropriate).

3.3 The practitioner may wish to bring a support companion to these meetings. This could be a family member or friend, a colleague or a trade union or defence association representative.

3.4 Confidentiality must be maintained by all parties at all times.

3.5 If a practitioner's ill health makes them a danger to patients and they do not recognise that, or are not prepared to co-operate with measures to protect patients, then exclusion from work must be considered in the interests of patient safety, and the professional regulatory body must be informed, irrespective of whether or not they have retired on the grounds of ill health.

3.6 In those cases where there is impairment of performance solely due to ill health, disciplinary procedures should only be considered in the most exceptional of circumstances, for example if the individual concerned refuses to co-operate with the Trust to resolve the underlying situation e.g. by repeatedly refusing a referral to the Occupational Health Service or Practitioner Performance Advice (where this is deemed appropriate).

3.7 It is recognised capability proceedings are stressful for any practitioner and the Trust is mindful of such issues. However, it is also recognised that delay in proceedings, for whatever reason, can prolong or increase stress. Therefore, the fact a practitioner is feeling stress will not delay capability proceedings. Investigations will proceed and meetings will be convened with the practitioner. If the practitioner is unable to attend in person, his or her representative can attend instead or written representations can be made by the practitioner.

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Equality Analysis Form A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

PART 1

1. **Assessment Date:** 30th September 2019

2. **Name of policy / guidance/ strategy / service development / Investment plan/Board Paper**:

   Capability: Dealing with Concerns Regarding Medical and Dental Practitioners

3. **Name and designation of author:**

   Tracy Mitchell - Head of Medical & Dental Resourcing & Trust Reward

4. **Names & Designations of those involved in the impact analysis screening process:**

   EPPCG / HR Heads

5. **Is this a:** Policy X Strategy ☐ Service ☐ Board Paper ☐

   Is this: New ☐ Revised X

   Who is affected: Employees X Service Users ☐ Wider Community ☐

6. **What are the main aims, objectives of the document you are reviewing and what are the intended outcomes?** *(These can be cut and pasted from your policy)*

   The aim of this policy is to provide guidance to Clinical Directors and Medical and Dental practitioners. The policy sets out guidance on:

   - Responsibilities
   - Acting on concerns
   - Categorisation of concerns
   - Management of Level 1 concerns

7. Does this policy, strategy, or service have any equality implications? Yes ☐ No X

If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:

See below

8. Summary of evidence related to protected characteristics

Protected Characteristic	Evidence What evidence do you have that the Trust is meeting the needs of people in all protected Groups related to the document you are reviewing– please refer to the Equality Evidence within the resources section at the link below: http://nuth-vintranet1:8080/cms/SupportServices/EqualityDiversityHumanRights.aspx	Does evidence/engagement highlight areas of direct or indirect discrimination? For example differences in access or outcomes for people with protected characteristics	Are there any opportunities to advance equality of opportunity or foster good relations? If yes what steps will be taken? (by whom, completion date and review date)
Race / Ethnic origin (including gypsies and travellers)	This policy applies to all Medical and Dental staff. The Trust is committed to ensuring that no employee should be treated less favorably on the grounds of their age, disability, race, nationality, ethnic origin, sex, sexual orientation, religion and belief, gender identity / expression, marriage and civil partnership or pregnancy and maternity. – ethnically minoritised groups account for over 10.8% of the Trust's workforce – Trust target 15% – local population (Newcastle) 15% (census 2011) – multi-faith chaplaincy service available for staff and patients – 5.57% of the workforce (consultants) of those 1.24% identify as BME – 1.97% of the workforce (career grades) of those 1.12% identify as BME	As at December 2022 28% of Medical and Dental staff were BME, 69% white and 3% not recorded 55% of those staff who were subject to unsatisfactory work performance were BME and 45% were white	Race Equality Staff Network in Place EDI dashboard in place as part of the performance management framework

Sex (male/ female)	– 5.57% of the workforce (consultants) of those 2.23% identify as female – 1.97% of the workforce (career grades) of those 0.92% identify as female	As at December 2022 44% of Medical and Dental staff were female, 56% were male. 27% of those staff who were subject to unsatisfactory work performance were female and 73% were male	EDI dashboard in place as part of the performance management framework
Religion and Belief	As above		
Sexual orientation including lesbian, gay and bisexual people	– Stonewall Workplace Equality Index top 40 in 2020 – Stonewall Gold Employer 2022 – Rainbow Badge phase II pilot – Silver accreditation 2021		Pride Staff Network in Place EDI dashboard in place as part of the performance management framework
Age	As above		EDI dashboard in place as part of the performance management framework
Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section	– 5.57% of the workforce (consultants) of those 0.04% identify as disabled – 1.97% of the workforce (career grades) of those 0.03% identify as disabled	As at December 2022 1% of Medical and Dental staff identified as disabled 79% identified as not disabled and 20% not recorded 64% of those staff who were subject to unsatisfactory work performance were non-disabled and 0% were disabled	Enabled staff network in place EDI dashboard in place as part of the performance management framework
Gender Identity / Expression			Guidance in place around transitioning for staff and managers
Marriage and Civil Partnership			
Maternity /			

Pregnancy			

9. Are there any gaps in the evidence outlined above. If 'yes' how will these be rectified ?

No

10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.

Do you require further engagement Yes No X

11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?

No

PART 2

Signature of Author

K Pearce / T Mitchell

Print name

Karen Pearce

Date of completion

29 December 2022

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Employment Policies and Procedures

Capability Procedure (for non-medical and dental staff)

Version No.:	6
Effective From:	10 August 2018
Expiry Date:	10 August 2021
Date Ratified:	06 June 2018
Ratified By:	Employment Policies & Procedures Consultative Group

1 Introduction

1.1 The efficiency and effectiveness by which the Trust discharges its responsibilities depends to a large extent on the ability of all its employees to achieve and maintain high standards of personal job performance.

1.2 In order to achieve the necessary standards, employees must be aware of what is expected of them, and managers have a personal responsibility to ensure that this is communicated. Open communication is encouraged to ensure understanding of expectations and during employment, proper training, supervision and encouragement are essential and will require the manager and/or immediate supervisor and employee regularly discussing job performance. Staff appraisal is also an essential part of this process.

1.3 Employees have a personal responsibility to ensure that they understand what standards are expected of them and they commit sufficient personal effort and self determination to achieve and maintain them. The consequence of unacceptable standards may be very serious to the Trust, therefore, depending on the circumstances of the case it may result in formal action.

1.4 In exceptional circumstances, it may be necessary to temporarily redeploy an employee immediately from their normal job in order to address any shortcomings.

2 Scope

2.1 The procedure applies to **all** employees with the exception of the following:

a) any matters concerning the competence of medical and dental staff, for which a separate procedure has been agreed

b) those employees within a probationary period, and with less than two years' continuous service with the Trust.

2.2 If it is considered that failure to achieve the required standard of job performance is because of the carelessness, lack of effort or negligence by the employee then the matter will be dealt with under the Disciplinary Procedure as misconduct.

2.3 Concerns about capability should not be confused with disability. If an employee becomes disabled during their employment it is important to ensure that every effort will be made to retain them in their original position or redeploy them to a suitable alternative post in line with the requirements of the Equality Act 2010 and the Employee Wellbeing Policy.

2.4 Where capability is related to an underlying or on-going health condition, consultation should take place with the employee to seek their opinion about their condition and advice should be sought from Occupational Health. Reasonable adjustments must be considered where they may help to overcome the capability concern. In some circumstances, redeployment is an issue which may need to be discussed with the employee, and whilst there is no obligation on the Trust to create a job where none exists, efforts should be made to identify if there are suitable alternative roles which can be considered.

3 Aims

The aim of this policy is to ensure those staff covered by this policy who do not meet requirements in relation to their capability are supported to improve..

4 Duties (Roles and Responsibilities)

4.1 The Executive Team is accountable to the Trust Board for ensuring Trust-wide compliance with policy.

4.2 Directorate managers and heads of service are responsible to the Executive Team for ensuring policy implementation.

4.3 Managers are responsible for ensuring policy implementation and compliance in their area(s).

4.3.1 The line manager is required to support all employees in his/her team to ensure that they all perform to the best of their ability.

4.3.2 The manager is responsible for ensuring an effective local induction programme is provided to each new employee or an employee promoted to a new post.

4.3.3 During employment the job performance of the employee should be continually assessed. This may include regular supportive 1 to 1 meetings and the formal annual review through the appraisal process.

4.3.4 It is the manager's responsibility to agree with the employee the standards of performance required from the employee as outlined in any performance action plan. The standards should be realistic and defined in respect of quality, quantity, time and cost. This can include the issue of a job description, which sets out the scope, purpose and main tasks of the job, and through the preparation of any further particulars which might affect the

performance in a job, e.g. details of working environment etc

4.3.5 The line manager is responsible for monitoring the progress of any employee who is working in accordance with a performance action plan, providing support and training (when relevant) to the employee, and identifying and addressing, where appropriate, any issues that arise which mean the targets within that plan are or are not being met.

4.4 Staff are responsible for complying with policy.

4.4.1 All employees are required to work effectively, and to perform to the highest standard achievable.

4.4.2 If the employee is struggling in any area of their work, they should speak to their line manager and ask for assistance.

4.4.3 The employee is responsible for working with their line manager to agree an appropriate way to address any capability difficulties. The employee is responsible for engaging fully with the capability procedure, including identifying action points to improve performance.

4.4.4 The employee is responsible for attending any learning and development activities that are planned to enhance their performance at work.

4.5 The Human Resources department is responsible for supporting the line manager and employee in their attempts to address any capability issues. The HR department will do this through:

- Advising the line manager on the processes to follow
- Contributing to the identification of any appropriate learning and development tools
- Meeting with the line manager and employee if required
- Giving any other advice as required
- Supporting with the redeployment process, if required
- Signposting the employee to support mechanisms, if this would be beneficial, for example, a Contact Officer, Trade Union or Chaplaincy

5 Definitions

Capability refers to the skills, aptitude, and health, impacting on the quality of work of an employee and their ability to carry out their role successfully. It may also include the requirement to attain or maintain 'qualifications', i.e. the academic, technical or professional qualification relevant to the position held by the employee. Factors such as skills/knowledge, experience and health may impact on capability.

Concerns about an employee's capability may be evident from a variety of information or observations including:

a) lack of proficiency or poor overall organisation in the job
b) lack of aptitude, skill or experience
c) personal difficulties
d) re-organisation or redefinition of the role
e) targets or deadlines not being met
f) difficulty in maintaining good working relationships with colleagues
g) lack of understanding by the employee related to the duties, priorities or goals of their role

6. Performance Management Procedure

6.1 Overview

6.1.1 This procedure is intended as a framework to use when performance concerns are identified and may need to be adapted to suit the needs of each situation. It may not be appropriate to follow each stage in turn or within the timeframes proposed and the Trust will take individual circumstances into account.

6.2 Counselling

6.2.1 As soon as a concern is identified by either a line manager or an employee, the issue should be discussed between the employee and nominated or designated manager/supervisor. At this time the employee's job performance will be reviewed to fully consider achievement of objectives/Personal Development Plan (PDP) and competency. This is to enable the manager to assess whether job requirements are being met. In these circumstances, both parties should have every opportunity to resolve problems or issues through discussion, and make any comments and suggestions for improvement.

6.2.2 This discussion will form the basis of a documented performance action plan, which will include details of any training and support offered to assist the employee to achieve the necessary improvements. The agreed action plan will clearly identify a review date and the plan for assessment during the interim period. A summary of the discussion, along with the documented action plan

should be sent to the employee as soon as reasonably practicable.

6.2.3 If this does not resolve the problem or the matter is more serious, there may be a need to use the formal procedure.

6.3 Formal Procedure

6.3.1 The formal procedure will normally follow a progressive escalation system (stage 1,2 and 3), whereby if counselling or the previous stage has not resulted in the improvement required, the next stage will be implemented. Management reserve the right to implement the procedure at any stage considered relevant to the individual circumstances.

6.3.2 Each formal stage of the procedure (stage 1,2 and 3) will prompt a meeting where an assessment of performance against an action plan will take place, followed by subsequent periods of interim review. Failure to achieve the required level of performance will result in the process proceeding to the next stage. This can include going to the next stage before the expiry of the assessment period.

6.3.3 Where formal action against an employee is considered necessary because of their performance, the level of action will depend on the circumstances. Action, at any level (including dismissal) can be taken at any stage of the Capability Procedure.

6.3.4 Redeployment may be considered at Stage 2 and **must** be explored at Stage 3, in accordance with the Redeployment policy and procedure.

6.3.5 Meetings held under the formal procedure must take place in accordance with the levels of authority as set out in Appendix A of the Disciplinary Policy. A member of the HR Department must also be present.

6.3.6 Once it has been determined that a Stage 1,2 or 3 meeting is required, the employee must be notified in writing, giving at least five working days' notice of the time, date and place of the meeting and the right to be accompanied by a trade union representative or workplace colleague. The correspondence will include copies of all previous documentation including:

a) notes of any previous meetings
b) letters of outcomes of any previous meetings
c) any previously agreed action plans
d) notes of any interim reviews of the action plans

The written confirmation must also include what the outcome of the meeting could be, for example a formal warning, demotion, redeployment or dismissal.

6.3.7 Where the chosen companion is unable to attend the meeting on the date proposed, then an alternative date and time may be offered as long as it is reasonable and falls within five working days of the originally proposed date.

6.3.8 If the employee fails to attend a meeting under the formal capability procedure and the meeting proceeds in their absence, the outcome will be decided on the information available and communicated to the employee in writing.

6.3.9 The purpose of meeting(s) is to:

- discuss job performance, including objectives/PDP and competency
- state factual examples of unsatisfactory performance
- state the standards required in terms of duties, outputs and targets
- identify what needs to improve and why
- explain the potential consequences for the employee if their performance continues to be unsatisfactory
- provide an opportunity for the employee (and/or their representative) to make any representations, express their opinion and/or offer any mitigation

6.3.10 At the meeting(s), an action plan should be developed and agreed to include some, or all of the following:

a) a clear description of the performance issue(s)
b) an acknowledgement of what's working well, or where there has been improvement
c) details of the improvement(s) required
d) what needs to be achieved to demonstrate satisfactory performance
e) what further support will be provided, for example, to meet any training needs to facilitate improvement
f) monitoring, review and variance of the workload as required, including timescales
g) method of reviewing and monitoring standards of performance in respect of the agreed objectives and requirements of the job, including timescales
h) review and monitoring of the supervision levels, including timescales
i) confirmation that in the event of insufficient improvement, formal action may be taken

A copy of the action plan should be given to the employee.

6.3.11 Monitoring and review of performance against the action plan is essential. This should take place within a reasonable period of time. In determining what is reasonable, consideration should be given to the circumstances and the need to improve.

6.3.12 In addition to the action plan, consideration can be given to formal action for unacceptable performance.

6.3.13 Where formal action is taken, the employee will not be eligible for pay progression until after the formal action (e.g. a warning) has expired, however, this will not affect their incremental date. The manager will need to ensure action is taken with ESR to stop any future pay progression based on performance appraisal. When the employee becomes eligible for pay progression again, payment will not be backdated to any date when the formal action was live.

6.3.14 The outcome of the meeting will be confirmed in writing by the nominated or designated manager concerned, and a copy placed on the employee's personal file in the HR Department. The letter should contain:

a) a summary of the identified inadequacies
b) a summary of the discussion held
c) a copy of any agreed action plan
d) the decision on any formal action taken and the reason for that decision
e) any impact on pay progression (as per 6.3.10)
f) details of the right to appeal against the decision (see paragraph 6.5) if any formal action is taken
g) notification that failure to improve to the required standard may lead to further formal action.

6.3.15 Where a warning is issued to an employee whose right to work is via a Certificate of Sponsorship, the Human Resources Department has a duty to report this to UKVI as per their regulations

6.4 Appeals Process

If an employee considers that the decision taken against them is wrong or unjust, they may appeal against the decision. To exercise this right they should write to the Director of Human Resources within 14 calendar days of receipt of the outcome letter. The appeal letter must identify the reason for the appeal i.e. perceived procedural errors, availability of new evidence, why the sanction imposed is considered to be inappropriate.

The appeal will be arranged and conducted in accordance with Paragraph 12 and Appendix D of the Disciplinary Procedure.

7 Training

Training will be provided by the Human Resources Department to managers as part of implementing this policy.

8 Equality and diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way services are provided and the way staff are treated reflects their individual needs and does not unlawfully discriminate against individuals or groups. This policy has been properly assessed.

9 Monitoring Compliance

Standard / process / issue	Monitoring and audit			
	Method	**By**	**Committee**	**Frequency**
identify the number of employees subject to formal action and the level of action taken	Report from ESR	Director of Human Resources	Trust Board / HR Performance Review	Quarterly / Bi-annually

10 Consultation and review

This policy has been reviewed in consultation with the Employment Policies and Procedures Consultative Group

11 Implementation (including raising awareness)

A summary of the key changes will be notified to managers following implementation. Further advice and guidance will be available from the Human Resources Department.

12 Associated Documentation

- Disciplinary Policy and Procedure
- Employee Wellbeing policy Redeployment policy

The Newcastle upon Tyne Hospitals NHS Foundation Trust

EMPLOYMENT POLICIES & PROCEDURES

DIGNITY AND RESPECT AT WORK

Version No.:	9.1
Effective From:	24 August 2022
Expiry Date:	18 July 2025
Date Ratified:	18 July 2022
Ratified By:	Heads of HR

1. General Policy Statement

We are fully committed to a working environment where all our staff are treated with dignity and respect. All staff have a responsibility to encourage and promote positive relationships and a culture that matches our values.

This policy should be used if staff feel their dignity and respect at work has been affected in some detrimental way. Staff should always try to resolve minor issues quickly and on an informal basis to avoid matters building up or escalating unnecessarily.

We will not tolerate bullying, harassment or similar acts and will take all such complaints seriously.

2. Scope

2.1 This policy applies to:

a) Relationships with managers, employees, contractors, agency staff and anyone engaged to work within the Trust as well as volunteers, visitors or patients. Where a complainant or alleged harasser is not employed by the Trust the policy will apply with the necessary modifications.

b) Inappropriate behaviour at work and can apply to situations outside of work including Web software that supports social networking (e.g. blogs, wikis, Facebook) and media sharing (e.g. YouTube, Flickr).

2.2 It does not apply to inappropriate behaviour from patients, visitors, customers or suppliers – staff should report incidents to their manager who will take appropriate action (see, Management of Violence and Aggression at Work Policy and Exclusion from Treatment of Violent or Abusive Patients.

3. Aims

This policy aims to ensure allegations of inappropriate behaviour are taken seriously and handled quickly and sensitively.

4. Duties (roles and responsibilities)

4.1 The Executive Team is accountable to the Trust Board for ensuring Trust-wide compliance with policy and is committed to tackling all forms of inappropriate behaviour at work.

4.2 Directorate Managers and Heads of Department/Service are responsible to the Executive Team for ensuring policy implementation.

4.3 Managers are responsible for ensuring policy implementation and compliance in their area(s).

4.4 Staff are responsible for complying with policy and treating their colleagues (and others) with dignity and respect.

4.5 Staff representatives are expected to treat all staff with dignity and respect.

Human Resources will ensure staff and managers are appropriately trained and will provide advice in relation to policy as necessary.

5. Principles

5.1 Wherever possible staff should try and resolve issues quickly and on an informal basis. Most people will want to improve a situation as soon as possible.

5.2 We know it is not easy to speak up about things that cause upset or concern, but a person simply may not know that their behaviour is having an unwelcome effect. If staff can discuss their concerns with the person, it may help them to understand and give them an opportunity to change.

5.3 Staff should complete the steps below before starting a formal process.

6. Procedure

6.1 Stage 1 - raising a concern with the person in question

Staff who feel able should speak to the person who is causing their concern.
Where necessary, staff may wish to consider requesting help from a colleague or Contact Officer
(List of Contact Officers is available here)

6.2 Stage 2 – informal stage

If staff are unable to resolve matters themselves, they should raise their concern with their manager. Ideally this should be in writing and contain enough information to enable the manager to understand the issue and who is involved/affected. Managers will seek advice from the HR department as necessary and then arrange a meeting with staff to discuss their concern and agree next steps to establish the most suitable resolution – HR can attend the meeting if required. If staff have concern about their manager, they should raise the matter with the manager's manager.

The Trust will provide notification you when Stage 2 is concluded but the Trust cannot disclose any third party outcome or sanctions by reason of confidentiality. The notification will also provide confirmation of what staff can do if they are not satisfied and wish to proceed to the formal stage.

6.3 Stage 3 – mediation

Mediation is a voluntary process conducted by an independent and impartial person who is either a trained mediator or someone with appropriate knowledge, skills and experience. It is intended as a positive way of facilitating a staff member and their manager to find a resolution to an issue – see Appendix B.

A list of trained mediators is available here.

Mediation cannot be used if the parties do not have the necessary authority to settle the matter.

If mediation is used during formal proceedings under another policy or procedure, those proceedings will be paused to allow reasonable time for mediation to take place. If matters are not resolved, the formal proceedings will continue.

6.4 Stage 4 – formal stage

If staff remain dissatisfied after the informal stage and feel they have reasonable grounds for moving to the formal stage, they should complete the 'Escalation of Concerns Form – Formal Stage form', located in Appendix C of the present policy. Staff should send this to their manager within seven calendar days of receiving written confirmation of the outcome of the informal stage.

Managers will inform their directorate HR advisor of the escalation and provide details of the initial concern and provide details of any actions already taken. The HR advisor will acknowledge receipt and forward it to an appropriate manager to arrange a meeting to discuss the concern as soon as possible.

Depending on the nature and seriousness of the concerns raised, interim measures may need to be considered while the formal stage is in process. Measures may

include a temporary change in duties or supervision/reporting arrangements or work location, temporary redeployment, or suspension from work.

Staff have a right to be accompanied by a trade union representative or work colleague if they wish. Where the chosen companion is unable to attend the meeting on the date proposed, an alternative date and time may be offered as long as it is reasonable and falls within five working days of the original date. If the alternative is not agreed, the meeting will go ahead without the companion. A member of the HR department will be present to take notes and provide advice as necessary.

Where necessary, managers may contact other parties and/or carry out fact-finding (which may include asking another suitable person to carry out an investigation and produce a report) to establish the most suitable resolution and decide whether any action is required under another policy or procedure, such as the disciplinary procedure.

Please see Appendix C for an example procedure for the conduct of a formal meeting. It may or may not be necessary to hold a meeting with all parties present (i.e. staff member and responding manager) – it will be up to the manager handling the matter to decide on a case-by-case basis. If an investigation report is produced, the manager will decide whether or not it is appropriate/necessary to share a copy.

The manager will adjourn the meeting to reflect on the discussion and make a decision. After their deliberations, the manager will reconvene the meeting and (separately and privately) give their decision to the person raising the concern and the person the concern refers to. They will then confirm their decision in writing including a summary of the key points from the meeting. Where a matter is referred for action under another policy or procedure, managers will inform the person who is referred and the person raising the concern. After receiving this information, the person raising the concern should regard the matter as closed and for reasons of confidentiality they will not be informed of the outcome of any other action taken unless there are exceptional and compelling reasons for doing so.

7. Withdrawing a concern

If staff decide to withdraw from the process the relevant manager will seek to understand the reason and where appropriate (due to the nature and substance of the issue) may continue the process even if staff do not wish this to happen.

8. Training

Training as necessary will be provided to managers and staff by the Human Resources Department as part of implementing this policy.

9. Equality and Diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way services are provided, and the way staff are treated reflects their individual needs and

does not unlawfully discriminate against individuals or groups. This policy has been properly assessed.

10. Monitoring and Compliance

Standard / process / issue	Monitoring and audit			
	Method	By	Committee	Frequency
Report on cases to show; • the number of harassment and bullying episodes • the nature of complaints e.g. race, age	Reporting from ESR	Director of Human Resources	People Committee	Annually

11. Consultation and review

This policy has been reviewed in consultation with the Employment Policies and Procedures Consultative Group.

12. Implementation (including raising awareness)

A summary of the key changes will be notified to managers following implementation. Further advice and guidance will be available from the Human Resources Department.

Appendix A

What do we mean by harassment and similar acts such as intimidation, bullying and victimisation

a) Unwanted conduct related to a relevant protected characteristic (with the exception of pregnancy and maternity and marriage and civil partnership) i.e. age, disability, gender identity, gender expression, race (which includes colour, nationality and ethnic or national origins), religion or belief, gender, sexual orientation which has the purpose or effect of violating an individual's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for that individual or anyone else who finds such behaviour offensive (even if it is not directed at them).

b) Refers to behaviour which is offensive, intimidating, malicious or insulting, an abuse or misuse of power which is meant to undermine, humiliate, denigrate, or injure the person on the receiving end.

c) Homophobic and bi-phobic bullying is the bullying and/or harassment of somebody who is lesbian, gay or bisexual (LGB) due to their sexual orientation. Homophobic and bi-phobic bullying can also take place when the conduct is not aimed towards an individual or is not about their sexual orientation, but where the conduct is considered derogatory – for example, using the word 'gay' for example to describe something negative.

d) Transphobic bullying is the bullying and/or harassment (or other similar acts, as defined in 5.1) of somebody who is, or identifies as a transgender person (this includes for the purposes of this policy gender identity and gender expression). It is illegal to disclose somebody's transgender status without their full consent and to do so would constitute unlawful discrimination.

e) Harassment, and similar acts such as intimidation, bullying or victimisation can take many forms and includes behaviour, comment or physical contact the effect of which is to cause offence, fear, humiliation or persecution. Harassment can occur even where the intention was not to offend. Some examples of harassment, and similar acts are:

- physical conduct: unwanted physical conduct including touching, pinching, brushing against another, staring, following, abusive threats or gestures.

- verbal conduct/abuse: offensive jokes, insulting language (including homophobic, bi-phobic, transphobic or racial name calling or reference to different parts of anatomy), innuendoes, unwanted nicknames, spreading malicious rumours or insulting someone (particularly on the grounds of age, race, sex, disability, sexual orientation, gender identity, gender expression

and religion or belief), taunts, pressure for sexual activity, unwelcome advances.

- non-verbal conduct: including display of offensive material objects, making insulting sexual gesture, written materials or graffiti.

- rejecting or isolating an employee: refusing to converse or work with an employee, non-cooperation at work, exclusion from normal work social activities, not included in training and development opportunities or exclusion.

- general conduct: behaviour that is threatening or intended to ridicule an employee, misuse of power irrespective of whether voices are raised.

- making unnecessary reference to an individual's private life: for example, making reference to an individual's sexual orientation (potentially 'outing' the individual), gender identity, gender expression and asking intrusive questions about an individual's private life.

- victimisation: is conduct designed to make an employee suffer by exceptional treatment e.g. someone is treated badly because they have made/supported a complaint or grievance under the Equality Act 2010. Treatment of a complainant does not need to be compared with that of a person who has not made or supported a complaint under the Act.

- using incorrect pronouns and names: refusing to address a trans/non-binary individual by the title, name and/or pronouns they identify with.

f) Harassment and the similar acts are often carried out as repeated acts but can be a series of isolated incidents. It does not refer to behaviour between people which is taken and given in good spirit, however if such behaviour is considered degrading this may cause offence to other people who may over-hear who may have cause to make a complaint.

g) Harassment may also occur where a person engages in unwanted conduct towards another because they perceive that the recipient has a protected characteristic (for example perceives they are gay or disabled) when the recipient does not have that protected characteristic. Similarly, harassment could take place where an individual is bullied or harassed because of another person with whom the individual is connected or associated with, for example if their child is disabled or they have a transgender/non-binary relative/friend. Bullying or harassment will constitute unlawful discrimination where it relates to a protected characteristic.

h) Some types of bullying and harassment may constitute unlawful discrimination and allegations may give rise to the possibility of other civil claims or criminal

proceedings against the offending staff which would proceed independently of the Trust's disciplinary process. The alleged harasser could be personally liable to pay compensation to the complainant if a successful complaint is brought in employment tribunal or other court. Criminal proceedings could lead to conviction and criminal penalty.

Appendix B

Internal Mediation

Terms of Reference

If mediation is requested, the mediator will seek to facilitate the following:

a) Explain the mediation process
b) Ask questions that help to uncover underlying problems, assist the parties to understand the issues and help them clarify the options for resolving their difference or dispute
c) Restore/maintain good working relations
d) Focus on working together to go forward
e) Avoid making judgments or determining who is right or wrong
f) Ensure agreement comes from those in dispute not the mediator
g) Take charge of the process of seeking a resolution but not the outcome
h) Ensure all parties are aware of confidentiality
i) The outcome will only be disclosed to colleagues or their managers if all parties agree with the exception where, for example, a potentially unlawful act has been committed or there is a serious risk to patient care or health and safety

Appendix C

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Dignity and Respect at Work Policy

Escalation of Concerns Form – Formal Stage

Your full name	
Job title	
Directorate	
Department	
Work base	

Please state your complaint

Please state how your complaint should be resolved

Signature		Date	

Note: If the complaint is about your manager, send form to your manager's manager.

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Equality Analysis Form A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

PART 1

1. **Assessment Date:** **10/06/22**

2. **Name of policy / strategy / service**:
Dignity & Respect at Work

3. **Name and designation of Author:**
Karen Pearce, Head of Equality Diversity and Inclusion (People)

4. **Names & designations of those involved in the impact analysis screening process:**
Heads of HR, EPPCG

5.

Is this a:	Policy	x	Strategy		Service	
Is this:	New		Revised	x		
Who is affected	Employees	x	Service Users		Wider Community	

6. **What are the main aims, objectives of the policy, strategy, or service and the intended outcomes?** (*These can be cut and pasted from your policy*)
This policy aims to ensure allegations of bullying and/or harassment made by staff in relation to other staff are investigated and if/where necessary, action is taken to prevent further bullying and/or harassment and if appropriate, action is also taken in accordance with the Trust's Disciplinary policy

7. **Does this policy, strategy, or service have any equality implications?** **Yes** [ ] **No** [x]

If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:

8. Summary of evidence related to protected characteristics

Protected Characteristic	Evidence, i.e. What evidence do you have that the Trust is meeting the needs of people in various protected Groups	Does evidence/engagement highlight areas of direct or indirect discrimination? If yes describe steps to be taken to address *(by whom, completion date and review date)*	Does the evidence highlight any areas to advance opportunities or foster good relations. If yes what steps will be taken? *(by whom, completion date and review date)*
Race / Ethnic origin (including gypsies and travellers)	The policy makes clear that no employee should be treated less favourably on the grounds of their age, disability, race, nationality, ethnic origin, sex, sexual orientation, religion and belief, gender identity, marriage and civil partnership or pregnancy and maternity. The purpose of the policy is to provide a means for staff to raise issues in respect of bullying and/or harassment. This may relate to protected characteristics and the Trust monitors any such complaints on an annual basis as part of the Public Sector Equality Duty and the Workforce Race Equality Standard.	The Trust reports its Workforce Race Equality Data annually as part of our NHS contract requirements. The information is available on the Trusts website. This data identifies that BAME staff have a worse experience than white staff in relation to BH&A and discrimination at work when compared to white staff The Trust has a WRES Action Plan in place and our equity objectives reflect a requirement to improve The Trust also has a BAME staff network and contact officers who are able to support and signpost for staff. An equality dashboard has been introduced as part of the performance management framework although the metrics don't cover experience, they enable a conversation. Employee relations events are reviewed in terms of their likelihoods Breakthrough objectives have also been set in relation to staff experience. Employee relations events are reviewed in terms of their likelihoods WRES Improvement Team in place look at reducing BH&A reported through the staff survey	– The Trust has WRES action plan. – A programme of awareness sessions are in place – BH&A triangulation report done bi annually last report 2021, covering all protected characteristics
Sex (male/ female)	As above	An equality dashboard has been introduced as part of the performance management framework although the metrics don't cover experience, they enable a conversation. Employee relations events are reviewed in terms of their likelihoods	**As above**
Religion and Belief	As above		
Sexual orientation including lesbian, gay and bisexual people	As above	An equality dashboard has been introduced as part of the performance management framework although the metrics don't cover experience, they enable a conversation. Employee relations events are reviewed in terms of their likelihoods.	– Top 100 employer 2020 – Gold Employer 2022 – Rainbow Badge Silver assessment – LGBT Staff Network in Place

		Measures are reviewed as part of the stonewall staff Survey	– LGBT senior Allies in place
Age	As above	An equality dashboard has been introduced as part of the performance management framework although the metrics don't cover experience, they enable a conversation. Employee relations events are reviewed in terms of their likelihoods.	
Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section	As above	An equality dashboard has been introduced as part of the performance management framework although the metrics don't cover experience, they enable a conversation. Employee relations events are reviewed in terms of their likelihoods.	– Disability Confident – level 2 – RIDI Pioneer – Disability staff network in place
Gender Re-assignment	As above	There is no local data available on gender identity, although national data generally shows that higher numbers of Transgender people experience bullying and harassment. Support and signposting is available to all staff through the contact officers, equality champions and staff networks	
Marriage and Civil Partnership	As above		
Maternity / Pregnancy	As above		

9. Are there any gaps in the evidence outlined above? If 'yes' how will these be rectified?

The Trust is seeking to improve the equality data it holds by encouraging staff to self report through ESR where possible.

10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.

Do you require further engagement? Yes [ ] No [x]

11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?

No, there is no negative impact envisaged.

PART 2

Name:

Karen Pearce

Date of completion:

06 May 2022

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Employment Policies and Procedures

Disciplinary Policy and Procedure

Version No.:	12.1
Effective Date:	15 June 2023
Expiry Date:	12 January 2026
Date Ratified:	1 February 2023
Ratified by:	Employment Policies and Procedures Group

1 INTRODUCTION

This policy is designed to help and encourage all staff to achieve and maintain standards of conduct. When something has not gone as planned equal emphasis is put on accountability and learning and ensure that a robust process is followed to determine what should happen next. Our aim is to ensure consistent and fair treatment for everyone.

Before starting a disciplinary procedure, consideration will be made to see whether the problem can be resolved in an informal way as this can often be the quickest and easiest solution.

The Trust and staff side are committed to a just and learning culture and want to embed the practice of reflection and improvement in everything we do.

This policy and procedure are written in accordance with the ACAS Code of Practice on Disciplinary Procedures. Managers are key to enabling all staff to flourish at work and reach their potential. This includes:

- handling all matters of conduct without unreasonable delay
- resolving problems through informal action where appropriate
- using the formal disciplinary procedure only where necessary

2 POLICY SCOPE

This policy applies to all staff.

This procedure does not apply to the following:

Does not apply to:	Use:
Professional competence of Medical and Dental staff	Capability procedure for Medical and Dental staff
Failure to achieve an acceptable standard of work	Capability policy

Where applicable the Probationary Periods policy should be read in conjunction with this procedure.

3 PRINCIPLES

Managers and staff will deal with issues promptly and will not unreasonably delay meetings, decisions, or confirmation of those decisions.

Informal action will be considered to resolve problems where appropriate.

No disciplinary action will be taken against staff until the case has been fully investigated.

Staff will be advised of the nature of the complaint against them and will be given the opportunity to state their case before any decision is made at a disciplinary meeting.

Staff will be provided with written copies of evidence and relevant witness statements in advance of a disciplinary meeting.

At all stages of the formal procedure staff will have the right to be accompanied by a trade union representative or work colleague (referred to as their chosen companion)

No staff will be dismissed for a first breach of discipline except in the case of gross misconduct when the penalty will be dismissal without notice or payment in lieu of notice.

Staff will have the right to appeal against any disciplinary action.

The disciplinary procedure may be implemented at any stage if a staff member's alleged misconduct warrants this. The Trust will ensure that action under this policy is free from unlawful discrimination. No staff will receive less favourable treatment on the grounds of their age, disability, race, nationality, ethnic origin, sex, sexual orientation, religion and belief, gender identity/expression, marriage and civil partnership or pregnancy and maternity.

4 AIMS OF POLICY

The aim of this policy is to:

a) ensure consistent and fair treatment for all staff
b) ensure that when something has not gone as planned there is equal emphasis on accountability and learning
c) promote a just and learning culture

5 DUTIES – ROLES AND RESPONSIBILITIES

5.1 The Executive Team is accountable to the Trust Board for ensuring Trust-wide compliance with policy.

The relevant Executive lead (or person with delegated authority) is responsible for referring professionally registered staff to their professional body where appropriate.

5.2 Directorate Managers and Heads of Service are responsible to the Executive Team for ensuring policy implementation.

5.3 Managers are responsible for ensuring policy implementation and compliance in their area(s).

5.4 Staff are responsible for complying with policy.

5.5 People with the authority to suspend, discipline and hear appeals – see Appendix A.

5.6 The HR department is responsible for:

a) Providing advice to managers
b) Recording and monitoring employee relations activity
c) Reporting disciplinary action to UK Visas and Immigration if staff have a Certificate of Sponsorship
d) Establishing the establishing the requirement for a Cultural Ambassador
e) Reporting cases to the Disclosure and Barring Service where appropriate

6 CONDUCT AND BEHAVIOUR

All staff should act in accordance with the Trust's values and expected standards of behaviour. In addition, staff who are professionally registered should also adhere to the code of conduct set by their professional body. Where conduct falls short of any of these it may be considered unacceptable and could lead to formal action for a breach of the Trust's disciplinary rules – see Appendix 1 and note this is not an exhaustive list.

7 ALLEGATIONS

7.1 All allegations/incidents of misconduct will be taken seriously and handled in strict confidence. To ensure they are dealt with fairly and consistently may mean that they need to be investigated. In the first instance, managers should consider whether informal action may be all that is required – some problems can often be settled quickly and without undue process.

7.2 Where informal resolution is not appropriate, practical or possible there are a number of considerations that managers should bear in mind when deciding if an investigation is necessary, for example does a policy or procedure require an investigation, does the matter warrant further action or will a preliminary 'management investigation' help to determine what needs to happen next?

7.3 If a formal investigation is necessary managers should act promptly. Unnecessary delay may cause memories to fade or give the perception of an unfair process. Importantly, an informal resolution of the matter should still be considered as an option at any stage of the process.

8 MEDIATION

8.1 Mediation will be offered to help resolve disagreements around workplace relationships such as bullying and harassment, communication problems, personality clashes and relationship breakdowns. All parties will try and resolve the problem informally first before thinking about using mediation.

8.2 Mediation is a voluntary and confidential process conducted by an impartial/neutral person (a 'mediator') who is trained in mediation or has appropriate knowledge, skills, and experience. It is intended as a positive way of facilitating staff and managers to:

- find a resolution to a problem everyone agrees with
- improve communication
- allow everyone involved to have control of what is finally agreed

8.3 A list of trained mediators is available on the following intranet link

8.4 Mediation cannot be used if the parties do not have the necessary authority to settle the matter.

8.5 If mediation is used, the disciplinary process will be paused to allow reasonable time for mediation to take place. If matters are not resolved, the disciplinary process will continue.

8.6 If mediation is requested, the mediator will seek to facilitate the following:

- explain the mediation process
- ask questions that help to uncover underlying problems, assist the parties to understand the issues and help them clarify the options for resolving their difference or dispute
- restore/maintain good working relations
- focus on working together to go forward
- avoid making judgments or determining who is right or wrong
- ensure agreement comes from those in dispute, not the mediator
- take charge of the process of seeking a resolution but not the outcome
- ensure all parties are aware of confidentiality

8.7 Outcomes to mediation might include:

- an acknowledgement of each party's views
- a commitment to change behaviour
- a commitment to regularly review the agreement reached
- an agreement to review policies and procedures
- an agreement to share work more fairly and provide more responsibility

8.8 The outcome will only be disclosed to colleagues or their managers if each party agrees. Exceptions will be where, for example, a potentially unlawful act has been committed or there is a serious risk to patient care or health and safety.

9 INVESTIGATIONS

9.1 An investigation plan* will be drawn up to assist in carrying out the necessary investigations of potential disciplinary matters without unreasonable delay to establish the facts of the case. This will include holding an investigatory meeting with the staff member (and separately with any witnesses) and collating evidence before proceeding to any disciplinary hearing.

9.2 The investigation plan can include:

- who has commissioned the investigation
- terms of reference (i.e., what the investigation is required to examine and report on)
- who will carry out the investigation (this should be decided in conjunction with a relevant senior officer, such as Directorate Manager/Head of Service/ Medical Director/Executive Chief Nurse
- anyone who needs to be spoken with, such as witnesses
- any sources of evidence, for example work records, emails, CCTV recordings
- any time limits, for example CCTV footage being deleted or staff going on leave
- timescale
- policies or guidelines to follow
- whether the investigating officer is expected to give any recommendations at the end of the investigation
- setting out the importance of confidentiality
- any other relevant points or information

Investigation Plan [amend as required]

Commissioning Officer	
Investigating Officer	
HR support	
Terms of reference	
Provisional timescale	
Policies and procedures to review and follow	
Issues that are required to be explored/clarified/examined/reported on	
Sources of evidence to be collected	
Persons to be interviewed (including planned order)	
Investigation meetings further arrangements (when/where/notes to be taken by)	
Persons to supply own statement	
Investigation meetings to be completed by	

Collection of evidence to have been completed by	
Further considerations	

9.3 If any new issues come to light during an investigation, the investigating officer and the commissioning officer will agree changes to the terms of reference as necessary. If this would make the investigation overly burdensome or unduly complicated, a further investigation will be commissioned.

9.4 If there is an investigatory meeting this will not by itself result in any disciplinary action.

9.5 The investigatory team will comprise of different people from those who may sit on any disciplinary panel

9.6 Staff have no statutory right to be accompanied at a formal investigatory meeting, but they can make a reasonable request and it will be considered

10 SUSPENSION

10.1 Most disciplinary situations will not require suspension. It should only be considered exceptionally if there is a serious allegation of misconduct and there are reasonable grounds to believe that the staff member might seek to tamper with or destroy evidence, influence witnesses and/or sway an investigation into the disciplinary allegation; or working relationships have severely broken down to the point that there is a genuine risk to other staff, property, patients, visitors or other business interests if the staff member remains in the workplace; or the staff member is the subject of criminal proceedings which may affect whether they can do their job.

10.2 Suspension can leave staff feeling prejudged, demotivated, and devalued. It will only be used after very careful consideration. The suspension consideration proforma is available here

10.3 Alternatives to suspension can include: a temporary change in shifts, work or work location, including working from home.

10.4 Suspension is not an assumption of guilt and is not considered a disciplinary sanction. A fair procedure will follow in which staff will have every opportunity to put their point of view and have their representations listened to and fairly considered.

10.5 In cases where a period of suspension from work is considered necessary, the period will be as brief as possible and will not be considered as any form disciplinary action.

10.6 Suspension will normally be with pay and the amount will be calculated based on an average of earnings received in the previous 3-months, including basic pay and any regularly paid supplements such as unsocial hours, on-call

availability payments and recruitment and retention premia. The following payments will be excluded from the calculation: overtime; additional basic hours; and work done on-call.

10.7 By exception, suspension can be without pay subject to approval from the Director of Human Resources. Examples where this may apply include allegations of gross misconduct; where staff refuse to carry out some or all of their duties; or where staff leave their place of work without permission from their manager.

10.8 If staff report sick during suspension their pay will be in accordance with any contractual sick pay entitlement and any reduction from full pay to half-pay or half-pay to no pay will apply accordingly.

10.9 Some staff may find it extremely distressing to be told they are being suspended. This may be the case even if the person does not show any obvious signs of distress. Any staff who are suspended will be able to access some immediate support and will be offered help to do this. For example, they can speak to their trade union representative, a colleague, a member of the HR department or the chaplaincy service. A referral can also be made to Occupational Health. Further guidance is available from ACAS at: www.acas.org.uk/suspension

11 DISCIPLINARY HEARINGS

11.1 If it is decided that there is a disciplinary case to answer, staff will be notified of this in writing. The notification will contain sufficient information about the alleged misconduct and its possible consequences to enable them to prepare to answer the case at a disciplinary meeting. A copy of the investigation report and any related written evidence/documentation, including witness statements will be provided 15 calendar days before the meeting.

11.2 The notification will include informing staff of their right to be accompanied at the meeting by a trade union representative or work colleague.

11.3 The meeting will be held without unreasonable delay whilst allowing the staff member reasonable time to prepare their case.

11.4 Staff (and their chosen companion) are required to make every effort to attend the meeting.

11.5 At the meeting, the investigating officer will present the evidence that has been gathered. The staff member will be given the opportunity to set out their case and answer any allegations that have been made. They will also be given an opportunity to ask questions, present evidence and call relevant witnesses. They will be given an opportunity to raise points about any information provided by witnesses. Where the investigating officer or staff member intend to call relevant witnesses, they should give notice that they intend to do so at least 10 calendar days in advance of the meeting. This meeting will be conducted in accordance with the procedure detailed in Appendix C

11.6 If the staff member's chosen companion will not be available at the time proposed for the hearing by the employer, the employer must postpone the hearing to a time proposed by the staff member, provided that the alternative time is both reasonable and not more than five working days after the date originally proposed.

11.7 The chosen companion should be allowed to address the hearing to put and sum up the staff member's case, respond on behalf of the staff member to any views expressed at the meeting and confer with the staff member during the hearing. The companion does not, however, have the right to answer questions on the staff member's behalf, address the hearing if the staff member does not wish it or prevent the employer from explaining their case.

12 DISCIPLINARY ACTION

12.1 After the meeting, the person hearing the case will adjourn and decide whether disciplinary action (or any other action) is justified. Once the decision is made the staff member will be informed in person and in writing as soon as possible, unless otherwise agreed.

12.2 Where misconduct is confirmed and a warning is issued, the information given in person and in writing, unless otherwise agreed, will include the following:

- the nature of the misconduct
- the change in conduct/behaviour required (with timescale)
- that a further act of misconduct during the period of the warning may lead to further formal action, including dismissal or some other contractual penalty such as demotion or loss of seniority
- how long the warning will remain current
- the right of appeal

12.3 A decision about formal action will only be taken by a person with the authority to do so – see Appendix A.

12.4 Where a decision is made to dismiss, the staff member will be informed in person and in writing, unless otherwise agreed, as soon as possible of the reasons for their dismissal, the date on which their employment contract will end, the appropriate period of notice (if applicable) and their right of appeal.

12.5 Where staff are persistently unable or unwilling to attend a disciplinary meeting without good cause, the meeting will take place in their absence, a decision will be made on the evidence available and they will be informed of the outcome in writing as soon as possible, including any right of appeal.

Levels of disciplinary action

12.6 The levels of disciplinary action and how long they will be live for are as follows:

- oral warning – 6 months

- first written warning – 12 months
- final written warning – 24 months*
- alternative to dismissal*
- dismissal with notice (or pay in lieu of notice)
- summary dismissal without notice

(* Can include demotion and/or transfer on a temporary or permanent basis. No allowance or protection will apply to any loss (e.g., pay or earnings) or any cost (e.g., travel or accommodation).

12.7 Disciplinary action can be taken at any level. If staff have live disciplinary action on file and they commit further misconduct, consideration will be given as to whether any action for the latest misconduct should be separate or added to the previous one.

12.8 When a warning is issued, we will consider whether any pay progression should be withheld and if so for how long.

'Fast-track' procedure

12.9 There may be occasions where staff admit to an offence and would prefer to deal with potential disciplinary action as quickly as possible without the need for undue process. In such cases, the following procedure will apply (if appropriate):

a) informal action will be considered to resolve problems where appropriate
b) no disciplinary action will be taken against staff until the case has been fully investigated
c) staff will be advised of the nature of the complaint against them, receive written copies of evidence and relevant witness statements and will be given the opportunity to state their case
d) at all formal stages of the fast-track procedure staff will have the right to be accompanied by a trade union representative or work colleague
e) if staff admit the offence and any potential disciplinary action (including consideration of any live disciplinary action on file) would not be greater than a first written warning, staff will be offered a fast-track decision
f) if accepted the Fast Track pro-forma will be completed and submitted to the disciplining officer with a copy to staff and their representative
g) the disciplining officer will make their decision and inform the staff member in writing, including their right of appeal if disciplinary action is taken

12.10 If fast-track is not appropriate or declined the normal disciplinary procedure will apply. The fast track proforma is available here

13 APPEALS

13.1 If staff feel that disciplinary action taken against them is wrong or unjust, they can appeal against the decision. Appeals will be heard without unreasonable delay.

13.2 Staff should set out the grounds for their appeal in writing to the Director of Human Resources within 14 calendar days of receiving written confirmation of the disciplinary decision.

13.3 The appeal will be dealt with impartially by a person who has not previously been involved in the case.

13.4 Staff have a statutory right to be accompanied by a chosen companion at the appeal hearing.

13.5 The outcome of the appeal will be notified in writing as soon as possible.

13.6 The example procedure for a disciplinary appeal hearing is at Appendix D.

14. Cultural Ambassadors

Cultural Ambassadors are trained to identify and challenge cultural bias. Where appropriate they will use their skills in the role of neutral observer within the disciplinary process and all formal investigations involving staff from an ethnic minority background or where racism forms part of the investigation.

The role supports the Trust to ensure processes are fair, equitable and free from bias and unlawful discrimination. Cultural Ambassadors will have discretion to challenge bias and will provide independent advice and guidance. They are able to adjourn proceedings if they believe any concerns raised are not being adequately addressed. Further information is available here

15. Trade union representatives

If an investigation is to be carried out into allegations against a staff member who is a trade union representative, the matter will be discussed with an official employed by the union after obtaining the representative’s agreement and the normal procedure for investigation and any disciplinary action will be followed.

16 OTHER CONSIDERATIONS

16.1 Criminal offences

If staff are arrested, cautioned, charged, or convicted in connection with a criminal offence, this will not normally in itself be a reason for disciplinary action. Consideration will be given to what effect the arrest, caution, charge, or conviction has on a staff member’s suitability to do the job and their relationship with the Trust and work colleagues, as well as patients and visitors.

If allegations against a staff member could amount to a criminal offence, the Trust will notify the police as soon as possible. The relevant staff member will be informed.

16.2 Fraud

The Trust's Fraud, Bribery and Corruption Policy and Response Plan sets out the procedure for handling allegations of fraud by staff and should be followed in association with the disciplinary procedure.

16.3 Prevent

PREVENT is part of CONTEST the UK Government Counter-Terrorism Strategy for reducing the risk to the UK and its interests overseas from international terrorism and is made up of four work streams which aims to stop people becoming terrorists or supporting terrorism. Health has been identified as a key strategic partner in supporting this strategy. It is about supporting and protecting those people that might be susceptible to radicalisation.

Any staff who have concerns in relation to vulnerable individuals or people who they think may becoming radicalised or being involved in violent extremism should discuss them with the safeguarding team and follow the process for raising an alert when someone is considered to be a victim of, or potentially susceptible to, becoming radicalised into terrorist activity.

16.4 Referral to external organisations

16.4.1 Professional registration

The Trust will report (or take advice on reporting) staff to their professional body when they are subject to investigation or disciplinary action. The professional body may separately investigate and decide what action they feel is necessary.

16.4.2 Safeguarding – children and vulnerable adults

Where an allegation has been made that suggests a staff member who works with children or vulnerable adults has behaved in an inappropriate way or has harmed a child or vulnerable adult or has possibly committed a criminal offence, the matter will be reported immediately to the Head of HR Services (for children) and the Head of Workforce Advisory Services (for adults) who will invoke the necessary procedures.

16.4.3 Disclosure and Barring Service (DBS)

If staff are dismissed or leave in connection with a safeguarding issue (children or vulnerable adults) we will report the matter to the DBS – see procedure at Appendix E.

16.4.4 Health professional alert notices

If it is considered that a registered healthcare professional is a serious risk to patients, staff or others we will make a request for an Alert Notice to be issued – see Alert Notices Procedure.

17 Monitoring Compliance

Standard/process/issue	Monitoring and audit			
	Method	**By**	**Committee**	**Frequency**
The following will be audited: a) Categorisation of allegations b) Number of tribunal cases	Report from ESR	Director of Human Resources	HR Performance Review Trust Board	Bi-annually Quarterly

18 Consultation and review

This policy has been reviewed in consultation with the Employment Policies and Procedures Consultation Group

19 Implementation (including raising awareness)

A summary of the key changes will be notified to managers as part of publishing this policy.

20 References

1) ACAS Code of Practice
2) Employment Rights Act 1996
   Available at www.legislation.gov.uk/ukpga/1996/18/contents
3) Safeguarding Vulnerable Groups Act 2006
   www.legislation.gov.uk/ukpga/2006/47/contents
4) The Disclosure and Barring Service Barring Referrals
   https://www.gov.uk/guidance/barring-referrals

21 Associated documents

- Alert Notices Procedure
- Capability Procedure
- Capability Procedure to address concerns regarding competence of medical and dental staff
- Child Protection and Safeguarding Children: Policies and Guidelines
- Concerns and Complaints Policy
- Corporate Governance Framework
- Email and Electronic communications policy
- Fraud, Bribery and Corruption: Policy and Response Plan
- Safeguarding Adults – Guidance on Handling Allegations/Complaints of Abuse Made Against Employees
- Safeguarding Adults Policy and Guidelines
- Safeguarding Children - Guidance on Handling Allegations/Complaints of Abuse Made Against Staff
- Shared Parental Leave Policy

- Social Media Policy
- Probationary Periods Policy
- Speak Up - We're Listening Policy (Voicing Concerns about Suspected Wrongdoing in the Workplace)

Appendix A

The Newcastle upon Tyne Hospitals NHS Foundation Trust
Disciplinary Procedure
Levels of Authority

The Newcastle upon Tyne Hospitals NHS Foundation Trust
Disciplinary Procedure
Levels of Authority

#	Category of staff	Oral Warning	Appeal	Written Warning	Appeal	Dismissal	Appeal	Suspension
1	Chief Executive	Chair of Trust Board	Trust Board	Chair of Trust Board	Trust Board	Chair of Trust Board	Trust Board Panel	Chair of Trust Board
2	Executive Team	Chief Executive	Chair of Trust Board	Chief Executive	Chair of Trust Board	Chief Executive	Trust Board Panel	Chief Executive or nominated deputy
3	Very Senior Managers (VSMs) and other Directors	Executive Team or nominated deputy	Chair of Trust Board, Chief Executive or nominated deputy	Executive Team or nominated deputy	Chair of Trust Board, Chief Executive or nominated deputy	Executive Team or nominated deputy	Trust Board Panel	Executive Team or nominated deputy
4	Those directly accountable to 2 or 3	Executive Team, VSM, other Director or nominated deputy	Executive Team or nominated deputy	Executive Team, VSM, other Director or nominated deputy	Executive Team or nominated deputy	Executive Team or nominated deputy	Trust Board Panel	Executive Team, VSM, other Director or nominated deputy
5	Consultant Medical & Dental staff (personal conduct only)	Medical Director or nominated deputy	Medical Director or nominated deputy	Medical Director or nominated deputy	Medical Director or nominated deputy	Medical Director or nominated deputy	Trust Board Panel	Medical Director or nominated deputy
6	Other Medical & Dental staff (personal	Clinical Board Chair or nominated deputy	Medical Director or	Clinical Board Chair or	Medical Director or nominated deputy	Clinical Board Chair or nominated deputy	Trust Board Panel	Clinical Board Chair or nominated deputy

	conduct only)		nominated deputy	nominated deputy				
7	All other staff	Those directly accountable to 2 or 3 or nominated deputy	Next level above disciplining officer or nominated deputy	Those directly accountable to 2 or 3 or nominated deputy	Next level above disciplining officer or nominated deputy	Executive Team or nominated deputy	Trust Board Panel	Those directly accountable to 2 or 3 or nominated deputy

NOTES:

1 Executive Team includes: Chief Executive; Chief Operating Officer; Executive Chief Nurse; Chief Finance Officer; Medical Director; Chief Information Officer; Director of Estates; Director of Enterprise & Business Development; Director of Quality and Effectiveness; Chief People Officer; Assistant Chief Executive.

2 Very Senior Manager and other Director. Examples include: Director of Pharmacy; Director of Procurement and Supplies; Deputy Chief Nurse; Chief Nurse Information Officer; Deputy Chief Operating Officer; Directors & Associate Directors of Operations; Associate Directors of Nursing, Midwifery & AHP's; Deputy Chief Finance Officer; Deputy Director of Business Development & Enterprise.

3 A "nominated deputy" is a person of appropriate experience and seniority.

4 Mutual termination of employment on grounds of ill health may be delegated to a level below the one listed in the dismissal column.

5 Termination of employment on grounds of unsatisfactory probation may be delegated to a level below the one listed in the dismissal column.

6 Where necessary there should be appropriate professional input to the disciplinary process.

Appendix B

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Disciplinary Rules

The rules below give an indication of the standards of conduct and behaviour expected of all staff. Failure to observe these standards or committing an offence may lead to disciplinary action.

Gross Misconduct

Some specific examples of gross misconduct where summary [instant] dismissal is justified irrespective of any previous warning are:

a) **Theft:** Any theft or attempted theft, including the use of Trust/NHS property, facilities or resources for personal/private purposes and borrowing Trust/NHS property without permission.

b) **Fraud:** Any deliberate attempt to commit fraud, either inside or outside of the Trust. Fraud is the dishonest intent to secure a gain or cause a loss. This includes but is not limited to:

- using false information when applying for jobs within the Trust (e.g., qualifications, references, employment history, DBS disclosure)
- falsifying documents (e.g., signatures, invoices, stock and non-stock requisitions, delivery notes, emails, references, fit notes)
- work or activity (paid or unpaid) that is not part of the contract of employment and is undertaken during working hours
- making false claims (e.g., travel expenses, subsistence, enhanced hours, overtime, Waiting List Initiative, duplicate claims)
- abuse of time and attendance system (e.g., using inappropriate hand scanners, failing to hand scan in a timely manner, failing to ensure the system records the actual hours worked)
- working in any other employment (paid or unpaid) whilst on sickness absence from the Trust.

Instances of suspected fraud will be considered under the Fraud, Bribery and Corruption Policy and Response Plan. Where evidence of criminality is apparent, the Trust may pursue criminal sanctions. Financial redress may be pursued where a financial loss has occurred.

c) **Ill Treatment:** Ill treatment of any person on or off Trust premises.

d) **Serious Unacceptable Behaviour:**
(Managers will need to exercise care in relation to incidents which occur off the Trust's premises where due regard should be paid to the prevailing circumstances particularly any potential impact on the Trust's good name and reputation)

- **Violence** – threatening behaviour, threats of violence, fighting or assault on or off Trust premises.
- **Bullying & Harassment and/or Discrimination –** including unacceptable behaviour which would be considered to be offensive to patients, staff and the public.
- **Gross insubordination** – failure to carry out reasonable instructions; insubordination to manager's supervision where consequences have been made clear.
- **Action which discredits the name and reputation of the Trust** – whether on or off the premises (e.g., actions offensive to the general public). This may include criminal offences (whether committed during or outside hours of work for the Trust which may adversely affect the staff member's suitability for employment or the type of work they do, or their acceptability to others, such as other staff, patients and visitors (see Section 3 below).
- **Offering, giving, receiving or requesting of bribes –** this includes a financial advantage or other reward that is offered to, promised to, given to, or received by an individual or company to induce or influence that individual or company to perform its public or corporate functions or duties in an improper manner (i.e., not in good faith, not impartially, or not in accordance with a position of trust). The Trust operates a zero-tolerance approach to any attempts at bribery by or of its staff.
- **Accessing pornographic, offensive or obscene material –** deliberately accessing internet sites containing pornographic, offensive or obscene material whilst at work or on work premises (by any means).
- **Misuse of social networking sites, including cyber bullying – for example:**
    - sharing confidential information online
    - posting inappropriate comments about employees, patients or the Trust
    - using social networking sites to bully or intimidate employees
    - pursuing personal relationships with patients or service users
    - distributing sexually explicit material
    - using social networking sites in any way which is unlawful

e) **Unfit for Duty:** Being under the influence of alcohol, drugs or other substances.

f) **Malicious Damage:** Deliberate or reckless damage to Trust/NHS property or the property of others on or off Trust premises.

g) **Corruption:** Receipt of money, goods, favours, etc, in respect of services rendered to the Trust.

h) **Gross or wilful negligence:** Gross or wilful negligence or reckless abuse of rules designed to produce safe working practices which could include, in more serious cases; non-adherence to safety rules, food hygiene regulations, and to any advice (general or specific) issued by Occupational Health.

i) **Failure to declare information:** Falsification of, or failure to declare, relevant information on an application form, medical questionnaire or Model Declaration form that is fundamental to the contract of employment. This includes the falsification of qualifications which are required for employment and/or result in additional remuneration and failure to declare a business interest.

j) **Breach of confidential or sensitive information.**
k) **Absent without leave.**
l) **Consumption of drugs (unless medically prescribed or over the counter), sale or distribution of drugs and other substances:** whether on or off Trust premises.
m) **Gross or serious misuse of Trust IT Systems.**
n) **Serious breach of trust and confidence.**
o) **Serious breach of the rules, regulations, policies and procedures of the Trust.** For example, where the Trust, staff, other workers, patients, visitors or members of the public are put at risk.

Misconduct

Some specific examples of unsatisfactory behaviour where disciplinary action is justified (and could lead to dismissal) are as follows:

a) **Breach of Confidences** – including a breach of information governance standards and responsibilities with regard to data protection, confidentiality and information security, including protecting information and information systems from unauthorised access, use, disclosure, disruption, modification or destruction (severe cases of a breach of confidence may result in dismissal). This would also include a breach of sensitive information for example, but not limited to, relating to patients other Trust staff and Trust business.
b) **Failure to follow the rules, regulations, policies and procedures of the Trust.**
c) **Delivering work below the standard expected** because of carelessness, lack of effort or negligence, or if the consequences of delivering work below the standard expected are serious to the Trust (see Capability Procedure).
d) **Negligence.**
e) **Unreasonable behaviour, appearance and/or language** which is offensive or harmful to others, such as staff and other workers including contractors, patients, visitors and the public.
f) **Any action which is discriminatory** in terms of the Trust's Equal Opportunities and Diversity Policy and specifically any act of racial or sexual discrimination, including bullying or harassment. (Extreme cases may result in dismissal, demotion or transfer).
g) **Falsification or failure to declare relevant information requested by the Trust.**
h) **Smoking on any Trust sites.**
i) **Breach of conditions specified in the contract of employment.**
j) **Failure to maintain an acceptable standard of attendance or punctuality.**
k) **Misuse of NHS premises and/or facilities** including the use of telephones for personal calls; use of NHS equipment (e.g., computers) for personal use without permission.
l) **Breach of conditions of use of a contract hire car** including wilful neglect of a contract hire car and failure to inform the Trust of changes to their circumstances which may impact on their car insurance or their driving license.

Appendix C

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Example procedure for the conduct of a disciplinary hearing

1. Where an employee's conduct, performance, alleged act or omission (which might have occurred on or off duty and has a bearing on the job/duties of the employee) is considered to be sufficiently serious to warrant formal action (which may or may not be after counselling or an investigation), the following procedure shall apply.

2. The person conducting the hearing shall introduce those present and outline the process for the hearing, including the use of adjournments.

3. This person conducting the hearing will also ask if there is any new evidence relevant to the case. If so, they will make a judgment on whether it is appropriate to allow that evidence to be considered. Where new evidence is allowed, they will ensure all parties have an opportunity to examine it and comment.

4. **The Formal Procedure:**

4.1 **Disciplinary Hearing**

4.1.1 At the hearing the manager will introduce those present and explain the purpose of the hearing, the role of the Representative and explain how the meeting will be conducted.

4.1.2 Management shall state their case first in the presence of the employee and their representative and may call witnesses.

4.1.3 Witnesses may be present only for their evidence. At the hearing the employee(s) or their representative is entitled to question any witness(es) called by the Trust, and to ask for additional witnesses to be called. The person conducting the hearing may also question the Trust representative and any witness(es). Such witnesses may be fellow employees provided they are relevant to the subject matter. If witnesses are to be called, advance notice should be given of this intention by the Trust.

4.1.4 The employee or their representative shall then state their case in the presence of management and may call witnesses.

4.1.5 The procedure for Witnesses called by the employee or their representative will follow that as outlined in 4.1.3.

4.1.6 If more time is needed to consider the matter, or new facts emerge, or further investigations are necessary, it may be appropriate to adjourn the meeting and reconvene. Any party may request an adjournment

during the meeting.

4.1.7 The investigating manager will sum up the case against the employee and shall not introduce any new evidence

4.1.8 The employee or their representative will sum up the case on their behalf and shall not introduce any new evidence.

4.1.9 The person hearing the case shall ask the employee if they feel they have had a fair hearing. If the employee feels they have not, the person hearing the case shall ask them for details and address the issues.

4.1.10 The decision whether to take disciplinary action will be taken after the hearing has concluded and at the earliest opportunity. Consideration should take account of the following:

a) any mitigating factors
b) current disciplinary record (if appropriate) of the employee
c) seniority of the post holder
d) length of service
e) nature of the misconduct
f) evidence produced by either party at the hearing
g) any sanctions imposed in the past for similar offences

Wherever possible, the decision (and any right of appeal) should be communicated in person by the person hearing the case and confirmed in writing as soon as possible. A copy of the letter should be recorded on the employee's personal file in the Human Resources Department and sent to the staff representative involved (where applicable).

4.1.11 A member of the Human Resources Department must be present at a hearing to provide advice on procedural matters and other issues as required, and to make a written record of the proceedings.

4.1.12 Where allegations of a professional nature are alleged, the person hearing the case inadequacy is alleged and/or where the employee is from a different profession to the manager, there has been appropriate professional input and advice in the disciplinary process (see also 2.7.4 of the policy).

4.1.13 If following the hearing the manager decides there is no case to answer, they shall notify all concerned in writing.

Appendix D

The Newcastle upon Tyne Hospitals NHS Trust

Example procedure for the conduct of a disciplinary appeal hearing

The person conducting the appeal hearing will:

i. introduce those present
ii. explain the purpose of the appeal hearing and how it will be conducted, including the use of adjournments
iii. explain what powers the appeal panel has
iv. establish whether there is any new evidence and, if so, make a judgment on whether to allow it
v. where new evidence is allowed, ensure all parties have an opportunity to examine it and comment

The Case Against the Employee:

a) Management shall state their case in the presence of the appellant and their representative and may call witnesses.

b) The appellant or their representative shall have the opportunity to ask questions of management and their witnesses.

c) The person or persons hearing the appeal shall have the opportunity to ask questions of the management or their witnesses.

d) Management shall have the opportunity to re-examine their witnesses on any matter referred to in their examination by the person or persons hearing the appeal, the appellant or their representative.

The Case for the Employee:

e) The appellant or their representative shall put their case in the presence of management explaining their grounds for appeal and may call witnesses. Any evidence to support the appeal, including relevant witness statements, should ideally be provided at least five working days before the Appeal hearing.

f) Management shall have the opportunity to ask questions of the appellant, their representative and their witnesses.

g) The person or persons hearing the appeal shall have the opportunity to ask questions of the appellant, their representative and their witnesses.

h) The appellant or their representative shall have the opportunity to re-examine their witnesses on any matter referred to in their examination by the person or persons hearing the appeal or management.

Summing Up the Case:

i) Management and the appellant or their representative shall have the opportunity to sum up their case if they so wish, the appellant or their representative shall have the right to speak last. In their summing up, neither party may introduce any new matters.

j) Nothing in the foregoing procedure shall prevent the person or persons hearing the appeal from inviting either party to clarify or amplify any statement they may have made; or from asking them such questions as may be necessary to ascertain whether or not they propose to call any evidence in respect of any part of their statement, or alternatively whether they is in fact claiming that the matters are within their own knowledge, in which case they will be subject to examination as a witness under (b) or (f) above.

k) The person or persons hearing the appeal may, at their discretion, adjourn the appeal in order that further evidence may be produced by either party to the dispute or for any other reason.

l) The person hearing the case shall ask the employee if they feel they have had a fair hearing. If the employee feels they have not, the person hearing the case shall ask them for details and address the issues.

l) Management, the appellant and their representative shall withdraw.

m) The person or persons hearing the appeal with the officer who has been charged with providing secretarial and procedural assistance shall deliberate in private, only recalling both parties to clear points of uncertainty on evidence already given. If recall is necessary, both parties shall return, even when only one is concerned with the point giving rise to doubt.

Communicating the Decision

n) No statement of previous acts of misconduct by the employee or the issue of a formal warning or warnings unrelated to the alleged offence(s) on which the disciplinary action is based shall be made until after the person or persons hearing the appeal have reached a decision on the appeal.

o) The employee will be informed in writing of the results of the appeal hearing as soon as possible, after the meeting. The person (s) hearing the appeal will advise those present of the timescale. The decision reached at this stage will be final.

IMPORTANT NOTE

Management in the context of this procedure may be the ‘disciplining officer’ i.e. the officer who was authorised to take disciplinary action. Alternatively, the case may be presented by the Human Resources Adviser involved and they will call the ‘disciplining officer’ as a witness at the appeal hearing; where this occurs, the

‘disciplining officer’ will have no additional rights and privileges as a witness in the context of the appeals hearing procedure.

Appendix E

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Referral to Disclosure and Barring Service

1. The Trust's responsibilities

1.1 The Trust has a legal duty to notify the Disclosure and Barring Service (DBS) (under the Safeguarding Vulnerable Groups Act 2006 (2006 Act)) of relevant information to ensure that individuals who pose a threat to vulnerable groups can be identified.

1.2 The DBS will receive referrals when.

- there is harm or risk of harm to children or vulnerable adults,
- relevant conduct has occurred, or
- an individual has received a caution or conviction for a relevant offence

1.3 The following conditions must be met before a referral can be made:

a) the Trust has dismissed or removed an individual from engaging in a regulated activity (or would or may have if the individual had not resigned, retired, been made redundant or been transferred to a position which is not regulated activity; and

b) the Trust has reason to believe the individual has:

- engaged in relevant conduct (i.e., an action or inaction [neglect] that has harmed a vulnerable adult or put them at risk of harm); or
- satisfied the 'harm test' (i.e., there has been no relevant conduct [i.e., no action or inaction] but a risk of harm to a vulnerable adult still exists); or
- received a caution or conviction for a relevant offence

1.4 Subject to the above, a referral should be made on the DBS referral form which can be obtained from https://www.gov.uk/government/publications/dbs-referrals-form-and-guidance.

1.5 In all cases the individual should be informed of the Trust's intention to make a referral to the DBS.

1.6 Further information can be obtained via the DBS referral guidance (found at https://www.gov.uk/government/publications/dbs-referrals-form-and-guidance). The guidance sets out in greater detail the:

a) referral process
b) circumstances under which a referral should be made
c) legal responsibilities of the Trust
d) main points of law.

1.7 The DBS will consider all information referred in relation to whether an individual should be included in a barred list, a referral may also be made in the following circumstances.

a) where following an internal investigation there is insufficient evidence to show *relevant conduct* occurred, but concerns about that individual remain
b) where there are concerns about an individual who has left employment

However, for a case to be considered as a risk of harm, relevant conduct may not have occurred but there must be tangible evidence rather than a "feeling" that a person represents a risk to children and / or vulnerable adults.

1.8 For the purposes of a referral relevant conduct is any conduct:

a) That endangers a child or vulnerable adult or is likely to endanger a child or vulnerable adult.
b) If repeated against or in relation to a child or vulnerable adult, would endanger them or would be likely to endanger them.
c) That involves sexual material relating to children (including possession of such material);
d) That involves sexually explicit images depicting violence against human beings (including possession of such images), if it appears to the DBS that the conduct is inappropriate; or
e) Of a sexual nature involving a child or vulnerable adult, if it appears to the DBS that the conduct is inappropriate.

2. Referral process

2.1 Once the Trust is satisfied that the relevant conditions for referral have been met the disciplining manager must complete the DBS referral form available at https://www.gov.uk/government/publications/dbs-referrals-form-and-guidance. Referral at this point will help to ensure that the DBS has sufficient evidence to commence its decision-making process while providing adequate safeguarding for vulnerable groups.

2.2 The completed form, along with the supporting documentation must be posted to the DBS. The DBS address is contained within the referral form. Where applicable and at the same time the Trust should also report the matter to the relevant regulatory body e.g., GMC, NMC, via the appropriate professional lead.

2.3 The DBS is required to acknowledge the referral by post within three working days of receipt. The DBS may request further information if required.

2.4 The DBS will then consider the referral. Any decisions to bar an individual will be communicated to the individual and any legitimately interested parties, in writing. The DBS will inform the Trust of the outcome if the individual remains an employee. The Trust will not be informed if the individual is no longer an employee.

2.5 Copies of all correspondence with the DBS must be kept on the individual's personal

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Equality Analysis Form A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

PART 1

1. **Assessment Date:** 22/11/2022

2. **Name of policy / strategy / service**:
Disciplinary Policy and Procedure

3. **Name and designation of Author:**
Karen Pearce, Senior HR Manager (Projects)

4. **Names & designations of those involved in the impact analysis screening process:**
Tor Metcalfe-Megginson, EDI Manager (People), EPPCG

5.

Is this a:	Policy	X	Strategy		Service	
Is this:	New		Revised	X		
Who is affected	Employees	X	Service Users		Wider Community	

6. **What are the main aims, objectives of the policy, strategy, or service and the intended outcomes?** (*These can be cut and pasted from your policy*)
It is accepted by the Trust and its employees (as represented by Staff Representatives on the Employment Partnership Forum) that a disciplinary policy and procedure is necessary to assist in maintaining standards of conduct and performance, and for promoting a fair and systematic approach in handling such matters.

7. **Does this policy, strategy, or service have any equality implications?** **Yes** X **No** ☐

If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:

8. Summary of evidence related to protected characteristics

Protected Characteristic	Evidence, i.e. What evidence do you have that the Trust is meeting the needs of people in various protected Groups	Does evidence/engagement highlight areas of direct or indirect discrimination? If yes describe steps to be taken to address *(by whom, completion date and review date)*	Does the evidence highlight any areas to advance opportunities or foster good relations. If yes what steps will be taken? *(by whom, completion date and review date)*
Race / Ethnic origin (including gypsies and travellers)	Between July 2019 - June 2022 192 members of staff went through the disciplinary process. Formal action was taken in 91 cases – of these 9 were against staff of a BAME background and 81 were against white staff. In one case the ethnicity of the staff member was not recorded Workforce data shows that the average duration of the disciplinary process where formal action was taken for staff of a BAME background took 99.8 days compared to 172.9 days for white staff Informal action / no action occurred in 101 cases – of these 8 staff were of a BAME background and 91 staff were of a white background. In two cases the ethnicity of the staff member was not recorded Workforce data shows that the average duration of the disciplinary process where informal / no action was taken for staff of a BAME background took 28.3 days compared to 66.5 days for white staff	No National NHS data around discipline shows that staff from BME groups are overrepresented in disciplinary procedures, however the Trust's workforce data has been analysed and shows that there is no disproportionate representation of staff from a BAME background in relation to disciplinary procedures. The policy is clear that any action taken under this policy is free from unlawful discrimination. No staff will receive less favourable treatment on the grounds of their age, disability, race, nationality, ethnic origin, sex, sexual orientation, religion and belief, gender identity/expression, marriage and civil partnership or pregnancy and maternity.	
Sex (male/ female)	Between July 2019 - June 2022 192 members of staff went through the disciplinary process. Formal action was taken in 91 cases – of these 49 staff members identified as female and 42 staff members identified as male. There were no cases where gender was not recorded. Workforce data shows that the average duration of the disciplinary process where formal action was taken against female staff was 180.9 days	The policy is clear that any action taken under this policy is free from unlawful discrimination. No staff will receive less favourable treatment on the grounds of their age, disability, race, nationality, ethnic origin, sex, sexual orientation, religion and belief, gender identity/expression, marriage and civil partnership or pregnancy and maternity. The policy is clear that any action taken under this policy is free from unlawful discrimination. No staff will receive less favourable treatment	

	compared to 143.7 days for male staff Informal action / no action occurred in 101 cases – of these 66 identified as female and 35 staff identified as male. There were no cases where gender was not recorded Workforce data shows that the average duration of the disciplinary process where informal / no action was taken for staff who identify as female took 65.1 days compared to 61.7 days for male identifying staff	on the grounds of their age, disability, race, nationality, ethnic origin, sex, sexual orientation, religion and belief, gender identity/expression, marriage and civil partnership or pregnancy and maternity.	
Religion and Belief	Workforce monitoring data is not available for this protected characteristic due to the system set up	The policy is clear that any action taken under this policy is free from unlawful discrimination. No staff will receive less favourable treatment on the grounds of their age, disability, race, nationality, ethnic origin, sex, sexual orientation, religion and belief, gender identity/expression, marriage and civil partnership or pregnancy and maternity.	Action for Workforce Information to set up a report around harvesting the data held around religion/belief in relation to the disciplinary process
Sexual orientation including lesbian, gay and bisexual people	Between July 2019 - June 2022 192 members of staff went through the disciplinary process. Of the 91 cases where formal action was taken 5 staff identified as LGBT and 61 as heterosexual. There were 25 cases where sexual identity was not recorded Workforce data shows that the average duration of the disciplinary process where formal action was taken against LGBT staff was 134.4 days compared to 167.2 for heterosexual staff. Informal action / no action occurred in 101 cases – of these 4 cases relate to staff who identify as LGBT and 74 where staff identify as heterosexual. There were 23 cases where sexual identity was not recorded	The policy is clear that any action taken under this policy is free from unlawful discrimination. No staff will receive less favourable treatment on the grounds of their age, disability, race, nationality, ethnic origin, sex, sexual orientation, religion and belief, gender identity/expression, marriage and civil partnership or pregnancy and maternity.	

	Workforce data shows that the average duration of the disciplinary process where informal / no action was taken for staff who identify as LGBT took 56.5 days compared to 62.0 days for heterosexual staff. In cases where sexual orientation wasn't recorded, the average duration of the process was 72.4 days		
Age	Between July 2019 - June 2022 192 members of staff went through the disciplinary process. Of the 91 cases where formal action was taken 19 were against staff aged 16-29, 61 were against staff aged 30-59 and 11 were against staff aged 60+ Workforce data shows that the average duration of the disciplinary process where formal action was taken was 175.4 days for staff aged 19-29, 165.1 days for staff aged 30-59 and 143.6 days for staff aged over 60 Informal action / no action occurred in 101 cases – of these 17 relate to staff aged 16-29, 67 relate to staff aged 30-59 and 17 relate to staff aged 60+ Workforce data shows that the average duration of the disciplinary process where informal / no action was taken was 32.5 days for staff aged 19-29, 58.6 days for staff aged 30-59 and 112.5 days for staff aged over 60	The policy is clear that any action taken under this policy is free from unlawful discrimination. No staff will receive less favourable treatment on the grounds of their age, disability, race, nationality, ethnic origin, sex, sexual orientation, religion and belief, gender identity/expression, marriage and civil partnership or pregnancy and maternity.	
Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section	Between July 2019 - June 2022 192 members of staff went through the disciplinary process. Of the 91 cases where formal action was taken 63 staff identified as not disabled, 5 identified as disabled and there were 23 cases where disability status was not recorded.	The policy is clear that any action taken under this policy is free from unlawful discrimination. No staff will receive less favourable treatment on the grounds of their age, disability, race, nationality, ethnic origin, sex, sexual orientation, religion and belief, gender identity/expression, marriage and civil	

	Workforce data shows that the average duration of the disciplinary process where formal action was taken was 165.3 days for staff who were not disabled compared to 192.0 days where staff had disclosed a disability. For those cases where disability status was not recorded, the average duration of the process was 157.3 days Of the 91 cases where informal / no action was taken 62 were against staff not recorded as having a disability and 4 were against staff who identified as disabled. There were 35 cases where disability status was not recorded Workforce data shows that the average duration of the disciplinary process where formal action was taken was 67.4 days for staff who were not disabled compared to 31.0 days where staff had disclosed a disability. For those cases where disability status was not recorded, the average duration of the process was 61.6 days	partnership or pregnancy and maternity. Attendance warnings issued under the employee wellbeing policy are counted towards the disciplinary figures (due to recording provisions); in such circumstances, reasonable adjustments are always considered where an underlying health reason has been declared, to improve attendance prior to issuing any warning.	
Gender Re-assignment	Workforce monitoring data is not available due to the confidentiality surrounding gender transition. There is no local / national data available – more generically the Trust's Gender Identity Group have confirmed the Trust (public bodies) are seen by the Trans community as inclusive employers.	The policy is clear that any action taken under this policy is free from unlawful discrimination. No staff will receive less favourable treatment on the grounds of their age, disability, race, nationality, ethnic origin, sex, sexual orientation, religion and belief, gender identity/expression, marriage and civil partnership or pregnancy and maternity.	The Trust has a Gender Identity Group and has developed several gender identity specific resources. Local systems do not capture data around trans status. An action has been added to the equality action plan with the aim of capturing this information once in place
Marriage and Civil Partnership	Workforce monitoring data is not available for this protected characteristic due to the system set up	The policy is clear that any action taken under this policy is free from unlawful discrimination. No staff will receive less favourable treatment on the grounds of their age, disability, race, nationality, ethnic origin, sex, sexual orientation, religion and belief, gender identity/expression, marriage and civil partnership or pregnancy and maternity.	Action for Workforce Information to set up a report around harvesting the data held around marriage/civil partnership in relation to the disciplinary process
Maternity / Pregnancy	Workforce monitoring data is not available for this protected characteristic due to the system set up	The policy is clear that any action taken under this policy is free from unlawful discrimination.	Action for Workforce Information to set up a report around harvesting the data held

		No staff will receive less favourable treatment on the grounds of their age, disability, race, nationality, ethnic origin, sex, sexual orientation, religion and belief, gender identity/expression, marriage and civil partnership or pregnancy and maternity.	around maternity/pregnancy in relation to the disciplinary process

9. Are there any gaps in the evidence outlined above? If 'yes' how will these be rectified?

Yes – gender reassignment is not monitored due to confidentiality surrounding transitioning at work.

10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances, please contact the Equality and Diversity Lead.

Do you require further engagement? Yes [ ] No [X]

11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?

No

PART 2

Name:

Tor Metcalfe-Megginson

Date of completion:

222/11/2022

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)

The Newcastle Upon Tyne Hospitals NHS Foundation Trust

Display Screen Equipment Policy

Version No.:	8.0
Effective From:	16 February 2022
Expiry Date:	16 February 2025
Date Ratified:	25 January 2022
Ratified By:	Clinical Policy Group

1 Introduction

The Trust recognises its general duty of care to employees under the Health and Safety at Work Act 1974 and Management of the Health and Safety at Work Regulations 1999. This policy aims to ensure that effective arrangements are in place for working with display screen equipment and to meet the requirements of the Display Screen Equipment Regulations 1992 (amended 2002). This policy will support the Trust vision in promoting a healthy working environment for staff working with display screen equipment (DSE).

2 Policy Scope

The risk factors associated with DSE work can lead to musculoskeletal problems, visual fatigue and stress. The risk increases with frequency, duration, intensity, periods of continuous DSE use as well as the amount of control the person has over how and when DSE is used.

The Trust will continue to work towards and take all reasonable steps to ensure that all DSE workstations used by staff in hospital and community settings adhere to the DSE regulations. This policy relates to all computer workstations in those settings and also gives consideration to the use of portable equipment such as laptops. The policy also covers the management of risk for staff who perform sonography.
It will outline the role and responsibilities of specialist departments including the Occupational Health Service (OHS), the Moving and Handling Team (MHT) and the Health and Safety Advisors. Managers, Moving and Handling Facilitators Level 1 (Object Handling) and Level 2 (Patient Handling) should consult this policy when managing issues related to DSE equipment particularly when problems are encountered affecting the health and working conditions of the user.

3 Aim of Policy

The aim of the policy is to safeguard staff safety and comfort whilst working with DSE.

4 Duties – Roles and Responsibilities

4.1 Trust Board

The Trust Board is ultimately responsible for fulfilling all Health and Safety duties as an employer, including those related to the use of display screen equipment.

4.2 Chief Executive

The Chief Executive has overall responsibility to the Trust Board for ensuring that appropriate and effective health and safety management systems are in place.

4.3 Trust Health and Safety Committee

The Trust Health and Safety Committee are responsible for agreeing this policy and approving all revisions before it is forwarded to the Clinical Policy Group for final approval.

4.4 Clinical Policy Group (CPG)

The Clinical Policy Group is responsible for giving final approval of this policy and all revisions following its approval by the Trust Health and Safety Committee.

4.5 Directorate Managers

The Directorate Managers should support the departmental managers in the implementation of this policy

4.6 Departmental Managers

The departmental managers will ensure that the relevant risk assessment documentation is completed and the recommendations are acted upon with concerns being raised with the directorate managers.

4.7 Moving and Handling Facilitators

The facilitators are nominated by the departmental managers to ensure that the policy is implemented in the department. Their role will include the monitoring of staff working with DSE. The co-ordination of the completion of relevant assessments and the making of recommendations on identified risks. If the person being assessed raises any specific display screen needs relating to a disability; for example they need the computer set with a specific font or background colour or need a screen reader, assessors should report this to the manager. The facilitators will also have a role in the assessment of the handling of objects in the department, which is covered by the Trust Moving and Handling Policy.

4.8 All staff

All staff using DSE should use the equipment in accordance with the policy, co-operate with the departmental manager/ facilitator by completing assessments, follow advice given in relation to use of DSE and identify any concerns with their departmental manager or facilitator.

5 Definitions

5.1 Definition of Display Screen Equipment as covered by the DSE Regulations

Any alphanumeric or graphic display screen, i.e. conventional display screens (cathode ray tube and other types such as liquid crystal or plasma displays

used in flat panel screens, touch screens and other emerging technologies); screens displaying text and numbers, line drawings, graphs, charts, computer generated graphics. The definition also covers non-electronic display systems such as microfiche and it includes screens where the main use is to show TV or film picture, e.g. CCTV.

5.2 **Definition of Workstation**

An assembly comprising:

- Display screen equipment whether provided with software determining the interface between the equipment and its user, a keyboard or any other input device. This includes portable devices.
- Any disk drive, telephone, printer, document holder, work chair, work desk, work surface or other item peripheral to the display screen equipment.
- The immediate work environment around the display screen equipment, e.g. shelving, lighting, and filing system.

5.3 **Definition of a User**

Employees who habitually use display screen equipment as part of their normal work and where the work involves:

- Continuous spells of one hour or more
- Daily use of DSE
- Fast information transfer to or from DSE
- High levels of attention and concentration
- Little choice of whether or not to use the DSE
- Special training or skills to use DSE

(See Appendix 1 for examples)

6 Responsibility for Assessment

6.1 Departmental managers are responsible for completing a risk assessment for all DSE and their users using the Trust Display Screen Equipment Assessment Checklist Analysis form held on the Moving and Handling Trust intranet site (Appendix 2).

6.2 The assessment should be completed by all individual users who have a specific workstation on commencement of employment. Where the user has specialist equipment e.g. chair, mouse, keyboard and is transferring within the Trust, arrangements should be made to transfer the equipment to the new department or where this is not appropriate the new department should supply new equipment.

6.3 Where there are multi-user workstations the department manager / facilitator should ensure that a generic DSE assessment has been completed to ensure the set up on each station complies with regulations. In departments where there are several multi user workstations set up in exactly the same configuration, in terms of desk, chair and hardware, one assessment can be completed.

6.4 The assessment should be reviewed if there has been a change to the workstation such as:

- A major change to the software used.
- A major change to the hardware (screen, keyboard input devices).
- A major change in the workstation furniture.
- A substantial increase in the amount of time spent working at the display screen.
- A substantial change in other task requirements (more speed or accuracy).
- A change to DSE worker population.
- The workstation is relocated.
- Major features of the workstation such as lighting is significantly modified.
- If a member of staff suffered from discomfort when working at the workstation.
- Changes to an individual's capability.

6.5 The manager may appoint suitable person(s) as facilitator(s) who will be responsible for the assessment of all DSE within their department. The identified person will attend a facilitator training course before they can commence their role within the department.

6.6 In order to update, MH level 1 (Object Handling) facilitators should attend a half day update training course every three years and MH Level 2 (Patient Handling) facilitators should attend a full day update training session every three years

6.7 Departmental managers must implement as far as is reasonably practicable any recommendations made on completed assessments by the facilitator or by the OHS, MHT and the Health and Safety Advisors.

7 Role of Advisors

Further advice and assistance can be sought from the Occupational Health Service, Moving and Handling Team or Health and Safety Advisors.

7.1 Health & Safety Advisor:

Consult the Health & Safety Advisor if there is a safety issue related to:

- The environment (heat, lighting, space, noise)
- The equipment (wires, cables, furniture)
- Access and egress
- Obstruction (contact injury, slips, trips, etc.)

7.2 Occupational Health Service: (OHS)

Consult the Occupational Health Service if there is:

- A health issue raised by the user which he / she attributes to DSE use that cannot be resolved by the facilitator /departmental manager following the completion of a Trust Display Screen Equipment Assessment Checklist Analysis form. The OHS will require a copy of the assessment E-mailed by the departmental manager before advice can be given. The

assessment should detail steps already taken by the department. (see Appendix 6 Trust System DSE Assessments)

- Following receipt of the assessment and referral the Occupational Health Practitioner (OHP) will provide advice and undertake further assessment of the workstation as appropriate

7.3 **Moving and Handling Team (MHT)**

- The Occupational Health Service will consult with the MHT on the more complex ergonomic issues and moving and handling tasks.
- The MHT provide an assessment service, which staff can access after a recommendation for a new chair/ keyboard/ mouse device or desking solution has been made by the OHS or where the MHT have identified a problem (Appendix 3).
- Provide support and assistance to facilitators and departmental managers on the management of assessments within the department and issues related to the facilitator role.
- Check the department DSE assessments through monitoring visits to the department bi-annually to monitor compliance with the policy.

8 Health Care for Users

8.1 **Eyesight Tests**

A user may be advised by OHS to visit an optician of their choice to have a full eye test. The receipt should be retained by the user and presented to the departmental manager for reimbursement of costs if it has been assessed that the user requires corrective glasses only when using DSE.

8.2 **Costs**

The Trust will meet the cost of the sight test and the cost of any corrective appliances considered necessary to work with DSE only and not for any other purpose up to a maximum of £60.00. Any corrective appliances recommended which are not considered necessary for DSE use must be met by the user as must any cost the considered user wishes to incur over £60.00. Costs will be reimbursed through the users own department. The users are requested to update their departmental manager prior to an appointment being arranged with an optician and process the claim with them for reimbursement of costs.

8.3 **Other Health Care Guidance for Departmental Heads and Users**

Departmental managers and users may seek guidance to mitigate the effects of DSE use from a Health & Safety Advisor, the Occupational Health Service and the Moving and Handling team. The guidance will cover:

- Instruction on hard and software being used
- Environmental awareness
- Ergonomic principles (posture, seating, screen glare)
- User recognition of problems
- Instruction on mechanical workstation adjustments

- The advantage of breaks and changes in activity including organisation of workload.
- Awareness of the DSE policy
- Exercises to manage negative effects of DSE use.

(See Appendix 4 for general health guidance related to DSE use)

8.4 **Minimum Requirements of a Work Chair**

According to 'Seating At Work' HS(G)57 (1991), the minimum requirements of an office chair are:

- Seat height adjustment
- Seat back adjustment in height and tilt
- A five star base with either castors or glides suitable for the floor surface.

8.5 **Castors on a Work Chair**

To ensure the health and safety to users on all floor surfaces, a risk assessment should be completed to determine the appropriate castor for the relevant floor surface (see Appendix 5).

8.6 **Effects on Pregnancy**

A risk assessment should be completed by the Health and Safety Advisor in conjunction with the departmental manager in adherence to the Trust Pregnant Workers Policy.

If a pregnant worker has a personal concern they can contact the OHS to discuss any issue confidentially.

9 Employee's Responsibilities

9.1 Staff should be aware that it is their responsibility to follow safe systems of work and use any equipment or appliances recommended, e.g. wrist rest, glasses appropriately.

9.2 Staff should co-operate with the departmental manager/ facilitator in completing required assessments and to report any concerns to their manager and/or facilitator.

9.3 Staff should check their workstation is set up in accordance with training prior to each use.

9.4 Staff should inform assessors if they have any specific display screen needs relating to a disability. For example they need the computer set with a specific font or background colour or need a screen reader.

9.5 Staff should ensure they have accessed training and updated on a 3 yearly basis according to the Mandatory Training Policy

10 Training

10.1 All staff are assigned either MH Level 1 or MH Level 2 competency depending on their role. Staff working in office and object handling areas should be assigned MH Level 1 competency. Staff who carry out patient handling tasks as a main part of their role should be assigned MH Level 2 competency.

10.2 Moving and Handling training is delivered as part of Corporate Induction for those staff who require it on commencement with the Trust. The training will be delivered via e-Learning and/or face to face based on the level required for the role. They should also receive departmental induction training from the facilitator or departmental manager related to their workstation and DSE. If appropriate, the staff member should complete a Trust Display Screen Equipment Assessment Checklist Analysis form (Appendix 2). Departmental induction training should be provided to new staff as soon as is reasonably practicable on commencement in the department.

10.3 Departmental induction training should also be completed for Trust staff who change roles or departments where the moving and handling tasks are different to their previous role. This would include the tasks related to DSE use and an up to date Trust Display Screen Equipment Assessment Checklist Analysis form (Appendix 2).

10.4 All staff must attend an update in accordance with the Mandatory Training Matrix in the Mandatory Training Policy.

10.5 Staff nominated to undertake the Facilitator role should attend a MH Level 1 or MH Level 2 facilitator training course before commencing the role.

10.6 All MH1 and MH 2 facilitators should attend an update course organised by the MHT in accordance with the Mandatory Training Matrix in the Mandatory Training Policy.

11 Agile working/ working with portable DSE

11.1 According to the current regulations there is no evidence that staff who work from home are at an additional or unique risk relating to DSE work. However they may encounter normal risks associated with DSE work and some potentially increased risks that may arise from social isolation, stress, lack of supervision, issues with posture and taking inadequate breaks.

11.2 Working with portable DSE such as a laptop is subject to DSE regulations if used for prolonged periods of time. This DSE generally has a smaller keyboard and a lack of keyboard/ screen separation making it more challenging for the user to achieve a comfortable working posture.

11.3 The Trust Display Screen Equipment Assessment form (Appendix 2) should be completed for workstations with portable DSE.

11.4 If it is not practicable to send an assessor to an employee's home to complete the Trust Display Screen Equipment Assessment form (Appendix 2) the individual should complete their own assessment checklist with support from the Moving and Handling Facilitator or Manager. There is a guide on how to complete the assessment available for staff as a resource. There should be a clear plan set out to manage identified risks associated with the workstation including the provision of equipment if required for use when working at home.

11.5 Additional guidance should be given to staff working with portable DSE regarding increased risks including:

- Taking more frequent and longer breaks from the DSE.
- Using docking stations and separate keyboards and mouse devices where able
- Where docking stations are not available using a laptop stand with a separate keyboard and mouse device to optimise working posture.
- How to set up and use of portable DSE.

12 Sonography – Standard Operating Procedure

12.1 Sonography uses high frequency sound waves to produce a real time image of the internal body. The images are used to check function, look for abnormalities and take measurements. Sonography work involves an operator guiding a handheld transducer against the patient's body while simultaneously monitoring a screen and using a keyboard to control/record the image. In the publication "*Upper Limb Disorders in the Workplace*" (HSG60 2nd Edition, 2002) the Health and Safety Executive (HSE) identified that "Healthcare professionals undertaking diagnostic imaging work using ultrasound equipment have a high prevalence of musculoskeletal disorders." In March 2012 the HSE published *"Risk Management of Musculoskeletal Disorders in Sonography Work*". The findings of this report in terms of recommended control measures have been used in establishing the standard operating procedure to be followed by relevant departments, MHT, OHS and Health and Safety.

12.2 The Trust Standard Operating Procedure (Appendix 7) sets out responsibilities of managers, facilitators, MHT and OHS in managing risks in departments where sonography is performed. It sets out the annual requirements in terms of assessment and training as well as the procedure for referring a member of staff to OHS.

12.3 The MHT will work with relevant departments to complete annual environmental risk assessments (Appendix 8) to identify existing and required control measures to be put in place. Departmental managers will be responsible for ensuring the recommendations are actioned with support and advice available from the MHT.

12.4 All staff who perform sonography tasks should receive bi-annual training from the MHT. Training will include exercises, body mapping, ergonomic advice relating to the workstation and environmental setup. Training can be delivered

face to face or via Microsoft Teams. Departmental managers should contact the MHT to organise the training when it is due.

12.5 Individual screening tools (Appendix 9) should be completed by relevant staff on commencing in the department and then every following year. The screening tools should be checked by the manager and department facilitator for any identified risks. Where an underlying musculoskeletal issue is identified, managers should refer staff to OHS by forwarding the completed screening tool along with the latest department environmental risk assessment. If there are any additional non-sonography issues to be assessed on the member of staff the manager should also forward a completed management referral form.

11.6 On receiving a referral related to sonography OHS will carry out an assessment and provide the manager with one or more recommendations

- No further action is required continue with annual screening
- A referral to OHS Physiotherapy is made for the member of staff
- A work place assessment for the staff member with referral to MHT
- The staff member will receive an annual recall by OHS

13 Equality and Diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. This document has been appropriately assessed.

14 Monitoring Compliance

Standard / process / issue	***Monitoring and audit***			
	Method	***By***	***Committee***	***Frequency***
Number of facilitators in each department *Required assessments completed in each department* *Any recommendations identified after an assessment have been actioned in each department* *Assessments are reviewed when there is a change* *All areas where sonography is undertaken require an annual*	*Two yearly monitoring visits are carried out in all departments across the Trust following a programme of visits.* *Compliance in the completion of workstation assessments within each department will be checked during each visit* *The number of facilitators is monitored as part of this visit*	*Moving and Handling Team*	*Trust Health and Safety Committee*	*Two yearly*

environmental assessment. All sonographers complete a screening tool on commencement in the Trust and then on an annual basis	*In sonography areas compliance in completing annual staff screening tools and environmental assessments is monitored as part of the visit in relevant areas.* *Information on compliance is included in a report sent to each directorate manager. Reports are attached to the three monthly report presented to the Trust Health and Safety Committee*			

15 Consultation and review

The policy will be reviewed every three years by the Moving and Handling Team with co-operation of the Health and Safety Advisors and the Occupational Health Service.

16 Implementation (including raising awareness)

16.1 Training in the completion of workstation assessments is included in the MH Level 1 and MH Level 2 Facilitator Courses to ensure that the learners apply the requirements of this policy in their department.

16.2 Moving and handling update training via e-learning includes information on the system outlined in this policy.

15.3 A month prior to monitoring visits in a directorate the directorate manager is contacted by e-mail and reminded of the need to complete workstation assessments in line with this policy

17 References

HSE Display Screen Equipment Regulations 1992 (revised 2002) HMSO Norwich

HSE Health and Safety at Work Act 1974 HMSO Norwich

HSE Seating at Work 1997 HMSO Norwich

HSE Project report "*Risk Management of Musculoskeletal Disorders in Sonography Work"* March 2012 HMSO Cardiff

HSE "*Upper Limb Disorders in the Workplace*" 2002 HSG60 HSE Books

18 Associated documentation

Moving and Handling Policy
Pregnant Workers Policy
Mandatory Training Policy
Advice and Guidance on Workplace Temperatures

Appendix 1

<table>
<tr><th rowspan="2">Job Example</th><th colspan="8">Does the Jobholder’s DSE work involve:</th></tr>
<tr><th>Continuous spells of an hour or more</th><th>Daily use of DSE?</th><th>Fast information transfer?</th><th>High attention and concentration</th><th>High dependency on the DSE?</th><th>Little choice whether or not to use the DSE?</th><th>Special training or skills?</th><th>Decision</th></tr>
<tr><td>Word processing</td><td>Yes</td><td>Yes</td><td>Yes</td><td>Maybe</td><td>Yes</td><td>Yes</td><td>Yes</td><td rowspan="6">Definitely ‘users’ or ‘operators’</td></tr>
<tr><td>Secretary</td><td>Yes</td><td>Yes</td><td>Yes</td><td>Maybe</td><td>Yes</td><td>Yes</td><td>Yes</td></tr>
<tr><td>Data input Operator</td><td>Yes</td><td>Yes</td><td>Yes</td><td>Maybe</td><td>Yes</td><td>Yes</td><td>Yes</td></tr>
<tr><td>CCTV control room worker</td><td>Yes</td><td>Yes</td><td>Maybe</td><td>Yes</td><td>Yes</td><td>Yes</td><td>Maybe</td></tr>
<tr><td>Senior manager</td><td>Yes</td><td>Yes</td><td>No</td><td>Maybe</td><td>Yes</td><td>Maybe</td><td>No</td></tr>
<tr><td>Librarian</td><td>Yes</td><td>Yes</td><td>Yes</td><td>Maybe</td><td>Yes</td><td>Yes</td><td>Yes</td></tr>
<tr><td>Nurse</td><td>Maybe</td><td>Yes</td><td>No</td><td>Maybe</td><td>Yes</td><td>Yes</td><td>Maybe</td><td rowspan="4">Maybe ‘users’ or ‘operators’</td></tr>
<tr><td>Physio</td><td>No</td><td>Maybe</td><td>No</td><td>Maybe</td><td>Yes</td><td>No</td><td>Maybe</td></tr>
<tr><td>Scientist technical advisor</td><td>Maybe</td><td>Yes</td><td>Maybe</td><td>Maybe</td><td>Maybe</td><td>Yes</td><td>Yes</td></tr>
<tr><td>Receptionist</td><td>Maybe</td><td>Yes</td><td>Maybe</td><td>Maybe</td><td>Maybe</td><td>Yes</td><td>Yes</td></tr>
<tr><td>Domestic</td><td>No</td><td>No</td><td>No</td><td>No</td><td>No</td><td>No</td><td>Maybe</td><td>Not ‘users’ or ‘operators</td></tr>
</table>

Yes means this does apply on a typical working day (not necessarily on all days).
Maybe means either this applies to the job on some days but not others, or that it applies to some such jobs but not others.
No means this never applies, or there are only occasional days in the year when it applies

Appendix 2

NEWCASTLE OCCUPATIONAL HEALTH / MOVING AND HANDLING SERVICE

DISPLAY SCREEN EQUIPMENT ASSESSMENT FORM

DEPARTMENT/HOSPITAL/BASE/HOME:	
EMPLOYEES GROUP/UNIT:	
WORKSTATION LOCATION (ROOM/POSITION):	
NOMINATED USER (NAME AND DESIGNATION):	
HOURS WORKED:	
MANAGER:	
ASSESSOR:	
DATE COMPLETED	(dd/mm/yy)

Risks Identified:

Recommendations:

Display Screen Equipment Assessment

The completion of this checklist will enable you to carry out a self-assessment of your own workstation. Your views are essential in order to enable us to achieve our objective of ensuring your comfort and safety at work. Please select the answer that best describes your opinion for each of the questions listed.

ENVIRONMENT

(1) Lighting	
Describe the lighting at your usual workstation	About right/too bright/too dark
Do you get distracting reflections on your screen?	Never/Sometimes/ Constantly
What control do you have over local lighting	Some Control/ No Control
(2) Temperature and Humidity	
At your workstation is it usually	Comfortable/Too warm/Too dry
Is the air around your workstation	Comfortable/ Reasonable/Too dry
(3) Noise	
Are you distracted by noise from work equipment?	Never/Occasionally/ Constantly
(4) Space	
Describe the amount of space around your workstation	Adequate/ Inadequate

FURNITURE

(5) Chair	
Can you adjust the height of your seat?	Yes/No
Can you adjust the height and angle of the backrest?	Yes/No
Is the chair stable?	Yes/No
Does the chair have castors that comply with the Trust guidelines for castors?	Yes/No
Is the chair in a good state of repair and the covering is intact?	Yes/No
If your chair has arms, do they get in the way?	Yes/No/NA
(6) Desk	
Is the desk surface large enough to allow you to place all your equipment where you want it?	Yes/No
Is the height of the desk suitable?	Yes/No-Too low/No-Too high
(7) Footrest	
If you cannot place your feet flat on the floor whilst keying, has a footrest been supplied?	Yes/No/NA
(8) Document Holder	
If it would be of benefit to use a document holder, has one been supplied?	Yes/No/NA

If you have a document holder, is it adjustable to suit your requirements?	Yes/No/NA

DISPLAY SCREEN EQUIPMENT

(9) Display Screen	
Can you easily adjust the brightness and contrast between the characters on screen and the background?	Yes/No
Does the screen tilt and swivel freely?	Yes/No
Is the image stable and free from flicker?	Yes/No
Is the screen at a height that is comfortable for you?	Yes/No
(10) Keyboard	
Is the keyboard separate from the screen?	Yes/No
Can you raise and lower the keyboard height?	Yes/No
Can you easily see the symbols on the keys?	Yes/No
Is there enough space to rest your hands in front of the keyboard?	Yes/No
(11) Mouse Device	
Is the mouse device suitable for your work?	Yes/No
Are you comfortable with the hand hold when operating the mouse device?	Yes/No
(12) Laptop	
Do you use a laptop as your desk top computer	Yes/No
Do you have a docking station with a separate keyboard, mouse and monitor?	Yes/No
If 'no' to the above question a laptop bundle should be used http://nuth-tranet/cms/Portals/0/Moving%20and%20Handling/Agile%20Working/Mobile%20Working%20Advice.pdf	
(13) Telecom Communications	
Do you carry out telephone consultations and /or virtual meetings?	Yes/No
Is your posture compromised when carrying out this task?	Yes/No/NA
If 'yes' to the above question http://nuth-intranet/cms/Portals/0/Moving%20and%20Handling/Agile%20Working/Phone%20and%20Dect%20Headset%20Guidance.0720.pdf	
(12) Training	
Have you been trained in the use of your workstation?	Yes/No
Have you been trained in the use of software and understand how to use it?	Yes/No
If you were to have a problem relating to display screen equipment work, would you know the correct procedures to follow?	Yes/No
Do you understand the arrangements for eye and eyesight tests?	Yes/No

Other Comments:

<u>Send copies to</u>:

Line Manager : Name Title Location

And if required to; Occupational Health ☐ and / or Estates Department ☐

Other ☐ Please state

NB: If this form is done electronically, just e-mail it to: newcastle.ohs@nhs.net

Please keep a copy readily available for inspection in your department. Review the assessment if there is a change eg a new member of staff, change of environment or a problem is identified that relates to working at the computer workstation.

Appendix 3

MOVING AND HANDLING ASSESSMENT SERVICE

- The Moving and Handling Team have a selection of adjustable office/task chairs, keyboards, mouse devices and desk solutions to be used for assessing staff with musculo-skeletal disorders referred to the service.

- If the Occupational Health Service recommends, as part of their assessment, a new chair/keyboards / mouse devices/desking solution or specialised DSE equipment, email handling.moving@nuth.nhs.uk or call the Moving and Handling Team on extension 25391 or 29378 to arrange an assessment.

- The assessments are carried out in the Moving and Handling office based in Peacock Hall at the RVI, so some travel between sites may be necessary.

- Order details for the required equipment will be sent to the member of staff, the manager responsible for ordering the equipment and the Occupational Health Service by email within two working days of the assessment.

- If the required equipment is a keyboard, mouse device, hands-free head set or other IT based product the information sheet will also be sent to IT Procurement so that a quote will be provided to the department to start the order process.

- To order the equipment an individual information sheet will be prepared with instructions on the order process to follow to ensure it is fast tracked through Finance and Supplies

- A record of the requisition number should be used by the department to track the progress of the order with the Supplies Team if there are concerns over a delay. Moving and Handling are not responsible for ordering/tracking the equipment.

Moving and Handling Team

November 2021

Appendix 4

HEALTH GUIDELINES FOR DISPLAY SCREEN EQUIPMENT USERS AND DEPARTMENTAL HEADS

1. POSTURE

1.1 Work Chairs

Work chairs should be stable, allowing users freedom of movement in a comfortable upright position, being of adjustable height including a height/tilt backrest. Users should remember to sit back in their chairs, adjusting the backrest to ensure good lower back support and adjusting seat height so that forearms are approximately horizontal with typing. Avoid pressure on underside of thighs and back of knees, using a footrest if your seat is too high. Being able to maintain good posture is fundamental to user's comfort.

1.2 Workstations

Workstations should provide a sufficiently large area for flexibility of equipment, e.g. screens, keyboards, documents and related equipment. DSE should have sufficient electrical and source cabling to allow for individual user preference and movement around workstation area. Organise your own desk surface to avoid overstretching.

1.3 Keyboards

Users should avoid over flexing their wrists or resting wrists on the edge of desks when using keyboards, remembering not to overstretch fingers and using soft touch on the keys. Wrist rests can be made available if users require then.

1.4 Portable Equipment

- Where a portable device (laptop/notebook) is supplied as the user's main computer, provision should be made for the portable equipment if used as a desk top computer. A docking station with desktop monitor and separate keyboard or a laptop stand, independent keyboard and mouse should be supplied. These accessories will allow the user to work at an appropriate desk height and an improved working posture.

- When the device is carried between work locations, the user should consider the weight of the device before purchase (preferably 3kg or less) and have a carrying case or backpack to reduce the strain on arms and distribute the weight more evenly across the body.

- Breaks from portable DSE should be taken regularly. Consideration should be given to increasing the frequency and length of the breaks to reduce the risks of working with portable DSE.

1.5 Environmental

DSE users and Departmental Heads must be aware of environmental factors around workstation areas giving consideration to adequate heating, humidity and lighting, also ensuring that noise levels are not sufficient enough to be distracting to the user and that normal speech is not disturbed.

1.6 Equipment

DSE users should inform their Departmental Heads if they suspect any DSE may be faulty or is not performing at its usual standard. The Department Head should take necessary steps to have equipment inspected and, if required, repaired prior to any further usage.

1.7 Avoiding Strain Injuries

Where DSE has moveable keyboards and swivel tilt screens along with other facilities for satisfactory operation, users should utilise these facilities to obtain the most comfortable position prior to the commencement of work. The chair and keyboard should be positioned to ensure minimal stretching or twisting of wrists, the user can rest their arms whenever their routine allows.

Users should adjust their screen height and angle to allow for comfortable head position, if using a document holder; it should be positioned appropriately to avoid excessive neck/head movement and refocusing of eyes.

If for any reason a user is experiencing musculoskeletal discomfort when working at a particular workstation, this should be reported to the Departmental Head and a review of the workstation area should be undertaken.

2 VISUAL PROTECTION

2.1 Lighting and Glare

Workstations should be sited away from obvious glare and disturbing reflections. Nearby windows should be fitted with suitable systems to adjust light. Internal light should be appropriate, taking in to account the user’s vision requirements, avoiding screen glare and reflections. Always clean your screen regularly with approved substances only.

2.2 Illumination of DSE Screens

Users should become accustomed to adjusting display screen illumination and contrast to their specific requirements prior to operation, making sure characters and printed text are easily readable particularly if lighting conditions change.

2.3 Screen Flickers and Drift

Some screens may have a small amount if flicker which would be considered normal. Where excessive screen flicker or drift of visual image becomes a problem for normal operation of the unit, users should report malfunctions to the Departmental Head for inspection/repair and avoid any further use of the equipment until the fault has been rectified.

3 NATURAL BREAKS AND CHANGES IN ACTIVITY

3.1 Users should vary their work routine to avoid prolonged work at display screens. Users should be able to manage their workload to allow them to take natural breaks or changes of activity before the onset of fatigue. These may take the form of other office tasks or just pauses of five – ten minutes taken away from the screen. Whenever possible, users should take some exercise and rest their eyes.

Departmental Heads should support users in organising their workloads and provide them with adequate information and guidance on taking breaks. No user should be required to work continuously for more than one hour at a time without taking a break of some type.

3.2 Some simple suggested exercises are as follows:

Sitting at the Desk

- Shoulder shrugging: gently raise shoulders towards the ears, hold for a second then relax, lowering shoulders. Repeat six times.
- Shoulder circling (similar to shrugging): raise shoulders up and forward, down and back in a circular motion. Repeat six times then circle in the opposite direction.
- Shoulder elevation (one arm at a time): start by shrugging shoulders then reach one arm up towards the ceiling, avoiding overstretching. Repeat with the other arm.
- Neck rotation: with the shoulders level and relaxed, turn head to the left as if trying to look over the left shoulder. Repeat the movement to the right side. Repeat the whole sequence three times.
- Neck retraction: draw chin gently in and back to feel a lengthening up the back of the neck. This helps to waken up the posture muscles.
- Hip flexion: push the chair slightly away from the desk for adequate space, sit comfortably in the chair and 'walk' on the spot, lifting one foot at a time off the floor raising the knees towards the chest. Try ten steps.
- Ankle circling: draw a circle with the feet in one direction, and then the other.
- Knee extension: in the same sitting position, straighten one leg out in front under the desk, pull the toes up keeping the knee straight, hold for a count of five then lower slowly. Try three stretches on each leg.

In standing

- Walk on the spot lifting the knees up towards the chest for as long as is comfortable.
- Standing with support on one side, swing the outside leg forward and back from the hip. Try ten swings each leg or, take a walk around the office, along the corridor or up and down the stairs.
- Lean back without over extending your spine and then lean side to side

You may find these suggestions helpful, or you may have exercises of your own. The number of repeats is up to you, but, remember don't overstretch; you want to feel relaxed and refreshed and ready to start work again.

Appendix 5

GUIDELINES FOR CASTORS ON OFFICE/TASK CHAIRS

‘Swivel-action chairs provided flexibility when the worker needs to conduct a variety of tasks and move from one location to another. Ensure that castors do not slide away too easily when the user gets up or sits down. This is a common problem when they are used on hard floors, or with chairs with a high or tilting seat. Different types of castors are available for different floor types, such as hard floors or carpet floors. In certain situations, glides are safer to use then castors. Ensure that the correct ones are chosen to meet workplace needs. Some seating is designed so that a brake is applied when the chair is sat on, or when the user gets up’.

‘Seating at Work’ HSE(1991), (Good Practice, para 27).

RECOMMENDATIONS

Carpeted Areas

- If the floor is carpeted, a **hard castor** is permissible.
- **Hard castors** allow free movement and are suitable on carpet only.

Hard Surface Areas such as lino, vinyl, wood or tile

- On a hard surface floor soft wheel castors are used.
- **Soft wheel castors** are un-braked and allow free movement when you are sitting but reduce any unpredictable movement through a rim of rubber around the castor; they are suitable on a hard floor surface.

Clinical Environment

When a clinical procedure is being carried out, the individual clinician, when choosing a chair, may have specific requirements in order to facilitate clinical practice. **A risk assessment should be completed** to balance the need for mobility and stability and make the safest choice of castor.

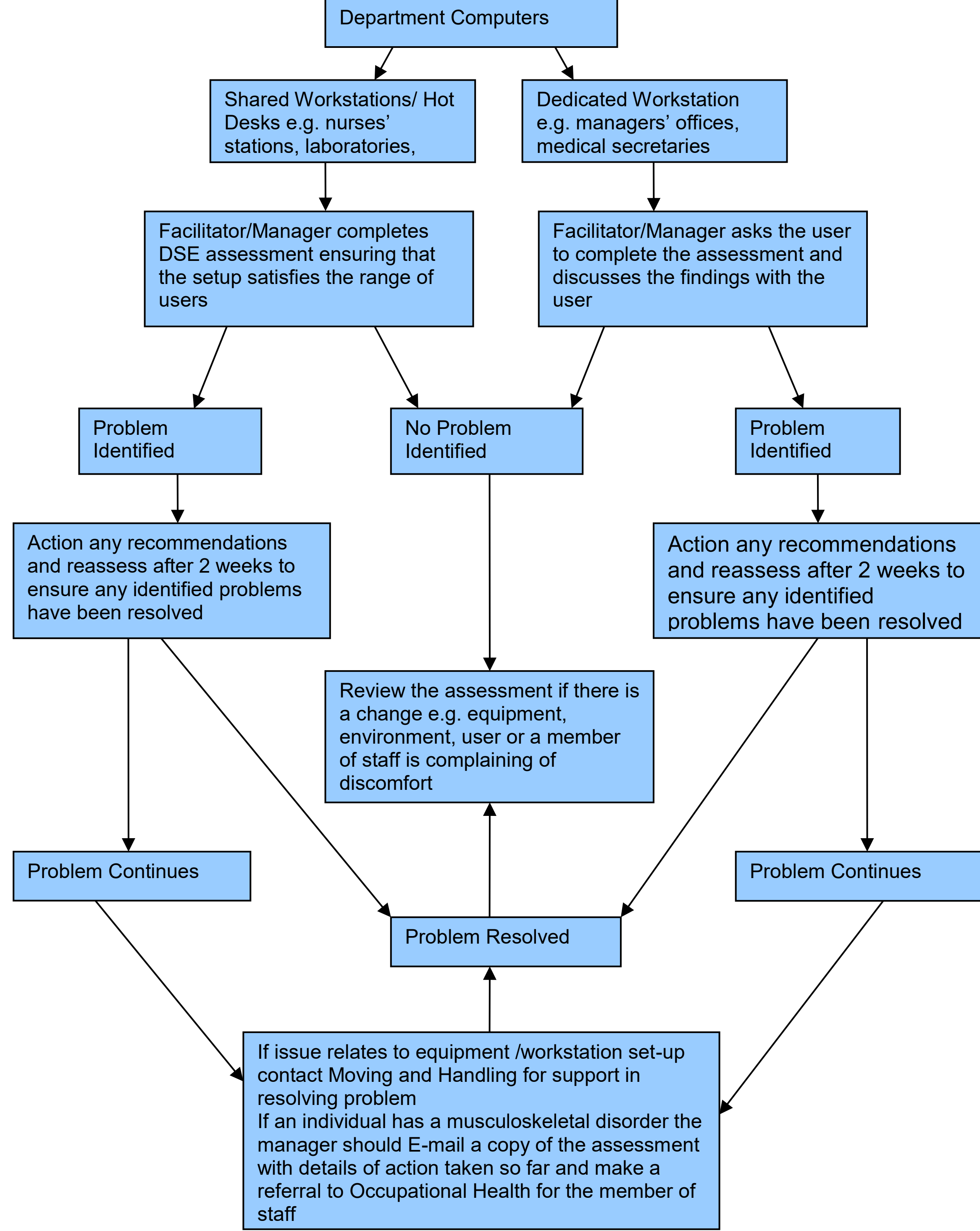
Laboratory Environment

Laboratory chairs are supplied with glides, as standard.

Always take care during the action of sitting down in a chair with castors. Locate your seat and ensure that the chair is stable and does not move from behind you.

Appendix 6

Trust System – DSE Assessments



Appendix 7

Trust Standard Operating Procedure - Managing Ultrasonography

Sonography environmental risk assessment conducted
Departmental compliance to be checked as part of monitoring visit
Bi-Annual departmental training to be delivered

Action recommendations identified on annual environmental risk assessment
Contact Moving and Handling to arrange training for sonography staff when due

↓

Identify staff performing ultrasonography for more than one hour at a time on a daily basis.
Ensure all relevant staff complete an individual sonography screening tool on commencing in post and then every year

↓

Assist the manager in reviewing completed staff individual sonography screening tools every year and provide on-going supervision and advice to staff

↓

Musculoskeletal issue reported – refer to OHS send screening tool and current environmental risk assessment +/- management referral form if additional non-sonography issues are identified

No musculoskeletal issues identified
Repeat sonography screening tools annually

↓

Assessed by OHS –
Report to manager with recommendations with one or more of the following:

- No action required
- Referral to OHS Physiotherapy
- Work place assessment – referral to Moving and Handling
- Annual recall by OHS

Key
Moving and Handling
Manager
Departmental Moving and Handling Facilitator
Occupational Health

Appendix 8

MOVING AND HANDLING SONOGRAPHY ENVIRONMENTAL RISK ASSESSMENT

WARD / DEPARTMENT/ BASE:	
HOSPITAL:	
DATE OF ASSESSMENT:	

ASSESSOR (PRINT NAME):	
TITLE:	

PRESENT SITUATION / COMMENTS

SONOGRAPHY CONTROL MEASURES CHECKLIST

ERGONOMIC CONTROL MEASURES IN PLACE	Yes ☑	No ☑	Not Applicable ☑
Equipment Do the scan rooms have:			
• Height adjustable couches?	☐	☐	☐
• Height adjustable seating with tilt option?	☐	☐	☐
• Ultrasound machine with height adjustable control panel?	☐	☐	☐
• Height adjustable monitor?	☐	☐	☐
• A wall mounted height adjustable monitor?	☐	☐	☐
• Are staff able to sit directly in front of the ultrasound machine when scanning?	☐	☐	☐
• Can staff look directly at a monitor?	☐	☐	☐
• Are staff able to alter their position as required during scanning to optimise their posture?	☐	☐	☐
• Do staff have access to a lightweight transducer?	☐	☐	☐
• Are there arrangements for supporting the weight of the transducer cable when scanning?	☐	☐	☐
• Does the Ultrasound equipment have workflow design software?	☐	☐	☐
• Do staff have access to Voice Recognition software to reduce time spent sitting at a computer workstation?	☐	☐	☐
• Is the age of the Ultrasound machine within the recommended time frame according to guidelines for your specialist area?	☐	☐	☐
• Have the computers within the department for reporting had a display screen equipment assessment completed?	☐	☐	☐
• Are staff aware of how to adjust the computer workstation to meet their individual needs?	☐	☐	☐
• Is there a suitable task chair available when completing reports?	☐	☐	☐
• Is there access to a barmouse at the computer workstation to reduce the shoulder movement when using the mouse device?	☐	☐	☐
Workplace Are the scan rooms:			
• A comfortable temperature for staff?	☐	☐	☐
• Free from distracting noise?	☐	☐	☐
• The recommended size for the required specialist areas (as per the findings from the HSE Report 2012): - General ultrasound 3.6m x 3.2m - Echo 3.6m x 3.6m - Vascular Ultrasound 3.2m x 4.2m	☐	☐	☐
• Are staff able to set up the room to meet their individual needs?	☐	☐	☐
• Can staff rotate between scanning rooms?	☐	☐	☐
• Is bilateral scanning encouraged within the department?	☐	☐	☐
• Is there a room set up to offer staff this option?	☐	☐	☐
The HSE (2012) advise that scanning as little as 10% of the working day with the opposite hand can reduce the risk of developing a work related musculoskeletal disorder.			
Caseload/Work Management			
• Do staff scan bariatric patients within their caseload?			

ERGONOMIC CONTROL MEASURES IN PLACE	Yes ☑	No ☑	Not Applicable ☑
• Do staff carry out mobile scans on inpatients throughout the department?	☐	☐	☐
Within the department is there:	☐	☐	☐
• Evidence of a member of staff who is responsible for co-ordination of the overall workload ensuring that all staff have an equal caseload and are managing this?	☐	☐	☐
• Assistants in place to assist sonographers when required for specialist scans?	☐	☐	☐
• Assistants in place to input measurements or freeze screens while the sonographer is performing a complicated scan or a scan on a bariatric patient?	☐	☐	☐
• Are requests for Ultrasound scans reviewed to ensure that the referral is appropriate?	☐	☐	☐
Appointments			
• Does the scheduled appointment incorporate adequate time for the staff to scan the patient, discuss with them and report?	☐	☐	☐
• Are appointments lengthened adequately to account for scans of multiple areas or complex scans?	☐	☐	☐
• Are clinics planned to allow staff time to take regular micro-breaks?	☐	☐	☐
• Do staff take their full meal breaks?	☐	☐	☐
	☐	☐	☐
• Is there evidence of staff rotation between speciality scans, the area scanned where appropriate, mobile scans and administration tasks?	☐	☐	☐

Risk reduction measures	YES	NO
• Have all staff attended the Moving and Handling training sessions that include exercises, body mapping, ergonomic advice relating to the workstation and environment set up?	☐	☐
• Are staff encouraged/ given time to perform exercises within the working day?	☐	☐
• Do all staff complete annual health screening questionnaires?	☐	☐
• Are staff referred to Occupational Health if they demonstrate symptoms of work related upper limb disorders?	☐	☐

Recommendations:

REVIEW DATE:	

Copies:

Moving and Handling Team, RVI
Newcastle Occupational Health Service
Manager

Reference

Health and Safety Executive March 2012 Project report "*Risk Management of Musculoskeletal Disorders in Sonography Work"* Cardiff

Appendix 9

The Newcastle upon Tyne Hospitals NHS
NHS Foundation Trust

NEWCASTLE OCCUPATIONAL HEALTH / MOVING AND HANDLING SERVICE

SONOGRAPHY SCREENING ASSESSMENT FORM

NAME:	
DATE OF BIRTH:	
DESIGNATION:	
DEPARTMENT/ HOSPITAL:	
HOURS WORKED:	
MANAGER:	
ASSESSOR:	
DATE COMPLETED:	

Advice for managers:

When to complete this form:
Complete for anyone performing ultrasonography for more than 1hr at a time and/or on a daily basis. This form should be completed as part of the sonographer's induction, and also annually thereafter.

What to do if a problem is identified:
See the separate prompt beside the relevant question.

Why is this form now required for ultra-sonographers:
Ultrasonography is identified as a practice which increases the likelihood of musculoskeletal complaints; particularly, but not exclusively, upper limb disorders. In order to minimise the risks associated with performing ultrasonography it is important to ensure that the work station is set up correctly, that appropriate ergonomic practices are employed, and that if any musculoskeletal complaints are identified, that these are referred in a timely fashion to Occupational Health for support.

If a musculoskeletal condition is identified as part of this assessment, should I get more information from the employee about their condition?
Other than a 'yes/no' answer to the relevant questions, further information should not be sought and is not required for the referral to Occupational Health.

Do I need to complete a separate Display Screen Equipment (DSE) assessment?
Yes. Ultrasonography uses DSE, so a separate DSE assessment should be undertaken – whilst this form looks at some of the elements of the DSE assessment the primary focus is on the setup and appropriate use of the scanning equipment.

Sonography Screening Assessment

EQUIPMENT

<table>
<tr><td colspan="2">Seat</td><td rowspan="11">If ‘no’ is selected then please reassess the work station and ensure that the following are available:
perch stool with appropriate casters
height and angle adjustable seat
height adjustable couch
height adjustable scan machine control panel & monitor
ability to move the scanning machine in relation to the couch
presence of a ‘slave’ monitor (separate screen) for the patient to use if they are viewing the scan as well
If further information/support is required regarding equipment, please contact the Moving & Handling team.</td></tr>
<tr><td>Do you have access to a specific perch stool when scanning?</td><td>Click here</td></tr>
<tr><td>Does the stool have castors that comply with the Trust guidelines for castors?</td><td>Click here</td></tr>
<tr><td>Can you adjust the height and angle of the seat?</td><td>Click here</td></tr>
<tr><td colspan="2">Couch</td></tr>
<tr><td>Is the couch height adjustable?</td><td>Click here</td></tr>
<tr><td colspan="2">Ultrasound Machine and Monitor</td></tr>
<tr><td>Can you position yourself directly in front of the scan machine and look directly at the monitor while scanning?</td><td>Click here</td></tr>
<tr><td>Can you adjust the height of the control panel on the scan machine?</td><td>Click here</td></tr>
<tr><td>Can you adjust the height of the monitor?</td><td>Click here</td></tr>
<tr><td>If the patient is to look at the scan while it is ongoing do you have a separate screen for the patient?</td><td>Click here</td></tr>
</table>

INDIVIDUAL FACTORS

<table>
<tr><td>Do you take micro-breaks between patients?
(e.g. 2-3mins every 30mins)</td><td>Click here</td><td rowspan="6">If ‘no’ is selected, then please consider that the following are recommended to minimise the chances of developing musculoskeletal problems from scanning:
Regular breaks away from scanning including micro-breaks in complex scans
Regularly changing your posture
Adjust the equipment at the beginning of each scan to ensure optimal positioning
Palmar grip is recommended
Changing the position of the transducer in your hand is preferable to awkward wrist postures
Consider alternating between dominant and non-dominant hand to allow your dominant hand to have a rest
Provision of a radiographic assistant may be helpful for scans requiring awkward/uncomfortable positioning</td></tr>
<tr><td>Do you vary between sitting and standing whilst scanning?</td><td>Click here</td></tr>
<tr><td>Do you adjust the couch height as required during scanning to optimise shoulder positioning?</td><td>Click here</td></tr>
<tr><td>Do you hold the transducer with a palmar grip?</td><td>Click here</td></tr>
<tr><td>Do you change the position of the transducer in your hand when changing from longitudinal to transverse scanning rather than flexing your wrist?</td><td>Click here</td></tr>
<tr><td>Do you alternate which hand you scan with?</td><td>Click here</td></tr>
<tr><td>Have you received training on using ergonomic principles when setting up for and carrying out ultrasound?</td><td>Click here</td><td>If ‘no’, please ensure the employee is given ergonomic advice from a Moving and Handling Facilitator and receives appropriate Moving & Handling training</td></tr>
</table>

CURRENT MUSCULOSKELETAL HEALTH:

<table>
<tr><td>Do you have a current or previous musculoskeletal condition?

If Yes: Is this condition ongoing and/or symptomatic?

NB: No further information is required other than a Y/N answer to this question and a Y/N answer to the follow-up question.</td><td>Click here</td><td>If it is ongoing and/or symptomatic, then REFER TO Occupational Health Service (OHS) – unless already under OHS for this problem

If the condition has fully settled or if you have no symptoms, then OHS referral is not required, but REFER EARLY IF SYMPTOMS DEVELOP or if any concerns</td></tr>
<tr><td colspan="3">This risk assessment will be done annually, but should you develop any musculoskeletal symptoms that are made worse, or possibly caused, by performing ultrasonography then it is strongly recommended that you inform your manager at the earliest opportunity to ensure a timely referral to Occupational Health is made.

If referring to Occupational Health:
1) Email a copy of this form to newcastle.ohs@nhs.net
2) Please ensure that the employee is aware of this referral
3) If you require additional information/input from OHS, then please also send the standard ‘Management Referral’ OHS form outlining the nature of the query/request, and attach this risk assessment form
4) Please confirm an up-to-date contact number for the employee:

If the individual declines a referral to Occupational Health, please:
1) Please ensure that the employee is aware that a referral to Occupational Health is recommended based on the answers on the form
2) The employee should sign that they are happy to decline the referral to Occupation Health.
Signed: Date</td></tr>
</table>

Risks Identified:
Recommendations:

Other Comments/ Additional information:

Send copies to:

Line Manager : Name Title Location Other ☐ Please state

Please keep a copy readily available for inspection in your department. Review the assessment if there is a change e.g. a new member of staff, change of environment or a problem is identified.

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Equality Analysis Form A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

PART 1

1. **Assessment Date:** **12.11.21**

2. **Name of policy / strategy / service**:

Display Screen Equipment

3. **Name and designation of Author:**

Jennifer Pye, Specialist Moving and Handling Co-ordinator

4. **Names & designations of those involved in the impact analysis screening process:**

Jennifer Pye, Specialist Moving and Handling Co-ordinator,

5.

Is this a:	Policy	✓	Strategy		Service	
Is this:	New		Revised	✓		
Who is affected	Employees	✓	Service Users		Wider Community	

6. **What are the main aims, objectives of the policy, strategy, or service and the intended outcomes?** *(These can be cut and pasted from your policy)*

The aim of the policy is to safeguard staff safety and comfort whilst working with Display Screen Equipment.

7. **Does this policy, strategy, or service have any equality implications?** **Yes** ✓ **No** ☐

If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:

8. Summary of evidence related to protected characteristics

Protected Characteristic	Evidence, i.e. What evidence do you have that the Trust is meeting the needs of people in various protected Groups	Does evidence/engagement highlight areas of direct or indirect discrimination? If yes describe steps to be taken to address *(by whom, completion date and review date)*	Does the evidence highlight any areas to advance opportunities or foster good relations. If yes what steps will be taken? *(by whom, completion date and review date)*
Race / Ethnic origin (including gypsies and travellers)	Provision of interpreters EDHR mandatory training BAME Staff Network	No evidence of discrimination	No
Sex (male/ female)	Mandatory EDHR training	No evidence of discrimination	No
Religion and Belief	None relevant to policy	No evidence of discrimination	No
Sexual orientation including lesbian, gay and bisexual people	Mandatory EDHR training LGBT Staff Network	No evidence of discrimination	No
Age	Mandatory EDHR training	No evidence of discrimination	No
Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section	Ophthalmic assessment available to staff Assessment by Occupational Health for further support Chair assessment service provided by Moving and Handling Team	Need to assess staff on an individualised basis to ensure there is no impact on certain disabilities.	Further information added to employee and assessor responsibilities in the policy
Gender Re-assignment	Mandatory EDHR training	No evidence of discrimination	No
Marriage and Civil Partnership	Mandatory EDHR training	No evidence of discrimination	No
Maternity / Pregnancy	Maternity risk assessment completed and if required referred to Moving and Handling for chair assessment Pregnancy workers policy	No evidence of discrimination	Addressed in policy, added to section 8.6

9. Are there any gaps in the evidence outlined above? If 'yes' how will these be rectified?

No

10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.

Do you require further engagement? Yes ☐ No ☑

11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?

No

PART 2

Name:

Jennifer Pye

Date of completion:

21.11.21

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Employment Policies and Procedures

Electronic Rostering & Attendance Policy (Non – Medical)

Version No.:	6.0
Effective From:	11 October 2022
Expiry Date:	11 October 2025
Date Ratified:	03 October 2022
Ratified By:	Heads of HR

GENERAL POLICY STATEMENT

The Newcastle upon Tyne Hospitals NHS Foundation Trust recognises the value of its workforce and is committed to supporting staff to provide high quality patient care. Whilst acknowledging the need to balance the effective provision of service with supporting staff to achieve an appropriate work life balance, it is recognised that the organisation needs to be able respond to changing service requirements. A flexible, efficient and robust rostering system is key to achieving this objective.

1 Policy Statement

1.1 The purpose of this policy is to ensure the effective utilisation of the workforce through efficient rostering by:

- Improving the utilisation of existing staff and reducing bank and agency spend by giving Ward / Unit / Department Managers clear visibility of staff contracted hours
- Ensuring that rosters are fair, consistent and fit for purpose, with the appropriate skill mix, to ensure safe, high quality standards of care
- Support the deployment of staff according to service needs across the organisation
- Providing accurate management information regarding the establishment thereby driving efficiencies in the workforce across wards/departments and opportunities for flexible working.
- Improving the monitoring and management of sickness and absence by department and/ or individual, generating comparisons, identifying trends and priorities for action
- Improving the planning of non-clinical working days (unavailability), e.g. annual leave and study leave
- Enabling the requirements of the European Working Time Directive to be balanced with the needs of service delivery
- Providing a mechanism for reporting against set Key Performance Indicators (KPIs)

- Facilitating the payment of staff through data being entered at source

1.2 The components of the e-Rostering system include:

- Rostering
- Absence management
- Registering attendance at work
- Payroll
- Safe Staffing
- E-Rostering reports which can facilitate staffing and service management decisions

2 Aim of Policy:

The aim of this policy is to provide guidance to managers and employees. The policy sets out guidance on:

- Responsibilities
- Key principles including roster responsibilities, general roster management, staffing levels, payroll
- Rules and guidelines for the use of the e-Rostering system
- How rosters can be managed including shift duration, gaps in rosters
- Guidance on roster methodology including registering attendance, shifts and working patterns, management of working time and leave

3 Scope

This policy applies to all staff (excluding Medical & Dental staff) using HealthRoster

4 Associated Documents

The policy must be read in conjunction with the following documents:

- Annual Leave and General Public Holidays Policy
- Working Flexibly Policy
- Working Time Regulations Policy
- NHS Terms & Conditions of Service
- NUTH On-Call Agreement
- Staff Bank and Agency Policy
- Health, Wellbeing & Attendance Management Policy
- Special Leave Policy
- Study Leave / Continuing Workforce Development (CWD) Policy
- Fraud, Bribery and Corruption Policy and Response Plan
- Allocate User Guides
- Nursing & Midwifery Safe Staffing Guidelines

- Efficient and Effective Rostering Nursing Staff Handbook
- Standards of Business Conduct Policy

5 Roles and Responsibilities

5.1 Corporate Responsibility

The Executive Team and Trust Board hold corporate accountability for ensuring there are robust systems and processes in place across the organisation to make informed and accurate decisions concerning workforce planning and provision. Responsibility is delegated to the Director of HR to ensure that there are systems and processes in place to capture accurate data on staffing levels and skill mix, staff movements, training and turnover to inform decisions on workforce planning. The Executive Team is accountable to the Trust Board for ensuring Trust-wide compliance with policy.

5.2 e-Rostering Team

The e-Rostering Team are responsible for:

- ensuring that the e-Rostering platform is fit for purpose and maximised to its full potential
- monitoring rosters on completion and reporting against KPIs, feeding back to the appropriate managers where better rostering could improve the utilisation of the workforce
- ensuring the HealthRoster system remains appropriately configured
- providing support and ongoing training to the HealthRoster users
- liaising with the Allocate Support Team to resolve system issues as required
- submitting the overall Trust payroll file
- producing the organisation wide Roster Calendar

5.3 Roster Service Manager

This is usually the Directorate Manager, Head of Service or Matron. The Roster Service Manager will:

- Review and approve rosters submitted from units / wards
- Reallocate staff and authorise the use of temporary staffing solutions if necessary and where required
- Continuously review and monitor staffing capacity and capability across areas of responsibility
- Support Unit Managers to ensure they have appropriate staffing capacity and capability on a shift by shift basis, and following escalation procedures where necessary

- Fully approve the roster (Level Two approval) or rejecting rosters that do not comply with the Key Performance Indicators in Roster Analyser
- Deal with any exceptions which are associated with their direct reports
- Complete full finalisation of shifts in line with payroll deadlines
- Be responsible to the Executive Team for ensuring policy implementation

5.4 Roster Unit Manager

This is usually a Unit Manager, Ward Manager or the budget holder / nominated deputy. The Roster Unit Manager will:

- Produce and manage safe and efficient staff rosters ensuring that rosters are updated on a shift by shift basis
- Ensure that a quality roster is produced, maintained and finalised in line with Key Performance Indicators
- Ensure that expenditure does not exceed the allocated budget within their unit(s)
- Partially approve the roster (Level One approval)
- Measure quality of care and outcomes achieved for patients and the capacity and capability of staff on a department-to-department basis
- Respond in a timely manner to unplanned changes in staffing, changing patient acuity / dependency numbers, including the request for the use of temporary staffing where shortages are identified
- Escalate concerns to line manager where staffing capacity and capability are inadequate to meet patient needs
- Nominate a roster deputy and ensure that these staff are appropriately trained
- Ensure that there are enough staff in the right place at the right time, based on the agreed and funded skill mix, to meet the needs of the service
- Ensure fair and equitable allocation of Annual Leave and Study Leave
- Consider all roster requests from staff, ensuring fairness and equity in working patterns
- Deal with any exceptions which are associated with their direct reports
- Complete finalisation on a weekly basis and full finalisation in line with payroll deadlines
- Take responsibility for making decisions relating to rostering and absence management in accordance with related HR policies.
- Be responsible for ensuring policy implementation and compliance in their area(s)

5.5 Roster Administrator:

This is usually someone in an administrative role, for example a Unit / Ward Clerk, Unit / Ward Secretary. This could also be any suitably trained member of staff. The Roster Administrator will:

- Update the roster as it is worked by inputting Unavailability's (unavailable for normal duty or non-clinical) time, including sickness and leave.
- Assist in the day to day maintenance of the roster

5.6 All Staff:

Staff are responsible for:

- Attending work as per their duty roster
- Adhering to the requirements set out by this policy
- Notifying the Unit Manager of any changes to a planned shift
- Requesting shifts (if required) and annual leave using EmployeeOnline
- Accurately registering their attendance at work

6 Overview

6.1 The Electronic Rostering and Attendance (ERA) system is a time and attendance, and e-rostering system that allows staff working time to be recorded electronically. The system also enables rosters to be compiled, leave to be requested and authorised, absences to be recorded and enhanced payments and overtime to be calculated and paid electronically.

6.2 The e-Rostering system is provided by Allocate Software and encompasses different platforms:

- HealthRoster (HRos) – Management module
- EmployeeOnline (EOL) – Employee module
- SafeCare (SC) – Safe Staffing module
- Roster Perform (RP) – Reporting module

6.3 Managers who are responsible for staff attendance and e-rostering will be supported by the e-Rostering team to effectively and accurately use the system, including training and staff support. The levels of authority are at Appendix A.

6.4 The e-Rostering system interfaces with the Trust's Electronic Staff Record system (ESR) so that information about employment, attendance and leave are shared between the two systems.

6.5 Any fraudulent activity must be reported in line with the Trust's Fraud, Bribery and Corruption Policy and Response Plan and will be subject to formal action.

7 Producing Rosters

7.1 Roster Overview

7.1.1 A roster is a tool that is used to ensure that the right people with the right skills are in the right place at the right time, to meet the demands of the service whist taking into account staff numbers, capacity, capability, adequate rest and headroom.

7.1.2 Managers are responsible for the allocation of staff to ensure the effective delivery of services with due consideration of:

- Service needs/demands
- The health, safety and welfare of patients and staff
- The agreed establishment and staffing rostering framework

7.1.3 Once a roster has been created it is firstly approved by the Roster Unit Manager and then by the Roster Service Manager before it goes live. Once the roster is live it can be viewed electronically via EmployeeOnline by the individuals who are scheduled to work on it.

7.1.4 During the roster period, Roster Unit Managers and Roster Service Managers can make shift by shift adjustments to take into account any changes in circumstances that may arise e.g. sick leave / other leave.

7.1.5 Once the roster has been worked, the Roster Unit Manager and the Roster Service Manager have up until the payroll deadline in the subsequent calendar month to review and finalise the roster to ensure that all the information contained within it is correct. The roster is then sent to payroll for processing by the e-Rostering team.

7.1.6 The roster planning and management process is explained in more detail below:

7.2 Roster Planning

7.2.1 Rosters must be completed at least six weeks in advance of the start date, using HealthRoster. This will enable staff to better manage their personal arrangements and to afford the Staff Bank office sufficient time to fill vacant shifts. All rosters will start on a Monday and run for a 28 day period in accordance with the published roster calendar that can be viewed on the ERA Intranet pages.

7.2.2 All rosters should be composed to adequately cover 24 hours (or agreed set hours) utilising permanent staff proportionally across all shifts.

7.2.3 Shifts given a high priority on HealthRoster should be filled first, i.e. nights and weekends. The use of bank, agency and overtime for nights and weekends should be avoided wherever possible.

7.2.4 Managers are expected to apply the use of additional basic hours, overtime and / or bank staff only where necessary and with due consideration of patient safety, service need and staff health and wellbeing.

7.2.5 All additional basic hours, overtime and / or temporary (short-term) staff cover is subject to approval in advance by the appropriate manager e.g., Directorate Manager, Matron, Clinical Director or *Patient Services Coordinator (* out of hours only).

7.2.6 Gaps in rosters should be covered in the first instance by asking part-time staff to work additional hours. Any remaining gaps should be covered by bank staff.

7.2.7 Long term placement of temporary staff requires prior approval from the Recruitment Control Group (RCG).

7.2.8 Overtime should not be authorised where it is to cover annual leave, unless required to cover a clinical safety risk. In this case the required approval should be sought from the Matron.

7.2.9 Routine booking of additional shifts and overtime during a period of Annual Leave should be avoided. If required, this needs to be escalated to a Senior Manager for approval.

7.3 Temporary Staffing

7.3.1 Temporary Staffing requests should be made in keeping with the Staff Bank and Agency Policy.

7.3.2 Duties should be sent to bank only once all efforts have been made to utilise all available contracted hours on the roster as well as seek available staff via redeployment from other areas.

7.3.3 Consideration should be given to "hard to fill" / "high priority" requests that may require immediate escalation to agency due to specialist skill requirements for example. Again, the use of agency should only be considered an option if all substantive and bank options of cover have been exhausted.

7.3.4 Agency workers should only be booked via the Bank Office or out of hours / on-call / site manager, using only the approved agencies in the first instance

7.4 Approve the Roster

7.4.1 Before rosters are worked, they must be reviewed and approved at two stages:

1. Partial Approval – Unit Manager i.e. Ward Sister/Charge Nurse
2. Full Approval – Service Manager i.e. Matron

This is approval of a planned roster, acknowledging that further changes may be required due to unpredictable changes in demand or available resource.

7.4.2 Roster approval only applies to units that have staff who work rostered shifts and not units with staff who are on fixed shift patterns.

7.4.3 The approval and publication of working rosters will be aligned to the published roster calendar which can be viewed here.

7.4.4 The roster will be measured against key performance indicators (KPI's) as specified in Appendix B which can be viewed and analysed via Roster Analyser.

7.4.5 Any roster that falls outside of the set parameters must be reviewed and scrutinised for approval / rejection. If the roster is not approved, it will be returned to the Roster Unit Manager to make the necessary adjustments to resubmit. When Second Approval has been reached, the roster is automatically published to EmployeeOnline for staff to view.

7.4.6 A checklist for validating and approving rosters is in Appendix C.

7.5 Work and Maintain the Roster

7.5.1 Any changes that are made to the published roster must be updated in real time; this includes shift changes, additional duties, temporary staff duties, sickness and other unavailability shifts (see section 13).

7.5.2 All changes made, after the roster has been approved, will be clearly marked for audit purposes. If this has impact on the booking of temporary staff, this should be immediately communicated to the Staff Bank office.

7.5.3 Shift changes should be kept to a minimum. Staff are responsible for negotiating their own changes once the roster is completed. These changes must be approved by the Unit Manager.

7.6 Finalise the Roster

7.6.1 All updates to the roster must be made as soon as practically possible after occurrence, taking into consideration Payroll deadlines (this includes changes to shifts, times of attendance, late finishes, sickness and holiday). The actual worked roster should be verified and finalised by the Unit Manager on a week

by week basis to ensure accuracy and timeliness. It is the Unit Manager's responsibility to ensure appropriate staff have access and have been trained to make these changes.

7.6.2 At the end of the calendar month the Roster Unit Manager is responsible for second stage finalisation. This involves checking and confirming that the roster accurately reflects any changes that have occurred during the relevant period and where applicable all additional hours / overtime and all absences have been correctly input.

7.6.3 Once this is complete, the roster can be fully finalised for payroll submission and Finalised Hours Report ran and validated. It is the Unit Managers responsibility to run and check this report to ensure payroll accuracy.

7.6.4 Managers should use the monthly payroll authorisation process as an opportunity to ensure the details displayed in HealthRoster are correct. Managers should pay particular attention to contracted hours, pay band and to ensure new starters have been added and all leavers removed (taking into account both the timescales for the interface with ESR and payroll deadlines). Any errors should be notified to the e-Rostering team in the first instance.

7.6.5 Managers are reminded that leavers must be notified to the Human Resources Department immediately when it is known a person is leaving – see Staff Leaving The Trust procedure on the intranet.

7.6.6 The e-Rostering team will prompt managers when the monthly electronic payroll process is due (on the 1st of the month or nearest working day) and when the process is due to close (payroll information is submitted by the rostering team on approximately 7th of the month or nearest working day).

7.6.7 Rosters should be finalised in keeping with Organisational cut off dates for Payroll. Units not finalised in line with deadline will be advised by the Rostering Team of any unfinalised duties or unavailabilities in the pay period. Failure to complete finalisation for the unit will result in non-payment.

7.6.8 Staff should check their individual rosters via EmployeeOnline to ensure the roster is a true reflection of hours worked and the electronic timesheets are as expected in terms of additional pay and payment rates. Any discrepancies must be escalated to the appropriate line manager without delay.

7.7 Payments

7.7.1 All additional basic hours, overtime, on-call payments and enhancements are recorded by the relevant manager in HealthRoster and paid automatically via an electronic link to Payroll Services. All unit managers must complete the Payroll authorisation process each month within the designated payroll approval window. Payroll authorisation must be in accordance with the Trust's Corporate Governance Manual: Scheme of Delegation i.e. the authorised

signatory should normally be at level two [Directorate Manager/Head of Department] or above.

7.7.2 All additional payments to basic pay must be recorded in HealthRoster. These payments are:

Payment	Definition
Additional Hours	Hours worked by part-time staff over and above their normal contracted hours, but less than full time hours
Enhanced [Unsocial] Hours	Hours worked per week within full-time hours (37½ per week) between 8.00pm and 6.00am Monday to Friday, and all hours worked on a Saturday, Sunday or Bank Holiday (midnight to midnight). (NB Enhanced hours cannot be claimed during overtime or work done whilst on-call)
Overtime	Hours worked in excess of standard (full time) hours i.e. more than 37½ per week. (Part-time staff cannot claim overtime rate until they have exceeded 37½ per week)
On-Call	Payment for each occasion an employee is available on-call AND any advice given by telephone during that time subject to agreement by the manager
On-Call: Work Done	Hours worked having been called in to work whilst available on-call (Refer to Trust's On-Call Agreement for more details)
Waiting List Initiative	Payment for hours worked as part of approved Waiting List Initiative activity

7.7.3 All rates of pay are in accordance with NHS Terms and Conditions of Service.

7.7.4 Payment of overtime for part time staff exceeding full time should be calculated over the reference period that is worked. For example, if a member of staff is contracted to 28.75, working 10 shifts over a four week reference period, equating to 115 hours. The staff member would need to work over full time (150 hours) within the reference period to be eligible for an overtime rate

of pay. Therefore an additional 35 hours of ‘Additional Basic Unit’s would need to be worked and credited within the four week reference period before any overtime.

7.7.5 All additional payments for part time staff that cross into overtime should follow a chronological pattern within their reference period.

7.7.6 The Unit Manager needs to ensure that no overtime or additional hours have been assigned to a member of staff who owes the Trust hours and special attention is paid to bank holiday shifts and sickness period to avoid over/under payments.

7.7.7 Where an employee holds more than one contract of employment with the Trust, the two contracts should be treated entirely separately i.e. no account should be taken of the total hours (of the two contracts together) for the purposes of overtime.

8 Skill Mix and Safe Staffing

8.1 Skill Mix

8.1.1 An agreed and funded staffing baseline is essential to delivering high quality care. Each nursing roster should have an agreed total number of staff and skill mix for each shift, approved by the Executive Chief Nurse, Senior Nursing Team, Matron and the Unit Manager.

8.1.2 The skill mix and establishment should be reviewed at least annually, with the budget setting and workforce planning process. Skill Mix and establishment reviews may happen more frequently if a need / risk is identified.

8.1.3 In areas where the workload is known to vary according to the day of the week staff numbers and skill mix should reflect this.

8.1.4 Each area should have an agreed level of staff with specific competencies on each shift, to enable appropriate cover

8.1.5 Within nursing rosters there must be designated person in charge for each shift who has been identified as having the required skills for a co-ordinating role.

9 Flexible Working

The Trust is committed to improving working lives and will support staff to positively explore ways in which they can better balance their work and personal lives. Managers are encouraged to accommodate flexible working arrangements and more informal day-to-day type arrangements if it works for the service, the team and the individual. All details are outlined in the Trust’s Working Flexibly Policy.

10 Time Owing

10.1 Time Off in Lieu (TOIL)

10.1.1 A manager can award TOIL as required for service need / continuation of care.

10.1.2 Managers and staff should review TOIL balances on a regular basis.

10.1.3 To maximise efficiency within the management of exceptions, no exceptions will be generated within a 30 minute tolerance before the planned shift start or 15 minute tolerance after the shift planned end. Exceptions will be generated if staff clock in late or clock out early against planned shift time.

10.1.4 If an employee clocks outside of tolerances an exception will be generated. It is manager’s responsibility to agree TOIL if appropriate and based on service need and manage the exception accordingly.

10.1.5 A manager has discretion to award TOIL within the tolerances if required for service need/continuation of care, even if an exception has not been generated. If this is required the shift times should be adjusted accordingly.

10.1.6 If TOIL is agreed it is for the whole-time above shift time end e.g. If a person stays 20 mins after their shift they receive 20 minutes TOIL, not 20 minutes minus the 15-minute tolerance.

10.1.7 TOIL should be taken back as soon as possible as the service needs allow.

10.1.8 If, for operational reasons, TOIL cannot be taken back within three months the employee is entitled to ask for payment for work done in accordance with NHS Terms and Conditions of Service.

10.1.9 The maximum amount of TOIL that can be utilised in one episode should not exceed one working day. If a full day is taken the Unit Manager should cancel the shift and select TOIL as the Cancel reason.

10.1.10 The net hours displayed on the roster support the tracking of hours worked over (and under) contracted hours for any given period.

10.1.11 When an employee leaves the Trust / moves internally, managers are required to review TOIL balances and to take action where necessary regarding any outstanding balances.

10.1.12 TOIL does not apply to staff that work Corporate Standard shifts please refer to section 10.2 below.

10.2 Corporate Standard Shifts

10.2.1 Staff working on corporate standard shifts (symbolised by CS on the roster) have a cumulative 'net hours left' balance based on their clockings. Managers should be aware of this +/- balance and ensure all staff work contracted hours within the rostered period. The manager should also note that a positive balance is not explicitly TOIL but should inform the degree of flexibility available within a rostered period.

10.2.2 Staff who routinely work corporate hours i.e. Monday to Friday 7.5 hour standard shifts and do not routinely accrue TOIL can be placed on a Corporate Standard pattern. This pattern can be authorised by a Service Manager alongside guidance from the e-Rostering Team.

11 Requests

11.1 Shift Requests

11.1.1 Where applicable staff should make requests to work specific shifts via EmployeeOnline.

11.1.2 The number of requests an individual can make will be calculated according to their hours of work. A full time member of staff can make six shift requests in a four week period. Part time staff can request a prorated number of shifts in a four week period.

Staff Hours per Week	Maximum Number of Requests per 4 Week Roster
31.5 to 37.5 hours	6 requests
25.5 to 31 hours	5 requests
19 to 25 hours	4 requests
13 to 18.5 hours	3 requests
6.5 to 12.5 hours	2 requests
0.5 to 6 hours	1 requests

11.1.3 Staff can make a maximum of two requests per week within the four week roster period.

11.1.4 All requests will be considered in the light of service needs and the Unit Manager will endeavour, as far as possible, to meet individual requests. However, it cannot be assumed that the roster will be developed to accommodate all requests, as service needs will take priority.

11.1.5 The Ward Unit Manager is responsible for approving all requests.

11.1.6 Personal patterns are not to be considered as requests.

11.1.7 Fairness in the allocation of requests will be monitored using the appropriate staff league tables.

11.2 Annual Leave Requests

11.2.1 All staff should make annual leave requests via EmployeeOnline.

11.2.2 All requests will be considered in the light of service needs and the Unit Manager will endeavour, as far as possible, to meet individual requests. However, it cannot be assumed that the roster will be developed to accommodate all requests, as service needs will take priority.

11.2.3 Unit managers for nursing and midwifery staff should be aware of the headroom allowed for Annual Leave and ensure this is taken into account when deciding whether to approve or reject a request.

11.2.4 A request for annual leave shall not be granted where it would incur additional cost to cover, for example, additional basic hours / overtime / temporary / bank / agency staff

11.2.5 Employees should review their outstanding annual leave entitlement on a regular basis via EmployeeOnline and plan their requests as far ahead as possible to ensure they take their entitlement before the end of the leave year and help ensure rosters can be covered at all times.

12 Shift Patterns

12.1 Overview

12.1.1 Shifts and the working pattern of shifts should reflect service needs. Managers requesting the creation of new shifts or shift patterns must be able to demonstrate this and provide clear justification of its requirement for the needs of the service.

12.1.2 Staff will be required to work a variety of shifts and shift patterns as agreed by their Unit Manager or as specified in their contract of employment.

12.1.3 Staff may work long shifts, short shifts or a combination of both in order to meet the service requirements.

12.1.4 Staff may have a minimum of one weekend off per 4-week roster, unless they specifically request not to have weekends off. Additional weekends off can be rostered if the departmental requirements allow.

12.1.5 The maximum number of consecutive long day shifts recommended for staff to work is 3.

12.1.6 Night Duty should not exceed a maximum of four consecutive shifts.

12.1.7 The maximum number of nights that a worker should be expected to work in a 28 day period is 7. This excludes staff who specifically request to work a greater number of nights.

12.1.8 Staff in clinical areas on permanent night duty will work a minimum of two consecutive weeks on day duty every six months to enable them to keep up to date.

12.1.9 Staff should be rostered for two consecutive days off per week whenever possible.

12.1.10 Where long days are agreed, the maximum amount of hours worked should not exceed 13 hours.

12.1.11 Working time on a night shift should not exceed 12 hours.

12.1.12 All staff should have a minimum of 11 hours continuous rest in every 24 hour period.

12.1.13 All staff should have a minimum of 24 hours continuous rest in every seven days or minimum 48 hours rest in every 14 days.

12.1.14 Staff should not work more than an average of 48 hours per week over a rolling 17-week reference period.

12.1.15 It is acknowledged that an employee may wish to work more hours than the maximum weekly limit. Such an employee shall be permitted to do so provided that he/she has entered into an individual and voluntary written agreement with the Trust to dis-apply the 48-hour rule. Please refer to the Working Time Regulations Policy.

12.1.16 Clinical areas should have no more than three handovers in a 24-hour period, and the handover period should not normally exceed two hours.

12.2 Breaks During Shifts

12.2.1 All shifts of more than six hours (up to 12 hours) should include a minimum of 20 minutes unpaid break in accordance with Agenda for Change and the European Working Time Directive.

12.2.2 The Trust standard break lengths are 30-60 minutes for a typical 7.5 hour shift and 60 minutes for a 11.5 hour shift.

12.2.3 Breaks should be accurately recorded within duties in HealthRoster, if there are any changes to the length of break, within EWTD guidelines, the break length should be updated on the duty.

12.2.4 The Unit Manager or person in charge and the individual are responsible for ensuring that breaks are taken. If breaks are unable to be taken an agreed time due to clinical need, they should be taken as soon after this point as possible.

12.2.5 Breaks should not be taken at the end of a shift, as their purpose is to provide rest time during the shift.

12.3 Staff Redeployment

12.3.1 During staff shortages, it is accepted that staff may be required to work in other clinical areas across the Trust to provide a safe and efficient service. The Senior Nurse / Matron or other designated person for each area is responsible for the redeployment of staff within the directorate to meet service requirements. Out of hours, this decision will be made by the Patient Services Coordinator.

12.3.2 It is recognised that staffing needs to be considered at an Organisational level (i.e. cross directorate when staffing redeployment in a directorate is not possible). The Senior Nurse / Matron or other designated person is then responsible for contacting the Duty Manager. They will together make the final decision as to which area a nurse can be moved from, considering staffing cross directorate, ward / unit dependencies and bed occupancy.

12.3.3 It is accepted that in the event of a Major Incident, staff will be redeployed, taking into consideration their skills, to provide the best patient care. The HealthRoster system will be used to manage workforce redeployment in the event of a major incident.

13 Unavailability

13.1 Annual Leave Entitlement

13.1.1 Annual Leave is calculated and arranged in accordance with the Annual Leave and General Public Holidays Policy and recorded in HealthRoster.

13.1.2 At the beginning of the new leave year the e-Rostering team will input Annual Leave entitlements, including Bank Holiday entitlements, into HealthRoster for all staff in accordance with data compiled from ESR in relation to contracted hours and length of service.

13.1.3 Any changes required to this balance in relation to change in contract hours / length of service mid-year, will be the responsibility of the Unit Manager to re-calculate and update HealthRoster.

13.1.4 All Trust new starters annual leave entitlement will be updated on the system within the first week of their employment and is derived from their Trust contract.

13.1.5 The split between recording Annual Leave and Bank Holiday absences should be accurately represented within HealthRoster in accordance with an employees entitlement to each.

13.1.6 Staff with two postings and therefore two contracts within the Trust should have their annual leave split.

13.1.7 Annual Leave entitlement for a term-time employee is calculated based on contracted (actual working hours) and not paid hours. Annual leave must be recorded in HealthRoster based on contracted hours, not paid hours. Staff on term-time contracts should request from their manager (via electronic annual leave requests in EmployeeOnline) which school holidays they would like to take as annual leave in line with their annual leave entitlement. Requests should be actioned by the manager in HealthRoster. Any further shifts within the school holidays that the member of staff does not work should be cancelled and recorded as ‘Term Time’ in the cancel reason. Incorrect recording of annual leave for term-timers who work unsocial hours is likely to result in under or over payments and so managers must ensure HealthRoster remains up to date.

13.2 Annual Leave Allocation

13.2.1 Each department should calculate how many registered and unregistered staff must be given annual leave in any one week, with a defined limit to ensure agreed skills mix. An agreed number should be set and adhered to.

13.2.2 Staff should be made aware of the need to maintain this number constantly throughout the year. If this number should not be met by way of requests and / or the manager considers the amount of outstanding annual leave will put rosters at risk of not being covered, staff will be required to submit a request to take some or all of their remaining leave (on available dates) without delay. If an employee fails to make a request, the manager will consult with them with a view to allocating some or all of their outstanding leave. Managers reserve the right to allocate dates on which leave must be taken. In such circumstances, no more than two consecutive weeks will be allocated at any one time, and notification of the date(s) will be given at least four weeks in advance.

13.2.3 The Trust’s weekly unavailability target for Annual Leave in clinical areas is 14%, with an agreed threshold of 12% to 16%. This relates to the percentage of staff within the establishment that are unavailable to work due to annual leave.

13.3 School Holidays and Bank Holidays

13.3.1 The amount of annual leave taken during school and bank holidays should remain within the above range.

13.3.2 Discussions should be encouraged between those requesting time off so that each member of staff has an equal chance of being granted annual leave.

13.3.3 Annual leave requests for school holidays will be shared equally amongst those making requests.

13.4 Christmas and New Year

13.4.1 This period will be treated as all other weeks in terms of leave. Each department will determine how the usual level of leave will be allocated i.e. a few staff may get some leave as opposed to a small number of staff having blocks of leave. This will depend on the staffing levels at the time.

13.4.2 All requests for Christmas / New Year annual leave should be made ideally by 1st October and agreed locally. Staff should be notified if their leave request has been approved by the end of October.

13.4.3 No temporary staff should be routinely booked on planned rosters for Christmas / New Year periods.

13.4.4 Fairness in allocating leave over Christmas and New Year will be ensured using the appropriate staff league tables.

13.5 Guide for Roster Unit Managers

13.5.1 Where possible, all leave should be planned and booked in advance, at the start of the annual leave year.

13.5.2 Staff should take 25% of their leave each quarter throughout the leave year as follows: -

- 25% of leave taken 1st quarter
- 50% next two quarters
- 25% last quarter

13.5.3 For planned annual leave the amount of hours taken should mirror the rostered patterns for that period. For example, if 3 x 12 hour shifts are normally worked within a week with the additional hours worked over further weeks, then 36 hours of annual leave should be taken not 37.5 hours for a full time member of staff.

13.5.4 If annual leave is not booked and is to be taken ad hoc, it is an individual's responsibility to ensure it is used before 31st March.

13.5.5 Annual leave should be booked or cancelled before a roster is planned. Annual leave requested after this can only be given if staffing levels permit near to the day.

13.5.6 Annual leave requests that exceed the documented acceptable level for the department will not be approved.

13.5.7 Staff on rotational programmes should take annual leave proportionate to each placement

13.6 Study Leave

13.6.1 Study leave will be assigned in line with Mandatory and Statutory requirements and the Study Leave and Continuing Workforce Development (CWD) Policy and recorded in HealthRoster

13.6.2 The Unit Manager should:

- Utilise the available number of study leave days in each roster
- Prioritise mandatory training requirements for staff which may include induction, updates, etc.
- Produce rosters ensuring staff have the required mandatory training

13.7 Sickness Absence

13.7.1 Sickness Absence will be managed in accordance with the Health, Wellbeing & Attendance Management Policy.

13.7.2 If off-duty days follow on from sick days, the Unit Manager / Team Leader or Staff Bank office must be kept informed of recovery. Unless notified otherwise off-duty days will be reclassified as sick leave.

13.7.3 Managers are responsible for ensuring only one sickness episode is entered for each period of absence.

13.7.4 When staff are absent due to sickness the planned working hours that have been scheduled on HealthRoster should be entered onto the system and not contractual hours. This will enable accurate measurement of lost productive hours and ensure Net Hours Left Balances are displayed correctly.

13.7.5 Following a period of short-term sick leave an employee must not work any additional hours or pick up any bank shifts for a period of one week. This period may be extended dependent upon individual circumstances following discussions with Occupational Health, HR and staff-side. There may be circumstances where, in order to meet the needs of the service, it may be necessary to allow an employee to work additional hours following a period of sickness.

13.8 Unavailabilities

13.8.1 All absences should be recorded by managers in the e-Rostering system. The only exceptions to this are:

- Paternity leave
- Maternity leave
- Shared Parental Leave
- Adoption leave
- Suspension from duty
- Career breaks

These are recorded by HR in ESR and interface to the HealthRoster system.

13.8.2 If any unavailabilities are recorded incorrectly for locked roster periods unit managers should submit an 'Unavailability Amendment Form' to the e-Rostering Team, so that the change can be made to both HealthRoster and ESR.

13.9 Headroom Allowance

13.9.1 The Trust headroom allowance in the majority of units is 20%. Some highly specialised areas have slightly higher headroom. This uplift is included within budgeted establishment to cover expected absence within clinical areas for specified staff:

- Annual Leave – 14% (acceptable parameters 12% - 16%)
- Sickness – 3%
- Study Days – 3%
- Maternity / Paternity Leave and other Special Leave – No additional time out allocated

13.9.2 The service demand plus headroom allowance are accounted for within the staff budgeted establishment. It is the responsibility of the Unit Manager and Service Manager to review the level of headroom achieved for any given roster period prior to approval.

14 Staff Registering Attendance

14.1 Flexible and Accessible Attendance

14.1.1 The Trust has flexible and accessible methods of registering attendance via different modes of technology. Employees can register their attendance using any of the on-site hand devices, or via EmployeeOnline on their mobile, tablet, laptop or PC

14.1.2 All employees should register their attendance at work using one of the above mentioned methods. Staff are trusted to use any method they see fit to accurately record their working time.

14.1.3 To access EmployeeOnline on a mobile device simply scan the below QR code on your smart phone's camera.

14.1.4 Staff should register their attendance in good time when they are ready to start and finish work at their workplace. If using an on-site hand device staff should use the nearest working device to their place of work.

14.1.5 For staff required to wear a uniform, it is their responsibility to change before the shift commences and after it finishes – staff are not entitled to changing time within working time.

14.1.6 In cases where an on-site hand device is faulty, staff should make every effort to find the nearest alternative device to use, or alternatively use another method to record attendance. Faulty on-site hand devices should be reported directly to the e-Rostering Team.

14.1.7 In cases where a staff member is unable to use any method to register their attendance, they should inform their line manager who will manually enter an accurate time in HealthRoster for them.

14.1.8 Managers have the ability within HealthRoster to monitor which method is being used to record attendance and if applicable which on-site device.

14.1.9 Attendance registering and usage is subject to audit.

14.2 On-Call Shifts

For all guidelines on On-Call shifts please refer to the Trusts On-Call Agreement. When called onto a Trust site, the employee should use On Call functionality in EmployeeOnline to record the times of the call out. Unit managers should review this information within HealthRoster.

15 Payroll Queries

15.1 If an employee finds an error on their roster/timesheet through EmployeeOnline or on their payslip the first point of contact should always be their manager.

15.2 It is the managers responsibility to investigate the error and contact the necessary department to correct the mistake.

15.3 If the error relates to already submitted payroll data in relation to overtime, additional hours or enhancements, the manager must complete a 'Payroll Re-Run Form' without delay and send to the e-Rostering Team to correct the mistake.

15.4 Payroll re-runs for payment errors must be identified and sent to the e-Rostering Team in reasonable time. Claims over three calendar months old will not be processed. It is the responsibility of both the employee and the manager to identify and highlight within the time frame.

15.5 Any monies owed to the employee or to be reclaimed will be made on the next available payroll run.

15.6 Queries regarding incorrect contracted hours or grades should be directed the Workforce Advisory Service.

16 Self Authorisation

A member of staff who has access to their own record within HealthRoster should not authorise or action any annual leave requests, exceptions, additional payments or finalise their own duties or unavailabilities.

17 Training

17.1 All users of the HealthRoster system will receive appropriate training. Unit managers will complete a computer-based e-learning course.

17.2 This training is a requirement for those managing attendance, annual leave, rosters and payroll processes on e-Rostering system.

18 Equality and Diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not unlawfully discriminate against individuals or groups on any grounds. This policy has been properly assessed.

19 Monitoring Compliance with the Policy

Breach of this policy may be subject to action under the Disciplinary Procedure. Records held on the e-Rostering system will be used (as appropriate) as part of any investigation.

Standard/Process/ Issue	**Monitoring and Audit**			
	Method	**By**	**Committee**	**Frequency**
Monitor the compliance of Wards / Departments with the rostering policy	Ongoing reporting and checking of all units within business as usual processes	e-Rostering Team Reporting	Heads of Human Resources Meeting	Monthly

20 Consultation and Review of this Policy

This policy has been reviewed in consultation with the Employment Policies and Procedures Consultation Group.

21 Implementation of the Policy (Including Raising Awareness)

Details of the policy will be circulated to all Trust managers following implementation. Further advice and guidance will be available from the e-Rostering Team and Human Resources.

Appendix A:

Authorisation Hierarchy

Purpose

This document indicates the Trust recommended authorisation hierarchy for dealing with absence, overtime and exceptions in the e-Rostering system.

Clinical Directors (or designated PA)

The PA must receive authorisation from the Clinical Director to act on their behalf in this capacity, e.g. PA to email the CD prior to each monthly payroll run to seek consent.

- Approve/acknowledge exceptions for Directorate Managers
- Approve/reject annual leave for Directorate Managers
- Record sickness for Directorate Managers
- Approve/reject study leave for Directorate Managers

Directorate Managers, Heads of Department and Corporate Leads

- Approve/acknowledge exceptions for Matrons/Senior Managers
- Approve/reject annual leave for Matrons/Senior Managers
- Record sickness for Matrons/Senior Managers
- Approve/reject study leave for Matrons/Senior Managers

Authorisation can be delegated to an appropriate member of staff to carry out certain actions in HealthRoster as long as the above mentioned continues to have final oversight.

Matrons/Senior Managers

- Approve/acknowledge exceptions for Sisters/Charge Nurses/Department Managers
- Approve/reject annual leave for Sisters/Charge Nurses/Department Managers
- Record sickness for Sisters/Charge Nurses/Department Managers
- Approve/reject study leave for Sisters/Charge Nurses/Department Managers

Authorisation can be delegated to an appropriate member of staff to carry out certain actions in HealthRoster as long as the above mentioned continues to have final oversight.

Sisters/Charge Nurses/Department Managers

- Approve/acknowledge exceptions for staff
- Approve/reject annual leave for staff
- Approve/record sickness
- Approve/reject study leave for staff

In addition to the above, roster managers should not make any pay affecting authorisations to a relative's record. Please see Standards of Business Conduct Policy for further information.

Appendix B:

Key Performance Indicators

The following KPI’s will be used to monitor headroom effectiveness:

Group	KPI	Unit of Measure	Trust Target	Amber Threshold	Red Threshold
Headroom Effectiveness	Total Awayness Allowance (Headroom) Minimum	Percentage	20%	16-19%	<15%
	Total Awayness Allowance (Headroom) Maximum	Percentage	20%	21-24%	>25%
	Annual Leave Minimum	Percentage	14%	12-13%	<11%
	Annual Leave Maximum	Percentage	14%	15-16%	>17%
	Sickness	Percentage	3%		
	Study Day	Percentage	3%		

The following KPI’s will be used to monitor roster effectiveness, fairness and safety:

Group	KPI	Unit of Measure
Rostering Effectiveness	Over Contracted Hours (4 weekly)	Hours
	Unused Contracted Hours (4 weekly)	Hours
	Additional Duty Hours (4 weekly)	Hours
Fairness	Requested Duties	Percentage
Safety	Missing Charge Cover	Count
	Skill Mix	Percentage
	Roster Unfilled	Percentage

Appendix C:

Checklist for Validating and Approving Rosters

Number	Action	Yes / No
1.	The roster has been created six weeks before the off duty commences	
2.	Check all shifts have been filled and the contracted hours are fully assigned	
3.	Unfilled duties % does not include night and weekends	
4.	Consecutive shift rules are adhered to	
5.	Hours Over and Hours Under figures are as near to 0 as possible	
6.	Overtime hours are as near to 0 as possible	
7.	There are 0 optional and additional duties unless agreed prior to the creation of the roster	
8.	Duties with warnings are acceptable	
9.	Shifts without charge cover are 0	
10.	Annual Leave is consistently allocated within agreed parameters	
11.	Check annual leave hours are accurate and no anomalies	
12.	Check the net hours left column for all staff – it is good practice that the net hours column should not exceed a long day shift	

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Equality Analysis Form A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

PART 1

1. **Assessment Date:** 26th July 2022

2. **Name of policy / guidance/ strategy / service development / Investment plan/Board Paper**:

   Electronic Rostering & Attendance Policy (Non – Medical)

3. **Name and designation of author:**

   Samantha Hunt, e-Rostering Systems Manager

4. **Names & Designations of those involved in the impact analysis screening process:**

   EPPCG / HR Heads

5. **Is this a:** Policy X Strategy ☐ Service ☐ Board Paper ☐

   Is this: New ☐ Revised X

   Who is affected: Employees X Service Users ☐ Wider Community ☐

6. **What are the main aims, objectives of the document you are reviewing and what are the intended outcomes?** *(These can be cut and pasted from your policy)*

   The aim of this policy is to provide guidance to managers and employees. The policy sets out guidance on:

   - Responsibilities
   - Key principles including roster responsibilities, general roster management, staffing levels, payroll
   - Rules and guidelines for the use of the e-Rostering system
   - How rosters can be managed including shift duration, gaps in rosters
   - Guidance on roster methodology including registering attendance, shifts and working patterns, management of working time and leave

7. **Does this policy, strategy, or service have any equality implications? Yes ☐ No X**

If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:

See below

8. **Summary of evidence related to protected characteristics**

Protected Characteristic	Evidence What evidence do you have that the Trust is meeting the needs of people in all protected Groups related to the document you are reviewing– please refer to the Equality Evidence within the resources section at the link below: http://nuth-vintranet1:8080/cms/SupportServices/EqualityDiversityHumanRights.aspx	Does evidence/engagement highlight areas of direct or indirect discrimination? For example differences in access or outcomes for people with protected characteristics	Are there any opportunities to advance equality of opportunity or foster good relations? If yes what steps will be taken? (by whom, completion date and review date)
Race / Ethnic origin (including gypsies and travellers)	This policy applies to all staff (excluding Medical & Dental staff) using HealthRoster. The Trust is committed to ensuring that no employee should be treated less favourably on the grounds of their age, disability, race, nationality, ethnic origin, sex, sexual orientation, religion and belief, gender identity / expression, marriage and civil partnership or pregnancy and maternity.		
Sex (male/ female)	As above		
Religion and Belief	As above		
Sexual orientation including lesbian, gay and bisexual people	As above		
Age	As above		

Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section	As above Where an employee has a physical disability which prevents them from using the biometric hand reader devices, other arrangements are available e.g. using the back of the left hand, or electronic methods.		Disability Staff Network
Gender Identity / Expression	As above		
Marriage and Civil Partnership	As above		
Maternity / Pregnancy	As above		

9. Are there any gaps in the evidence outlined above. If 'yes' how will these be rectified ?

No

10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.

Do you require further engagement Yes No X

11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?

No

PART 2

Signature of Author

S. Hunt

Print name

Samantha Hunt

Date of completion

26th July 2022

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Employment Policies and Procedures

Equality Diversity and Inclusion Policy

Version No.:	7.0
Effective Date:	27 January 2023
Expiry Date:	27 January 2026
Date Ratified:	16 January 2023
Ratified by:	HR Heads of Service

1 Introduction

1.1 This policy sets out our approach to equality and diversity and our commitment to promoting equality, diversity and inclusion and promoting a culture that actively values difference and recognises that people from different backgrounds and experiences can bring valuable insights to the workplace and enhance the way we work. We aim to be an inclusive employer committed to providing equal opportunities throughout employment including in the recruitment, training, and development of staff, and to pro-actively tackling and eliminating discrimination.

We recognise the benefits of having a diverse workforce and are committed to providing a working environment that's free from discrimination and creating an environment where no member of staff, worker or applicant is treated less favourably because of their protected characteristics, social background, domestic circumstances or employment status.

We recognise and value the different backgrounds and experience of all our staff and aim to have a workforce that reflects the community we serve at all levels.

1.2 We recognise equality of opportunity is not about treating everyone the same, but about responding to different needs and circumstances in a positive and fair way. It is important that staff are provided with support, guidance, and training to enable them flourish at work and achieve their best potential, making a positive contribution to service delivery and patient care.

This policy sets out our responsibilities in maintaining and promoting equality, diversity and inclusion. It will also tell you how you can complain or raise a concern if you feel you or another person is being discriminated against.

1.3 Mainstreaming Diversity and Inclusion into everything we do matters to us because it;

- supports our vision of clinical and non-clinical excellence.
- is instrumental in driving up and maintaining high standards of performance delivery.
- enhances our reputation and improves both staff and patient experience.
- makes our workforce feel included, proud to work for us and helps us to attract and retain the best
- it helps us to eliminate discrimination and advance equality of opportunity

2 Scope

The policy applies to all staff and those working within the Trust.

3 Aims

The Trust Board is committed to ensuring.

– that no employee or job applicant is subject to unlawful discrimination, either directly or indirectly, on the grounds of any protected characteristics.

– this applies to all aspects of employment, including recruitment and selection, training, promotion opportunities, terms and conditions of employment, grievance handling, application of disciplinary procedures and selection for redundancy.

– We will aim to embed equality standards in everything we do and seek to promote the principles of equality and inclusion in all our dealings with staff, job applicants, patients, visitors, contractors, recruitment agencies and the public.

4 Duties – roles and responsibilities

4.1 Every staff member has a responsibility to bring any potential discriminatory practice to their line manager's attention.

4.2 The Trust Board is fully committed to adopting and promoting the key principles of equality and inclusion within this policy and will ensure that all our policies and procedures do not discriminate.

4.2 Trust managers and heads of department are responsible for ensuring practical application of this policy at a local level and they are expected to actively promote high standards.

4.3 The Trusts Equality, Diversity and Inclusion team will lead on the equality and inclusion agenda for staff, and will develop, monitor and add value to the Trusts equality and inclusion strategic framework, specifically our responsibility and actions around Workforce Race and Disability Equality Standards, Disability Confident, Gender Pay, Equality Delivery System and our duties under the Public Sector Equality Duty. Further information can be found here

4.4 The HR Department has a specific responsibility to ensure the promotion of equality and inclusion through its employment practices, policies and procedures.

4.5 All employees and those who act on the Trusts behalf are required to work within this policy when undertaking their duties or when representing the Trust.

5 What do we mean by Equality Diversity and Inclusion

- When we talk about 'equity' we mean fairness and ensuring everyone has the ability to fulfil their potential i.e., removing barriers, eliminating discrimination for example in access to employment, professional development, and career progression. It is often summarised in terms of equal access, equal treatment and equal outcomes

- When we talk about 'diversity' we mean celebrating recognising and valuing our differences int heir broadest sense. Aiming to create a working environment and practices that recognise, respect, value and harness difference for the benefit of the Trust, our staff, patients and visitors. Diversity is about the collective mixture of individuals, cultures and organisational expertise

- When we talk about 'inclusion' we mean building a strong sense of belonging, respect and support. It's ensures actively inviting and valuing authentic contributions and fully empowering participation in a psychologically safe environment

- We are committed to a working environment where ll staff are treated with dignity and respect with an acknowledgment that all staff have a responsibility to encourage, support and promote positive relationships at work. We will not tolerate bullying, harassment or similar acts and

will take all such complaints seriously, for further information refer to the Dignity and Respect at Work Policy. It's also important to understand there are many types of discrimination, harassment and victimisation a definition and explanation of each can be found in Appendix A

6. Supporting Staff

Our Equality, Diversity and Inclusion Team has a remit for staff
and provides advice and guidance with regard to legislation and employee rights. Overcoming prejudice, bias (including unconscious and micro-aggressions) can be difficult

Our Cultural Ambassadors are trained to support our disciplinary and grievance procedures, to identify and challenge cultural bias. The role supports the Trust to ensure processes are fair, equitable and free from bias and unlawful discrimination. Further information can be found here

Our staff can join various specialist staff led networks representing different groups with different needs to meet, share experiences and discuss issues that may be affecting their particular community, these networks work to actively to support, shape and develop our strategy, policies and guidance in relevant areas.

7. Bringing a complaint or raising a concern

We will treat all complaints made under this policy seriously. If you believe that you've been discriminated or subject to inappropriate behaviours against you then you against, you are encouraged to raise the matter as soon as possible with your line manager, other senior manager or the HR Department. Routes to making a complaint and receiving support are available here

Allegations regarding potential breaches of this policy will be treated in confidence and investigated thoroughly. If you make an allegation of discrimination, we are committed to ensuring that you are protected from victimisation, harassment or less favourable treatment because you have complained.

8. Equality Analysis

Any development or change to any existing or proposed policy, procedure, strategy or service must be subject to a systematically and thorough Equality Analysis. Each policy, procedure, strategy or service should be analysed in partnership, to ensure;

- the effects on any protected group are fully understood and minimized

- they do not actually or potentially, directly or indirectly, discriminate against any protected group.

- Guidance regarding how to conduct an Equality Analysis is provided in the Trust's Development and Approval Process.

9. Training

Training as necessary will be provided to managers and staff by the Human Resources Department as part of implementing this policy.

10. Equality and Diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way services are provided, and the way staff are treated reflects their individual needs and does not unlawfully discriminate against individuals or groups. This Agreement has been properly assessed.

11. Monitoring compliance with the policy

Standard / Process / Issue	**Monitoring and Audit**			
	Method	**By**	***Committee***	**Frequency**
Reporting of information from ESR: • Report on mandatory training compliance • Report on employee relations and recruitment activity • Directorate Equality Dashboards	Reporting of information from ESR	Director of Human Resources	Trust Board *Trust Board via Performance Management Framework (Mandatory training) Performance Review Process*	Annually Quarterly

12. Consultation and review of this policy

This policy has been reviewed in consultation with the Employment Policies and Procedures Consultative Group

13. Implementation of the policy (including raising awareness)

A summary of the key changes will be notified to managers as part of publishing this policy,

14. Additional Documents

- Appraisal Policy – Senior Medical and Dental Staff
- Dignity and Respect at Work Policy
  Employee Wellbeing Policy Incorporating Absence Management Procedure
- Induction Policy
- Mandatory Training Policy
- Recruitment and Selection (Junior Medical and Dental Trust Doctor Posts)
- Recruitment and Selection (non-medical)
- Recruitment and Selection (Senior Medical and Dental)
- Redeployment Policy
- Staff Appraisal Non-Medical

Appendix A

Work Streams in relation to Protected Characteristics

Protected Characteristic	Work Stream	Detail

Ethnicity	Workforce Race Equality Standard	- The NHS Workforce Race Equality Standard (WRES) was introduced in 2015 to help prompt enquiry to better understand why it is that BME staff often experience much poorer treatment than White staff and facilitate the closing of those gaps in experience.
		- Getting this right is critical; evidence shows that a motivated, included and valued workforce helps deliver high quality patient care, increased patient satisfaction and better patient safety – it also leads to more innovative and efficient organisations.
		- The evidence of the link between the treatment of staff and patient care is particularly well evidenced for BME staff in the NHS, it's an issue for patient care, not just for staff.
		- There are nine WRES indicators
		  - four of the indicators focus on workforce data
		  - four are based on data from the national NHS Staff Survey questions, and
		  - one indicator focuses upon BME representation on boards.
		- The WRES highlights any differences between the experience and treatment of white staff and BME staff in the NHS with a view to organisations closing those gaps through the development and implementation of action plans focused upon continuous improvement over time
		
		- The Trusts WRES data and WRES Action Plan are available here

	Race Equality staff network	- Launched in 2014 the Trusts Race Equality staff network meets on a fortnightly basis with the aim of supporting members of staff within the working environment and promoting an

		awareness of equality, diversity and inclusion within the Trust - A WRES Sub Group monitors progress against the Trust's WRES action plan - Further information can be found here
Disability	Disability Confident	- Disability Confident is designed to help recruit and retain disabled people in employment - Recognised as a Disability Confident Employer, level 2 - and working towards Disability Leader - Further information about the scheme can be found here
	Enabled staff network	The Enabled staff network meets regularly with the aim of supporting members of staff within our working environment and promoting an awareness of equality and inclusion within the Trust Further information can be found here
	Project Choice	- Project Choice is a supported internship programme for people with learning disabilities, difficulties or autism (LDDA). - NHS Health Education England, support NHS Trusts to deliver the programme nationally. The focus is 'work readiness' and matching skills to employment. - The project is designed to support young people to enhance their strengths in the labour market, and with support, develop key employability skills. - In addition to providing work experience placements within the Trust, the project links with other organisations within Newcastle upon Tyne who provide additional work experience placements - The programme provides young people with work based transferable skills and provides equal opportunities for all. - Further information can be found here and here
	Reasonable Adjustments	Recruitment - The Trust is an equal opportunities employer and will provide reasonable

		support to disabled applicants throughout the recruitment process - Such support will include making reasonable adjustments to the method of application, the interview process and working environment Disablement during employment - The Trust will support staff with disabilities and those who become disabled during employment, and encourages open dialogue between staff and managers to ensure appropriate reasonable adjustments are considered. - Where an employee becomes disabled during the course of his/her employment, every effort will be made to enable the employee to continue in their current post. Full consideration will be given to the provision of adaptation/aids, job redesign and consideration of any other reasonable adjustment. - Requirements are addressed on an individual basis
	Workforce Disability Equality Standard	- The Workforce Disability Equality Standard (WDES) is a data-based standard that uses a series of measures (Metrics) to help improve the experiences of Disabled staff in the NHS. - The evidence-based Metrics will enable NHS organisations to compare the reported outcomes and experiences of disabled with non-disabled staff - The WDES highlights any differences between the experience and treatment of white staff with and without a disability within the NHS with a view to organisations closing those gaps through the development and implementation of action plans focused upon continuous improvement over time - The Trusts WDES data and WDES Action Plan are available here

Gender	Gender Pay Gap Reporting	- We are required to publish data on our mean and median gender pay gap, mean and median bonus pay gap, and information on the proportions of male and female employees in each salary quartile - The Trusts Gender Pay Gap Report and action plan can be found here
Religion or Belief	Religious Observance	- Prayer rooms are available on Trust sites for use by staff - If a prayer room is not available, an employee may use a meeting room by booking it in the normal way. - The Chaplaincy Team are responsible for ensuring that the Spiritual and Religious needs of patients, relatives and carers and staff are recognised and provided for by all staff across the organisation - Chaplaincy are a reference point for Spiritual/Religious matters within the Trust - Further information can be found here
	Pride staff network	- The Trusts Pride staff network meets bi-monthly with the aim of supporting members of staff within the working environment and promoting an awareness of equality and inclusion within the Trust - Our Senior LGBTQ+ Allies work with members of the staff network to ensure the we are visibly inclusive - Further information can be found here
Gender Identity / Expression	Gender Identity in the Work Place	- Working with the Pride staff network hawse have developed a number of resources including; - - work-related guidance for managers on how to support an employee who is transitioning - information which supports all non-trans employees (including lesbian, gay and bi employees) to become trans allies through training and resources - work-related guidance on the process for an employee to change their name and gender markers on workplace systems

		- a work-related guidance for employees on how to support a colleague who is transitioning - To find out more refer to our Gender Identity resources here

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Types of unlawful discrimination

1. **Direct discrimination** is where a person is treated less favourably than another because of a protected characteristic, for example, refusing to employ a woman because she is pregnant. In limited circumstances direct discrimination can apply, for example where there is an occupational requirement that is crucial to a job (and not merely one of several important factors) and the requirement is a proportionate means of achieving a legitimate aim.

2. **Indirect discrimination** Indirect discrimination is the legal term that describes situations when policies, practices or procedures are put in place that appear to treat everyone equally but, in practice, are less fair to those with a certain protected characteristic under the Equality Act. An example of indirect discrimination may be a minimum height requirement for a job where height is not relevant to carry out the role. Such a requirement would likely discriminate disproportionately against women 2010.

3. **Harassment** is unwanted conduct, related to one of the protected characteristics that has the purpose or effect of violating a person's dignity; or is reasonably considered by that person to create an intimidating, hostile, degrading, humiliating or offensive environment. It does not matter whether or not this effect was intended by the person responsible for the conduct.

4. **Associative discrimination** is where an individual is directly discriminated against or harassed for association with another individual who has a protected characteristic.

5. **Perceptive discrimination** is where an individual is directly discriminated against or harassed based on a perception that he/she has a particular protected characteristic when he/she does not..

6. **Victimisation** occurs where an employee is subjected to a detriment, such as being denied a training opportunity or a promotion because he/she made or supported a complaint or raised a grievance under the Equality Act 2010, or because he/she is suspected of doing so.

7. An employee is not protected from victimisation if he/she acted maliciously or made or supported an untrue complaint in bad faith. for example, if a blind employee raises a grievance that the employer is not complying with its duty to make reasonable adjustments, and is then systematically excluded from all meetings, such behaviour could amount to victimisation.

8. **Failure to make reasonable adjustments** is where a physical feature or a provision, criterion or practice puts a disabled person at a substantial disadvantage compared with someone who does not have that disability and the employer has failed to make reasonable adjustments to enable the disabled person to overcome the disadvantage.

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Equality Analysis Form A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

PART 1

1. **Assessment Date:** 22/12/22

2. **Name of policy / strategy / service**:
   Equality Diversity and Inclusion Policy

3. **Name and designation of Author:**
   Ms Karen Pearce, Head of Equality Diversity and Inclusion

4. **Names & designations of those involved in the impact analysis screening process:**
   Ms Karen Pearce, Head of Equality Diversity and Inclusion

5. | | | | | | | |
   |---|---|---|---|---|---|---|
   | **Is this a:** | Policy | X | Strategy | | Service | |
   | **Is this:** | New | | Revised | x | | |
   | **Who is affected** | Employees | X | Service Users | x | Wider Community | |

6. **What are the main aims, objectives of the policy, strategy, or service and the intended outcomes?** (*These can be cut and pasted from your policy*)
   The policy aims to ensure all staff and managers are aware of their individual responsibilities in relation to preventing and eliminating unlawful discrimination, promoting equality and diversity and maintaining good working relationships.

7. **Does this policy, strategy, or service have any equality implications?** **Yes** [ ] **No** [x]

   If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:
   Evidence below does highlight areas of potential discrimination, however action plans are in place, as a result of this policy, to address areas of difference and disproportionality.

8. Summary of evidence related to protected characteristics

Protected Characteristic	Evidence, i.e. What evidence do you have that the Trust is meeting the needs of people in various protected Groups	Does evidence/engagement highlight areas of direct or indirect discrimination? If yes describe steps to be taken to address *(by whom, completion date and review date)*	Does the evidence highlight any areas to advance opportunities or foster good relations. If yes what steps will be taken? *(by whom, completion date and review date)*
Race / Ethnic origin (including gypsies and travellers)	The policy is clear that it does not discriminate on the grounds of race/ethnic origin, sex, religion and belief, sexual orientation, age, disability, gender identity/expression, marriage and civil partnership and maternity and pregnancy. Trust produces and analyses (annually) workforce data around each protected characteristic. Data informs the Equality Delivery System and each process informs the Trusts Equality and Diversity action plan. In addition the Trust complies with the requirements of the Workforce Race Equality Scheme (WRES) More specifically BME staff are less likely to entre formal disciplinary processes within the Trust, this have been the case since 2014 when the Trust first reported on the WRES Metrics. In addition with the exception of 2021/22 and BME staff were more likely to have access to non-mandatory training provision	WRES data indicates: Percentage of staff believing the Trust provides equal opportunities for career progression or promotion (2021) - BAME respondents: 43.5% - White respondents: 62.3% Percentage of staff who reported that in the last 12 months they had personally experienced discrimination at work from a manager, team leader or other colleague (2021) - BAME respondents: 20.6% - White respondents: 6.5% Indicator 9 has improved with the Trust Board being more representative reducing the difference between the organisations board voting membership and its overall workforce from -9 to -4 The Trust equality action plan has been updated to seek to reduce the difference and has been granted Board approval. A WRES subgroup has been created to review progress against the Action Plan and to specifically address the concerns raised around discrimination/bullying and harassment.	The Trust has a Race Equality staff network and actively promotes diversity days. Equality and Diversity information is available at Trust Career Fairs and promoted through the Trust's Facebook and Twitter Pages Funded work about to commence in terms of widening participation for Health Care Assistants There is a WRES working group delivering on a WRES action plan. EDI dashboards have been created for each directorate reporting in real time granular data sets across 5 protected characteristics including Race and ethnicity, sexual orientation, gender, age and disability. The dashboards focus are on disparity ratios, leadership, pay, flexible working, likelihood of recruitments and employee relations. BAME recruitment event planned to take place in October 2023. Call In/Out staff resource developed
Sex (male/ female)	As above	We annually report on our gender pay gap and have a gender pay gap action	EDI dashboards have been created for each directorate reporting in real time granular

		plan in place. The summary is as follows: Gender Pay Gap • The mean hourly pay gap has reduced by 2.53% • The median hourly pay rate gap has reduced by 2.35% • 21.94% (1,735) of all staff in the lower and lower middle quartiles are male. This is an increase from 21.43% last year • 32% of staff in the upper quartile are male and increase of 1% from last year, with 34.69% (1879) of the male workforce residing in the upper quartile a slight increase from last year where 34.41% (1925) were within the upper quartile. • Quartiles - the highest variance remains in the upper middle quartile where 16% of staff are male and 84% are female; the lowest remains the upper quartile where 32% of staff are male and 68% are female. Gender Bonus Gap • In December 2021, all staff (excluding the Board) received a covid 'thank you' bonus which must be included within the figures as at March 2022. This was a one-off bonus that distorts our reporting as at March 2022 • Work undertaken to refresh the employer-based awards committee (EBAC) to better represent the diversity of the consultant body has achieve a positive result • For the period between 2018 – 2020 female staff had an equal likelihood of receiving an	data sets across 5 protected characteristics including Race and ethnicity, sexual orientation, gender, age and disability. The dashboards focus are on disparity ratios, leadership, pay, flexible working, likelihood of recruitments and employee relations. Equalled the likelihood of males and females applying an attaining CEA's

		award and an equality likelihood if not more likely of applying for a LCEA • 71% (181) of males are in receipt of CEA's compared to only 29% of females. • Males are significantly more represented in the higher CEA award categories attracting higher award values • The difference in the mean and median bonus payments remains strongly influenced by the pay and gender make-up of the medical and dental staff group An action plan to address the pay and bonus gap is in place.	
Religion and Belief	As above		
Sexual orientation including lesbian, gay and bisexual people	As above The trust has an established pride staff network.	Top 40 employer in 2020 in Stonewall Work Place Equality Index Employers Gold Award in 2022 Accredited Silver in the Rainbow badge pilot the only NHS Trust to be awarded that level	Trust attended Northern Pride to increase community engagement and promote the Trust as an equal opportunities employer and promotes awareness days and events throughout the year. 2023 sees a full program of events for LGBT history month to raise awareness and promote the trust as an inclusive employer of choice. EDI dashboards have been created for each directorate reporting in real time granular data sets across 5 protected characteristics including Race and ethnicity, sexual orientation, gender, age and disability. The dashboards focus are on disparity ratios, leadership, pay, flexible working, likelihood of recruitments and employee relations. Pride Staff Network in place Gender Identity Policy, colleague guide and pronouns guidance in place Annual Programme of events for LGBTQ+ History Month
Age	As above		EDI dashboards have been created for each directorate reporting in real time granular

			data sets across 5 protected characteristics including Race and ethnicity, sexual orientation, gender, age and disability. The dashboards focus are on disparity ratios, leadership, pay, flexible working, likelihood of recruitments and employee relations.
Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section	Trust policies are clear that they do not discriminate on the grounds of disability. The Trust has a disability staff network The Trust has Project Choice an internship for young people with learning disabilities with a clear route into paid employment. The Trust has provision for early ill health retirement to support employees who are permanently incapable of performing their current role, or regular employment. Relevant Trust policies are clear that consideration will always be made to explore reasonable adjustments to support an employee or applicant who has a disability. The Redeployment policy is clear that if redeployment is being considered and an employee is disabled, they will be given prior consideration. Disabled staff are equally likely to have their flexible working requests accepted as non-disabled staff.	A 2020-2023 WDES action plan has been approved and is in place with key measurables to achieve: Reduction in the number of disabled staff experiencing BH&A from managers Reduction in Disabled staff compared to staff saying that they have felt pressure to come to work Monitor Disability in EDI performance management framework monitor progress Training and awareness on micro aggressions in place and development of cascade training	The Trust is a Disability Confident Employer and is working towards Disability Confident Leader status. Project choice is promoted externally to local schools and colleges and has achieved fantastic result in enabling young people with learning disabilities to enter employment. Disability recruitment event planned for 2023 The Trust has signed the Time to Change pledge. The Trust have 'Togetherall' provision for all staff to access both at work and remotely. MHFA are available within the trust alongside OHU and a stress preventions site. ICS wellbeing hub is available for all staff and volunteers to access. EDI dashboards have been created for each directorate reporting in real time granular data sets across 5 protected characteristics including Race and ethnicity, sexual orientation, gender, age and disability. The dashboards focus are on disparity ratios, leadership, pay, flexible working, likelihood of recruitments and employee relations. A neurodiversity guide has been created in partnership with the staff network to support individuals and teams internally to best support their colleagues this will continue to be promoted. Feedback has been extremely positive and it has been used to improve relationships between managers and staff.

			A targeted development program has been ran for staff with a disability with 2 cohorts completing the program with positive evaluations. Enabled Staff Network in Place Annual programme of events for Disability History Month
Gender Identity/Expression	The policy is clear that it does not discriminate on the grounds of gender identity/expression. The Trust has a functioning Gender Identity Group with representatives from third section and staff and an LGBT staff network. An employee who wishes to take annual leave in relation to absence attributable to pre-planned surgery, may be allowed to do so provided the leave is approved in accordance with normal procedure. The Trust has a gender transition at work policy which includes colleague guides.	No	Trust attended Northern Pride to increase community engagement and promote the Trust as an equal opportunities employer and promotes all awareness days. EDI dashboards have been created for each directorate reporting in real time granular data sets across 5 protected characteristics including Race and ethnicity, sexual orientation, gender, age and disability. The dashboards focus are on disparity ratios, leadership, pay, flexible working, likelihood of recruitments and employee relations. Pride Staff Network in place Gender Identity Policy, colleague guide and pronouns guidance in place Annual Programme of events for LGBTQ+ History Month Gender neutral HR Policies in place
Marriage and Civil Partnership	The policy is clear that it does not discriminate on the grounds of marriage and civil partnership.	No	
Maternity / Pregnancy	The policy is clear that it does not discriminate on the grounds of maternity/pregnancy. The Trust has a number of policies to support pregnant employees and employees, employees on maternity leave and breastfeeding employees. These policies ensure that risk assessments are undertaken to ensure the safety of the employee and these will be reviewed, should the employee have pregnancy related absences.		

9. **Are there any gaps in the evidence outlined above? If 'yes' how will these be rectified?**

No

10. **Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.**

Do you require further engagement? Yes [ ] No [X]

11. **Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?**

No

PART 2

Name:

Karen Pearce

Date of completion:

23/12/22

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)

The Newcastle Upon Tyne Hospitals NHS Foundation Trust

Human Resources Policies & Procedures

Expenses & Travel Policy

Version No.:	6.0
Effective Date:	13 May 2022
Expiry Date:	13 May 2025
Date Ratified:	03 May 2022
Ratified by:	Heads of HR

GENERAL POLICY STATEMENT

This policy sets out the travelling and subsistence rates payable to all Trust staff and others who may incur expenses whilst conducting Trust business and related research activity. The Trust has adopted Agenda for Change Terms and Conditions of Service and Medical and Dental Terms and Conditions for this purpose. This policy will help you to understand what you may and may not claim. It will also provide managers with guidance on authorising claims and minimising risk of fraudulent claims

Expenses are the costs incurred by you while on official business for NUTH, as covered by this policy. This may include, but is not limited to, travel costs, accommodation and subsistence (expenses such as food, drink and accommodation incurred while you are away from your permanent workplace on Trust business).

1. The Trust may withhold payment of any expenses incurred not in accordance with this policy and seek reimbursement of any invalidly paid expenses. Duties (Roles and Responsibilities)

1.1 The Executive Team is accountable to the Trust Board for ensuring Trust-wide compliance with policy.

1.2 Directorate managers and heads of service are responsible to the Executive Team for ensuring policy implementation.

1.3 Managers are responsible for ensuring policy implementation and compliance in their area(s).

1.4 The Trust's Travel Team (Supplies and Procurement Department) are responsible for booking appropriate travel and accommodation when provided with the appropriate details from the traveller. They are responsible for ensuring a balance of value for money and environmental sustainability whilst staff are on Trust business. Staff are responsible for complying with policy

2. Expenses Policy

2.1 Travel

2.1.1 Travel should be by the most cost effective and environmentally friendly means, having regard for:

- time and duration of journeys (and connecting travel)
- requirement for flexibility of itinerary
- our commitment to reduce carbon emissions
- booking as early as possible to attract discounts
- accessibility for staff

2.1.2 To book travel arrangements, you should complete the Travel Request form, seek authorisation from your Directorate Manager and Financial Management representative and submit this to the Travel Team (Supplies department) Staff should not normally make their own bookings.

2.1.3 The exception to 2.1.2 above is zone 3 London underground travel. If zone 3 and above is required, the traveller will need to purchase the ticket and reclaim via expenses.

2.1.4 Journeys booked by the Travel Team will be paid directly by the Trust. 2.1.5 Any cancellation costs incurred may be recharged to the employee's Directorate/Department.

2.1.6 Any accidents which occur whilst on Trust business should be placed on Datix and the line manager should be informed. Staff should not enter discussions regarding liability when this has involved them using their own vehicle or a hire car but, should be aware of any details which may need to be exchanged in the event of an accident. Refer to Driving at Work information Intranet > General Information > Transport and Travel > Driving at Work

2.2 Use of Own Vehicles

2.2.1 The Trust is committed to a significant and sustained reduction in its carbon emissions. Use of private cars for long distance journeys will normally be the highest carbon option and is discouraged. In addition, individuals must consider health and safety implications before undertaking long journeys. Nevertheless, it is recognised that the use of private cars will often be the most cost effective option for short journeys, particularly if more than one person is travelling.

For guidance refer to Intranet > General Information > Transport and Travel > Driving at Work

http://nuth-intranet/cms/GeneralInformation/TransportandTravel/Taxi.aspx

2.2.2 The expenses system will collect full details of the journey including starting point, places visited en route, the point at which the journey ended and total business mileage (for further details regarding 'eligible mileage' refer to the NHS Terms and Conditions of Service Handbook or relevant medical and dental terms and conditions).

2.2.3 Users of private vehicles on Trust business must ensure that they have;

- insurance for business use, for the vehicle used
- a valid driving licence for the type of vehicle used
- a validMOT certificate for the type of vehicle used
- That the vehicle is roadworthy and driver checks have been conducted before departure – refer to Intranet > General Information > Transport and Travel > Driving at Work
- valid road tax

2.2.4 Before authorising an expenses claim, managers must record in the e-Expenses system that the check of the requirements outlined in 2.2.3 has been undertaken (road tax and MOT Certificate can be checked via the following link https://www.vehicleenquiry.service.gov.uk). Managers should recheck these documents on an annual basis and update the –e-Expenses system accordingly.

2.2.5 Mileage incurred whilst on Trust business will be reimbursed at a rate determined by the Trust. These are as follows:

- Private vehicles – at the rates detailed in the appropriate section of the NHS Terms and Conditions of Service Handbook or medical and dental terms and conditions. Regular User Allowance (RUA) is payable only to medical and dental staff and is subject to meeting the eligibility criteria and approval – see Appendix 1 for further details
- Vehicles issued in accordance with the Contract Business Car Lease Scheme Policy and Family Lease vehicles (i.e. salary sacrifice)– at the advisory fuel rate for a company car as set by Her Majesty's Revenue and Customs (HMRC). The rate will be either the rate for a petrol engine size 1400cc or less, or a diesel engine size 1600cc or less, whichever is the lower amount.
- Family Lease vehicles (i.e. salary sacrifice) –RUA (for medical and dental staff only) is not payable as Family Lease Car holders are not liable for 'wear and tear' – it is included as part of the lease agreement.

(HMRC rates are available at http://www.hmrc.gov.uk/cars/fuel_company_cars.htm)

2.3 Home to Work

2.3.1 Journeys between home and normal place of work are regarded as private journeys and the cost of such journeys cannot be reclaimed except when required to work outside of 'normal' working hours. Staff will be reimbursed for miles travelled in the performance of their duties which are in excess of the home to agreed work base return journey. Normally, the miles eligible for reimbursement are those travelled from the agreed work base and back. When the journey being reimbursed starts at a location other than the agreed work base, for example home, the mileage eligible for reimbursement will be as set out in the NHS Terms and Conditions of Service Handbook. For Consultant staff there may be specific exceptions, thus please refer to the relevant section of the Consultant Terms and Conditions.

2.3.2 Staff using lease vehicles (including salary sacrifice and contract business car arrangements) should be aware that claiming home to base mileage (regardless of the purpose of travel) will trigger a fuel benefit charge from HMRC which will exceed the mileage claimed.

2.4 Air Travel

Air travel within the UK is discouraged except where this is either less costly overall, taking account of other travel and accommodation costs, or it is demonstrably much more convenient.

2.5 Rail Travel

The Travel Team will take advantage of all 'discounted' tickets, including any discounts that may be obtained through the use of railcards. You can help by notifying the travel team if you possess such a discount when requesting your booking. Journeys at the Trust's expense should normally be standard class.

2.6 Taxis

Where the use of a taxi is agreed, the taxi should be pre-booked using the Trust's taxi provider on the Trust account by calling 0191 2231818 (31818 internally). Reference should be made to the Taxi Policy, found here: http://nuth-intranet/cms/GeneralInformation/TransportandTravel/Taxi.aspx prior to any booking being requested. If the taxi requirement is outside of the Newcastle area a local taxi should be used, a receipt obtained and costs reclaimed via this policy.

2.7 Hire Cars

2.7.1 Hire cars should be requested through the Supplies Department, which has established agreements with hire car companies. Hire cars should only be used if this is the most cost effective means of travel. This would normally occur where staff travel together to the same destination or the journey is in excess of 100 miles.

2.7.2 The same requirements apply for the driver of a hire car as using your own vehicle, as outlined in 2.2.3 and 2.2.4

2.7.3 Hire cars are covered by the Trust's Insurance policy, however, any cost as a result of reckless/careless conduct whilst driving will not be met by the Trust. Staff using hire cars must notify Clinical Governance and Risk Department of vehicle registration to ensure it is added to the Trust Insurance Register2.7.4 Staff using hire cars on Trust sites should notify Transport and Travel Team in advance of receipt of hire car to agree location for delivery / collection and then provide notification of the car registration number. Transport and Facilities may be contacted on nuth.enquiries.carparking@nhs.net or extension 31353.

2.7.4 Staff using hire cars should always ensure any tolls are paid and parking signage is always read and understood to avoid fines at the destination. Parking Charge Notices / Penalty Charge Notices (PCN's) incurred will generate administrative fees from the hire car provider and any costs incurred for receiving PCN's will be recharged to the employee.

2.8 Cycling

In order to help reduce the Trust's Carbon Footprint, environmentally friendly methods of travel are actively encouraged. Cycling where ever reasonably practicable is a useful way to achieve this. Any mileage covered using the your own bicycle will be paid in accordance with the standard rates detailed in the appropriate NHS Terms and Conditions or medical and dental terms and conditions.

2.9 Accommodation

2.9.1 All accommodation must be booked through the Travel Team, by completing the Travel Request Form

2.9.2 Items of a personal nature such as mini bar items, pay per view TV, WiFi etc., will not be reimbursed. Where these are included in the bill, the costs must be deducted prior to submission of the bill for reimbursement.2.10 Subsistence Allowances

Subsistence expenses will be reimbursed at the level of actual expenditure but no more than the maximum rates detailed in the appropriate section of the relevant NHS Terms and Conditions of Service Handbook. All costs must be accompanied by associated receipts, actual costs (up to the maximum rates) will be reimbursed.

2.10 Overseas Trips

Overseas travel must be requested in writing and agreed in advance by a member of the Executive Team, and standard fares will be the expected norm.

Overseas accommodation must be booked by the Supplies Travel team. Where meal costs are claimed for visits abroad, authorisers will need to satisfy themselves of the reasonableness of claims. When working outside the UK, incidental expenses may be claimed with receipts to the appropriate level contained in the appropriate section of the relevant NHS Terms and Conditions of Service Handbook. If the Trust requires staff to travel abroad for business/study leave purposes, the Trust's travel insurance policy may apply. Details of the Trust's insurance arrangements are available from the Legal Services Department. Staff are however advised to ensure they are appropriately/fully covered prior to travelling e.g. health conditions that may impact on insurance.

Hire cars should only be used where it can be demonstrated that this represents value for money when compared with other forms of transport. The minimum specification of vehicle for the required trip should be used.

It is the responsibility of the traveller to ensure that they provide all of the relevant information regarding visas, accommodation etc. that will be required by the country travelling to.

2.11 Employees of other organisations

Where the Trust has arranged and paid for travel and/or accommodation for employees of other organisations, in order for individuals to travel and/or be accommodated together, a Notification of Debt order will be raised in order to recover the associated costs, including an administration fee of £25.

2.12 Spouse/Partner Travel & Hospitality

The Trust will not reimburse expenses incurred by a spouse or partner accompanying an individual on business travel. A Notification of Debt order will be raised in order for the employee to reimburse the Trust for any tickets purchased through the Travel Team and any other costs paid by the Trust for a spouse or partner travelling with you, including an administration fee of £25.

2.13 Subscriptions

The Trust does not permit payment, either by reimbursement or direct from the service, of employee's personal subscriptions to professional organisations and clubs.

2.14 Telephone Calls

Any costs incurred for telephone calls relating to Trust business whilst on Trust business will be reimbursed where appropriate.

2.14.1 Call barring

All calls to international numbers including roaming services and all premium rate numbers are barred. Such restrictions will not be lifted unless a business need is identified.

Requests to have call barring removed or amended must be logged with the IT Service Desk stating the reason and time period required.

2.14.2 Personal Use

Trust phones should be used only for Trust business. You may be required to reimburse the cost of personal use, including calls, text and data usage. If so, this will be charged to you via a Notification of Debt (NOD) plus an additional 10% to cover administrative costs.

2.14.3 Telephone Landline and Equipment Rental

The Trust will not reimburse the following expenses where it deems it to be inappropriate on the grounds of cost and efficiency

- calls made from a landline
- any costs associated with a mobile telephone not provided by the Trust

Where the Trust deems that it is essential for staff to be contactable out of hours, for example, for on-call purposes, the Trust will provide access to a mobile telephone. Normally, this will be achieved by allocating on-call teams with an appropriate number of mobile telephones (normally two) so that they can be shared and made available to each person when they are on-call.

2.16 Study Leave

The Trust has discretion to grant payment or part payment of:

- course and conference fees in line with the Study Leave and Continuing Workforce Development Policy.
- travelling expenses

- Where study leave is categorised as level 1 (critical to role, service delivery or patient safety), and the mileage claim has been authorised centrally by the Education and Workforce Development Department, the claim will be paid at the standard (or RUA applicable to medical and dental staff only) rate applicable. Otherwise the reserve /public transport rates will be paid.

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- subsistence allowances (paid at the current rate, excludes alcoholic drinks)
- examination fees (for first attempts only)

Please see the Trust's Study Leave/Continuing Professional Development (CPD) Policy on the Intranet for further information.

2.16.1 The Trust encourages staff to book all non-study leave related travel and accommodation through the Trust's Travel Team; however to provide staff with greater flexibility when arranging travel for study leave there may be occasions in which staff wish to book their own travel and then reclaim their expenses. This exception is only applicable to study leave in accordance with the Study Leave and Continuing Workforce Development (CWD) Policy.

2.16.2 When booking travel staff should:

- have regard for personal safety and the impact on the environment.
- book travel arrangements as soon as formal approval has been given and their requirements are known.
- be able to demonstrate that they have endeavoured to book at the cheapest rate.
- always seek to get good value for money. Standard Class is usually the cheapest fare; therefore, this should always be taken unless the cost of First Class is no higher. If this occurs, the cost of both fares will have to be evidenced.

2.16.3 The above is not applicable to overseas travel which must be booked by the Travel team.

2.17 Expenses for Teaching Fees

If a member of Trust staff is commissioned to undertake paid teaching or examination assessment outside their normal contracted hours, this may be paid through the payment of additional hours through their salary.

2.18 Relocation

The Trust has discretion to grant payment or part payment of relocation expenses. This will be subject to agreement and in accordance with the Relocation Expenses Policy.

2.19 Interview Expenses

The Trust has discretion to grant payment or part payment of interview expenses. The Trust's Interview Expenses Claim Form contains further information and is available from the Staff Engagement team.

3. Expense Claims and Payment

3.1 The Trust uses Selenity's E-Expenses system for the processing of all expenses and travel claims.

Using E-Expenses: Payroll are able to set up E-Expenses accounts. Once logged on to https://sel-expenses.com there is a purple box entitled 'Help' in the bottom right corner. Use this tool to search for 'articles' which will guide you in the use of E-Expenses. Alternatively, contact Payroll on 0191 203 1234 who will transfer to the Selenity Expenses admin team for assistance

3.1.1 All claims must be completed, certified and submitted with any relevant receipts for goods and services within six weeks of the date the costs were incurred. Payment for any expenses is made by BACS into a nominated bank account and is made on a monthly basis in arrears when usual salary payment is made. All expenses must have been authorised and received by Payroll Services by the appropriate deadline. Claims not authorised by that time should be included in the next payroll run.

3.1.2 The Trust reserves the right to refuse (and not pay) any claim that is not submitted on time or without receipts.

3.1.3 Receipts should be scanned into the e-expenses system. You should note the date of the claim on the receipt. Original receipts are required rather than credit card vouchers. Managers must ensure that receipts are not used for more than one claim by ensuring the claim date is visible on the stored image.

3.1.4 Your letter of approval for study leave and travel expenses should be scanned into the system using the receipt function where a claim relates to approved training.

3.1.5 When you submit a claim related to study leave approved by Education Workforce and Development, you should select "EWD Approved Training" from the drop down menu in the system. All other claims should be submitted under "All Other Expenses".

You should ensure that:

- Expenditure is approved in advance by the relevant budget holder;
- All expenses claimed are necessarily and wholly incurred on Trust business, consistent with this policy, represent value for money, are appropriate and proportionate;

- Claims are accurate, unambiguous and truthful;

3.2 Approval of Claims

3.2.1 Authorised signatories are responsible for verifying claims and should scrutinise claims prior to authorisation3.2.2 Authorisation should be completed promptly after each calendar month end to ensure all claims are received by payroll no later than the 12th day of the following month. This will ensure that payments are made one month in arrears. Any claims received after the 12th day will not be paid until the following month i.e. two months in arrears.

3.2.2 The Finance Department will maintain a schedule of authorised signatories to be used to populate the e-expenses system. The Line Manager will ensure that any employment changes affecting an authorised signatory's status are notified to Finance.

3.2.3 Authorisers should refer suspected fraudulent irregularities to the Fraud Team for further advice, whereby the Fraud, Bribery and Corruption Policy and Response Plan will be invoked.

3.4 Tax

3.4.1 The Trust will comply with all relevant tax law and Her Majesty's Revenue and Customs guidance. UK Income Tax will be deducted from any expense payment which is considered to be taxable benefit, bearing in mind the special dispensations the Trust holds from the HMRC.

3.4.2 In accordance with HMRC requirements, the Trust will deduct basic or higher rate of income tax depending upon the individual from any reimbursement received in respect of travel expenses.

4. Training

A summary of key elements will be notified to managers following implementation. Further advice and guidance will be available from the HR Department. Awareness training can be delivered upon request.

5. Equality and Diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way services are provided and the way staff are treated reflects their individual needs and does not unlawfully discriminate against individuals or groups. This policy has been properly assessed.

6. Monitoring compliance

Standard / process / issue	Monitoring and audit			
	Method	**By**	**Committee**	**Frequency**
All mileage claims will be assessed to ensure the most cost effective vehicle travel is achieved and may result in the Trust recommending a Business Lease Car Ensure users of private vehicles have provided the appropriate evidence of MOT, Tax, Driving Licence	Report from Transport and Travel Advisor on mileage and journeys exceeding 3000 miles P.A. in a private car Report from e-Expenses	Director of Human Resources	Heads of Human Resources	Annually

7. Consultation and Review

This policy has been reviewed in consultation with the Employment Policies and Procedures Consultative Group

8. Implementation

A summary of the key changes will be notified to managers following implementation. Further advice and guidance will be available from the Human Resources Department.

9. References

HMRC rates are available at http://www.hmrc.gov.uk/cars/fuel_company_cars.htm

10. Associated documentation

- Contract Business Car Lease Scheme Policy
- Employees using their own vehicles on Trust business policy
- Fraud, Bribery and Corruption Policy and Response Plan
- Relocation Expenses policy
- Study leave/Continuing Professional Development (CPD) policy
- Taxi and Courier Policy
- Car Parking Policy (Staff)
- Driving at Work Policy (still to be added to intranet by CGARD)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

APPLICATION FOR REGULAR USER ALLOWANCE (MEDICAL AND DENTAL STAFF ONLY)

Please select (tick) ONE of the following criteria which most applies to you:

Criteria 1
There is a requirement to travel an average of 3,500 miles per year ☐

Criteria 2
There is a requirement to travel an average of at least 1,250 miles per year **and** a necessity to use the vehicle an average of three days per week ☐

Criteria 3
There is a requirement to travel an average of at least 1,250 miles per year **and** a need to spend an average of at least 50% of your time on such travel including the duties performed during the visits ☐

Criteria 4
Consultant who is classified as an essential user ☐

Please complete your details below:

Name: ………………………………………………………………….

Job Title: ………………………………………… Directorate/Dept: ………..……….. ……....

Line Manager: …………………………………. Budget Holder: ………………………

Please specify your mileage per month for the last 12 months:

Year & Month	Mileage	Year & Month	Mileage

If you do not have 12 months mileage available please give reason(s):

………………………………………………………………………………………………………

………………………………………………………………………………………………………

Estimated future annual mileage: …………………… miles per year

Signed: ……………………………………………………. Date: ………………………..

This section must be completed by the Line Manager

I confirm this person does/does not fulfil the criteria for Regular User Allowance

Signed (Line Manager): …………………………………………………

Print Name: ……………………………………………………………………………………...

Designation: …………………………………………… Date: ………………………..

This section must be completed by the Budget Holder

I confirm this person does/does not fulfil the criteria for Regular User Allowance

Signed (Line Manager): …………………………………………………

Print Name: ……………………………………………………………………………………...

Designation: ………………………………………….…… Date: …………..…..…………

1. The breakeven point between the cost of RUA and a contract hire car is 3,500 miles a year. Applications for payment of RUA for business mileage of 3,500 miles or more a year must be justified below:

   Reason(s): ………………………………………………………………………………………

   ……………………………………………………..……………………………………………

   ……………………………………………………………………………………………………..

2. Managers must review an employee's Regular User status on an annual basis and inform the Senior Human Resources Manager (Medical and Dental) of any change.

3. Once completed, please send form for approval to the Senior Human Resources Manager (Medical and Dental Staffs), Human Resources Department, RVI

This section must be completed by the Senior Human Resources Manager (Medical and Dental Staffs) as appropriate

I confirm this person should/should not be paid Regular User Allowance

Signed: ………………………………………………………… Date: ………………………….
(Senior Human Resources Manager, Medical and Dental)

Print Name: ……………………………………………………………………………………….

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Equality Analysis Form A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

PART 1

1. **Assessment Date:** 21/02/2022

2. **Name of policy / strategy / service**:

   Travel and Expenses Policy

3. **Name and designation of Author:**

   Karen Pearce, Head of EDI (People)

4. **Names & designations of those involved in the impact analysis screening process:**

   ~~Natalie Cowan, HR Manager~~ Tor Metcalfe-Megginson EDI Manager (~~Projects~~People), Heads of HR, EPPCG

5.

Is this a:	Policy	X	Strategy		Service	
Is this:	New		Revised	X		
Who is affected	Employees	X	Service Users		Wider Community	

6. **What are the main aims, objectives of the policy, strategy, or service and the intended outcomes?** (*These can be cut and pasted from your policy*)

   The aim of the policy is to reimburse any 'out of pocket' expenses which are reasonably, wholly, exclusively and necessarily incurred in the performance of duties for the Trust.

7. **Does this policy, strategy, or service have any equality implications?** **Yes** [ ] **No** [X]

   If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:

   See information below

8. Summary of evidence related to protected characteristics

Protected Characteristic	Evidence, i.e. What evidence do you have that the Trust is meeting the needs of people in various protected Groups	Does evidence/engagement highlight areas of direct or indirect discrimination? If yes describe steps to be taken to address *(by whom, completion date and review date)*	Does the evidence highlight any areas to advance opportunities or foster good relations. If yes what steps will be taken? *(by whom, completion date and review date)*
Race / Ethnic origin (including gypsies and travellers)	The policy is clear that it does not discriminate on the grounds of race/ethnic origin, sex, religion and belief, sexual orientation, age, disability, gender identity/expression, marriage and civil partnership and maternity and pregnancy.	No	
Sex (male/ female)	As above	No	
Religion and Belief	As above	No	
Sexual orientation including lesbian, gay and bisexual people	As above	No	
Age	As above	No	
Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section	As above The Trust will consider making reasonable adjustments when required by travelers in terms of the most appropriate form of travel.	No	
Gender Re-assignment	As above. No gender pronouns are used in this policy.	No	
Marriage and Civil Partnership	As above	No	
Maternity / Pregnancy	As above	No	

9. Are there any gaps in the evidence outlined above? If 'yes' how will these be rectified?

No

10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.

Do you require further engagement? Yes [ ] No [X]

11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?

No

PART 2

Name:

Tor Metcalfe-Megginson

Date of completion:

21/02/2022

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)

The Newcastle Upon Tyne Hospitals NHS Foundation Trust

Employment Policies and Procedures

Maintenance of General Medical/General Dental Council Registration

Version No.:	9
Effective From:	05 February 2021
Expiry Date:	05 February 2024
Date Ratified:	07 December 2020
Ratified By:	HR Heads of Service

General Policy Statement

The General Medical/Dental Council (GMC/GDC) maintains the professional register containing the names of all those who meet the requirements by law to enable them to practise as Doctors and Dentists. After initial registration Doctors and Dentists are also required to renew their registration every year in order to remain eligible to practise.

The policy applies to all medical and dental staff working within the Trust.

The aim of this policy is to ensure all staff required to hold GMC/ GDC registration are registered with a licence to practise at all times.

1 Duties (roles and responsibilities)

1.1 The Medical Director is accountable to the Trust Board for ensuring Trust-wide compliance with policy.

1.2 Clinical Directors are responsible to the Medical Director for ensuring policy implementation and compliance in their area(s).

1.3 All medical and dental staff have a responsibility to ensure they maintain their professional registration at all times.

2 Individual responsibilities

2.1 Each individual Doctor/Dentist is responsible for maintaining their professional registration in order to assure patients and clients of safe professional care, in line with the General Medical/Dental Council Code of Professional Conduct/standards.

2.2 The Human Resources Department (Medical & Dental) is responsible for checking an individual's registration status upon initial appointment and at their annual renewal fee date, and for recording this on the individual's personal file and the Electronic Staff Record (in the case of those registered with GDC). For those registered with GMC there is an interface between GMC and ESR therefore once renewal of GMC registration is actioned by

GMC, ESR is updated and electronic notification provided to HR to confirm this.

3 Process for checking proof of registration

3.1 Prior to interview, a member of the HR team (Medical & Dental) will;

- obtain proof of professional registration and licence to practise (where applicable) via the GMC/GDC website
- Review the Healthcare Professionals Alert Notices (HPAN) List to ensure that the new recruit is not currently subject to action which may affect their appointment, e.g. restrictions or suspension and make a note of the date the HPAN list was checked on the individual's recruitment paperwork
- Place a print out of the online registration and licence to practise confirmation (where applicable, see below) on the personal file
- Ensure that the renewal date is recorded on ESR
- Check fitness to practise:
  - For GMC this will be recorded on the online register
  - For GDC this will be recorded on the online register. The individual's consent is required if there are Fitness to Practise issues on which we are seeking further detail.

These checks will be repeated on the staff member's date of commencement.

3.2 It is at all times the practitioner's responsibility to ensure professional registration is maintained. The practitioner is solely responsible for returning the necessary documentation and payment to the GMC/GDC.

3.3 Practitioners may be removed from the register for administrative reasons, such as failure to pay an annual fee or failure to maintain an effective registered address. The HR Department (Medical & Dental) will verify that all practitioners whose registration renewal date is known to have occurred in the previous month, has been renewed.

3.4 Where the renewal has taken place the new renewal date will be recorded on ESR by a member of the HR team (Medical & Dental) in the case of GDC and in the case of GMC this will be automatically updated in ESR via the interface with GMC (see section 5.2 above) . In instances where a renewal appears not to have been actioned following the expiry date, but the Doctor/Dentist remains on the professional register, a member of the HR team (Medical & Dental) will contact the practitioner and relevant Clinical Director directly and advise of the need for immediate renewal. If a practitioner's name is removed from the professional register paragraph 7 of this process will apply.

4 Action to be taken where current registration is not maintained

4.1 Directorate/Departmental level information on registrations is available to the HR team (Medical and Dental) through ESR Business Intelligence. The HR

team will access this on a regular basis (i.e. monthly) and may contact individuals in cases where renewals are due.

4.2 If a practitioner's name is removed from the professional register, the individual is not legally entitled to practice as a qualified doctor/dentist.

4.3 Any practitioner who becomes aware of a lapse in registration must **immediately** inform their Clinical Director and the HR Department (Medical & Dental) to ensure that appropriate action is taken.

4.4 If a practitioner's registration lapses, the individual will be excluded from the workplace without pay until evidence of renewal is provided. The HR Department (Medical & Dental) should be notified immediately by the practitioner of the date when registration is re-established. Failure to renew registration will have contractual implications for the individual practitioner.

4.5 The appropriate Clinical Director and a member of the HR team (Medical & Dental) will formally investigate each lapse in registration. This may result in disciplinary action being taken and the practitioner may be referred to the GMC/GDC.

4.6 All lapses in registration are viewed extremely seriously and will be notified to the Medical Director.

5 Agency staff and contractors

5.1 Arrangements will only be made with agency staff suppliers and contractors where they confirm, prior to the practitioner's commencement in the Trust, that the practitioner is professionally registered and holds a licence to practise (where applicable) with the relevant regulatory body.

5.2 Prior to commencement a member of the HR team (Medical & Dental) will obtain proof of professional registration and licence to practise (where applicable) from the GMC/GDC website and the GMC automated telephone service to ensure that the agency worker is not currently subject to action which may affect their appointment e.g. restrictions or suspension. A print out of the online registration confirmation and a note of the date the GMC were contacted by telephone will be placed with the individual's booking documentation. If a worker's professional registration expiry date falls within the period of their placement with the Trust, the Authorised Booker will assure themselves that the workers' registration has been renewed.

5.3 A check of the NHS Healthcare Professionals Alert Notices list also will be conducted by a member of the HR team (Medical & Dental). The date of the check will be recorded on the booking documentation.

6 Self-employed

6.1 Managers who use any self-employed professional covered by this policy must check and verify their professional registration, fitness to practise and

that they do not appear on the Healthcare Professionals Alert Letter List before they start work.

6.2 Depending on the duration of the practitioner's employment and/or when their registration is due to expire, managers must ensure they verify the practitioner's re-registration each time it is renewed.

7 Individuals employed by the Lead Employer Trust (LET)

7.1 Arrangements exist with the LET to ensure practitioners employed by the LET who work within the Trust are professionally registered with the GMC/GDC. The LET is responsible for conducting a check on each doctor rotating into the Trust to obtain proof of professional registration and licence to practise. The LET are also responsible for conducting a check of the NHS Healthcare Professionals Alert Notices list.

7.2 Following verification a report containing the details of those due to rotate to the Trust will be provided by the LET approximately six weeks prior to each rotation.

7.3 It is the responsibility of the HR Department (Medical and Dental) to ensure the report is verified to ensure the required data has been provided by the LET for each practitioner and that the data is current.

8 Training

Training will be provided by the Human Resources Department to managers upon request.

9 Equality and Diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way services are provided and the way staff are treated reflects their individual needs and does not unlawfully discriminate against individuals or groups. This policy has been properly assessed.

10 Monitoring Compliance with the Policy

Standard / Process / Issue	Monitoring and Audit			
	Method	**By**	**Committee**	**Frequency**
• Monitoring of the process in relation to the types of check required ensuring that they are being completed in accordance with the NHS Employment Check Standards i.e. • that a professional registration check was completed and recorded (where applicable), and that documentary evidence to	Monitoring of ESR reports and random sample personal file audits quarterly	Director of Human Resources	HR Heads of Department Trust Board	Annually Quarterly

support this was recorded in the personal file • whether any lapses in registration occurred and were dealt with. • The number of referrals to professional bodies will be reported				

11 Consultation and Review of this Policy

This policy has been reviewed in consultation with the Employment Policies and Procedures Consultative Group.

12 Implementation of the Policy (including raising awareness)

A summary of key changes will be notified to managers following implementation. Further advice and guidance will be available from the Human Resources Department.

13 References

GMC members' code of conduct available here
GDC standards for dental professionals available here

Author: Employment Policies and Procedures Consultative Group

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Equality Analysis Form A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

PART 1

1. **Assessment Date:** **26/3/2020**

2. **Name of policy / strategy / service**:
Maintenance of General Medical/General Dental Council Registration

3. **Name and designation of Author:**
Karen Pearce, Senior HR Manager (Projects)

4. **Names & designations of those involved in the impact analysis screening process:**
Natalie Cowan, HR Manager (Projects), HR Heads, EPPCG

5.

Is this a:	Policy	X	Strategy		Service	
Is this:	New		Revised	X		
Who is affected	Employees	X	Service Users		Wider Community	

6. **What are the main aims, objectives of the policy, strategy, or service and the intended outcomes?** *(These can be cut and pasted from your policy)*
The aim of this policy is to ensure all staff required to hold GMC/ GDC registration are registered to practice at all times.

7. **Does this policy, strategy, or service have any equality implications?** **Yes** [ ] **No** [X]

If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:
See below

8. Summary of evidence related to protected characteristics

Protected Characteristic	Evidence, i.e. What evidence do you have that the Trust is meeting the needs of people in various protected Groups	Does evidence/engagement highlight areas of direct or indirect discrimination? If yes describe steps to be taken to address *(by whom, completion date and review date)*	Does the evidence highlight any areas to advance opportunities or foster good relations. If yes what steps will be taken? *(by whom, completion date and review date)*
Race / Ethnic origin (including gypsies and travellers)	The Trust is committed to ensuring that the way staff are treated reflects their individual needs and does not unlawfully discriminate against individuals or groups.	There is no evidence which highlights areas of discrimination.	**n/a**
Sex (male/ female)			**n/a**
Religion and Belief			**n/a**
Sexual orientation including lesbian, gay and bisexual people			**n/a**
Age			**n/a**
Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section			**n/a**
Gender Re-assignment			**n/a**
Marriage and Civil Partnership			**n/a**
Maternity / Pregnancy			**n/a**

9. Are there any gaps in the evidence outlined above? If 'yes' how will these be rectified?

No

10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.

Do you require further engagement? Yes [ ] No [X]

11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?

No

PART 2

Name:

Natalie Cowan

Date of completion:

26/3/2020

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

EMPLOYMENT POLICIES AND PROCEDURES

GRIEVANCE PROCEDURE

Version number:	8.0
Effective from:	25th July 2022
Effective to:	25th July 2025
Date Ratified:	18th July 2022
Ratified by:	Heads of HR

GENERAL STATEMENT

This procedure is to provide a way for staff to raise an issue (problem or complaint) about their employment and for the matter to be dealt with promptly. It applies to all staff and supersedes any previous grievance procedure.

This procedure does not apply to the following:

Does not apply to:	Use:
Allegations of bullying, harassment, victimisation or discrimination	Dignity and respect at work policy
Dissatisfaction with a decision to withhold or defer an increment following appraisal (non-Medical and Dental staff only)	Appraisal policy for non-medical and dental staff
Grading of posts	Banding of posts procedure
Raising concerns or seeking redress in connection with the application of any Trust policy or procedure where that policy or procedure has provision for an appeal	The relevant policy or procedure appeal provision should be used and will be final

1 AIMS

The aim of this procedure is to ensure issues raised by staff in relation to their employment are resolved at the earliest possible opportunity.

2 DUTIES (Roles and Responsibilities)

2.1 The Executive Team is accountable to the Trust Board for ensuring Trust-wide compliance with policy and procedure.

2.2 Directorate managers and heads of service are responsible to the Executive Team for ensuring policy and procedure implementation.

2.3 Managers are responsible for ensuring policy and procedure implementation and compliance in their area(s).

2.4 Staff are responsible for complying with policy and procedure.

3 PROCEDURE

3.1 Stage 1 – informal stage

Staff should act promptly and attempt to resolve any issues informally by raising them with their manager. If the issue is regarding the manager and staff feel unable to approach them, they should speak to the manager's manager.

When managers receive a grievance, they will seek advice from their directorate HR advisor as necessary and arrange a meeting with staff as soon as possible to fully understand the issue and discuss next steps so that the matter can be resolved informally. Where necessary, managers may contact other parties and/or carry out fact-finding to establish the most suitable resolution.

Once completed, managers will meet again with staff to outline potential resolutions and a way forward. They will confirm the outcome in writing including what staff can do if they are not satisfied and wish to proceed to the formal stage.

3.2 Stage 2 – mediation

Mediation is a voluntary process conducted by an independent and impartial person who is either a trained mediator or someone with appropriate knowledge, skills and experience. It is intended as a positive way of facilitating a staff member and their manager to find a resolution– see Appendix B.

A list of trained mediators is available on the following intranet link.

Mediation cannot be used if the parties do not have the necessary authority to settle the matter.

If mediation is used during formal proceedings under another policy or procedure, those proceedings will be paused to allow reasonable time for mediation to take place. If matters are not resolved, the formal proceedings will continue.

3.3 Stage 3 – formal stage

If staff remain dissatisfied after the informal stage, and feel they have reasonable grounds for moving to the formal stage, they should complete the form and send it to their manager within seven calendar days of receiving written confirmation of the outcome of the informal stage.

Managers will inform their directorate HR advisor who will acknowledge receipt and forward it to an appropriate manager to arrange a meeting to discuss the grievance as soon as possible.

Staff have a right to be accompanied by a trade union representative or work colleague if they wish. Where the chosen companion is unable to attend the meeting on the date proposed, an alternative date and time may be offered, as long as it is reasonable and falls within five working days of the original date. If the alternative is not agreed, the meeting will go ahead without the companion. A member of the HR department will be present to take notes and provide advice as necessary.

Where necessary, managers may contact other parties and/or carry out fact-finding to establish the most suitable resolution.

An example procedure for the conduct of a formal meeting is at Appendix A. It may or may not be necessary to hold a meeting with all parties present (i.e. staff member and responding manager) – it will be up to the manager handling the matter to decide on a case-by-case basis. The manager will adjourn the meeting to reflect on the discussion and make a decision. After their deliberations, the manager will reconvene the meeting to give their decision (including the right of appeal). They will then confirm their decision in writing including a summary of the key points from the meeting and the right of appeal.

3.4 Stage 4 – appeal

Staff will have 8 calendar days to appeal in writing starting from the date they receive the confirmation letter from their manager. The appeal should be addressed to the Director of HR at Regent Point and set out the reasons for appeal together with how they would like the matter resolved.

The appeal will be arranged by HR and be heard by a more senior person from a different directorate/service. It will follow the procedure at Appendix A with the previous manager and the staff member each being required to attend to present their case and answer any questions. Staff have a right to be accompanied by a trade union representative or work colleague if they wish. A member of the HR Department will attend the hearing to act as secretary and provide advice, as necessary.

Five working days before the hearing the staff member will receive all the documentation considered at the formal meeting including the notes of the meeting and the outcome letter.

Where necessary, appeal managers may contact other parties and/or carry out fact-finding to establish the most suitable resolution. The outcome of the appeal will be final and communicated in writing without unreasonable delay.

3.5 Overlap of grievance procedure and disciplinary procedure

If a grievance is raised during a disciplinary process, disciplinary process will be paused to allow reasonable time for the grievance to be dealt with. Where the grievance is related to the disciplinary matter, it may be appropriate to deal with it as part of the disciplinary process.

3.6 Collective grievance

If more than one person raises a grievance and they are seeking resolution as a group, they may raise a collective grievance under this procedure. Normally any planned changes that caused the grievance will be paused and the status quo (the situation before the change) will be maintained until it has been considered. However, in some circumstances this may not be possible or advisable because it may risk breaching statutory, mandatory or regulatory obligations, or delays might compromise service delivery. In such exceptional circumstances, management will reserve the right to implement the change and explain the reason(s).

Collection grievances will follow the same procedure for individual grievances.

4 TRAINING

Training as necessary will be provided to managers by the Human Resources Department as part of implementing this policy.

5 EQUALITY AND DIVERSITY

The Trust is committed to ensuring that as far as is reasonably practicable, the way services are provided and the way staff are treated reflects their individual needs and does not unlawfully discriminate against individuals or groups. This policy has been properly assessed.

6 MONITORING COMPLIANCE

Standard / process / issue	**Monitoring and audit**			
	Method	**By**	**Committee**	**Frequency**
Identify: • categories of grievance • number of appeals • process start/end dates	report from ESR	Director of HR	Heads of HR	Annually

7 CONSULTATION AND REVIEW

This policy has been reviewed in consultation with the Employment Policies and Procedures Consultative Group

8 IMPLEMENTATION (including raising awareness)

A summary of the key changes will be notified to managers following implementation. Further advice and guidance will be available from the Human Resources Department.

9 REFERENCES

This policy is compliant with the ACAS Code of Practice.

10 ASSOCIATED DOCUMENTATION

- Appraisal Policy (Non-Medical Staff)
- Banding of Posts Procedure
- Dignity and Respect At Work Policy

Appendix A

The Newcastle upon Tyne Hospitals NHS Foundation Trust

GRIEVANCE FORM – FORMAL AND/OR APPEAL

The person conducting the meeting will introduce those present and outline the process, including the use of adjournments.

The following procedure shall be observed:

a) The staff member or their representative shall state their case in the presence of Management and may call witnesses.

b) Management shall have the opportunity to ask questions of the staff member, their representative and witnesses.

c) The person conducting the meeting shall have the opportunity to ask questions of the staff member, their representative and witnesses.

d) The staff member or their representative shall have the opportunity to re-examine their witnesses on any matter referred to in their examination by the person conducting the meeting and by Management.

e) Management shall put their case in the presence of the staff member and their representative and may call witnesses.

f) The staff member and their representative shall have the opportunity to ask questions of Management and their witnesses.

g) The person conducting the meeting shall have the opportunity to ask questions of Management and their witnesses.

h) Management shall have the opportunity to re-examine their witnesses on any matter referred to in their examination by the person conducting the meeting and by the staff member or their representative.

i) Management and the staff member, or their representative shall have the opportunity to sum up their case if they wish. The staff member or their representative shall have the right to speak last. In summing up, neither party may introduce any new matters. The person conducting the meeting shall ask the staff member if they feel they have had a fair hearing. If the staff member feels they have not, the person conducting the meeting shall ask them for details and address the issue(s).

j) The person conducting the meeting has discretion to adjourn it if they feel further evidence and/or investigation is required.

k) Management, the staff member and their representative shall withdraw from the meeting.

l) The person conducting the meeting and the HR representative will deliberate in private and the person conducting the meeting will make their decision and confirm this in writing.

m) If, before making a decision, there is a need to seek clarification on any points from one or both parties, both parties will be recalled to the meeting whilst the point(s) is dealt with.

IMPORTANT NOTE

Management in the context of this procedure may be a manager, or a representative from the Human Resources Department who is accompanying the manager.

Appendix B

MEDIATION

Terms of Reference

If mediation is requested, the mediator will seek to facilitate the following:

a) Explain the mediation process
b) Ask questions that help to uncover underlying problems, assist the parties to understand the issues and help them clarify the options for resolving their difference or dispute
c) Restore/maintain good working relations
d) Focus on working together to go forward
e) Avoid making judgments or determining who is right or wrong
f) Ensure agreement comes from those in dispute not the mediator
g) Take charge of the process of seeking a resolution but not the outcome
h) Ensure all parties are aware of confidentiality
i) The outcome will only be disclosed to colleagues or their managers if all parties agree with the exception where, for example, a potentially unlawful act has been committed or there is a serious risk to patient care or health and safety

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Equality Analysis Form A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

PART 1

1. **Assessment Date:** June 2022

2. **Name of policy / guidance/ strategy / service development / Investment plan/Board Paper**:

   Grievance Policy

3. **Name and designation of author:**

   Karen Pearce, Head of Equality, Diversity & Inclusion - People

4. **Names & Designations of those involved in the impact analysis screening process:**

   EPPCG / HR Heads

5. **Is this a:** Policy X Strategy ☐ Service ☐ Board Paper ☐

   Is this: New ☐ Revised X

   Who is affected: Employees X Service Users ☐ Wider Community ☐

6. **What are the main aims, objectives of the document you are reviewing and what are the intended outcomes?** *(These can be cut and pasted from your policy)*

   The aim of this policy and procedure is to support staff to ensure any concerns raised in relation to their employment are resolved at the earliest possible opportunity and offers a range of options for resolving concerns.

7. Does this policy, strategy, or service have any equality implications? Yes ☐ No X

   If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:

   See below

8. Summary of evidence related to protected characteristics

Protected Characteristic	Evidence What evidence do you have that the Trust is meeting the needs of people in all protected Groups related to the document you are reviewing– please refer to the Equality Evidence within the resources section at the link below: http://nuth-vintranet1:8080/cms/SupportServices/EqualityDiversityHumanRights.aspx	Does evidence/engagement highlight areas of direct or indirect discrimination? For example differences in access or outcomes for people with protected characteristics	Are there any opportunities to advance equality of opportunity or foster good relations? If yes what steps will be taken? (by whom, completion date and review date)
Race / Ethnic origin (including gypsies and travellers)	This policy applies to all staff. The Trust is committed to ensuring that no employee should be treated less favourably on the grounds of their age, disability, race, nationality, ethnic origin, sex, sexual orientation, religion and belief, gender identity / expression, marriage and civil partnership or pregnancy and maternity.	0.11% of BAME staff registered a grievance against 0.14% of white staff	BAME Staff Network Availability of cultural ambassadors
Sex (male/ female)	As above	0.15% of female staff registered a grievance against 0.11% of white staff	
Religion and Belief	As above		
Sexual orientation including lesbian, gay and bisexual people	As above	0.14% of BAME staff registered a grievance against 0.18% of white staff	LGBT Staff Network
Age	As above		
Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers	As above	0.12% of non-disabled staff registered a grievance against 0.32% of white staff	Disability Staff Network

in this section			
Gender Identity / Expression	As above		
Marriage and Civil Partnership	As above		
Maternity / Pregnancy	As above		

9. Are there any gaps in the evidence outlined above. If 'yes' how will these be rectified ?

No

10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.

Do you require further engagement Yes No X

11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?

No

PART 2

Signature of Author

K Pearce

Print name

Karen Pearce

Date of completion

June 2022

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

EMPLOYMENT POLICIES & PROCEDURES

Health, Wellbeing and Attendance Management

Version No.:	16.2
Effective From:	05 December 2022
Expiry Date:	04 July 2025
Date Ratified:	05 December 2022
Ratified By:	Heads of HR

1. GENERAL POLICY STATEMENT

1.1 The aim of this policy is to maintain and improve the physical and mental health and wellbeing of staff. The attendance management procedure incorporated in this policy recognises there will be times when staff cannot attend work because of illness or health-related reasons and there will be need in those circumstances to ensure they receive the necessary support to aid their recovery and rehabilitation to return to work and manage their absence to minimise the impact on the Trust.

1.2 We are committed to providing an environment and culture that promotes health and wellbeing and aim to achieve this by:

a) implementing a health and wellbeing strategy and action plan
b) widely promoting health and wellbeing
c) promoting our values, policies, support services, networks and health promotion campaigns
d) encouraging a culture where everyone feels able to discuss their health and wellbeing with their manager, including any need for support. We will offer all staff the opportunity of an annual health and wellbeing conversation
e) creating and maintaining an environment where staff who experience ill health receive the necessary support (including reasonable adjustments) to stay at or return to work
f) ensuring leaders and managers maintain a health and wellbeing focus and have the skills to support their teams

1.3 Our health and wellbeing focus is on activities and resources related to the following key themes:

a) physical
b) emotional
c) work environment
d) healthy lifestyles
e) social

f) feeling valued
g) financial
h) cultural
i) compassionate leadership

2. SCOPE

This policy applies to all staff.

3. AIMS

The aim of this policy is to maintain and improve the physical and mental health and wellbeing of all staff and manage attendance.

4. DUTIES (ROLES & RESPONSIBILITIES)

4.1 The Executive Team is accountable to the Trust Board for ensuring Trust-wide compliance with policy.

4.2 Directorate managers and heads of service are responsible to the Executive Team for ensuring policy.

4.3 Managers are responsible for ensuring policy implementation and promoting awareness of this policy amongst their employees.

4.4 Employees are responsible for complying with this policy.

5. PROMOTING HEALTH & WELLBEING

We will promote positive health and wellbeing by:

a) providing information and raising awareness via induction, engagement, consultation, newsletters, email and web-based communication, posters and leaflets
b) promoting key wellbeing dates and events via our health and wellbeing calendar
c) promoting policies, guidance and practices that support wellbeing
d) holding health and wellbeing events to raise awareness, promote initiatives and campaigns, celebrate success, engage our staff to encourage a happier healthier lifestyle inside and outside of work

6. MANAGEMENT & LEADERSHIP

6.1 Our managers are best placed to provide initial health and wellbeing support to staff and it is essential that we develop their knowledge and skills to ensure they can:

a) be aware of the key issues related to health and wellbeing

b) recognise signs of ill health including mental ill-health
c) signpost staff to get the support they need

6.2 We will ensure managers are supported and trained (where necessary).

7. KEY HEALTH & WELLBEING SUPPORT

The following are available for everyone and are key to supporting health and wellbeing:

7.1 Health and wellbeing strategy

The overarching aim of our strategy is to provide an overview of our aspirations in supporting the wellbeing of our staff and provide assurance that we have a coherent and holistic "wellbeing offer" in place. A copy of the strategy is available here.

7.2 Health and wellbeing conversations

These are an important step to ensuring that managers have dedicated time to talk to their colleagues about how they are. They are informal meetings that are intended to provide staff with an opportunity to talk in a safe and supportive space about their physical and emotional wellbeing and how this affects them at work. All staff will be offered the opportunity for an annual health and wellbeing conversation.

7.3 Mental health first aid

We will train and provide mental health first aiders who will be able to identify and recognise in colleagues the warning signs of mental ill health and signpost them to appropriate support.

7.4 Occupational health support

Our occupational health service provides a range of support to maintain, promote and improve physical and mental wellbeing, including:

a) pre-employment checks and vaccinations
b) opinion about fitness for work
c) opinion on the appropriateness of any agreed phased return to work following sickness absence
d) supporting the development of rehabilitation plans to facilitate return to work following sickness absence
e) assisting staff to remain at or return to work
f) providing advice and assistance to staff who seek advice/self-refer in connection with work

7.5 Managing & supporting stress

Stress can affect any one and it can affect people differently. Staff who think they are experiencing stress are encouraged to tell us as soon as possible so we can help. They should talk to their manager so they can receive support. It can be mentioned at one-to-one meetings or a health and wellbeing conversation. If the manager is unavailable or staff do not feel they can talk to them, they should contact occupational health, chaplaincy, the HR team or their trade union representative (if they are a member).

Staff have an active role to play in maintaining their health and wellbeing and communicating with others is a helpful step towards resolving any stress that may be affecting them. We know that stress is not always work-related and we will try to support staff with matters outside of work as well. We will help staff to identify what they think is causing their stress with the aim of making reasonable changes to their work or working environment if necessary. The best way to do this is through completing a stress risk assessment to understand what is causing the problem(s) and what could help.

Our risk assessment approach will be based on the Health and Safety Executive six key standards:

#	Standard	Assessment
1.	**Demands**	Staff can cope with the demands of the job
2.	**control**	Staff can have a say about the way work is done
3.	**Support**	Staff receive adequate information and support from colleagues and managers
4.	**Relationships**	Staff are not subject to unacceptable behaviour
5.	**Roles**	Staff understand their role and responsibilities
6.	**Change**	Staff are involved in and consulted about any organisational change

As part of the risk assessment process managers may ask occupational health for advice and guidance. Before considering a referral to Occupational Health, managers are expected to complete a risk assessment and implement an action plan as this may avoid the need for any referral and issues related to stress can often be resolved quickly and without undue process.

We are committed to supporting colleagues who are experiencing symptoms of crisis and will aim to do all we reasonably can to get them the necessary help including signposting to specialist services. If staff are worried about themself or a colleague they should speak to their manager, occupational health, chaplaincy, the HR team, a mental health first aider or their trade union representative (if they are a member). Information is also available on the intranet.

ATTENDANCE MANAGEMENT PROCEDURE

1. GENERAL

1.1 We recognise there will be times when staff cannot attend work because of illness or health-related reasons. In those circumstances there will be a need to ensure they receive the necessary support to aid their recovery and rehabilitation to return to work and manage their absence to minimise the impact on the Trust.

1.2 This procedure explains how sickness absence should be reported, the effects of sickness on pay and annual leave and how to manage short-term and long-term sickness absence respectively. (Staff on probation who are absent due to sickness will be managed using this procedure and the probationary policy).

1.3 Staff are entitled to be accompanied by a work colleague or trade union representative at all meetings held in connection with this procedure with the exception of the third 'return to work and wellbeing' meeting where staff are counselled.

1.4 The following definitions will apply:

a) **Short-term sickness absence** – any occasion of absence that lasts for between one day and 27 consecutive calendar days
b) **Long-term sickness absence** – any occasion of absence that lasts for four or more consecutive calendar weeks (i.e. 28 consecutive calendar days or more)
c) **Underlying health condition** – illness or injury with potential to influence daily living or attendance but may be mitigated through medical treatment and/or adaptation/management by the staff member and/or reasonable adjustment(s) by the Trust

1.5 Although sickness can be categorised as short-term and/or long-term, managers have discretion to count any sickness absence towards the triggers and the decisions they make under this procedure.

1.6 Our management of sickness absence is based on the following principles:

a) staff are expected to make every reasonable effort to attend work
b) staff who cannot attend work due to ill health must report their absence and managers must record it
c) staff with an underlying health condition will receive the necessary support to aid their recovery and rehabilitation to remain at or

return to work, including referral to occupational health and consideration of reasonable adjustments

d) managers will consider the health needs of colleagues based on individual circumstances and have discretion to adapt the application of this attendance management procedure as appropriate
e) managers will ensure they have all the necessary information and that it is accurate and up to date, including any mitigation, before making a decision under this procedure
f) managers will apply the procedure in a fair and consistent way with due consideration of individual circumstances

1.7 Managers will support staff to achieve an acceptable level of attendance. Staff should not remain at work if they are too unwell to attend and should discuss this with their manager at the earliest opportunity and before leaving work if they can.

1.8 Human Resources will provide any necessary advice and support to staff and managers on this and related policies and procedures in connection with attendance at work.

1.9 Occupational Health will provide advice to staff and managers about health and wellbeing in relation to remaining at or returning to work from sickness absence.

1.10 Staff should alert their manager at the earliest opportunity if they are aware of changes to their health and wellbeing that may impact on their ability to do their job.

1.11 Staff are required to attend occupational health appointments and relevant meetings with their manager and HR in connection with their attendance at work.

1.12 Staff who are sick and unable to attend work must ensure they (or someone on their behalf) directly contacts their manager (or their nominated deputy) to inform them. Contact must be made on the first day of sickness (even if it is a non-working day) and occur before the beginning of any shift that is due to be worked that day – as much notice as possible should be given to enable necessary cover to be arranged. Staff should provide the following details:

a) reason for absence/nature of sickness (highly sensitive and personal information need not be disclosed)

b) whether sickness is related to work and if so in what way (e.g. accident/ incident)
c) estimated time they will be absent
d) what they intend to do to support recovery (e.g. rest, medication, contact/see GP)

1.13 Managers will agree with staff how and when contact will continue during sickness absence to receive updates and check on progress for return to work. They will also complete the 'notification of absence' form and send a copy to HR for the personal file and ensure all sickness absence and related information, such as return to meetings and referrals to Occupational Health is recorded without delay in Allocate (for non-M&D staff) and ESR (M&D staff).

1.14 Potentially infectious conditions require staff to be symptom-free for a certain length of time before returning to work. The whole absence period will be recorded as sickness absence, but only the period of actual sickness will be counted for the purposes of absence triggers. (For further information on infection control, please refer to relevant Trust policies on the intranet).

1.15 Staff are required to provide sickness absence certification as follows:

a) absences of one to seven calendar days (including non-working days): a self-certification form must be completed and submitted to manager no later than first day of return to work
b) **absences of eight calendar days or more (including non-working days):** a medical certificate from a GP/hospital (also known as a fit note) must be submitted to manager without delay. Staff can return to work before their medical certificate/fit note expires if they are feeling better. In some instances, it may be necessary for a manager to seek advice from occupational health beforehand to ensure the staff member is well enough to return

1.16 After any period of sickness absence, staff will meet with their manager for a return to work and wellbeing discussion which will include completing a return to work form. Staff may have a copy and a copy will be placed on their personal file.

1.17 Any sick pay that is due during absence will be paid in accordance with the staff member's contract of employment and current national/local terms and conditions. Staff are required to follow the reporting and certification process otherwise sick pay may not be paid on time or at all.

1.18 If staff are sick just before [or during] annual leave they are required to contact their manager immediately to discuss whether they still wish to take the leave [or remaining amount] or have it back and replace it with sickness absence. The manager will amend the staff member's annual leave and sickness records as necessary to ensure they are accurate.

1.19 If staff are sick on a public holiday no compensatory holiday will be given. This applies regardless of whether annual leave entitlement is calculated inclusive or exclusive of public holidays.

1.20 Staff will continue to accrue statutory and contractual annual leave entitlement during periods of sickness in accordance with statutory regulations and the terms of their contract of employment. Contractual annual leave entitlement will not accrue during periods when only statutory sick pay or no pay is paid.

1.21 Staff who are off sick are required to use their holiday entitlement (including replacement days given back due to sickness) before the end of the leave year. There is no statutory right to carry over annual leave entitlement from one leave year to the next, however the Trust does permit a maximum of one week of a staff member's contracted hours subject to approval in advance from their line manager. Taking holiday will not break the period of sickness absence but the number of days will not be counted as sickness.

1.22 If it is not possible to take annual leave in the current leave year due to long term sickness absence, carry over will be limited to the statutory entitlement of 20 days in accordance with the European Working Time Directive. The first annual leave taken in any leave year will be statutory annual leave until the amount of any statutory entitlement due (plus any statutory amount carried over) is exhausted. Public holidays will be counted when calculating entitlement to statutory annual leave.

1.23 If staff have an annual leave request declined and are subsequently sick on some or all of the days requested they may be required to provide a medical certificate from their GP. Any costs associated with this will be met by the staff member. Where a medical certificate is not provided within a reasonable time, sick pay will not be paid.

2. SHORT-TERM SICKNESS

2.1 The trigger for an unacceptable level of attendance will be:

a) three occasions of short-term sickness absence in a rolling 12-month period; or

b) any pattern of attendance that gives cause for concern, for example, it significantly impacts on a staff member's role or service – this may include two or more occasions of long-term sickness absence in a rolling 12-month period

2.2 Once staff have met a trigger and been counselled or warned, the trigger will not be reset. Any further occasion(s) of sickness absence in the active period after the counselling or warning will be considered when deciding what action to take next under this procedure and there will be no requirement for managers to wait until the number of occasions stated in paragraph 2.1 above have been met.

2.3 There are usually four stages in the management of short-term sickness absence (see table below), however depending on the circumstances formal action at any level (including dismissal) can be taken at any stage.

Stage	Action	Consequence
1	Return to work and wellbeing meetings	On-going support; counselling at third meeting (active for the following 12 months)
2	First formal short-term absence review	Potential for first attendance warning; active for 12 months from date of decision
3	Second formal short-term absence review	Potential for final attendance warning; active for 24 months from date of decision
4	Final formal short-term absence review	Potential for dismissal

Stage 1 short-term sickness – return to work and wellbeing meeting

2.4 Following any period of short-term sickness absence managers (on their own) will hold a return-to-work and wellbeing meeting with staff to:

a) welcome them back to work and better understand the reason for their absence, including whether it was work-related or there is an underlying health condition
b) inform them of the dates, frequency and pattern of their absence and ensure they are aware of the implications when a trigger is met. If a trigger is met, managers will counsel staff that their level of attendance is a concern/problem and further attendance which is felt to be unacceptable could lead to formal action under other stages of the procedure

c) consider whether any support is necessary to help improve attendance, such as referral to occupational health, risk assessment or reasonable adjustments

Managers will complete a return-to-work review form and make a record of the meeting. Any medical certificates should be collected. Staff may have a copy of the record and a copy will be placed on their personal file.

Stage 2 short-term sickness – first formal absence review

2.5 If staff hit a trigger and have further absence, managers (on their own) will arrange to meet them to consider whether formal action is necessary.

2.6 Managers should ideally give staff at least 5 calendar days' notice to prepare for the meeting and arrange to be accompanied if they wish – managers should ensure that staff are informed they can be accompanied by a work colleague or trade union representative.

2.7 At the meeting the manager will talk through the attendance record and their concerns and staff will have the opportunity to respond and raise any relevant points and/or mitigation. The meeting will then consider any necessary measures to help support attendance, such as: referral to occupational health; identification and action related to any work-related issues or underlying health condition(s); and consideration of reasonable adjustments.

2.8 The manager will adjourn the meeting to reflect on the information available to them and decide the question of whether to issue a formal attendance warning. They may seek advice from the HR team if necessary.

2.9 After their deliberations, the manager will:

a) reconvene the meeting
b) give their decision (including any right of appeal if a warning is issued – they will have 14-days in which to appeal in writing starting from the date they receive the confirmation letter from their manager. Their appeal should be addressed to the Director of HR at Regent Point and set out the reasons for appeal. It will be heard by an officer within the Directorate/ service of more senior authority than the one who issued the warning. The appeal will mirror the procedure in the disciplinary policy with the line manager and the staff member each being required to attend to present their case and answer any questions)
c) advise that the attendance warning (if issued) will be active for 12-months from the date of the decision
d) advise that attendance will continue to be monitored and any further sickness absence could – but will not automatically – lead to further [formal] action. Normal procedure will apply to:

i. meet with staff
ii. review their attendance
iii. consider all the circumstances (including any underlying health condition(s); reasonable adjustments; and any mitigation)
iv. decide next step(s)

e) advise whether any restrictions will be placed on the staff member working additional hours or on the staff bank
f) confirm their decision in writing including a summary of the key points from the meeting and the right of appeal
g) arrange for a copy of the written confirmation and notes from the meeting to be placed on the personal file

Stage 3 short-term sickness – second formal absence review

2.10 If staff have sickness absence in the active period after the first formal absence review, a second absence review meeting will be arranged.

2.11 The manager, supported on this occasion by an HR representative, will take staff through the same process as set out in the previous stage taking account of what support has been given.

2.12 If a final attendance warning is issued it will be active for 24 months.

Stage 4 short-term sickness – final formal absence review

2.13 If staff have sickness absence in the active period after the second formal absence review, a final absence review meeting will be arranged.

2.14 This will be arranged with a member of the Trust's Executive Team (or nominated senior officer acting with delegated authority) who will be supported by an HR representative who has not been involved at a previous stage.

2.15 The review meeting will mirror the procedure in the disciplinary policy with the line manager and the staff member each being required to attend to present their case and answer any questions.

2.16 The Executive Team member (or nominated senior officer acting with delegated authority) will consider the following:

a) whether policy and procedure has been followed
b) whether due consideration has been given to relevant factors, such as any work-related issues or underlying health condition(s), reasonable adjustments, occupational health advice and any mitigating circumstances
c) whether the Trust can continue to support the level of attendance
d) whether dismissal would be reasonable and proportionate
e) whether dismissal would be consistent with practice and have due regard for the position held by the staff member and their length of service

2.17 If staff are dismissed, they will have the right of appeal as described above. An appeal will be heard by a panel comprising of two members of the Trust Board. The appeals process will be administered by the HR department.

3. LONG-TERM SICKNESS

3.1 The same stages in section 2 for the management of short-term sickness absence will apply to long-term sickness absence with the exception of the paragraphs set out below in this section 3.

3.2 The trigger for an unacceptable level of attendance will be:

a) two or more occasions of long-term sickness absence in a rolling 12-month period, or

b) any pattern of attendance that gives cause for concern, for example, it significantly impacts on a staff member's role or service

3.3 Once staff have met a trigger and been counselled or warned, the trigger will not be reset. Any further occasion(s) of sickness absence in the active period after the counselling or warning will be considered when deciding what action to take next under this procedure and there will be no requirement for managers to wait until the number of occasions stated in paragraph 3.1 above have been met.

Health and wellbeing meeting

3.4 Managers should identify signs that sickness may become long-term as soon as possible and arrange appropriate early intervention, such as a health and wellbeing meeting, referral to occupational health and/or risk assessment.

3.5 Managers (on their own) will hold regular meetings with staff on long-term sickness absence and refer them to occupational health for assessment as necessary. If staff are too ill to attend meetings alternative arrangements will be considered such as home visit, telephone call or virtual meeting

3.6 Ideally meetings will be held every four to six weeks to ensure managers are up to date and staff have the necessary support to aid their recovery and rehabilitation to return to work. The meeting will be an opportunity for the manager to:

a) receive updates on how staff are
b) check on progress with their recovery including any planned treatment or appointments
c) signpost them to useful resources on health, wellbeing and psychological support
d) discuss a referral to occupational health or any reports/advice received
e) explore and consider reasonable adjustments
f) decide whether a risk assessment is necessary
g) share information about sick pay such as full pay and half-pay expiry dates and what to do with fit notes if statutory sick pay expires
h) provide an update on what is happening at work
i) agree next steps including plans for return to work

Formal long-term sickness absence review meeting

3.7 Managers with support from an HR representative will hold a formal absence review meeting as soon as possible if the following occurs:

a) staff have met a trigger for unacceptable long-term sickness absence, or
b) long-term sickness is going to continue into half-pay and no return to work is expected in the foreseeable future, or
c) medical opinion advises at any time that a return to work is unlikely

The manager will give notice of the meeting and inform the staff member of their right to be accompanied by a work colleague or trade union representative if they wish – see paragraphs 2.6 to 2.10 above for further details about conducting a formal absence review.

3.8 The purpose of the meeting will be to review the situation, consider the options and decide next steps. This can include the following:

a) providing further support and continuing to monitor attendance
b) for staff who have met a trigger, following the process to issue an attendance warning and/or allowing further occasion(s) of long-term sickness absence by way of reasonable adjustment
c) for staff who are currently on long-term sickness absence, allowing more time to see whether their situation improves
d) exploring redeployment
e) applying for ill health retirement (if applicable) – see below
f) the Trust terminating employment – see paragraphs 2.14 to 2.18 above
g) ending employment by mutual agreement – see below

Ill health retirement

3.9 If staff are a member of the NHS Pension Scheme with at least two years' service, are below a certain age (below age 60 for 1995 members; 65 for 2008 members; and below the state pension age or age 65 if their state pension age is before age 65) and have medical evidence that they are unlikely to be able to return to work because of ill health, they may be eligible to retire on the grounds of ill health. The decision will rest with NHS Pensions. Staff who wish to explore this option, should discuss it with their manager, HR or their trade union representative.

Ending employment by mutual agreement

3.10 Staff who believe there is no prospect of a return to work within a reasonable timeframe may request a meeting to discuss their ongoing employment. At this meeting, they will be asked to explain the reasons why they believe they are unable to return to work and consideration will be given as to whether there are any reasonable adjustments or other support that could change this. Managers will ensure staff fully understand the process being followed, the implications and they [staff] are giving their informed consent to proceed. If it is mutually agreed to end employment this will be on the basis staff are no

longer able to fulfil their role on grounds of ill health and will be effective from the date of the meeting. Staff will receive pay in lieu of notice under the terms of their contract of employment plus payment/deduction for any annual leave entitlement under/overtaken (as applicable). Everything will be confirmed in writing by the manager within seven calendar days of the meeting.

4. KEY GUIDANCE DURING SICKNESS ABSENCE

Occupational health

4.1 Staff will be asked to attend occupational health where necessary. For example, if:

a) they hit attendance triggers
b) they are absent on long-term sickness or their current absence is likely to become long-term
c) they have an illness or injury that may impact on their ability to carry out their role
d) they, their manager or a medical practitioner requests a change of duties on medical grounds
e) there is a need to hold a *case conference
f) they wish to be considered for ill-health retirement
g) an assessment is required following an injury sustained at work

(* A case conference is a confidential meeting which can be used as part of the attendance management process to support staff and managers to find solutions that help make progress for a return to work. The meeting lasts around an hour and is between a staff member, their representative (if staff wish to be accompanied), the manager, an HR representative and an occupational health clinician).

4.2 Occupational health will send managers (and staff if they request it) a copy of their report following referral or review. Reports may include recommendations to change the working environment, work patterns or work practice to help staff remain at or return to work or improve their attendance. Managers will discuss reports and recommendations with staff and decide what to do taking into account the impact on service delivery, the immediate work team and other colleagues. If necessary, occupational health may seek consent from staff to contact their GP or specialist for a medical report. Confidentiality will be maintained in line with the consent provided.

Phased return to work

4.3 Occupational health may suggest a return to work on a phased basis for up to four weeks, but this is not a requirement in every situation. This can involve adjustment or temporary cessation of certain duties or a temporary reduction of working hours. Where duties and/or hours are reduced, staff will receive full basic pay for their normal hours.

4.4 Managers will consider staff requests to extend a phased return to work taking into account the impact on service delivery, the immediate work team and other colleagues. Where an extension is granted, staff will be required to use any or a combination of the following to make up their normal contracted hours: annual leave; accrued time owing; or unpaid leave. Where unpaid leave is taken, pay will be adjusted accordingly.

Return to work plan

4.5 Managers will complete and implement a return to work plan with staff who are returning to work from sickness absence which has lasted for two months or more It will be completed at least seven calendar days before staff are physically due to return to work. A copy will be held on the personal file.

Return to work and wellbeing meeting

4.6 The manager will hold a return to work and wellbeing meeting with staff on or shortly after their first day back at work. The purpose of the meeting is as follows:

a) to welcome staff back to work and (if necessary) better understand the reason for their absence, including whether it was work-related or there is an underlying health condition
b) to inform staff of the dates, frequency and pattern of their absence and ensure they are aware of the implications when a trigger is met
c) to check they feel well enough to be at work and consider whether any support is necessary, such as referral to occupational health, risk assessment or reasonable adjustments
d) to confirm or amend a return to work plan including any arrangements for a phased return
e) to update staff on anything new or that may have changed during their absence
f) to confirm any agreed phased return plan, including that the trust will support the first four weeks on full pay
g) to arrange any necessary risk assessment(s)
h) to agree regular health and wellbeing meetings to support their return (if appropriate)

i) to complete a return to work review form and make a record of the meeting. Any medical certificates should be collected. Staff may have a copy of the record and a copy will be placed on their personal file

Disability-related sickness absence

4.7 The Equality Act 2010 requires employers to consider reasonable adjustments to help people with a disability to remain in work and carry out their role effectively.

4.8 The definition of a disability under the Act is:

> *"A person is disabled if they have a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities".*
>
> *"Long-term" means the condition must last or be likely to last for more than 12 months or is likely to last for the rest of the person's life. People with cancer, multiple sclerosis or HIV/ AIDS are defined as disabled from the date of diagnosis, regardless of the illness's impact on their life at the time of diagnosis."*

4.9 Managers will consider reasonable adjustments where staff are absent from work due to a disability that is likely to be considered by an employment tribunal as covered by the disability provisions of the Equality Act 2010.

4.10 Staff should let their manager and occupational health know about any disabilities they have so that due consideration can be given to reasonable adjustments and ways of supporting them.

4.11 Examples of reasonable adjustments may include: changes to duties; hours or work pattern; specialist equipment; or redeployment (temporary or permanent).

New staff on probation

4.12 New staff on probation who have an unacceptable level of attendance will be managed using this procedure and the probationary policy. If they have completed their probation but have less than two years' service the manager may decide to arrange a final review meeting at which dismissal may be considered. The manager should seek any necessary advice in advance from the HR team.

Management of injuries and diseases

4.13 If staff have been injured because of an accident/incident at work or have contracted a disease in course of their employment or developed a condition due to work, managers must report it in Datix without delay and keep a record of all injuries resulting in absence of more than three days. In cases of infectious or communicable disease, musculo-skeletal injury, stress/anxiety/depression or absence of more than three days, managers should make an immediate referral of the staff member to occupational health for assessment.

4.14 Staff may be entitled to the payment of NHS injury allowance if they have an injury, illness or other health condition that is wholly or mainly attributable to their NHS duties and are on authorised sickness absence or a phased return to work with reduced or no pay. Managers and staff can seek help and further information from the HR team as necessary.

4.15 Where required under health and safety legislation, the reporting of injuries, diseases and dangerous occurrences regulations (RIDDOR) will be handled by the Clinical Governance and Risk department (CGARD). They will also handle reports to the Health & Safety Executive (HSE) where death, major injury or injuries for more than seven days absence result, and for notifiable diseases.

IVF treatment

4.16 If staff are having a procedure under sedation, leave will be regarded as authorized absence. Where staff are absent following such treatment (i.e. the following day due to feeling unwell) absence will be regarded as sickness. All other IVF appointments, such as routine check-ups without sedation will be regarded as hospital appointments under the special leave policy – this applies to all parties where they are required to attend the meeting themselves and not solely to accompany a partner. Following implantation, staff will be regarded as being pregnant. A pregnancy test is taken two weeks after implantation. If the test is negative staff will be protected as being pregnant for a further two weeks. If the pregnancy is not successful protection will end two weeks after the end of the pregnancy.

Absence related to being a living donor

4.17 The Trust will support staff who chose to be living donors and will discount sickness absence related to this for the purposes of managing their attendance under this attendance management procedure. (Further guidance

can be found in the NHS England Commissioning Policy: Reimbursement of Expenses for Living Donors).

Absence to receive cosmetic treatment

4.18 Absence from work for cosmetic treatment purposes will not be regarded as sickness absence and staff will need to arrange annual leave and/or unpaid authorised absence unless they provide certified evidence from a medical practitioner that the procedure is for medical reasons.

Terminal illness

4.19 Managers recognise that terminal illness requires compassion, kindness, understanding and support. We are committed to supporting staff following their diagnosis and liaising with them regarding their right to choose the best course of action for them and, if appropriate, providing safe and reasonable work to help support their choice. Managers and staff can seek further support and guidance from occupational health and the HR team. In addition, staff may wish to contact their trade union representative if they are a member.

Confidentiality

4.20 Information shared during the process for managing sickness absence will be treated in strict confidence and will be protected in line with relevant legislation.

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Equality Analysis Form A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

PART 1

1. **Assessment Date:** **24/05/2022**

2. **Name of policy / strategy / service**:
Employee Wellbeing

3. **Name and designation of Author:**
Ms Karen Pearce, Senior HR Manager (Projects)

4. **Names & designations of those involved in the impact analysis screening process:**
Tor Metcalfe- Megginson, EDI Manager HR (Projects), HR Heads, EPPCG, Workforce Planning

5. **Is this a:** Policy [X] Strategy [ ] Service [ ]
Is this: New [ ] Revised [x]
Who is affected Employees [X] Service Users [ ] Wider Community [ ]

6. **What are the main aims, objectives of the policy, strategy, or service and the intended outcomes?** *(These can be cut and pasted from your policy)*
This policy has been developed to enable the Trust to manage its obligations in assisting its employees to maintain their attendance at work.

The Trust is committed to providing a working environment where employees are fully motivated to contribute to the delivery of the highest quality healthcare and achieve job satisfaction.

7. **Does this policy, strategy, or service have any equality implications?** **Yes** [ ] **No** [X]

If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:

8. Summary of evidence related to protected characteristics

Protected Characteristic	Evidence, i.e. What evidence do you have that the Trust is meeting the needs of people in various protected Groups	Does evidence/engagement highlight areas of direct or indirect discrimination? If yes describe steps to be taken to address *(by whom, completion date and review date)*	Does the evidence highlight any areas to advance opportunities or foster good relations. If yes what steps will be taken? *(by whom, completion date and review date)*
Race / Ethnic origin (including gypsies and travellers)	The policy is clear that it does not discriminate on the grounds of race/ethnic origin, sex, religion and belief, sexual orientation, age, disability, gender reassignment, marriage and civil partnership and maternity and pregnancy.	Local data demonstrates that White staff are more likely (by 20%) to be absent due to sickness than BAME staff and more likely (50%) to be managed formally for their absence. This data highlights differences in absence rates rather than how the procedure is applied, however this will be monitored if figures increase to give cause for concern.	
Sex (male/ female)	As above	National data shows that women appear to have a higher risk than men of experiencing work related stress, depression or anxiety. Local workforce data suggests the relative likelihood of females being of sick with Anxiety/stress/depression/other psychiatric illnesses is 1.53 times greater than males. The Trust has a Management of Stress policy which is maintained by a dedicated Stress at Work group; this ensures that stress is appropriately managed for all employees, regardless of race/ethnic origin, sex, religion and belief, sexual orientation, age, disability, gender reassignment, marriage and civil partnership and maternity and pregnancy.	
Religion and Belief	As above	Local data demonstrates that those of Muslim faith are half as likely to be absent due to sickness than those of other faiths. There is no significant difference between faiths for those who are formally managed.	
Sexual orientation including lesbian, gay and bisexual people	As above	Local data demonstrates no significant difference between heterosexual staff or LGB staff for the level of sickness absence for formal management	
Age	As above The Trust has provision for early ill health retirement and flexible retirement to support employees who may need to revise their working arrangements.	Local data shows the only age group which differs for levels of sickness absence is the 61-75 age bracket, where this group is 20-30% less likely to be absent than other age groups. There are no significant differences between staff groups for formal management, other than between the 16-30 and 61-75 age bracket, where 16.30s are 20% more likely to be managed formally. This will be monitored.	
Disability – learning difficulties, physical	The policy is clear that it does not discriminate on the grounds of disability.	Analysis of levels of sickness absence or formal action taken under the employee wellbeing policy does not show any	

disability, sensory impairment and mental health. Consider the needs of carers in this section	Where it is considered that a doctor/hospital appointment is related to a condition which may be considered a disability, as defined by the Equality Act 2010, managers should consider any reasonable adjustment in accordance with the Special leave policy An employee who wishes to take annual leave in relation to absence attributable to pre-planned surgery, may be allowed to do so provided the leave is approved in accordance with normal procedure. The Trust has provision for early ill health retirement to support employees who are permanently incapable of performing their current role, or regular employment. The policy is clear that consideration will always be made to explore reasonable adjustments to support an employee who has a disability. The Redeployment policy is clear that if redeployment is being considered and an employee is disabled, they will be given prior consideration.	significant difference between staff who have declared they have a disability or do not have a disability.	
Gender Re-assignment	The policy is clear that it does not discriminate on the grounds of gender re-assignment. Where it is considered that a doctor/hospital appointment is related to gender re-assignment, managers should consider any reasonable adjustment in accordance with the Special leave policy An employee who wishes to take annual leave in relation to absence attributable to pre-planned surgery, may be allowed to do so provided the leave is approved in accordance with normal procedure.	No	
Marriage and Civil Partnership	The policy is clear that it does not discriminate on the grounds of marriage and civil partnership.	No	
Maternity / Pregnancy	The policy is clear that it does not discriminate on the grounds of maternity/pregnancy.	Analysis of formal action taken under the employee wellbeing policy does not show any formal action because of	

	The Trust has a number of policies to support pregnant employees and employees, employees on maternity leave and breastfeeding employees. These policies ensure that risk assessments are undertaken to ensure the safety of the employee and these will be reviewed, should the employee have pregnancy related absences.	absence related to pregnancy.	

9. Are there any gaps in the evidence outlined above? If 'yes' how will these be rectified?

No

10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.

Do you require further engagement? Yes [ ] No [X]

11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?

No

PART 2

Name:

Tor Metcalfe-Megginson

Date of completion:

24/05/2022

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)

The Newcastle Upon Tyne Hospitals NHS Foundation Trust

Induction Policy

Version No.:	8.0
Effective From:	7 August 2020
Expiry Date:	7 August 2023
Date Ratified:	17 July 2020
Ratified By:	Heads of HR

1 General Statement

An effective induction process is essential in terms of welcoming staff to the trust and ensuring the safety of both staff and patients. A comprehensive induction programme is important as we look to build positive relationships with staff newly appointed and those new to a role. It helps them to understand the values and culture of the organisation. It is an opportunity to demonstrate how we put patients at the heart of all we do, It sets out the expectations for the early days of employment as well as longer term expectations for all employees of the Trust.

This policy outlines the key content and processes for induction within the Trust as all staff are required to be inducted and this policy is aimed at supporting the Trust's expectations.

2 Scope

This policy applies to all staff, including permanent, bank workers, temporary and agency staff (those that will work with the Trust for three months or more), students/trainees and volunteers. The completion of corporate induction is mandatory for all staff newly appointed, managers may wish to consider corporate induction for those who have had a significant break from working in the Trust (see 2.1). A local/departmental induction is mandatory for all staff newly appointed, staff new to role or those staff who move to a different department/location

2.1 Staff

All newly appointed staff regardless of grade or profession must attend the corporate induction and complete local/departmental induction (see section 3.6) excluding staff on a temporary contract with a duration less than 3 months.

Staff who move to a different department and/or job within the Trust (including secondments) must undertake a local/departmental induction in their new post. This must be completed in full within four weeks of commencement.

All staff who have been absent from work for 12 months or more should have appropriate 'return' to work' arrangements in place before they return. This is to facilitate effective orientation to the workplace/Trust and their role. Managers may wish to consider placing the employee on Corporate Induction and/or carrying out a local/departmental induction – the return to work action plan' may also be a useful tool to record the arrangements for return which

have been agreed with the employee, such as shift pattern and completion of statutory and mandatory training. Where it is determined the returning member of staff should attend Corporate Induction the manager should email Training.Administration@nuth.nhs.uk advising them of the return date, whether the employee is in a clinical or non-clinical role and request a place on Trust Induction to be booked.

2.2 Staff Bank Workers

Staff Bank workers attend the Corporate Induction programme. However additional requirements and considerations include:

The Trust Wide Corporate Induction Programme provides mandatory training as appropriate to role and must be undertaken prior to working in the Trust Those staff bank workers who do not attend and complete the Corporate Induction programme should have the offer of Bank work withdrawn until attendance has been completed.2.3 Agency Workers

If, at the point of engagement with the Trust, the agency worker is "contracted" to work for 3 months or more they must attend the Corporate Induction Programme. They should attend all of the delivered sessions on Day 1 as well as any other face to face training (role specific) and then sign up to eLearning for Health for any other learning requirements.

If the original contractual agreement was for less than three months, and subsequently the agency worker is engaged for three months or longer, then, with the exception of agency nurses, they must attend Corporate Induction retrospectively, at that point. .

3 Role and Responsibilities

3.1 Director of Human Resources:

Ensure that the provision of corporate and departmental induction is accessible and provides staff with current and reliable information to meet internal and external standards for all new starters and/or movers.

3.2 Associate Director, Education and Workforce Development (E&WD):

Ensure that appropriate Corporate Induction programmes are in place, which meet local and national standards and provide a high quality education and development experience for the inductee.

Ensure a framework for Local/Departmental Induction in both the Acute and 'out of hospital settings'

Ensure a robust mechanism for recording staff attendance and non-attendance at Induction and produce regular reports to the Trust Education Group (TEG) in order to monitor compliance and agree actions where compliance is unsatisfactory.

Ensure provision of appropriate and up to date corporate induction programmes, providing sufficient capacity to avoid delays in appointment.

Ensure work with key presenters and trainers is undertaken throughout the year and ensure information is delivered in an effective way and covers current key messages required by the Trust.

Ensure the programme is reviewed and evaluated on an ongoing basis ensuring a quality provision and that staff receive current information and skills to enable them to practice safely and effectively.

Ensure an accurate and timely course administration service, recording and reporting attendance and non-attendance, including notification to Human Resources for non-attendance at corporate induction.

Ensure monitoring and reporting on compliance with Corporate and local/departmental induction.

Ensure work with wider HR colleagues is undertaken ensuring a seamless induction process for all new starters.

3.3 Learning & Education Group: (LEG)

This is a delegated subcommittee of the Board. The group is responsible for overseeing all aspects of mandatory training including induction and ensuring action is in place for the Trust to be compliant. LEG is required to assure the Board that staff are inducted and have the means by which to practice safely and effectively whilst employed by the Trust.

3.4 Human Resources Recruitment & Medical HR , Staff Bank Administration, Volunteer Coordinator, Practice Placement Facilitators/Professional Education Leads & the Medical Education Team

Medical HR:

Ensure induction arrangements relating to the senior medical workforce including Trust Employed Doctors is communicated and this includes details of e-induction. Ensure the information required to support an effective induction is provided to all relevant parties in line with current recruitment processes in relation to ESR requirements.

Medical Education:

Ensure that the induction for Junior Doctors is aligned to the Corporate Induction programme requirements.

Ensure the monitoring of attendance and completion at the Corporate Induction and Lead Employer Trust (LET) as appropriate.

Ensure induction arrangements are in place for all medical students on placement within the Trust.

Ensure monitoring of compliance for Junior Doctors, reporting to relevant authorities i.e. (LET) and LEG.

Staff Bank Administration:

Ensure induction arrangements are in place for all staff employed as Bank workers and that training requirements are aligned to the post appointed to.

Volunteer Co-ordinator:

Ensure that all volunteers attend a Corporate Induction programme and are booked to attend in line with current Recruitment/Workforce Development processes.

Ensure induction arrangements are monitored for all volunteers, ensuring that the training requirements are suitable for the post appointed too.

Practice Placement Facilitators:

Ensure induction of student nurses and midwives is in line with policy.

Professional Educational Leads:

Ensure induction of trainees (students), including Allied Health Professionals and Healthcare Scientists.

General Recruitment:

Ensure induction arrangements are in place for all other newly appointed staff and that information relating to these staff is accurate

3.4.1 In all cases colleagues listed in 3.4 should:

Ensure that staff are allocated a place and provided with information on their corporate and local/departmental induction process prior to commencing work.

Work with Workforce Development:

Ensure that all individuals as contained within the scope of this policy attend induction on Day 1 of employment. Should this not be the case then staff who have commenced ahead of Induction have commenced based on an assessment of risk to the individual and/or the patient/service/Trust.

Ensure that non-attendance is followed up until induction is completed.

Ensure the Workforce Development administration service have accurate information relating to new starters on a weekly basis, with Supervisor/Line Manager and Directorate Manager information. Ensure that local records are maintained where new starters are not employed by the Trust.

3.5 Directorate/Departmental Manager/Clinical Director/Heads of Department and Educational Leads

Ensure monitoring of overall attendance/non-attendance of their staff and ensure action is taken to ensure all staff within their service comply with this policy.

Ensure the attendance of staff on the Corporate Induction programme on Day 1 of employment.

Ensure a local induction checklist is completed for on the portal here to ensure accurate recording and monitoring of compliance.

3.6 Line Manager/Educational Supervisor

Ensure new staff attend Corporate Induction ahead of them commencing work in their area (day 1 of employment) however where this is not possible (patient care priorities) the decision to start them ahead of attendance at Corporate Induction should be based on a risk assessment.

Ensure all new staff complete both corporate induction and local/departmental induction within 4 weeks of appointment to the Trust.

Ensure that non-attendance is followed up until induction is completed.

3.7 New to the Trust/Post or Role or returning to work after a break of 12 months or more.

All staff who are new to the Trust/post or role have a responsibility to ensure they are inducted in line with this policy. They should raise concerns with their manager should this not happen. Staff who are returning after a break of 12 months or more should refer to the requirements in 2.1 above.

Staff who commence employment with the Trust and do not attend an induction should be recorded as Did Not Attend (DNA). Where staff do not attend, this should be escalated to the line manager for follow up by Human Resources.

4 Corporate Induction Programme Content

The Corporate Induction programme covers essential information to meet national and local standards (Appendix 1). It is a requirement for all new starters to attend.

Please note: The content is reviewed annually

5 Local/Departmental Induction

This section describes the generic local induction arrangements for all new permanent staff, staff on secondment, Junior Doctors, long term locums and agency staff within 4 weeks. Bank workers are also required to complete induction as well as a local/departmental induction.

5.1 It is essential that all staff complete a local/departmental induction. Appendix 2 outlines the local checklist arrangements and timescales.

5.2 A Local Induction Checklist is provided. The form to be completed will differ depending on the staff group:

Appendix 3 – Permanent Staff

Appendix 4 – Locum & Agency Staff

Appendix 5 – Non-Clinical Temporary Staff

5.3 Notification of all successful local/departmental induction completions shall be undertaken by the line managers/booking manager and should to be recorded on the online portal; https://hrportal.app3/Home/Index.

5.4 Notification of all successful local/departmental induction completions undertaken for agency staff should be recorded locally.This information is held as evidence that local/departmental induction has been completed for this group of workers. 5.5 Completion of the induction process is a requirement of the probationary period for all new staff and staff new to role.

6 Did Not Attend (DNA's)

Definition – this refers to any member of staff booked onto any element of the Corporate Induction programme who does not attend on the day and has not given 24 hours' notice of their intention to withdraw from the programme

6.1 DNA's will be monitored by the Workforce Development team and information passed to LEG as appropriate. DNA's will be reported back to those responsible for bookings; Human Resources, Medical Staffing, Volunteer service or Staff Bank dependant on which area completed the member of staffs recruitment.

7 Recording & Reporting of Corporate & Local Induction Activity

7.1 Workforce Information should ensure reporting via Business Intelligence (BI) to Workforce Development in order to furnish LEG with current compliance

7.2 The BI data should be used by Directorate/Department managers to monitor compliance and to follow up those members of staff who have not completed induction training.

7.3 The Performance Review process should be used to monitor compliance and actions taken at an individual service level.

8 Monitoring Compliance

Standard / Process / Issue	Monitoring and Audit			
	Method	**By**	**Committee**	**Frequency**
Course completion of Corporate Induction in OLM:				
a) Line Managers informed of non attendance	Contact via email	Human Resources	Learning & Education Group	LEG: Bi-monthly Training reports: Monthly
b) Completion of Corporate & Local/departmental induction checklists	Monitoring reports from BI	Line Manager	LEG	As Above

Reporting on compliance should be reported through LEG.

9 Training

Training as appropriate should be provided by the Human Resources Department to managers following implementation of the procedure.

10 Equality and Diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way services are provided and the way staff are treated reflects their individual needs and does not unlawfully discriminate against individuals or groups. This policy has been properly assessed.

11 Consultation and Review of this Policy

This policy has been reviewed in consultation with the Employment Policies and Procedures Consultative Group

12 Implementation of the Policy (including raising awareness)

A summary of the key changes should be notified to managers following implementation. Further advice and guidance should be available from the Human Resources Department.**13 Links to other policies**

Please consider this policy is to be read in conjunction with:

- Mandatory Training Policy
- Appraisal Policy
- Study Leave Policy

Author: Employment Policies and Procedures Group

Appendix 1

Course Content (Day One) Please note that this content will be reviewed annually

08:00 – 08:20	**Registration – Please ensure you sign the register**	
Delivered sessions will take place in Function Rooms 137 & 138, Level 1, Freeman Education Centre		
08:20 – 10:10	**Welcome to the Trust** – Customer Care & Enhancing the Patient Experience, will include the following competencies: - Investigation of Incidents & Complaints - Equality, Diversity and Human Rights - Bullying & Harassment Includes a welcome message from a member of the Trust Board	Applicable to all staff
10:10 – 10:25	**Break – courtesy of UNISON**	All Staff
10:25 – 10:45	**Chaplaincy**	
10:45 – 11:15	**Dementia**	
11:15 – 11:45	**Fire**	
11:45 – 11:55	**Allocate**	Excludes Medical Staff
11:55 – 12:45	**Lunch**	All Staff
12:45 – 13:00	**The Market Place Event**	
13:00 – 13:45	**Health, Safety & Welfare** – including CGuard information	Applicable to all staff unless they have a current competency
13:45 – 14:30	**Information Governance** – Data Security Awareness	
Day 1 - Continued		

IT Room 3	Any additional staff will be taken to the Library	IT Room 4
Non-clinical Staff	All of this learning can be completed via e-learning and by completing the e-Assessment only. If you fail the e-assessment 3 times then you will be required to complete the learning prior to attempting the e-Assessment again	**Clinical Staff**
14:45 – 17:00		**14:45 – 17:00**
Resuscitation – Level 1		Resuscitation - Level 2
Infection Prevention & Control		Infection Prevention & Control
Anti-Bribery & Corruption		Anti-Bribery & Corruption
Prevent		Prevent
CRT		CRT
Safeguarding Adults – Level 1 Safeguarding Children – Level 1		Safeguarding Adults – Level 1 Safeguarding Children – Level 1
Moving & Handling - Level 1		VTE
Case Note Tracking – (if required)		Consent for Examination
		Patient Falls
The above timings will include at least a 15 minute comfort break and staff will be encouraged to stretch their legs and take a break from the screen.		
Day 2		
8:30 – 12:00 **(as necessary)**		**8:30 – 16:00** **(as necessary)**
Timings will depend upon how much e-learning is left to be completed.	**Lecture Theatre 2**	**End of Life Care** – 08:30 – 09:30
	Classroom 1	**Moving & Handling** – 09:30 – 12:30 or 13:00 – 16:00
	Classroom 2 – Practical IT Room 4 – e-learning	**Resuscitation** – Practical – 09:30 – 10:30 or 13:30 – 14:30. Staff requiring Paediatric resuscitation will be required to stay approx. 1 hour more.

	Any time between sessions should be used to complete all of your remaining e-learning.

Day 3 **08:30 – 12:00**
E-record 420 Inpatient Clinical (if required – nurses working in inpatient areas, doctors and midwives). Theatre nurses will only require this training if they are working in recovery.
Additional Information Corporate Induction Day 1 - Welcome will include training that will be delivered both face to face and via E-learning. All training should be completed prior to the end of the Corporate Induction programme depending upon your role and a local induction checklist should be completed online with your manager or nominated person no later than 4 weeks following commencement of employment. Staff will be allocated training based on their position number and whether or not they have current competencies that are aligned to the Core Skills Training Framework. Following the face to face delivered sessions on day 1 you will be taken to an IT Room where you will be supported to log into ESR where you will access your e-learning modules. Safeguarding Children & Adults Level 1 will not be required for clinical staff if they are required to complete a higher level for their roles. Your e-learning has been listed in a specific order and it is important that you follow this order. This will ensure that you are able to complete practical elements as part of day 2 where applicable. During the lunch break we will have a Market Stall type event running in and around the main induction rooms which will give you the opportunity to gather other information which we hope will give a little more insight into what we have available for staff here at NuTH. We appreciate your feedback so please take a couple of minutes to complete the evaluation form which you will receive at induction, this information helps us to continuously improve upon the delivery of the corporate induction programme.

Appendix 2

Local Induction

Local Induction Checklist Arrangements and Timescales

Staff Group	Checklist	Timeframe
Permanent staff/staff with contracts over 3 months duration	Local Induction checklist	One month of start date
Temporary Staff contracts (2 weeks – 3 months contract duration)	Local induction checklist (not required to do Trust induction)	2 weeks of start date
Temporary staff not Bank Workers	Agency staff checklist	First shift
Junior Doctors	Doctors Departmental induction. All new, existing and returning Junior Doctors require a local/departmental induction on rotation to a new department.	One month of start date
Non-medical students/trainees	Student induction programme (provided by local training lead/placement facilitator)	Start of first placement with Trust
Bank workers	All new starters require Corporate and Local Induction	Corporate: subject to staff availability but before picking up any work Local: Local orientation and introduction to department, this does not need to be recorded in ESR.

Appendix 3

Local Induction Checklist

Name ………………………………………………………………………………………..

Post Title ……………………………………………………………………………………….

Assignment Number ……………………………………………………………………………………

Department ………………………………………………………………………………………..

Directorate ………………………………………………………………………………………..

Start Date………………………………………………………………………………

Name of Line Manager ………………………………………………………………………………………

- Completion of Local Induction is a Mandatory requirement for all permanent staff
- ALL items discussed must be signed or marked N/A
- Once completed, keep copy for self, copy by manager (local file)
- Manager to record electronically via the online portal; https://hrportal.app3/Home/Index

All the following forms must be completed and signed off by the line manager or nominated deputy

:MPLOYMENT)OCUMENTATION :HECKS	Line Manager Sign and Print Name	Date	Comments

THE WARD/DEPARTMENT	N/A	Line Manager Sign and Print Name	Date	Employee Sign and Print name	Date
Orientation to the ward/department and any other areas within the organisation relevant to post					
Induction partner/mentor identified/introduced					
Local access/security arrangements					
Catering and washroom facilities					
Explain the function and structure of the ward/department, location of notice boards					
Introduction to key individuals within the ward/department					
Confirm hours of work and shift patterns where applicable					
On Call and bleep arrangements/use of telephone system					
• Resuscitation procedures: • equipment • procedures • crash trolley location • emergency telephone numbers					
• Fire safety procedures and assembly points: • fire exits • equipment • alarms • emergency telephone numbers • evacuation procedures • other emergencies including bomb alert					
• Moving & handling procedures: • equipment • procedures • moving and handling regulations/policy					
• Medicine safety procedures: • pharmacy and local protocols • E Record • prescriptions • administration • standard operating procedures • medications common to area					
• Incident reporting procedures/DATIX • DATIX submissions • completing the forms • reporting arrangements					

THE WARD/DEPARTMENT	N/A	Line Manager Sign and print	Date	Employee sign and print	Date
• Any additional Infection control procedures pertaining to the unit out with the Mandatory training					
Health and safety procedures: • Security • Waste disposal • VDU regulations and complete DSE assessment form if required (submit to Departmental DSE assessor for sign					
INFORMATION GOVERNANCE					
•					
•					
• Explanation of the key documents used within the ward/department					
Explanation of the key equipment/medical devices used within the ward/department and training requirements – please refer to individual policy: •					
ROLES & RESPONSIBILITIES/CONDUCT The list below represents examples of topics to be covered in this section.					
The specific duties and responsibilities of the post: • Probation period requirements • Job description • Behaviour & dress appearance • Personal hygiene					
Expectations and limitations of the post					

KEY POLICIES AND PROCEDURES ***The list below represents examples of topics to be covered In this section.***	**N/A**	**Line Manager sign and print**	**Date**	**Employee sign and print**	**Date**
Resuscitation					
Fire safety					
Moving and handling					
Medicines management					
Incident reporting					
Infection control					
Health and safety					
Duty of Candour					
NHS Constitution					
Benefits everyone, added value for the people we value.					
Dignity & Respect at work					
Equality, Diversity & Inclusion					
Dress, Appearance and Uniform					
Employee Wellbeing					
Whistleblowing					
Policies relevant to department: (please state below)					
Clinical Records Management					
LEAVE & ABSENCE ARRANGMENTS ***The list below represents examples of topics to be covered In this section.***					
• Explanation of the policy and procedures regarding sickness and absence: • reporting • return to work procedures • reporting to occupational health					
• Annual leave entitlement • Process for booking • entitlement					
• Study leave policy /application process • Expenses • Extra duty claims/rotas/timesheet • Hours of work, breaks, lateness • Off duty requests • Official duty/special leave					

COMMUNICATION	N/A	Line Manager sign and print	Date	Employee sign and print	Date
Use of the organisation's intranet/email system & standards of behaviour					
Location and use of general organisational policies • Use of telephone/mobile telephone and personal computing devices within Trust premises. • Department Communication arrangements					
SUPERVISION ***The list below represents examples of topics to be covered In this section.***					
Explanation of the organisation's appraisal and review system					
Planned date of appraisal					
Check Corporate Induction has been completed					
Review learning from Corporate/local Induction; http://intranet/trust_intranet/staffdevelopment/mandtrain.html					
Agree Personal Development Plan (PDP)					
MANDATORY TRAINING It is the responsibility of the line manager to ensure all Mandatory Training requirements are undertaken within the first 4 weeks of employment					
•					

•					

Additional Information for Nursing & Midwifery

- Access to clinical skills
- Acting up rota
- Duty Rota
- Handover day/night shift
- On Call Rules
- Patient Equipment
- Report Writing
- Medical Equipment Loan Library
- Saving Lives Practice Improvements
- Special Equipment for Relief of Pressure
- Treatment Room/Dressing Room/5 Moments of Care
- Types of Bed Issue
- Use of Bed Pan
- Use of Pneumatic Tube Transport System

Appendix 4

Newcastle Upon Tyne Hospitals NHS Foundation Trust
Induction Checklist for Locum and Agency Clinical Staff

This checklist must be completed by **ALL** locum/agency clinical staff at the commencement of their shift. The form should be held by the booking manager/department.

Line/Manager/Booking managers are responsible for updating the online portal https://hrportal.app3/Home/Index, as a competence for the Local/Departmental Induction.

Name of Employee:	Agency:
Job Title:	Ward/Department:
Date of Commencement:	Name of Manager/Supervisor:

Please tick or mark
Not Applicable (N/A)

General	**Tick or mark N/A**
Description of Main Duties	
Ward/Department Layout (Including Changing Facilities/WCs)	
Code of Conduct	
Being Open Policy	
Bleep Arrangements	
Departmental Information (if available)	
Health and Safety/Clinical	
Fire Precautions/ What to do in the event of fire	
Reporting of Accidents and Incidents (Datix)	
Infection Control policy/procedures including waste management	
Protective Clothing*	
Security and Personal Safety	
Cardiac Arrest Process/Do not resuscitate policy/Crash Trolley	
Drug Administration/Prescribing record	

Equipment Familiarisation (e.g. hoists, medical devices)*	
Intranet/policy locations/Documentation /E-record/lab requests*	
Inoculation incidents management (needle stick/sharps)	
Positive Patient Identification Process	
Death certification/coroner notification*	
Transfer of patients policy*	
Social and Welfare	
No Smoking Policy	
Dealing with Complaints at Local Level	
Information Governance - Confidentiality and data protection	
Important Telephone Number Folder/List	
Use and Misuse of Telephones	
Use and Misuse of Computer /IT security	
Meal/Break arrangements	

Employee: Name (Print)...Signed: .... Date:

Manager: Name (Print) ....Signed: .... Date:

Appendix 5

Newcastle upon Tyne Hospitals NHS Foundation Trust

Non-Clinical Temporary Staff Induction checklist

This checklist must be completed by **ALL** non-clinical temporary staff, including agency staff, at the commencement of their shift. The form should be held by the booking manager/department.

- Booking managers are responsible for completion of the electronic notification that induction has been undertaken - see Trust Induction policy for full details

Name of Employee:	Agency:
Job Title:	Ward/Department:
Date of Commencement:	Name of Manager/Supervisor:

Activity	Key Points	Completed
Health & safety	Outline key H&S issues relevant to role including manual handling/ VDU checks, prevention of slips, trips and falls, reporting of incidents/accidents	
Information Governance	Outline data protection/confidentiality requirements including safe use of materials/data sticks and transportation of information. Trust information systems (relevant to role)	
Infection Control	Outline importance of hand washing and prevention of infection/ promoting cleanliness	
Fire	Provide instruction on action in the event of fire alarm and fire e.g. location of fire-fighting equipment, fire exits, telephone number, muster points	
Violence/Aggression/ Security	Discuss basic safe practice on dealing with situations that may arise. Provide security response telephone number	
General	Ensure worker is aware of: • Duties/responsibilities and reporting arrangements • Location of toilets, changing and washing facilities, rest room, dining areas • Telephone/email information and standards of conduct in use • Dress code • No smoking policy • Car parking	

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Equality Analysis Form A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

PART 1

1. **Assessment Date:** **07/08/2020**

2. **Name of policy / strategy / service**:
Induction Policy

3. **Name and designation of Author:**
Gill Long, Associate Director of Education, Training and Workforce Development

4. **Names & designations of those involved in the impact analysis screening process:**
Natalie Cowan, HR Manager (Projects), HR Heads, EPPCG

5.

Is this a:	Policy	X	Strategy		Service	
Is this:	New		Revised	x		
Who is affected	Employees	X	Service Users		Wider Community	

6. **What are the main aims, objectives of the policy, strategy, or service and the intended outcomes?** (*These can be cut and pasted from your policy*)
An effective induction process is essential to an organisation in terms of ensuring staff and patient safety, and introducing staff to the business. Completion of corporate and departmental induction processes is mandatory for all new employees. A comprehensive induction programme is therefore of fundamental importance to building positive relationships with new staff when they are appointed. It welcomes people, helps them to settle in and to understand the culture and values of the organisation. It is also an opportunity to clearly state expectations for both the early days of employment and longer term expectations of the individual as an employee of the Trust

7. **Does this policy, strategy, or service have any equality implications?** **Yes** ☐ **No** X

If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:
See below

8. Summary of evidence related to protected characteristics

Protected Characteristic	Evidence, i.e. What evidence do you have that the Trust is meeting the needs of people in various protected Groups	Does evidence/engagement highlight areas of direct or indirect discrimination? If yes describe steps to be taken to address *(by whom, completion date and review date)*	Does the evidence highlight any areas to advance opportunities or foster good relations. If yes what steps will be taken? *(by whom, completion date and review date)*
Race / Ethnic origin (including gypsies and travellers)	The policy is clear that it does not discriminate on the grounds of race/ethnic origin, sex, religion and belief, sexual orientation, age, disability, gender reassignment, marriage and civil partnership and maternity and pregnancy. An induction programme welcomes people, helps them to settle in and to understand the culture and values of the organisation.	No	
Sex (male/ female)	As above	No	
Religion and Belief	As above	No	
Sexual orientation including lesbian, gay and bisexual people	As above	No	
Age	As above	No	
Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section	As above The policy is clear that where redeployment has occurred, the new line manager must ensure the individual receives a local induction for their new area of work.	No	
Gender Re-assignment	The policy is clear that it does not discriminate on the grounds of gender reassignment. An induction programme welcomes people, helps them to settle in and to understand the culture and values of the organisation.	No	
Marriage and Civil Partnership	The policy is clear that it does not discriminate on the grounds marriage and civil partnership. An induction programme welcomes people, helps them to settle in and to understand the culture and values of the organisation.	No	
Maternity / Pregnancy	The policy is clear that it does not	No	

	discriminate on the grounds of maternity and pregnancy. An induction programme welcomes people, helps them to settle in and to understand the culture and values of the organisation.		

9. Are there any gaps in the evidence outlined above? If 'yes' how will these be rectified?

No

10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.

Do you require further engagement? Yes [ ] No [X]

11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?

No

PART 2

Name:

Natalie Cowan

Date of completion:

07/08/2020

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Job Planning Policy

Version No.:	1.0
Effective From:	12 July 2022
Expiry Date:	12 July 2025
Date Ratified:	13 June 2022
Ratified By:	Heads of HR

GENERAL POLICY STATEMENT

Job planning is recognised as an important means of linking best use of resources with quality outcomes for patients and as a useful element in service redesign.

By documenting professional activity in job plans, the Trust can better understand our workforce capacity and match it to patients' needs.

The key principles of job planning should characterise a collaborative approach:

- undertaken in a spirit of collaboration and cooperation
- completed in good time
- reflective of the professionalism of being a healthcare professional
- focused on measurable outcomes that benefit patients
- consistent with the objectives of the NHS, the organisation, teams and individuals
- transparent, fair and honest
- flexible and responsive to changing service needs during each job plan year
- fully agreed and not imposed
- focused on enhancing outcomes for patients whilst maintaining service efficiency

Job plans put together and agreed in line with these principles will help our healthcare professionals and managers meet the challenge of delivering high quality care within a testing financial environment during a period of significant organisational change.

1 Introduction

The purpose of job planning is to ensure enough clinical capacity to meet the expected demand on the clinical service, seven days a week, 52 weeks per year, while balancing the development needs of people and organisations.

Job planning enables the effective and efficient use of resources in a way that brings mutual benefits to organisations, patients and clinical staff in planning and delivering high quality care. At its heart is a drive to provide patient-centred care that meets our local population's needs and improves outcomes.

2 Scope

This policy applies to all clinical staff who are expected to have a job plan.

3 Aims

This policy covers the principles for the annual job planning process to ensure that prospective job plans fit into the overall strategic service delivery and meet Trust objectives.

4 Duties (Roles and responsibilities)

4.1 **The Executive Team** is accountable to the Trust Board for ensuring Trust wide compliance for the procedure.

4.2 **The Medical Director, designated Associate Medical Director, Chief Nurse and Clinical Service Leads** are responsible for ensuring implementation of the procedure for their respective staff groups.

4.3 **Line managers of all clinical staff requiring a job plan** are responsible to the Medical Director and Chief Nurse for implementation of the procedure and compliance within their areas of responsibility.

4.4 **Employees** who are expected to have a job plan are responsible for complying with the procedure.

5 Definitions

PA	Programmed Activity
APA	Additional Programmed Activity
DCC	Direct Clinical Care
SPA	Supporting Professional Activities
ANR	Additional NHS Responsibilities
ED	External duties
CPD	Continuing Professional Development
SMART	Specific, Measurable, Achievable, Realistic and Time Based
AHP	Allied Health Professional
CD	Clinical Director
SAS	Specialty and Associate Specialist Doctors
ESR	Electronic Staff Record

6 The Job Plan

6.1 Defining a job plan

A job plan is an annual, prospective, professional agreement between employees and the Trust describing:

- the work the employee does for the Trust (and in the case of clinical academics, the work they do for the University)
- the objectives to be achieved by the employee and supported by the Trust
- when that work is done
- where it is done
- how much time the employee is expected to be available for work
- what this work (quantified where possible) will deliver the for the Trust, employee and patients
- resources required for the work to be achieved

6.2 Key elements of a job plan

- clearly identified objectives
- DCC
- SPA
- ANR
- ED
- analysis of expected clinical and non-clinical activity
- location of planned activity
- speciality/service line of planned activity
- outcomes that the job plan is expected to deliver

Depending on the staff group, the job plan may also include:

- on-call and emergency work
- private professional services
- fee-paying services
- travel time
- annual leave and study leave

6.2.1 Objectives

The job plan should reflect the Service objectives identified by the line manager and record agreed personal SMART objectives. These

should be explicitly aligned to Directorate and Trust strategic objectives and performance.

Personal objectives should be agreed, representing a reasonable expectation of successful professional practice, and may refer to protocols, policies, procedures and work patterns. Where objectives are set in terms of output and outcome measures, these must be reasonable and agreement should be reached.

6.2.2 DCC

Direct clinical care is work directly relating to the prevention, diagnosis or treatment of illness, ie clinical and clinically related activity. This will include associated work such as clinical administration.

6.2.3 SPA

This includes but is not limited to:

- CPD
- Audit
- Appraisal
- Revalidation (if applicable)
- Job Planning
- Mandatory training
- Research
- Clinical management
- Service development
- Teaching and training
- Educational Supervision of 2 trainees (consultants)

6.2.4 Split between DCC and SPA

6.2.4.1 Consultant and SAS

A full time job plan consists of 10 PAs. A standard full time job plan for a consultant will comprise 8.5 DCC and 1.5 SPA, and for SAS, 9 DCC and 1 SPA.

6.2.4.2 Other Clinical staff

NHSI have not recommended a set percentage for DCC and SPA and it is likely that the percentages may vary

between staff on different bands. The Trust will determine its approach when job planning is rolled out for this group of staff.

6.2.5 APAs

The Trust may request medical staff to work more than 10 PAs a week (APAs). These are temporary, non-contractual, and can be ended via three months' notice on either side.

6.2.6 ANR

These are special responsibilities within the NHS but not necessarily within the Trust which are agreed between the employee and line manager and which cannot be absorbed within the time that would normally be set aside for SPA.

6.2.7 ED

These include roles undertaken by employees that are external to the Trust and externally funded. They should be discussed and agreed in advance with the line manager, including the time allocation.

6.2.8 On-call and emergency work

On call arrangements will be as outlined in the Terms and Conditions of Service relevant to the staff group in question.

6.2.9 Private professional services

Arrangements around private practice will be in line with the relevant Terms and Conditions for each staff group, and Trust policy.

6.3 The annual job planning cycle

Directorates should aim for an annual cycle of job planning that follows these six steps:

Step 1: Set the directorate's objectives, in line with the Trust's objectives.

Step 2: Undertake service-level capacity and demand analysis.

Step 3: Team job planning meetings (if required).

Step 4: Individual job planning meetings.

Step 5: Monitor delivery of team and individual plans.

Step 6: Identify and respond to changing service needs.

6.4 If a job plan is not agreed

The job planning process should operate in a spirit of collaboration and mutual respect and all employees are expected to participate.

On the rare occasions when a job plan has not been agreed because it is in dispute, every effort should be made by the two parties to reach a resolution via an informal route.

If the informal route is not successful, further escalation will be in line with the relevant Terms and Conditions for each staff group, and/or Trust policy.

7 Equality and Diversity

The Trust is committed to ensuring that the way services are provided to the public and the way staff are treated reflects individual needs and does not unlawfully discriminate against individuals or groups on any grounds. This policy has been properly assessed.

8 Monitoring Compliance with the Policy

Standard/ Process/ Issue	**Monitoring and Audit**			
	Method	**By**	**Committee**	**Frequency**
To ensure compliance with the policy job planning completion rates will be monitored.	Reporting via the e-Job Planning System.	Medical Director	Medical Director's Group	Annually

9 Consultation and review of this policy

This policy has been reviewed in consultation with the Employment Policies and Procedures Consultative Group.

10 Implementation of the policy (including raising awareness)

A summary of the key changes will be notified to Clinical Directors and Directorate Managers following implementation.

11 References and associated documents

Further guidance and information on job planning is available on the Trust Intranet.

Author: Employment Policies and Procedures Consultative Group

Annex 1: Job Planning Guidance for Senior Medical and Dental Staff

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Equality Analysis Form A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

PART 1

1. **Assessment Date:** 31 May 2022

2. **Name of policy / guidance/ strategy / service development / Investment plan/Board Paper**:

Job Planning Policy

3. **Name and designation of author:**

Karen Pearce, Head of EDI (People)

4. **Names & Designations of those involved in the impact analysis screening process:**

Tracy Mitchell, Head of Medical Staffing

5. **Is this a:** Policy X Strategy ☐ Service ☐ Board Paper ☐

Is this: New X Revised ☐

Who is affected: Employees X Service Users ☐ Wider Community ☐

6. **What are the main aims, objectives of the document you are reviewing and what are the intended outcomes?** *(These can be cut and pasted from your policy)*

This policy covers the principles for the annual job planning process to ensure that prospective job plans fit into the overall strategic service delivery and meet Trust objectives.

7. Does this policy, strategy, or service have any equality implications? Yes ☐ No X

If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:

8. Summary of evidence related to protected characteristics

Protected Characteristic	Evidence What evidence do you have that the Trust is meeting the needs of people in all protected Groups related to the document you are reviewing– please refer to the Equality Evidence within the resources section at the link below: http://nuth-vintranet1:8080/cms/SupportServices/EqualityDiversityHumanRights.aspx	Does evidence/engagement highlight areas of direct or indirect discrimination? For example differences in access or outcomes for people with protected characteristics	Are there any opportunities to advance equality of opportunity or foster good relations? If yes what steps will be taken? (by whom, completion date and review date)
Race / Ethnic origin (including gypsies and travellers)	The policy includes a statement that the Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. Data available on completed job plans has been reviewed, the generic data shows no areas of concern relating to any of the protected characteristics.		n/a
Sex (male/ female)	n/a	n/a	n/a
Religion and Belief	n/a	n/a	n/a
Sexual orientation including lesbian, gay and bisexual people	n/a	n/a	n/a

Age	n/a	n/a	n/a
Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section	n/a	n/a	n/a
Gender Identity / Expression	n/a	n/a	n/a
Marriage and Civil Partnership	n/a	n/a	n/a
Maternity / Pregnancy	n/a	n/a	n/a

9. Are there any gaps in the evidence outlined above. If 'yes' how will these be rectified ?

No

10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.

Do you require further engagement No

11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?

No

PART 2

Signature of Author

Print name

Karen Pearce

Date of completion

31 May 2022

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Employment Policies and Procedures

Loyalty Award Policy

Version No.:	4.0
Effective From:	14 October 2019
Expiry Date:	14 October 2022
Date Ratified:	23 September 2019
Ratified By:	Employment Policies and Procedures Consultative Group

GENERAL POLICY STATEMENT

The Trust wishes to recognise and reward long serving employees' loyalty and commitment to the Trust and contribution to delivering high quality healthcare to patients. This will be formally recognised in accordance with this policy.

This policy applies to all staff currently employed by the Trust on a permanent contract of employment, subject to the criteria outlined. It will not be backdated and will be applicable only to those employees who become eligible after the date of implementation.

This benefit will be awarded at the absolute discretion of the Trust.

1 Aims

To formally recognise and reward long serving employee's loyalty and commitment to the Trust and contribution to delivering high quality healthcare to patients. To clarify the eligibility required in order to receive an award.

2 Duties (Roles and responsibilities)

2.1 The Executive Team is accountable to the Trust Board for ensuring Trust-wide compliance with policy.

2.2 Directorate managers and heads of service are responsible to the Executive Team for ensuring policy implementation.

2.3 Managers are responsible for ensuring policy implementation and compliance in their area(s).

2.4 Staff are responsible for complying with policy.

2.5 HR are responsible for administering the process of identifying those eligible for the award and inviting them to an awards event.

3 Award

All awards will be in the form of 'Landmark Vouchers' which are redeemable against a wide range of retail, travel, leisure and experience choices. Subject to eligibility, awards will be presented at key intervals as follows:

Years Service	Voucher Award
25	£100
35	£200
45	£250

4 Eligibility

4.1 To be eligible for an award, the employee must:

- Have completed the required continuous years' service with the Trust (service with other NHS employers does not apply) at the applicable anniversary date;
- Be currently employed by the Trust on a permanent contract of employment;

4.2 The award will not be made in advance of the applicable anniversary date confirming eligibility.

5 Procedure

5.1 The Human Resources department will identify those employees eligible for the receipt of an award, verify the employee's continuous service record with the Trust and inform them of their entitlement to a Long Service Award.

5.2 The employee will be invited to an awards event, with members of the Executive Team, to celebrate their achievement.

5.3 The employee will be presented with their Award and will be able to select the vouchers they want and redeem them online.

6 Training

Training will be provided by the Human Resources Department to managers following implementation of the procedure.

7 Equality and diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way services are provided and the way staff are treated reflects their individual needs and does not unlawfully discriminate against individuals or groups. This policy has been properly assessed. Monitoring compliance with the policy

Standard / Process / Issue	Monitoring and Audit			
	Method	By	Committee	Frequency
Monitoring eligibility for the award via ESR	Reporting of information from ESR	Director of Human Resources	Heads of Human Resources	Annually

8 Consultation and Review of this Policy

This policy has been reviewed in consultation with the Employment Policies and Procedures Consultative Group.

9 Implementation of the Policy (including raising awareness)

A summary of the key changes will be notified to managers following implementation. Further advice and guidance will be available from the Human Resources Department.

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Equality Analysis Form A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

PART 1

1. **Assessment Date:** 19th June 2019

2. **Name of policy / guidance/ strategy / service development / Investment plan/Board Paper**:

   Loyalty Award Policy

3. **Name and designation of author:**

   Karen Pearce, Senior HR Manager – Projects

4. **Names & Designations of those involved in the impact analysis screening process:**

   EPPCG / HR Heads

5. **Is this a:** Policy X Strategy ☐ Service ☐ Board Paper ☐

   Is this: New ☐ Revised X

   Who is affected: Employees X Service Users ☐ Wider Community ☐

6. **What are the main aims, objectives of the document you are reviewing and what are the intended outcomes?** *(These can be cut and pasted from your policy)*

   To formally recognise and reward long serving employee's loyalty and commitment to the Trust and contribution to delivering high quality healthcare to patients. To clarify the eligibility required in order to receive an award

7. **Does this policy, strategy, or service have any equality implications? Yes ☐ No X**

If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:

8. Summary of evidence related to protected characteristics

Protected Characteristic	**Evidence** **What evidence do you have that the Trust is meeting the needs of people in all protected Groups related to the document you are reviewing–** please refer to the Equality Evidence within the resources section at the link below: http://nuth-vintranet1:8080/cms/SupportServices/EqualityDiversityHumanRights.aspx	**Does evidence/engagement highlight areas of direct or indirect discrimination?** For example differences in access or outcomes for people with protected characteristics	**Are there any opportunities to advance equality of opportunity or foster good relations**? If yes what steps will be taken? (by whom, completion date and review date)
Race / Ethnic origin (including gypsies and travellers)	The Trust is committed to ensuring that no employee should be treated less favourably on the grounds of their age, disability, race, nationality, ethnic origin, sex, sexual orientation, religion and belief, gender identity / expression, marriage and civil partnership or pregnancy and maternity. Trust data shows of all employees that have received a long service award within the last 96.30% identified as White, 0.62% identified as BAME and 3.09% had not disclosed their ethnicity.		WRES action plan – actively working to improve the experience of BAME employees. BAME recruitment events – encouraging applications from BAME applicants.
Sex (male/ female)	Trust data shows that 83.95% of staff who have received a long service award in the last 12 months are female and 16.05% are male.		
Religion and Belief	The Trust is committed to ensuring that no employee should be treated less favourably on the grounds of their age, disability, race, nationality, ethnic origin, sex, sexual orientation, religion and belief, gender identity / expression, marriage and civil partnership or pregnancy and maternity.		

Sexual orientation including lesbian, gay and bisexual people	Trust data shows that of all employees that have received a long service award within the last 12 months 29% identify as heterosexual and 71% have not declared their sexual orientation. Staff in post figures show that 29.63% of staff are heterosexual 0.62% are LGBT and 69.75% of staff have not disclosed their sexual orientation.		LGBT Staff Network Trust is a Stonewall Champion
Age	Trust figures show that 59.26% of staff who have received a long service award in the last 12 months are aged between 50-59, 21.60% between 60-69 and 16.05% between 40-49 and 3.09% 70+		
Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section	Trust data shows that of all employees that have received a long service award within the last 12 months 1.23% have a disability, 54.69% do not have a disability and 74.07% have not disclosed their disability status.		Disability Staff Network WDES action plan – actively working to improve the experience of disabled employees.
Gender Identity / Expression	The Trust is committed to ensuring that no employee should be treated less favourably on the grounds of their age, disability, race, nationality, ethnic origin, sex, sexual orientation, religion and belief, gender identity / expression, marriage and civil partnership or pregnancy and maternity.		
Marriage and Civil Partnership	The Trust is committed to ensuring that no employee should be treated less favourably on the grounds of their age, disability, race, nationality, ethnic origin, sex, sexual orientation, religion and belief, gender identity / expression, marriage and civil partnership or pregnancy and maternity.		
Maternity / Pregnancy	The Trust is committed to ensuring that no employee should be treated less favourably on the grounds of their age, disability, race, nationality, ethnic origin, sex, sexual orientation, religion and belief, gender identity / expression, marriage and civil partnership or pregnancy and maternity.		

9. Are there any gaps in the evidence outlined above. If 'yes' how will these be rectified ?

Unable to identify percentage of BAME staff from 25 years ago due to recording systems. Plans to promote completion of employee equality data in ESR.

10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.

Do you require further engagement Yes No X

11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?

No

PART 2

Signature of Author

K.Pearce

Print name

Karen Pearce

Date of completion

19th June 2019

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)