The Shrewsbury and Telford Hospital NHS Trust

Paper 12

Recommendation ☑ **DECISION** ☐ **NOTE**	**The Board** is asked to **ratify** the Disciplinary Policy, Employee Investigations Policy, Freedom to Speak Up Policy and Smoking Policy
Reporting to:	**Trust Board**
Date	30th August 2018
Paper Title	Policies for Ratification
Brief Description	**W7 - Disciplinary Policy** This is an update to our current Disciplinary Policy. The policy sets out arrangements to ensure a fair, consistent and effective approach in dealing with disciplinary matters. A key change has been the removal of the investigation process into a separate policy (see below). **W21 - Smoking Policy** This policy provides clear guidance on the restrictions for smoking and the use of e-cigarettes on Trust property in line with the Health Act 2006. It also outlines the assistance that will be offered to individuals who wish to stop smoking. **HR37 - Employee Investigations Policy** This is a new Trust policy which sets out arrangements to ensure a fair, consistent and effective approach in dealing with employee investigations. The process is designed to ensure a full and thorough investigation takes place to allow appropriate management decisions to be made. This can be used for a variety of employment issues including disciplinary matters, grievances and whistleblowing. **Freedom to Speak Up policy** The policy provides transparent arrangements for staff to be able to escalate concerns. This includes, but is not restricted to, disclosures which can be legally defined as 'protected disclosures'. It outlines the support available to staff who wish to raise concerns in good faith for the benefit of patients and colleagues.
Sponsoring Director	Workforce Director
Author(s)	HR Advisory Team Manager / Staff Involvement Lead
Recommended / escalated by	Workforce Committee
Previously considered by	Joint Negotiation and Consultation Committee (JNCC) Workforce Committee Policy Approval Group
Link to strategic objectives	VALUES INTO PRACTICE - Valuing our workforce and achieving cultural change by putting our values into practice; to make our organisation a great place to work with an appropriately skilled and fully staffed workforce.

Link to Board Assurance Framework	If we do not get good levels of staff engagement to get a culture of continuous improvement then staff morale & patient outcomes may not improve (RR 423)
Equality Impact Assessment	◉ **Stage 1 only (no negative impacts identified)** ○ **Stage 2 recommended (negative impacts identified)** ○ negative impacts have been mitigated ○ negative impacts balanced against overall positive impacts
Freedom of Information Act (2000) status	◉ **This document is for full publication** ○ **This document includes FOIA exempt information** ○ **This whole document is exempt under the FOIA**

Equality Impact Assessment Form

Stage 1 – Initial Assessment

Managers Name	Nick Dowd	**Division**	Workforce - Human Resources
Function, Policy, Practices, Service	W7 Disciplinary Policy	**Purpose and Outcomes – intended and differential**	Guidance for managers on arrangements to ensure a fair, consistent and effective approach in dealing with disciplinary matters.
Implementation Date		**Who does it affect?**	All staff
Consultation Process	Managers, HR, JNCC Policy Group, JNCC, PAG, Trust Board	**Communication and awareness**	Intranet, one minute brief, global email, chatterbox

For completion of the following table please see point 7 in the guidance notes.

Equality Target Group	(a) Positive Impact	(b) Negative Impact	Reason/Comment
Men	None	None	Policy applied consistently regardless of gender. To be reviewed as part of monitoring compliance in section 18 of the policy.
Women	None	None	As above.
Black/Black British	None	None	Policy applied consistently regardless of race. To be reviewed as part of monitoring compliance in section 18 of the policy.
Asian/Asian British	None	None	As above.
Chinese	None	None	As above.
White (including Irish)	None	None	As above.
Other racial/ethnic group (please specify)	None	None	As above.
Mixed race	None	None	As above.
Disabled	None	None	Policy applied consistently regardless of ability/disability.
Gay/Lesbian/Bi-sexual	None	None	Policy applied consistently regardless of sexual preference.
Transgender	None	None	Policy applied consistently regardless of gender. To be reviewed as part of monitoring compliance in section 18 of the policy.
Younger People (17-25) and children	None	None	Policy applied consistently regardless of age. To be reviewed as part of monitoring compliance in section 18 of the policy.
Older People (50+)	None	None	As above
Faith groups (please specify)	None	None	Policy applied consistently regardless of faith group.

Following completion of the Stage 1 assessment, is Stage 2 (Full Assessment) necessary? **No**

Date Completed: **23/11/17**

Manager completing the assessment: **Nick Dowd – HR Advisory Team Manager**

The Shrewsbury and Telford Hospital NHS Trust

Disciplinary Policy

W7

Additionally refer to:

- HR07 Disciplinary Policy for Doctors and Dentists
- HR04 Verification of Professional Registration Policy
- HR13 Reimbursement of Travel, Accommodation and Subsistence Expenses Policy
- HR31 Managing Attendance & Employee Wellbeing
- HR45 Dignity at Work Policy
- W10 Employee Performance Management Policy & Procedure
- W12 Appraisals and Pay Progression
- W37 Employee Investigations Policy
- CG07 Concerns and Complaints
- CG26 Managing Allegations against staff who work with Children and Young People

Version:	V4.5
V1 issued	March 2008
V4 approved by	JNCC
V4 date approved	May 2018
V4 Ratified by:	Trust Board
V4 Date ratified:	July 2018
Document Lead	HR Advisory Team Manager
Lead Director	Workforce Director
Date issued:	March 2008
Review date:	May 2023
Target audience:	All Trust Employees

Version Control Sheet

Document Lead/Contact:	HR Advisory Team Manager nick.dowd@sath.nhs.uk
Document ID	W7 (Previously HR36)
Version	4.5
Status	In Consultation
Date Equality Impact Assessment completed	February 2018
Issue Date	March 2008
Review Date	May 2023
Distribution	Please refer to the intranet version for the latest version of this policy. **Any printed copies may not necessarily be the most up to date**
Key Words	Disciplinary, Misconduct, Standards of Behaviour, suspension, restriction of duties, safeguarding.
Dissemination	Global Email, One Minute Brief, Chatterbox

Version history

Version	Date	Author	Status	Comment
3.1	March 2014	Anna Martin	Final	Full redraft of original Trust Policy, issued June 2014.
4.1 – 4.5	June 2017	Nick Dowd	Draft	Policy discussed at JNCC Policy meeting between June 2017 and July 2018. Some parts removed and added to new Employee Investigations Policy. Appendix 4 added.

Contents

1 Policy on a Page

- Policy for all Trust staff. For Medical and Dental staff please also refer to Trust's Disciplinary Policy for Doctors and Dentists (HR07).
- The Trust is committed to a fair, consistent and effective approach to disciplinary matters.
- All staff are required to comply with this policy
- All staff must notify their manager if they are arrested, charged or investigated for a criminal offence, or if they are referred to their professional body.
- There is a right to be accompanied at all formal stages of the process.
- Employees may be suspended where required.
- There are specific requirements relating to safeguarding (see section 8)
- Employees have a right of appeal against any formal disciplinary sanctions applied.

2 Document Statement

2.1 This process sets out arrangements to ensure a fair, consistent and effective approach in dealing with disciplinary matters. The procedure is designed to encourage improvements in standards of conduct and behaviour and to ensure that reasonable sanctions are applied in addressing issues of staff who fail to meet standards of conduct set out in this and other Trust policies.

3 Overview

3.1 This policy applies to all employees of the Trust, including those employed via the Temporary Staffing Department, and should be read in conjunction with all appropriate codes of conduct/rules for professional bodies.

3.2 For cases where there are allegations against Medical and Dental staff please refer to the Trust's Disciplinary Policy for Doctors and Dentists (HR07).

3.3 The policy does not apply to issues of capability, poor performance or ill health, which should be dealt with under the appropriate policies listed on the front page.

4 Responsibilities

4.1 Trust Board

The Board has responsibility to oversee this policy and ensure that appropriate processes and actions are in place to ensure employees are treated in a fair and consistent manner.

4.2 Directors/COO/Assistant COO

Are responsible for ensuring appropriate systems and processes are in place across their Care Groups and Departments to monitor timescales for disciplinary investigations, disseminate shared learning from any matters arising from the investigations, for assisting the appointment of investigating officers and ensuring that disciplinary matters are dealt with in a timely manner and in accordance with this policy.

4.3 Line Managers

Line Managers are responsible for ensuring employees are aware of this policy and its contents and understand the standards of conduct and attendance required. They are also responsible for ensuring that high standards are maintained, bringing any concerns they may have about a particular employee to their attention in a timely and sensitive manner.

4.4 Workforce Directorate

The Workforce Directorate team will provide support and guidance to the process to ensure a fair and consistent process is followed and take part in decision making at disciplinary hearings and appeals, with the chair of the meeting making the final decision.

4.5 All Staff

4.5.1 Where an informal or formal disciplinary investigation is invoked, employees are required to participate fully in the investigation, in a timely and constructive manner, whether this concerns them personally or a work colleague. Adequate paid time off will be provided. The purpose of an investigation is to establish the facts fully and as quickly as possible and, unless all contribute appropriately, the findings may be incomplete, possibly resulting in inaccurate conclusions being drawn.

4.5.2 Where an employee wishes to be accompanied or represented during the formal stages of the procedure (in accordance with section 4) they will be responsible for contacting their support.

4.5.3 Conduct whilst employees are off duty may become subject to action under this policy where such conduct has a detrimental effect on the individual's position as an employee of the Trust or to the reputation of the Trust.

4.5.4 Any employee who is arrested, charged or investigated for a criminal offence must inform their manager as soon as possible. For staff who drive as part of their role, this includes all cautions, summons or convictions for driving offences. It does not include fixed penalty notices. Failure to inform the manager may, in itself, result in disciplinary action being taken. Staff may also be required to notify their professional bodies.

4.5.5 Any employee who is referred or self-refers to their professional body (NMC, GMC, GDC, HCPC etc) must inform their manager as soon as possible. Failure to do so may, in itself, result in disciplinary action being taken.

4.6 Trade Unions/Professional organisations

The role of the trade union/Professional organisation representative (TUPO) is to act as a representative and an advocate and to provide the employee with advice and support on matters relating to staff discipline.

4.7 Trust Employed Work Colleague

The role of the Trust Employed Work Colleague is to provide the employee with support. They may also take part in relevant meetings/hearings and speak on behalf of the employee with their permission.

4.8 Accountable Officer for Controlled Drugs

The Trust's Accountable Officer for Controlled Drugs (currently the Chief Pharmacist) must be notified of any disciplinary matters relating to medicines. They are then responsible for ensuring the legal requirements relating to the Health Act 2006 are complied with. This includes notifying regulators (e.g. the CQC, NHS England) and statutory bodies (e.g. the Police).

5 Employee representation

5.1 An employee has the right to be represented, if they wish, at any formal stage of the proceedings by either a representative from a recognised TUPO or a Trust employed work colleague.

5.2 It is strongly advised by the Trust and Staff Side that should this procedure be invoked that the employee seeks the support of their TUPO where applicable. It is the employee's responsibility to liaise with their representative to arrange support. The Trust will facilitate time off for accredited TUPOs and workplace colleagues acting as support to the employee.

5.3 Employees who are suspended are able to meet with their representative in relation to this policy. Where meetings take place on Trust premises, management must be advised in advance of the meeting.

6 Informal stage

6.1 Informal Discussion

6.1.1 A decision must be made at the earliest opportunity as to whether the process will be formal or informal. Cases of minor misconduct should be resolved through informal discussion, advice or coaching and in these circumstances it may be appropriate for a line manager to meet informally with the employee to discuss their conduct with the aim of improving their behaviour. The emphasis will be on agreeing corrective action without recourse to the formal Disciplinary

Policy. Managers may also wish to utilise the Trust's Employee Performance Management Policy (W10) where appropriate.

6.1.2 When discussing the expected behaviour, the manager should explain the purpose of the discussion and outline the issues of concern, giving the employee the opportunity to identify any reasons for the misconduct. During the meeting the possible consequences and impact of the employee's behaviour should be explained. The manager should ensure the employee understands the standards of conduct expected, and explore the need for further training or support to enable the employee to achieve these standards. This may include reference to the relevant codes of professional conduct.

6.1.3 It should be emphasised to the employee that future misconduct of a similar or related nature is likely to lead to a formal disciplinary process. The outcome of the meeting should be confirmed to the employee in writing and a copy of the letter kept on the employee's personal file.

7 Suspension and/or Temporary Redeployment/Adjustment to duties

7.1 Suspension

7.1.1 In certain cases it may be necessary to suspend the employee from duty. Suspension should only take place where there is a risk to patient safety, the member of staff or colleagues and/or to ensure the investigation can be completed unhindered and re-deployment is not a reasonable alternative (see 7.2). A risk assessment (available from the workforce department) must be completed by the line manager prior to any decision being taken. Any decision to suspend should be taken by a member of the hospital executive team in conjunction with the Workforce Director or his/her nominated deputy.

7.1.2 The suspension should be as brief as possible and be reviewed on a monthly basis, with an update provided to the employee.

7.1.3 Suspension is a neutral act and is not a disciplinary sanction. Suspension is on full pay which is the guaranteed remuneration that the employee would have received had they been at work, it is calculated based on a reference period of the previous 12 weeks at work (this includes bank staff).

7.1.4 The suspending manager will outline the terms of the suspension in writing to the employee as soon as possible.

7.1.5 If the employee needs to attend hospital sites for meetings or medical appointments they must gain permission from the suspending manager, the investigating officer or the commissioning manager in writing, prior to attending. In cases of medical emergencies for themselves or family members employees are not required to get permission in advance but should notify one of the above managers as soon as possible afterwards.

7.1.6 The employee must make themselves available for any meetings that may be arranged as part of the investigation and disciplinary process. If they have flexible working arrangements in place this will be taken into account.

7.1.7 Suspended employees will be asked to notify the suspending manager of any other work (voluntary or paid) that they do and this may only continue during the suspension with the written permission of the commissioning manager. In some circumstances the Trust may be required to notify other agencies of this work (see Safeguarding section of this policy for more information).

7.1.8 Normal annual leave procedures will continue to apply, including the process for requesting time off and carry over of leave between leave years.

7.2 Temporary Redeployment/Adjustment to duties

7.2.1 Where suspension is not deemed to be necessary, but it is considered inappropriate for the employee to remain in their current position and/or performing their current duties the employee may be temporarily redeployed. Consideration will be given to the individual's specific circumstance in each case. This will be reviewed on a monthly basis.

7.2.2 Redeployment could involve all or any of the following:

- Moving location
- Restricted or alternative duties
- Increased supervision or supervised access to patients
- Restricted contact with patients or colleagues

This is not an exhaustive list

7.2.3 Where redeployment or an adjustment to current duties will result in a detriment to pay then payment will be made in line with that stated above i.e. the guaranteed remuneration that the employee would have received had they not been redeployed or duties adjusted, their pay will be calculated based on a reference period of the previous 12 weeks.

7.2.4 Where an employee is redeployed on a temporary basis to an alternative location travel expenses will be reimbursed in accordance with the Trust Reimbursement of Travel, Accommodation and Subsistence Expenses Policy (HR13). Travel time will not normally be given, however individual circumstances can be discussed with the line manager.

7.2.5 Where an employee undertakes additional assignments for the Trust via the bank, the Trust reserves the right to notify the Temporary Staffing Department of the suspension or restrictions on duties and of the fact that the employee must not be requested to undertake any shifts during this period, depending on the restrictions. Pay will be calculated as per section 7.1.3.

8 Safeguarding

8.1 Where the concerns relate to an allegation of abuse or neglect of a patient, or raises concern about the employee's suitability to work with children or vulnerable adults, action may be taken in accordance with this policy and a referral must be made in accordance with the appropriate safeguarding procedure.

8.2 Safeguarding Allegations relating to Children

8.2.1 Statutory Guidance requires the Trust to have clear policies in line with those from the Local Safeguarding Children Board (LSCB) for dealing with allegations against people who work with children. An allegation may relate to a person who works with children who has:

- behaved in a way that has harmed a child, or may have harmed a child;
- possibly committed a criminal offence against or related to a child; or
- behaved towards a child or children in a way that indicates they may pose a risk of harm to children.

Please see the Trust's policy for Managing Allegations against staff who work with Children and Young People (CG26) for more information.

8.2.2 Each LSCB has a specific procedure and the LSCB websites hold this information. Staff dealing with a concern of this nature must check their LSCB Procedure.

8.2.3 All safeguarding allegations relating to people who work with children must be reported to the Trust's 'Named Senior Officer'*. All such allegations must also be discussed with the Local Authority Designated Officer (LADO) within one working day of the allegation coming to light. The LADO will advise as to how the investigation process will proceed. Advice and guidance can be obtained from the Named Nurse for Safeguarding Children or Named Doctor for Child Protection.

*Named Senior Officer is a role required by statutory safeguarding children guidance. This is to provide accountability to local safeguarding children boards.

8.3 Allegations relating to Vulnerable Adults

8.3.1 Reference should be made to the local Safeguarding Adult Board procedure. In addition all incidents must be notified to the Trust's Safeguarding Consultant Practitioner.

8.3.2 In all circumstances the safeguarding investigation will make recommendations to the Trust on how to proceed.

9 Investigation

9.1 Prior to the commencement of a formal investigation a fact finding exercise should be carried out, which will normally involve collation of written statements, review of relevant patient notes etc.

9.2 In circumstances where the required evidence is clearly available (and provided the employee has had a reasonable opportunity to provide a statement) there will be no need to conduct a separate investigation. Some examples of such matters are outlined below:

- Repeated occasions of poor timekeeping or unauthorised absence where the line manager has a clear record of the dates/times of these occasions and notes/evidence of previous discussions on occasions where clear standards have been set;

- Repeated failure to engage with the Attendance and Wellbeing Policy, including persistent failure to attend for Occupational Health Appointments and/or failure to attend arranged meeting with a line manager without justifiable reason;

9.3 A full and thorough fact find / investigation must always take place. In some circumstances the evidence gathered during the fact find will be sufficient and in such circumstances the Trust reserves the right to dispense with further investigation and proceed directly to a formal disciplinary hearing, sanctions meeting or decision of no case to answer based on the evidence available. This decision must be reviewed by another manager (equivalent to those acting as a commissioning manager) and a HR representative.

9.4 Where a further investigation is needed, the investigation should take place in accordance with the Trust's Employee Investigations Policy (W37).

10 Formal Action

10.1 Where it is determined that there is a case to answer the commissioning manager should decide whether the case should proceed to a formal sanctions meeting (with the consent of the employee - see Appendix 1) or a disciplinary hearing (see Appendix 2).

10.2 Appendix 4 describes those who have the authority to take formal disciplinary action.

10.3 In accordance with the General Data Protection Regulations any evidence provided by employees during this process may be retained within their personal file and/or stored securely

(electronically or hard copy) within the HR department. If the evidence contains sensitive personal data, the employee may request that this is deleted or returned to them at the end of the process. The HR department will confirm in writing when this has been completed.

10.4 Witnesses

All witness statements relating to the allegations will be provided to the employee and any witnesses may be called to disciplinary hearings in accordance with Appendix 2.

11 Disciplinary Sanctions

11.1 First Written Warning

11.1.1 In the case of minor offences, the employee may be given a first written warning, setting out the nature of the offence and the likely consequences of any further offences. The employee should be told that their conduct is not acceptable and more serious disciplinary action will be taken in the event of continued breaches of conduct.

11.1.2 The written warning will be confirmed in writing within 7 calendar days of the date of the decision by the chair of the panel. The letter will contain the right of appeal. The warning will be live for up to 9 months from the date of issue after which it will become spent but will remain on the personal file.

11.1.3 Receipt of a formal disciplinary warning may effect pay progression. See section 7.5 of the Annual Appraisal and Pay Progression Policy (W12) for more information.

11.2 Final Written Warning

11.2.1 In the case of further offences of a similar nature or a first instance of more serious misconduct (that would warrant dismissal if it were repeated), the employee may be given a final written warning. The employee should be clearly warned that further misconduct may result in dismissal.

11.2.2 The final written warning will be confirmed in writing within 7 calendar days of the date of the decision by the chair of the panel together with the right of appeal against the decision and the outcome letter will be kept on file; the warning will be live for up to 18 months from the date of issue after which it will become spent but will remain on the personal file.

11.2.3 Receipt of a formal disciplinary warning may effect pay progression. See section 7.5 of the Annual Appraisal and Pay Progression Policy (W12) for more information.

11.3 Dismissal and Summary Dismissal

11.3.1 Dismissal or summary dismissal may take place where:

- a final written warning remains live and the misconduct or related behaviour has been repeated or continues; or
- the employee is considered to have committed an act of gross misconduct or
- the employee is charged with or convicted of a criminal offence which is considered to be sufficiently serious as to justify dismissal; or
- a Statutory Bar is imposed on the employee which prevents them from carrying out some or all of their duties; or
- the employee no longer meets the standards set down for their profession by the relevant Authority; or
- the employee loses their professional registration (see also HR04 Verification of Professional Registration).

This list is not exhaustive.

11.3.2 The Trust reserves the right to make a payment in lieu of notice. In all cases, any outstanding payments in respect of annual leave, agreed time owing, overtime worked, unsocial hours payments etc., due on the date of termination will be paid, normally on the next available pay date.

11.3.3 In cases of gross misconduct the employee may be summarily dismissed without notice or payment in lieu of notice. Any decision to dismiss will only be taken as the outcome of a full disciplinary hearing in accordance with this procedure.

11.3.4 Any decision to dismiss an employee will be confirmed in writing by the chair of the panel within 7 calendar days of the hearing, together with the right of appeal against the decision.

12 Appeals

12.1 An employee has the right to appeal against the decision of the chair of the disciplinary hearing under this procedure. The appeal should be made in writing to the next level of management within 14 calendar days of receipt of written confirmation of the decision.

12.2 Employees who are appealing their dismissal will need to inform the workforce representative from the disciplinary panel of any meeting with their TUPO representative which occurs on Trust premises.

12.3 Appeal hearings are convened to review the decision and the outcome of the original disciplinary hearing.

12.4 An employee must set out clearly the grounds upon which the previous decision is being contested and the outcome they are seeking, as this will form the basis of the appeal hearing.

12.5 Grounds of appeal:

- they disagree with the finding that they committed the alleged act(s) of misconduct
- they feel that Trust procedures were not correctly and fairly implemented
- discrimination and/or sanction inconsistent with how others have been treated
- new evidence not previously available at the original hearing.

12.6 If the reason for the appeal is unclear, the employee may be asked to clarify their grounds before the appeal hearing takes place.

12.7 Where new evidence is presented (see paragraph 11.5) the chair of the appeal meeting may choose to refer the matter back to the original disciplinary panel for them to consider the evidence and decide whether this changes their outcome. Following this, if the employee remains dissatisfied they retain their right of appeal and may continue with their appeal provided it still meets one of the grounds of appeal listed above.

12.8 The appeal is not a re-hearing of the original disciplinary hearing, but a consideration of the specific areas with which the employee is dissatisfied in relation to the original disciplinary hearing. The appeal panel will consider the grounds that the employee has put forward and assess whether or not the conclusion reached in the previous disciplinary hearing was appropriate. In considering appeals against disciplinary action, the panel will be required to satisfy itself on the following points:

- Whether the misconduct investigation was adequately investigated, undertaken and substantiated

- Whether Trust's procedures were correctly and fairly implemented
- Whether the disciplinary action taken was reasonable, in all of the circumstances

12.9 The disciplinary sanction and decision of the original disciplinary hearing may be upheld, reduced or removed as a result of any appeal lodged. If the sanction is removed then this will also be removed from the personal file

12.10 In the event of an appeal hearing decision that an employee should be reinstated, the employee will receive payment from the date of termination to the date of re-employment. However, this payment may be reduced if the employee has gained other earnings between dismissal and re-employment. The employee will be required to provide this information on request.

12.11 The appeal hearing will be heard by the next level of management and will be supported by a workforce representative. In cases of professional misconduct the panel chair may be accompanied by a professional lead.

12.12 There will be no further right of appeal within the Trust following this stage of the procedure.

13 Standards of behaviour

13.1 Examples of behaviour expected by the Trust

- The following are examples of the behaviour expected by the Trust of all of its colleagues, although the list is not exhaustive:
- Attend work punctually and regularly in line with the operational requirements
- Carry out reasonable request/instructions from your manager promptly and efficiently and to the required standard
- Time off must be approved in advance by the appropriate level of manager and be in line with your contract of employment
- Follow the procedure outlined in the Managing Attendance and Wellbeing when notifying the Trust of your sickness absence
- You must comply with all the Trust policies and procedures, including but not limited to the Dignity at Work Policy, the relevant Code of Conduct and the Health and Safety Policies
- Adhere to professional body and statutory guidelines as appropriate and act professionally at all times
- Adhere to the Trust values
- Bring serious breaches of the Trust Policies and Procedures to the attention of management

13.2 Examples of Misconduct

13.2.1 No set of disciplinary standards can cover all circumstances that may arise during the course of employment; therefore, the following list should not be regarded as exhaustive or complete. It has been drawn up to enable employees to know and understand the types of conduct that will warrant disciplinary action and describe the Trust's approach to issues of staff misconduct:

- Failure to comply with reasonable instructions
- Acts of insubordination
- Persistent failure to wear ID badge(s) or adhere to dress codes
- Deliberate failure to administer drugs in accordance with NMC and Trust guidelines
- Persistent bad timekeeping

- Unauthorised absence
- Unauthorised or inappropriate use of NHS property, including IT equipment or patient property
- Smoking in non-designated smoking areas
- Using offensive language (see Dignity at Work Policy)
- Other actions likely to bring the Trust into disrepute
- Deliberate failure to provide an efficient, safe and high quality service with concern and respect for the feelings and well being of other employees, patients and visitors
- Failure to observe the Trust internal policies, including H & S
- Persistent failure to attend for meetings when reasonably requested to do so by their line manager
- Failure to Disclose an Interest

This list is not exhaustive

13.2.2 In serious or persistent cases of the above, the misconduct may be regarded as 'gross misconduct' and treated as such

13.3 Examples of Gross Misconduct

- Dishonesty / Theft
- Serious personal or professional misconduct
- Deliberate failure to disclose an Interest
- Assault (verbal or physical)
- Harassment and/or bullying including cyber bullying
- Harassment and/or bullying of an employee who has made a protected disclosure
- Gross carelessness
- Malicious damage
- Being under the influence of alcohol, drugs or other substance whilst on duty
- Breach of contract
- Breach of confidentiality
- Intentionally making false statements
- Inappropriate use of the internet or trust mobile media
- Deliberate failure to renew professional registration
- Permanent or temporary loss of professional registration (see HR04 Verification of Professional Registration Policy)
- Breach of professional standards
- Criminal offences outside employment affecting the employee's role
- Fraud and/or corruption
- Breach of Equality and/or Human Rights Legislation
- Breach of legislative or regulatory duty e.g H&S, CQC

This list is not exhaustive.

14 Referral to the disclosure and barring service

14.1 In cases where the Trust dismisses or removes a member of staff/volunteer from working with children and/or vulnerable adults (in what is legally defined as a regulated activity) because they have caused harm to a child or vulnerable adult, there is a legal duty to inform the Disclosure and Barring Service (DBS).

14.2 This also applies where the Trust would have taken this action had that individual not resigned, retired, been made redundant or been transferred to a position which is not a regulated activity.

14.3 The referral should be made to the DBS when the investigation has gathered sufficient evidence to support the belief that relevant conduct has occurred, and their reasons for withdrawing permission for the employee to engage in a regulated activity.

14.4 The DBS referral should be made by the Line Manager, or their nominee. Following good practice, they will have consulted with their Local Authority Designated Officer (LADO) or Chair of the Adult Protection Investigation meeting. If there is any uncertainty as to whether the person meets the referral criteria, they should contact the Safeguarding Consultant Practitioner or the Workforce Department for advice. The Line Manager should provide the Assistant COO/Care Group Director/Clinical Director with a copy of the referral form and all supporting documentation who will confirm that the information is appropriate before the referral is made. The Assistant COO/Care Group Director/Clinical Director should be notified when the referral has been made.

14.5 For guidance about definitions of 'regulated activity', and how to make a referral or go to the DBS website https://www.gov.uk/government/publications/dbs-referrals-form-and-guidance

14.6 On completion, a copy of all referrals, documents and subsequent correspondence should be provided to the Workforce Directorate.

15 Referral to professional bodies and other outside agencies

15.1 The Trust will make a referral to the relevant professional body where the employee is seen to not be upholding their professional values, brings their profession into disrepute or potentially breaches their professional codes. All referrals will be led by the Corporate Nursing team and Care Group Lead Nurses with support from the Workforce Directorate.

15.2 The Trust may refer the employee to the National Clinical Assessment Service (NCAS), who may issue a Healthcare Professional Alert Notice (HPAN) to inform NHS bodies and others of healthcare professionals whose performance or conduct gives rise to concern.

15.3 Where there is a reasonable suspicion that fraud or corruption may have occurred, the Commissioning Manager or HR Advisory Team must immediately notify the Local Counter Fraud Specialist (LCFS), Finance Director or the NHS Counter Fraud Authority. Where the initial assessment indicates that other criminal offences may have been committed, these matters should be discussed with the appropriate senior manager and reported to the Police.

16 Training needs

16.1 The Trust acknowledges the importance of training for managers involved in the application of this policy and will therefore ensure that appropriate training and support is available from the Workforce Directorate.

16.2 Any manager who is undertaking any formal stage of the procedure will be expected to contact the Workforce Department in the first instance for advice and support on the implementation of the policy.

16.3 All managers are expected to disseminate information in relation to this policy to staff.

17 Review process

17.1 This policy will be reviewed as and when required or before if there are legislation changes. The monitoring of this policy includes an annual audit (see section 18). Where non-compliance

is identified an action plan will be drawn up and monitored at the Workforce Committee. Where remedial action can be taken immediately, the action must be recorded appropriately.

17.2 In order that this document remains current, any of the appendices to the policy can be amended and approved during the lifetime of the document without the document strategy having to return to the ratifying committee.

18 Equality Impact Assessment (EqIA)

18.1 This policy applies to all employees equally and does not discriminate positively or negatively between protected characteristics.

19 Process for monitoring compliance

Aspect of compliance or effectiveness being monitored	Monitoring method	Responsibility for monitoring (job title)	Frequency of monitoring	Group or Committee that will review the findings and monitor completion of any resulting action plan
The policy is fairly applied to staff in a transparent and consistent manner	Use of workforce database to review cases by protected characteristics under the Equality Act 2010.	HR Advisory Team Manager	Yearly	Workforce committee
Number of cases being referred to HR Advisors/Managers for support	Use of workforce database	HR Advisory Team Manager	Yearly	Workforce committee
Number of appeals against decisions taken under this procedure.	Use of workforce database	HR Advisory Team Manager	Yearly	Workforce committee
Ongoing discussions with JNCC representatives		Deputy Director of Workforce	Ongoing	JNCC

20 References

- Legislation
  - Employment Act 2008
  - Employment Tribunals (Constitution and Rules of Procedure) (Amendment) Regulations 2008
  - Employment Rights Act 1996 as amended
  - Employment Rights Dispute Resolution Act 1998
  - Employment Relations Act 1999
  - Employment Rights Act 2004.

Previous legislation covering discipline and grievances at work was historically found in the Employment Act 2002 and the Employment Act 2002 (Dispute Resolution) Regulations 2004

(SI 2004/752). However, the procedures were repealed in their entirety from 6 April 2009 under the Employment Act 2008)

- CIPD – Good Practice Guidelines for Disciplinary and Grievance Procedures (Members only section of website)
- ACAS – Code of Practice for Disciplinary and Grievance Procedures - http://www.acas.org.uk/media/pdf/k/b/Acas_Code_of_Practice_1_on_disciplinary_and_grievance_procedures-accessible-version-Jul-2012.pdf
- HR Inform Guidelines for Disciplinary and Grievance Procedures (Members only section of website)
- DBS website https://www.gov.uk/government/publications/dbs-referrals-form-and-guidance

21 Associated Documentation

HR01 Equality and Diversity PolicyHR07 Disciplinary Policy for Doctors and Dentists.
HR09 Alcohol and Substance Misuse.
HR13 Reimbursement of Travel, Accommodation and Subsistence Expenses PolicyHR31 Managing Attendance & Employee Wellbeing
HR65 Occupational Health ServiceHR66 Staff Counselling Service.
W10 Employee Performance Management Policy & ProcedureW19 Leave Policy Cluster
W37 Employee Investigations Policy

All the above are available from:

Internal - http://intranet/hr/HR_Policies.asp
External - https://www.sath.nhs.uk/working-with-us/hr/policies/

CG26 Managing Allegations against Staff who work with Children and Young People
CG07 Concerns and Complaints

Available from http://intranet/document_library

Appendix 1 - Disciplinary Sanctions Meeting

Disciplinary Sanctions Meeting

1. It is recognised that there are occasions where staff identify that their behaviour or action was not in line with normal practice/expectations. The Sanctions Meeting process aims to speed up the process for all parties and is applicable in cases where:-
    - an employee accepts full responsibility for their actions, and
    - the outcome of the investigation would result in a sanction of up to and including a Final Written Warning.

2. The decision to progress to a Sanctions meeting will not be made until after a full and thorough investigation.

3. The sanctions process is not appropriate in circumstances where:-

    - the case involves a member of medical and dental staff (HR07 applies in these matters),
    - the employee disputes the allegations and/or specifically requests a full hearing,
    - the commissioning manager does not support a decision to progress to a Sanctions Meeting.
    - the outcome may be dismissal, or
    - the employee is already subject to a final written warning.

    In these circumstances a full disciplinary hearing must be convened.

4. Where the decision is reached to use the sanctions process the Sanctions proforma must be completed prior to the meeting commencing (Appendix 2)

5. The Sanctions Meeting is a formal meeting that would follow the principles outlined in the ACAS Guide, including the right to representation and the right of appeal, but does not require the attendance of an Investigating Officer to present the case. In these circumstances the right of appeal follows the principles set out in paragraph 7.

6. The Sanctions Meeting will be convened consisting of the Chair of the Sanctions Meeting (usually the Commissioning Manager), HR representative, the employee and their staff side representative or workplace colleague (where applicable). With the consent of the employee the meeting will be audio recorded using digital recording equipment. The meeting will be held in accordance with the process set out in Appendix 1.

7. If the employee chooses not to accept the sanction imposed they must notify the Chair of the Sanctions Meeting within 10 working days of receipt of the outcome letter. In this eventuality a disciplinary hearing will be arranged and action could include dismissal, following which the employee will have a further right of appeal.

Sanctions Meeting Process

Before the meeting

1.1 When a full and thorough investigation has been completed, all documents or evidence collated during this process will be shared with the employee (and their representative if applicable).

1.2 A formal letter will be sent by the Chair for the possible Sanctions Meeting; this letter will:

- Confirm the arrangements for the Sanctions Meeting and notify the employee of their right to representation.
- Request that the employee considers and confirms their consent to progress to a Sanctions Meeting (using Appendix 2).
- Request that the employee confirms their attendance at the Sanctions Meeting and that of any representative.
- Share the documents set out in 1.1 or confirm when these will be available.

Note:- The meeting must be arranged at a mutually convenient date or with reasonable notice.

1.3 The employee will be able to submit a statement of case detailing the events that took place or any other concerns with the documents shared as per 1.1 for the Chair of the Sanctions Meeting to consider. If this is to be provided it should be sent, wherever possible, electronically to the Chair of the Meeting at least the day before the meeting.

At the Sanctions Meeting

2.1 Ensure that the proforma in Appendix 2 has been completed by all parties.

2.2 The information gathered during the investigation will be reviewed alongside any information provided by the employee.

2.3 The employee will be asked to confirm that they admit the allegations.

2.4 The employee (or representative) will have the opportunity to put forward any comments or statements relating to the incident, including any mitigation. Written documentation submitted in advance can be taken as read, if all parties agree.

2.5 The Chair of the Sanctions Meeting may ask questions about the case.

2.6 The meeting will be adjourned to allow the Chair of the Sanctions Meeting to reach a decision on the sanction to be offered taking into consideration that the employee has accepted and taken responsibility for their actions.

Sanction could include:-

- No Warning issued
- No Warning issued but action plan agreed,
- Employee management in accordance with the Employee Performance Management Policy (W10)
- First Written Warning issued
- First Written Warning issued and action plan agreed,
- Final Written Warning issued
- Final Written Warning issued and action plan agreed,

- Referral to a disciplinary hearing if the action is considered to be serious or gross misconduct or if further concerns not previously identified have been raised which may require further investigation.

2.7 The outcome will be confirmed verbally on the day where possible and confirmed in writing within 7 calendar days of the meeting. The outcome letter will confirm action to be taken by the employee if they do not wish to accept the sanction offered.

SANCTIONS PROFORMA

Employee Name:	
Position Held:	
Care Group:	
Ward/Department:	
Date of Allegation:	
Allegation: (to be written by the Commissioning Manager)	
I (*insert name*) ……request a sanctions meeting where a sanction of no case to answer, action in line with the Employee Performance Management Policy (W10), a first written or final written warning in accordance with the Disciplinary Policy (HR36)may be given for the above allegation/s.	
I have/have not *(delete as appropriate)* discussed the sanctions meeting with Staff Side rep or Workplace colleague Signature of Staff Side rep or Workplace colleague (where applicable) Signature …… Date ……..	
I understand and admit the allegation occurred as stated	☐

Employee Signature …..…… Date ……..

On completion forward to the Commissioning Manager within the timescales set out in your letter

_____

Received by Commissioning Manager

Signature …… Date ……..

Appendix 2 – Procedure at Disciplinary Hearing

PROCEDURE AT A DISCIPLINARY HEARING

1. The Disciplinary Hearing Panel

1.1 The disciplinary hearing panel will normally comprise the Chair and a member of the Workforce Team. No member of the panel should have had any previous involvement in the investigation and must be replaced if a conflict of interest is declared. The Chair is:

- the manager authorised to hear a disciplinary case
- responsible for determining the composition of the panel (which may include external members); and
- responsible for deciding what action is to be taken consequent to the hearing.

1.2 Where the case concerns professional conduct, a senior member of that profession should be part of the panel if the Chair is not qualified in that profession. The role of this panel member is to provide professional advice to the panel and to participate in the hearing and decision making process. Where appropriate, this panel member may be external to the Trust.

1.3 The role of the HR representative is to provide support and advice to the Chair (and other members of the panel) and to participate in the hearing and decision-making process, with the chair making the final decision. All members of the panel may ask questions at the hearing and this process will be led by the chair.

1.4 Where there are justifiable reasons for doing so, an individual may request that an alternative panel be appointed. Such a request must be made in writing, giving detailed reasons, to the HR representative supporting the panel **at least five working days before the hearing is due to take place**. Such a request will be considered and may or may not be accommodated. Where such a request is refused, the individual will be informed of the reasons.

2. Exchange of Evidence and Witnesses

2.1 The employee will be given reasonable notice of the hearing date and provided with a copy of the investigation report, all relevant documentary evidence and names of management witnesses. This will be as soon as possible but no later than 10 working days prior to the hearing (unless there is an exceptional circumstance).

2.2 If the individual intends to rely on any written evidence at the hearing which is not already included in the management evidence, this should normally be presented to the Chair, together with the names of any witnesses to be called and a brief reason for calling them. This will normally be at least 3 working days prior to the hearing.

2.3 The Chair of the panel may agree to alternative timescales following discussions with the manager presenting the case at the hearing and the employee or their representative.

2.4 It is the responsibility of the chair of the panel to arrange for exchange of documents prior to the hearing

2.5 It is the responsibility of each party to arrange for their witnesses to be present at the hearing. In the absence of a witness, the panel will have discretion as to the weight to be given to any written statement presented as part of the evidence. Department managers will ensure that duty rotas are arranged so that witnesses are available to attend the hearing. Witnesses who are not employees of the NHS will not normally be requested to attend disciplinary hearings.

2.6 Non-availability of witnesses must be shared as far in advance as possible by both sides. If there is any concern over the relevance of a witness from either side, the chair will decide whether it is appropriate for the witness to attend the hearing.

2.7 It will not normally be acceptable for either party to present their written evidence on the day of the hearing. If written evidence is presented, the hearing may be adjourned to allow time for all parties and the panel to consider this evidence. The party presenting the evidence will be expected to explain to the panel the reasons for it not being available in advance of the hearing.

3. The Process

3.1 The Chair will open the hearing with introductions and will outline the process to be followed.

3.2 Management will present the case against the employee and summarise the findings of the investigation. (The management representative will normally be the Investigating Officer but the overall presentation of the case may be by a senior manager, with the Investigating Officer presenting their findings.) The lead Management representative may be supported in the hearing by a representative from Human Resources.

3.3 Management will then call each of their witnesses to answer questions, with the first questions being from themselves.

3.6 The employee or their representative may question each witness.

3.7 The Chair and other members of the hearing panel may question each witness.

3.8 Management may then re-question each witness to clarify any matters that have arisen during the hearing.

3.9 The employee or their representative will present their case.

3.10 The employee will call any witnesses who have not already given evidence to answer questions, with the first questions being from the employee or their representative.

3.11 Management may question each witness.

3.12 The Chair and other members of the hearing panel may question each witness.

3.13 The employee or their representative may then re-question each witness to clarify any matters that have arisen during the hearing.

3.14 Management will sum-up the case against the employee.

3.15 The employee or their representative will sum-up their case.

3.16 The Chair of the hearing will ask any further questions of either party to resolve any outstanding queries or matters that have arisen during the hearing. Where necessary, witnesses may be recalled by the Chair.

3.17 The Chair of the hearing may adjourn the hearing at any time to seek advice or clarification on any matters that remain outstanding, for example if further evidence is required on any issue raised.

3.18 Once all evidence has been presented, the panel will adjourn to consider the information and reach a decision.

3.19 The Chair will reconvene the meeting, calling back the employee and their representative and the Management representative(s) to inform them of the decision. In many cases, the hearing will reconvene on the same day. In other circumstances, the Chair will inform both parties that more time will be required before a decision can be reached.

3.20 On reconvening the panel, the Chair will inform the employee of the decision. Where appropriate, he/she will also inform the employee of the right of appeal.

3.21 In all cases the Chair will confirm the outcome of the hearing and, where relevant, of the right of appeal in writing to the employee, with copies to the employee's representative and to the management representative.

4. Attendance

4.1 Employees are required to attend any disciplinary hearing arranged in accordance with this procedure. If it is necessary to postpone any hearing then another will be arranged by the Trust. Where an employee fails to attend a hearing without reasonable cause notified before the date of the hearing, the hearing will go ahead in their absence and a decision made on the evidence presented.

4.2 Witnesses attending the hearing may be accompanied by their accredited trade union or professional organisation representative or by a colleague employed by the Trust. This representative is there to accompany the individual and not to answer questions or to make any statement on their behalf. It is for the witness to arrange such representation and the hearing will not be delayed by the unavailability of a representative.

5. Learning and Improving

5.1 Disciplinary matters should always consider what lessons can be learned to prevent things happening again. This relates not only to employee actions but also to system factors that may have contributed. Commissioning Managers or the Chair of the hearing have a responsibility to feedback through line management structures any feedback or learning that has been identified. If there are actions to be taken forward the Commission Manager/Chair will ensure these are allocated to specific and appropriate individuals to take forward.

6. Records

6.1 All disciplinary hearings will be recorded. With the consent of the employee this will normally be an audio recording using digital recording equipment. The audio recording will only be transcribed if there is an appeal.

Appendix 3 – Procedure at an Appeal Hearing

PROCEDURE AT AN APPEAL HEARING

1. The Appeal Hearing Panel

1.1 The appeal hearing panel will normally comprise the Chair and one member of the Workforce Team. Wherever possible, no member of the panel should have had any previous involvement in the case. The Chair is:

- the manager authorised to hear an appeal
- responsible for determining the composition of the panel (which may include external members); and
- responsible for deciding what action is to be taken consequent to the hearing.

1.2 Where the case concerns professional conduct, a senior member of that profession who has not previously been involved in the case should be part of the panel if the Chair is not qualified in that profession. The role of this panel member is to provide professional advice to the panel and to participate in the hearing and decision making process. Where appropriate, this panel member may be external to the Trust.

1.3 The role of the Workforce representative is to provide support and advice to the Chair (and other members of the panel) and to participate in the hearing and decision-making process, with the chair making the final decision.

1.4 Where there are justifiable reasons for doing so, an individual may request that an alternative panel be appointed. Such a request must be made in writing, giving detailed reasons, to the HR representative supporting the panel **at least five working days before the hearing is due to take place**. Such a request will be considered and may or may not be accommodated. Where such a request is refused, the individual will be informed of the reasons.

2. Exchange of Evidence

2.1 Both parties to the case (i.e. the appellant and the management representative) should normally present a copy of their written evidence, together with the names of any witnesses to be called, to the Chair of the panel before the hearing. The appellant will also notify the Chair of the name of the representative who will be presenting their case, if this has not already been done. The Chair of the panel will provide a copy of the evidence and the names of the witnesses who are to attend to the other party and an additional copy for the appellant's representative.

2.2 It is the responsibility of each party to arrange for their witnesses to be present at the hearing. In the absence of a witness the panel will have discretion as to the weight to be given to any written statement presented as part of the evidence. Department managers will ensure that duty rotas are arranged so that witnesses are available to attend the hearing. Witnesses who are not employees of the NHS will not normally be requested to attend disciplinary hearings.

2.3 It will not normally be acceptable for either party to present their written evidence on the day of the hearing. If written evidence is presented, the hearing may be adjourned to allow time for all parties and the panel to consider this evidence. The party presenting the evidence will be

expected to explain to the panel the reasons for it not being available in advance of the hearing.

2.4 The evidence presented at the disciplinary hearing and the notes taken at the hearing will be available to the panel hearing the appeal.

2.5 The employee's line manager will arrange for their personal file to be made available to the appeal hearing panel at the same time as the written evidence for the case.

3. The Process

3.1 The Chair will open the hearing with introductions and will outline the process to be followed.

3.4 The appellant or their representative will present their appeal, explaining why they believe the decision taken at the disciplinary hearing was unfair or unreasonable.

3.5 The appellant or their representative may, at this point, present any new evidence that was not available at the disciplinary hearing and explain why the new evidence was not available at the disciplinary hearing. The appeal hearing Chair will then decide whether to continue with the appeal hearing or to remit the case back to the earlier hearing panel or to have the case re-investigated.

3.6 If new witnesses are to be called by the appellant, the appellant or their representative should question them, followed by management and then members of the panel.

3.7 If appropriate, the Chair of the appeal panel may adjourn the hearing to allow new evidence to be properly considered by all parties.

3.8 The appellant or their representative will then sum up/conclude their case.

3.9 Management will then present their response, explaining the basis on which their decision was made, including any mitigation offered by the appellant that was taken into account. The lead management representative may be supported in the appeal hearing by other panel members.

3.10 The management representative may, at this point, respond to any new evidence presented by the appellant, including relevant witnesses. If witnesses are to be called by management, the management representative should question them, followed by the appellant or their representative and then members of the panel.

3.11 The management representative will then sum-up/conclude their case.

3.12 The Chair of the appeal hearing may adjourn the hearing at any time to seek advice or clarification on any matters that remain outstanding, for example if professional advice is sought and no member of the panel is able to provide it or if further evidence is required on any issue raised.

3.13 Once all relevant information has been gathered, the panel will adjourn to consider the information.

3.14 The Chair will reconvene the appeal hearing, calling back the appellant, their representative and the management representative responding to the appeal to inform them of the decision. In many cases, the hearing will reconvene on the same day. In other circumstances, the Chair will inform both parties that more time will be required before a decision can be reached.

3.15 On reconvening the panel, the Chair will inform the appellant of the decision.

3.16 Where the appellant has already left the employment of the Trust, they may be informed of the decision in writing and so may not be recalled to a further meeting.

3.17 The Chair will confirm the outcome of the hearing in writing to the appellant, with copies to the appellant's representative and the management representative

3.18 The decision of the appeal panel is final and concludes the Disciplinary Procedure.

4. Attendance

4.1 Appellants are required to attend any appeal hearing arranged in accordance with this procedure. If it is necessary to postpone any hearing then another will be arranged by the Trust, normally within fourteen calendar days of the original date. Where an appellant fails to attend a hearing without reasonable cause notified before the date of the hearing, the hearing will go ahead in their absence and a decision made on the evidence presented.

4.2 Witnesses attending the hearing may be accompanied by their accredited trade union or professional organisation representative or by a colleague employed by the Trust. This representative is there to accompany the individual and not to answer questions or to make any statement on their behalf. It is for the witness to arrange such representation and the hearing will not be delayed by the unavailability of a representative.

5. Records

5.1 All disciplinary appeals will be recorded. With the consent of the employee this will normally be an audio recording using digital recording equipment.

Appendix 4 – Authority to Take Action Chart

AUTHORITY TO TAKE ACTION

<table>
<tr><td></td><td colspan="5">Minimum level of Authority to take action or hear appeals</td></tr>
<tr><td>Employee Status</td><td>Suspension</td><td>First or Final Written Warnings</td><td>Written Warning Appeals</td><td>Dismissal</td><td>Dismissal Appeal</td></tr>
<tr><td>Chief Executive and Board Directors</td><td colspan="5">As determined by the Remuneration Committee</td></tr>
<tr><td>Managers who report to a Trust Board Director</td><td>Must be authorised by Trust Board Director</td><td>Trust Board Director*</td><td>Chief Executive*</td><td>Trust Board Director *</td><td>Chief Executive*</td></tr>
<tr><td rowspan="2">Consultants and other career grade medical and dental employees</td><td rowspan="2">See Human Resources policy HR07</td><td colspan="4">As set out in the Trust's Disciplinary Policy for Doctors and Dentists (HR07). Where the case is remitted back into this procedure, the following applies:</td></tr>
<tr><td>Care Group Medical/Clinical Director or Assistant COO</td><td>Medical Director or Deputy Medical Director*</td><td>Medical Director or Deputy Medical Director*</td><td>Medical Director or Chief Executive*</td></tr>
<tr><td rowspan="2">Other medical and dental employees</td><td rowspan="2">See Human Resources policy HR07</td><td colspan="4">As set out in the Trust's Disciplinary Policy for Doctors and Dentists (HR07). Where the case is remitted back into this procedure, the following applies:</td></tr>
<tr><td>Centre Manager</td><td>Care Group Medical/Clinical Director</td><td>Care Group Medical/Clinical Director</td><td>Deputy Medical Director</td></tr>
<tr><td>Other employees</td><td>Must be authorised by Trust Board Director</td><td>Min. Band 7 (see section 6 of Appendix 1)</td><td>Must be more senior than the manager who issued the warning</td><td>Min. Band 8a</td><td>Must be more senior than dismissing manager</td></tr>
</table>

Notes

- Action may only be taken by an individual who is more senior than the member of staff against whom allegations have been made.

- *The Chief Executive and Trust Board Directors may delegate their authority to another Trust Board Director or to a Care Group Director where appropriate. The delegate must still be senior to the employee being disciplined.

Equality Impact Assessment Form - Stage 1 – Initial Assessment

Managers Name	Charlotte Banks	**Division**	Workforce
Function, Policy, Practices, Service	To provide guidance on the smoking restrictions for staff, visitors, contractors and patients.	**Purpose and Outcomes – intended and differential**	The aim of this document is to provide clear guidance on the restrictions for smoking and the use of e-cigarettes on Trust property in line with the Health Act 2006. It also outlines the assistance that will be offered to individuals who wish to stop smoking.
Implementation Date	Pending	**Who does it affect?**	**Staff, patients, visitors, contractors, members of the public**
Consultation Process	JNCC Policy Meeting	**Communication and awareness**	Launch new policy internally, staff training, new signs, press release, website.

For completion of the following table please see point 7 in the guidance notes.

Equality Target Group	(a) Positive Impact	(b) Negative Impact	Reason/Comment
Men	None	None	There are no positive or negative impacts on any of the protected characteristics.
Women	None	None	
Black/Black British	None	None	There are no positive or negative impacts on any of the protected characteristics.
Asian/Asian British	None	None	
Chinese	None	None	
White (including Irish)	None	None	
Other racial/ethnic group (please specify)	None	None	
Mixed race	None	None	
Disabled	None	None	There are no positive or negative impacts on any of the protected characteristics.
Gay/Lesbian/ Bi-sexual	None	None	There are no positive or negative impacts on any of the protected characteristics.
Transgender	None	None	There are no positive or negative impacts on any of the protected characteristics.
Younger People (17-25) and children	None		There are no positive or negative impacts on any of the protected characteristics.
Older People (50+)	None	None	There are no positive or negative impacts on any of the protected characteristics.
Faith groups (please specify)	None	None	There are no positive or negative impacts on any of the protected characteristics.

Following completion of the Stage 1 assessment, is Stage 2 (Full Assessment) necessary? □ **Yes** x **No**
Date Completed: 04/05/2018
. . . . . .

Signed by Manager completing the assessment:

Charlotte Banks

Equality Impact Assessment Form

Stage 2 – Full Assessment

Managers Name		**Division**	
What adverse/negative impact(s) were identified in stage one and which group(s) were affected/			
What changes or actions do you propose/recommend to improve the Function, Policy, Practices and Service to eradicate or minimise the negative impacts on the specific groups?			
How do you intend to communicate or consult in relation to the actions and proposals for improvements?			
How will actions and proposals be monitored to ensure their success?		**When is the date of the next review?**	

Date Completed: . . . . . .

Signed by Manager completing the assessment: . . . . . .

Equality Impact Assessment Improvement Plan

As a result of Stage 2 departments must design an Improvement Plan clearly defining and planning the actions and proposals identified above. This must include

- Lead Manager
- Area(s) of negative impact
- Recommendations/amendments proposed
- Action to be taken
- Timescale
- Resource implications

The Shrewsbury and Telford Hospital NHS Trust

Smoking Policy

W21.1

Additionally refer to: W9: Dress Code and Appearance Policy

Version:	V3.2
V2 issued	September 2007
V3.2 approved by	Policy Approval Group and JNCC
V3.2 date approved	
V3.2 Ratified by:	Workforce Committee
V3.2 Date ratified:	
Document Lead	Workforce Director
Lead Director	Workforce Director
Date issued:	September 2007
Review date:	May 2023
Target audience:	All Trust Staff and Visitors

Document Control Sheet

Document Lead/Contact:	Workforce Director
Version	3.2
Status	Final
Date Equality Impact Assessment completed	May 2018
Issue Date	September 2007
Review Date	May 2023
Distribution	Please refer to the intranet version for the latest Version of this policy. **Any printed copies may not necessarily be the most up to date**
Key Words – including abbreviations if these would be reasonably expected to be used as search terms	Smoking / E-cigarettes
Dissemination plan	This document will be disseminated via policy leads and the management cascade using 4policies

Versions History

Version	Date	Author	Status	Comment – include reference to Committee presentations and dates
V2	Sept 07	Head of HR	Final	Approved
V3	Jan 18	Staff Involvement Lead and Staff Side Chair	Draft	Rewritten to new policy format
V3.1	March 18	Staff Involvement Lead and Staff Side Chair	Draft	Following comments from JNCC Policy Group
V3.2	April 18	Staff Involvment Lead	Draft	Following final comments from JNCC Policy Group

Contents

Policy on a Page

- The risk from passive smoking must be eliminated or reduced as far as reasonably possible

- To maintain the Trust's commitment to have a smoke-free site.

- The Trust is a no smoking/e-cigarette organisation except for designated external areas. The use of e-cigarettes are only permitted outside Trust buildings and away from doors and windows.

- Smoking is not permitted in any vehicle parked on Trust property.

- Smoking is only permitted in designated smoking shelters as seen on site map in appendix A

- Designated external smoking areas for the Royal Shrewsbury Hospital include:
    - Copthorne Building entrance, RSH
    - Outside ward block area, RSH
    - Rear of catering department, RSH
    - Outpatients entrance, RSH

- Designated external smoking areas for the Princess Royal Hospital include:
    - External shelter on patient car park opposite main entrance
    - External shelter by rear entrance staff car park

- Visitors must be informed of the Smoking Policy prior to visiting Trust site or as early as possible and signposted as to how they can access support to be smoke-free:

- Useful contacts for visitors and patients
    - Hospital Stop Smoking Nurse PRH: 4464 / Bleep 256
    - Hospital Stop Smoking Nurse RSH: 4464 / Bleep 980
    - Quit Smoking Midwife: 5732 – for Telford & Wrekin patients only
    - Help2Quit (Shropshire Council)
    - Healthy Lifestyles (Telford and Wrekin Council)

- Visitors or patients who persistently fail to adhere to the Smoking Policy will be managed in line with 'Violence and Aggression' policy at the earliest possible opportunity.

    - Staff who infringe this policy will normally be dealt with under the Trust's Disciplinary Policy and Procedures.

- Staff members must not smoke in uniform unless appropriately covered up, in line with the Dress Code and Appearance Policy (W9).

1 Document Statement

1.1 This policy applies to all patients, visitors and staff.

1.2 The Trust is committed to ensuring a healthy and safe environment for the staff it employs and the families that it serves. The Trust recognises that to meet its responsibilities, the risk from passive smoking must be eliminated or reduced as far as reasonably possible. The Trust is also committed to providing a healthy and safe environment for patients and visitors to the Trust through ensuring a smoke-free atmosphere.

1.3 The aim of this document is to provide clear guidance on the restrictions for smoking and the use of e-cigarettes on Trust property in line with the Health Act 2006. It also outlines the assistance that will be offered to individuals who wish to stop smoking.

1.4 In implementing this policy, managers must ensure that all staff are treated fairly and within the provisions and spirit of the Trust's Equality and Diversity Policy (HR01).

2 Overview

2.1 To reduce the impact of smoking and the use of e-cigarettes on patients, visitors and staff.

2.2 To provide guidance on the smoking and e-cigarette restrictions applied to Trust premises.

2.3 To maintain the Trust's commitment to have a smoke-free site.

2.4 To meet statutory requirements. These include:-

- Health Act 2006
- Smoke-free Regulations (Premises and Enforcement) 2006 - Signs, Penalties and Discounted amounts
- Health and Safety at Work Act 1974, to ensure employees, patients, visitors and contractors are not exposed to risks due to smoking, second hand smoke or associated risks of fire
- Workplace (Health, Safety and Welfare) Regulations, to ensure that every employer shall make a suitable and sufficient assessment to the risks to the health and safety of its employees, to which they are exposed whilst at work. Where risks are foreseeable, the employer has a duty to devise measures that provide a safe work place
- The Trust's public health responsibility to improve the health of the local population beyond those who are currently receiving care.

3 Definitions

3.1 The following definitions apply to this document:

Smoking	The inhalation of smoke of burning tobacco encased in cigarettes, pipes, and cigars.
E-cigarette	The term includes a personal vaporizer (PV), and electronic nicotine delivery system (END). The devices are battery operated that mimic

tobacco smoking. They produce vapour, including flavoured aromas either with or without nicotine, rather than traditional smoke.

Staff — The term includes substantive, temporary staff, bank staff, agency staff, locums, volunteers and contractors on site.

Visitors — The term includes all users of services provided by the Trust, members of the public and any other persons who enter Trust premises.

4 Duties

4.1 Trust board

- Oversee the Smoking Policy and set out the Trust's commitment to introduce the arrangements included.

4.2 Managers

- Implement this policy and ensure that all members of staff are aware of their responsibilities, opportunities and restrictions under it as required.
- Report to Human Resources (HR), the Fire Safety Officer and Smoking Cessation Nurse for support and guidance should there be any circumstances of breach of this policy.
- Ensure that staff, patients and visitors are aware of the location of external smoking/e-cigarette areas.
- Ensure that smoking and the use of e-cigarettes are restricted to authorised unpaid breaks in line with agenda for change.
- Ensure that all staff are appropriately trained to discuss the policy, offer support and if necessary challenge anyone who does not comply with the policy.
- All managers/leaders have a responsibility to raise awareness with anyone who is not adhering to the policy.

4.3 Fire Safety Officer/Estates

- To monitor the implementation of this policy through monitoring of Fire Incident Reports and cleaning regimes.
- Ensuring adequate signage of smoking and e-cigarette restrictions at all entrances to Trust smoke-free premises.

4.4 Human Resources

- Provide support and guidance to staff and managers on the implementation and application of this policy.
- Monitor the application of this policy and update it as required.

4.5 Smoking Cessation Team

- To promote the benefits of smoking cessation.
- To provide stop smoking support, advice, education, pharmacotherapy and withdrawal management interventions for all patients that smoke at the Trust, and to refer/signpost patients to community based stop smoking services.
- Support and advise all staff in line with the Trusts smoking cessation standard operating procedures.

4.6 Clinical staff

- Assess and document smoking status as part of clinical assessments.
- Offer smoking cessation referrals to all smokers.
- Ensure Nicotine Replacement Therapy (NRT) is prescribed to all in-patient smokers where appropriate and in accordance with the Trusts prescribing guidelines.

- Advise all planned admissions of the Trust's Smoking Policy and refer/signpost them to the Hospital Stop Smoking Service prior to admission, where appropriate.
- Ensure there is adequate NRT available in wards and departments.

4.7 Staff

- All staff have a responsibility to raise awareness with anyone who is not adhering to the policy, where they feel safe to do so.

5 Application of the policy

5.1 Restrictions

5.1.1 The Trust is a no smoking/e-cigarette organisation except for designated external areas. Smoking is strictly limited to the smoking shelters and smoking bins provided must be used at all times for cigarette waste. A site map can be found in Appendix A, page 11 and 12. The use of e-cigarettes are only permitted outside Trust buildings and away from doors and windows.

5.1.2 Smoking is not permitted in the cycle shelters.

5.1.3 Smoking is not permitted in any vehicle parked on Trust property.

5.1.4 Designated external smoking areas for the Royal Shrewsbury Hospital are:

- Copthorne Building entrance, RSH
- Outside ward block area, RSH
- Rear of catering department, RSH
- Outpatients entrance, RSH

5.1.5 Designated external smoking areas for the Princess Royal Hospital are:

- External shelter on patient car park opposite main entrance
- External shelter by rear entrance staff car park

5.2 Visitors

5.2.1 Visitors must be informed of the Smoking Policy prior to visiting Trust site or as early as possible and signposted as to how they can access support to be smoke-free:

- Hospital Stop Smoking Nurse PRH: 4464 / Bleep 256
- Hospital Stop Smoking Nurse RSH: 4464 / Bleep 980

5.2.2 Persistent failure to adhere to the Smoking Policy will be managed in line with 'Violence and Aggression' policy, or where appropriate be reported to their organisation under their local smoke-free policy.

5.3 Patients

5.3.1 Patients must be informed of the Smoking Policy prior to elective admission, appointment or procedure and advised how to access support to be smoke-free and commence treatment prior to admission. This will be included in appointment letters. Unplanned admissions should be informed of the Smoking Policy as early as possible and offered support to be smoke-free or

offered NRT to treat nicotine withdrawal during their hospital admission where appropriate and in accordance with the Trusts prescribing guidelines:

- Hospital Stop Smoking Nurse PRH: 4464 / Bleep 256
- Hospital Stop Smoking Nurse RSH: 4464 / Bleep 980

5.3.2 All patients should be screened for smoking status and the information to be recorded.

5.3.3 Patients may be escorted to an external smoking/e-cigarette area at the discretion of the Ward Manager. However, agreement must also be reached with the individual undertaking the escort duty. The escort must not smoke or use e-cigarettes during the escort duty.

5.3.4 Persistent failure to adhere to the Smoking Policy will be managed in line with 'Violence and Aggression' policy at the earliest possible opportunity.

5.4 Patients during pregnancy and childbirth

5.4.1 Pregnant women accessing Trust pregnancy and childbirth services should be asked about their smoking status.

5.4.2 Pregnant women accessing the Trust pregnancy and childbirth services should be given verbal or written information about the risks of smoking and exposure to passive smoking to the unborn child, and information about the health benefits of stopping smoking.

5.4.3 Pregnant women accessing trust pregnancy and childbirth services who smoke should be offered referral to specialist stop smoking support:

- Quit Smoking Midwife: 5732 – for Telford & Wrekin patients only.
- Hospital Stop Smoking Nurses for all other patients:
    - PRH: 4464 / Bleep 256
    - RSH: 4464 / Bleep 980

5.5 Staff

5.5.1 Staff members must only smoke or use e-cigarettes on authorised unpaid breaks in line with agenda for change.

5.5.2 Staff members must not smoke in uniform unless appropriately covered up, in line with the Dress Code and Appearance Policy (W9).

5.5.3 Staff may only escort patients to an external smoking/e-cigarette area at the discretion of the Ward Manager. However, agreement must also be reached with the individual undertaking the escort duty. The escort must not smoke or use e-cigarettes during the escort duty.

5.5.4 Staff who infringe this policy will normally be dealt with under the Trust's Disciplinary Policy and Procedures.

5.5.5 The Trust will provide support for smokers who wish to stop smoking. Staff who smoke can access support from the stop smoking service to quit or withdraw from smoking, and may access these services within work time in accordance with the Special Leave Policy (see question 28). These include: -

- Help2Quit (Shropshire Council)
- Healthy Lifestyles (Telford and Wrekin Council)

6 Training needs

6.1 Details of the Smoking Policy will be covered in department induction on entry to the Trust or department.

6.2 There is no mandatory training in relation to this policy.

7 Review process

7.1 The Trust will review this policy every 5 years, unless there are significant changes made to legislation, national policy, or locally.

8 Equality Impact Assessment (EQIA)

This document has been subject to an Equality Impact Assessment. This policy has positive impacts by clearly stating areas where smoking is not allowed and outlining the support for help to quit. Health outcomes are particularly poor in relation to smoking cessation.

9 Process for Monitoring Compliance

Aspect of compliance or effectiveness being monitored	Monitoring method	Responsibility for monitoring (job title)	Frequency of monitoring	Group or Committee that will review the findings and monitor completion of any resulting action plan
Access and uptake to be monitored	**At policy review**	**HR Team**	**On policy review**	**JNCC**

10 References

- The Health Act 2006, Department of Health
- Workplace health, safety and welfare. http://www.hse.gov.uk/pUbns/priced/l24.pdf
- ACAS Guidance on E-cigarettes in the workplace. http://www.acas.org.uk/index.aspx?articleid=4900
- Smoke-free Regulations (Premises and Enforcement) 2006. http://www.legislation.gov.uk/uksi/2006/3368/contents/made
- Health and Safety at Work Act 1974. https://www.legislation.gov.uk/ukpga/1974/37
- NICE Guideline on Quitting Smoking in Pregnancy and following Childbirth. (PH 26), June 2010
- NICE Guidance on Smoking cessation in Secondary care: acute, maternity and mental health services. (PH 48), November 2013
- Smoking Kills – A White Paper on Tobacco https://www.gov.uk/government/publications/a-white-paper-on-tobacco Healthy Lives, Healthy People https://www.gov.uk/government/publications/healthy-lives-healthy-people-our-strategy-for-public-health-in-england
- Schraufnagel et al (2014) Electronic cigarettes: A position statement of the Forum of Internation Respiratory Societies. AJRCCM. 190(6): 611-618. http://www.atsjournals.org/doi/abs/10.1164/rccm.201407-1198PP#VCLV3fldV4

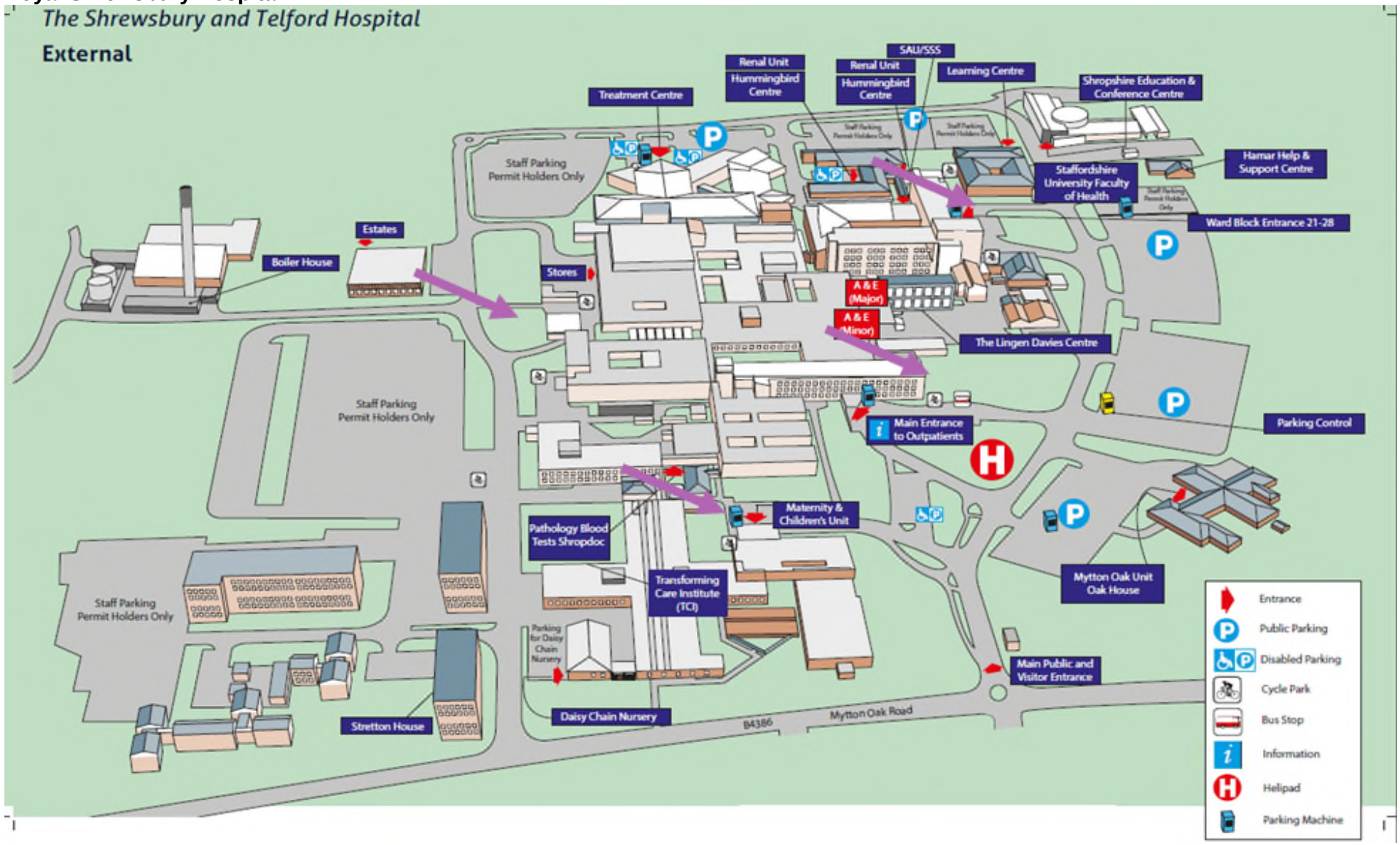
- E-cigarettes: an evidence update,19 August 2015
  https://www.gov.uk/government/publications/e-cigarettes-an-evidence-update

11 Associated documentation

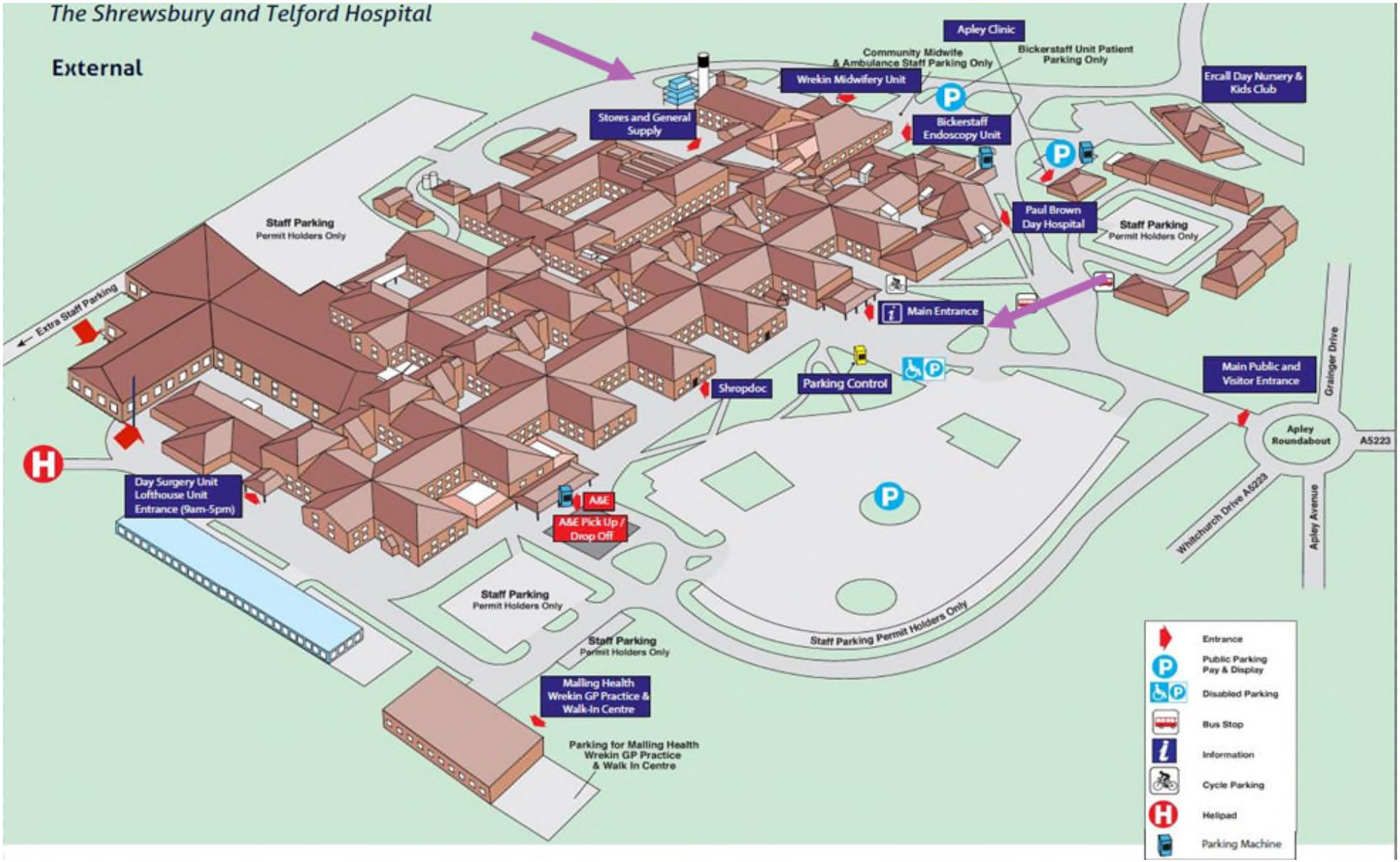
Dress Code and Appearance Policy (W9)

Appendix A: Smoking Shelter Site Map

Royal Shrewsbury Hospital



Princess Royal Hospital



Equality Impact Assessment Form

Stage 1 – Initial Assessment

Managers Name	Nick Dowd	**Division**	Workforce - Human Resources
Function, Policy, Practices, Service	W37 Employee Investigations Policy	**Purpose and Outcomes – intended and differential**	Guidance for managers on arrangements to ensure a fair, consistent and effective approach in carrying out employee investigations.
Implementation Date		**Who does it affect?**	All staff
Consultation Process	Managers, HR, JNCC Policy Group, JNCC, PAG, Trust Board	**Communication and awareness**	Intranet, one minute brief, global email, chatterbox

For completion of the following table please see point 7 in the guidance notes.

Equality Target Group	(a) Positive Impact	(b) Negative Impact	Reason/Comment
Men	None	None	Policy applied consistently regardless of gender. To be reviewed as part of monitoring compliance in section 18 of the policy.
Women	None	None	As above.
Black/Black British	None	None	Policy applied consistently regardless of race. To be reviewed as part of monitoring compliance in section 18 of the policy.
Asian/Asian British	None	None	As above.
Chinese	None	None	As above.
White (including Irish)	None	None	As above.
Other racial/ethnic group (please specify)	None	None	As above.
Mixed race	None	None	As above.
Disabled	None	None	Policy applied consistently regardless of ability/disability.
Gay/Lesbian/Bi-sexual	None	None	Policy applied consistently regardless of sexual preference.
Transgender	None	None	Policy applied consistently regardless of gender. To be reviewed as part of monitoring compliance in section 18 of the policy.
Younger People (17-25) and children	None	None	Policy applied consistently regardless of age. To be reviewed as part of monitoring compliance in section 18 of the policy.
Older People (50+)	None	None	As above
Faith groups (please specify)	None	None	Policy applied consistently regardless of faith group.

Following completion of the Stage 1 assessment, is Stage 2 (Full Assessment) necessary? **No**

Date Completed: **23/11/17**

Manager completing the assessment: **Nick Dowd – HR Advisory Team Manager**

The Shrewsbury and Telford Hospital NHS Trust

Employee Investigations Policy

HR37

Additionally refer to:

- W7 Disciplinary Policy
- W10 Employee Performance Management Policy & Procedure
- HR07 Disciplinary Policy for Doctors and Dentists
- HR31 Managing Attendance & Employee Wellbeing
- HR45 Dignity at Work Policy
- CG04 Serious Incident Policy
- CG05 Reporting and Investigation of incidents, Complaints and Claims
- CG07 Concerns and Complaints
- CG17 Guidelines for Managers and Employees on the management of individuals involved in adverse events
- NHSI Just Culture Guide

Version:	V1
V1 issued	May 2018
V1 approved by	JNCC
V1 date approved	May 2018
V1 Ratified by:	Trust Board
V1 Date ratified:	July 2018
Document Lead	HR Advisory Team Manager
Lead Director	Workforce Director
Date issued:	May 2018
Review date:	May 2023
Target audience:	All Trust Employees

Version Control Sheet

Document Lead/Contact:	HR Advisory Team Manager nick.dowd@sath.nhs.uk
Document ID	W37
Version	1
Status	In Consultation
Date Equality Impact Assessment completed	May 2018
Issue Date	May 2018
Review Date	May 2023
Distribution	Please refer to the intranet version for the latest version of this policy. **Any printed copies may not necessarily be the most up to date**
Key Words	Investigation, Disciplinary, Dignity at Work, Performance Management, Grievance, Whistleblowing
Dissemination	One Minute Brief, Chatterbox

Version history

Version	Date	Author	Status	Comment
1	Nov 2017	Nick Dowd (HR Advisory Team Manager)	Draft	Discussed at JNCC Policy Group November 2017 to July 2018.

Contents

1 Policy on a Page

- This policy is in-line with ACAS Code of Practice on Disciplinary and Grievance Procedures
- Intended for all staff. For Medical and Dental staff there is also the Trust's Disciplinary Policy for Doctors and Dentists (HR07)
- Policy can be used for a variety of situations and concerns
- Employees subject to investigation must be updated monthly and advised on all information that is shared about them. They can also request to view their personal file and have a support member with them in meetings.

Process

- Commissioning Manager appoints an Investigating Officer
- Commissioning Manager shares all information gathered so far to Investigating Officer.
- Investigating Officer attempts to gather all relevant information.
- Investigating Officer consults with HR Advisory Team and Commissioning Manager and presents findings in a report.
- Commissioning Manager reviews report and decides on action. Informs all relevant members of staff.

2 Document Statement

This policy sets out arrangements to ensure a fair, consistent and effective approach in dealing with employee investigations. The process is designed to ensure a full and thorough investigation takes place to meet the guidance of the ACAS Code of Practice on Disciplinary and Grievance Procedures and to allow appropriate management decisions to be made.

The Trust recognises that investigations may be difficult for those involved and is committed to working with staff and their representatives to provide adequate support throughout the process.

3 Overview

This policy applies to all employees of the Trust. However, for investigations relating to the conduct/capability of Doctors and Dentists, there are additional requirements as stipulated by the Maintaining High Professional Standards in the NHS (MHPS) which are outlined in the Trust's Disciplinary Policy for Doctors and Dentists (HR07). Any investigations relating to the conduct/capability of Doctors and Dentists must comply with HR07 and MHPS.

This policy may be used in a variety of circumstances which include (but are not limited to):

Allegations relating to employee conduct or behaviours
Concerns raised under the Trust's Dignity at Work Policy
Gathering information to determine the outcome of a Grievance
Gathering information in relation to whistleblowing concerns

Where an incident/complaint forms part of the Clinical Governance processes within the Trust, an investigation under this policy may run in parallel where appropriate. Reference should be made to the Trusts Clinical Governance guidelines and policies for supporting staff when adverse events, incidents or complaints are received.

4 Responsibilities

4.1 Trust Board

The Board has responsibility to oversee this policy and ensure that appropriate processes and actions are in place to ensure employees are treated in a fair and consistent manner.

4.2 Directors/COO/Assistant COO

Are responsible for ensuring appropriate systems and processes are in place across their Care Groups and Departments to disseminate shared learning from investigations, assisting the appointment of investigating officers and ensuring that these matters are dealt with in a timely manner and in accordance with this policy.

4.3 Line Managers

Line Managers are responsible for ensuring employees are aware of this policy and its contents and for supporting employees if they are required to participate in an investigation. This includes ensuring that employees are given appropriate paid time to take part in an investigation in a timely manner and making referrals to the Occupational Health and Staff Counselling Services where appropriate.

4.4 Commissioning Managers

The commissioning manager will normally be a senior manager within the relevant Care Group. However, they must be independent of the issue.

At the start of an investigation Commissioning Managers are responsible for setting out the terms of reference for the investigation and appointing an appropriate Investigating Officer and administrative support.

The Commissioning Manager then has oversight on the progress of the investigation to ensure it is completed in accordance with this policy and in a fair, consistent and timely manner. This is normally achieved through a case review which should take place at least monthly during the investigation.

The Commissioning Manager must also ensure the employee(s) being investigated is updated on the progress of the investigation on a monthly basis.

At the conclusion of the investigation the Commissioning Manager will review the findings and make a decision on appropriate action in accordance with the relevant Trust policy.

4.5 Investigating Officers

Investigating Officers are responsible for carrying out investigations in accordance with this policy and in a fair, consistent and timely manner. Appropriate training and/or support will be provided by the HR Advisory Team.

Their role is to establish the facts of the case and to present these to the Commissioning Manager, it is not to make any recommendations or judgments.

Investigating officers must be independent of the issue and if the allegations relate to a professional issue they must have an appropriate level of knowledge to conduct the investigation.

4.6 Workforce Directorate

The HR Advisory Team will provide support and guidance to the process to ensure a fair and consistent process is followed, in accordance with ACAS guidance, and to assist in the timely completion of investigations. In exceptional circumstances this may include assisting the Investigating Officer in compiling their investigation report. The report remains the responsibility of the Investigating Officer who must have final sign off of the completed report.

4.7 All Staff

Employees are required to participate fully in employee investigations, in a timely and constructive manner, whether this concerns them personally or a work colleague. Adequate paid time off will be provided. Employees are always expected to provide full and honest evidence.

All matters relating to investigations are considered strictly private and confidential. Employees should not discuss the details of the investigation with anyone, with the exception of their representative/colleague, the Investigating Officer, the Commissioning Manager and members of the HR Advisory Team. Failing to maintain confidentiality may result in disciplinary action.

Where an employee wishes to be accompanied or represented (in accordance with section 4) they will be responsible for contacting their support and arranging their attendance at meetings.

4.8 Trade Unions

The role of the Trade Union/Professional organisation representative (TUPO) is to act as an advocate and representative for the employee and to provide the employee with advice and support. They may also be asked to assist in sharing any learning that comes from investigations.

4.9 Trust Employed Work Colleague

The role of the Trust Employed Work Colleague is to provide the employee with support. They may also take part in relevant meetings and speak on behalf of the employee with their permission.

5 Employee representation

At any formal meeting relating to an investigation, an employee has the right to be represented, if they wish, by either a representative from a recognised TUPO or a Trust employed work colleague. The representative/colleague cannot be someone who is involved in the investigation.

The Trust will facilitate time off for TUPOs and workplace colleagues acting as support to the employee.

It is strongly advised by the Trust and Staff Side Representatives that employees seek the advice and support of their TUPOs when involved in investigations.

6 The Investigation Process

6.1 Commissioning an Investigation

6.1.1 Prior to commissioning an investigation advice must be sought from the HR Advisory Team.

6.1.2 The Commissioning Manager must have enough information to be assured that a formal investigation is appropriate in the circumstances. This may include documentation and written statements from those involved. The decision should not be taken lightly as it may have a significant negative affect on those involved and can be a costly and time consuming process.

6.1.3 At the start of each investigation, the Commissioning Manager will specify the terms of reference for the investigation and provide this to the appointed Investigating Officer along with any relevant documentation already gathered. Where the investigation involves a specific professional issue, an appropriately qualified person should be appointed as the Investigating Officer, or as a specialist advisor to the Investigating Officer.

6.1.4 The Commissioning Manager will also notify the employee(s) of the scope of the investigation and the name of the Investigating Officer at the earliest opportunity and given sufficient details to enable them to respond.

6.1.5 Where there are justifiable reasons for doing so, an individual may request that an alternative Commissioning Manager and/or Investigating Officer is appointed before the investigation is started. Such a request will be considered by a suitable alternative manager and clear reasons given if the request is refused.

6.1.6 The Commissioning Manager will review the necessary employee personal files and provide any relevant information to the Investigating Officer. The employee should be informed of any information that is shared. Employees may request to review their personal file with the Line Manager.

6.1.7 In some circumstances the Commissioning Manager may benefit from referring to the NHSI Just Culture Guide when making a decision to commission an investigation.

6.1.8 Where the investigation relates to the actions of an accredited Trade Union representative no formal investigation shall be commenced until the circumstances of the case have been discussed with a fulltime officer of the organisation concerned

6.1.9 Where there is a reasonable suspicion that fraud or corruption may have occurred, the Commissioning Manager or HR Advisory Team must immediately notify the Local Counter Fraud Specialist (LCFS), Finance Director or the NHS Counter Fraud Authority. Where the initial assessment indicates that other criminal offences may have been committed, these matters should be discussed with the appropriate senior manager and reported to the Police.

6.2 The Investigation

6.2.1 Investigating Officers should always read this policy prior to an investigation and seek advice from the HR Advisory Team. Appropriate training/support will be provided.

6.2.2 All individuals involved in the investigation will have the opportunity to receive support from the Trust's Occupational Health Department and Staff Counselling service. It is the responsibility of the Investigating Officer, in conjunction with the employee's line manager, to ensure all those involved in the investigation have appropriate support.

6.2.3 The Investigating Officer will undertake a detailed and thorough investigation by attempting to gather all relevant evidence. This is usually through formal interviews and review of documentation but may extend to other methods (e.g. CCTV). The Investigating Officer will decide who they need to interview and what evidence they need to gather in consultation with the HR Advisory Team, the Commissioning Manager and the appointed specialist advisor (if one has been appointed).

6.2.4 Prior to an investigation interview, the Investigating Officer will write to the employee outlining what will be discussed, providing sufficient information to allow them to respond at interview. There is no requirement for the Investigating Officer to provide a list of questions in advance of the interview.

6.2.5 All individuals who are formally interviewed must be offered the opportunity to be accompanied to their interview in accordance with section 4 of this policy. This companion may (with the employee's permission) speak on the employee's behalf but cannot answer questions for them.

6.2.6 Reasonable notice of meetings will be given (normally 7 calendar days). If it is necessary to postpone any interview due to the availability of the employee or their representative/colleague another date will be arranged by the Trust, ideally within 5 working days of the original date. All parties must work together to find a suitable date within a reasonable time frame. The Investigating Officer should raise any concerns about delays with the Commissioning Manager.

6.2.7 Formal interviews will be digitally or manually recorded. Consent must be gained from all those taking part for digital audio recording to take place. After the meeting the Investigating Officer should check the accuracy of the minutes before providing a copy to the individual concerned and their representative/colleague if the employee consents to this. Individuals will then be given an opportunity to review the minutes and make any comments as needed.

6.2.8 Interviews will take place in person. However, at the discretion of the Investigating Officer and with the agreement of the individual there may be occasions where evidence is gathered via other means (e.g. telephone interviews, questions in writing).

6.2.9 In extreme and exceptional circumstances the evidence of a witness may be anonymised and the witness will not be required to attend relevant meetings where this is seen as necessary to protect the witness. This must be determined by the Investigating Officer in consultation with the HR Advisory Team and Commissioning Manager.

6.2.10 Personal data gathered by, or released to, the Investigating Officer must be held securely and its use limited to the matter under investigation. The Trust will operate consistently with the guiding principles of the General Data Protection Regulations (GDPR).

6.2.11 In accordance with GDPR any evidence provided by employees during the investigation may be retained within their personal file and/or stored securely (electronically or hard copy) by the HR Advisory Team. If the evidence contains sensitive personal data, employees may request that this is deleted or returned to them at the end of the process. The HR department will confirm in writing when this has been completed.

6.2.12 During the investigation, dependant on the information gathered, the Terms of Reference may be changed or added to. It is important that the Investigating Officer provides the Commissioning Manager with an update on progress on at least a monthly basis. The Commissioning Manager must then update the employee on a monthly basis.

6.2.13 The findings of the investigation should be documented in a report with accompanying appendices and provided to the Commissioning Manager. Templates and guidance will be provided by the HR Advisory Team.

6.2.14 All patient identifiable data in documents **must** be anonymised or pseudonymised in the investigation report and appendices.

6.2.15 Where an employee under investigation leaves the employment of the Trust before the investigation has been concluded, where appropriate the process will be completed and a record of the outcome put in writing to them. Completing the process will enable the Trust to make a judgment on what further action is appropriate. Any finding may also be reflected in any future work or professional reference.

6.2.16 With the consent of the individual, evidence may be shared with the Trust's Patient Advice and Liaison Service (PALS) where the investigation is linked to a complaint. See Concerns and Complaints Policy (CG07) for any investigations linked to patient/relative complaints. The Trust may also be required to share evidence with the police if requested to do so.

6.3 <u>After the Investigation</u>

When the findings of the investigation have been received and reviewed, the Commissioning Manager will decide what action is appropriate and notify the relevant employee(s). There are many possible circumstances and outcomes which cannot all be described here, however some of the possible outcomes to an investigation may include:

- No further formal action is required.
- Local department learning, updates to policies, SOP's etc.
- Action in accordance with the Trust's Disciplinary Policy (W7) where the investigation relates to an employee's conduct or behaviour.
- Management in accordance with the Trust's Managing Attendance and Employee Wellbeing Policy (HR31) where the findings indicate a health issue.
- Management in accordance with the Trust's Employee Performance Management Policy (W10) where the findings indicate a performance issue.

7 Training needs

The Trust acknowledges the importance of training for managers involved in the application of this policy and will therefore ensure that appropriate training and support is available from the Workforce Directorate.

Any manager commissioning or undertaking an investigation must receive appropriate training/support from the HR Advisory Team before and during the process.

All managers are expected to disseminate information in relation to this policy to staff. Any staff involved in investigations will be directed towards this policy.

8 Review process

This policy will be reviewed as and when required. The monitoring of this policy includes an annual audit that comprises of the following table. Where non-compliance is identified an action plan will be drawn up and monitored at the Workforce Committee. Where remedial action can be taken immediately, the action must be recorded appropriately.

9 Equality Impact Assessment (EqIA)

This policy applies to all employees equally and does not discriminate positively or negatively between protected characteristics.

10 Process for monitoring compliance

Aspect of compliance or effectiveness being monitored	Monitoring method	Responsibility for monitoring (job title)	Frequency of monitoring	Group or Committee that will review the findings and monitor completion of any resulting action plan
The policy is fairly applied to staff in a transparent and consistent manner	Use of workforce database to review cases by protected characteristics under the Equality Act 2010.	HR Advisory Team Manager	Yearly	Workforce committee
Number of cases being referred to HR Advisors/Managers for support	Use of workforce database	HR Advisory Team Manager	Yearly	Workforce committee
Number of investigations that result in no case to answer	Use of workforce database	HR Advisory Team Manager	Yearly	Workforce committee

11 References

- Legislation
  - Employment Act 2008
  - Employment Tribunals (Constitution and Rules of Procedure) (Amendment) Regulations 2008
  - Employment Rights Act 1996 as amended
  - Employment Rights Dispute Resolution Act 1998
  - Employment Relations Act 1999
  - Employment Rights Act 2004.

  - Previous legislation covering discipline and grievances at work was historically found in the Employment Act 2002 and the Employment Act 2002 (Dispute Resolution) Regulations 2004 (SI 2004/752). However, the procedures were repealed in their entirety from 6 April 2009 under the Employment Act 2008)

- ACAS – Code of Practice for Disciplinary and Grievance Procedures - http://www.acas.org.uk/media/pdf/k/b/Acas_Code_of_Practice_1_on_disciplinary_and_grievance_procedures-accessible-version-Jul-2012.pdf

12 Associated Documentation

- NHSI Just Culture Guide

Available:

- W7 Disciplinary Policy
- W10 Employee Performance Management Policy & Procedure
- HR01 Equality and Diversity Policy.
- HR07 Disciplinary Policy for Doctors and Dentists
- HR09 Alcohol and Substance Misuse.
- HR31 Managing Attendance & Employee Wellbeing
- HR45 Dignity at Work Policy
- HR65 Occupational Health Service
- HR66 Staff Counselling Service.

All the above are available from:

Internal - http://intranet/hr/HR_Policies.asp

External - https://www.sath.nhs.uk/working-with-us/hr/policies/

- CG04 Serious Incident Policy
- CG05 Reporting and Investigation of incidents, Complaints and Claims
- CG07 Concerns and Complaints
- CG17 Guidelines for Managers and Employees on the management of individuals involved in adverse events

Available from http://intranet/document_library

Equality Impact Assessment Form - Stage 1 – Initial Assessment

Managers Name	Helen Sendles	**Division**	Workforce
Function, Policy, Practices, Service	Freedom to Speak Up Policy	**Purpose and Outcomes – intended and differential**	The policy outlines the Trust arrangements for staff to be able to raise concerns safely. There are no unintended consequences identified.
Implementation Date	tbc	**Who does it affect?**	Staff, patients and service users
Consultation Process	PSAG, JNCC, Workforce Committee and Trust Board ratification	**Communication and awareness**	Staff newsletter, HR pages on intranet, Freedom to Speak up (FTSU) Guardians, Values Guardians.

For completion of the following table please see point 7 in the guidance notes.

Equality Target Group	(a) Positive Impact	(b) Negative Impact	Reason/Comment
Men	None	None	The policy provides transparent arrangements for staff to be able to escalate concerns. This includes, but is not restricted to, disclosures which can be legally defined as 'protected disclosures'. It outlines the support available to staff who wish to raise concerns in good faith for the benefit of patients and colleagues. By making it easier for staff to raise concerns in a safe and supported manner, the policyis anticipated to have a low positive impact on older people and people with disabilities who form the majority of service users.
Women	None	None	
Black/Black British	None	None	
Asian/Asian British	None	None	
Chinese	None	None	
White (including Irish)	None	None	
Other racial/ethnic group (please specify)	None	None	
Mixed race	None	None	
Disabled	Low	None	
Gay/Lesbian/ Bi-sexual	None	None	
Transgender	None	None	
Younger People (17-25) and children	None		
Older People (50+)	Low	None	
Faith groups (please specify)	None	None	

Following completion of the Stage 1 assessment, is Stage 2 (Full Assessment) Necessary? □ **No**

Date Completed: 22nd August 2018

Signed by Manager completing the assessment:

Helen Sendles (with support from Mary Beales)

The Shrewsbury and Telford Hospital NHS Trust

Freedom to Speak Up: Raising Concerns (Whistleblowing)

HR05

Additionally refer to:

HR01 Equality and Diversity
HR16 Grievance Policy
HR36 Disciplinary Policy
HR45 Dignity at Work
HR58 Fraud and Corruption
W37 Employee Investigations Policy
Managing Conflicts of Interest in the NHS
NHS Constitution
Safeguarding Children Policy
Safeguarding Adults Policy
NHS Prevent Strategy

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V1 issued	October 2005
V5 approved by	TNCC
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V5 ratified by	Trust Board
V5 date ratified	
Document Lead	Workforce Director
Date issued:	
Review date:	July 2023
Target audience:	All staff, managers

Document Control Sheet

Document Lead/Contact:	Victoria Maher, Workforce Director Victoria.maher@sath.nhs.uk
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Issue Date	
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Distribution	Please refer to the intranet version for the latest version of this policy. **Any printed copies may not necessarily be the most up to date**
Key Words – including abbreviations if these would be reasonably expected to be used as search terms	Whistleblowing; fraud; prevent strategy; freedom to speak up, FTSU guardians, FTSU
Dissemination plan	Staff newsletter, HR pages on intranet, Freedom to Speak up (FTSU) Guardians, Values Guardians.

Version history

Version	Date	Author	Status	Comment – include reference to Committee presentations and dates
V1			Final	
V2			Final	
V3			Final	
V4.0	January 2012		Draft	Amendment to sections 8.4, 9.1 and Appendix A
V4.1	February 2012		Draft	Amendment to format to comply with NHSLA standards Contact details updated
V4.2	March 2012		Final	Minor amendments Inclusion of NHS National Prevent Strategy
V5	July 2018		Final	Amended to reflect National Freedom to Speak Up guidance.

Policy on a Page

- This policy outlines the process that staff can follow to raise concerns.
- The policy illustrates the avenues available to raise concerns. These include line management, workforce team, Freedom to Speak Up Guardians, Trade Union Representative and Non-Executive Directors
- In addition the external avenues are explained.
- Staff are fully supported to raise concerns

Contents **Page**

1 Freedom to speak up Vision

1.1 Based on the national vision as defined by the Francis review (2015) (appendix B). The Trust is committed to:

- Creating a culture of openness and transparency
- Creating a culture where speaking up and raising concerns are everyday business
- Ensuring that there are no repercussions for those that raise concerns
- Ensuring that the Trust is a safe and kind place to work

2 Our commitment: Speak up – we will listen

2.1 Speaking up about any concern you have at work is really important. In fact, it's vital because it will help us to keep improving our services for all patients and how it feels to work here.

2.2 In raising a concern you may feel worried, and we understand this. However it is really important that you raise your concerns and we will support you to do so. The Board and senior leaders are committed to a safe, open and values based culture. We will always look into what you say and you will always have access to the support you need.

3 Policy Statement

3.1 This 'standard integrated policy' was one of a number of recommendations of the review by Sir Robert Francis into whistleblowing in the NHS, aimed at improving the experience of whistleblowing in the NHS. It has been produced in accordance with NHSI and NHSE guidance, feedback from our people, learning from concerns that have been raised previously and best practice.

3.2 This policy applies to all staff employed by the Trust, including those employed via the Temporary Staffing Department, agency staff, external secondees temporarily working with the Trust, or other individuals who are not directly employed by the Trust.

3.3 In implementing this policy, managers must ensure that all staff are treated fairly and within the provisions and spirit of the Trusts Equality & Diversity policy, (HR01). Special attention should be paid to ensuring the policy is understood when using it for staff new to the NHS or Trust, by staff whose literacy or use of English is weak or for persons with little experience of working life.

4 What concerns can I raise?

4.1 You can raise a concern about **risk, malpractice, worry or wrongdoing** you think is harming the service we deliver. Just a few examples of this might include (but are by no means restricted to):

- unsafe patient care
- unsafe or inappropriate staff experience
- unsafe working conditions
- inadequate induction or training for staff
- lack of, or poor, response to a reported patient safety incident
- suspicions of fraud (which can also be reported to our local counter-fraud team on Telephone: 0121 695 5539)
- a bullying culture
- Adult or child safeguarding concerns contact via trust leads

For further examples of concerns, please see the Health Education England video [https://www.youtube.com/watch?v=zjau1Ey0di8]

4.2 We all have a responsibility to raise concerns, as this is how we will develop the culture we want to have in the organisation. Remember that if you are a registered professional you may have a professional duty to report a concern. **If in doubt, please raise it.**

4.3 Don't wait for proof. We would like you to raise the matter while it is still a concern. It doesn't matter if you turn out to be mistaken as long as you are genuinely troubled.

4.4 Where an employee has a concern about their employment that affects only them, the concern may be better suited to our Grievance or Dignity at Work policies and advice should be sought from the HR advisory team.

4.5 If the matter is raised under this policy we may decide that your concern would be better looked at under another process: for example, our process for dealing with bullying and harassment. If so, we will discuss that with you. If your concern suggests a Serious Incident has occurred, an investigation will be carried out in accordance with the Serious Incident Framework.

4.6 Any employment issues (that affect only you and not others) identified during the investigation will be considered separately.

5 Feel safe to raise your concern

5.1 If you raise a genuine concern under this policy, you will not be at risk of losing your job or suffering any form of reprisal as a result. We will not tolerate the harassment or victimisation of anyone raising a concern. Nor will we tolerate any attempt to bully you into not raising any such concern. Any such behaviour is a breach of our values as an organisation and, if upheld following investigation, could result in disciplinary action.

5.2 Provided you are acting honestly, it does not matter if you are mistaken or if there is an innocent explanation for your concerns.

6 Confidentiality

6.1 We hope you will feel comfortable raising your concern openly, but we also appreciate that you may want to raise it confidentially. This means that while you are willing for your identity to be known to the person you report your concern to, you do not want anyone else to know your identity. Therefore, we will keep your identity confidential, if that is what you want, unless required to disclose it by law (for example, by the police). You can choose to raise your concern anonymously, without giving anyone your name, but that may make it more difficult for us to investigate thoroughly and give you feedback on the outcome.

7 Who can raise concerns?

7.1 Anyone who works (or has worked) in the NHS, or for an independent organisation that provides NHS services can raise concerns. This includes agency workers, temporary workers, students and volunteers.

8 Who should I raise my concern with?

8.1 In many circumstances the easiest way to get your concern resolved will be to raise it formally or informally with your line manager (or lead clinician or tutor). Appendix A contains more information about raising information formally or informally.

8.2 Where you don't think it is appropriate to do this, you can use any of the options set out below in the first instance.

8.3 If raising it with your line manager (or lead clinician or tutor) does not resolve matters, or you do not feel able to raise it with them, you can contact one of the following people:

- Our Freedom to Speak Up Guardians on 07773 976983 or 07773976980. This is an important role identified in the Freedom to Speak Up review to act as an independent and impartial source of advice to staff at any stage of raising a concern, with access to anyone in the organisation, including the chief executive, or if necessary, outside the organisation

8.4 If you still remain concerned after this, you can contact:

- Our executive director with responsibility for whistleblowing our Workforce Director, *01743 261609.*
- Our non-executive director with responsibility for whistleblowing, 07849 080026.
- Your Trade union representative.

8.5 All these people have been trained in receiving concerns and will give you information about where you can go for more support.

8.6 If for any reason you do not feel comfortable raising your concern internally, you can raise concerns with external bodies, listed on page 7.

9 Advice and support

9.1 Details on the local support available to you can be found on the intranet. However, you can also contact the Whistleblowing Helpline for the NHS and social care, your professional body or trade union representative.

10 How should I raise my concern?

10.1 You can raise your concerns with any of the people listed above in person, by phone or in writing (including email).

10.2 Whichever route you choose, please be ready to explain as fully as you can the information and circumstances that gave rise to your concern.

11 What will we do?

11.1 We are committed to the principles of the Freedom to Speak Up review and its vision for raising concerns, and will respond in line with them (see Appendix B).

11.2 We are committed to listening to our staff, learning lessons and improving patient care. On receipt of a concern this will be raised with the Freedom to Speak up Guardians who will record the concern and you will receive an acknowledgement within two working days. The central record will record the date the concern was received, whether you have requested confidentiality, a summary of the concerns and dates when we have given you updates or feedback.

12 Investigation

12.1 Where you have been unable to resolve the matter quickly (usually within a few days) with your line manager, we will carry out a proportionate investigation using Trust policies where appropriate and using someone suitably independent (usually from a different part of the organisation) and properly trained – and we will reach a conclusion within a reasonable timescale (which we will notify you of). Wherever possible we will carry out a single investigation (so, for example, where a concern is raised about a patient safety incident, we will usually undertake a single investigation that looks at your concern and the wider circumstances of the incident). The investigation will be objective and evidence-based, and will produce a report that focuses on identifying and rectifying any issues, and learning lessons to prevent problems recurring.

12.4 If a concern is found to have been raised when the individual has knowingly done so in a malicious or vexatious manner, the individual raising it may be subject to disciplinary action in line with the Trust Disciplinary Policy.

13 Communicating with you

We will treat you with respect at all times and will thank you for raising your concerns. We will discuss your concerns with you to ensure we understand exactly what you are worried about. We will tell you how long we expect the investigation to take and keep you up to date with its progress. Wherever possible, we will share the full investigation report with you (while respecting the confidentiality of others).

14 How will we learn from your concern?

The focus of the investigation will be on improving the service we provide for patients. Where it identifies improvements that can be made, we will track them to ensure necessary changes are made, and are working effectively. Lessons will be shared with teams across the organisation, or more widely, as appropriate.

15 Board oversight

The board will be given high level information about all concerns raised by our staff through this policy and what we are doing to address any problems. We will include similar high level information in our annual report. The board supports staff raising concerns and wants you to feel free to speak up.

16 Raising your concern with an outside body

16.1 Alternatively, you can raise your concern outside the organisation with:

- NHS Improvement for concerns about:

    - how NHS trusts and foundation trusts are being run
    - other providers with an NHS provider licence
    - NHS procurement, choice and competition
    - the national tariff
- Care Quality Commission for quality and safety concerns
- NHS England for concerns about:
    - primary medical services (general practice)
    - primary dental services
    - primary ophthalmic services
    - local pharmaceutical services
- Health Education England for education and training in the NHS
- NHS Protect for concerns about fraud and corruption.
- Accredited NHS Trade Unions for individual staff who wish to seek advice and be represented by a Trade Union when using the provisions of this policy.

17 Making a protected disclosure

If you bring information about a wrongdoing to our attention (or to the attention of an organisation listed above), you are protected in certain circumstances under the Public Interest Disclosure Act 1998.*

This is commonly referred to as 'blowing the whistle'. The law that protects whistle-blowers is for the public interest - so people can speak out if they find malpractice in an organisation. Blowing the whistle is more formally known as 'making a disclosure in the public interest'.

There are very specific criteria that need to be met for an individual to be covered by whistleblowing law when they raise a concern (to be able to claim the protection that accompanies it). There is also a defined list of 'prescribed persons', similar to the list of outside bodies on page 7, who you can make a protected disclosure to. To help you consider whether you might meet these criteria, please seek independent advice from the Whistleblowing Helpline for the NHS and social care, Public Concern at Work or a legal representative.

For a disclosure to be protected by the Act's provisions it must relate to matters that 'qualify' for protection under the Act. Qualifying disclosures are disclosures which the worker reasonably believes tends to show that one or more of the following matters is either happening now, took place in the past, or is likely to happen in the future:

- *A criminal offence*
- *The breach of a legal obligation*
- *A miscarriage of justice*
- *A danger to the health and safety of any individual*
- *Damage to the environment*
- *Deliberate concealment of information tending to show any of the above five matters*

A qualifying disclosure to the commission will be a 'protected' disclosure provided the worker:

- Makes the disclosure in good faith
- Reasonably believes that the relevant failure relates to 'the proper administration of charities and funds given, or held, for charitable purposes'
- Reasonably believes that the information disclosed and any allegation contained in it are substantially true.

18 National Guardian Freedom to Speak Up

The National Guardian can independently review how staff have been treated having raised concerns where NHS trusts and foundation trusts may have failed to follow good practice, working with some of the bodies listed above to take action where needed.

19 Training

There is no mandatory training associated with this guidance. If staff have queries about its operation, they should contact their line manager in the first instance.

20 Process for monitoring compliance with the effectiveness of this policy

We will review the effectiveness of this policy and local process at least annually, with the outcome published and changes made as appropriate.

Aspect of compliance or effectiveness being monitored	Monitoring method	Responsibility for monitoring (job title)	Frequency of monitoring	Group or Committee that will review the findings and monitor completion of any resulting action plan
Reporting and response	Reports	Freedom to speak up Guardians	6-monthly	Trust Board
Feedback	Verbal	Workforce Director	Quarterly	Workforce Committee
Concerns response reports	Annual report	Workforce Director	Annual	Audit Committee

21 Equality Impact Assessment

This document has been subject to an Equality Impact Assessment and is anticipated to have a low positive impact on older people and people with disabilities.

22 Standards of Business Conduct

The Trust follows good NHS Business practice as outlined in the Code of Conduct and HR52 Standards of Business Conduct and has robust controls in place to prevent bribery. Due consideration has been given to the Bribery Act 2010 in the review of this policy document and no specific risks were identified.

23 Review arrangements

This document will be reviewed in 5 years of approval date, or sooner if required. The document will be reviewed in light of feedback and learning from any adverse incidents. In order that this document remains current, any of the appendices to the policy can be amended and approved during the lifetime of the policy without the document having to return to the ratifying committee.

24 References / bibliography

NHSI https://improvement.nhs.uk/
Francis Report www.gov.uk
PIDA www.legislation.gov.uk

Appendix A: Example process for raising and escalating a concern

Step one

If you have a concern about a risk, malpractice or wrongdoing at work, we hope you will feel able to raise it first with your line manager, lead clinician or tutor (for students). This may be done orally or in writing.

Step two

If you feel unable to raise the matter with your line manager, lead clinician or tutor, for whatever reason, please raise the matter with our local Freedom to Speak up Guardians:

This person has been given special responsibility and training in dealing with whistleblowing concerns. They will:

- treat your concern confidentially unless otherwise agreed
- ensure you receive timely support to progress your concern
- escalate to the board any indications that you are being subjected to detriment for raising your concern
- remind the organisation of the need to give you timely feedback on how your concern is being dealt with
- ensure you have access to personal support since raising your concern may be stressful.

If you want to raise the matter in confidence, please say so at the outset so that appropriate arrangements can be made.

Step three

If these channels have been followed and you still have concerns, or if you feel that the matter is so serious that you cannot discuss it with any of the above, please contact *[chief executive, medical director, responsible officer, nursing director, nominated non- executive director].*

Step four

You can raise concerns formally with external bodies *[relevant list of prescribed bodies to be provided, similar to that on page 8].*

Appendix B: A vision for raising concerns in the NHS

Source: Sir Robert Francis QC (2015) *Freedom to Speak Up: an independent report into creating an open and honest reporting culture in the NHS.*

Equality Impact Assessment Form - Stage 1 – Initial Assessment

Managers Name	Sam Hooper	**Division**	Medical Directorate
Function, Policy, Practices, Service	Medical Job Planning Policy	**Purpose and Outcomes – intended and differential**	To provide a clear outline of the requirements of job planning and to provide consistency and transparency of both the job plan and the process
Implementation Date	01.07.2018	**Who does it affect?**	Consultants and SAS doctors
Consultation Process	Via LNC and PAG and distributed to all relevant stakeholders	**Communication and awareness**	Notification will be communicated to all relevant staff members.

For completion of the following table please see point 7 in the guidance notes.

Equality Target Group	(a) Positive Impact	(b) Negative Impact	Reason/Comment
Men	Yes	None	Postive impact by showing a transparent and equitable process for all Senior Medical Staff, Consutlants and SAS doctors.
Women	Yes	None	
Black/Black British	Yes	None	
Asian/Asian British	Yes	None	
Chinese	Yes	None	
White (including Irish)	Yes	None	
Other racial/ethnic group (please specify)	Yes	None	
Mixed race	Yes	None	
Disabled	Yes	None	
Gay/Lesbian/ Bi-sexual	Yes	None	
Transgender	Yes	None	
Younger People (17-25) and children	Yes		
Older People (50+)	Yes	None	
Faith groups (please specify)	Yes	None	

Following completion of the Stage 1 assessment, is Stage 2 (Full Assessment) necessary? □ **Yes** x **No**

Date Completed: . . . . . 19.6.2018. . . . . .

Signed by Manager completing the assessment:

S M Hooper

The Shrewsbury and Telford Hospital NHS Trust

Medical Staff Job Planning

HR71

Additionally refer to: National Terms and Conditions

Managing Conflicts of Interest in the NHS

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V2 approved by	Policy Approval Group
V2 date approved	July 2018
V2 ratified by:	Trust Board
V2 Date ratified:	
Document Lead	Medical Performance Manager
Lead Director	Director of Workforce in conjunction with Medical Director
Date issued:	
Review date:	July 2023
Target audience:	All Consultant Medical Staff

Proud To Care
Make It Happen
We Value Respect
Together We Achieve

Document Control Sheet

Document Lead/Contact:	Sam Hooper, Medical Performance Manager sam.hooper@sath.nhs.uk
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Status	Final
Date Equality Impact Assessment completed	June 2018
Issue Date	
Review Date	July 2023
Distribution	Please refer to the intranet version for the latest version of this policy. **Any printed copies may not necessarily be the most up to date**
Key Words – including abbreviations if these would be reasonably expected to be used as search terms	Medical Job Planning Medical Job Planning Consistency Committee Job Plan MJPCC SPA, DCC
Dissemination plan	Distributed to Care Group Medical Directors Clinical Directors, Operational Managers, Workforce Business Partners Uploaded to the Medical Director's Intranet Pages

Version history

Version	Date	Author	Status	Comment – include reference to Committee presentations and dates
V1	Nov 11		Final	Approved
V2	June 18	Sam Hooper	Final	20 June 2018 LNC 27 June 2018 Medical Job Planning Consistency Committee 9 July 2018 Policy Approval Group 16 July 2018 Workforce Committee

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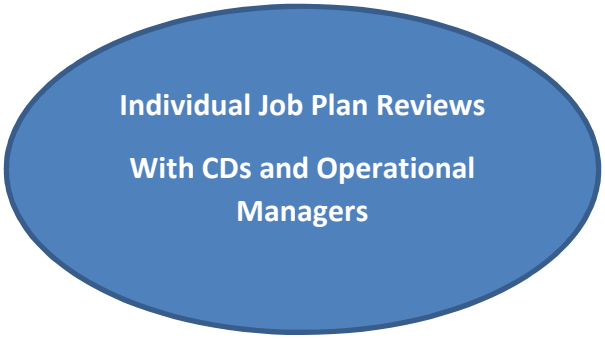

Step 3

Step 4

1 Introduction

1.1 The 2003 Consultant and the 2008 Associate Specialist contracts included a new and more robust system for job planning. The contracts and the job planning processes allow a reasonable amount of flexibility for local discretion and agreement. The purpose of this paper is to set out SaTH's approach to Consultant, Associate Specialist and Specialty Doctors job planning.

1.2 This document is the result of extensive discussion among stakeholders within the Trust, including Medical Staff, Clinical Managers, LNC Representatives, BMA representatives, Education Leads, Trust HR and Information.

1.3 Further help and guidance is available from the Medical Director's Office.

2 Key Principles

2.1 The principles in this document were developed in line with the Terms and Conditions of the Consultant Contract (2003) and the Specialty Doctors and Associate Specialist Contracts (2008). The terms and conditions state that the annual job plan review may result in a revised prospective job plan. Although not all Consultants, Associate Specialist and Staff Grade Doctors may have moved to the new contract, the general principles of job planning will apply. The following principles should be observed when conducting job planning with clinicians:

- **Equity**: the essence of the Medical Staff contract is to remunerate individuals on the basis of the activities they undertake which are in line with the Trust objectives. The Trust's intention therefore is neither to under nor over reward any individual but to pay them fairly for the work undertaken.

- **Consistency**: it is crucial that a consistent and fair approach is adopted between individuals and specialties. This will be based upon a set of logical and transparent guidelines that will apply to all.

- **Collaboration**: the fundamental concept is for the Trust to work in partnership with its clinicians to agree mutually acceptable job plans.

- **Trust**: the Trust regards its Medical Staff body as motivated, ethical and professional, and will treat them accordingly. The Trust's expectation is that clinicians will reciprocate with honesty and openness throughout this process.

- **Accountability**: as a publicly funded organisation the Trust has a statutory responsibility for probity. For this reason job plans must be based upon fact and evidence.

- **Prospective approach**: the job planning process is prospective; therefore decisions made will affect further work, future workload and payments.

3 Strategic Goals

3.1 To have an accurate and up to date job plan for each clinician that sets out the agreed number of Planned Activities (PAs) and on-call commitments he or she will undertake, plus an understanding of the activities he or she has agreed to perform within those PAs.

3.2 To align the objectives of individuals and clinical teams with the objectives of the Trust and to recognise and to reward the work that clinicians undertake within the agreed job plan. Managers will support the job planning process to ensure this is implemented.

3.3 To provide support to the clinician in delivering the responsibilities identified in the agreed job plan.

3.4 To prioritise the work of clinicians and reduce excessive workload.

3.5 To agree how clinical teams can most effectively meet patients' needs and support the wider objectives of the NHS.

3.6 To provide the clinician with evidence for appraisal, job planning and revalidation in a timely fashion.

3.7 To ensure that the implementation of job planning is clinically-led.

3.8 To establish a model job planning template for use across the Trust.

4 Work Commitment

4.1 The Terms and Conditions of the Consultant Contract (2003) and Associate Specialist and Specialty Doctors Contracts (2008) are based upon a full-time work commitment of 10 core Programmed Activities (PAs) per week. These core PAs will be clearly identified in the job plan and will include both the predictable and unpredictable activity associated with out of hours emergency work. Any PAs agreed beyond the 10 core PAs will be separately identified as additional PAs on the job plan so it is clear which activity is core and which is additional.

4.2 Four hours of work has a value of one PA, unless it has been agreed between the clinician and the Trust to undertake the work in premium time, in which case it is 3 hours.

Premium time is classified as any time that falls outside of the hours 07.00 to 19.00 Monday to Friday. Any time on a Saturday or Sunday or Public Holiday is premium time. Periods of activity less or more than a full PA should be recorded and paid pro rata.

4.3 PAs above 10 per week are temporary, Additional Programmed Activities (APAs). The allocation of all APAs is to be negotiated annually as part of the job planning review. APAs must be separately identified in each job plan. Either party may give 3 months notice to terminate APAs. Core activity will be retained (section 4.1). Requirements related to private practice will remain (section 17.7)

4.4 This guidance should be read in conjunction with the European Working Time Directive (EWTD). The Trust will not require anyone to work more than 48 hours per week over the cycle of their job plan. Individuals who wish to work in excess of this limit will be required to agree this and sign an opt-out agreement as part of their annual job plan review.

4.5 If clinicians choose to undertake a PA in premium time rather than core working hours for their personal convenience, the time allocation for the PA is 4 hours.

4.6 The job plan will set out the agreed places of work. The default position is that the clinician is expected to undertake activities at their principal place of work.

5 Direct Clinical Care (DCC)

5.1 DCC activity relates directly to the prevention, diagnosis or treatment of illness. This comprises operating sessions, outpatient clinics, direct patient related administration, ward rounds, clinical diagnostic work, emergency duties and other patient treatments.

5.2 A Multi-Disciplinary Team (MDT) meeting is counted as DCC time. Mixed meetings should be explicitly divided into time for planning patient care and time for other purposes. Preparation for an MDT meeting (for example diagnostics) is also counted as DCC.

5.3 The amount of DCC time allocated to direct patient related administrative activity may vary according to the requirements of a particular role but will be broadly similar for all doctors. The requirement of 4 hours administration in excess of clinic allocation and additional allocation for theatre activity would be the expected norm for most job plans.

5.4 The PA allocation to various activities depends on the time spent and so the allocation to outpatient clinics will depend on the clinic template. There is an expectation that clinics will run for 3 ½ hours with an allocation of ½ hour for administration associated with completion of the clinic. Operating theatre lists that involve both pre- and post-operative assessment of patients would be expected to last for 4 hours for the surgical session and 1 hour for the other activities associated with the session.

5.5 PAs required for prospective cover for annual leave and study leave should be calculated during the job planning review.

5.6 Through the job planning process there may be opportunities for agreement that some DCC activities may be worked flexibly e.g. an annualised hours/PAs approach.

6 Supporting Professional Activities (SPAs)

6.1 SPAs are activities that underpin and improve DCC.

6.2 All doctors will require 1.0 SPA to complete the requirements for appraisal and revalidation and this includes attendance at monthly audit/governance meetings and statutory and mandatory training. If there are requirements for greater than monthly audit/governance meetings then these should be job planned separately to this core SPA time.

6.3 The majority of doctors will require 0.5 SPA to contribute to activities such as clinical supervision, clinical guidelines, completion of national audits, completion of responses to NICE Technology appraisals, quality improvement work and guidance, mortality reviews, contribution to incident investigations (eg root cause analyses and high risk case reviews) and response to complaints.

6.4 One further SPA is available to most doctors for corporate activities and examples may be found on Appendix 1. It is expected that this corporate PA will be performed on-site and the timetable should be agreed by the Consultant's Clinical Director.

6.5 SPA activities must be relevant to the individual clinician and to the Trust. The content should be discussed and agreed at the both group and individual job planning sessions.

6.6 The 2003 contract and BMA guidance states that a full time consultant will "typically" undertake 2.5 SPAs per week. 2.5 is neither a minimum nor a maximum, nor is it an allowance. It is envisaged that a contract for a newly appointed full time Consultant will typically include an allocation of 7.5 DCC PAs and 2.5 SPAs. There is flexibility to alter this balance where, in order to best meet the needs of the population served and the Trust, a clinician's level of duties

for SPAs, Additional NHS Responsibilities and/or External Duties is significantly different from these norms.

It is envisaged that a contract for a newly appointed full time Associate Specialist or Specialty Doctor will include an allocation of 9 DCC PAs and a minimum of 1 SPA.

6.7 Clinicians must be able to demonstrate that the time identified is needed for the agreed activities and that these activities are undertaken. Evidence for this can be provided in the following two ways:

- The output from this SPA time (research, articles, teaching etc.) will be reviewed and discussed during job planning discussions.
- Clinicians may keep a work diary which includes details of SPA activities.

6.8 Clinicians have an obligation to attend key sessions (e.g. audit and governance meetings) and must aim to achieve attendance of at least 75%, excluding the time they are away from work due to leave. These activities are included within core SPA time. Those not doing so without valid reason (e.g. leave or urgent clinical care) may be expected to account for their absence. The Trust and individual clinician should agree job plans that facilitate this.

6.9 SPA time may legitimately be undertaken at a variety of locations, but it is expected that typically no more than 1 of these SPAs will be offsite. Exceptions would require specific agreement at the job planning meetings. Supporting resources such as office space and access to a computer will be provided by the Trust to facilitate this.

6.10 Meeting objectives is an integral part of the Consultant contract. Objectives are derived from the job planning process, and to be a combination of personal and corporate objectives and job planning needs to be linked to the Trust strategy.

7 General Teaching Commitments

7.1 Individuals will vary in their responsibilities and the time needed to deliver these commitments.

7.2 All clinicians are expected to participate in education as part of their employment and those who clinical or educationally supervise trainees are expected to fulfil the GMC requirements for trainers.

7.3 Time spent teaching in clinics and ward rounds is included in the DCC allocated for these duties and is not additional.

7.4 Workplace-based teaching may affect the volume of activity which can be undertaken within a clinical session. Variations in activity will be identified and accommodated as part of the job planning process (up to 30 minutes per PA).

7.5 Some doctors will be appointed to specific undergraduate teaching roles with time seconded to University activities. This activity will be funded by Educational tariff reimbursed by the undergraduate department. Doctors must agree any proposed change to their job plan with their line manager/Clinical Director prior to accepting these roles.

7.6 For Postgraduate Educational Supervisor roles an appropriate allowance of corporate SPA activity will be agreed, the usual expectation is of 0.25 SPA per trainee up to maximum of 1.0 SPA ie 4 trainees. This equates to spending approximately 1 hour per week with each trainee. This allocation will include the time required for completion and review of educational portfolios and attendance at educational supervisor meetings as defined by the Director of Medical Education or nominated educational lead. Time can only be included in the job plan if there is a trainee allocated to the supervisor.

7.7 The same principal of SPA allocation can be applied to Educational Supervision of other Health Care Professionals if agreed at the time of job planning eg ACPs, PAs, Trust doctors etc.

8 Additional NHS Responsibilities

8.1 The nature of the additional NHS responsibility should be discussed and agreed before any role is accepted. It is advisable for Consultants to agree this prior to application for any role since appointment panels for many external roles will expect agreement to have been reached in advance. The time required for these roles should be clearly identified in the job plan with associated objectives and supporting resources. For some doctors this may be agreed as an alternative to other corporate SPA work. For other doctors this may be agreed either as additional programmed activities or as substitution for core DCC. The Trust wishes to encourage clinicians to undertake roles within the wider NHS. There is a cost to the Trust and to other members of the clinical team when clinicians undertake such activities because it takes them away from their duties within the Trust. However, some additional NHS responsibilities will require additional SPA time.

8.2 A reasonable assessment of the time taken to discharge the responsibility is brought into the job plan discussion.

8.3 The time required for substantial internal SaTH additional responsibilities will be explicitly stated in job descriptions. Typical examples of such roles include:

- Deputy Medical Director
- Care Group Medical Director
- Clinical Director
- Director Medical Education
- Cancer Lead
- Royal College Tutor
- Informatics Lead
- Research and Development Lead
- SAS Tutor
- LNC Chair
- Appraisal Lead
- Some senior management posts may attract additional remuneration as a responsibility allowance which will be identified within the job plan.
- Undergraduate and postgraduate lead /training programme director roles to which appointments are made by the educational partner in conjunction with the Trust.

9 External Duties

9.1 The Trust wishes to encourage clinicians to undertake roles within the wider NHS. There is a cost to the Trust and to other members of the clinical team when clinicians undertake such activities because it takes them away from their duties within the Trust. Some examples include:

- Royal College work and examinations
- National representation on committees and teaching
- Health Education England activities
- NICE
- CQC
- GMC
- NHS England

- NHS Improvement
- External lectures.

9.2 The clinician concerned is responsible for informing the Clinical Director of their intention to apply for any external duty so that a full understanding of responsibilities is reached. The Trust may request formal confirmation of such activities.

9.3 All external duties should be agreed in advance of the appointment by the clinical director as part of the job planning process. If there is a dispute with the Clinical Director, the Consultant may ask for the decision to be reviewed by the Care Group Medical Director, and following the escalation process. The Trust will adopt a pragmatic approach to the issue on an individual basis and will support external duties so long as:

- There is a demonstrable benefit to the individual, the Trust or the wider NHS
- The Medical Director, Clinical Director or relevant line manager for the department supports the request
- It should be agreed whether any loss of service delivery within the speciality/department should be replaced or not and whether the time required can be incorporated within corporate SPA time or by allocation of professional leave.

10 Joint Contracts/Secondments with Other Organisations

10.1 Some doctors will have time seconded or employed with other organisations and in these circumstances both the DCC and SPA allocation must be agreed by both organisations with an expectation that SPA resource is balanced between the two.

11 On-call

11.1 On-call is defined as when an individual is timetabled to be available to respond to an emergency situation but is not necessarily required to remain on site. Predictable on-call on site should be largely allocated within fixed DCC sessions. Unpredictable on-call activity should be recorded as an average weekly allocation in the job plan and showed to include time for return to work, telephone calls etc and any directly related required admin. On-call arrangements will vary between specialties and this will need to be clarified through the job planning process. For non-resident on-call arrangements to annual expectation of delivery should be identified within the job plan with the allocation of time for return to work, telephone calls, etc.

11.2 Definitions

Consultant of the week
Many specialities operate a Consultant of the Week. In these circumstances all or a proportion of the normal weekly activities will be substituted for predictable emergency activities. These substitutes will be reflected in the annual PA calculation.

On-call category A
Availability for immediate recall to work means that the clinician should be contactable via a telephone or pager for complex consultations and, if determining that personal attendance is appropriate, the clinician shall be present on site within thirty minutes of that determination.

On-call category B
This typically applies when the clinician can respond by giving telephone advice and/returning to site later. Availability supplements are appropriate where the clinician's level of availability is

lower than immediate. Details of on-call availability arrangements will be determined and agreed for each specialty grouping and on call rota.

11.3 Consultants

11.3.1 Consultants on an on-call rota are paid an on-call availability supplement in addition to basic salary. The level of supplement depends upon the overall Consultant's contribution to the rota and the typical nature of response when called.

Number on On-Call Rota	**Value of supplement as % full-time basic salary**	
	Category A	**Category B**
High frequency: 1 – 4 Consultants	8%	3%
Medium frequency: 5 - 8	5%	2%
Low frequency: 9 or more Consultants	3%	1%

N.B. It should be noted that prospective cover arrangements cannot be considered when determining the frequency of a rota.

11.3.2 There are some Consultants on more than one rota. For these individuals a calculation will be undertaken to identify the overall frequency of their on call commitment. Complex cases may be referred to the Medical Job Planning Consistency Committee.

11.4 Associate Specialists and Specialty Doctors

11.4.1 Associate Specialists and Specialty Doctors are paid an on-call supplement in addition to their basic salary if the on-call work is not part of their DCC allocation. The level of supplement depends on the frequency of non-resident on-call.

Number on On-Call Rota	**% of Basic Salary**
More frequent than or equal to 1 in 4	6%
Less frequent than 1 in 4 or equal to 1 in 8	4%
Less frequent than 1 in 8	2%

11.4.2 The expected time that a doctor is likely to spend on unpredictable emergency work each week whilst on-call will contribute towards the number of DCCs in the job plan. Where on-call work averages less than 30 minutes per week, compensatory time will be deducted from normal programmed activities on an *ad hoc* basis.

11.4.3 Tables 1 and 2 below set out illustrations of the relationship between the average weekly emergency work arising from on-call duties and the number of programmed activities that this work is regarded as representing. The tables indicate how the individual clinician can calculate the PA allocation depending on whether the work is within normal time (1 PA = 4 hours) or premium time (1 PA = 3 hours).

Table 1 Possible allocation of Programmed Activities where emergency work does not arise during Out of Hours

Average emergency work per week likely to arise from on-call duties	Possible allocation of Programmed Activities (PAs)
½ hour	1 PA every 8 weeks, or a half-PA every 4 weeks
1 hour	1 PA every 4 weeks, or a half-PA every 2 weeks
1½ hours	3 PAs every 8 weeks
2 hours	1 PA every 2 weeks, or a half-PA every week
3 hours	3 PAs every 4 weeks
4 hours	1 PA per week
6 hours	1 ½ PAs per week, or 3 PAs every 2 weeks
8 hours	2 PAs per week

Table 2 Possible allocation of Programmed Activities where emergency work arises during Out of Hours

Average emergency work per week likely to arise from on-call duties	Possible allocation of Programmed Activities (PAs)
½ hour	1 PA every 6 weeks, or a half-PA every 3 weeks
1 hour	1 PA every 3 weeks
1½ hours	1 PA every 2 weeks, or a half-PA per week
2 hours	2 PAs every 3 weeks
3 hours	1 PA per week
4 hours	3 PAs every two weeks
6 hours	2 PAs per week

12 Honorary Consultant Medical Staff with Substantive University Contract

12.1 Clinical Academics, as well as undertaking clinical commitments within the NHS, undertake teaching and research commitments in both the NHS and University setting.

12.2 The Follett principles must be applied to these posts and joint job planning must be undertaken to ensure that the job plan is mutually agreed by the University/Medical School, the NHS Trust and the Clinical Academic and that all parties are aware of the Clinical Academic's full range of commitments.

12.3 Equal importance should be given to NHS and university commitments and wherever possible there should be identification of when and where the Clinical Academic is working for each of the organisations, or when working for both.

12.4 The SPA entitlement for these post-holders should be allocated by mutual agreement between the Trust and the Medical School.

12.5 The responsibility to acknowledge and resource SPA time should be shared by both employers.

12.6 As with all job plan discussions, agreement about a Clinical Academic's SPA entitlement should be evidence based and focused around the individual's development requirements and both organisations' needs.

13 Performance Objectives

13.1 Service standards and performance objectives will be discussed and agreed within the job planning review.

13.2 Supporting resources will be identified and agreed so that the objectives can be achieved. The Trust and clinician have joint responsibility for working together to promote efficient and effective working arrangements.

13.3 Key Performance Indicators agreed within Care Groups and nationally recognised specified standards including for example, NICE/NCEPOD and Royal College standards may be used as triggers for assessing performance.

13.4 Working patterns and performance objectives will need to be reviewed through the job planning process to reflect changing technologies, service requirements and changing clinical practice.

14 Pay Progression

14.1 Schedule 15 of the Consultant Terms and Conditions (2003) and the Associate Specialist and Specialty Doctor (2008) Terms and Conditions make provision for a salary that rises through a series of pay thresholds. Pay progression is not automatic; however, it will be the norm for clinicians who:

- satisfy the criteria set out in Schedule 15, and
- for those doctors undertaking private practice, have taken up any offer to undertake additional PAs in accordance with Schedule 7 of the Terms and Conditions of Service and met the standards governing the relationship between private practice and NHS commitments set out in Schedule 10 of the Terms and Conditions of Service.

A copy of the national terms and conditions is available on the Trust intranet.

14.2 The Clinical Director will confirm each year whether the clinician has met the criteria for pay progression purposes.

14.3 Where a doctor disputes a decision that he or she has not met the required criteria to progress either incrementally or through a threshold, the mediation procedure and the appeal procedure should be followed. These are set out in the national terms and conditions of service (a copy of which is on the Trust intranet).

15 Clinical Excellence Awards

15.1 Please refer to local policy and process for clinical excellence awards. Clinical excellence awards only apply to Consultants*.*

15.2 Completion of annual job planning and appraisal processes will be required for an application to be considered for clinical excellence awards.

15.3 Clinical Excellence Awards are allocated for work carried out over and above the agreed job plan.

16 Travel Time

16.1 Travelling time between a clinician's main place of work and home or private practice premises will not be regarded as part of working time.

16.2 Where clinicians are expected to spend time on more than one site during the course of a day, travelling time to and from their main base to other sites will be included as working time.

16.3 Travel to and from work for NHS emergencies and 'excess travel' will count as working time. 'Excess travel' is defined as time spent travelling between home and a working site other than the consultant's main place of work, after deducting the time normally spent travelling between home and main place of work.

16.4 Travelling time to and from the usual place of work is not included. However, travel between sites and for on-call duties is included within the PA for which the travel is necessary. Travelling time for emergencies is also included. In allowing for travel time employers and consultants should clarify and agree what constitutes the normal place of work. This could include any location within the trust rather than a specific location. Where sites are spread out and there is regular travel between them employers should consider agreeing standard travel times applicable to all staff.

16.5 The main base will be defined in the original contract of employment. Any change in working practices which implies that the main base will change will involve a renegotiation of the contract in a mutually agreed way outside of the job planning process.

17 Private Practice

17.1 Within the contracts clinicians have a right to undertake private practice. The individual is responsible for ensuring that the provision of Private Professional Services or Fee Paying Services for other organisations does not:

- result in detriment to NHS patients or services
- diminish the public resources that are available for the NHS.

17.2 The clinician will inform their Clinical Director of any regular commitments to Private Professional Services or Fee Paying Services as part of the job planning process. This information will include the location, timing and work involved. Regular private commitments must be noted in the job plan. This includes any payments made in relation to section 9, 10 and 11 of the Terms and Conditions for Consultants 2003 and 10, 11 and 12 of the Terms and Conditions for Associate Specialists and Specialty Doctors (2008).

17.3 Where there would be a conflict or potential conflict of interest, NHS commitments must take precedence over private work. The clinician is responsible for ensuring that private commitments do not conflict with PAs. Clinicians undertaking private practice, which is predominately individual patient care, are unlikely to create a conflict of interest, but undertaking roles in strategic management for companies competing with the Trust may not be covered by the right to undertake private practice. To avoid any doubt, clinicians should declare their interests to the Trust and seek advice on their personal position from their trade union, professional association or other advisor. It is recognised that individuals with medico-legal practices may be called for a significant number court appearances for medico-legal work, which may interfere with NHS activity. Arrangements with regard to reallocating PA time will need to be by written agreement with the Chief Executive in these circumstances. Histopathologists undertaking coroner's work locally are excluded from this requirement: such work should be addressed within the job planning process. All Consultants are required to make a declaration of interest (including a null declaration) in line with Trust policy on managing conflicts of interest in the NHS. This includes clinical private practice, relevant

shareholdings, patents, and loyalty issues. Any gifts, hospitality and sponsorship must also be declared in line with this policy.

17.4 The clinician should ensure that there are arrangements in place to avoid significant risk of private work disrupting NHS commitments, e.g. by causing NHS activities to begin late or to be cancelled. In particular, where a clinician is providing private services that are likely to result in the occurrence of emergency work, he or she should ensure that there is sufficient time before the scheduled start of PAs for such emergency work to be carried out.

17.5 Subject to the following provisions, a clinician will not undertake Private Professional Services or Fee Paying Services when on on-call duty. The exceptions to this rule are where:

- the clinician's rota frequency is 1 in 4 or more frequent, his or her on-call duties have been assessed as falling within the category B described in Schedule 16, and the employing organisation has given prior approval for undertaking specified Private Professional Services or Fee Paying Services
- the clinician has to provide emergency treatment or essential continuing treatment for a private patient. If this work regularly impacts on his or her NHS commitments, he or she will make alternative arrangements to provide emergency cover for private patients.

Private on-call commitments must not run concurrently with NHS duties.

17.6 As a general principle, work undertaken during PAs will not attract additional fees to the individual unless the work involves minimal disruption. For more guidance in this area Consultants should refer to the Trust's Private Practice Policy. Where the employing organisation agrees that the work can be done in NHS time without the employer collecting the fee the arrangement needs to be agreed by the Care Group Medical Director. The undertaking of such work, covered by additional fees, is voluntary for clinicians in line with schedule 9, 10 and 11 of the Consultant Terms and Conditions of service (2003) and schedule 10, 11 and 12 of the Terms and Conditions for Associate Specialists and Specialty Doctors (2008).

17.7 Where a consultant wishes to undertake private practice (s)he must discuss this with their Clinical Director. If the Clinical Director considers that there is a requirement for further APAs in the department then he/she must offer it equally to all relevant members of the department. If the offer is not taken up by any other members of the team then the consultant must offer an APA (unless already providing one).

18 Additional Clinical Activity

18.1 Any additional clinical activity (previously know as waiting list initiative, WLI) must be recorded and included in job planning discussions.

18.2 Additional clinical activity should not be undertaken when clinicians are on call.

18.3 Any SPA work displaced by additional clinical activity must be re-provided and this includes teaching and training.

19 Job Plan Reviews

19.1 A job plan review should take place annually. (see appendices 2 and 3). The review should normally take place as soon as possible after the annual appraisal meeting. Either the clinician or the Clinical Director may propose an interim job plan review, for instance where duties, responsibilities or objectives have changed or need to change significantly within the year.

19.2 The review should be designed to:

- consider what factors have affected the carrying out of the duties and responsibilities set out in the job plan
- consider progress against the personal objectives in the job plan
- consider current levels of workload
- agree any changes to the Consultant's duties and responsibilities, taking into account opportunities in relation to staffing, skill mix and ways of working and, if the Consultant wishes, the scope for more flexible ways of working
- agree a plan for achieving a Consultant's personal objectives
- agree what support the Consultant will need from the organisation and from colleagues to help achieve these objectives.

19.3 The job plan review should also be the occasion for reviewing the relationship between NHS duties and any private practice (in line with the Code of Conduct for Private Practice).

19.4 To support a more planned and phased approach to Consultant careers, it is good practice to hold a broader career review from time to time, possibly linked to the revalidation process.

Where agreement cannot be reached on a job plan

19.5 Clinicians and reviewers will make every possible effort to agree job plans. In the rare circumstances where a doctor cannot reach agreement on their job plan with their Clinical Director, then the process of mediation and appeal is available. Full details of this process are set out in the relevant national terms and conditions of service:

- Schedule 4 of the new Consultant contract
- Schedule 5 of the new Associate Specialist contract
- Schedule 5 of the new Specialty doctor contract Copies of the national terms and conditions are available on the Trust intranet.

19.6 The first step in this process is an appeal by the clinician to the Medical Director within 10 working days of the disagreement arising. The Medical Director may seek a review by the Medical Job Planning Consistency Committee before making a decision on an appeal. A mediation meeting will be held to seek to resolve the matter and, if the clinician remains dissatisfied, he or she may lodge a formal appeal to the Chief Executive as set out in Schedule 4 of the Consultant Contract Terms & Conditions.

20 Records

20.1 Job planning must be recorded within the Trust's electronic job planning system.

20.2 Where a job plan review results in a change to existing commitments, an effective date for the change should be agreed. In the absence of an agreement, three months' notice of the change will be given.

20.3 Where the job plan review is to increase the number of PAs to be paid requires the prior approval/authorisation from the Care Group Boards (where PAs are to be exchanged between team members at the same grade without a net increase then this may be approved by the Clinical Director). Reductions in PAs may be approved by the Clinical Director, subject to the development of a job plan that meets service needs. Where a reduction is agreed to below 10 PAs there should be a balanced reduction in DCC and SPAs.

20.4 Where a change in contracted PAs or the on-call availability supplement is approved, a Change of Circumstances form must be sent to ESR by the Clinical Director.

21 Medical Job Planning Consistency Committee

21.1 A Medical Job Planning Consistency Committee (MJPCC) has been set up in the Trust, with the purpose of agreeing and overseeing the process of job planning across the specialties, to ensure consistency and to provide assurance that job planning is in line with Trust guidance.

21.2 Membership of the MJPCC comprises the Deputy Medical Director (chair), Deputy Chief Operating Officer, 3 Care Group Medical Directors, a Workforce Business Partner, a Trust LNC representative and the Revalidation Programme Manager.

21.3 The scope of the MJPCC is to:

- review new job plans for permanent medical and dental staff
- review a representative sample of job plans across the Trust specialties and ensure that they achieve the required standards
- support the Care Groups in the process of job planning across the Trust
- review job planning policy and procedures across the Trust
- report compliance and submit progress reports to the Executive Medical Director and Workforce Committee.

22 Training

22.1 There is no mandatory training associated with this guidance.

23 Equality Impact Assessment

23.1 This document has been subject to an Equality Impact Assessment and is anticipated to have a positive impact by ensuring a fair and equitable process for all consultants.

24 Process for monitoring compliance with the effectiveness of this policy

Aspect of compliance or effectiveness being monitored	Monitoring method	Responsibility for monitoring (job title)	Frequency of monitoring	Group or Committee that will review the findings and monitor completion of any resulting action plan
Review of consistency of job plans	Job plan review	Deputy Medical Director via MJPCC	Six monthly	Workforce Committee

25 Review arrangements

25.1 This document will be reviewed in 5 years of approval date, or sooner if required. The document will be reviewed in light of feedback. In order that this document remains current, any of the appendices to the policy can be amended and approved during the lifetime of the policy without the document having to return to the ratifying committee.

Appendix 1 Examples of Corporate Activities for SPA

- Educational Supervision
- Principal and chief investigators
- Human Tissue Authority Lead
- Pandemic Flu
- Appraisal Lead
- Safeguarding
- Training Leads
- VTE Lead
- Clinical Leads
- Governance Leads
- Service Leads
- Educational Leads
- Committee work with external/internal partners
- Audit
- Medical Education
- Research
- Systematic Quality Improvement
- Continuing Professional Development (CPD)
- Clinical management: this does not include formal clinical management roles such as Clinical Director, which are encompassed in the Additional NHS Responsibilities section (8). All Consultants are expected to contribute to the management of their service
- Teaching: (see General Teaching Commitments, Section 7)
- Job Planning – as a job planner
- Appraisal – as an appraiser
- Non patient-related administration

This is not an exhaustive list and will be updated as necessary.

Appendix 2 Content of a Job Plan Review

1. The front page should be completed and signed by the clinician undergoing a job plan review and the reviewer to confirm mutual agreement of the job plan.

2. The previous agreed timetable should be completed in full.

3. The new revised timetable should be completed in full including:

    a. Start and finish times of elective sessions
    b. Time that the clinician will be expected to be on-site when on-call (including weekends)
    c. The PA allocation unpredictable on-call
    d. Times of any business-related travel
    e. Timings and location of SPA activity
    f. Teaching or university sessions should be displayed separately.

4. Job plan objectives

    Each clinician should agree a minimum of 5 objectives to achieve by the time of the next job plan review. Two of these will be corporate objectives supplied by the Medical Director, and the remaining objectives will be related to work carried out for the benefit of the clinician's team in support of the organisation's strategy.

    The job plan review should include evidence supporting the achievement of objectives agreed at the previous review or provide an explanation as to why this was not possible.

Appendix 3 The Annual Job Planning Cycle

1. Group Job Planning Meetings

The Clinical Director and Business Manager meet each group of clinicians to agree the following:

a. Clinic templates
b. Start and finish times of elective sessions
c. Allocation of PAs for on-call and their distribution
d. On-call supplement
e. Allocation of SPA activities within the group
f. Group job planning objectives
g. Template for the group job planning review.

These meetings should be completed by 31 December.

2. Individual Job Plan Reviews

Each clinician meets with the Clinical Director to discuss their individual job plan and agree any changes. The Business Manager for the specialty should be involved either at this meeting or with the output from this meeting in order to inform the demand and capacity model for the specialty.

This meeting should include review of the following:

a. Clinic templates
b. Start and finish times of elective sessions
c. Allocation of PAs for on-call and their distribution
d. On-call supplement
e. Review of allocated SPAs
f. Review of the outputs of SPA activity for the previous year
g. Assessment of achievement of previous job plan objectives
h. The listing of new job plan objectives for the next financial year.

This may take a series of face-to-face or virtual meetings before a job plan is agreed and signed off.

Individual job planning meetings should be completed by 28 February.

3. Medical Job Planning Consistency Committee

A Medical Job Planning Consistency Committee (MJPCC) meets to review a sample of job plans to ensure consistency and to provide assurance that job planning is in line with Trust guidance.