Oxford University Hospitals
NHS Foundation Trust

**Cover Sheet**

**Trust Board Meeting in Public: Wednesday 13 March 2024**

**TB2024.27**

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| **Title:** | **Trust Management Executive Report** |

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| **Status:** | **For Information** |
| **History:** | **Regular Reporting** |

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| **Board Lead:** | **Chief Executive Officer** |
| **Author:** | **Joan Adegoke, Corporate Governance Officer** |
| **Confidential:** | **No** |
| **Key Purpose:** | **Assurance** |

**Trust Management Executive Report**

## 1. Purpose

1.1. The Trust Management Executive [TME] has been constituted by the Trust Board and is the executive decision-making committee of the Trust. As such, it provides a regular report to the Board on some of the main issues raised and discussed at its meetings.

1.2. Under its terms of reference, TME is responsible for providing the Board with assurance concerning all aspects of setting and delivering the strategic direction for the Trust, including associated clinical strategies; and to assure the Board that, where there are risks and issues that may jeopardise the Trust's ability to deliver its objectives, these are being managed in a controlled way through the Trust Management Executive Committee. This regular report provided aims to contribute to the fulfilment of that purpose.

## 2. Background

2.1. Since the preparation of its last report to the Trust Board, the Trust Management Executive has met on the following dates:

- 11 January 2024
- 1 February 2024
- 15 February 2024
- 29 February 2024

## 3. Key Decisions

<u>Enhancements to sustainability and carbon management services</u>

3.1. TME approved two additional posts within the Sustainability Team to lead a sustainability programme of work and associated workstreams to ensure that carbon reduction and efficiency reduction plans were delivered, and realisation of emission and financial savings was achieved.

3.2. The targets set out for emission reduction are, for the emissions that the Trust controls directly (the NHS Carbon Footprint), to reach net zero by 2040, and for the emissions the Trust can influence (our NHS Carbon Footprint Plus), to reach net zero by 2045.

Proposal for Spending Plan for Additional Obstetric Workforce Funding

3.3. TME approved a proposal for recruitment to the obstetric medical workforce, fully funded by the Buckinghamshire, Oxfordshire and Berkshire West Local Maternity and Neonatal System.

3.4. The plan includes dedicated job-planned activity for equality, diversity and inclusion (EDI), which will provide ringfenced time to progress the health inequalities agenda, and the creation of a dedicated psychiatrist role in order to better support perinatal mental health.

Addressing Demand and Capacity Issues in Rheumatology

3.5. TME approved a proposal to recruit £295k of additional substantive staffing for the Rheumatology Department, to replace existing temporary staff and insourcing.

3.6. Rheumatology activity would be delivered in a more sustainable and cost-effective way, with an extra 420 new and 2,100 follow-up appointments per year. The proposal would improve patient access and patient experience while also supporting the expanding demands for general medicine at the Horton General Hospital.

MK Radiotherapy Capital MOU

3.7. TME approved signing a Memorandum of Understanding between Milton Keynes University Hospital and the Trust to develop the OUH Radiotherapy Centre @ Milton Keynes. This will be a satellite unit, similar to the one opened on the Great Western Hospital site in Swindon last year. It will enable people who require radiotherapy treatment for cancer to have treatment closer to home.

Nuffield Orthopaedic Centre (NOC) Plain Film Rooms

3.8. TME supported the Full Business Case for the replacement and installation of the four general plain film units at the NOC. Work will start with the replacement of the two rooms which are not currently able to be used due to condemned equipment.

3.9. The NOC Radiology service is essential to multiple treatment pathways, to the provision of established regional services, and to the Trust's status as an accredited elective orthopaedic hub. The new equipment will improve image quality for diagnosis and increase patient throughput as image acquisition will be faster.

## Expression of Interest in the delivery of the Ovarian and Testicular Fertility Preservation Service

3.10. In August 2023, NHS England (NHSE) commissioned the provision of an ovarian and testicular tissue Fertility Preservation Service for NHS patients who are at high risk of reproductive and endocrine failure and cannot store mature eggs or sperm.

3.11. NHSE proposes commissioning this service in three distinct parts – a Hub (will work with a network of spoke sites); Tissue Establishment (to cryopreserve the ovarian and testicular tissue); and Fertility and Endocrine Restoration Services (to reimplant the tissue) – with each part being commissioned for both the north and south of England.

3.12. TME members agreed that the Trust should submit an Expression of Interest in providing all three parts of the service for the south of England.

## Spinal Surgery Staffing Proposal to meet service demand

3.13. TME approved a proposal to recruit an additional substantive Consultant Spinal Surgeon (10 PAs) into the Spinal Surgery department funded from within current budget. The post would reduce reliance on agency staff and extra sessions.

3.14. The post would cover both adult and paediatric spinal surgery and help address the paediatric and adolescent scoliosis backlog.

## Use of NIHR-allocated Commercial Revenue

3.1. TME approved the proposal a proposal to reinvest the NIHR Oxford Biomedical Research Centre (BRC) allocated commercial revenue into new translational research and to support Nursing, Midwifery, and Allied Health Professionals research infrastructure posts.

3.2. Research supported by NIHR Oxford BRC had generated commercial revenue over a number of years and the contract requires return of these funds to NIHR or use it to support further research.

## Policies and Procedures

3.3. TME reviewed the following Policies and Procedures before recommending these be approved by the Trust Board:

- Prevention and Management of Sharps and Splash Injuries Policy (appendix 1);
- Display Screen Equipment Policy (appendix 2);
- Optical Radiation Protection Policy (appendix 3);
- Managing Organisational Change Procedure (appendix 4);

- Conduct and Expected Behaviours Procedure (including Sexual Misconduct) (appendix 5).

## 4. Other Activity Undertaken by TME

Deep Dive into Bullying and Harassment

4.1. TME received an update about established workstreams following the analysis of the 2022 OUH NHS Staff Survey data, Employee Relations (ER) case data, and Freedom to Speak Up (FtSU) case information raised between 1 April 2022 and 31 March 2023, relating to staff experiencing physical violence and or bullying and harassment.

4.2. As part of this update, TME noted the Trust's Respect and Dignity at Work Procedure.

Quality Improvement Programme Update

4.3. TME was briefed on the progress and achievements of the Quality Improvement Programme. These included significant improvements in Gynaecology triage which nearly halved waiting times, and improved patient flow from the Emergency Departments as part of the Clinically Ready to Proceed Project.

Travel and Transport

4.4. TME considered issues related to travel and transport and noted that over the recent period whilst there has been no charge for staff car parking the pressure on the limited car parking spaces on hospital sites had increased and that alternative and sustainable travel and transport options would become a key focus moving forwards.

4.5. TME recommended to the Board the reintroduction of charges for staff car parking permits from 1 April 2024. Car parking charges were fully subsidised by the Government during the COVID pandemic from March 2020 and following that, further supported by the Trust since September 2021. Charges were to be re-introduced in line with the Trust's Staff Travel and Car Parking Policy.

4.6. This change followed discussions with and agreement of Staff Side and was in line with a national directive from NHS England for the re-introduction of charges.

4.7. TME also heard that a Framework Travel and Transport Strategy was being developed and that a Travel Consultation was to be launched to survey and explore modes of transport and understand views on alternative sustainable ways of travel to support the Trust in meeting its mandated sustainability and net zero targets.

Financial Performance and Financial Planning for 2024/25

4.8. TME continued to be updated on the financial position including a summary of current forecast performance, the actions that TME had approved to improve this and the key current risks and opportunities.

4.9. TME discussed and approved the process for setting the Trust level external plan and internal budgets for the clinical divisions and corporate directorates for the financial year 2024/25.

Annual Report and Annual Accounts 2023/24

4.10. TME reviewed and likely requirements for the Annual Report for 2023/24, recognising that the Foundation Trust Annual Reporting Manual had not yet been issued.

4.11. Members were briefed on accounting changes for PFI liabilities under IFRS 16 and a review of the valuation of land and buildings.

Self-Certification for Protecting and Expanding Elective Capacity Update

4.12. TME received an update on progress on the key lines of enquiries outlined within the self-assessment further to its presentation to the Trust Board in September.

Nursing and Midwifery Staffing Establishment Reviews

4.13. TME received the results of a review of the nursing and midwifery staffing establishments during autumn 2023 in line with the requirement that all NHS Trusts undertake a formal nursing and midwifery inpatient establishment review bi-annually, using evidence-based tools, professional judgement, and clinical outcomes.

## 5. Regular Reporting

5.1. In addition, TME reviewed the following regular reports:

- Integrated Performance Report (this is now received by TME prior to presentation to the Trust Board and Integrated Assurance Committee);
- Medical Education Annual Report;
- Equality Delivery system 2023/24 Report;
- Internal Audit Report – Outpatient Management Advisory Report (unrated);
- Capital Schemes: TME continues to receive updates on a range of capital schemes across the Trust;
- Quarterly Industrial Action Report;

- Finance Report: TME continues to receive financial performance updates;
- People Performance Report: TME receives and discusses monthly updates of the key KPIs regarding HR metrics;
- People and Communications Committee Report;
- Clinical Governance Committee Report;
- Divisional Performance Reviews;
- Corporate Performance Reviews;
- Business Planning Pipeline Report;
- Procurement Pipeline Report; and
- Summary Impact of TME Business (which allows TME members to more easily track the combined financial impact of decisions taken.)

## 6. Key Risks

6.1. **Risks associated with the financial performance:** TME continued to recognise the risks and opportunities to deliver at pace the changes required to recover the financial position.

6.2. **Risks associated with workforce:** TME maintained continued oversight on ensuring provision of staff to ensure that services were provided safely and efficiently across the Trust and to maintain staff wellbeing in the light of substantial operational pressures.

6.3. **Risks to operational performance:** TME continued to monitor the risks to operational performance and the delivery of key performance indicators and the mitigations that were being put in place.

6.4. **Risks associated with industrial action:** TME noted planning to manage and mitigate the risks associated with planned industrial action.

## 7. Recommendations

7.1. The Trust Board is asked to:

- **note** the regular report to the Board from TME's meetings held on 11 January 2024, 1 February 2024, 15 February 2024, and 29 February 2024.
- **approve** the policies and procedures recommended by TME.

Oxford University Hospitals
NHS Foundation Trust

# Prevention and Management of Sharps and Splash Injuries Policy

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| **Category:** | Policy |
| **Summary:** | Blood Borne viruses (BBV) such as Hepatitis B (HBV), Hepatitis C (HCV) and Human Immunodeficiency Virus (HIV) pose a risk for healthcare workers. This policy and associated guidance outlines the standard precautions to offer the best protection for staff when handling blood and bodily fluids, and procedures to be followed after any exposure. |
| **Equality Impact Assessment undertaken:** | August 2023 |
| **Valid From:** | |
| **Date of Next Review:** | 3 years<br>Until such time as the review is completed and the successor document approved by the relevant committee this policy will remain valid. |
| **Approval Date/Via:** | |
| **Distribution:** | Via Human Resources intranet , Via PFI Quality and Performance Team to PFI providers |
| **Related Documents:** | Centre for Occupational Health and Wellbeing (COHWB) Procedures & Guidance<br>Infection Prevention and Control Policy<br>Risk Management Strategy<br>Incident Reporting and Investigation Policy<br>Core Skills Learning Policy (previously known as Statutory and Mandatory Training) |
| **Author(s):** | Consultant in Occupational Health<br>Occupational Health Manager<br>Director of Infection Prevention & Control / Infection Prevention & Control Doctor |
| **Further Information:** | ▪ Centre for Occupational Health and Wellbeing<br>▪ Infection Prevention and Control Team<br>▪ Microbiology<br>▪ Health & Safety<br>▪ Health & Safety Executive sharps injuries<br>▪ Health & Safety Executive Blood Borne Viruses in the workplace |

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| **This Document replaces:** | The Prevention and Management of Sharps and Splash Injuries Procedure v3.0 |

**Lead Director:** Chief Nursing Officer

**Issue Date:**

## Contents

## Introduction

1. Health care workers are at risk of occupational transmission of blood borne viruses (BBV) such as Hepatitis B (HBV), Hepatitis C (HCV), Human Immunodeficiency Virus (HIV) and other blood borne agents, because they come into regular contact with patients' blood or other body fluids. Standard precautions, as outlined in the Trust's Infection Prevention and Control Policy, offer the best protection for staff when handling blood and body fluids.
2. Oxford University Hospitals NHS Foundation Trust ("the Trust") recognises that sharps and splash injuries constitute actual or potential harm to patients or staff that is frequently avoidable. As such, sharps and splash injuries must be prevented by the adoption of relevant legal requirements and clinical best practices as set out below.

## Procedural Statement

3. The Trust will minimise and manage sharps and splash injuries by:
    - 3.1. Continuing to evaluate and introduce needle free devices where practicable throughout the Trust and ensuring exemptions are in place and have been approved by the Sharp Safety Action Group where this is not possible.
    - 3.2. Ensuring that suitable and sufficient risk assessments are carried out and recorded for work activities where there is a foreseeable risk of a sharp or splash injury and introducing where necessary appropriate control measures.
    - 3.3. Providing information and training on preventative measures, including the use of needle safe devices and appropriate personal protective equipment. (See **Appendix 2**)
4. It is the responsibility of all staff to avoid needle stick or splash incidents by applying good clinical practice as outlined in the Trust's Infection Prevention and Control Policy and specifically as outlined below:
    - 4.1. Needles and other sharps will be handled with care.
    - 4.2. Needles will not be re-sheathed.
    - 4.3. Needles and/or syringes will be disposed of in designated sharps bins at the point of use.
    - 4.4. Any other disposable sharps will be placed in sharps bins.
5. This policy fulfils the requirements of the the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (Dec 2022) by combining the following three recommended clinical care protocols:
    - 5.1. Safe handling and disposal of sharps. (See **Appendix 3**)
    - 5.2. Prevention of occupational exposure to blood-borne viruses, including prevention of sharps injuries.
    - 5.3. Management of occupational exposure to BBVs and post exposure prophylaxis.

## Scope

6. This document applies to all areas of the Trust, and all employees of the Trust, including individuals employed by a third party, by external contractors, as voluntary workers, as students, as locums or as agency staff.

## Aim

7. The purpose of this policy is to reduce and manage the risk of the transmission of blood borne virus infection from patients to members of staff involved in a needle stick or splash incident and vice versa in the case of a reverse needle stick or splash incident (see Reverse Needlestick Procedure outlined below).

## Definitions

8. The terms in use in this document are defined as follows:

8.1. **Sharps/Needlestick/Inoculation Injury** – penetration of the skin by a 'sharp object' which has, or may have been contaminated by blood, tissue or body fluids from another person.

8.2. **Sharp** – this includes hypodermic needle, suture needle, blades, sharp bone, glass ampoules or a bite from a person.

8.3. **Recipient** – the individual receiving the needlestick/splash incident.

8.4. **Source patient**– the individual who the needlestick/splash injury occurred from.

8.5. **Splash Injury** – splashing into the eyes or mouth of a body fluid.

8.6. **Body Fluids** – are one of the following:

- Blood
- Cerebral Spinal Fluid
- Pericardial fluid
- Pleural fluid
- Synovial fluid
- Any other visibly blood stained fluid
- Tears
- Semen
- Urine
- Faeces
- Amniotic fluid
- Breast milk
- Peritoneal fluid
- Saliva *(associated with dentistry)*
- Unfixed human tissue
- Exudates or fluid from burns/skin lesions
- Vaginal secretions
- Vomit

9. The following abbreviations are used in this policy:

9.1. Blood borne virus – BBV

9.2. Centre for Occupational Health and Wellbeing - COHWB

9.3. Hepatitis B – HBV

9.4. Hepatitis C – HCV

9.5. Human Immunodeficiency virus – HIV

9.6. HIV Post Exposure Prophylaxis – HIV PEP

## Responsibilities

10. **The Chief Nursing Officer** has been designated as the Lead Board member with responsibility for Health and Safety, and as such will ensure that robust management systems exist to reasonably minimise and/or adequately control risks to patients, staff and others from sharps and splash injuries.

11. **All Managers and Supervisors** are responsible for:

11.1. Ensuring that staff are familiar with this policy and associated guidance and that they understand and adhere to the control measures detailed.

11.2. Ensuring that risk assessments are undertaken, so as to identify hazards associated with activities with the potential for sharps and/or splash injuries, and to provide written control measures for minimising the risk of exposure (**see Appendix 4)**.

11.3. Ensuring the provision of appropriate and adequate training.

11.4. Providing appropriate first aid measures.

11.5. Ensuring that all sharps and splash incidents/near misses/hazards are reported in line with the Trust's Incident Reporting and Investigation Policy

11.6. Ensuring that a root cause analysis is undertaken at a local level following every exposure

11.7. Ensuring that targeted reductions used as performance indicators are achieved.

12. **Medical Staff** are responsible for the care of the source patient. This includes making the source patient aware of the incident and gaining informed consent to test for evidence of a Blood Borne Virus infection (see **Appendix 5**). They will ensure the source is aware of the implications of being tested i.e. a possible positive result and arrange for blood to be taken and tested.

13. **The Centre for Occupational Health and Wellbeing (COHWB)** during working hours (Monday to Friday 8am – 4pm) will co-ordinate the response for employees during working hours by carrying out a primary risk assessment where an injury has occurred and establishing care plans. This will include the initial follow up tests plus psychological support as required. The COHWB Manager will be responsible for the aggregate analysis of sharps incidents and report these bi-annually to the Sharps Safety Action Group, Hospital Infection Prevention and Control Committee, and the Health and Safety Committee. When required, the microbiologist on lab service (consultant or registrar) will assist the COHWB with risk assessments.

14. **The On-Call Infectious Diseases/Microbiology Registrar** will undertake a risk assessment and advise on immediate action when the incident occurs out of hours or COHWB not available. They will advise the employee to arrange follow-up in the Centre for Occupational Health and Wellbeing. For high risk incidents, the on-call Infectious Diseases/Microbiology registrar will counsel the staff member, if needed, arrange prescription of HIV Post exposure prophylaxis. The registrar will discuss with the Infectious Diseases Consultant on call if needed. Urgent follow up in the Infectious Diseases clinic will be arranged as needed.

15. **The Needlestick Safety Action Group** will meet on a quarterly basis to review the number of sharps incidents, recommend and co-ordinate and monitor the safer needle exemption applications and work to reduce the number of injuries occurring within the Trust.

16. **All Staff** are required to follow this policy and be responsible for ensuring that their own actions minimise the risk of injury to themselves and others. They should attend training as required of their role.

## Process for the management of an inoculation incident (including prophylaxis)

17. Following a needlestick injury or splash it is important that the following first line actions are undertaken by the recipient, COHWB and/or the on call Microbiologist to ensure that a risk assessment can be undertaken and access to HIV PEP obtained within 1 hour of the incident.

18. **Appendix 6** outlines the procedures to be followed by the recipient immediately following an injury and provides information on First Aid and who to contact. This should be displayed where all staff in Departments can see it.

19. **Appendix 7** outlines the procedures to be followed by COHWB/On-call Microbiologist. This includes ensuring that First Aid has been given, a risk assessment on the source has been undertaken and that both the donor and the recipient have been counselled and blood tests obtained if appropriate. It also outlines what follow up needs to be undertaken if the donor is identified as positive for any of the three Blood Borne Viruses.

20. **The COHWB Practitioner** will also contact the medical staff responsible for the care of the source patient for further information so that a risk assessment can be undertaken. The medical staff will be asked to gain informed consent and take blood to test for blood borne viruses. Consent will be obtained from the recipient to inform the Health and Safety department of the incident to ensure that an incident form is completed.

## Risk Assessment

21. Each situation will carry a different level of risk. Following first aid, an individual risk assessment is required which will consider the type of exposure, HBV, HCV and/or HIV status of the source and the recipients own hepatitis B antibody status.

22. Risk assessment is about making an informed judgement. It is a logical process looking at the hazard *(potential to cause harm)* and the risk *(likelihood that harm will occur)* following exposure to blood or body fluids. To arrive at a judgement, the following will be considered:

    22.1. Type of exposure i.e. has there been a significant injury with potential for transmission of BBV.

    22.2. Status of source.

    22.3. Status of recipient.

23. Sharps or splash injuries can be:

    23.1. **Low risk** – intact skin contaminated with blood or bodily fluid; injury involving low risk fluids saliva (not from dentistry), vomit, urine, faeces).

    23.2. **High risk** – penetrating injury with high risk fluids (blood, pleural fluid, blood-stained low risk fluid, saliva associated with dentistry, tears, semen, vaginal secretions, breast milk, CSF, synovial fluid, pericardial fluid, unfixed tissues or organs, peritoneal fluid).

24. Following the risk assessment and discussion with either COHWB or On-Call Infectious Diseases/Microbiology registrar or Infectious Diseases consultant, a decision as to whether HIV PEP may be indicated will be made. If PEP is indicated this will be offered within 1 hour of the exposure.

## Dealing with the Source

25. When a significant injury as defined above has occurred and the status of the source patient for BBVs is unknown, it is the responsibility of the senior clinician caring for the source patient and available at the time of the incident to:

    25.1. Inform the source patient about the contamination incident

    25.2. Obtain informed consent from the source patient for HBsAg, anti HCV antibody and HIV Ab/Ag testing. A ‘Careset’ for Needlestick donor test requesting is available on EPR (‘Needlestick donor (Virology) Careset’)

26. Source patient information sheets and a guide to pre-test discussion/counselling are available on the intranet. This information sheet emphasises that source patients may decline to be tested and that refusal will not affect their medical care.

27. Specialist support is available for full pre-test counselling for those source patients who want it or who have risk factors for BBVs. This support is provided by the Infectious Diseases Team, Genito-Urinary Medicine.

28. If the source patient lacks capacity to consent to testing at the time of the needlestick injury but is expected to regain capacity, while there is still on opportunity to offer PEP, i.e. within the next 72 hours e.g. following anaesthetic, then testing must be delayed until source patient has regained capacity and consented.

29. In circumstances where the source patient consent has been actively withheld, management of the injury must be based on risk assessment only.

30. Where a source patient is not expected to regain capacity before a decision needs to be made, doctors are entitled to make a decision whether to test the source patient without consent. This must be done by assessing whether testing is in the best interests of the source patient. The doctor must follow a structured decision-making process in making the decision (balance sheet approach). Testing should only be undertaken if the ‘balance sheet’ comes out in favour of doing so (see **appendix 8).**

31. While the next of kin cannot be approached to give consent unless they have the legal authority to make treatment decisions under a health and welfare lasting power of attorney, they should be consulted where reasonably possible when assessing a patient's best interests.

32. **This guidance is not intended for source patients who have the capacity to consent, are incapacitated for a short space of time (e.g. surgical procedure) or are deceased.**

33. In most cases source patients who do not have capacity will be those:

    33.1. who are unable to communicate due to acute illness or intubation on intensive care where the time to recovery is unknown;

    33.2. with longer term cognitive impairment (more common in the elderly); or

    33.3. with long-term or permanent mental impairment or disability.

34. If the source patient has a decision maker under a **health and welfare lasting power of attorney or a court-appointed deputy** then this individual can be asked to consent on behalf of the source patient. It is likely that source patients with long-term or permanent mental impairment or disability will have an appointed decision maker, so in such cases this option should be explored first. ***Details of the needlestick injury and the consent process along with the results of any tests should be recorded in the source patient's notes.***

35. **Testing a pre-existing sample without consent is not permitted**. Further advice can be obtained from the Consultant Occupational Health Physician or Consultant Microbiologist.

36. Where the source patient is deceased, testing for BBVs can be performed only with the consent of the next of kin. Where incidents occur in the Mortuary resulting from a Coroner's post-mortem the Coroner can be asked to authorise testing for BBVs him/herself. This will involve the need to seek the agreement of relatives if the test is not part of the Coroner's investigation.

## Dealing with the Recipient

37. It is essential that contact is made with the COHWB (or Infectious Diseases/Microbiology registrar after 4pm and at weekends) for the assessment of risk and administration of any treatment that might be required.

38. The COHWB practitioner will follow the standard procedure for testing and follow up if required.

39. COHWB will offer counselling and support to the affected member of staff as required.

40. **Under no circumstances** should the recipient seek consent from the source patient.

41. It is the responsibility of the medical staff caring for the source patient to ensure that guidance in relation to testing source patients without the capacity to give informed consent is followed (see paragraph 12 for further information).

## Contact Numbers for Assistance

42. The following contact services or individuals can be contacted for advice or assistance:

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| Centre for Occupational Health and Wellbeing | Bleep 1474<br>(Mon-Fri 8am-4pm) |
| On-call Infectious Diseases/Microbiology registrar (out of hours) | Weekends and bank holidays 9am to 5pm and weekdays 4pm to 5pm: bleep 4077<br>After 5pm: via switchboard |
| Infection Prevention and Control | ext. 22192 Bleep 1747 (Mon-Fri 9am-5pm) |

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|---|---|
| Senior nurse on-call/Duty Manager | via switchboard |
| Consultant Virologist/Microbiologist | via switchboard |
| On-call Consultant in Infectious diseases | via switchboard |
| Health & Safety | ext. 22707 |

## Reverse Needlestick Procedure

43. This procedure is written for the protection of patients and the public in case of accidental exposure to the blood or body fluids of a member of staff. If this situation occurs it is recommended that the procedure is followed treating the staff member as the ***source*** and the patient as the ***recipient***.

44. COHWB staff responsible for the care of the member of staff *(known as **the source**)* will discuss the incident and try to gain informed consent, ensuring the source is aware of the implications of being tested *i.e. a possible positive result*, and arrange for blood to be taken and tested for blood borne viruses if there has been a significant exposure, *i.e. which has the potential to transmit infection*. Under no circumstances should the member of staff enter into discussion with regard to this incident with the patient involved *(known as **the recipient**)*.

45. The Medical Staff caring for the patient ***(recipient)***, will discuss the incident with the patient and request consent at the earliest convenient opportunity to take blood from them for long term save. The COHWB Practitioner *(or On-call Microbiologist)*, will co-ordinate a **risk assessment** with regard to the incident. The Medical Team caring for the patient *(**recipient**)* will provide appropriate psychological support following the incident.

46. If the source is HIV positive, the On-call Infectious Diseases/Microbiology registrar or Infectious Diseases consultant will counsel the recipient and arrange prescription if any post exposure prophylaxis required.

47. If the source is a member of staff and the recipient is another member of staff, both the source and recipient must be referred to COHWB. The same procedure for staff to source patient exposure will be implemented.

## How Inoculation Incidents are Reported and Investigated

48. All adverse events/near misses involving sharps or splashes, whether there has been an injury or not, must be reported by staff in accordance with the Trust's Incident Reporting and Investigation Policy, by completion of an incident form.

49. Managers are responsible for investigating the incident, completing a root cause analysis and agreeing on any preventative actions to be taken to prevent recurrence.

50. Managers are responsible for reporting sharps injuries to the Health and Safety Executive (HSE) under the Reporting of Injuries, Disease and Dangerous Occurrences Regulations 1995 (RIDDOR) if:

    50.1 an employee is injured by a sharp known to be contaminated with a blood-borne virus (BBV) e.g. Hepatitis B or C or HIV. This is a reportable dangerous occurrence.

    50.2 the employee receives a sharps injury and acquires a BBV by this route (i.e. seroconverts or has a positive BBV viral load). This is a reportable disease.

    50.3 if the injury itself it so severe that it must be reported.

51. If the sharp is not contaminated with a BBV, or the source of the sharps injury cannot be traced, it is not reportable to the HSE, unless the injury causes over a seven day injury. If the employee develops a disease attributable to the injury, then it must be reported.

52. The COHWB Manager will be responsible for the aggregate analysis of sharps incidents on a quarterly basis (e.g., to identify themes in equipment involved and liaise with procurement

to identify safer alternatives). The aggregate analysis and proposed action plan will be reviewed by the Needlestick Safety Action Group on a quarterly basis.

53. The Health and Safety Committee will approve the plan and ensure all key actions have been implemented.

## Training

54. Training required to fulfil this policy will be provided as part of the Infection Prevention and Control training. Management and monitoring of training will be in accordance with the Trust's Core Skills Learning Policy (previously known as Statutory and Mandatory Training).

55. For ROE staff training records kept by third party internally. Training compliance reported monthly to the PFI Quality and Performance

56. Information will be provided to all staff (clinical and non-clinical) at induction about the hazards and safe systems of work associated with the use & disposal of sharps, as well as the potential for splash incidents.

57. Information will be provided at the local level to all staff about appropriate use/ handling of sharps and personal protective equipment.

58. Update sessions and refresher training will be covered via the mandatory Infection prevention and Control training and incident report training.

## Monitoring Compliance

59. Compliance with the document will be monitored in the following ways.

| What is being monitored | How is it monitored | By who, and when: | Minimum standard | Reporting to: |
|---|---|---|---|---|
| Compliance with the Prevention and Management of Sharps and Splash Injuries Procedure | Annual audit of 10% sample of exposures against this policy | COHWB Manager | At least annual<br>97% compliance | Hospital Prevention and Infection Prevention and Control Committee,<br>Health and Safety Committee<br>Needlestick Safety action group |

## Ad-hoc monitoring

60. In addition to the monitoring arrangements described above the Trust may undertake additional monitoring of this policy as a response to the identification of any gaps or as a result of the identification of risks arising from the policy prompted by incident review, external reviews, or other sources of information and advice. This monitoring could include:

    60.1. Commissioned audits and reviews

    60.2. Detailed data analysis

    60.3. Other focused studies

61. Results of this monitoring will be reported to the nominated Committee.

62. Implementation of policies & procedures can only be effective if adequate evaluation and monitoring is used to check the system and ensure any shortcomings are identified and dealt with. Locally, Managers are responsible for initiating an on-going performance monitoring process within their areas of responsibility. The monitoring should include as a minimum, an annual review against a 'Manager's Checklist', **(see Appendix 9)**.

## Review

63. This policy will be reviewed in 3 years, as set out in the Developing and Managing Policies and Procedural Documents Policy.

64. Until such time as the review is completed and the successor document approved by the relevant committee this procedure will remain valid.

## Document History

| Date of revision | Version number | Reason for review or update |
|---|---|---|
| 06/01/2017 | V2 | Document out of date, and new guidance now available |
| March 2017 | V3.0 | Approved procedure |
| August 2021 | | Three year review of procedure undertaken by the Occupational Health Manager |

## References


65. UK Health Security Agency. Hepatitis B: The green book, chapter 18. February 2022

66. UK Health Security Agency: Bloodborne viruses in healthcare workers: report exposures and reduce risks. 2021

67. UK Health Security Agency: Bloodborne viruses: Eye of the needle 2021

68. Health and Safety Executive: Blood-borne viruses (BBV)

69. Health and Safety Executive: Sharps Injuries. 2019

70. The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013

71. The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (July 2015)

72. Health and Safety at Work Act 1974

73. Mental Capacity Act 2005

74. Human Tissue Act 2004

75. UK Health Security Agency Immunisation against Infectious Disease. (November 2020)

76. British Standard BS EN ISO 23907-1:2019 – 'Sharps injury protection. Requirements and test methods. Single-use sharps containers'

77. BMA guidance– Needlestick injuries and blood-borne viruses: testing adults who lack capacity. (September 2020)

78. The Control of Substances Hazardous to Health Regulations 2002

79. The Management of Health and Safety at Work Regulations 1999

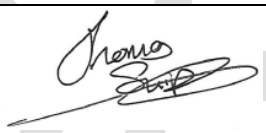
80. The Provision and Use of Work Equipment Regulations 1998

81. The Personal Protective Equipment at Work Regulations 1992

82. The Reporting of Injuries, Deaths and Dangerous Occurrences Regulation 2013

# Appendix 1: Equality Analysis

## 1. Information about the policy, service or function

| | |
|---|---|
| **What is being assessed** | Existing Policy / Procedure |
| **Job title of staff member completing assessment** | Occupational Health Manager |
| **Name of policy / service / function:** | Prevention and Management of Sharps and Splash Injuries Procedure |
| **Details about the policy / service / function** | This document outlines the responsibilities of all Trust employees to recognise, prevent, reduce the risk and manage sharps and splash incidents/injuries |
| **Is this document compliant with the Web Content Accessibility Guidelines?** | Yes |
| **Review Date** | 3 years |
| **Date assessment completed** | August 2023 |
| **Signature of staff member completing assessment** | |
| **Signature of staff member approving assessment** |  |



## 2. Screening Stage

**Who benefits from this policy, service or function? Who is the target audience?**

- Patients
- Staff

**Does the policy, service or function involve direct engagement with the target audience?**

Yes - *continue with full equality impact assessment*

## 3. Research Stage

**Notes:**

- If there is a neutral impact for a particular group or characteristic, mention this in the 'Reasoning' column and refer to evidence where applicable.
- Where there may be more than one impact for a characteristic (e.g. both positive and negative impact), identify this in the relevant columns and explain why in the 'Reasoning' column.
- The Characteristics include a wide range of groupings and the breakdown within characteristics is not exhaustive, but is used to give an indication of groups that should be considered. Where applicable please detail in the 'Reasoning' column where specific groups within categories are affected, for example, under Race the impact may only be upon certain ethnic groups.

### Impact Assessment

| Characteristic | Positive Impact | Negative Impact | Neutral Impact | Not enough information | Reasoning |
|---|---|---|---|---|---|
| **Sex** | | | ✓ | | Under the Health and Safety at Work Act 1974 and the Management of Health and Safety at Work Regulations 1999, employers have a legal duty to protect the health of their employees and anyone else, for example the public, who may be affected by work, or who may be on a Trust premises and experience an injury. The management of an injury is based on the risk of blood-borne virus transmission from the injury and source and neutral impact has been identified. The policy should have no bearing on this protected characteristic as it focuses on prevention and management of sharps/splash injuries across all groups and would not result in differential treatment. |
| **Gender Re-assignment** | | | ✓ | | Under the Health and Safety at Work Act 1974 and the Management of Health and Safety at Work Regulations 1999, employers have a legal duty to protect the health of their employees and anyone else, for example the public, who may be affected by work, or who may be on a Trust premises and experience an injury. The management of an injury is based on the risk of blood-borne virus transmission from the injury |

| Characteristic | Positive Impact | Negative Impact | Neutral Impact | Not enough information | Reasoning |
|---|---|---|---|---|---|
| | | | | | and source and neutral impact has been identified. The policy should have no bearing on this protected characteristic as it focuses on prevention and management of sharps/splash injuries across all groups and would not result in differential treatment. |
| **Race** - Asian or Asian British; Black or Black British; Mixed Race; White British; White Other; and Other | | | ✓ | | The policy should have no bearing on this protected characteristic as it focuses on prevention and management of sharps/splash injuries across all groups and would not result in differential treatment |
| **Disability** - disabled people and carers | | ✓ | | | Individuals with impaired immunity or chronic transmissible infections (e.g. BBV) may require additional support to ensure that any exposure and/or treatment does not compromise their current health situation. |
| **Age** | | | ✓ | | The policy should have no bearing on this protected characteristic as it focuses on prevention and management of sharps/splash injuries across all groups and would not result in differential treatment |
| **Sexual Orientation** | | | ✓ | | The policy should have no bearing on this protected characteristic as it focuses on prevention and management of sharps/splash injuries across all groups and would not result in differential treatment |
| **Religion or Belief** | | | ✓ | | The policy should have no bearing on this protected characteristic as it focuses on prevention and management of sharps/splash injuries across all groups and would not result in differential treatment |
| **Pregnancy and Maternity** | | ✓ | | | The policy focuses on prevention and management of sharps/splash injuries across all groups and should not generally result in differential treatment however pregnant individuals would need additional support and specialist advice from the infectious disease team as some aspects of treatment could be affected by their condition |

| Characteristic | Positive Impact | Negative Impact | Neutral Impact | Not enough information | Reasoning |
|---|---|---|---|---|---|
| **Marriage or Civil Partnership** | | | ✓ | | The policy should have no bearing on this protected characteristic as it focuses on prevention and management of sharps/splash injuries across all groups and would not result in differential treatment |
| **Other Groups / Characteristics** - for example, homeless people, sex workers, rural isolation. | | | ✓ | | The policy should have no bearing on this protected characteristic as it focuses on prevention and management of sharps/splash injuries across all groups and would not result in differential treatment |

**Sources of information**

- Health and Safety Executive – Sharps injuries – Further information
- The Green Book on Immunisation – Chapter 18: Hepatitis B
- Bloodborne viruses in healthcare workers: report exposures and reduce risks – GOV.UK (www.gov.uk)
- Bloodborne viruses: Eye of the needle - GOV.UK (www.gov.uk)
- Health and Safety (Sharp Instruments in Healthcare) Regulations 2013
- The Health and Social Care Act 2008
- Health and Safety at Work Act 1974
- Mental Capacity Act 2005
- Human Tissue Act 2004

Under the Health and Safety at Work Act 1974 and the Management of Health and Safety at Work Regulations 1999, employers have a legal duty to protect the health of their employees and anyone else, for example the public, who may be affected by work, or who may be on a Trust premises and experience an injury. Specific legislation on hazards that arise from working with biological agents such as blood is contained in the Control of Substances Hazardous to Health Regulations 2002. Again, under COSHH there is a legal duty to assess the risk of infection for employees and others affected work. When the risk is known, suitable precautions must be taken to protect health. Employees must have adequate information, instruction and training on any risks to their health which they may face at work.

Should an injury occur whether to an employee, contractor, patient or visitor, management of this is based on the risk of blood-borne virus transmission from the injury and source.

**Consultation with protected groups**

| Group | Summary of consultation |
|---|---|
| Clinical and non clinical managers randomly selected<br>Divisional HR Business partners<br>HR consultants<br>Staff representation RCN Unison<br>Equality, Diversity and Inclusion Manager<br>Oxford University Hospitals NHS Foundation Trust | This policy has been reviewed in line with its three year review and incorporates current guidance and best practice.<br><br>A draft version of the policy is being circulated to health and safety, infectious diseases, HR and other key stakeholders for consultation and feedback and changes will be incorporated into the policy as appropriate |

# 4. Summary stage

### Outcome Measures

The purpose of this procedure is to reduce and manage the risk of the transmission of blood borne virus infection from patients to members of staff involved in a needle stick or splash incident

### Positive Impact

This policy is applied to all healthcare workers, contractors, students, visitors and patients. Implementation of the Policy will ensure that healthcare staff do not suffer adverse consequences from acquisition infectious illnesses that might otherwise impair health and limit career choices

### Unjustifiable Adverse Effects

N/A

### Justifiable Adverse Effects

This policy focuses on the prevention and management of sharps/splash injuries across all groups and should not generally result in differential treatment however pregnant individuals and those whose health conditions affect their immunity or have long-term transmissible infections would need additional support, specialist advice and bespoke management as some aspects of treatment could be affected by their conditions.



## Equality Impact Assessment Action Plan

Complete this action plan template with actions identified during the Research and Summary Stages

| Identified risk | Recommended actions | Lead | Resource implications | Review date | Completion date |
|---|---|---|---|---|---|
| | | | | | |

## Appendix 2: Preventative Measures for Staff

1. Eliminate any unnecessary use of sharp instruments and needles, e.g. by appropriate substitution of electrocautery, blunt-tipped needles and stapling devices.
2. Opt for alternative less invasive surgical procedures where practicable and effective.
3. Avoid scalpel injuries associated with assembly/disassembly, by using scalpels which are either disposable, have retractable blades or which incorporate a blade release device.
4. Cover **all** *cuts and breaks* in your skin with *waterproof dressings or gloves*. **Wear** *gloves* if there is a risk of contact with a patient's *blood, mucous membranes or body fluids*.
5. Decontaminate your *hands* carefully by following the *5 moments for hand hygiene at point of care.*
6. **Avoid** splashes in the *eye or mouth*. **Wear** *goggles or visor* if there is a risk of splashing, especially when dealing with known hazardous materials.
7. **Avoid** wearing open footwear in situations where blood may be spilt, or where sharp instruments or needles are handled.
8. **Clear up blood spillages** promptly and disinfect surfaces.
9. Seek advice from the Centre for Occupational Health and Wellbeing if you have *eczema/dermatitis* or other skin problems.
10. Have no more than one person working in an open wound/body cavity at any time (unless essential to the safe and successful outcome of an operation).
11. Direct sharp needles and instruments away from own non-dominant, or assistant's hand.
12. Use instruments rather than fingers for retraction and holding tissues while suturing.
13. Use instruments to handle needles and remove scalpel blades.
14. Remove sharp suture needles before tying suture; tie suture with instruments rather than fingers.
15. **Plan** for *safe disposal*. Have *sharps' container* **at the point of use** before opening and using *sharps*. **Never** have a *container* in a position where you have to walk to it.
16. **Never** relax until you have disposed of used *sharps* into the *sharps' container*.
17. **Never** carry out another task with a used *sharp* in your hand.
18. **Never** lay used *sharps* down on *bed-lockers, windowsills, or work surfaces*.
19. **Never** leave used *sharps* lying amongst *swabs, dressing towels, etc*. on a trolley. They **must** be immediately disposed of into a *sharps' container*.
20. It is the personal responsibility of the individual using a *sharp* to ensure that it is used and disposed of correctly. ***The only exception is within operating theatres where the surgeon may place used sharps into a metal tray*** (or similar receptacle) ***prior to disposal into a sharps' container by the nursing staff.***
21. **Sharps must not** be passed directly from hand to hand. Handling should be kept to the absolute minimum. ***The only exception is in theatre, when the procedure necessitates this; clean sharps may be handed by the nursing staff to the medical staff.***
22. There are ***situations outside of the theatre environment*** where it may be necessary to pass a clean sharp to medical staff and it is not always possible to place a used sharp directly into the sharps bin due to the procedure taking place, e.g. insertion of a chest drain or during an emergency. In these cases the used sharp must be placed into a metal tray *(or similar receptacle)*, disposed of as soon as the procedure has been completed and disposal must be by the **user**.
23. *Needles* **must not** be bent or broken prior to or after use.

24. Safety devices should be deployed according to manufacturer's instructions
25. *Syringes/Cartridges and needles* should be disposed of intact.
26. **Never** re-sheathe used *needles*.
27. **Always** dispose of used *sharps* in a *sharps' container*, **never** in plastic *waste bags or waste bins*.

**Pick up all dropped *sharps* carefully and dispose of safely.**

## REMEMBER! OPEN - USE - DISPOSE

## DON'T LET ANYTHING INTERRUPT

## Appendix 3: Use and Management of Sharps Containers

1. *Sharps' containers* for use within the Trust will be of a type recommended by the *Infection Prevention and Control Committee* and comply with **British Standard BS EN ISO 23907-1:2019 Sharps injury protection. Requirements and test methods. Single-use sharps containers".**
2. When assembling *sharps' containers* for use, ensure that the *manufacturer's* instructions are followed.
3. **Do not** expose *sharps' containers* to extreme temperatures.
4. *Sharps' containers* **must not** be placed on the floor. Place on a *work surface, trolley or in a holder*.
5. **Ensure** *sharps' containers* are placed out of the reach of *children* at **all** times, and **ensure** that other unauthorised people cannot gain access to them.
6. **Dispose** of *sharps* **immediately** after use, into the approved *sharps' container*.
7. **Do not** attempt to retrieve items from *sharps' containers*. **Hands must never be inserted into containers**.
8. **Do not** attempt to press down upon *sharps* to make more room in the *sharps' container*.
9. **Do not** fill *sharps' containers* above the manufacturer's marked *'fill line'*.
10. **Lock** the *sharps' container*, in accordance with *manufacturer's instructions*, when the marked *'fill line'* has been reached or at intervals specified by *local procedures*.
11. **Label** the *used sharps' container* with the following information – **"Name of Ward/Department and the date"**.
12. Handle *used sharps' containers* with extreme care.
13. **Always** carry used *sharps' containers* by the *handle* and hold away from you.
14. **Do not** place used *sharps' containers* ready for disposal in *yellow or black bags*.
15. **Place** any *damaged used sharps' containers* into a larger secure **rigid** container, and properly label the outer container.
16. **Do not** allow *used sharps' containers* to accumulate. Arrange for *container(s)* to be conveyed to a *secure storage area* while awaiting collection for disposal.
17. **All** *used sharps' containers* will be disposed of by incineration.

# DO NOT DISPOSE OF SHARPS WITH OTHER TYPES OF WASTE

# Appendix 4: Control measures and Risk assessment

The Control of Substances Hazardous to Health Regulations (COSHH) requires you to follow a hierarchical approach to the prevention of sharps injuries. The hierarchy reflects the fact that eliminating and controlling risk by using physical engineering controls and safeguards is more dependable than relying solely on systems of work.

### 1. Preventing the risk of exposure

The complete removal of a hazard from the work area is the most effective way to control hazards; this approach should be used whenever possible. Examples include:

- removing sharps and needles when possible e.g. substituting jet injectors for needles and syringes or using needleless intravenous systems
- eliminating all unnecessary injections

### 2. Controlling the risk of exposure

If the risk cannot be prevented, then the risk of exposure to hazardous substances must be adequately controlled.

Controls that need to be considered:

- The design and use of appropriate work processes, systems and engineering controls and the provision and use of suitable work equipment and materials, e.g. providing safer sharps devices.
- Engineering controls – These are used to isolate or remove a hazard from a workplace. Examples include use of safety engineered devices for all procedures. Many medical devices incorporating sharps injury prevention mechanisms are now available. These are designed to significantly reduce or eliminate the risk of needlestick injury. They include safety shielded and retractable needles, safety lancets, blunt needles (for example for suturing), needle-free systems, blunt plastic cannula and shielded cannulas.
- Use of safety engineered devices – There is a large range of diverse products available, so it is essential to select the most appropriate product for a particular clinical procedure. It is important that devices are evaluated locally by relevant parties.



When considering safety-engineered medical devices the following selection criteria should be applied:

- The device must not compromise patient care.
- The device must perform reliably.
- The safety mechanism must be an integral part of the safety device, not a separate accessory.
- The device must be easy to use and require little change of technique on the part of the health professional.
- The activation of the safety mechanism must be convenient and allow the care-giver to maintain appropriate control over the procedure.
- The device must not create other safety hazards or sources of blood exposure.

The guidelines acknowledge that safety devices not only minimise the risk of operator injury but also reduce ‘downstream injuries following the disposal of sharps, involving housekeeping or portering staff’.

### 3. The control of exposure at source

These are Clinical waste procedures that ensure safe collection, storage, transport and final disposal of waste.

These controls aim to change the behaviour of workers to reduce exposure to occupational hazards.

- No needle recapping or resheathing.
- Availability of portable sharps containers.
- Adequate number and placing of sharps containers within arm's reach.
- Disposing of sharps immediately at the point of use in designated sharps containers.
- Sealing and discarding sharps containers when they are three quarters full.
- Establishing means for the safe handling and disposal of sharps devices before the beginning of a procedure.

This should also reduce the number of incidents resulting from incorrect disposal or non-disposal of sharps, for example in clinical waste bags, bed linen and laundry, or on floors and other surfaces.

- Ideally sharps bins should be designed to prevent overfilling and accidental spillage of contents. They should be easy to close temporarily and permanently and there should be no risk of puncture of the container.
- Care is needed to ensure portable sharps bins are not left unattended in areas where non-healthcare workers (especially children) can access them.

**4. Following standard precautions (formerly known as universal precautions)**

The Guidance for Clinical Health Care Workers: Protection against infection with bloodborne viruses, published by the Department of Health in 1998 contains standard precautions. These are aimed at preventing the transmission of bloodborne viruses by considering that blood and certain body fluids are potentially infectious and adopting specific procedures where contact is anticipated.

The principle of following standard precautions means never assuming that there is no risk. If every patient is assumed to be potentially infected with a blood-borne infection, the same precautions to prevent exposure should be used for every procedure.

Following these precautions alone will not help you prevent sharps injuries, but following them alongside other control measures, i.e. using safety engineer devices; safe disposal and training etc. will help you reduce the risk.

**5. Provision of suitable personal protective equipment (PPE) in addition to the measures outlined above.**

PPE provides barriers and filters between the worker and the hazard, they prevent exposures from blood splashes and reduce the risk from sharps injuries.

- Gloves – although a needle or sharp instrument can easily penetrate a glove, the risk of transmission of infection is significantly reduced. The glove material will remove up to 86 per cent of the blood on the outside of a needle. An inner glove will remove most of blood not removed by the outer glove. Double gloving therefore substantially reduces the risk of blood-borne virus transmission from a sharps injury
- Eye protection – this is important wherever blood or other body fluids could splash into the eye. Ordinary prescription spectacles offer inadequate protection, as they are not generally designed for this purpose. Eye protection should therefore be worn routinely, not just in operating theatres, delivery suites and endoscopy suites, but also in emergency departments and any other clinical areas where pressure may lead to spurting or splashing of body fluids, such as when unblocking or irrigating lines and tubes.
- Blood may become aerosolised due to surgical drilling techniques, such as those used in orthopaedic surgery, and mucous membrane exposure may not always be recognised.

## 6. Administrative controls that limit the exposure to hazards

The above hierarchical approach needs to be underpinned by administrative controls providing the right information and training to workers. These controls may include:

- ensuring that the health and safety responsibilities of all staff are clear,well coordinated and adequately resourced
- an organisational sharps injury prevention committee is set up (which may be part of health and safety committee)
- a sharps policy which covers exposure prevention as well as treatment and follow up is in place
- ensuring there is reference to sharps injury prevention in infection control and procurement policies
- removal of all unsafe devices
- safe systems of work particularly in high risk areas such as theatres, obstetrics and emergency care
- consistent information and training which includes safe systems of work, correct use and disposal of sharps, the use of medical devices incorporating sharps protection mechanisms, measures to be taken in the event of a sharps injury and how to use any PPE provided
- promotion of a no blame culture
- incident reporting procedures and investigations that include feedback to staff/staff groups involved
- vaccination programmes and follow up procedures.

# Example of Controls for Contamination Risk When Completing a Risk Assessment

**Assessment Title:** Exposure to BBV during venepuncture

**Describe the process, activity or other health and safety related issue being risk assessed:**

Taking blood from a patient using various types of equipment - Vacutainer, ABG syringe, Butterfly – all with **safety device** mechanism.



| What are the hazards? | Who can be harmed and how? | What control measures are currently in place? | What additional control measures can be implemented to reduce the risk as low as reasonably practicable (ALARP)? | Who is responsible for any actions relating to this risk assessment? Provide name and details of actions | When are the actions due to start by? | When are actions to be completed by? (if not ongoing actions |
|---|---|---|---|---|---|---|
| Skin contact with body fluids | Staff with direct patient contact | All staff to wear gloves when taking blood.<br>Good hand hygiene measures to be used at all times | Visors to be worn if risk of spray.<br>Cover any open wounds. | | | |
| Needlestick injury | Staff with direct patient contact | All staff to use needle safe devices at all times.<br>All staff to be trained in use of needle safe devices.<br>Correct disposal immediately after use. | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Use of Sharps bins | Staff with direct patient contact<br><br>Housekeeping staff | Adequate number of sharps bins and correctly sited.<br><br>Staff trained in correct disposal.<br><br>Sharps bins to be taken to bedside at all times.<br><br>Do not overfill bins. | | | | |

# Appendix 5: A Guide to Pre-Test Discussion Following Needlestick Injury/Splash to Member of Staff

**A suggested dialogue follows that may be used by a member of the source patient's medical/surgical team to request testing for blood borne viruses (*The recipient of the needlestick injury should not obtain informed consent).***

1. "A member of staff has sustained an injury to themselves which involved your blood/other body fluid. The injury has the potential to transmit blood borne infection".
2. "As part of routine health and safety procedure for staff *(based on Department of Health guidance)* we would like your permission to take a sample of your blood to test for HIV *(the virus that causes AIDS)* Hepatitis B and Hepatitis C *(viruses which affect the liver)*. Alternatively, we may be able to test a recent blood sample from you that is already in the laboratory. The main reason for the tests is to reassure the member of staff who has sustained the injury. If any virus is detected in your blood both you and the member of staff will be able to get appropriate treatment and advice. "You may be aware that all blood donors have these tests so that blood can be given safely to patients. On this occasion a member of staff has inadvertently given themselves some of your blood/body fluid and we are trying to reassure them".
3. "The likelihood of one of these tests being positive is generally very low *(in blood donors in the UK - no more than 6 per 10,000)* but there are certain factors that are known to increase the risk of getting one of these viruses. In order to help you decide if you have an increased chance of having one of these viruses, you may like to ask yourself the following questions:"
   - 3.1 Have you had unprotected *(without a condom)* sex with lots of casual partners?
   - 3.2 If you are a man have you had unprotected sex with another man?
   - 3.3 Have you had unprotected sex with someone from an area where these infections are more common: Sub Saharan Africa, SE Asia, Egypt (HCV) and China (HBV)?
   - 3.4 Have you ever injected drugs and shared needles or equipment?
   - 3.5 Have you had unprotected sex with someone who has injected drugs?
   - 3.6 Have you received a blood transfusion? If YES, when & where? ***(NB: For information, since 1990 blood has been screened for Hep. B, C and HIV infection in the UK)***
   - 3.7 Have you ever had unprotected sex with a prostitute?
   - 3.8 Does your sexual partner have HIV, Hepatitis B or Hepatitis C.?
   - 3.9 Have you had sex with anyone who might fall into any of the above categories?
4. "If your answer to any of these questions is 'yes' OR you are anxious about having these tests done, I can arrange for you to talk to a specialist who would be able to give you more detailed information and support."
5. "The results of the test are confidential - only those directly involved in your care **(and the member of staff who sustained the injury)** will be informed. A **negative** test does not affect your insurance policies you currently hold or may seek in future".

## Appendix 6: Flowchart - Action to be taken following a needlestick/sharps injury, human bite/scratch or splash of body fluid to the eyes or mouth

**IMPORTANT MESSAGE TO ALL STAFF**

Action to be taken following a needlestick/sharps injury, human bite/scratch or splash of body fluid to the eyes or mouth.

Step 1

*First Aid*
Encourage wound to bleed. Do **not** suck.
Wash wound well with soap under running water.
Apply waterproof dressing.

If body fluids splash into mouth do **not** swallow, rinse out mouth several times with cold water.
If into eyes, irrigate well with running water.

Step 2

*Report Incident*
Report the incident to the senior person on duty on your area and **complete Ulysses form**

Step 3

*Assess Infection Risk*

a Unused/clean sharp – **No** risk of infection.
Contact First Aider or the Centre for Occupational Health and Wellbeing for advice if needed.
Complete Ulysses form.

b Used sharp
Call the Centre for Occupational Health and Wellbeing immediately for follow up treatment and advice.

**Monday to Friday 8am-4pm: (Bleep 1474)**

**If outside these hours, please call the Infectious Diseases/Microbiology Registrar**
Monday to Friday 4pm - 5pm: 20875 (Bleep 4077)
After 5pm/bank holidays/weekends: via JRH Switchboard.

**NB:** Please refer to the Trust Prevention and Management of Sharps and Splash Injuries Procedure (available from the HR Policies and Procedures section on the intranet) for further information.

## Alternative text description of flowchart detailing the action to be taken following a needlestick/sharps injury, human bite/scratch or splash of body fluid to the eyes or mouth.

### Step 1 - First Aid

- Encourage wound to bleed. Do **not** suck.
- Wash wound well with soap under running water.
- Apply waterproof dressing.

- If body fluids splash into mouth do **not** swallow, rinse out mouth several times with cold water.
- If into eyes, irrigate well with running water.

### Step 2 - Report Incident

- Report the incident to the senior person on duty on your area and **complete Ulysses form.**

### Step 3 - Assess Infection Risk

a. Unused/clean sharp – **No** risk of infection.

- Contact First Aider or the Centre for Occupational Health and Wellbeing for advice if needed.
- Complete Ulysses form.

b. Used sharp

- Call the Centre for Occupational Health and Wellbeing immediately for follow up treatment and advice.

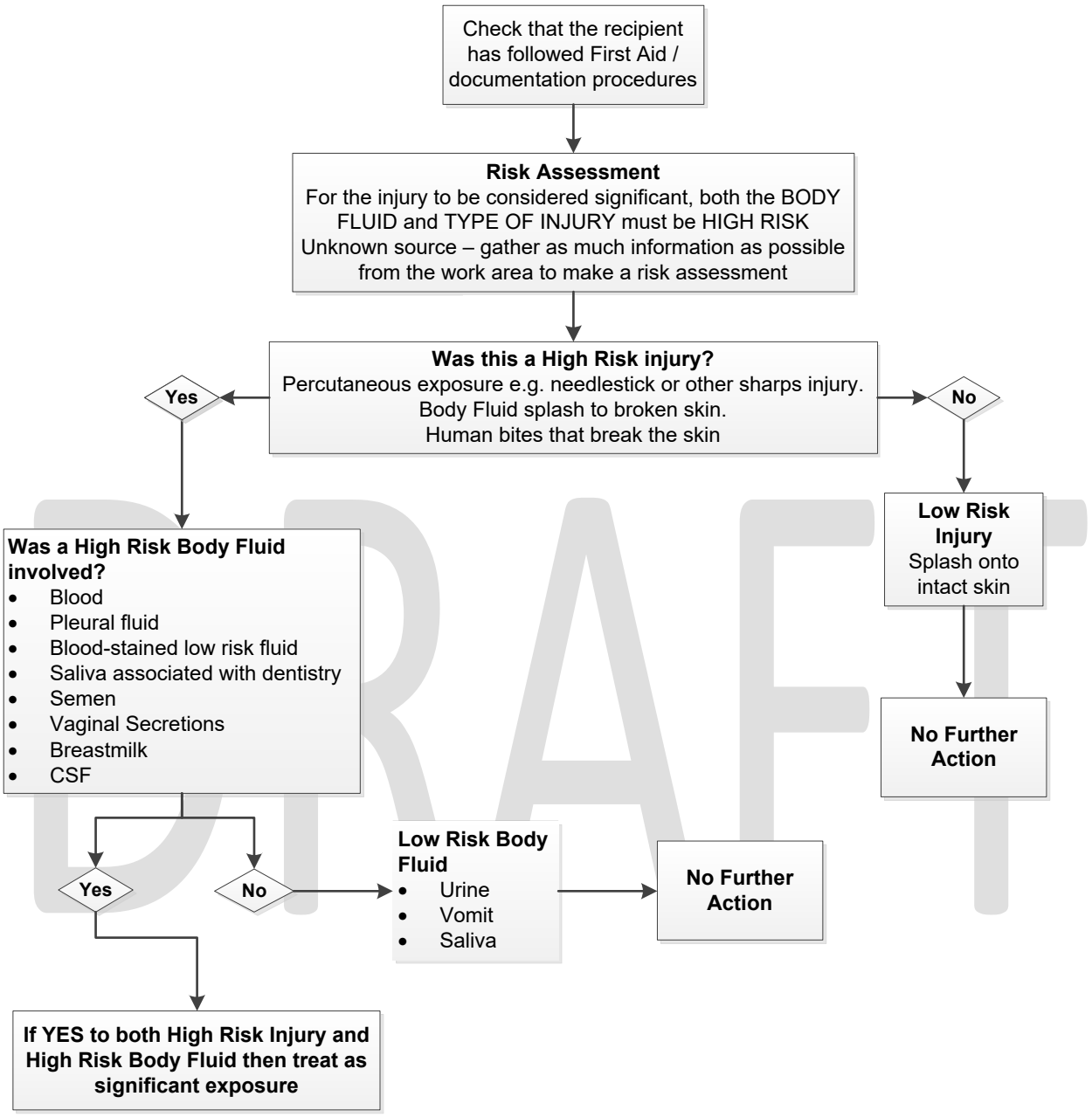
**Monday to Friday 8am-4pm: (Bleep 1474)**

**If outside these hours, please call the Infectious Diseases/Microbiology Registrar**

Monday to Friday 4pm - 5pm: 20875 (Bleep 4077)

After 5pm/bank holidays/weekends: via JRH Switchboard

# Appendix 7: Action to be taken by COHWB/On-Call Microbiologist when a needlestick/splash incident is reported



## Alternative Text Description of flowchart depicting action to be taken by COHWB/On-Call Microbiologist when a needlestick/splash incident is reported.

- Check that the recipient has followed First Aid / documentation procedures.
- **Risk Assessment –** for the injury to be considered significant, both the BODY FLUID and TYPE OF INJURY must be HIGH RISK. Unknown source – gather as much information as possible from the work area to make a risk assessment.
- **Was this a High Risk injury?** Percutaneous exposure e.g. needlestick or other sharps injury. Body fluid splash to broken skin. Human bites that break the skin.
    - **If the answer to was this a high risk injury is no**, this is considered a low risk injury (splash onto intact skin) no further action is needed.
    - **If the answer to was this a high risk injury is yes,** was a high risk body fluid involved (blood, pleural fluid, blood-stained low risk fluid, saliva associated with dentistry, semen, vaginal secretions, breastmilk, CSF)?
        - **If yes to both high risk injury and high risk body fluid** then treat as significant exposure.
        - **If yes to high risk injury, and low risk body fluid** (urine, vomit, saliva) no further action required.

## Appendix 8: Assessing best interests (Balance sheet)

If a patient lacks capacity, the COHWB Practitioner (or On-call Microbiologist) should determine together with the patient's medical team whether the patient has a valid and applicable advance decision to refuse treatment, or whether there is anyone with legal authority to make the decision.

Where a patient is not expected to regain capacity before a decision needs to be made, and there is no applicable advance decision to refuse treatment, attorney or appointed deputy/guardian an assessment should be made of whether testing is in the best interests of the patient.

When carrying out a best interests analysis it is appropriate for doctors to adopt the 'balance sheet' approach which has been adopted by the courts in assessing best interests. The 'balance sheet' approach requires any factors of benefit to the source patient to be set out on one side of the balance sheet and any dis-benefits to the source patient to be set out on the other side. As part of this process any 'factors of magnetic importance' should be identified; these are factors that might have a decisive influence on the outcome. Testing should only be undertaken if the 'balance sheet' comes out in favour of doing so.

When carrying out this assessment all relevant circumstances must be considered, including (but not limited to):

1. the source patient's past wishes and feelings (in particular, any written statement made by the source patient when he or she had capacity);
2. the source patient's present wishes and feelings (which might include any altruistic wishes or feelings)
3. the beliefs and values that would be likely to influence the source patient's decision if he or she had capacity (including beliefs and values such as altruism);
4. Other factors that the source patient would be likely to consider if he or she were able to do so. Factors which might be relevant include the effect of the decision to give or withhold consent on the health professional concerned and the duties of a responsible citizen

The fact that the primary beneficiary of a decision is a third party does not prevent the decision being in the best interests of a source patient, particularly if there is some indirect benefit and very little (if any) dis-benefit for the source patient.

**Clinical benefit**

Where the test would potentially bring clinical benefit to the source patient this must be entered on the side of the balance sheet in favour of testing, although all other relevant circumstances must also be considered. Whilst testing is not routinely offered to all source patients with capacity, it is arguably in the best interests of all source patients to be aware of whether they suffer from a blood-borne condition such as hepatitis B or HIV, particularly if that condition is asymptomatic at some stages in the development of the condition and/or can be effectively treated or managed.

The fact that testing would benefit the health professional does not prevent the testing being in the best interests of the source patient. The fact that the test was not contemplated before the needlestick injury occurred does not undermine the argument for clinical benefit.

Where testing has the potential to result in a clinical benefit to the source patient (for example, by ruling out the possibility that the source patient has unsuspected conditions or permitting earlier diagnosis), it is highly likely that ultimately the balance sheet will indicate that it is in the best interests of the source patient to be tested.

It is likely to be an exceptional case in which the potential clinical benefit is outweighed by considerations on the 'do not test' side of the balance sheet. Nevertheless, the law requires *all* relevant circumstances to be considered.

Once the source patient regains capacity, he or she should be advised of the needlestick injury and that a test was undertaken for blood-borne viruses. In some cases treatment will have commenced while the source patient lacked capacity and so the source patient should be

informed of this and consent should be sought for the treatment to continue. Where that is not the case, information should be provided to allow the individual to make an informed decision about whether to receive the test result.

Testing is not undertaken initially on a on a pseudo-anonymised basis to ensure test results are reliably linked to the correct medical record. However, when a patient opts not to know the result of their test, they should be provided with the option of this result being removed, as far as is practically possible, from their medical record.

## Appendix 9: Checklist for Managers (to be completed annually)

| Action Required | Achieved | Date | Additional Comments |
|---|---|---|---|
| 1. Have contents of the policy and associated guidance been conveyed to all staff? | Yes/No | | |
| 2. Has it been communicated to staff which Personal Protective Equipment (PPE) should be used for procedures involving the use of sharps and where there is a possibility of splashing? | Yes/No | | |
| 3. Have staff received training in the safe use & disposal of sharps, plus the management of sharps' containers? | Yes/No | | |
| 4. Have all staff been made aware of the correct procedures to follow in the event of receiving a sharps/splash injury? | Yes/No | | |
| 5. Do staff receiving a sharps/splash injury contact COHWB? | Yes/No | | |
| 6. Are all sharps and/or splash incidents/near misses/hazards reported via Ulysses | Yes/No | | |
| 7. Have risk assessments been carried out and recorded to identify any hazards associated with sharps and/or splash? | Yes/No | | |
| 8. Have practical controls been introduced that either eliminate or minimise exposure? | Yes/No | | |
| 9. Have safer needle device alternatives been introduced and are they being used at all times? | Yes/No | | |
| 10. If no safety device available, has an exemption been approved by the Sharps Safety Action Group? | Yes/No | | |
| 11. Are sharps' containers placed out of reach of children & vulnerable adults at all times? | Yes/No | | |
| 12. Have you identified targeted reductions in sharps/splash incidents to use as a performance indicator? | Yes/No | | |

| | |
|---|---|
| **Review undertaken by:** | |
| **Job Title:** | |
| **Date:** | |
| **Next Review Date:** | |

Oxford University Hospitals
NHS Foundation Trust

# Display Screen Equipment Policy

| | |
|---|---|
| **Category:** | **Policy** |
| **Summary:** | This policy provides instruction and guidance to managers and others on the safe and effective use of Display Screen Equipment within Oxford University Hospitals NHS Foundation Trust.<br>All Chief Officers, Directors and Managers are required to instigate action to ensure the successful implementation of the policy within their area(s) of control. |
| **Equality Impact Assessment undertaken** | July 2020. Reviewed November 2023. |
| **Valid From:** | |
| **Date of Next Review:** | 3 years<br>Until such time as the review is completed and the successor document approved by the relevant committee this policy will remain valid. |
| **Approval Date/ Via:** | Trust Board |
| **Distribution:** | Trust wide |
| **Related Documents:** | ▪ Health and Safety Management Policy<br>▪ Risk Management Strategy<br>▪ Manual Handling Policy<br>▪ Remote Working Policy |
| **Author(s):** | Senior Occupational Health Physiotherapist |
| **Further Information:** | Centre for Occupational Health and Wellbeing |
| **This Document replaces:** | Display Screen Equipment Procedure V4.0 |

**Lead Director:** **Chief Nursing Officer**

**Issue Date:**

## Introduction

1. Oxford University Hospitals NHS Foundation Trust ("the Trust") is required to ensure that all legislation relating to the minimum health and safety requirements for work with Display Screen Equipment (DSE) is observed (Appendix 1). The three most relevant legislations are:

    1.1. The Health and Safety at Work Act 1974;

    1.2. The Health and Safety (Display Screen Equipment) Regulations 1992 as amended by the Health and Safety (Miscellaneous Amendments) Regulations 2002; and

    1.3. The Management of Health and Safety at Work Regulations 1999.

2. The main risks associated with Display Screen Equipment (DSE) are:

    2.1. musculoskeletal disorders of the back, neck, arms and hands;

    2.2. headaches and migraines;

    2.3. eye strain but not eye damage; and

    2.4. fatigue and mental stress.

3. DSE assessments should take into consideration the workstation (equipment, furniture, software and environment); the individual's needs including stature and any disabilities and organisational factors including workload pattern, breaks, training and information. If DSE users follow good practice such as setting up their workstation correctly and taking breaks during periods of intensive use, the likelihood of suffering from ill health associated with DSE use can be significantly reduced.

## Policy Statement

4. The Trust believes that an organisation should, by definition, be a safe, secure and healthy organisation. It therefore follows that all staff working with Display Screen Equipment within the Trust are subject to the Health and Safety (Display Screen Equipment) Regulations 1992 as amended by the Health and Safety (Miscellaneous Amendments) Regulations 2002.

## Scope

5. This document applies to all areas of the Trust, and all employees of the Trust, including those working directly for or on behalf of the Trust. This includes Retention of Employment (RoE) staff; volunteers, students, locums and agency staff.

## Aim

6. The purpose of this policy is:

    6.1. to eliminate, reduce and control the risks associated with Display Screen Equipment use;

    6.2. to ensure that DSE users are trained in the risks associated with DSE use through completion of the Trust DSE e-learning package which is available via the intranet;

    6.3. to ensure a workstation assessment is carried out by every DSE user, using a self-assessment approach, and re-completed at least every 2 years (or sooner if required). The assessment findings must be reviewed with the user's Line Manager; and

    6.4. where appropriate, to ensure action plans are completed where risks are identified to ensure the risk is eliminated or reduced to as low as reasonably practicable.

## Definitions

7. The terms in use in this document are defined in the relevant legislation[1] as follows:

   7.1. **Display Screen Equipment (DSE)** is any alphanumeric (written or numeric text) or graphic display screen, which includes equipment such as, computers, laptops, microfiche and other medical equipment which includes a keyboard and screen e.g. medical scanning equipment. It also includes other types of display including liquid crystal or plasma displays used in flat panel screens, touch screens and other emerging technologies.

   7.2. A **DSE user** is a person who habitually uses display screen equipment as a significant part of their normal work. Someone who uses DSE for an hour or more at a time, on most days would generally be classed as a user. If further clarification is required contact the Centre for Occupational Health and Wellbeing (COHWB).

   7.3. A **workstation** includes a display screen, any associated accessories, including disk drives, modem, printer, mouse, keyboard, telephone, document holder, furniture and the immediate work environment around the display screen equipment. NB: The total volume of a room, when empty, divide by the number of people normally working in it should be at least 11 cubic metres.

   7.4. A **homeworker** is an employee who has a contractual agreement to work from home as an alternative to their work base, including where this arrangement is agreed as part of a flexible working request. Regardless of the number of days it is agreed an employee may work from home a DSE self-assessment checklist must be completed.

   7.5. A **remote worker** is an employee who spends at least part of their week working away from a main Trust location. This might be working on other sites, from home or in other non-Trust locations. The Trust's Remote Working Policy identifies two main categories: occasional/ad hoc or regular remote working. Where an employee works remotely on a regular basis, they must ensure that a DSE Self-Assessment is completed.

   7.6. '**So far as is reasonably practicable'** means balancing the level of risk against the measures needed to control the risk in terms of money, time or trouble. The decision is weighted in favour of health and safety so that the measures are adopted unless they are grossly disproportionate.

   7.7. **Hot desking** is where more than one user occupies the same workstation at different times. The workstation used for hot desking should be flexible enough in its adjustments to accommodate the range of individuals required to use it. It is the responsibility of the employee to adjust the workstation and associated equipment to meet their needs e.g. screen height, chair height and seat backrest height and tilt.

## Responsibilities

8. The **Chief Executive Officer** has overall responsibility for Health and Safety within the Trust and as such, should ensure:

   8.1. so far as is reasonably practicable, compliance with the DSE Policy; and

   8.2. that the requirements within the Policy are resourced and implemented within the Trust.

9. The **Chief Nursing Officer** has delegated authority as the Lead Board member with responsibility for Risk Management and Health and Safety, and as such will ensure that robust management systems exist to reasonably minimise or adequately control risks relating to the use of DSE.

10. All **chief officers** and **directors** are responsible for the implementation of the policy into their service areas and taking appropriate action should any breach of this policy arise.

11. All department **managers** are responsible for implementing the policy within their area:

    11.1. ensure that those employees identified as DSE users (Appendix 2) have received suitable and adequate training in the correct use of their DSE equipment/workstation (this training is provided by the DSE e-learning tool);

    11.2. ensure that DSE users have undertaken a DSE self-assessment checklist online or in paper form (See DSE section of COHWB intranet site;

    11.3. ensure that the DSE self-assessment checklist is reviewed with the user's manager and any risks are identified. The action plan must be agreed and completed, to eliminate and reduce the identified risks. The DSE Assessor is involved (if available) for further assessment/advice based on the self-assessment findings. If the risks cannot be resolved locally, review the DSE information on the COHWB intranet site. A referral should be made to the Centre for Occupational Health and Wellbeing for further advice if all advice has been followed and problems persist (see DSE section of COHWB intranet site);

    11.4. identify when a review or further action is required for DSE users. This could include new starters, new equipment, relocation or because the current assessment is no longer valid, including, for example, ill health arising from DSE use.

    11.5. ensure DSE Assessments are undertaken for agency staff or contractors and any relevant results of Assessments are forwarded to the employing agency for action as required;

    11.6. plan changes of activities to incorporate short frequent breaks from DSE work as appropriate to prevent fatigue;

    11.7. monitor sickness absence where it is suspected to be related to DSE or associated working environment and promptly bring this to the attention of the Centre for Occupational Health and Wellbeing;

    11.8. respond to all reported incidents related to DSE by:

        11.8.1. completing an Incident Reporting Form using the Trust's Incident Reporting System;

        11.8.2. taking all necessary steps to investigate the incident; and

        11.8.3. making a referral to the Centre for Occupational Health and Wellbeing if appropriate.

    11.9. ensure all equipment, aids and furniture provided for DSE use are suitable and maintained; equipment must be purchased from OUH approved suppliers. Furniture must meet the minimum standards and comply with all the relevant safety regulations including fire safety for the upholstery. Further information on upgrading equipment can be found on the COHWB intranet site.

    11.10. provide suitable and sufficient information and instruction on adequate eye and eyesight test examinations on request (see DSE section of COHWB intranet site);

    11.11. ensure that all the minimum requirements (Appendix 1) are considered during the planning stage, prior to installation of new DSE equipment/workstations; and

    11.12. monitor and review workstation arrangements with staff, making improvements and seeking assistance where necessary. Managers must undertake an annual audit (see DSE section of COHWB intranet site) to review the list of identified DSE users, DSE self-assessment checklists and control measures in place.

12. The **Centre for Occupational Health and Wellbeing (COHWB)** are responsible for:

    12.1. identifying any individual who declares an underlying medical condition that would require either a risk assessment or modifications to the workstation prior to employment. This involves reviewing the health profile of an employee, the nature of their working environment and the demands of the job;

    12.2. providing clear advice to managers in relation to staff experiencing possible symptoms related to DSE use, or following referrals for return to work (RTW);

    12.3. providing support, advice and guidance to DSE users; managers; Safety, Quality and Risk and Procurement;

    12.4. A Workplace Ergonomic Advice referral (see DSE section of COHWB intranet site) can be made when all local adjustments have been made and problems persist. A completed DSE self-assessment checklist must be included with any referral to the COHWB; and

    12.5. monitoring sickness absence patterns within the Trust and identify areas of concern relating to DSE. Provide support and advice on resolving issues related to ill health associated with DSE use.

13. The **Occupational Health Physiotherapist Team –** as part of the Centre for Occupational Health and Wellbeing, are responsible for:

    13.1. providing support, advice, guidance and training to the Trust to ensure the safe use of DSE throughout all work activities;

    13.2. providing advice for managers where necessary, following receipt of a Workplace Ergonomic Advice referral and any additional information requested;

    13.3. monitoring, reviewing and auditing the application of this Policy;

    13.4. providing ergonomic advice to departments that are relocating or refurbishing departments where DSE is used;

    13.5. liaising with IM&T, Procurement and preferred suppliers in the identification, purchasing or adaptation of equipment;

    13.6. loaning specialist ergonomic equipment for employees to trial before purchase; and

    13.7. engaging with external ergonomic equipment assessors, when more bespoke DSE equipment advice is required.

14. All **employees** who are classed as a DSE user are required to comply with any instruction, information and training to safeguard their own, colleagues' and others health and safety by following recommendations and advice in the Policy and provided by their manager and Centre for Occupational Health and Wellbeing. They must:

    14.1. undertake the DSE e-learning training and comply with any information and advice provided;

    14.2. complete the DSE self-assessment checklist every two years or following any major changes to equipment, furniture or office environment; change of work location; change to nature of work; change of job; change in health or if there is any other reason to believe the assessment needs to be repeated;

    14.3. discuss any issues arising from the DSE self-assessment checklist with their manager and agree an action plan;

    14.4. undertake the actions indicated by the self-assessment or when recommended by a manager;

14.5. notify their manager of any significant changes associated with the use of DSE; and

14.6. report any health problems related to DSE work to their manager and/or Centre for the Occupational Health and Wellbeing.

15. **Agency, NHS Professionals and zero hours staff**

15.1. For **NHS Professionals (NHSP) staff** the contract with NHS Professionals ensures minimal training requirements have been met. The **host employer** (OUH manager) should:

15.1.1. assess risks to NHSP workers of using their workstations;

15.1.2. ensure all workstations in their department comply with minimum requirements (Appendix 1);

15.1.3. ensure activities are planned so that NHSP workers can have breaks from DSE work;

15.1.4. provide training to NHSP workers when their workstation is being modified; and

15.1.5. provide information to NHSP workers about risks, risk assessment and risk reduction measures.

15.2. For **agency/self-employed workers** the **employment business** should:

15.2.1. on request, provide eye tests and special corrective appliances if required by their employees;

15.2.2. provide health and safety training to such workers; and

15.2.3. provide information, instruction and training to workers about the risks associated with DSE use.

15.2.4. Where an agency/self-employed worker demonstrates musculoskeletal problems as a result of work carried out at their workstations, they must be referred back to their employment business.

15.3. External contractors working on behalf of the Trust who report musculoskeletal problems as a result of work carried out at their workstations should be referred to their own Occupational Health Service for advice, treatment and any necessary follow ups for rehabilitation, redeployment or job modification.

15.4. Staff on OUH **zero hours** contracts are covered by paragraph 14 (**employees**) and should follow the guidance provided.

## Organisational Arrangements

### Risk Assessment

16. The assessment of risks associated with workplace hazards is an accepted concept and managers have the responsibility to ensure that a risk assessment is carried out for all DSE users every 2 years. The assessment should be completed before problems arise and should assess the working environment, the job and each individual user. This is a simple process which involves the DSE user accessing the DSE e-learning tool, undertaking the training component and then completing the DSE self-assessment checklist. The DSE self-assessment checklist (see DSE section of COHWB intranet site) must then be discussed with their manager and action plan completed and agreed.

## DSE Self-Assessment

17. The DSE user should make an initial assessment of their workstation using the DSE Self-Assessment Checklist (see DSE section of COHWB intranet site). This is carried out after completion of the DSE e-learning tool.

18. On completion, the DSE self-assessment checklist must be reviewed with the manager.

19. The manager must complete the checklist by signing the checklist and completing the Action Plan (see above section *Risk Assessment*).

20. The review date should be set so that it falls either at the same time or shortly after the expected resolution of issues raised (take into account the time scales for obtaining resources/equipment when setting the review date). Once the outstanding issues have been resolved a new review date can be set.

21. A more in-depth ergonomic DSE risk assessment may be required if solutions cannot be found locally. Further advice can be found on the Centre for Occupational Health and Wellbeing intranet site.

22. Where there are no risks identified or actions required the DSE self-assessment checklist should be re-completed every 2 years. The line manager will keep a record of DSE self-assessments completed.

23. The DSE self-assessment must be repeated/reviewed if any of the following occur (this list is not exhaustive):

    23.1. an employee reports musculoskeletal and/or visual discomfort;

    23.2. an employee reports fatigue and/or stress related to their DSE use;

    23.3. a major change to any equipment/furniture (screen, keyboard, input devices, desks, chairs);

    23.4. a substantial increase in the amount of time required to be spent using DSE;

    23.5. if the workstation is relocated (even if all equipment and furniture stay the same);

    23.6. if major features of the working environment are modified e.g. lighting; or

    23.7. if a major change to software is implemented.

    23.8. The process described above is detailed in the DSE Training, Assessment and Referral Flow Chart (Appendix 2)

## Minimum Requirements for DSE Workstations

24. Workstations and equipment must comply with specific minimum requirements laid down in The Health and Safety (Display Screen Equipment) Regulations 1992 as amended by the Health and Safety (Miscellaneous Amendments) Regulations 2002. The full schedule and guidance on minimum DSE workstation requirements can be found in Appendix 1.

## Equipment Selection

25. When selecting equipment and furniture, consideration should be given to features which will provide greater adjustability. Equipment may need to be provided for users with specific difficulties and/or disabilities which do not meet the minimum standard.

26. The BS EN ISO 9241-11 2018 '*Ergonomics of human-system interaction. Usability: Definitions and concepts*', provides high standards for office workstations and software. Its application may not be appropriate in its entirety, nor is it mandatory, but if applied will meet the requirements of the DSE Regulations. The technical data may assist procuring suitable equipment.

27. A Workplace Ergonomic Advice Referral is recommended when standard equipment is not meeting the needs of the individual and all necessary adjustments have been made and advice followed.

### Home Working

28. The risks of working at home with DSE are the same as using DSE in the workplace.
29. The home workstation should be assessed using the DSE self-assessment checklist (see DSE section of COHWB intranet site).
30. If the Trust agrees that the individual can work from home or work remotely from some other identified location, then the responsibility lies with the Trust to provide appropriate equipment to facilitate this.
31. If the self-assessment identifies issues that cannot be resolved, then the line manager should complete a Workplace Ergonomic Advice Referral form.

### Shared Workstations/Hot Desking

32. In some areas workstations may be used by more than one person. A DSE self-assessment must be completed by each individual user. The range of adjustments must meet the needs of each user e.g. the chair must have sufficient range in height/size adjustment for each user- chair upgrade information can be found on the COHWB intranet site.

### Portable Computers

33. Laptops (including tablets/notebooks/smartphones) must comply with the regulations where they are in prolonged use (e.g. for periods of an hour or more and on most working days).
34. If a laptop is used for long periods an attempt should be made to find a sensible compromise that retains the benefits of mobile working but removes the risk of causing harm to staff. Further guidance is provided on the COHWB intranet site.
35. Specific modifications will be required when the laptop is used in a fixed location, such as an office (Appendix 1). There are several options which aim to raise the screen to the recommended eye level position. The option you choose will depend on desk space and whether you need to easily move the laptop.
    - 35.1. place the laptop on a laptop stand and use a separate keyboard and mouse; or
    - 35.2. use the laptop (keyboard) with a separate screen; or
    - 35.3. use the laptop with a docking station and have separate screen, keyboard and mouse.
36. It is best to avoid using a laptop and other portables if full sized equipment is available.
37. Additional risks may also be associated with portable DSE equipment:
    - 37.1. Manual handling: If the portable equipment is carried for long periods of time across sites, then it is important to consider the weight and type of carrying case/rucksack/trolley. The lightest laptop should be made available for the task (3kg or less).
    - 37.2. Personal safety: Consider the level of risk of theft, when transporting the laptop between locations and/or home.
    - 37.3. Unauthorised access to OUH confidential information. All OUH owned portable computers should have IM&T approved encryption. Please refer to the Information Protection Policy: Mobile Device Policy for further details.

### Rest Breaks/work routine

38. These should be planned into the work activity such that DSE work is periodically interrupted by breaks or changes of activity to reduce the risk of DSE related ill health.

39. These breaks may naturally occur in many tasks e.g. collecting printing, reading printed material, phone calls and attending meetings.

40. It is best if breaks or changes of activity allow the user to get up from their workstation and move around, or at least stretch and change posture.

41. For some tasks which involve high data input, screen monitoring, screening images and intensive phone use, deliberate breaks will have to be factored in due to the static nature of the task and the limited opportunity for breaks in the task.

### Eyesight Tests

42. In accordance with Regulation 5 of the Display Screen Equipment Regulations the cost of an eye test by a registered ophthalmic optician will be paid for by the Trust for anyone on first becoming defined as a DSE User – on joining the Trust or changing job role.

43. Employees are entitled, but have no obligation, to undergo an appropriate eye and eyesight test, provided by their employer, when they are identified as a DSE user.

44. The purpose of the eye test is to determine if the user has any defect in sight which requires correction when working with DSE.

45. Staff members who consider themselves as DSE users should make their request to their manager. Further information about the Trust's eye-test scheme is available from the DSE section of the COWHB intranet site.

46. The Trust will cover the cost of the basic lens and frame which falls under the remit of the eye-test scheme (see the DSE section of the COWHB intranet site for further information). Only eye tests conducted under the scheme will be provided. Any member of staff making their own arrangements will not be entitled to recover the cost from the Trust.

47. DSE users should have their eye and eyesight test repeated as recommended by their Optometrist, this is normally every 2 years. Where a staff member is required to have an eye and eyesight test more frequently than every 2 years, they should provide their manager with evidence of the recommendation by the Optometrist if the problem is related to DSE use.

48. Managers must ensure the DSE User has completed the DSE e-learning module and they have signed off the Users DSE self-assessment (see DSE section of COHWB intranet site).

### Risk Register

49. Any outstanding risks not resolved at a local level need to be identified and escalated onto the appropriate Risk Register as per the Trust's Risk Assessment Policy.

### Record Keeping

50. Departments must ensure that records such as DSE risk assessments (self-assessment checklist and ergonomic DSE risk assessments) are retained for a period of 7 years and are checked annually to ensure necessary controls are still appropriate and effective.

## Training

51. Where an employee has been classified as a DSE user they must be provided with adequate information and instruction aimed at reducing and minimising the risks of DSE related ill health.

51.1. The DSE e-learning tool provides the necessary training for all users to then complete their own DSE self-assessment checklist.

51.2. Information/instruction must cover the health and safety aspects of using DSE, including the detection and recognition of risks and hazards; causes of risks; importance of comfortable posture; correct use of equipment and how to get the best set-up; importance of taking breaks and changes of activity; understanding of how to raise concerns.

51.3. Additional information can be sourced from the HSE web site.

51.4. Training should be provided on new computer software particularly where there is significant data or information entry to ensure individuals are using the package appropriately e.g. function and shortcut keys are used to reduce mouse use.

## Monitoring Compliance

52. Compliance with the document will be monitored in the following ways:

| Aspect of compliance or effectiveness being monitored | Monitoring method | Responsibility for monitoring | Frequency of monitoring | Group or Committee that will review the findings and monitor completion of any resulting action plan |
|---|---|---|---|---|
| DSE e-learning tool completed | Learning and Development quarterly report | Culture and Leadership | Quarterly | Health and Safety Committee |
| DSE Self-assessment checklist completed | Safety, Quality and Risk | Health and Safety Team | Quarterly | Health and Safety Committee |
| MSK incidents related to DSE reported via Trust's Incident Reporting System | Safety, Quality and Risk | Health and safety Team | Quarterly | Health and Safety Committee |

53. In addition to the monitoring arrangements described above the Trust may undertake additional monitoring of this policy as a response to the identification of any gaps or as a result of the identification of risks arising from the policy prompted by an incident review, external reviews, or other sources of information and advice.

## Review

54. This policy will be reviewed in 3 years, as set out in the Policy for the Development and Implementation of Procedural Documents. Policies may need to be revised before this date, particularly if national guidance or local arrangements change.

55. Until such time as the review is completed and the successor document approved by the relevant committee this policy will remain valid.

## References

56. [1] Health and Safety (Display Screen Equipment) Regulations 1992 as amended by the Health and Safety (Miscellaneous Amendments) Regulations 2002.

57. BS EN ISO 9241-11 2018 Ergonomics of human-system interaction. Usability: Definitions and concepts.

58. The Health and Safety at Work etc. Act 1974.

59. The Management of Health and Safety at Work Regulations 1999.

## Equality Impact Assessment

60. As part of its development, this policy and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible, remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation or religious belief. A copy of the completed EIA is available in Appendix 3.

61. This policy is supportive of a DSE user with a disability as it helps ensure the disability is taken into account in regard to their workstation. Those DSE users with a disability may require support from COHWB. A DSE user with a disability e.g. visual may require assistance from their Manager/DSE Assessor and/or COHWB to complete the DSE e-learning and DSE self-assessment checklist.

62. For employees that are pregnant, the new and expectant mothers risk assessment must be completed and any actions taken.

## Document History

| Date of revision | Version number | Reason for review or update |
|---|---|---|
| 1999 | 1.2 | New document |
| 2006 | 2.0 | Update of previous version |
| 2008 | 3.0 | Update of previous version |
| 2010 | 4.0 | Update of previous version |
| 2019 | 4.1 | Review of policy to reflect current legislation, guidance and best practice. Amendments to DSE Assessor role, new DSE e-learning tool and DSE self-assessment checklist. |
| 2020 | 4.2 | Updated following feedback on draft from Health and Safety |
| 2023 | 4.7 | New eye voucher scheme |

# Appendix 1: Workstation minimum requirements and guidance

The DSE Regulations[1] set out minimum requirements for workstations and is applicable mainly for typical office workstations. The Trust is obliged to meet these minimum workstation requirements. Workstation assessments need to be completed to ensure that the relevant hazards and associated risks to the user have been assessed and appropriate control measures put in place (DSE e-learning and self-assessment checklist available via Learning and Development intranet site). This appendix contains the minimum requirements as set out in the Schedule to the DSE Regulations[1] and also guidance which will assist compliance.

## a) Workstation

***Schedule***

- Each workstation (desk and seating area) should be large enough to accommodate the range of task's being carried out and allow a flexible arrangement of the screen, keyboard, documents and related equipment.
- There should be sufficient space for the user to get to and from the desk with ease.
- Regulation 10 of the Workplace, (Health, Safety and Welfare) Regulations 1992 states every room where people work must have sufficient floor area, height and unoccupied space for the purposes of health, safety and welfare. The total volume of the room, when empty, divided by the number of people normally working in it should be at least 11 cubic metres.
- Shared workstations should have equipment that can be adjusted to accommodate both a tall and a petite user.

***Guidance***

- The work surface dimensions need to be adequate to accommodate equipment and take into account the range of tasks performed e.g. telephone use and paper-based tasks.
- The work surface should be at a minimum of 720mm in height and a minimum depth of 750mm. The viewing distance of the screen will be affected by the desk depth- it is recommended that the screen is at arm's length when seated.
- The length of a DSE users' desk is not specified and is dependent on the users' needs and task requirements. In the Trust there are a variety of surfaces used to support DSE e.g. workstation on wheels and fixed work tops.

## b) Work Chair

***Schedule***

- The work chair shall be stable allowing the user easy freedom of movement and a comfortable position with adequate spinal support.
- The chair seat shall be adjustable in height.
- The seat back rest shall be adjustable in both height and tilt.
- A footrest shall be made available to anyone who requires one.

***Guidance***

- The primary requirement is that the work chair should allow the user to achieve a comfortable position.
- The work chair should be a swivel type with 5 castors/feet for stability

- The seat height adjustment should accommodate the needs of the user for the tasks performed and allow them to sit at the workstation with their upper limbs in a comfortable position (upper arm vertical/forearm horizontal).
- Some staff may require a seat tilt option for comfort.
- The seat cushion should provide adequate support and cushioning and be of adequate size to allow thigh support with no compression (i.e. under thighs or behind knees).
- Armrests are optional and should be adjustable in height. The armrests should not interfere with freedom of movement or impede access to the desk. The user must be able to pull in close to the desk. Armrests can be removed if they are found to restrict movement.
- A DSE user chair of standard height will be fitted with standard castors suitable for a carpeted floor. If the chair is to be used on a hard floor e.g. vinyl/wood, it is recommended that 'soft castors' are ordered- these have a higher friction level and thereby reduce the risk of the chair moving excessively.
- Alternative castors/glides are available, examples for use:
    - Glides used on high draughtsman style chairs to eliminate the likelihood of the chair rolling as the user climbs onto the chair. If the high chair is on carpet- castors may be preferred.
    - Locking castors i.e. locked when chair is occupied or unoccupied. The selection would depend on how the chair was being used and by whom: contact COHWB for guidance.
- The chair should be easily adjusted by the user who should be familiar with all the controls.
- All chairs need to be adjusted to suit the user. Guidance on setting up a DSE chair can be found on the OH intranet pages under DSE.
- Guidance on upgrading a faulty or uncomfortable chair can be found on the COHWB intranet site
- Footrests: required when a user is unable to rest their feet on the floor and/or a foot ring of a high chair is uncomfortable/difficult. DSE users who are < 5ft 2" tall usually require a footrest when seated at a standard height desk.

## c) Work desks (surfaces)

***Schedule***

- The work desk or work surface shall have a non-reflective, sufficiently large surface and allow a flexible arrangement for equipment and documents.
- The height of the work surface should allow a comfortable position for the arms and wrists and appropriate seating to be used at the height of the desk.
- The depth and width of the desk must be adequate for the task and user.
- If a document holder is required it should be stable and adjustable and positioned so as to minimise the need for uncomfortable head and neck movements.

***Guidance***

- The tasks carried out at the workstation need to be considered in relation to the size of the work surface.

- There shall be adequate clearance for thighs, knees and lower legs and feet. There should be room for postural change under the work surface and between furniture components.
- Where worktop/benching has been installed and used instead of a desk, the width and depth must be adequate for the task and user.
- There should be adequate storage for paperwork and lockable storage for paperwork containing patient or other confidential information.
- Employees who spend prolonged periods sitting due to lack of task variety should aim to change their posture hourly.
- A sit/stand workstation may need to be considered for staff with an underlying medical condition or when their job tasks involve prolonged sitting with no task rotation. Contact COHWB for further information.
- The work surface should be at a height of 720mm (+/- 20mm) for a fixed height desk and 630-1200mm for adjustable height desks.
- The work surface depth should be between 700mm-800mm. The length/width of the desk is not specified in the regulations however a guide would be minimum 1200mm wide.
- The mobile workstations need to be easily adjustable in height, so that they can be used in sitting or standing and awkward postures are not adopted to view the screen.
- Document holders can be useful for work with hard copies to avoid repetitive awkward neck movements. Dependent on the hard copy- the holder should be placed between the keyboard and screen or to the side of the screen at the same visual height as the screen.
- Shelves fitted above the desk can limit screen height and may need to be raised.

## d) Display Screens

***Schedule***

- The characters on the screen should be well defined, clear and legible and be of adequate size and adequate spacing.
- The image on the screen should be stable, with no flickering or other forms of instability.
- The brightness and contrast between the characters and the background shall be easily adjustable by the user and also easily adjustable to ambient conditions.
- The screen should be able to swivel and tilt easily
- The screen should be free of reflection and glare liable to cause discomfort to the user.

***Guidance***

- Choice of screen should be considered in relation to other elements of the work system, such as the type and amount of information required for the task and environmental factors.
- Ideally the screen should be adjustable in height to accommodate all users.
- Sizes of screen are not specified in the DSE Regulations. The screen and the characters/images on it need to be large enough for the user to do their work comfortably. Larger screens/multiple screens may benefit those who have to access multiple applications simultaneously to transfer data.

- The screen should be positioned centrally at approximately arm's length away.
- The height of the screen should be such that eye level is at the top of the screen to allow a slightly downward gaze to the screen. Wearers of bifocals/varifocal glasses may prefer a lowered screen height as they are reading the screen from the lower third of their lenses.
- Screen risers/arms are useful to achieve the correct screen height, especially when there are multiple users of the same workstation. The riser/arm should be stable and an appropriate size.
- Additional screens should be set in line with the primary screen and the same considerations applied.
- Glare and reflections need to be avoided by primarily having the screen positioned at a right angle to a natural light source. Further information can be found under the environmental section.
- Keeping the screen clean will aid its legibility- use the appropriate screen wipes to avoid smearing.

## e) Keyboards

***Schedule***

- The keyboard should be separate from the screen, have the ability to tilt and be non-reflective.
- The space in front of the keyboard should be sufficient to provide support for the hands and wrists of the user.
- The symbols on the keys shall be adequately contrasted and legible from the working position.

***Guidance***

- Keyboard design should allow users to locate and activate keys quickly, accurately and without discomfort.
- The choice of keyboard will be dictated by the nature of the task and determined in relation to other elements of the work system.
- Hand/wrist support may be incorporated into the keyboard design, depending on what the worker finds comfortable. Support can also be gained by leaving an adequate space between the keyboard and the front edge of the desk; or may be provided by a separate hand/wrist support (remove any existing wrist support from keyboard).
- There should be approximately 10cms of clear desk space in front of the user's keyboard to rest their wrists during pauses in work, when they are not typing.
- It is not a requirement of the DSE regulations to provide ergonomic keyboards for all users. However, there may be cases where a specialist keyboard is recommended due to an underlying medical problem or report of upper limb pain. A manager should refer an employee if they are experiencing a musculoskeletal problem related to their DSE work, which has not resolved following the guidance in the DSE e-learning/intranet.
- DSE is increasingly being used with other, non-keyboard input devices such as mouse or trackball.

## f) Mouse and other input devices (trackball or other pointing device)

***Schedule***

- The mouse/input device must be positioned to avoid over stretching of the arm.

- The choice of mouse must be comfortable for the user, in relation to size, shape, handedness and ease of operation.
- The choice of input device (e.g. trackball, touchpad, ergonomic mouse) must be suitable for the task and easily used with a good working posture when viewing the screen.
- Speech can be another form of non-keyboard input: though not strictly a pointing device, some brief guidance on speech interfaces is included below.

***Guidance***

- Use the device with a relaxed arm and as close to the body/midline as possible - not out to the side.
- The arm using the device should feel reasonably relaxed and be supported on the work surface or chair arm.
- The device should be on a suitable surface and there should be enough space to use it.
- If used with the keyboard, the mouse should be kept close to the keyboard. If the keyboard is not being used the keyboard can be moved so the mouse can be positioned closer to the centre.
- The device needs to be the right size and shape for the user and accommodate left or right-handed use.
- The device may need special features for a user with a disability or a reported musculoskeletal problem- seek guidance from COHWB.
- If the mouse/device is being used at a stretch due to a mismatch in size between the keyboard and the users shoulder width then consider using a mini keyboard- this will bring the mouse arm in closer- contact COHWB for information.
- A wireless mouse/input device can be heavier to move due to battery weight. Carefully consider whether a wireless mouse is necessary.
- Mouse mats are now generally not required due to mice being infra-red. Users may prefer a mouse mat with an integral wrist rest- care needs to be taken over the size and position of the mat.
- The speed and sensitivity of the pointing device can be adjusted in the software settings. Both cursor speed and sensitivity of the buttons can be adjusted.
- When purchasing new equipment consider the device size, shape, handedness, number and position of buttons, ease of operation and user comfort. The Trust has a specialist ergonomics advisor who can advise further. The DSE e-learning and self-assessment DSE checklist must be completed prior to contacting the COHWB. The COHWB has several mice/pointing devices that can be loaned for a trial period.

## g) Touchscreens (iPads/tablet PC's)

***Schedule***

- There are various uses for touchscreens- some are built into the main display; others are stand-alone screens.
- Some of the general advice given in the input devices section applies to touchscreens, but there are some special considerations.

***Guidance***

- The touchscreen needs regular maintenance, particularly cleaning. The screen's sensitivity to touch needs to be suitable, to ensure the screen is easy to use.

- Screen positioning may require some care. In the workplace the position of the screen for viewing plus the position of the screen for using as a touch screen need to be considered.
- When using an iPad whilst standing the user needs to be comfortable. A case for the iPad can be used to protect the iPad and also provide an improved method of holding the iPad to reduce gripping it too tightly.
- Where a desk top PC or laptop can be used this is preferable to an iPad.
- Where possible the iPad should be rested on an angled surface at a comfortable height for both reading and typing. If the user experiences discomfort whilst using the iPad they should stop using it and advise their manager.
- The position of the screen needs to avoid any reflection and glare from the ceiling lights but also but in a position to avoid any awkward upper limb postures e.g. overreaching at shoulder height (consider using a mouse if the screen viewing position is critical).
- The software needs to be suitably designed for the touchscreen e.g. active areas large enough to respond to users with large or small fingers.
- This type of equipment is designed for work of a short duration and should not be used in preference to a desktop computer.
- Advice should be sought from the specialist ergonomics advisor in COHWB, if in any doubt on how to achieve the optimum position/use.

### h) Speech Interfaces

Speech interfaces are becoming more readily available as the technology improves. Little is currently known about the health and safety aspects associated with their use. As with other forms of non-keyboard device, the characteristics of this form of input should be considered in assessing its suitability for the task, the environment and the user. Relevant factors include:

- The position of the microphone
- The software settings
- How noisy the environment is in which it will be used
- Whether the use will be a distraction to others
- Possible effects on the user e.g. voice strain

Voice recognition software is becoming more powerful and versatile and can be used exclusively or in conjunction with other input devices. If used, particular attention should be given to the initial and refresher training of users and specialist IT support for them.

Contact the COHWB for further advice on specialist computer assisted software.

### i) Portable DSE (Laptops/notebooks)

Portable DSE, such as laptop and notebook computers, are subject to the DSE guidance if they are in prolonged use (periods of an hour or more and on most days). Some of the risks associated with portable DSE are different to those of a desktop DSE; these can be attributable to the size, design and function of the hardware. Lack of keyboard/screen separation can make it more difficult to achieve a comfortable position. Common health issues that can arise include:

- Neck or eye problems from trying to see the screen at an awkward angle
- Shoulder or back problems from carrying the equipment

- Wrist and hand problems from overusing input devices which require greater manual dexterity.

Portable DSE is also used in a wider range of environments, some of which may be poorly suited to DSE work, such as cramped or non-adjustable workplaces e.g. train and cars.

A laptop should only be used by employees when they are away from their main place of work and they should not be a replacement for a desktop computer. A more rigorous and reinforced attitude to taking regular breaks and/or changes of activity for portable users not working at docking stations is essential and must be adhered to.

Additional equipment or accessories are required to make laptops safer to use, such as:

- Laptop stand
- Large and clear screens
- Keyboards and mice that are separate from the rest of the laptop
- Sufficient memory and processor speed
- Docking station/e-port at the workstation
- Suitable laptop bag/rucksack

The screen height needs to be appropriate for the user and therefore for prolonged use a laptop stand should be used. The screen size may have an impact on visual comfort due to reflection on the screen, characters being too small and inappropriate colours or inadequate contrast.

It is important that users of portable DSE are given instruction and training in how to best utilise such equipment and reduce avoidable risks. The training is provided in the DSE e-learning package and a user must complete their own DSE self-assessment checklist.

Where an employee is required to work from home as part of their normal role then they should be provided with the appropriate equipment to use their laptop which helps minimise the possible risks associated with prolonged laptop use.

As well as the risks common to both portable and desktop DSE work, the following additional risks must also be considered:

**Manual Handling**

A manual handling risk assessment may be required if the weight being transported will exceed 8kg.

Working between locations may mean transporting other equipment and materials such as spare batteries, printer, projector, paper and paperwork which is in addition to the portable DSE itself.

- Taking into account the shape and size of a laptop and or portable device- lighter models will often be best (e.g. 3kg or less) - but this should not compromise good ergonomic design.
- Consider the loading and unloading of the equipment into cars/public transport/shuttle bus and the distances to be carried and terrain (e.g. stairs, slopes)
- Provide users with a lightweight rucksack-style bag or wheeled luggage trolley to help reduce the risk of injury. The choice of carrying case/bag will depend on the user's needs, capabilities, equipment carried, job role and transport used.
- Consider sending paperwork in advance electronically.
- Reduce miscellaneous items, such as leads, cases and paperwork by providing them in each location where the portable DSE is used.

**Risk of Theft**

The portable equipment may be compact and therefore more accessible and desirable to an opportunistic thief. All users should take sensible precautions and be aware of the risk of theft and possible attack; store equipment out of site and do not leave it unattended; back up information regularly, avoid computer branded bags and avoid lone working in circumstances where theft is likely.

## j) Environment

The Workplace (Health, Safety and Welfare) Regulations 1992 contain minimum environmental requirements for all workplaces, covering space, lighting, heating and ventilation.

**Space**

The workstation should have the necessary dimensions and be designed so as to provide sufficient space for the user to change positions and vary movement. There needs to be adequate clearance for thighs, knees, lower legs and feet under the work surface and between the furniture components. The user needs to be able to sit down and get up without difficulty. The height of the work surface should allow a comfortable position for the arms and wrists, if a keyboard, mouse or other input device is used. Safe and easy access must be available to access files, documents and other office equipment. Adequate space must also be provided to store personal belongings.

**Lighting**

The lighting should be appropriate for all tasks at the workstation, including reading from the screen; keyboard work and reading printed text. General lighting, by artificial or natural light or a combination, should illuminate the entire room to an adequate standard.

Any supplementary individual or task lighting provided to cater for individual's needs or a task should not adversely affect visual conditions at nearby workstations. Further guidance is available from the HSE guidance 'Lighting at work'.

**i) Illuminance**

- Any room lighting or task lighting provided should ensure satisfactory lighting conditions and appropriate contrast between the screen and the background environment, taking into account the type of work and the vision requirements of the user.
- High illuminances render screen characters less easy to see but improve the ease of reading documents.

**ii) Reflections and glare**

- Workstations should be designed so that sources of light, such as windows and other openings, transparent or translucent walls and brightly coloured fixtures or walls cause no direct glare and no distracting reflections on the screen.
- Desks placed at a right angle to the window/light source will reduce the amount of reflection and glare on a screen. Avoid the user or screen facing a window or bright lights.
- Problems which can lead to visual fatigue and stress can arise, for example from unshielded bright lights or bright areas in the worker's field of view; from an imbalance between brightly and dimly lit parts of the environment; and from reflections on the screen or other parts of the workstation.
- Windows should be fitted with a suitable system of adjustable covering to reduce the daylight that falls on the workstation.

- Measures to minimise these problems include shielding (e.g. window films), replacing or repositioning sources of light; rearranging or moving work surfaces, documents or all or parts of workstations; modifying the colour or reflectance of walls, ceilings, furnishings, etc. near the workstation; altering the intensity of vertical to horizontal illuminance; or a combination of these.
- Anti-glare screen filters should only be considered as a last resort. They are not likely to improve a modern screen that already has an anti-glare finish.

**Noise**

Noise from equipment such as printers or other DSE workstations should be kept to levels which do not impair concentration or prevent normal conversation. Noise from equipment is best reduced at source by specifying quieter alternatives when ordering replacements. Sound-insulating partitions between noisy equipment and co-workers can help reduce the distracting noise. There are certain levels of noise which require action under the Noise at Work Regulations 2005 however "nuisance noise" would be below this level (80 decibels). Actions need to be considered if staff are having difficulties undertaking their tasks due to distracting noise.

**Temperature/Humidity**

Equipment at a workstation should not produce excess heat which could cause discomfort to the user. Ventilation and humidity should be maintained at levels which prevent discomfort and problems of sore eyes. There may be occasions in the summer months when temperatures reach above 24°C and local cooling with fans is needed. Further information can be obtained from the HSE '*Thermal comfort in the workplace: Guidance for employers'*.

**Radiation**

All radiation with the exception of the visible part of the electromagnetic spectrum should be reduced to negligible levels from the point of view of the protection of user's health and safety. LCD flat-panel screens do not emit any electromagnetic radiation, except visible light. There is no special action required due to the exceedingly small amounts.

## k) Task design and software:

***Principles of task design***

Inappropriate task design can be among the causes of stress at work. Stress jeopardises employee motivation, effectiveness and efficiency at work and in some cases can lead to significant health problems. The DSE Regulations are only applicable where health and safety rather than productivity is being put at risk. In DSE work, good design of the task can be as important as the correct choice of equipment, furniture and working environment. It is advantageous to:

- Whenever possible design jobs in a way that offers users variety, opportunities to exercise discretion, opportunities for learning and appropriate feedback in preference to simple repetitive tasks.
- Match staffing levels to volumes of work, so that the individual users are not subject to stress through being either overworked or underworked.
- Allow users to participate in the planning, design and implementation of work tasks whenever possible.

***Principles of software ergonomics***

In designing, selecting and commissioning and modifying software and in designing tasks using DSE, the employer should take into account the following principles:

- Requirements of the organisation, the task and the DSE workers concerned should first be established as they provide the basis of designing, selecting and modifying software.
- Software must be suitable for the task
- Software must be easy to use and where appropriate, adaptable to the level of knowledge or experience of the user.
- Training will need to be adapted to the requirements of the particular DSE tasks, be adapted to the users skills and capabilities and be refreshed or updated as the hardware, software, workstation, environment or job are modified.
- Systems should provide feedback to users on the performance of those systems.
- Systems should display information in a format and at a pace, which are adapted to users.
- The principles of software ergonomics must be applied, in particular to human data processing.
- Involving a sample of users in the purchase or design of software can help to avoid problems.

## l) Breaks

The purpose of a break for DSE work is to prevent/reduce the risk of DSE related ill health. To achieve this objective, the Trust will seek to incorporate changes of activity into the working day. These breaks may naturally occur in many tasks e.g. collecting printing, photocopying, reading over printed material, filing, conversing with colleagues. Any employee who believes that his or her DSE workload does not permit adequate breaks should bring this to the attention of the management.

Some general guidance:

- Breaks or changes of activity should be included in working time.
- There is no prescribed frequency or duration of breaks from DSE work.
- Breaks should be taken before the user starts getting symptoms/tired.
- Short, frequent breaks (3-5 minutes) every 60 minutes are more beneficial than a longer less frequent break.
- Where possible, users will be given the discretion to decide the timing and extent of off-screen tasks.
- Breaks should be taken away from the workstation
- Stretching, blinking, changing focus and/or position regularly is encouraged hourly.
- An information sheet is available on the OH intranet site, with simple work stretches to undertake at your desk which may help reduce minor aches and pains.

## m) Eyes and Eyesight Tests

Employees are entitled, but have no obligation, to undergo an appropriate eye and eyesight test, provided by their employer, when they are:

- Employees who are DSE users
- Existing employees being transferred to work that will make them a user
- People who are being recruited as a user

An appropriate eye and eyesight test is one carried out by a registered ophthalmic optician or a registered medical practitioner with suitable qualifications. It includes a test for vision,

examination of the eye and should take into account the users work, including the distance at which the screen is viewed. The purpose of the test is to determine if the user has any defect in sight which requires correction when working with DSE. The screening is not conducted such that it will identify individuals with defective vision e.g. short sightedness or eye defects such as injury or disease.

The Trust has an eye sight test scheme and details can be found on the COHWB intranet site

## n) Information, Consultation and Training

Users of Display Screen Equipment are required under the Regulations to receive information and training on the measures taken by the Trust to protect them from, or to reduce the risks associated with the use of DSE; these provisions are met within the Trust by:

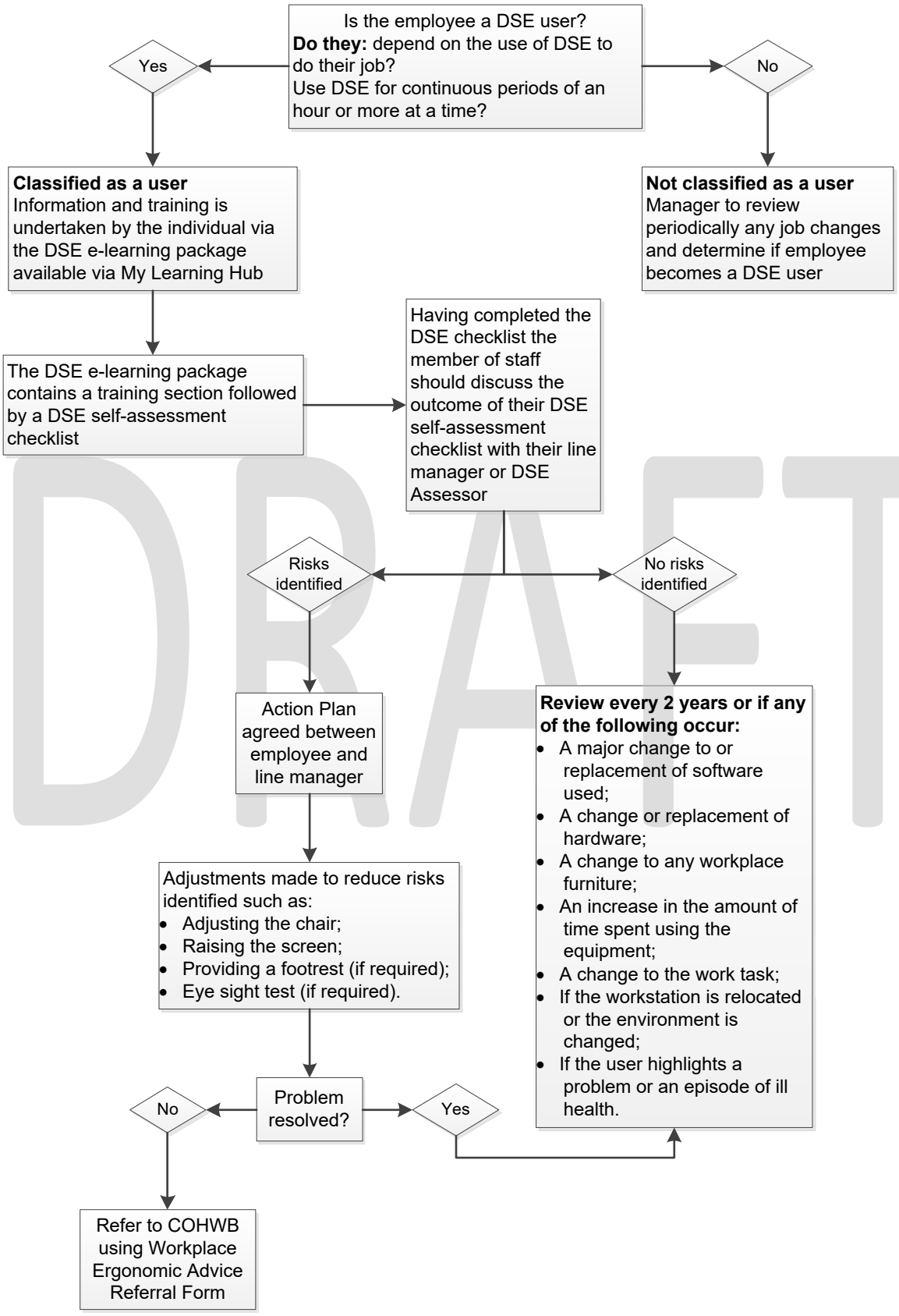
- Training courses aimed at all DSE users, available via the My Learning Hub site(DSE e-learning package).
- Further DSE information can be found on the COHWB intranet site

### o) Reporting adverse effects from working with DSE

Users of DSE who feel that they are suffering from any adverse effects from their work from either a health and/or safety viewpoint must report the problem to their Line Manager. The User must ensure they have an up-to-date DSE self-assessment checklist (Appendix 2) completed and this must be discussed with their Line Manager. An action plan must be agreed and any guidance/advice sought is followed.

If following the guidance and adjustments made with the Line Manager the problems have not resolved, contact can be made with the COHWB and a Workplace Ergonomic Advice Referral Form completed and sent to COHWB (Appendix 4). The OH Physiotherapy team will triage any referrals into COHWB and offer advice and/or assessment. A DSE self-assessment checklist (Appendix 2) must be completed prior to any referral for a workplace assessment.

# Appendix 2: DSE Training, Assessment and Referral Flow Chart



### Alternate text description of flowchart

An employee is defined as a DSE user if they depend on the use of DSE to do their job and use DSE for continuous periods of an hour or more at a time.

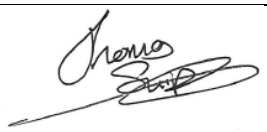
If the employee is not classed as a DSE user the manager should review periodically any job changes to determine if the employee becomes a DSE user.

If the employee is classed as a DSE user the following must happen:

- Employee undertakes DSE e-learning package via the Trust's electronic learning management system;
- Having completed the DSE e-learning package the employee must complete the DSE Self Assessment Checklist and discuss the findings with their line manager
- If the DSE Self Assessment Checklist identifies risks an action plan should be agreed between the employee and their line manager, which may include adjusting the chair, raising the screen, providing a footrest (if required) or eye sight test;
- If the adjustments identified in the action plan do not resolve the issue(s) a referral should be made to the Centre for Occupational Health and Wellbeing using the referral form in appendix 4 (no referral is necessary if the actions resolve the issue);
- If the DSE Self Assessment Checklist does not identify any risks (or if the action plan resolves the risks) the checklist should be reviewed every two years or if any of the following occur:
    - A major change or replacement of the software or hardware used;
    - A change to any workplace furniture;
    - An increase in the amount of time spent using the equipment;
    - A change to the work task;
    - If the workstation is relocated or the environment changed;
    - If the user highlights a problem or an episode of ill health.

# Appendix 3: Equality Impact Assessment

## 1. Information about the policy, service or function

| | |
|---|---|
| **What is being assessed** | Existing Policy / Procedure |
| **Job title of staff member completing assessment** | Senior Occupational Health Physiotherapist |
| **Name of policy / service / function:** | Display Screen Equipment Policy |
| **Details about the policy / service / function** | The procedures and guidelines in this policy are made in compliance with the Health and Safety (Display Screen Equipment) Regulations 1992 as amended by the Health and Safety (Miscellaneous Amendments) Regulations 2002.<br>The DSE Regulations 2002 apply to employees covered as users and are designed to protect users whether they are employed to work:<br>• At their own employers workstation<br>• At a workstation at home<br>• At another employers workstation |
| **Is this document compliant with the Web Content Accessibility Guidelines?** | Yes |
| **Review Date** | 3 years |
| **Date assessment completed** | July 2020. Reviewed November 2023. |
| **Signature of staff member completing assessment** |  |
| **Signature of staff member approving assessment** |  |

## 2. Screening Stage

**Who benefits from this policy, service or function? Who is the target audience?**

- Staff

**Does the policy, service or function involve direct engagement with the target audience?**

Yes - *continue with full equality impact assessment*

## 3. Research Stage

**Notes:**

- If there is a neutral impact for a particular group or characteristic, mention this in the 'Reasoning' column and refer to evidence where applicable.
- Where there may be more than one impact for a characteristic (e.g. both positive and negative impact), identify this in the relevant columns and explain why in the 'Reasoning' column.
- The Characteristics include a wide range of groupings and the breakdown within characteristics is not exhaustive, but is used to give an indication of groups that should be considered. Where applicable please detail in the 'Reasoning' column where specific groups within categories are affected, for example, under Race the impact may only be upon certain ethnic groups.

### Impact Assessment

| Characteristic | Positive Impact | Negative Impact | Neutral Impact | Not enough information | Reasoning |
|---|---|---|---|---|---|
| **Sex** | | | X | | This policy will have a neutral impact on this characteristic as it details a process all DSE users will have to undertake with no scope for differential treatment. |
| **Gender Re-assignment** | | | X | | This policy will have a neutral impact on this characteristic as it details a process all DSE users will have to undertake with no scope for differential treatment. |
| **Race** - Asian or Asian British; Black or Black British; Mixed Race; White British; White Other; and Other | | | X | | This policy will have a neutral impact on this characteristic as it details a process all DSE users will have to undertake with no scope for differential treatment. |
| **Disability** - disabled people and carers | X | | | | This policy is supportive of a DSE user with a disability as it helps to ensure their disability is taken into account in regard to their workstation. Those DSE users with a disability may require support from COHWB in regard to completion of their workstation assessment. |
| **Age** | | | X | | This policy will have a neutral impact on this characteristic as it details a process all DSE users will |

| Characteristic | Positive Impact | Negative Impact | Neutral Impact | Not enough information | Reasoning |
|---|---|---|---|---|---|
| | | | | | have to undertake with no scope for differential treatment. |
| **Sexual Orientation** | | | X | | This policy will have a neutral impact on this characteristic as it details a process all DSE users will have to undertake with no scope for differential treatment. |
| **Religion or Belief** | | | X | | This policy will have a neutral impact on this characteristic as it details a process all DSE users will have to undertake with no scope for differential treatment. |
| **Pregnancy and Maternity** | X | | | | For employees that are pregnant, the new and expectant mothers risk assessment must be completed and any actions taken. This will ensure that the needs of this group are met. |
| **Marriage or Civil Partnership** | | | X | | This policy will have a neutral impact on this characteristic as it details a process all DSE users will have to undertake with no scope for differential treatment. |
| **Other Groups / Characteristics** - for example, homeless people, sex workers, rural isolation. | | | X | | This policy will have a neutral impact on this characteristic as it details a process all DSE users will have to undertake with no scope for differential treatment. |

### Sources of information

- The Health and Safety at Work Act 1974
- The Health and Safety (Display Screen Equipment) Regulations 1992 as amended by the Health and Safety (Miscellaneous Amendments) Regulations 2002
- The Management of Health and Safety at Work Regulations 1999.
- HSE DSE Guidance Notes

### Consultation with protected groups

*List any protected groups you will target during the consultation process, and give a summary of those consultations*

| Group | Summary of consultation |
|---|---|
| Disabled staff | |

### Consultation with others

This policy is subject to a 30-day consultation period, during which all staff will have the opportunity to comment.

## 4. Summary stage

### Outcome Measures

- The key outcome of this policy is to minimise the risks associated with working with DSE. Therefore the policy is intended to raise awareness amongst DSE users and to provide managers and staff with the details of how they can avoid and reduce the risks associated with the use of DSE.
- All DSE users should have access to training in DSE risk reduction and be able to complete a DSE self-assessment. Support from their manager and/or COHWB can be provided for staff that are unable to complete these requirements themselves.
- Any risks should be identified and primarily managed locally and further advice requested if required.

### Positive Impact

- This procedure will have a positive impact in terms of disability and pregnancy and maternity as, through the DSE assessment, it will enable the needs of these groups to be highlighted and action to be taken if any adjustments are needed.

### Unjustifiable Adverse Effects

None identified

### Justifiable Adverse Effects

None identified.

## Equality Impact Assessment Action Plan

Complete this action plan template with actions identified during the Research and Summary Stages

| Identified risk | Recommended actions | Lead | Resource implications | Review date | Completion date |
|---|---|---|---|---|---|
| | | | | | |

# Optical Radiation Protection Policy

| | |
|---|---|
| **Category:** | Policy |
| **Summary:** | To ensure compliance with legislative requirements and national guidance when making use of optical radiation. |
| **Equality Analysis undertaken:** | October 2023 |
| **Valid From:** | January 2024 |
| **Date of Next Review:** | January 2027 |
| **Approval Date/ Via:** | Radiation Protection Committee 10th October 2023<br>Health and Safety Committee 27th October 2023 |
| **Distribution:** | Trust Wide |
| **Related Documents:** | Trust Laser Local Rules<br>Laser Departmental Audit Procedure (RP&P-NIEQ-L2-006)<br>Laser Training Procedure (RP&P-NIEQ-L2-007)<br>Trust Radiation Protection Policy<br>Trust Health & Safety Policy<br>Trust Medical Devices Policy<br>External Reviews Policy and Flowchart<br>Trust Risk Management policy and Handbook |
| **Author(s):** | Laser Protection Adviser |
| **Further Information:** | Laser Protection Adviser, Department of Medical Physics & Clinical Engineering |
| **This Document replaces:** | Optical Radiation Protection Policy, version 1.1 |

**Lead Director:**

**Issue Date:**

## Document History

| Date of revision | Version number | Author | Reason for review or update |
|---|---|---|---|
| | 1.0 | James Harries | New Document |
| 18/01/2021 | 1.1 | James Harries | Review date reached |
| 05/10/2023 | 1.2 | James Harries | Review date reached plus additions made. Requirement for urgent referral to Occupational Health following adverse exposures (clause 53) and comment on exposure limit values not being exceeded. (clause 16) |

## Consultation Schedule

| Who?<br>Individuals or Committees | Rationale and/or<br>Method of Involvement |
|---|---|
| Radiation Protection Committee | Trust Level Committee. October 2023 |
| Health and Safety Committee | Trust Level Committee. October 2023 |
| Laser Protection Supervisors, Clinical Laser Experts, Departmental Managers, other staff who use or work in the presence of optical radiation. | Staff with specific responsibilities for optical radiation safety. E-mail consultation. Meetings. |
| Radiation Protection Advisers Group | Expert advice. E-mail correspondence and meeting |

## Endorsement

| Endorsee Job Title |
|---|
| Clinical Director Oncology |
| Chair, Radiation Protection Committee |
| Chair of Health and Safety Committee |

# Contents

## Who should read this document?

1. This policy applies to all employees of the Oxford University Hospitals NHS Foundation Trust (the Trust), other persons, and contractors, whilst they are on the sites managed by the Trust.

2. This policy should be read by all staff associated with the use of optical radiation

## Key Standards/Messages.

3. This policy outlines the management arrangements and responsibilities for the protection of staff, patients, the public and the environment.

4. This policy forms part of the Trust's intent to maintain compliance with optical radiation safety legislation.

## Background/ Scope.

5. Oxford University Hospitals NHS Foundation Trust (the Trust) has a legal duty to provide a safe and healthy environment for patients, employees and visitors. This policy outlines the actions the Trust will take to ensure that exposure to optical radiation is managed effectively and the risk of exposure is minimised across the organisation.

6. This policy forms part of the Trust's arrangements for clinical governance and risk management, and for health and safety as required by the Health and Safety at Work etc. Act 1974. In making use of radiation the Trust will ensure compliance with all extant legislative requirements and relevant national guidance

7. A list of the relevant statutes and guidance that applies to this policy can be found in 12.2 Regulatory Position.

8. Failure to comply with this policy may lead to disciplinary action and prosecution of the Trust and/or individual.

9. In the event that departments are non-compliant, the relevant Divisional Director will be informed by the Chair of the Trust's Radiation Protection Committee.

## Key Updates

10. This is the third edition of the Trust Optical Radiation Protection Policy. Updates for this version are the requirement for urgent referral to Occupational Health following adverse exposures (point 53).

## Aim

11. The aim of this policy is to provide an optical radiation protection framework, within which, employees and contractors can work safely, patients can be treated safely and the public can visit the Trust safely. This safety framework is built from guidance and standards relating to optical radiation safety which exist to support compliance with current UK legislation.

# Policy Content

## Introduction

12. Across the Trust Optical Radiation equipment is in use for laser surgery, blue light and Ultra Violet (UV) therapies in the delivery of patient services. In addition, optical radiation equipment is also in use in non-patient areas of work such as desktop projectors and UV insect traps.

13. Where Hazardous Optical Radiation Sources are in use, appropriate safety control measures will be agreed and actioned.

14. Optical radiation encompasses the Ultraviolet, Visible (Light) and Infrared radiation divisions of the electromagnetic spectrum, with a wavelength range from 100nm (UV-C) to 1mm (IR-C).

## Trust Commitment

15. It is the intention of the Trust to fulfil its statutory and mandatory obligations by complying with the Control of Artificial Optical Radiation at Work Regulations 2010[67] and British Standards[71-75] and Guidelines on safe working with Optical Radiations[76-78].

16. The Trust aims to ensure the safety of all persons on Trust premises from any risk from exposure to optical radiation and will ensure that legal exposure limit values (ELV) are not exceeded.

17. The Trust achieves this aim by consistently meeting the following objectives:

- Avoiding the use of lasers and equipment emitting hazardous optical radiation wherever possible.
- Where it is not possible to replace equipment, identifying optical radiation risks across the Trust.
- Assessing the risks of use of optical radiation.
- Implementing appropriate measures to remove, reduce, or control hazardous optical radiation sources.

## The Avoidance of the Use of Lasers and Equipment Emitting Optical Radiation Wherever Possible

18. The Trust will minimise the risks of optical radiation by:

- Using optical radiation equipment classified as non-hazardous wherever possible (Appendix D)
- Ensuring use of optical radiation equipment classified as hazardous is kept to a minimum and only considered where a less hazardous alternative is not available (Appendix C)
- Reviewing existing equipment and replacing with less hazardous alternatives when new equipment is purchased.

- Minimising the number of people exposed to hazardous optical radiation sources and the duration of exposures.

19. Where it is not possible to avoid use of hazardous optical radiation sources a risk assessment is to be completed and Local Rules (Safe System of Work) will be developed and their use implemented.

## Identifying Optical Radiation Risks

20. Across the Trust optical radiation equipment is in use for laser surgery, blue light and UV therapies. These are considered to be hazardous optical radiation sources (Appendix C) and as such must be identified and potential risks of exposure managed.

21. Some optical radiation sources are defined as Safe (Non-Hazardous) optical radiation Sources. These are not hazardous to health and do not require a risk assessment (Appendix D)

22. The Trust recognises that there are a range of radiation exposure risks across sites. In order to successfully manage optical radiation risks there is a Trust Register of all hazardous optical radiation equipment, including class 3B and 4 lasers. The Laser Protection Adviser (LPA) is responsible for ensuring the Trust register is maintained and that its contents is reported to, and reviewed by, the Radiation Protection Committee .

23. New equipment procured must be included in the Trust Register and risk assessed before use.

24. Where uncertainty exists the Laser Protection Adviser must be consulted.

25. Examples include:

- Apparatus described as UV, Infra-red, blue or other light therapy
- Infra-red warming devices
- UV Sterilisation equipment
- UV Laboratory equipment

## Risk Assessment

26. For all optical radiation sources a risk assessment will be completed to ensure hazards are identified and controlled adequately.

27. Risk assessments must be reviewed:

- At least annually
- If there is a change to the equipment, procedure or use location
- If there is a change to working practice
- Following any incident involving that equipment.

28. A completed risk assessment is to provide information about local conditions (equipment, use environment, procedures, staff) from which local safe systems of work can be derived to manage the risks identified.

29. Department/Directorate Heads must ensure a risk assessment is completed for all hazardous optical radiation sources in their work area or areas of responsibility.

30. Department/Directorate Heads must ensure that risk assessments are controlled and managed within their areas of responsibility.

31. The findings of the risk assessments must be incorporated into the Local Rules for each relevant area, and should be used to assess the requirements for control measures that are required to restrict exposure to optical radiation.

## Local Rules (Safe Systems of Work)

32. Department/Directorate Heads must ensure information about safe working will be available for all staff where hazardous optical radiation sources are in use. Department/Directorate Heads must ensure that Local Rules are controlled and held within the department.

33. Local Rules must be drawn up in consultation with the relevant Laser Protection Supervisor or Optical Radiation Protection Supervisor, Laser Protection Adviser and responsible person. These rules will reflect any relevant changes made to the laser risk assessment and hence be reviewed annually.

34. All safe systems of work are to detail the procedures for managing emergency situations (contingency plans), first aid guidance and will define the Controlled Area and safe egress and ingress.

35. All staff are to have access to documented safe systems of work and implement these systems of work at all times.

## Maintenance and Testing of Equipment

36. All hazardous optical radiation equipment in use is to be serviced by the manufacturer/supplier at least annually (or more often if advised by the manufacturer).

37. All hazardous optical radiation equipment will be subject to a service and maintenance contract for the life of the equipment.

38. Departments must have procedures for the handover of equipment and any associated Controlled Area when equipment undergoes maintenance or repair. The Handover procedure will include a description of the tests carried out, with relevant signatures, and clearly demonstrate the status of the equipment, e.g.' Fit for Clinical Use'.

39. As part of the LPA review, equipment will be inspected for safety and compliance.

40. An equipment fault log will be maintained centrally for each piece of hazardous optical radiation equipment (e.g. Class 3B or 4 lasers) and made available for inspection by the LPS, LPA, Service Engineer or NHS/Government inspector.

## Personal Protective Equipment

41. The requirement for protective eyewear use (for staff, patient and visitors) will be determined during local risk assessment. The risk assessment will evaluate equipment and environmental engineering controls and administrative safety control measures prior to recommending the use of PPE.

42. The advice of the LPA will be sought on the use of appropriate protective eyewear.

43. PPE will be regularly inspected (as part of the annual departmental audit) with records kept.

44. If PPE is required to work safely staff are to receive instruction in the correct use, fitting, storage and maintenance of their PPE.

45. PPE specification will be stated within the departments Local Rules

46. In no circumstances will employees substitute Trust provided PPE with their own PPE. The use of prescription eyewear in place of Trust PPE is prohibited.

## Training

47. The relevant Department/Directorate head must ensure that adequate training is provided and recorded for all staff who work around or use hazardous optical radiation or who regularly enter Optical Radiation Controlled Areas (see Training procedure). Training records will be competency based according to the relevant radiation equipment used, clinical procedures carried out, and/or optical radiation areas entered.

48. All new members of staff must receive appropriate instruction on optical radiation protection and safety procedures which will be kept under review.

49. All staff working in designated optical radiation areas must sign a statement saying they have read and understood the appropriate Local Rules.

## Incident Reporting & Investigation

50. All radiation incidents will be reported, recorded and investigated in accordance with Trust policies and procedures. The Department/Directorate Head, in liaison with their governance lead, will be responsible for ensuring that actions and recommendations are taken forward and closed out.

51. A summary of all radiation incidents will be presented to the Radiation Protection Committee on behalf of the relevant departments, together with any recommendations or actions taken including learning points.

52. Where the LPA advises that incidents require notification to an external inspectorate or body, this will normally be done by the LPA in liaison with the relevant governance lead after consultation with Trust senior managers.

53. An urgent referral to Occupational Health is recommended for any member of staff who reports any personal injury as a result of optical radiation exposure at work.

## Internal Audit

54. The Department/Directorate Head is responsible for initiating an on-going monitoring process within their areas of responsibility as described in the Trust Departmental Audit Procedure.

55. Internal departmental Audit should cover all areas of compliance to national legislation and guidance. The LPS, or designate, will carry out the audit program and report to the relevant Clinical Governance Management Committee.

56. The LPA will advise departments on the content for compliance audits, aid in the production of targeted audit forms and an audit plan.

57. As part of the audit processes, it shall be the responsibility of the Department/Directorate Head to monitor that this procedure is being adhered too, and that appropriate actions are being taken to prevent and control exposure to risks associated with optical radiation.

58. It is the responsibility of the Department/Directorate Head to ensure non-compliance is escalated via the Trusts risk and clinical governance framework.

## External Audit

59. The Department/Directorate Head will ensure that external audits and inspections by the various organisations and bodies, e.g. Care Quality Commission, Health and Safety Executive, etc. will be managed according to the Trust's External Reviews Policy and Flowchart.

## External Communications

60. When communications are received from external sources (eg HSE, CQC) relating to radiation protection, the relevant Trust's External Review Policy will be consulted along with the Laser Protection Adviser.

## Document Author

61. The document Author is responsible for identifying the need for a change in this document as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and resubmitting the document for approval and republication if changes are required.

## Target Audience

62. This policy will be posted on the Trust intranet and issued to all Department/Directorate Heads, Clinical Laser Experts, Optical /Laser Protection Supervisors.

63. The target audience has the responsibility to ensure their compliance with this document by:

- Ensuring any training required is attended and kept up to date.
- Ensuring any competencies required are maintained.
- Co-operating with the development and implementation of policies as part of their normal duties and responsibilities.

## Review

64. This document will be fully reviewed every three years in accordance with the Trust's agreed process for reviewing Trust-wide documents.

65. Changes in practice, to statutory requirements, revised professional or clinical standards and/or local/national directives are to be made as and when the change is identified.

## References

### Regulations

66. Health and Safety at Work Etc Act, 1974.

http://www.legislation.gov.uk/ukpga/1974/37/contents (Accessed 4th December 2023)

67. Management of Health and Safety at Work Regulations 1999 (SI 1999 No 3242).

http://www.legislation.gov.uk/uksi/1999/3242/contents/made (Accessed 4th December 2023)

68. The Control of Artificial Optical Radiation at Work Regulations 2010 ( SI 2010 No. 1140). http://www.legislation.gov.uk/uksi/2010/1140/contents/made (Accessed 4th December 2023)

69. Control of Substances Hazardous to Health Regulations 2002 (SI 2002 No 2677).

http://www.opsi.gov.uk/SI/si2002/20022677.htm (Accessed 4th December 2023)

70. Personal Protective Equipment at Work Regulations 1992 (SI 1992 No 2966).

http://www.opsi.gov.uk/si/si1992/UKsi_19922966_en_1.htm (Accessed 4th December 2023)

71. Personal Protective Equipment Regulations 2002 (SI 2002 No 1144).

http://www.opsi.gov.uk/si/si2002/20021144.htm (Accessed 4th December 2023)

72. The Personal Protective Equipment (Enforcement) Regulations 2018 (SI 2018 No 390)

https://www.legislation.gov.uk/uksi/2018/390/made (Accessed 4th December 2023)

73. The Medical Device Regulations 2002 (SI 2002 No. 618)

**https://www.legislation.gov.uk/uksi/2002/618/contents (Accessed 4th December 2023)**

**Standards**

74. British Standard BS EN 60825-1: 2014 “Safety of laser products. Equipment classification and requirements. Incorporating corrigendum December 2017.”

https://bsol.bsigroup.com/Bibliographic/BibliographicInfoData/000000000030364399

75. British Standard BS EN 62471: 2008, Photobiological safety of lamps and lamp systems.

https://bsol.bsigroup.com/Bibliographic/BibliographicInfoData/000000000030149289

76. British Standard BS EN 207:2017 “Personal eye-protection. Filters and eye-protectors against laser radiation (laser eye-protectors)”.

https://bsol.bsigroup.com/Bibliographic/BibliographicInfoData/000000000030336444

77. British Standard BS EN 60601-2-22:2020 Medical electrical equipment. Particular requirements for basic safety and essential performance of surgical, cosmetic, therapeutic and diagnostic laser equipment.

https://bsol.bsigroup.com/Bibliographic/BibliographicInfoData/000000000030085294

78. British Standard BS EN 14255-3:2008 Measurement and assessment of personal exposures to incoherent optical radiation. UV-Radiation emitted by the sun. BSI 2008

https://bsol.bsigroup.com/Bibliographic/BibliographicInfoData/000000000030152271

79. PD IEC/TR 62471-3:2015. Photobiological safety of lamps and lamp systems. Guidelines for the safe use of intense pulsed light source equipment on humans

https://bsol.bsigroup.com/Bibliographic/BibliographicInfoData/000000000030290200

**Note: the above Standards are available, via the links provided, using Oxford University networked PC’s within JR Cairns, NOC and Knowledge Centre (Churchill) Libraries.**

**Guidance**

80. Lasers, Medicines and Healthcare products Regulatory Agency (2015) Lasers, intense light source systems and LEDs, Guidance for safe use in medical, surgical, dental and aesthetic practices. Available at https://www.gov.uk/government/publications/guidance-on-the-safe-use-of-lasers-intense-light-source-systems-and-leds (Accessed 4th December 2023)

81. Non-Directorate-General for Employment, Social Affairs and Inclusion (European Commission) (2011) Non-binding guide to good practice for implementing Directive 2006/25/EC “artificial optical radiation”. Available at https://publications.europa.eu/en/publication-detail/-/publication/556b55ab-5d1a-4119-8c5a-5be4fd845b68/language-en (Accessed 4th December 2023)

82. Phototherapy Hart, G. C., Taylor, D. K. and Diffey, B. L. (2010), Phototherapy physics: principles, dosimetry, sources and safety. York: Institute of Physics and Engineering in Medicine, IPEM Report number 101. Available for purchase at Report 101 Phototherapy Physics: principles, Dosimetry, Sources and Safety - IPEM

83. Public Health England, Guidance, Laser radiation: introduction and safety advice (Aug 2017) https://www.gov.uk/government/publications/laser-radiation-safety-advice (Accessed 4th December 2023)

## Appendix 1: Responsibilities

**The Chief Executive will:**

84. Have overall responsibility for ensuring the health and safety and welfare of all persons who are, or may be, affected by the use of radiation and for ensuring systems are in place to manage risks and maintain compliance with relevant legislation.

85. Endeavour to ensure that sufficient resources including staff and finance are made available to ensure compliance with this policy.

86. Discharge their responsibility through designated individuals.

**Department/Directorate Heads**

87. Where a department uses optical radiation, the Department/Directorate Heads will have delegated responsibility for ensuring the Trust's Optical Radiation Protection Policy is implemented within their respective areas. They will report to the Radiation Protection Committee regarding degree of compliance within their own department.

**The following tasks may be delegated but the responsibility may not.**

The Department/Directorate Head must:

88. Ensure employees are aware of the risks to their health and safety from optical radiation and the precautions they must take to minimize those risks.

89. Ensure that employees, who may be exposed to risks optical radiation, are provided with the appropriate training (see Training procedure (laser)), specialist personal protective equipment and/or devices, and receive adequate information and supervision.

90. Ensure that, for all optical radiation areas and optical radiation equipment, risk assessments are carried out and reviewed annually and whenever changes are made, and that safe systems of work and local rules are in place as appropriate.

91. Ensure that (in liaison with the LPA) an LPS, deputy LPS and CLE are formally appointed by letter for all Controlled Areas to monitor and control the application of Local Rules, to ensure adequate radiation protection standards are adhered to, and to inform and advise staff on safe working practices. In departments where lasers are not used but other artificial optical radiation equipment is (e.g. Phototherapy), the term Optical Radiation Protection Supervisor will be used.

92. Ensure radiation safety compliance is audited according to the Trust's approved audit schedule (see Departmental Audit Procedure (laser)) and that the results are reported through the department's governance committees and the Radiation Protection Committee and that any issues are actioned in a timely manner or escalated through the approved governance pathways.

93. Ensure that any radiation safety issues or non-conformances (identified through whatever route, e.g. audits, incidents, external inspections, peer review, QA) are addressed in liaison with the relevant adviser in a timely manner. These should be

recorded on their own risk register, or escalated via their Governance Lead through the Trusts risk and clinical governance framework and reported to the RPC and other relevant committees.

94. Ensure that the LPA and other advisers as appropriate are involved in the planning, purchase, installation and optimisation of all new and replacement facilities, equipment and procedures that utilise ionising or non-ionising radiation sources.

95. Ensure that all users of optical radiation equipment are aware of their obligations under the policy, relevant legislation and guidance.

96. Ensure local rules and written systems of work are drawn up with the approval of the LPA, and reviewed at least every 3 years.

97. Ensure that all optical radiation equipment and monitoring equipment is specified, installed, accepted, maintained and subject to a suitably managed and documented QA program.

98. Ensure that advice is sort from the LPA where loan equipment is being considered for use on Trust property or by Trust staff.

99. Ensure that all types of optical radiation incidents and near-misses are reported, recorded and investigated according to the Trust's incident procedures in liaison with the LPA.

100. In the interests of patient, staff, and visitor safety ensure that an optical radiation equipment replacement programme has been approved and is implemented.

101. Ensure an inventory of optical radiation equipment is maintained and ensure that the amount of equipment is limited to that required to provide an adequate clinical service.

102. Ensure that reviews or inspections carried out by external organisations and bodies are managed according to the Trust's External Reviews Policy and Flowchart and that the LPA is also involved.

103. Ensure adequate resources are made available to the department to maintain compliance with extant legislation and guidance.

### Divisional Governance Leads

104. Governance Leads are responsible for ensuring that action plans and recommendations are closed out and that issues are escalated through the Trust's agreed governance pathways.

### Laser Protection Adviser

The LPA will be knowledgeable and have expertise in matters related to optical radiation equipment safety. The Laser Protection Adviser is to:

105. Provide the Trust with a framework of safety to enable the safe use of hazardous optical radiation equipment, by staff, on patients and in the presence of visitors/carers.

106. Provide expert advice to the Trust with regard to the safe use of hazardous optical radiation equipment.

107. Ensure a Trust Register of Class 3B and 4 laser equipment and other hazardous optical radiation equipment is maintained.

108. Ensure safe systems of work are agreed prior to the purchase or demonstration of new laser or optical radiation equipment.

109. Devise and lead an appropriate quality assurance programme for optical radiation equipment.

110. Provide the Trust with tools to enable and support a departmental audit program

111. Provide the Trust with tools to support and document training.

112. Review departmental audit annually and benchmark compliance.

113. The Laser Protection Adviser can be contacted via the department of Medical Physics & Clinical Engineering on 01865 235324

**Laser Protection Supervisor/ Optical Radiation Protection Supervisor**

The Laser/Optical Radiation Protection Supervisor will:

114. Understand the hazards associated with the use of optical radiation equipment.

115. Develop safe systems of work (Local Rules) for the use of hazardous optical radiation sources in their working area.

116. Ensure staff have completed appropriate training and have read the Local Rules and this is documented as described in the Trust Training Procedure.

117. Develop and maintain equipment specific training material.

118. Maintain a list of Authorised Users for medical lasers and ensure only those named on the list use the equipment (Lasers only).

119. Maintain a list of Authorised Assistants for medical lasers and ensure only those named on the list assist in the use the equipment (Lasers only).

120. Carry out the departmental audit program and provide reports to relevant committees as described in the Departmental Audit Procedure (Laser).

121. Ensure equipment is kept in good condition.

122. Report any incidents or issues of safety (near misses) via Trust reporting systems.

123. Work with the LPA to review risk assessments if there is a change to working practice or new equipment is purchased.

124. Ensure all personnel who enter an Optical Radiation Controlled Area (including Service Engineers) follow safe systems of work.

125. Maintain all relevant safety documentation for the equipment within their areas of work.

**Clinical Laser Expert (Lasers only)**

The Clinical Laser Expert will:

126. Understand the hazards associated with the use of lasers.

127. Works with the LPS to enforce departmental Local Rules.

128. Maintain expert knowledge in their specialty with regard to medical procedures carried out with Laser equipment

129. Develop and maintain procedural specific training material.

130. Oversee the training of those wishing to become Authorised Users.

131. Sign off trained staff as competent to work as Authorised Users.

**Authorised Users, Authorised Assistants & Employees Individual Responsibilities**

All employees that use or operate optical radiation devices are to:

132. Have read and understood the relevant Local Rules prior to entering an Optical Radiation Controlled Area.

133. Have attended relevant training as described in the relevant Trust Training Procedure.

134. Ensure they have suitable knowledge on how to work safely with equipment in their department, both on a day to day basis and in an emergency or unexpected situation.

135. Know where information about hazardous optical radiation sources is kept.

136. Correctly use any control measures, PPE or safe system of work to minimize the risks of using optical radiation.

137. Report any failings in existing systems or equipment or any other concerns relating to the use of optical radiation immediately to their Laser Protection Supervisor.

138. Attend, or co-operate with, health surveillance if requested.

139. Observe and obey all optical radiation protection signage, and relevant Trust procedures.

140. Make full and proper use of any personal protective equipment provided. They must report any defect in such equipment, or any suspected equipment fault or procedural problem, to the LPS or Department/Directorate Head.

141. Must report any incidents whereby a person may have (or has) received an optical radiation exsposure. They must also report any adverse health effects that could have developed as a result of exposure to optical radiation during employment.

### Radiation Protection Committee (RPC)

142. The Radiation Protection Committee (RPC) reports through the Trust's Health & Safety Committee and Clinical Risk Management Committees to the Trust Board.

143. It will meet regularly, at least bi-annually, and will provide an annual report. RPC members will be chosen from all major areas in which radiation is used, and will collectively advise the Trust on measures, policies and procedures that may be necessary to protect patients, staff and the general public from ionising and non-ionising radiations.

144. The Chair of RPC will seek feedback from Department\Directorate Heads and governance leads on level of compliance, status of audit, and progress on action plans.

## Appendix 2: Definitions

145. The following terms and acronyms are used within the document:

| | |
|---|---|
| **CQC** | Care Quality Commission |
| **NHS** | National Health Service |
| **ELV** | Exposure Limit Value: the maximum safe exposure to optical radiation, as defined in the relevant standards or guidelines |
| **IPLs** | Intense Pulsed Light sources |
| **LED** | Light Emitting Diodes |
| **LPA** | The Laser Protection Adviser (LPA) is given responsibility by their employer to oversee laser safety. The LPA will be knowledgeable and have expertise in matters related to optical radiation equipment safety. |
| **LPS** | Laser Protection Supervisor: a member of staff appointed by the Trust who understands the nature of the work with lasers and can exercise proper supervision and manage laser safety on a day to day basis. |
| **CLE** | Clinical Laser Expert: a consultant who has specialised in the use of lasers in a specific area or areas of treatment, appointed by the Trust to oversee procedural training with lasers in that area. |
| **MHRA** | Medicines and Healthcare Products Regulatory Agency |
| **PPE** | Personal Protective Equipment |
| **IR** | Infrared Radiation |
| **UV** | Ultra Violet Radiation |
| **Authorised User** | An individual who has been trained adequately and signed off by the CLE to use the laser clinically. |
| **Authorised Assistant** | An individual who has been adequately trained and signed off by the LPS to assist with laser procedures. |
| **Controlled Area** | The region around the optical radiation equipment where people may be present and in which specific protective controls measures are required. |

## Appendix 3: Training

146. Training for staff who use or work with equipment that emits hazardous optical radiation is mandatory.

147. The required levels of training are detailed in the Departmental Training Procedure

## Appendix 4: Monitoring Compliance

148. The arrangements for monitoring compliance are outlined in the table below: -

| Aspect of Compliance | Monitoring Method | Responsibility for Monitoring | Frequency of Monitoring | Committee responsible for reviewing |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| | | | | **the findings and monitoring completion of any resulting action plans** |
| The Trust will ensure that arrangements for the safety of staff, patients, and visitors when using radiation, including this document and the composition, terms of reference and membership of the RPC are regularly reviewed. | Standing agenda item for Radiation Protection Committee (RPC) | Chair of RPC | At least every 3 years | Radiation Protection Committee |
| Evidence that staff are appropriately trained for their specific responsibilities when using radiation. | Audit of training records and statutory /mandatory on-line training system | Directorate/Department Head | Annual | Radiation Protection Committee |
| The Departmental Manager will implement the Trust's approved internal audit plan using the agreed templates focussing on compliance with policies and procedures, including legislation and guidance, taking | Completion of agreed auditing templates | Directorate/Department Head | Annual | Radiation Protection Committee |

| | | | | |
|---|---|---|---|---|
| into account any recent changes. The audit programme, and the corresponding action plans, will be reviewed by the RPC. | | | | |
| Closure of actions plans associated with incidents, audits, equipment quality assurance, etc. | Audit of all action plans | Departmental Governance Leads | Annual | Radiation Protection Committee |
| Evidence that incident learning points are being shared with all relevant departments across the Trust | Review of incident reporting systems including spot check of departmental minutes | Directorate/Department Head | Annual | Radiation Protection Committee |
| Monitor compliance and progress of any external review action plans in accordance with the Trust's External Reviews Policy. | Review status of actions annually through the Trust's Accreditation and Regulation Team | Trust's Accreditation and Regulation Manager | Annual | Accreditation and Regulation |

# Appendix 5: Equality Analysis

| Have you considered how the Policy will affect people: | Yes | No | How have these groups been included in the development of the Policy? | How will the Policy affect them? |
|---|---|---|---|---|
| Who have a physical or sensory impairment? Have you consulted with them? | Yes | ☐ | | The Policy will not adversely affect this group |
| With a disability? | Yes | ☐ | | The Policy will not adversely affect this group |
| Of different gender? | Yes | ☐ | | The Policy will not adversely affect this group |
| Of different ages? | Yes | ☐ | | The Policy will not adversely affect this group |
| With different racial heritages? | Yes | ☐ | | The Policy will not adversely affect this group |
| With different sexual orientations? | Yes | ☐ | | The Policy will not adversely affect this group |
| Who are pregnant or recently had a baby? | Yes | ☐ | | The Policy will not adversely affect this group |
| With different religions or beliefs? | Yes | ☐ | | The Policy will not adversely affect this group |
| Who are going through gender re-assignment or have transitioned? | Yes | ☐ | | The Policy will not adversely affect this group |
| Of different marital/partnership status? | Yes | ☐ | | The Policy will not adversely affect this group |
| Who are carers? | Yes | ☐ | | The Policy will not adversely affect this group |
| Any other group who may be affected by this policy | Yes | ☐ | | The Policy will not adversely affect this group |

**Summary of Analysis**

| Does the analysis show evidence of: | Yes | No | Please explain your answer |
|---|---|---|---|
| The potential to discriminate? | ☐ | ☐ | |
| The advancement of equality of opportunity? | ☐ | ☐ | |
| The promotion of good relations between groups? | ☐ | ☐ | |

## Appendix 6 Safe (Non-Hazardous) Artificial Optical Radiation Sources

The following are considered to be safe optical radiation sources and do not create risks of harm to staff and therefore do not require a Risk Assessment:-

- All forms of ceiling-mounted lighting used in offices etc that have diffusers over bulbs or lamps.
- All forms of task lighting including desk lamps and tungsten-halogen lamps fitted with appropriate glass filters to remove unwanted ultraviolet radiation.
- Photocopiers.
- Computer or similar display equipment, including personal digital assistants (PDAs).
- Light emitting diode (LED) remote control devices.
- Photographic flash lamps – when used singly.
- Gas-fired overhead heaters.
- Vehicle indicator, brake, reversing and fog lamps.
- Any exempt or Risk Group 1 lamp or lamp system (including LEDs), as defined in British Standard BS EN 62471:2008.
- Any Class 1 laser product, as defined in British Standard BS EN 60825-1:2014, for example laser printers and bar code scanners.

There are also some sources of artificial optical radiation that, if used inappropriately, e.g. placed extremely close to the eyes or skin, have the potential to cause harm but which are perfectly safe under normal conditions of use.

Examples include:

- Ceiling-mounted fluorescent lighting without diffusers over bulbs or lamps.
- High-pressure mercury floodlighting.
- Desktop projectors.
- Vehicle headlights.
- Non-laser medical applications such as: operating theatre and task lighting; diagnostic lighting such as foetal/neonatal trans-illuminators and X-ray light/ viewing boxes.
- UV insect traps.
- Art and entertainment applications such as illumination by spotlights, effect lights and flash lamps (provided that any ultraviolet emissions have been filtered out).
- Multiple photographic flash lamps, for example in a studio.

# Appendix 7 Hazardous Artificial Optical Radiation Sources

Examples of hazardous sources of optical radiation that present a 'reasonably foreseeable' risk of harming the eyes and skin of workers and where control measures are needed include:

- Metal working – welding (both arc and oxy-fuel) and plasma cutting.
- Pharmaceutical and research – Ultra Violet fluorescence and sterilisation systems.
- Hot industries – furnaces.
- Printing – UV curing of inks.
- Motor vehicle repairs – UV curing of paints and welding.
- Medical and cosmetic treatments – laser surgery, blue light and UV therapies,
- Intense Pulsed Light sources (IPLs).
- Industry, research and education, for example, all use of Class 3B and Class 4 lasers, as defined in British Standard BS EN 60825-1:2007(Ref 5).
- Any Risk Group 3 lamp or lamp system (including Light Emitting Diodes), as defined in British Standard BS EN 62471:2008 (Ref 6), for example search lights, professional projections systems.
- Less common hazardous sources are associated with specialist activities – for example lasers exposed during the manufacture or repair of equipment, which would otherwise not be accessible.

## Appendix 8 Laser Classification

The laser standard BS EN 60825-1:2014 classifies laser products according to the beam hazard.

- **Class 1:** Safe under reasonably foreseeable conditions of operation (Wavelength 180nm – 1mm).
- **Class 1C** - Safe without viewing aids, lasers are designed explicitly for contact applications to the skin or non-ocular tissue (Wavelength 180nm – 1mm).
- **Class 1M:** As Class 1 but not safe when viewed with optical aids such as eye loupes or binoculars (Wavelength 302.5nm – 4000nm).
- **Class 2:** (Visible laser beams only). Output power less than 1 mW. Not inherently safe but the eye is protected by the normal aversion responses, including the blink reflex and head movement (Wavelength 400nm-700nm).
- **Class 2M:** As Class 2 but not safe when viewed with optical aids such as eye loupes or binoculars. (Wavelength 400nm-700nm).
- **Class 3R:** Output power up to 5mW. More likely to cause harm to the eye than lower class lasers but do not need as many control measures as higher class lasers.
- **Class 3B:** Output power < 500 mW. Eye damage likely to occur if the beam is viewed directly or if specularly reflected (Wavelength 180 nm - 1 mm).
- **Class 4:** Output power exceeds 500 mW. Eye and skin damage likely from the main laser beam and reflected beams (diffuse & specular). These lasers may cause fires. (Wavelengths 180 nm - 1 mm)

Oxford University Hospitals
NHS Foundation Trust

# Managing Organisational Change Procedure

A supporting toolkit for this procedure is available – **Organisational Change Toolkit**

| | |
|---|---|
| **Category:** | Procedure |
| **Summary:** | This procedure outlines the principles of organisational change, the processes for formal consultation and the support available to employees. |
| **Equality Impact Assessment** | October 2023 |
| **Valid From:** | |
| **Date of Next Review:** | 3 years<br>Until such time as the review is completed and the successor document approved by the relevant committee this procedure will remain valid. |
| **Approval Date/ Via:** | Trust Board |
| **Distribution:** | Trust-wide |
| **Related Documents:** | Agenda for Change Terms and Conditions of Service<br>Conduct and Expected Behaviours Procedure Procedure<br>Consultant Recruitment Procedure<br>Fixed Term Contract Procedure<br>Flexible Working Procedure<br>Freedom to Speak Up Policy<br>Handling Concerns Relating to Conduct, Capability or Ill Health of Medical and Dental Practitioners Procedure<br>Job Evaluation Procedure<br>Job Planning Policy<br>Maternity, Paternity, Adoption and Shared Parental Leave Procedure<br>Professional Registration Policy<br>Recruitment and Selection Procedure<br>Resolution (Grievance and Collective Disputes) Procedure<br>Sickness Absence Management Procedure<br>Supporting Employee Performance Procedure<br>Trade Union Recognition Agreement<br>Workforce Equality, Diversity and Inclusion Procedure<br>Working Time Regulations Policy |
| **Author(s):** | Assistant Director of Workforce – Employee Relations |
| **Further Information:** | Human Resources Department |
| **This document replaces:** | Managing Organisational Change Procedure v2.1 |

**Lead Director:** Chief People Officer

**Issue Date:**

## Contents

## Introduction

1. Oxford University Hospitals NHS Foundation Trust ("the Trust") recognises the contribution of its employees and in partnership has established agreed values which follow six themes: excellence, compassion, respect, learning, delivery and improvement.
2. Our Trust values guide everything we do, help us make decisions, and shape the way that we interact with patients and with each other. All staff are expected to behave in a way that brings these values to life. For each value the Trust has defined three sets of behaviours:
    2.1. What we love to see – these are the practices and attitudes that will ensure we provide an outstanding level of patient care and service;
    2.2. What we expect to see – these are the practices and attitudes that we expect from everyone who works for us; and
    2.3. What we don't want to see – these are the practices and attitudes that are not acceptable and will not support the Trust to deliver the expected standards of patient care and services.
3. In order to provide appropriate, effective, and sustainable services there is a need to continually review and revise the organisation so we can respond to change. Often changes impact on the working lives of employees and when involved and included in discussions, we believe employees can contribute to improving services and the patient experience.
4. Organisational change may involve an increase or reduction in employee numbers (outside of routine recruitment and attrition), a change of line management to another area, changes to job descriptions, changes in provision of patient services and changes in the locations at which and the way in which the work is carried out.
5. The scale of change will vary; therefore the Trust seeks to ensure that employees understand the reasons for and that they are committed to change. We consider it is important to maintain stability of employment and to act reasonably.
6. The Trust recognises that change can be a positive experience for employees, offering opportunities for personal growth and development and to influence service improvement. We also appreciate that change can be unsettling, therefore we wish to outline the support available to employees undergoing organisational change.
7. When talking to employees about changes to the organisation and their working lives, we will commit to give clear reasons for any changes taking place. We will ensure that concerns are listened to by senior managers and we will seek to give honest feedback and reassurance about how change will affect employees individually. We believe in giving employees the true picture even if it feels like bad news and we promise regular updates during the change process. All employees directly affected will be consulted.

## Procedural Statement

8. This procedure aims to facilitate the implementation of change and outlines the processes that will apply to employees who are affected by change. The Trust will:
    8.1. Maintain and preserve continuity of employment by careful forward planning and by taking every reasonable step to identify suitable alternative employment for employees affected by redundancy wherever possible.
    8.2. Ensure that change will be implemented in as fair and transparent a way as possible where the impact on employee's working lives is unavoidable.

## Scope

9. This procedure applies to all employees of Oxford University Hospitals NHS Foundation Trust on substantive or fixed term contracts, including medical and dental employees, Retention of Employment (RoE) employees, locums, research and secondees.

## Aim

10. The purpose of this procedure is to outline the steps that must be followed in cases where organisational change is being considered and set out the Trust's position for consulting on redundancies, TUPE and changes to terms and conditions, and to outline the support available to employees experiencing organisational change.

## Definitions

11. The terms in use in this document are defined as follows:

11.1. **At risk employees:** Employees will be considered to be potentially at risk where their posts are redundant and they have not been identified for slotting in or limited competition.

11.2. **Consultation:** The process by which management and employees or their representatives jointly examine and discuss issues of mutual concern. It involves seeking acceptable solutions to problems through a genuine exchange of views and information.

11.3. **Disability:** As defined by the Equality Act 2010 it refers to a physical or mental impairment that has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities.

11.4. **Fixed term employees:** Under the Fixed-term Employees (Prevention of Less Favourable Treatment) Regulations 2002, this is an employee employed under a contract of employment that will terminate on the expiry of a specific term, or the completion of a particular task.

11.5. **Job Bulletin:** A weekly internal vacancy list produced by the Resourcing Department.

11.6. **Limited competition:** The process by which those employees identified as at risk receive priority ring-fenced consideration for any suitable alternative posts.

11.7. **Maternity leave, adoption leave and shared parental leave protection:** The situation in which an employee on this leave who is prevented by reason of redundancy from returning to their substantive post is offered first refusal of suitable alternative employment and will not be required to attend an interview or selection process.

11.8. **Organisational change:** Any structural or managerial change in the organisation which may affect working arrangements, skills, workload, staffing levels and/or terms and conditions of employment. This may include new methods of working, alterations in working patterns to meet service needs, transfer of services to other providers, reductions in staffing or service provisions associated with cost improvement programmes, change of use or closure of premises where employees are employed, or any other organisational change.

11.9. **Prior consideration interview:** Where an employee at risk of redundancy is given an interview for a suitable alternative role before any internal or external candidates.

11.10. **Redeployment:** The movement of an employee into a different role or department because the employee was identified as at risk of redundancy. Candidates on the redeployment and at risk register will have priority over other internal and external candidates for new roles in the Trust, providing they are suitable for the roles. Redeployment through organisational change will be in accordance with the Trust's statutory duties and may be different to redeployment in other situations or outlined in other Trust documents.

11.11. **Redundancy:** A dismissal will be by reason of redundancy if it is mainly or wholly attributable to:

the fact that the employer has ceased, or intends to cease to carry on the business for the purposes of which the employee was employed; or to carry on the business

in the place where the employee was so employed; or the fact that the requirements of the business for employees to carry out work of a particular kind; or the requirements of the business for employees to carry out work of a particular kind in the place where they were so employed, have ceased or diminished or are expected to cease or diminish.

11.12. **Representative:** An individual elected to negotiate with the Trust on behalf of its employees.

11.13. **Ring-fenced vacancies:** Jobs that are restricted to a limited pool of employees who apply for posts in competition with each other.

11.14. **Slotting in:** Where an employee is automatically slotted into a post in a new structure or is appointed to a suitable alternative role. The criteria for slotting in are described at paragraph 47.

11.15. **Statutory Trial period:** Employees who have been redeployed are entitled to a four-week statutory trial period in the alternative role.

11.16. **Suitable alternative employment:** A vacant post, of similar status, for which an 'at risk' employee meets the essential criteria in the person specification or would with appropriate retraining.

11.17. **TUPE:** The Transfer of Undertakings (Protection of Employment) Regulations 2006 protect employees' existing terms and conditions of employment when a business or part of a business is transferred from one employer to another or where there is a change of service provider. Any dismissal of an employee by reason of the transfer is automatically unfair, unless it is for an economic, technical or organisational reason entailing changes in the workforce.

11.18. **Voluntary programme:** A process for seeking voluntary applications from employees either in the department or area affected by change or across other areas for specific changes to terms and conditions of employment. The voluntary changes may help facilitate organisational change and maintain employment security, for example, voluntary requests for reduced hours, job share, voluntary redundancy or early retirement.

## Responsibilities

12. The **Trust Board** has overall responsibility for ensuring that the Trust meets its legal obligations and enables effective change management to take place. It also has responsibility for the continued provision of efficient effective services.

13. The **Chief People Officer** has delegated responsibility for the update of this procedure and to ensure:

13.1. A Managing Organisational Change Procedure is in place for the Trust which meets its legal obligations and enables effective change management in order to ensure the continued provision of efficient and effective services.

13.2. A fair and equitable application of the procedure to all employees, ensuring that this meets employment legislation and best practice.

13.3. Recruitment activity is able to respond to change management requirements and the organisation has systems in place to ensure redeployment opportunities for employees at risk of redundancy.

14. **Human Resources** is responsible for:

14.1. Advising on best practice and legal requirements.

14.2. Advising on alternatives to compulsory redundancy to ensure that it is a measure of last resort.

14.3. Supporting the redeployment of at-risk employees and highlighting any vacancies that are available for limited competition.

14.4. Advising on support available to employees undergoing organisational change, including advice on support from trade unions and the Centre for Occupational Health and Wellbeing.

15. **Trade union representatives** are responsible for**:**

15.1. Supporting their members by providing guidance and representation so that their views are fully communicated.

15.2. Enabling meaningful formal consultation to take place when required before contractual change is implemented in accordance with legislative requirements.

16. **Managers** are responsible for:

16.1. Leading change in line with the procedures outlined in this document.

16.2. Involving Staff Side representatives at an early stage.

16.3. Ensuring the most effective use of the resources available and utilising these to improve the services they provide. They are responsible for identifying opportunities for service improvement and empowering their employees to do likewise.

16.4. writing the consultation document and completing the Equality Impact Assessment (EIA)

16.5. Providing support, including individual meetings, for employees affected by change.

16.6. Providing reasonable work time to participate in the consultation process and to seek alternative employment as far as possible.

16.7. Identifying suitable alternative employment for staff considered at risk.

16.8. Supporting staff considered at risk search and find suitable alternative employment.

17. **Individual employees** are responsible for:

17.1. Engaging in the consultation process and any subsequent search for suitable alternative employment.

# Redundancy and Reorganisation

## Types of Change and Consultation

18. Meaningful consultation forms an integral part of the partnership between management, employees, and their representatives. However, the degree and duration of consultation will depend upon the nature of the organisational change and its implications for the workforce. The purpose of consultation is to consult about ways of avoiding dismissal, implementing redeployment, and mitigating the consequences of any redundancies.

19. Minor changes should ordinarily be discussed between the line manager and the affected employees. The manager should explain the reasons for the change and confirm this in writing. There is not normally a need for formal consultation and representation. Trade union members may seek advice from their representatives if they so wish. Examples include:

19.1. changes to a job description with no impact on banding (please refer to the Job Banding Procedure);

19.2. change of job title;

19.3. changes in line management or reporting lines.

20. Where significant change which may result in redeployment or redundancy is proposed, managers must follow a formal consultation process with employees and their representatives.

21. Current legislation requires that in cases of redundancy consultation must in any event begin:

21.1. At least 30 days before the first dismissal takes effect if between 20 and 99 employees are to be made redundant at one establishment within a 90-day period. It is Trust policy to give at least 30 days' notice whenever any redundancies are considered. The period of consultation may need to be extended or reduced depending on the circumstances, by agreement between the parties.

21.2. At least 45 days before the first dismissal takes effect if 100 or more employees are to be made redundant at one establishment within a 90-day period.

22. The Trust also has a statutory duty to notify the Redundancy Payments Service if 20 or more employees are to be made redundant at one establishment within a 90-day period. If 20 to 99 redundancies are proposed, notification must be provided at least 30 days before the first dismissal takes effect. If more than 100 redundancies are proposed, notification must be provided at least 45 days before the first dismissal. Form HR1 available from The Insolvency Service should be used. This should be completed in consultation with the relevant HR Consultant.

23. The collective consultation obligations will apply when it is intended to offer different terms and conditions of employment to 20 or more employees when the employees are to have such radically different terms and conditions that accepting the new posts amounts to dismissal and re-engagement.

## The Consultation Process

24. The purpose of meaningful consultation is to involve the appropriate people at the earliest opportunity to explore all the options available and to allow the views of employees and their representatives to be taken into account.

25. The consultation period for any proposal with significant change, which does not involve redundancy will be over a 30-day period and will allow for proper consideration of comments from affected staff and their representatives.

26. When communicating any proposed change initiative to employees, full details should be provided wherever possible to enable greater understanding and elicit associated responses through cooperation and partnership.

27. The consultation process should precede any public announcement of a redundancy programme and the issue of notices of termination. Redundancy notices can only be issued to the formally at risk pool of staff, when the consultation has been completed, for example where the consultation has either resulted in agreement with employee representatives or has otherwise reached its conclusion.

28. A consultation will not start before it has been presented to the Consultation Sub Committee.

## Consultations with Trade Unions

29. Consultation with the appropriate recognised trade unions will take place at the earliest opportunity, either at the point that serious consideration is given to changes or once specific proposals for change that will affect employees have been formulated. The proposals for change will be discussed with Staff Side in advance of the formal consultation document being issued more widely:

29.1. Staff Side and the Joint Local Negotiating Committee (JLNC), for Medical and Dental matters, will be issued with full written discussion documents at least 7 days prior to the commencement of any consultation period.

29.2. The appropriate information will include the department, numbers and descriptions of employees affected and the implications for the affected employees.

30. During a period of change, management will meet regularly with representatives and will ensure that they are kept informed of developments as they occur. Representatives and employees will be given the opportunity to put forward their views and to discuss the proposals with management. Adequate information will be provided and adequate time given in which to respond. Written responses to any written submission will be issued within

7 calendar days of the close of the consultation, unless there is mutual agreement by all parties.

31. Trade union representatives must be invited to all consultation launch meetings.

32. In the event that managers are consulting on potential redundancy situations, there is a statutory duty to disclose in writing to recognised Trade Unions the following information concerning proposals for redundancies so that they can play a constructive part in the consultation and negotiation process:

    32.1. The reasons for the proposed dismissals.

    32.2. The number and descriptions of posts it is proposed to remove.

    32.3. The total number of employees of any such description employed at the establishment in question.

    32.4. The criteria used to select employees for redundancy.

    32.5. How the redundancy dismissals are to be carried out, including the timescale over which the redundancy dismissals are to take effect.

    32.6. The proposed method of calculating any redundancy payments must be made available and projections, if available.

33. This duty applies even when only one person is to be made redundant and even when employees have volunteered for redundancy, irrespective of whether or not they are members of a recognised trade union. Failure to consult could lead to a claim for compensation, known as a protective award.

34. The consultation must take place with a view to reaching agreement with the appropriate representatives and must include discussion about ways of avoiding redundancies, reducing the numbers to be dismissed and mitigating the consequences of any redundancies.

35. In addition to those areas outlined above managers may work in partnership to address post-consultation issues such as:

    35.1. Any impact on earnings and pensions as a result of suitable alternative employment.

    35.2. Whether a redundant employee may leave during the notice period or postpone the date of expiry of notice.

    35.3. Any effects on Trust benefits (e.g. salary sacrifice) where an employee is made compulsorily redundant.

    35.4. Any extension of the length of the trial period in alternative employment.

36. Managers must complete an Equality Impact Analysis on the impact of change on employees and service delivery as part of the consultation document.

## Consultation with Employees

37. Managers should ensure that employees are made aware of the agreed timelines, procedure and of the opportunities available for consultation and for making representations. Case law has shown that dismissals have been found to be unfair where the union has been consulted but not the individual. It is therefore essential that affected individuals are consulted, whether or not they are members of the recognised trade unions.

38. Employees will be invited to a group consultation meeting with their manager, HR Consultant (if applicable) and trade union representatives. The meeting will explain the change, the process that will be followed and give employees an opportunity to ask initial questions. Employees should be provided with the following information:

    38.1. A copy of the consultation document, including the rationale for change and the expected impact on employees.

    38.2. A minimum of one key contact for all queries plus relevant trade union contacts.

38.3. Proposed timescales for the programme with an anticipated end date.

38.4. Job descriptions for all vacant roles within the consultation document for which employees can apply.

38.5. The location of support and advice available to employees affected by the change.

39. All documentation will be provided to employees who are absent from the Trust, for example, through sickness, secondment, suspension, or leave due to maternity, paternity, shared parental or adoption leave or career break. These employees will be fully included throughout the process.

40. During the consultation period, employees will be offered the opportunity to attend a meeting with their line manager, who may be supported by a HR Consultant. Employees will be advised of their right to be accompanied by their recognised trade union representative or workplace colleague at all meetings and to seek their advice throughout the process.

41. The purpose of the meeting will be to:

41.1. Discuss and explore the options.

41.2. Invite the employee to comment and respond to the proposals. The employee may need a little time to respond and not be able to do so at that meeting. Responses may be made as a group or individually.

41.3. The detail and outcome of individual interviews should be recorded and confirmed in writing.

42. The line manager should continue to meet with the individual employee on a regular basis throughout the period of change. The line manager should investigate these concerns and queries. A response should be fed back to employees as quickly as possible. Managers should provide regular updates where the feedback is delayed for any reason.

43. In addition to the regular meetings with their manager, employees will be kept informed by briefings from their line managers and other appropriate forms of communication. Employees are responsible for ensuring that they familiarise themselves with the distributed communication. Feedback, discussion and questions will be positively encouraged at all times throughout the consultation process and can be given verbally or in writing.

44. The manager will produce a consultation outcome document that responds to the feedback received in reference to the timeframes outlined at paragraph 25. Trade union representatives should be consulted on the content of this document prior to communicating to employees. Employees will be invited to the meeting and the document will be shared with them.

## Handling and Avoidance of Redundancies

45. The Trust is committed to maintaining as secure an employment environment as is possible for all employees. If there is a planned reduction in the workforce, the following measures should be considered in order to minimise the impact on employees:

45.1. Proposals from employees for voluntary reduction in hours of work, career breaks and unpaid leave.

45.2. Reduction in the usage of agency staff.

45.3. Voluntary early retirement/normal retirement.

45.4. Seeking volunteers for voluntary redundancy or mutually agreed resignation schemes.

45.5. Management of secondments and acting up arrangements.

45.6. Review of the current and future functions of the Trust to establish staffing levels and skill mix required.

45.7. Ring-fencing of suitable alternative posts, by the manager and HR Consultant should occur as soon as possible but ideally at the beginning of consultation.

45.8. Cessation of external recruitment unless approved by the Director of Workforce in consultation with the relevant union representatives.

45.9. Review of work undertaken by external consultants, contractors and agencies.

45.10. Cessation of overtime/additional hours unless there is prior approval from the divisional budget holder in consultation with the relevant union representatives at the beginning of the consultation process.

45.11. Review of temporary and fixed term contracts in line with the Fixed Term Contract Procedure.

## Filling Roles in the New Structure

46. Managers should carefully consider the allocation of roles in the new structure, maintaining a balance between limiting the number of displaced employees in the structure and avoiding "pools of one" for redundancy that may be unfair. Advice should be sought from the Human Resources department. The following principles should be considered when filling roles in the new structure:

47. **Slotting in** should take place where the following are satisfied:

47.1. An individual's current role and a role in the new structure are broadly comparable to their existing role.

47.2. The role is the same band or one band lower than the employee's existing band.

47.3. The individual meets the essential criteria for the new role.

47.4. There are no other at risk candidates who meet the criteria above.

48. **Limited competition** should take place where:

48.1. An individual's current role is similar to, but not broadly comparable to a role in the new structure.

48.2. The role contains new responsibilities or duties; meaning that clarity is required as to an employee's competence or suitability for a role.

48.3. The role is at the same band, or one band lower than their existing role. Movement to a higher band will always be subject to a limited competition process.

48.4. The first three criteria for slotting in are met, but there is more than one candidate who meets these criteria. (note – in such circumstances we will deal with on a case by case basis basis.)

49. Consideration should be given to:

49.1. Whether retraining is reasonable, this should be assessed throughout the limited competition process based on objective criteria.

50. **Open competition** will apply where the criteria applicable to slotting in or limited competition are not met. The available posts will be opened for competition to all employees in the old structure.

## Selection Criteria

51. Where selection for posts is subject to limited or open competition, the selection criteria should be objective, precisely defined and capable of being applied in an independent way. Employees and unions should be informed of the selection criteria at the commencement of the consultation period, including the weighting given to each criterion.

52. Selection criteria may include, but need not be limited to:

52.1. performance;

52.2. skills;

52.3. experience;

52.4. competence;

52.5. attendance (excluding disability and pregnancy-related absence); and

52.6. conduct and disciplinary records (excluding historic or expired warnings).

53. In assessing the above, managers may wish to consider using a combination of some or all of the following:

53.1. appraisals;

53.2. references and/or testimonials;

53.3. selection tests (e.g. IT, typing);

53.4. HR records on attendance, conduct and performance;

53.5. selection interviews; and

53.6. assessment centres.

54. Selection interviews should follow the process specified in the Recruitment and Selection Procedure. The panel should include one objective assessor who is external to the department or a HR Consultant.

55. The selection process must be clearly documented and scored. Employees should receive feedback on their performance, whether successful or not. The information may be used to identify training and development needs in the new role.

## Notice of redundancy

56. If it has not been possible for the employee to secure a new role through the consultation process, the manager will confirm the redundancy at a meeting with the employee. The employee will be entitled to be accompanied by a trade union representative or work colleague. The relevant HR Consultant must be in attendance at these meetings.

57. Following the meeting written confirmation will be given to the employee of the number of weeks' notice in accordance with their contractual notice period and the effective date of redundancy, which will also be recorded as their last day of service.

58. This letter must be signed by a manager with authority to dismiss (see Appendix 3).

59. An employee will forfeit their right to a redundancy payment if they:

59.1. Are dismissed for reasons of misconduct, with or without notice.

59.2. Have obtained suitable alternative employment with the same or another NHS employer at the date of termination of the contract without a break or with a break not exceeding four weeks.

59.3. Unreasonably refuse to accept or apply for an offer of suitable alternative employment with the same or another NHS employer.

59.4. Leave their employment before their notice expires, except if it has been agreed they can be released early.

59.5. Are offered a renewal of contract with the substitution of the new employer for the Trust or where the employment is transferred to another public service employer who is not an NHS employer.

60. If an employee who is made redundant lives in Trust residential accommodation, this should be handled sensitively. The employee should be permitted to stay in accommodation for a transitional period in order to secure new accommodation.

**Redundancy and Suitable Alternative Employment**

61. Suitable Alternative Employment Section 141 of the Employment Rights Act 1996 governs the rules on suitable alternative offers of employment in relation to redundancies.

62. The legal framework establishes the duty on employers to take reasonable steps to find, where possible, suitable alternative employment for affected staff. Whether a job is 'suitable alternative employment' depends on several things including:
    - how close the work is to current job
    - the terms of the job being offered
    - skills, abilities and circumstances in relation to the job
    - pay (including benefits), status, hours and location of the job

63. The question of suitable alternative employment should be determined on a case-by-case basis.

64. If an employee is unsuccessful at securing a position in a new organisational structure, they will be placed at risk of redundancy. The employee will be notified of this at a meeting with their line manager. Employees will be given the opportunity to be accompanied by a trade union representative or colleague. If it is not possible for a HR Consultant to attend, the manager must ensure that full and detailed meeting notes are taken.

65. Every effort will be taken to avoid redundancy by seeking suitable alternative employment within the organisation. New posts will be advertised through a weekly Job Bulletin and can be held at the request of a HR Consultant. A 'held' post may have been advertised, but cannot be offered to an internal or external candidate if it has been identified as suitable for an employee who is at risk.

66. Consideration should be given to exploring redeployment opportunities with neighbouring NHS Trusts.

67. If a role is identified as suitable for an at risk employee, then the employee should be offered a prior consideration interview. If the employee meets the essential criteria for the post, they should be offered the role. If there is more than one suitable at risk candidate, there should be limited competition for the role.

68. Whether employment is considered to be suitable will depend on individual circumstances. The following criteria should be considered:

    68.1. **Pay:** In line with the Pay Protection section at Appendix 1 of this procedure, earnings should be protected against a fall in the current rate of pay. Alternatively, there may be opportunities for employees to earn more through appointment to a higher band or pay enhancements.

    68.2. **Status:** A drop in status is likely to make an alternative job unsuitable. However, the loss of status may be eased by allowing the individual preferential treatment should a similar comparable job become available**.** The line manager will oversee this with support from the HR Consultant.

    68.3. **Working environment:** This may be especially important for those people who suffer a health complaint or disability.

    68.4. **Location:** Travel expenses will be reimbursed in line with the Pay Protection section of this procedure and the Payment of Expenses Procedure.

    68.5. **Hours of work:** Any change in an employee's hours of work, for example in shift patterns, may make an alternative job unsuitable depending on the individual's personal circumstances.

    68.6. **Banding:** Suitable posts are deemed to be ones falling in the same band, or one band below the current band of the post holder.

69. Employees should receive any offer of suitable alternative employment in writing from their line manager. The offer should show how the terms of the new employment differ from the employee's current position.

70. In accordance with legislation, an offer must be made before the employment under the current contract ends. This offer should be made formally in writing by the relevant manager.

## Trial Period

71. A trial period will only apply to Staff At Risk and where a formal offer of suitable alternative employment has been made.

72. The employee has a statutory right to a trial period of four weeks in an alternative job where the provisions of the new contract differ from the original contract. The statutory trial period can only begin at the end of the employee's employment under their old contract (i.e. the end of their notice period).

73. The statutory trial period will normally last for four weeks but may be extended for the purpose of retraining the employee in the alternative employment. Any extension must be agreed in writing and can extend the trial period by up to a further 8 weeks (i.e. the maximum length of a statutory trial period can be 12 weeks). The purpose of a trial period is for both the manager and the individual to assess the suitability of the post as alternative employment.

74. If the individual works beyond the end of the four-week period or the jointly agreed extended period, any redundancy entitlement will be lost because the individual will be deemed to have accepted the new employment.

75. Should either the manager or employee feel that the role is unsuitable, they should bring this to the attention of their line manager or HR Consultant before the end of the trial.

76. If the trial period is unsuccessful, as determined by the individual and/or the manager concerned, redundancy arrangements will apply as from the date when the original contract of employment terminated.

77. If a manager wishes to end the new contract for a reason unconnected with redundancy for example gross misconduct, the individual will not be entitled to a redundancy payment.

## Time off to look for new work or for training

78. Employees who have been issued notice of redundancy will be given as much assistance as is practicable to find new employment or training for new employment. The employee will be permitted reasonable paid time off during working hours to seek alternative work or to make arrangements for future training, as permitted by the Employment Rights Act 1996. This must be agreed with the relevant line manager in advance and employees will be asked for details of how work time is used (e.g. evidence of attending an interview).

79. Employees who do not find suitable alternative employment with the Trust or any other NHS organisation may be released early during their notice period to take up employment outside the NHS.

## Unfair Selection for Redundancy

80. If the reason (or principal reason) an employee is selected for redundancy is one of the prohibited grounds set out in section 105 of the Employment Rights Act 1996, the dismissal will be unfair. These include:

    80.1. pregnancy, childbirth, or statutory maternity, paternity, adoption, parental or dependent care leave;

    80.2. a health and safety reason;

    80.3. for making a protected disclosure;

    80.4. for asserting a specified statutory right;

80.5. for performing functions as an employee representative on a TUPE transfer or collective redundancy.

## Voluntary Redundancy

81. Voluntary redundancy can assist where an employee is at risk of redundancy or under notice of redundancy and where it is cost-effective to do so.

82. Voluntary redundancies will only be available in circumstances where managers seek volunteers from at risk employees within specific departments or roles. Under no circumstances will applicants for voluntary redundancy be permitted from non-affected employees.

83. All requests for voluntary redundancy will be considered by a panel. Responses to requests must be supported by data concerning the total cost of redundancy, including pension entitlements, as supplied by the Pensions Agency or Pensions Officer. Employees will be notified of the outcome of their request in writing within 7 calendar days of the panel decision being taken.

84. Employees should be aware that a decision to take voluntary redundancy may have an impact on their right to job seekers allowance and any other benefits.

85. Managers should be aware that even when redundancy is voluntary, an employee may bring an employment tribunal claim for unfair dismissal. A fair procedure should therefore be followed.

86. Requests for voluntary redundancy may be considered in the following circumstances:

86.1. If the post has been identified as ‘at risk’ of redundancy.

86.2. The application for voluntary redundancy will assist in relieving an ‘at risk’ or ‘under notice of redundancy’ situation, either for the individual employee or others within the Trust.

## Contractual Changes

87. The majority of changes affecting terms and conditions of employment and employment contracts are negotiated locally by the Trust Alliance Committee and/or Joint Local Negotiating Committee (JLNC) or the NHS Staff Council nationally. However, service changes and improvements may result in further changes that affect the contracts of employees, for example significant changes to shift patterns, involving loss of enhancements or a reduction in hours or withdrawal of additional payments.

88. Managers should follow the principles for consultation bearing in mind that changes may be covered by statutory requirements for collective consultation (minimum consultation periods and completion of a HR1 form).

89. Managers must consult fully and meaningfully with employees, giving a clear rationale for the change, explaining the impact on employees and providing outlets for feedback. They should explain any entitlements to pay protection and transitional arrangements.

90. Every effort should be made to secure an employee’s consent to the change and to discuss any adjustments that should be made, for example, flexible working options. Reasonable notice should be provided prior to the implementation of the change.

91. If, following meaningful consultation, employees do not consent to the change, it is possible to terminate an employee’s contract with notice and re-engage on the new terms. This should be done with care only after following HR advice and should always be considered to be a last resort.

92. Individuals and/or trade unions have recourse to the Resolution (Grievance and Collective Disputes) Procedure to challenge this decision.

# Transfer of Undertakings (TUPE)

## Overview

93. The Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE) is designed to protect employees when there has been a "relevant transfer" which is defined as:

    93.1. A transfer of the whole or part of a business or undertaking from one employer to another as a going concern, a circumstance defined for the purposes of this guidance as a **business transfer**. This can include cases where two organisations cease to exist and combine to form a third organisation.

    93.2. A client engaging a contractor to do work on its behalf, reassigning such a contract or bringing the work 'in-house', a circumstance referred to as a **service provision change**.

94. Employees employed by the previous employer (the **transferor**) automatically become employees of the new employer (the **transferee**) on their existing terms and conditions of employment, along with any collective agreements previously made.

95. TUPE stipulates that any dismissal where the reason for the dismissal is the transfer or a reason connected with the transfer will be unfair unless it is an economic, technical or organisational (ETO) reason that entails a change in the workforce.

96. TUPE prevents employees from suffering a detriment to their contractual arrangements after the transfer. It also prevents any changes to an employee's terms and conditions being made solely because of the transfer, unless the reason is an economic, technical or organisational reason or the employment contract permits the new employer to make changes.

97. If an employee objects to the transfer and refuses to transfer, their contract of employment will end on the transfer date. The employee will not be dismissed and they will not be entitled to redundancy pay.

## Duty to Inform and Consult

98. Where the Trust is the transferor, it will be required to give certain information about the transferring employees to their trade union representatives. The Human Resources department will be responsible for disseminating the requisite information to representatives, but line managers may be asked to help collate the information.

99. Staff Side will be provided with details of all employees who:

    99.1. will be transferred;

    99.2. will not be transferred but who might be affected; or

    99.3. might be affected by the transfer.

100. The consultation paperwork will provide information of:

    100.1. the fact that a transfer is going to take place, when it will take place and the reason for the transfer;

    100.2. the legal, economic and social implications of the transfer for the affected employees; and

    100.3. whether any measures, such as reorganisation will be taken, and how the employees are likely to be affected.

101. The Trust will be required to consult with the trade union representatives of affected employees about any proposed measures. By 'measures' is meant any action, step or arrangement in connection with the transfer in relation to affected employees.

102. The purpose of consultation is to seek the representatives' agreement to the measures to be taken. Affected employees are allowed to take paid time off work to attend meetings with their representatives.

103. Failure to inform and consult may result in the Trust becoming liable for the payment of compensation to the affected employees, which may be up to 12 weeks' pay per employee.

### Due Diligence

104. Where the Trust is the transferor, it is required to provide the transferee with information about any transferring employee. This should be done no later than 28 calendar days prior to the transfer date. Failure to comply with this obligation may result in financial penalties being incurred by the Trust.

## Support Available to Employees

105. The Trust is committed to minimising uncertainty caused to employees through regular communication, meaningful consultation and seeking alternatives to redundancy.

106. Nevertheless, the Trust is aware that organisational change can be distressing and employees undergoing organisational change should be made aware of sources of support available to them. These may include:

106.1. Line managers – In the majority of cases, line managers are able to offer immediate support to employees. Where this is not sufficient or appropriate, other sources of support may be obtained.

106.2. Staff Side representatives – If an employee is a member of a trade union, they can contact their union representative for support and advice.

106.3. Human Resources – Each division has a dedicated HR Consultant who works with managers and employees to provide advice and guidance in all areas of employment, including redundancy entitlement, pay protection, redeployment, out-placement support

106.4. Care First, the Trust's free and confidential Employee Assistance Programme, which can be accessed on freephone 0800 174319 or via www.carefirst-lifestyle.co.uk Username: ouh, Password: employee.

106.5. Centre for Occupational Health and Wellbeing – This department provides a service for employees with health issues to offer advice, support and guidance for the manager regarding any adjustments which may need to take place for the employee whilst at work. This is usually completed in conjunction with HR and managers following a management referral to occupational health.

106.6. Staff Support Service – this is a psychological support service provided to staff and can be accessed by emailing staffsupport.account@ouh.nhs.uk

106.7. NHS Business Services Authority – Can offer support and advice on NHS pension matters. General pension advice can also be obtained by contacting the Pensions team via email 321pensions@uhb.nhs.uk.

## Special Circumstances

### Maternity, Adoption and Shared Parental Leave

107. Employees who are on shared parental leave, maternity, paternity, adoption or shared parental leave when an organisational change is implemented should be kept fully informed and given the opportunity to contribute to the consultation process.

108. If a redundancy situation arises during such leave, the employee on maternity, , adoption or shared parental leave is entitled to be offered suitable alternative employment. Such employees have a statutory right to any suitable alternative employment that exists, ahead of any other employee including at-risk employees.

109. If the employee accepts the suitable alternative role, it must be kept open until they return from leave and are able to undertake the 4-week statutory trial period. If the employee refuses a suitable offer, they may lose their right to a redundancy payment.

### Disabled employees

110. In accordance with the Equality Act 2010, there is a requirement on the Trust to make reasonable adjustments where a disabled employee is at risk of redundancy.

111. Managers should consider what disadvantages a disabled employee may face when undergoing the redundancy process. It may be necessary to make adjustments where reasonable to alleviate a particular disadvantage.

112. Managers should also consider whether adjustments should be made to vacant positions to enable the disabled employee to do the role.

### Fixed term employees

113. Under the Fixed-term Employees (Prevention of Less Favourable Treatment) Regulations 2002, it is unlawful to select an employee on a fixed term contract for redundancy solely on the basis of their fixed term status.

114. Where an employee has been appointed on a fixed term contract and is affected by organisational change, the manager should liaise with the relevant HR Consultant.

115. Where the Trust is proposing to dismiss an employee employed on a fixed term contract for reasons other than redundancy as a result of organisational change this should be managed in line with the Fixed Term Contract Procedure.

### Career breaks

116. If an employee is on a career break at the time that the change is proposed, the employee should be kept fully informed and involved in the consultation process. The process for managing career breaks in the Flexible Working Procedure should be followed when they return to work.

### Long-term sickness absence

117. For employees on long-term sickness absence, it is important for these individuals not to be overlooked during the management of the change process. However, dependent upon the nature of the sickness absence, sensitivity and flexibility may need to be applied in the handling of these situations. If practical these employees should be sent all the relevant documentation and be fully included in the consultation process.

118. If an employee is too ill to participate in the process, the line manager should seek advice from the relevant HR Consultant at the earliest possible opportunity. Additionally, the Centre for Occupational Health and Wellbeing may be able to advise on whether an employee is fit to be fully included within a consultation process and how this might best be achieved.

## Redundancy Payments

119. All payments related to redundancy should only be considered if the Trust is satisfied that termination of the employee's employment is in the best interests of the Trust and represents value for money. Advice must be sought from the Director of Workforce prior to issuing any notice of redundancy.

## Appeals

120. Employees wishing to appeal an organisational change initiative can do so through the Trust's Resolution (Grievance and Collective Disputes) Procedure.

121. Employees have a right to appeal against their dismissal by way of redundancy.

121.1. The employee may appeal in writing to the Director of Workforce, stating their full grounds of appeal, within 7 calendar days of the date they received written confirmation of redundancy.

121.2. An appeal meeting will be arranged, normally within 14 calendar days of receiving the written appeal. The appeal meeting will be chaired by a manager who has not been previously involved in the case.

121.3. The chair of the appeal meeting may ask anyone previously involved to be present. The employee has the right to bring a colleague or trade union representative to the meeting.

121.4. The Trust will confirm the final decision in writing, normally within seven calendar days of the appeal meeting.

121.5. Once the final decision is made, this is the end of the process and there is no further right to appeal against dismissal.

## Training

122. Whilst there is no statutory or mandatory training associated with this procedure, ad hoc training sessions based on an individual's training needs will be provided on request. Please speak to your divisional HR Consultant in the first instance who will assess the training need against what can be provided.

## Monitoring Compliance

123. Compliance with the document will be monitored in the following ways.

| 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 |
|---|---|---|---|---|
| Number and type of organisational restructures and TUPE transfers | Consultations submitted to the Consultation Sub Committee | Assistant Director of Workforce – Employee Relations | At least annual | People Governance Committee |
| Number of formal grievances lodged related to organisational change | Recorded on the ER Tracker by HR Consultants | Assistant Director of Workforce – Employee Relations | Quarterly | People Governance Committee |

124. In addition to the monitoring arrangements described above, the Trust may undertake additional monitoring of this procedure as a response to the identification of any gaps or as a result of the identification of risks arising from the procedure prompted by incident review, external reviews, or other sources of information and advice. This monitoring could include:

124.1. Commissioned audits and reviews

124.2. Detailed data analysis

124.3. Other focused studies

125. Results of this monitoring will be reported to the nominated Committee.

## Review

126. This procedure will be reviewed in three years or following request by either party, as set out in the Developing and Managing Policies and Procedural Documents Policy.

127. Until such time as the review is completed and the successor document approved by the relevant committee this procedure will remain valid.

## References

128. The references in this document include:

128.1. NHS terms and conditions of service (Agenda for Change) | NHS Employers (02/2023)

128.2. ACAS guide to managing redundancy for pregnant employees or those on maternity leave

128.3. Transfer of undertakings (TUPE): an introduction (CIPD, 2023)

128.4. The NHS Constitution for England (Department of Health and Social Care, 2023)

128.5. NHS TDA Guidance NHS Trusts on Processes for Making Severance Payments (2014)

128.6. Employment Rights Act 1996

128.7. Trade Union and Labour Relations (Consolidation) Act 1992

128.8. Transfer of Undertakings (Protection of Employment) Regulations 2006

128.9. Equality Act 2010

## Equality Impact Assessment

129. As part of its development, this procedure and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible, remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation, religion or belief, pregnancy and maternity, marriage and civil partnership, and gender reassignment. The completed Equality Impact Assessment can be found in Appendix 2.

## Document History

| Date of revision | Version number | Reason for review or update |
|---|---|---|
| September 2009 | 1.1 | Harmonisation of ORH and NOC Policies |
| 2010 | | Harmonisation of ORH and NOC Policies |
| November 2023 | | Inclusion of statement from ERA to clarify Suitable Alternative Employment. Confirmation that process for suitable alternative employment in accordance with ERA and specific to this policy only.<br>Incorporated parental leave, maternity and adoption leave into the process for protection<br>Updated references to Fixed term Contract procedure and AFC terms and conditions<br>JNLC to receive papers appropriate to Medical & Dental staff . |

# Appendix 1 - Protection of Pay and Conditions of Service Agreement

## Introduction

1. The Oxford University Hospitals NHS Foundation Trust believes that it is essential to the success of the Trust to be able to identify the need for change and to manage that change, taking into account organisational objectives as well as the aspirations and wellbeing of its staff. It is, therefore, the intention of the Trust to provide arrangements for safeguarding the pay and conditions of service of staff adversely affected by organisational change as an alternative to redundancy and early retirement.

## Scope

2. The terms of this agreement apply to all employees of the Oxford University Hospitals NHS Foundation Trust who, as a consequence of organisational change are required to move to a post with lower remuneration.

3. It provides for:-

   a. Long-term protection of basic wage or salary where downgrading is involved;

   b. Short-term protection of contractual and regular payments and allowances, whether or not downgrading is involved, e.g. rostered overtime, unsocial hours, stand-by, on-call duty, recruitment and retention premia;

   c. Where the employee works fewer hours in the new post short-term protection of pay and allowances will be based on the hours worked in the new post plus up to 10% of the hours worked on the old post.

## Definition of Terms used in the Agreement

4. **Organisational Change** – means any structural or managerial change in the Oxford University Hospitals NHS Foundation Trust.

5. **New Post** – as defined in the circumstances described in point 62.

6. **Protectable earnings, basic wage or salary** – the weekly or monthly sum due in respect of basic hours worked by the individual concerned, within the standard working week, reckoned on the day immediately preceding the first day of employment in the new post plus additional contractual allowances. This is based on an average calculated over a four-month period immediately preceding the first day of appointment in the new post. Allowances include contractual overtime, unsocial hours and contractual on call payments.

7. **Earnings in the new post** – the sum of the basic wage or salary in the new post plus additional regular allowances as specified:

   a. Contractual overtime;

   b. Contractual on-call and standby;

   c. Contractual unsocial hours;

   d. Long-term Recruitment and Retention premium.

8. **Downgrading** – occurs when the post, irrespective of its job title, is a lower band than the previous post.

9. **A more senior post** – is a post which is of a higher band than the previous post.

10. **Suitable Alternative Employment** – refer to paragraphs 61-70 of the Managing Organisational Change Procedure.

11. **Reckonable service** – for the purpose of an NHS redundancy payment (calculated on the basis of the service up to the date of the termination of the contract, means continuous full-time or part-time employment with the present or any previous NHS employer:

    11.1 Where there has been a break in service of 12 months or less, the period of employment prior to the break will count as reckonable service;

11.2 Periods of employment as a trainee with a general medical practitioner, in accordance

11.3 The following will not count as reckonable service:

11.3.1 employment that has been taken into account for the purposes of a previous redundancy, or loss of office payment by an NHS Employer;

11.3.2 where the employee has previously been given NHS pension benefits, any employment that has been taken into account for the purposes of those pension benefits.

## Protection of Earnings

### Short-term Protection

12. Short-term protection relates to payments which form a regular or contractual part of the job (see table A below). They will be eligible for protection on a mark time basis, as in Table A.

13. Short term protection of earnings is triggered when the total pay and allowances of the new post are less than the earnings in the old post based on a four-month average.

14. In calculating earnings in the new post, the rates used for calculating payments in respect of contracted and other additional duties shall be those applicable to the new post.

15. Pay, in any pay period, will be the higher of the pay in the new post or the protected pay.

### Long-term Protection

16. Long-term protection of basic wage or salary is used where downgrading is involved (see table A below). It is triggered when the banding of the new post is lower than the post occupied by the individual before the organisational change.

17. Basic pay in the former post is protected for a period of time in accordance with Table A.

18. Staff are entitled to protection of basic wage or salary, with the benefit of any subsequent improvements, including annual cost of living and pay step progression rises, until:

a. The period specified for protection expires, or

b. The individual is appointed to a post where the basic wage or salary is equal to or exceeds the protected basic wage or salary, or

c. The individual chooses to move to a lower paid post.

19. Long-term protection of basic wage or salary where downgrading is involved is conditional on the individual undertaking to accept a subsequent offer of suitable alternative employment at the equivalent of the protected band or a higher graded post, within the Trust, should one become available.

20. The salary would be at the individual's original grade step point before the downgrading.

21. If an employee unreasonably refuses to apply for or to accept a more suitable senior post, s/he will forfeit their right to protection.

### Interaction between short-term and long-term protection

22. An employee with a right to long-term protection will also have a concurrent right to short-term protection. The employee shall be paid on the basis of whichever conditions are the more favourable to the employee.

### Period of Notice

23. Staff required to move to a new post are entitled to retain the period of notice appropriate to the former post during the protection period.

### Pension

24. In order to ensure receipt of the maximum possible pension benefits, an employee whose earnings are reduced as a result of organisational change or through no fault of their own,

can request that their membership of the pension scheme at the higher rate of pay be treated as preserved membership.

25. Staff will need to meet the eligibility criteria for preserved pension. Acceptable reasons to meet the criteria for "through no fault of their own" for example are: a change in the nature of the duties performed, for example, ill-health, a move to a lower paid post because of pending or actual redundancy and being transferred to other employment with an employer. You need not apply if: you are only reducing hours and not your rate of pay or for those who are in protection under Agenda for Change, preserved membership is automatic.

26. The request must be submitted in writing **within three months** of pay reducing and sent to: 321pensions@uhb.nhs.uk.

27. If subsequently the employee is promoted, the preserved membership will automatically be converted to service at the higher rate of pay.

**Appeals**

28. Any appeal arising out of the application of this agreement shall be heard under the Trust's Resolution (Grievance and Collective Disputes) Procedure.

*Table A*

| **Reckonable Service** | **Short Term Protection Period** | **Long Term Protection Period** |
|---|---|---|
| 0 to less than 4 months | Notice period * | 0 |
| 4 to less than 12 months | Notice period * | 0 |
| 1 to less than 2 years | Notice period * | 3 months |
| 2 to less than 3 years | Notice period * | 3 months |
| 3 to less than 4 years | Notice period * | 9 months |
| 4 to less than 5 years | Notice period * | 9 months |
| 5 or more years | Notice period * | 12 months |

* Contractual or statutory, whichever is greater. Statutory is 1 week per complete year of service up to 12 years.

# Appendix 2 – Equality Impact Assessment

## 1. Information about the policy, service or function

| | |
|---|---|
| **What is being assessed** | Existing Policy / Procedure |
| **Job title of staff member completing assessment** | Divisional Head of Workforce NOTSSCAN<br>Divisional Head of Workforce SUWON |
| **Name of policy / service / function:** | Managing Organisational Change Procedure |
| **Details about the policy / service / function** | This procedure aims to facilitate the implementation of change and outlines the processes that will apply to employees who are affected by change.<br>The Trust will:<br>• Maintain and preserve continuity of employment by careful forward planning and by taking every reasonable step to identify suitable alternative employment for employees affected by redundancy wherever possible.<br>• Ensure that change will be implemented in as fair and transparent a way as possible where the impact on employee's working lives is unavoidable. |
| **Is this document compliant with the Web Content Accessibility Guidelines?** | *Delete as appropriate*<br>Yes |
| **Review Date** | October 2026 |
| **Date assessment completed** | 19/10/23 |
| **Signature of staff member completing assessment** | Sara Bowen<br>Mark Elmore |
| **Signature of staff member approving assessment** |  |

## 2. Screening Stage

**Who benefits from this policy, service or function? Who is the target audience?**

*Delete as appropriate*

- Staff

**Does the policy, service or function involve direct engagement with the target audience?**

*Delete as appropriate*

Yes - *continue with full equality impact assessment*

## 3. Research Stage

**Notes:**

- If there is a neutral impact for a particular group or characteristic, mention this in the 'Reasoning' column and refer to evidence where applicable.
- Where there may be more than one impact for a characteristic (e.g. both positive and negative impact), identify this in the relevant columns and explain why in the 'Reasoning' column.
- The Characteristics include a wide range of groupings and the breakdown within characteristics is not exhaustive, but is used to give an indication of groups that should be considered. Where applicable please detail in the 'Reasoning' column where specific groups within categories are affected, for example, under Race the impact may only be upon certain ethnic groups.

### Impact Assessment

| Characteristic | Positive Impact | Negative Impact | Neutral Impact | Not enough information | Reasoning |
|---|---|---|---|---|---|
| **Sex** | | | X | | This procedure should have a neutral impact. Individual organisational change processes will be equality impact assessed mitigating likelihood of discrimination. |
| **Gender Re-assignment** – men (including trans men), women (including trans women) and non-binary people. | | | X | | This procedure should have a neutral impact. Individual organisational change processes will be equality impact assessed mitigating likelihood of discrimination. |
| **Race** - Asian or Asian British; Black or Black British; Mixed Race; White British; White Other; and Other | | | X | | This procedure should have a neutral impact. Individual organisational change processes will be equality impact assessed mitigating likelihood of discrimination. |
| **Disability** - disabled people and carers | | | X | | This procedure should have a neutral impact. Individual organisational change processes will be equality impact assessed mitigating likelihood of discrimination. Specific consideration is given in the policy to disabled staff to ensure their needs are met throughout the process. |
| **Age** | | | X | | This procedure should have a neutral impact. Individual organisational change processes will be |

| Characteristic | Positive Impact | Negative Impact | Neutral Impact | Not enough information | Reasoning |
|---|---|---|---|---|---|
| | | | | | equality impact assessed mitigating likelihood of discrimination. |
| **Sexual Orientation** | | | X | | This procedure should have a neutral impact. Individual organisational change processes will be equality impact assessed mitigating likelihood of discrimination. |
| **Religion or Belief** | | | X | | This procedure should have a neutral impact. Individual organisational change processes will be equality impact assessed mitigating likelihood of discrimination. |
| **Pregnancy and Maternity** | | | X | | This procedure should have a neutral impact. Individual organisational change processes will be equality impact assessed mitigating likelihood of discrimination. Specific consideration is given in the policy to those on parental leave to ensure they are not unfairly impacted. |
| **Marriage or Civil Partnership** | | | X | | This procedure should have a neutral impact. Individual organisational change processes will be equality impact assessed mitigating likelihood of discrimination. |
| **Other Groups / Characteristics** - for example, homeless people, sex workers, rural isolation. | | | x | | This procedure should have a neutral impact. Individual organisational change processes will be equality impact assessed mitigating likelihood of discrimination. |

### Sources of information

- ACAS website
- Shelford Group Organisational Change Procedures

### Consultation with protected groups

*List any protected groups you will target during the consultation process, and give a summary of those consultations*

| Group | Summary of consultation |
|---|---|
| N/A | |

### Consultation with others

*List any other individuals / groups that have been or will be consulted on this policy, service or function.*

*All staff will have opportunity to feedback on this procedure as part of the approval process.*

## 4. Summary stage

### Outcome Measures

List the key benefits that are intended to be achieved through implementation of this policy, service or function and state whether or not you are assured that these will be equitably and fairly achieved for all protected groups. If not, state actions that will be taken to ensure this.

*This policy sets out a clear process for managing organisational change to ensure that all such processes are handled fairly and equitably. An equality impact assessment is required to be conducted for each individual managing organisational change process which ensures that potential inequities are considered on a case-by-case basis and mitigates the likelihood of discrimination taking place whilst following this procedure.*

*Specific consideration is given in the procedure to protected characteristics that may otherwise experience challenges (i.e. disability and pregnancy & maternity) to ensure that those challenges are addressed and equality of outcomes and experience are achieved.*

### Positive Impact

List any positive impacts that this policy, service or function may have on protected groups as well as any actions to be taken that would increase positive impact.

*N/A*

### Unjustifiable Adverse Effects

List any identified unjustifiable adverse effects on protected groups along with actions that will be taken to rectify or mitigate them.

*N/A*

### Justifiable Adverse Effects

List any identified unjustifiable adverse effects on protected groups along with justifications and any actions that will be taken to mitigate them.

*N/A*

## Equality Impact Assessment Action Plan

Complete this action plan template with actions identified during the Research and Summary Stages

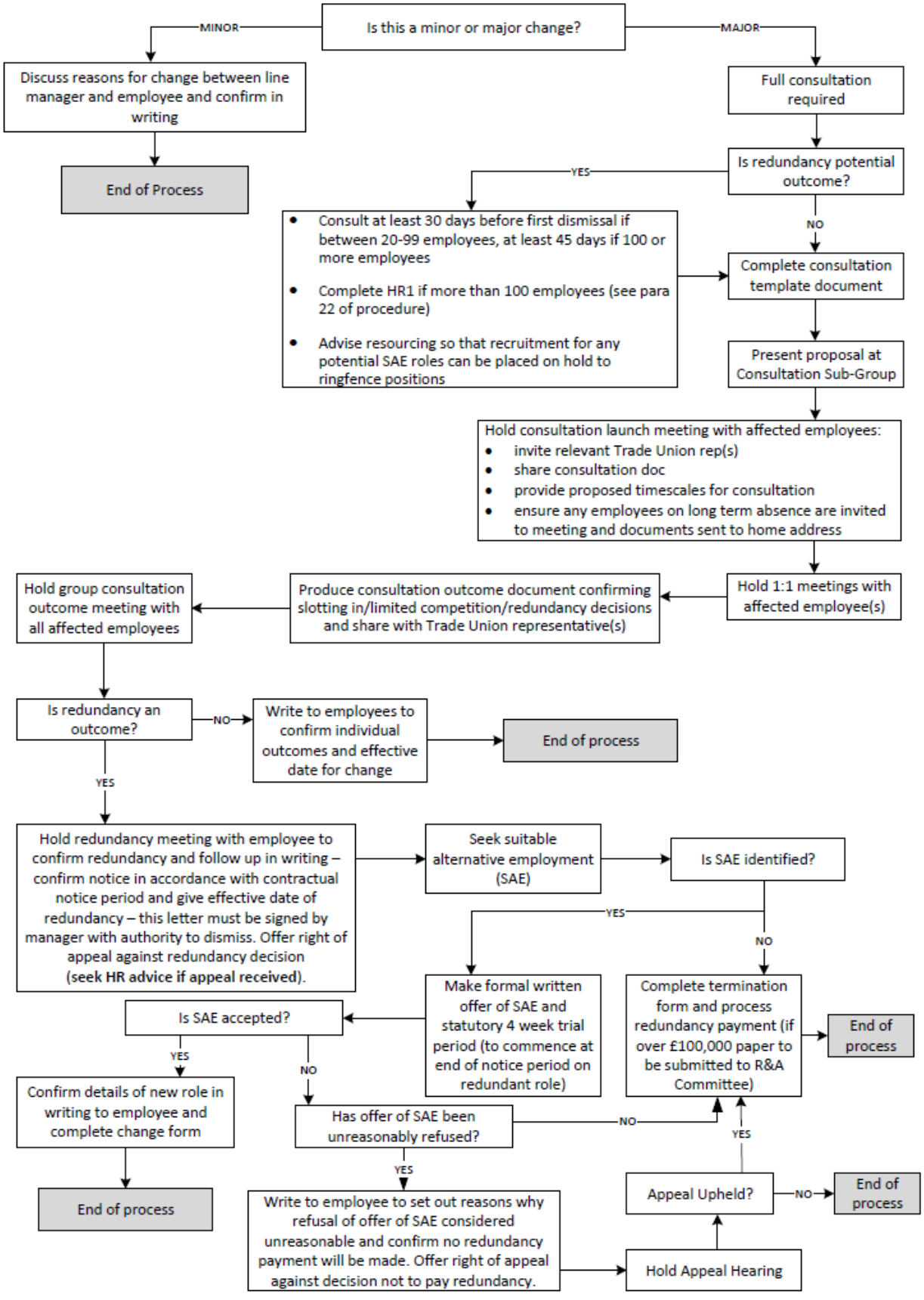
| Identified risk | Recommended actions | Lead | Resource implications | Review date | Completion date |
|---|---|---|---|---|---|
| N/A | | | | | |
| | | | | | |

## Appendix 3 – Authority to Act as Dismissing Officer

1. The Trust views a decision to dismiss an employee as being exceptional. In cases where an employee is made redundant the letter confirming the redundancy must be signed by a senior manager with the authority to act as dismissing officer. These are as follows:

    - Chief Executive Officer
    - Chief Officers
    - Directors
    - Deputy Directors
    - Divisional Directors of Nursing
    - Divisional Directors of Operations

# Appendix 4 – Management of Organisational Change Process



Oxford University Hospitals
NHS Foundation Trust

# Conduct and Expected Behaviours Procedure (including Sexual Misconduct)

**FOR OUH STAFF ONLY:** A supporting toolkit for this procedure is available – **Conduct and Expected Behaviours Procedure**

| | |
|---|---|
| **Category:** | Procedure |
| **Summary:** | This document establishes the expected standards of behaviour for all employees and actions that should be taken when behaviours fall short of the expected standards. |
| **Equality Impact Assessment undertaken:** | October 2023 |
| **Valid From:** | TBC |
| **Date of Next Review:** | 3 years<br>Until such time as the review is completed and the successor document approved by the relevant committee this policy will remain valid. |
| **Approval Via/Date:** | Trust Board |
| **Distribution:** | Trust-wide |
| **Related Documents:** | Alcohol and Drugs Misuse Guidelines<br>Counter Fraud and Bribery Policy<br>Criminal Records Checks Policy<br>Freedom to Speak Up Policy<br>Handling Concerns Relating to Conduct, Capability or Ill Health of Medical and Dental Practitioners Procedure<br>Managing Allegations Against Staff and Persons in a Position of Trust Policy<br>NMC Revalidation Policy<br>Onboarding and Induction Procedure<br>Pay on Appointment and Pay Progression Policy<br>Professional Registration Procedure<br>Resolution Procedure<br>Respect and Dignity at Work Procedure<br>Safeguarding Adults and Children Policy<br>Special Leave Procedure<br>Supporting Employee Performance Procedure<br>Workforce Equality, Diversity and Inclusion Policy |
| **Author(s):** | Assistant Director of Workforce – Employee Relations |

| | |
|---|---|
| **Further Information:** | Divisional Workforce Team |
| **This Document replaces:** | Disciplinary Procedure v 7.0 |

**Lead Director:** Chief People Officer

**Issue Date:**

## Table of Contents

## Introduction

1. This procedure supports and promotes Oxford University Hospital NHS Foundation Trust's ("the Trust") values and the strategic aim to make OUH a great place to work by delivering the best staff experience and wellbeing for all Our People, supported by a sustainable workforce model and a compassionate culture.

2. The Trust's aim is to ensure that conduct matters are dealt with fairly and in a timely manner, and that steps are taken to establish the facts using the principles of a Just and Learning Culture together with the Trust Values and Behaviours to give employees an opportunity to reflect and learn from their behaviours before taking formal action wherever possible.

3. The fair treatment of our employees will support a culture of fairness, openness and learning in the NHS by making employees feel confident to speak up when things go wrong, rather than fearing blame. An objective and prompt examination of the issues and circumstances will be carried out to establish whether training for the employee, support, guidance and/or informal management may be more appropriate and productive or if there are truly grounds for a formal investigation and/or for formal action under this procedure.

4. This procedure sets out the Trust's expectation that both managers and employees always maintain acceptable standards of behaviour and conduct. The Trust is committed to supporting and encouraging its employees in achieving this.

5. Our Trust values guide everything we do, help us make decisions, and shape the way that we interact with patients and with each other. All staff are expected to behave in a way that brings these values to life.

6. For each value the Trust has defined three sets of behaviours:

   6.1. What we love to see – these are the practices and attitudes that will ensure we provide an outstanding level of patient care and service;

   6.2. What we expect to see – these are the practices and attitudes that we expect from everyone who works for us; and

   6.3. What we don't want to see – these are the practices and attitudes that are not acceptable and will not support the Trust to deliver the expected standards of patient care and services.

   The Trust Values and Behaviours can be found on the intranet.

7. Employees should have regular interaction with their line manager and should be made aware of any concerns about the standard of their behaviour and/or conduct at the earliest opportunity so that there can be prompt resolution. Advice should be sought from Divisional Workforce Teams before invoking the formal stages of this procedure.

8. Where an issue is one of both performance and conduct, then the matter will be dealt with under this procedure and the employee informed accordingly.

9. All information related to employees under this procedure is confidential. Any employees who do not maintain confidentiality may be subject to separate action under this procedure.

## Scope

10. This procedure applies to all employees of Oxford University Hospitals NHS Foundation Trust on substantive or fixed term contracts, and Retention of Employment (RoE) employees.

11. Employees on medical and dental contracts should be managed under the Trust's Handling Concerns Relating to the Conduct, Capability or Health of Medical and Dental Practitioners Procedure in the first instance. Where the issue is then determined to be related to misconduct and not related to clinical practice it may subsequently be heard under this procedure.

12. Where behaviour and/or conduct matters arise relating to an agency/NHS Professionals (NHSP) worker, the Trust will contact the agency/NHSP to inform them of the concern and ask that it is addressed through their procedures.

13. For conduct matters relating to honorary contract holders the Trust will work with the substantive employer to address the concerns through the agreed process.

14. This procedure does not form part of any employee's contract of employment and does not apply to employees during their probationary period.

## Aim

15. The purpose of this procedure is to ensure that:

    15.1. conduct cases are managed consistently across the Trust and in line with current legislation, employment case law and best practice; and

    15.2. conduct issues are dealt with in a non-discriminatory, transparent, fair and timely manner; and

    15.3. conduct issues are managed in accordance with the principles of a just and learning culture.

## Definitions

16. The terms in use in this document are defined as follows:

    16.1. **Alternative to suspension** may occur where it is necessary to restrict an employee's normal duties due to concerns about their behaviour and/or conduct which may impact on the health, safety or wellbeing of patients, colleagues or the employee concerned.

    16.2. A **formal conduct hearing** is the meeting held under the formal stage of this procedure which has been convened to consider the findings of the investigation into alleged misconduct and determine whether any sanction is required.

    16.3. **Exclusion** from work may be required in certain circumstances and this term applies for Medical and Dental Staff only. Further information on exclusion can be found in the Trust's Handling Concerns Relating to Conduct, Capability or Ill Health of Medical and Dental Practitioners Procedure

    16.4. **Gross misconduct** is misconduct of such a serious nature that it fundamentally breaches and destroys the contractual relationship between employer and employee. It is an act (or an omission), which makes any further working relationship and mutual trust impossible. If on completion of the conduct process it is concluded gross misconduct has taken place, the result will normally be dismissal without notice (i.e. summary dismissal). Gross misconduct does not always automatically mean summary dismissal, this must be reasonable taking into account any mitigating factors.

    16.5. An **investigation** is an impartial and independent process by which information is gathered to determine the facts of the case.

    16.6. A **Just and Learning Culture** creates a culture of openness where the emphasis is on establishing the facts of an incident first before any decision is made to undertake a formal investigation. This approach allows for the setting of expectations and standards and supports the establishment of trust between employees and their managers.

    16.7. **Mediation** is a confidential and voluntary process which brings two or more employees together in the presence of a mediator to resolve problems, disputes or disagreements.

    16.8. **Misconduct** is unacceptable and improper behaviour which may breach the Trust's policies, procedures, values or behaviours but does not normally warrant dismissal unless repeated after due warning.

16.9. A **senior manager**, for the purposes of this procedure, is an employee who holds authority to dismiss (See Appendix 2).

16.10. A **statement** is the signed and dated written evidence of an individual given as part of an investigation.

16.11. **Suspension** from work may be required in certain circumstances (see paragraphs 48-66) whilst an investigation into allegations of misconduct is undertaken and will normally be on full pay. It should be made clear to the employee that suspension is not a disciplinary sanction and is not a presumption of guilt. Suspension will be for the shortest possible time and reviewed on a regular basis to ensure it remains appropriate.

## Responsibilities

17. The **Chief Executive Officer** has overall responsibility for this document.

18. The **Chief People Officer** has delegated responsibility for updates and implementation of this procedure.

19. **Line Managers** are responsible for:

19.1. Exhibiting behaviour which meets the Trust's standards at all times and which is also in line with the Trust values and behaviours.

19.2. Ensuring that their employees are aware of this procedure. Each employee should be informed of the conduct and standard of behaviour expected in their job.

19.3. Referring new employees to this procedure as part of their local induction and encouraging them to familiarise themselves with the document.

19.4. Ensuring that this procedure is applied fairly and consistently.

19.5. Regularly reviewing the period of suspension or any restriction of duties, as appropriate; there may be occasions where this responsibility is undertaken by another senior manager.

19.6. Ensuring that staff who are subject to this procedure are signposted to appropriate health and wellbeing support (see paragraph 36)

20. The **Workforce Directorate** is responsible for:

20.1. Providing consistent, legally sound advice and guidance on the application of this procedure.

20.2. Monitoring the application of the formal stages of this procedure to ensure that it is being applied in a consistent and non-discriminatory manner.

20.3. Assigning HR support to the Case Manager and the Investigating Officer

20.4. Providing advice and guidance to the Case Manager and Investigating Officer throughout the procedure.

20.5. Reviewing and updating this procedure and associated guidance documents on a regular basis.

20.6. Providing support and training for managers appointed as Case Manager and/or Chair of formal conduct hearings.

21. **Employees** are responsible for:

21.1. Maintaining appropriate standards of conduct, acting within their level of competence, and seeking advice from their manager if they are unsure of what to do in a certain situation.

21.2. Acting in accordance with Trust policies, procedures, values and behaviours and familiarising themselves with this procedure.

21.3. Providing a witness statement and/or attending an investigation meeting if requested to do so.

21.4. Maintaining confidentiality throughout the conduct process and only discussing the facts of the case with their Trade Union Representative/Work Colleague, Welfare Officer, Case Manager, Investigating Officer or Divisional HR support.

21.5. Attending formal conduct hearings and appeal hearings when required, unless there are extenuating circumstances which prevent attendance. Any extenuating circumstances must be reported to the Case Manager.

22. The **Case Manager** is responsible for:

22.1. Overseeing the formal conduct process.

22.2. Preparing the terms of reference for the investigation and keeping these under review.

22.3. Setting the timescales for completion of the investigation.

22.4. Commissioning the Investigating Officer to investigate the allegations.

22.5. Informing the employee of the allegations, the name of the Investigating Officer and the timescale for the investigation to be completed.

22.6. Providing updates to the employee on case progression to ensure the employee receives regular and clear communication about the case. If the timescale for completion of the investigation is extended, the Case Manager should communicate this to the employee at the earliest opportunity.

22.7. Receiving the final investigation report and determining whether the case needs to be referred to a formal conduct hearing.

22.8. Making arrangements for formal conduct hearings including confirming who will present the management case.

22.9. Where other agencies are involved, for example the police, Local Authority Representative (in the case of safeguarding issues) or the Local Counter Fraud Specialist/NHS Counter Fraud Authority, the Case Manager should ensure regular contact is maintained with the agency.

23. The **Chair** is responsible for:

23.1. Chairing a formal conduct hearing and determining the outcome, based on the evidence presented by all parties.

23.2. Presenting the management response to any appeal hearing.

23.3. Where a case relates to a matter of misconduct by a medical or dental practitioner, previously investigated under the Procedure for Handling Concerns Related to Conduct, Capability or Health of Medical and Dental Practitioners the formal conduct hearing will be chaired by an appropriate manager in accordance with that procedure.

24. The **Investigating Officer** is responsible for:

24.1. Undertaking a full and thorough investigation, establishing the facts of the case and collecting all relevant evidence and information thoroughly and impartially.

24.2. Undertaking investigation interviews with all witnesses and/or requesting statements from witnesses, as appropriate.

24.3. Producing an investigation report that addresses the allegations detailed in the Terms of Reference, providing sufficient information, referenced to relevant policies/procedures, to enable the Case Manager to determine if there is a case to answer.

24.4. Completing the investigation in a timely manner and without undue delay. Where necessary, liaising with the Case Manager regarding any potential delays in completing the investigation.

24.5. Attending a formal conduct hearing as a witness, to present, and answer questions on, the findings of the investigation, where appropriate.

25. The **Welfare Officer** is responsible for:

25.1. Providing support to the employee once a formal conduct investigation begins; acting as the nominated individual for the employee to speak to about the conduct process and what to expect at each stage.

25.2. Signposting the employee to wellbeing support and resources.

25.3. Escalating concerns to the Case Manager in relation to employee wellbeing.

26. The **Chief Nursing Officer/Chief Medical Officer** is responsible for making a referral to any relevant professional regulator or professional body where the Trust considers there is an issue which breaches professional standards.

27. The **Designated Workforce Safeguarding Lead** is responsible for making a referral to the Disclosure and Barring Service following the completion of internal investigations and/or when the Trust has permanently removed an individual from regulated activity, either because that person has caused harm, or poses a future risk of harm to children or vulnerable groups.

# Conduct and Expected Behaviours Procedure

## Anonymous Information

28. Where a manager receives an anonymous letter, they should exercise caution before relying on the information for use under this procedure and make efforts to substantiate the information through other sources.

29. Managers receiving anonymous information by telephone should:

29.1. record all details of the call, including the date, time and duration;

29.2. ask for details and encourage the caller to put the complaint in writing, seeking an explanation if they decline; and

29.3. ask how the caller knows the information, whether it is direct knowledge or hearsay, whether they know the employee personally and whether anyone else knows about the information.

30. The manager should then seek further advice from their Divisional Workforce Team before progressing to the Pre-Assessment stage of this procedure.

31. Where an issue is raised as a concern or a whistleblowing issue, reference should be made to the Trust Freedom to Speak Up Policy.

## Sexual Misconduct

32. The Trust has a zero-tolerance approach to sexual misconduct and violence in the workplace. There may be occasions where concerns about sexual misconduct are initially raised under the Trust's Respect and Dignity at Work Procedure. The Trust will give careful consideration to continuing to manage those concerns through that procedure, or if it is more appropriate to address them under this procedure.

33. Sexual misconduct covers a range of inappropriate sexual behaviour with different legal and operational definitions and processes. It includes language of a sexualised nature, sexual harassment, sexual assault, and rape. The supporting toolkit for this procedure includes definitions that are used when referring to acts of sexual misconduct.

34. If an employee has experienced sexual misconduct in the workplace, the Trust encourages them to use the contact details in the supporting toolkit, so that they can be supported confidentially, and necessary action can be taken.

35. If an employee has witnessed sexual misconduct, the Trust asks them to consider the following:

35.1. Offering support to anyone targeted or affected by the behaviour, and/or let them know that the behaviour witnessed is unacceptable.

35.2. To speak to a colleague and/or consider reporting the behaviour to their line manager, Freedom to Speak up Guardian, Divisional HR Team, Workforce Safeguarding Team, or Trade Union. Before reporting the behaviour, employees should try and make sure that the employee who was targeted is aware of, and supports, the intention to report it. If they do not support the intention to report it and the employee is concerned, they should not disclose their identity, but can speak anonymously to our Freedom to Speak Up Guardian for advice and support.

35.3. Challenge the behaviour by speaking to the person responsible either at the time or at an appropriate time and place, but only if the employee feels comfortable and it is safe to do so.

36. Some behaviour raised under this procedure will be unlawful and consequently there may be different, sometimes overlapping, legal and operational processes being followed, including safeguarding, employment and/or police. In these instances, advice must be sought from the Employee Relations team.

## Pre-Assessment

37. This is the first informal stage of any potential behaviour and/or conduct matter and should be undertaken by the employee's line manager (or the line manager's manager if the line manager is involved) within 2 working days of the incident becoming known.

33. The purpose of the pre-assessment is an informal process to establish facts when there is reasonable belief that Trust policies, procedures or guidelines have not been followed, and does not require terms of reference to be set.

34. The pre-assessment checklist (see toolkit) must be completed to inform and record the decision as to whether the matter can be resolved informally or if the formal conduct process should be initiated.

35. The Trust will advise the employee that the pre-assessment process is taking place but any meeting with the employee in this part of the process is informal.

36. At this stage, the employee must be offered a referral to the Centre for Occupational Health and Wellbeing and provided with details of the Employee Assistance Programme. In cases where there is significant concern for the employee's wellbeing, they should be signposted to the Trust's Staff Support Service.

37. Where the pre-assessment outcome indicates further formal investigation is not required the early resolution stage of this procedure should be followed.

38. Where the pre-assessment outcome indicates further formal investigation is required, this must be reviewed and signed off by a Chief Officer. This authority can be delegated if the sign off would cause undue delay. The Chief Officer must have had no previous involvement in the case and will provide independent oversight.

## Early Resolution

39. At the early resolution stage, it will not usually be necessary to involve Trade Union representatives or a member of the Divisional Workforce team. Where an employee requests support, or it is felt that the employee would benefit from support at this stage, it will be considered on a case-by-case basis.

40. Where the pre-assessment outcome identifies misconduct, but having considered this in line with the Just Culture checklist it does not warrant formal investigation, the manager should meet with the employee with the aim of providing a supportive environment which allows the employee and the Trust to learn from the incident and ensure appropriate standards of conduct and behaviour in the future as well as identifying any appropriate organisational procedural/policy changes needed.

41. Both managers and employees are responsible for ensuring that such discussions take place promptly when issues arise and that they are managed confidentially.

42. The manager should have a two-way open and honest discussion with the employee which may determine any underlying issue and/or identify potential solutions.

43. The manager will provide guidance on acceptable standards of conduct and behaviour and set targets and timescales for improvement where appropriate. The outcome of these meetings should be documented on the 'Letter of Early Resolution' (see toolkit), and a copy kept by both parties to ensure clarity of expectations and commitments.

44. The manager must make sure the employee is aware that if the issues resolved through early resolution reoccur then they may progress to the formal stage of the conduct procedure.

45. The timescales for any follow-up or review meetings will be by agreement by both parties but will usually be limited to a maximum 6-month timeframe.

46. The follow-up or review meeting(s) will involve the manager meeting with the employee to review whether the standards of conduct and behaviour have been met and any targets set have been achieved.

47. At the end of the agreed timescales, where the required improvement has been met, the manager will confirm that no further action will be taken. Where the required improvement(s) are not met, the manager will advise the employee that the formal stage of this procedure will be initiated.

## Alternative to Suspension and Suspension

### Medical and Dental Staff

48. The process for restricted practice and/or exclusion for Medical and Dental staff is set out in the Trust's Handling Concerns Relating to Conduct, Capability or Ill Health of Medical and Dental Practitioners Procedure. The following paragraphs 49 to 66 therefore **do not** apply to Medical and Dental staff.

### Assessing the Risk

49. The manager should assess if there is a significant risk to the organisation by using the Trust's suspension checklist (see toolkit) which should be completed at a meeting with the manager, HR support and a member of the Employee Relations team. Where these risks can be managed alternatives to suspension should be used. These will include temporarily moving the employee to another work area or considering other duties; the expectation is that the manager will work with colleagues in other Divisions where it is not possible to temporarily redeploy within the employee's own Division.

50. Should it not be possible for the member of staff to remain in their workplace due to the allegations made, every effort should be taken to consider a temporary move. This can be to another work area or for restrictions to be placed on their practice in order to avoid a suspension. Suspension should only be considered as a last resort and only at the point that all other options have been exhausted; or if is deemed that it could be harmful to the investigation, the member of staff, patients or other staff for the employee to remain in the workplace.

51. Once completed the suspension decision must be approved by both a senior manager at the Trust (Divisional Director of Nursing/Divisional Director of Operations/Director or above) and a senior member of the Employee Relations Team/Director of Workforce/Chief People Officer.

52. If suspension/alternative to suspension is being considered for an employee who is a Trade Union representative, the relevant Full Time Officer should be notified first before confirming any decision to the employee.

**Communicating the Decision to Suspend and Supporting Employees**

53. The Trust will make every effort to ensure that employees are informed of the decision to suspend in a face-to-face meeting; the outcome of which will be confirmed in writing to the employee within 5 calendar days of the meeting taking place.

54. The employee can be accompanied by a Trade Union representative or work colleague at the suspension meeting however the unavailability of a representative cannot prevent the suspension from taking place.

55. At the meeting the manager communicating the decision to suspend will:

    55.1. Clearly explain the reasons for suspension and how long it is expected to last;

    55.2. Provide details of a designated contact person (usually the employee's line manager) who the employee can contact with any concerns and a named point of contact in the Workforce Team;

    55.3. Agree how regular contact will be maintained with the employee while they are suspended;

    55.4. Confirm a referral will be made to the Centre for Occupational Health and Wellbeing and advise the employee of the support available to them while they are suspended e.g. Employee Assistance Programme, Centre for Occupational Health and Wellbeing, Staff Support Service, Welfare Officer;

    55.5. Explain that the employee may still contact work colleagues who they usually socialise with outside of work but must not discuss the investigation with them; and

    55.6. Agree with the employee how their absence will be explained to colleagues and/or patients should it be necessary to do so.

56. At the meeting the terms of the suspension will also be provided to the employee. These should include:

    56.1. Not doing anything that could interfere with the investigation;

    56.2. Treating the matter confidentially;

    56.3. How to contact witnesses to support their case;

    56.4. Any restrictions on visiting Trust premises unless given prior permission;

    56.5. Requirement to remain available during their normal working hours to attend meetings. In instances where these hours are outside normal working hours agreement should be sought as to how meetings will be arranged; and

    56.6. How to request periods of absence while suspended e.g. annual leave and sickness absence

57. If deemed necessary, the employee may be asked to hand in Trust property such as keys, ID card, Trust mobile phone etc. at the time of suspension. This should be considered on the basis of risk as opposed to being the norm.

**Review and Ending of Suspension**

58. Suspension will be for the minimum time period. The first review by the Manager should be no later than 14 calendar days after the employee is informed of the suspension, with a second review after a further 14 calendar days if the suspension remains in place.

59. If, following the second review, the employee remains suspended for 4 weeks, the suspension review should move to weekly intervals to ensure the employee is supported and to determine whether ongoing suspension remains the most appropriate course of action.

60. After each suspension review, the Manager responsible for the suspension (usually the line manager) must write to the employee to confirm the outcome of the review.

61. Where the Manager considers that suspension is no longer necessary, they should meet with the employee to inform them of their decision and to discuss how they will be supported to return to the workplace. The Manager should also confirm to the employee whether there are any restrictions of duties and/or temporary redeployment when they return.

**Pay During Suspension**

62. Employees who are suspended will be paid as if at work unless there are exceptional circumstances which warrant suspension without pay (See paragraph 66). This pay will be calculated on the basis of the employee's average pay in the 3 months prior to the suspension and will include overtime, enhancements and/or other regular allowances.

63. Where an employee is suspended and subsequently reports as being sick, whilst the terms of the suspension will remain in place, the employee will receive occupational sick pay (according to their entitlement) during the sickness absence period.

64. When an employee is suspended, they must not undertake any other paid work during the hours they are contracted to work for the Trust. Where a suspended employee usually works an irregular shift pattern and has secondary employment, they should discuss with the Manager responsible for the suspension how this can be undertaken during the period of suspension.

65. Where an employee has additional employment outside the Trust, details relating to their suspension may be shared with other employers if it is in the public interest, for example, where it is considered that there is a risk to patient safety.

66. Suspension without pay may be considered in some cases e.g. where an employee's professional registration has lapsed or been suspended/is subject to conditions of practice, because they have lost the right to work under the Immigration and Asylum Act or they are subject to criminal proceedings. Consideration will be given to the individual circumstances of employees in such cases before determining whether suspension without pay is a proportionate measure to be taken.

## Right to be Accompanied

67. An employee has the statutory right to be accompanied by a Trade Union Representative or accompanied by a work colleague at a formal conduct hearing under this procedure; in addition to this, the Trust allows an employee to be accompanied at other meetings under this procedure, including investigation interviews. In cases where an employee is an accredited Trade Union Representative, the Full-Time Officer may be involved as the employee's representative. The companion will not be permitted to act in a legal capacity.

68. Medical practitioners may have additional rights of representation as set out in the Handling Concerns Relating to the Conduct, Capability or Health of Medical and Dental Practitioners Procedure. A doctor can be represented by a friend, partner/spouse, work colleague, trade union/defence organisation representative, and also has a right to a legal representative instructed or employed by a defence organisation.

69. The Trust reserves the right to ask for identification of a Trade Union Representative, if they are not an employee of the Trust.

70. The Trade Union Representative/Work colleague may address the hearing in order to present and/or sum up the employee's case and respond on the employee's behalf to any view expressed at the hearing. They may also confer with the employee during the hearing. The Trade Union Representative/Work colleague cannot answer questions on the employee's behalf, address the hearing if the employee does not wish it or prevent the Trust from explaining its case.

71. In exceptional circumstances, and at the Trust's discretion, the employee may be permitted to be accompanied by a friend or partner, but this companion will not usually be allowed to represent the employee in any way.

72. It is the employee's responsibility to ensure their chosen Trade Union Representative/Work colleague is willing and able to attend a hearing. The employee must inform the Chair, at least five calendar days in advance of the hearing, who they will be accompanied by including the person's name and contact details.

73. It is not reasonable for an employee to insist on being accompanied by a person whose presence would prejudice the hearing or investigation or who might have a conflict of interest. The Trust reserves the right to refuse the attendance of such a person.

74. If the employee cannot attend an investigation interview or conduct hearing because their Trade Union Representative/Work colleague is unavailable on the date given, the Trust will postpone the meeting or hearing to a time proposed by the employee, provided that is within seven calendar days of the original date and the alternative time and date is appropriate for all other parties involved. Only one attempt will usually be made to reschedule the meeting.

75. If this is not possible to achieve within the timescale, the employee will be advised to seek alternative representation as the meeting will proceed as scheduled.

76. Under no circumstances should employees be unreasonably refused the right to be accompanied by a Trade Union Representative or a work colleague.

77. In cases where English is not the employee's first language, it may be necessary to involve the services of an interpreter. In such cases the interpreter will be sourced by the Trust, it is not appropriate to allow a colleague or family member to act as an interpreter.

78. Where an employee may have a disability which could affect their understanding of the process, guidance should be sought from HR before proceeding.

# Formal Conduct Process

## Investigation

79. When the outcome of the pre-assessment is that the alleged behaviour requires investigation under the formal section of the Conduct Procedure, a Case Manager will be appointed by the Divisional Management Team. The Divisional Head of Workforce will then allocate HR support to the Case Manager and to the Investigating Officer.

80. The Employee Relations Team will assign an impartial Welfare Officer who will provide support to the employee throughout the formal process (see paragraph 25).

81. The Case Manager, together with their HR support, will produce the Terms of Reference setting out the scope of the investigation, ensuring the allegations to be investigated are clear and unambiguous.

82. The Case Manager will then refer the case to the Workforce Investigation Unit who will allocate an Investigating Officer to the case and confirm their details to the Case Manager.

83. The Case Manager will then inform the employee in writing of the allegations that have been made against them. The letter should include the Terms of Reference, inform the employee that they will be required to participate in a formal investigation and remind the employee of sources of support, which may include their Welfare Officer, Trade Union, the Employee Assistance Programme, Centre for Occupational Health and Wellbeing and the Chaplaincy team.

84. The purpose of the investigation is to gather relevant evidence to establish the facts to enable the Case Manager to determine if there is a case to answer and whether a formal conduct hearing is required. It is not the role of the Investigating Officer to make recommendations on the next steps of the case or to suggest what sanction may be appropriate.

85. If there is no disagreement concerning the facts because the employee admits the misconduct, a full investigation may not be necessary before a hearing is arranged. While there will always be a robust and comprehensive investigation the intention is that any

formal investigation will be proportionate to the nature of the allegations being investigated.

86. Investigations must be undertaken with guidance and support from HR, and should be concluded thoroughly, impartially and in a timely manner.

87. A written record of the investigation interview will be made, and this record will form part of the investigation report. The employee will have the opportunity to review the notes of the interview to confirm it is an accurate record. If the employee considers any amendments to the interview notes are necessary, these can be submitted to the Investigating Officer.

88. If an employee does not attend an investigation interview without good reason the Investigating Officer should contact the employee to understand why they did not attend, and a second date should be offered for the interview. If an employee fails to attend for a second time without good reason, they should be given an opportunity to submit a written response to the allegations within a reasonable timeframe. If an employee fails to attend two scheduled interview times and to provide a written submission without good reason, the investigation may be concluded without their input.

89. When the investigation is complete, the Investigating Officer will produce an investigation report for the Case Manager's consideration, clearly setting out the evidence established by the investigation.

### Witness Interviews

90. During the investigation stage of this procedure the Investigating Officer should interview any witnesses who may have evidence related to the alleged misconduct. The notes from the interview with witnesses should be accurate and reflect the content of the interview but will not usually be verbatim. The interview notes will be typed up and sent for the witness to check, sign and date as an accurate record of the interview.

91. A witness may be asked to provide a written statement, either in addition to or instead of attending an investigation interview. If a written statement is required, the Investigating Officer should ask the witness to produce a written statement, taking account of the following guidance:

    91.1. Assume that the reader knows nothing about the facts of the matter.

    91.2. State the name and job title of the witness and, if appropriate, their qualifications and experience.

    91.3. Deal with events in the order in which they occurred, giving precise dates and times if known.

    91.4. Use plain English and where possible, avoid jargon or technical and complex language.

    91.5. If the allegation is in relation to protocols or procedures not being followed, the witness should explain what the agreed or usual procedure is and then describe the nature of the departure from this.

    91.6. Statements should be signed and dated as an accurate statement of facts.

92. Anonymous witness statements will not usually be accepted as part of a conduct investigation. If a witness is worried about suffering a reprisal or victimisation, they should be offered appropriate support and the employee against whom allegations have been made should be reminded that victimisation or harassment of a witness may be treated as a separate conduct matter.

## Investigation Outcome

93. Within 7 calendar days of receiving the report, the Case Manager, together with their HR support, must determine whether there is evidence which needs to be considered at a formal conduct hearing and inform the employee of their decision.

94. Where the decision is that a formal conduct hearing is necessary the Case Manager will make arrangements for the hearing to take place. This will usually be within 14 calendar days of informing the employee of their decision. Where this is not possible, for example, due to planned annual leave or sickness, the hearing will be arranged to take place as soon as possible.

95. The Case Manager, together with their nominated HR support, will be responsible for appointing a Chair of the conduct hearing. This will be a senior manager who has had no prior involvement in the case at any stage (including pre-assessment). Appendix 2 provides guidance on panel composition.

96. The Case Manager will write to the employee to advise them of the arrangements for the hearing including details of the allegations to be heard and names of the panel members hearing the case. A copy of the full investigation report, including all appendices, should be included with this letter, and it must also advise the employee of their right to be accompanied and the right to call witnesses in support of their case.

97. If the Case Manager concludes that there is no case to answer, all documentation relating to the case will be held on the Trust's Employee Relations case management system in accordance with GDPR regulations but will not be held on the employee's personal file. In these circumstances a copy of the investigation report will not be shared with the employee.

## Conduct Hearing

98. The conduct hearing panel will consist of a Chair and an HR representative. In matters of technical or clinical misconduct, it may be necessary to have an additional adviser to the panel. To ensure impartiality, panel members, including the Chair, must have had no prior involvement in the case. Information on the format for the hearing can be found in the toolkit.

99. If the case relates to a matter of misconduct by a medical or dental practitioner, previously investigated under the Handling Concerns Related to Conduct, Capability or Health of Medical and Dental Practitioners Procedure, the conduct hearing will be chaired by the appropriate manager in accordance with that procedure.

100. In cases involving allegations of gross misconduct, the employee must be advised that if gross misconduct is found then this could lead to their dismissal.

101. Medical and dental practitioners employed by the Trust on medical and dental contracts have the right to representation set out in the Trust's Handling Concerns Related to Conduct, Capability or Health of Medical and Dental Practitioners Procedure.

102. The employee will usually be given 14 calendar days' notice of any hearing date and will be provided with the management case and all associated documents at this point. In some circumstances and where both parties agree it may be beneficial to expedite the process less than 14 calendar days' notice may be agreed.

103. Where the employee or management intend to call witnesses to the hearing, names of the witnesses and any statements they will be giving must be provided to the Chair at least five calendar days before the hearing. Witnesses will only be present in the conduct hearing when giving their own evidence. It is the responsibility of any party calling witnesses to inform them of the arrangements for the hearing.

104. If the employee wishes to provide additional evidence, this should be submitted to the Chair of the conduct hearing no later than 5 calendar days before the hearing and will be shared with all other parties.

105. At the hearing an appropriate manager (usually the Case Manager) will be responsible for presenting the management case, and the Investigating Officer will be called as a witness to present the investigation findings. The Investigating Officer will be accompanied by their HR support at the hearing.

106. A record of the meeting will be taken by a confidential note taker and/or a recording. A copy of the conduct hearing notes will be circulated to all parties in the case of an appeal.

107. If an employee is absent from work due to sickness at the time of the hearing, then an alternative date may be arranged for the hearing. Advice will be sought from the Centre for Occupational Health and Wellbeing about the employee's fitness to attend a formal hearing if it appears the employee will not be fit within a short period of time, usually within seven calendar days or depending on the reason for the sickness absence. If the employee is deemed not fit to attend a hearing within a reasonable time frame, then they may be invited to provide written submissions and the hearing will proceed in their absence.

108. Where an employee is not able to attend the hearing, without good reason, the Chair may decide to proceed in their absence and will make a decision on the evidence available.

## Decision Following Formal Hearing

109. Following the hearing the panel will adjourn to consider the case. The hearing will then be reconvened to inform the employee of the outcome and if appropriate, any sanction to be imposed. In cases considering allegations of gross misconduct, the Chair should advise the employee that a decision will not normally be reached on the same day, and instead, the hearing will be reconvened within 7 calendar days to provide the outcome. In exceptional circumstances, the decision may be communicated in writing only.

110. The Chair must come to a view on the facts. If the facts have been disputed, the Chair must decide on the version of events they believe to be correct on the balance of probabilities. The balance of probabilities means that the Chair is satisfied that the occurrence of the event was more likely than not.

111. Previously issued warnings which have expired must be disregarded. However, consideration may be given to circumstances where the background to such warnings demonstrates a repeated pattern of behaviour taking into account the time that has elapsed.

112. There are three potential outcomes of a conduct hearing:

- the allegation is not upheld;
- learning outcomes; and/or
- formal conduct sanction.

113. The formal conduct sanctions available to the panel are as follows:

- first written warning – 12 months
- final written warning – 24 months
- alternatives to dismissal
- dismissal

## Alternatives to dismissal

114. In some cases, we may at our discretion consider alternatives to dismissal. These must be authorised by the Chief People Officer (or a deputy) and will usually be accompanied by a final written warning. Examples include:

114.1. Demotion;

114.2. Transfer to another department or job;

114.3. A period of suspension without pay;

114.4. Loss of seniority;

114.5. Reduction in pay;

114.6. Loss of future pay increment or bonus;

114.7. Loss of overtime.

115. Any sanction applied by the conduct panel should take into account the seriousness of the allegations against the employee, the evidence presented and any mitigation which is offered. The Chair should also ensure the decision is consistent with similar previous cases.

116. In the case of warnings, the Chair will explain what improvement is expected, the timeframe for improvement, what training and support may be provided to achieve improvement, how long the warning will remain on file and the consequences of a failure to improve. At the end of the time period of the written warning, it will be removed from the employee's personal file.

117. All conduct hearing outcomes will be confirmed in writing to the employee and their representative within 7 calendar days following the hearing, informing of the right of appeal within 14 calendar days. The Chair will also confirm that as a result of the warning the employee's incremental point will be placed on hold for the duration of the formal warning, in accordance with the Pay on Appointment and Pay Progression Policy.

118. Outcome letters should be copied to the employee's manager. This ensures they are aware of the outcome and any matters that may need to be taken forward or implemented.

119. If the outcome of a conduct hearing relates to a registrant, there may be instances where it is necessary to refer them to their regulatory body. Employees in regulated work will also be referred to the Disclosure and Barring Service where they have been removed from regulated work. The referral will be made by the Designated Workforce Safeguarding Lead (see paragraph 27) and employees should be informed in advance that a referral will be made.

### Dismissal

120. Any decision to dismiss shall be confirmed in writing and shall:

120.1. clearly state the reason for the dismissal;

120.2. state the date on which the employment will terminate;

120.3. specify whether the dismissal is with or without notice/pay in lieu of notice; and

120.4. inform the employee of their right of appeal and how it might be exercised.

121. Dismissal as a result of repeated misconduct will be with notice. In cases of gross misconduct, there is no entitlement to notice, and the employee may be summarily dismissed with immediate effect and without notice or payment in lieu of notice. This will be confirmed in writing.

122. If an employee is dismissed with notice, the length of the notice period or payment in lieu of notice must be equivalent to their contractual or statutory notice period, whichever is greater.

123. Where dismissal is the outcome, the employee's final salary will be adjusted to reflect any under/overtaken annual leave at the date of the dismissal.

## Conduct Outside Employment

124. Conduct proceedings may be commenced where:

124.1. conduct outside employment seriously impairs an employee's ability to undertake their duties;

124.2. the conduct of an employee calls into question their integrity or suitability to carry out their duties; and/or

124.3. the conduct of the employee is likely to bring the Trust into disrepute.

125. Action under this procedure should not be taken automatically against an employee because they have been charged with or convicted of a criminal offence committed outside their employment.

126. Each situation should be considered individually on the basis of whether the employee's conduct warrants action because of its employment implications or because of its impact on other employees. The manager should also consider information regarding any previous convictions.

127. In a situation where the employee refuses to co-operate, they should be advised in writing that unless further information is provided, a decision will be taken at the hearing, up to and including dismissal, on the basis of the information available.

128. In some cases, the nature of the offence may have no bearing on the employee's employment, but the employee may not be available for work because they are in custody or on remand. In these circumstances, the employer will need to decide whether, considering the needs of the service, the employee's job can be kept open.

129. The fact that an employee has been charged with a criminal offence should not be regarded as an indication of guilt. Conviction of an offence, however, is sufficient proof that an offence has been committed.

130. If criminal proceedings are ongoing, an interim option available to the manager is suspension without pay until such time as an informed decision can be taken. Advice should be taken from the Divisional Head of Workforce and any decision to suspend on nil pay authorised in accordance with paragraphs 48-66 of this procedure.

131. Criminal proceedings may take significant time to be concluded and the manager does not have to wait until the matter has been brought before the courts before proceeding with an investigation and if required a conduct hearing. However, it is essential to ensure that any investigation undertaken by the Trust does not interfere with or prejudice any police investigation. Interviews with staff should not usually take place until the member of staff has been interviewed by the police as this could interfere with the police investigation. Advice should be sought from the Employee Relations team before deciding upon a course of action.

132. A full investigation may not be necessary before convening a hearing, depending on the circumstances. It is usually necessary for the employee to be provided with an opportunity to respond to the allegations before any decision is made. Alleged breaches of the contract of employment may be considered at a conduct hearing before a court has decided whether the employee is guilty of an offence.

## Fraud Allegations

133. Where fraudulent activity is suspected, the manager should immediately refer the matter to the Trust's Anti-Crime Specialist for investigation. An investigation will be undertaken in accordance with the Trust's Counter Fraud and Bribery Policy.

134. Where an employee is a victim of an incidence of fraud or an allegation of fraud is reported to them, they should contact their line manager in the first instance. If their line manager is not available, they should report the incident to the next most senior person.

135. Investigations undertaken by the Counter Fraud Service may result in criminal or civil sanctions and redress.

136. This procedure does not detract from employee's right to raise a concern under the Trust's Freedom to Speak Up Policy.

## Involvement of Other Agencies

137. Occasionally a manager may be approached by another agency such as the police, Local Authority Representative for Child Protection Issues or the Anti-Crime Specialist / NHS Protect with concerns about the conduct of an employee. In such instances it may be necessary to put the internal conduct process on hold pending an external investigation, in

order to prevent a loss of evidence. Advice should be sought from the Employee Relations team before deciding upon a course of action.

138. Close liaison with the other agency will be required including, where appropriate, the coordination of arrangements to place the employee concerned on special leave. However, the fact that an external investigation is taking place will not in itself prevent the Trust from taking forward proceedings under this procedure. Advice should always be sought from HR. For safeguarding issues, the Trust's Managing Allegations Against Staff and Persons in a Position of Trust Policy should be referred to.

139. Where the allegations involve criminal activity, the police may need to become involved, and the Trust may be involved in the reporting process. The decision to refer the matter to the police should be made by a senior manager.

## Some Other Substantial Reason

140. An employee may, in certain circumstances, be dismissed for 'some other substantial reason' (SOSR). There is no legal definition of SOSR but it may be used in situations where there has been a fundamental breakdown of trust and confidence with an employee which is not as a result of a distinct conduct or performance issue but may occur where relationships with work colleagues have broken down irreparably, or where an employee's conduct has, or has the potential to, seriously damaged the reputation of the Trust.

141. It is essential that a fair, transparent and evidence-based process is followed, and that the employee is informed of the potential consequences of their conduct or behaviour. The Trust must act reasonably, taking into account the circumstances of each individual case, ensuring there is sufficient evidence to justify the dismissal.

142. If a manager is considering that the conduct or behaviour of an employee falls within this reason, then they should seek advice in the first instance from their Divisional Head of Workforce.

143. Before a hearing is convened to consider dismissal for SOSR a thorough and impartial investigation into the facts of the alleged behaviours should be undertaken, with an investigation report detailing the findings produced. This will follow the formal stages of this procedure, including the arrangements for convening a hearing.

144. A dismissal for SOSR would ordinarily be with paid notice, unlike dismissal for gross misconduct which would usually be summary, without notice.

## Overlapping Conduct and Resolution Procedures

145. Where an employee raises a concern under the Resolution Procedure during the conduct process, and where the resolution and conduct cases are related, both cases will be dealt with under this procedure and within the existing process.

## Appeal

146. Employees have a right to appeal against the outcome of a conduct hearing.

147. The employee may appeal in writing to the Director of Workforce, stating their full grounds of appeal (which must be one or more of the following: procedural correctness, conclusion in light of the evidence presented at the hearing, appropriateness of the penalty, extenuating circumstances, new evidence, some other substantial reason), within 7 calendar days of the date on which the decision was sent or given to them.

148. An appeal meeting will be arranged, normally within 14 calendar days of receiving the written appeal. Where practicable, the appeal meeting will be conducted by a manager more senior than the one who chaired the original meeting and who has not been previously involved in the case.

149. The chair of the appeal meeting may ask anyone previously involved to be present. The employee has the right to bring a colleague or trade union representative to the meeting (see paragraphs 67-78).

150. The Trust will confirm the final decision in writing, normally within 7 calendar days of the appeal meeting.

151. Once the final decision is made, this is the end of the process and there is no further right to appeal.

## Training

152. There is no mandatory training associated with this procedure.

153. Workshops on the Conduct Procedure and on undertaking specific roles within the Procedure are provided and managers should attend these as part of their management training. Ad hoc training sessions based on an individual's training needs may also be defined within their annual appraisal or job plan.

## Monitoring Compliance

154. Compliance with the document will be monitored in the following ways:

| 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 |
|---|---|---|---|---|
| Number of formal conduct cases | Internal Audit | Chief People Officer | Quarterly | Trust Board |
| Protected characteristics of employees subject to the formal conduct procedure | Internal Audit | Chief People Officer | Quarterly | Trust Board |
| Protected characteristics of employees subject to the formal conduct procedure | Equality Delivery System 2 (EDS2) and Workforce Race Equality Standard (WRES) | Workforce E&D Lead | Annually | People and Communications Committee and Equality, Diversity and Inclusion Steering Group |

155. In addition to the monitoring arrangements described above, the Trust may undertake additional monitoring of this procedure as a response to the identification of any gaps or because of the identification of risks arising from the procedure prompted by incident review, external reviews, or other sources of information and advice. This monitoring could include:

    155.1. Commissioned audits and reviews

    155.2. Detailed data analysis

    155.3. Other focused studies

    155.4. Results of this monitoring will be reported to the nominated Committee.

## Review

156. This procedure will be reviewed in three years, as set out in the Developing and Managing Policies and Procedural Documents Policy.

157. Until such time as the review is completed and the successor document approved by the relevant committee this policy will remain valid.

## References

ACAS Code of Practice

Agenda for Change Terms and Conditions Handbook

Maintaining High Professional Standards in the Modern NHS for Doctors and Dentists.

NHS Counter Fraud Authority

NHSE Sexual Safety in the Workplace – Resource and Support

## Equality Impact Assessment

158. As part of its development, this procedure and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible, remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation, religion or belief, gender reassignment, marriage and civil partnership and pregnancy and maternity. The completed Equality Impact Assessment can be found in Appendix 1.

## List of Appendices

**Appendix 1 – Equality Impact Assessment**

**Appendix 2 - Guidance on Conduct Panel Composition**

**Appendix 3 – Behaviours the Trust Considers to be Misconduct**

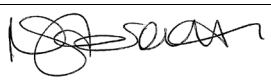
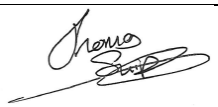
**Appendix 4 – Behaviours the Trust Considers to be Gross Misconduct**

## Document History

| Date of revision | Version number | Reason for review or update |
|---|---|---|
| May 2014 | 2.3 | Review due in previous document |
| June 2015 | 4 | Reference to Linking Pay Progression and Performance Policy added. |
| January 2016 | 4.1 | Review of procedure |
| February 2016 | 4.2 | Review of formatting |
| April 2016 | 4.3 | Updated following consultation and feedback |
| November 2016 | 5.0 | Review of procedure |
| June 2023 | 7.0 | Minor amendment approved by People and Communications Committee to paragraph 10 of Appendix 7 to clarify if the employee is calling witness(es) management side will have the opportunity to ask questions. |
| October 2023 | 7.5 | Review of procedure |

# Appendix 1 – Equality Impact Assessment

## 1. Information about the policy, service or function

| | |
|---|---|
| **What is being assessed** | *Delete as appropriate*<br>~~New Policy / Procedure~~<br>~~New Service Function~~<br>Existing Policy / Procedure<br>~~Existing Service / Function~~ |
| **Job title of staff member completing assessment** | Assistant Director of Workforce – Employee Relations |
| **Name of policy / service / function:** | Conduct Procedure – Workforce Directorate |
| **Details about the policy / service / function** | Review of the Conduct Procedure |
| **Is this document compliant with the Web Content Accessibility Guidelines?** | *Delete as appropriate*<br>Yes / ~~No / Not applicable for the following reason(s)~~ |
| **Review Date** | 3 years |
| **Date assessment completed** | 16 October 2023 |
| **Signature of staff member completing assessment** |  |
| **Signature of staff member approving assessment** |  |

## 2. Screening Stage

**Who benefits from this policy, service or function? Who is the target audience?**

*Delete as appropriate*

- ~~Patients~~
- Staff
- ~~Family / Carers~~
- ~~Other (please specify)~~
- ~~Not applicable~~

**Does the policy, service or function involve direct engagement with the target audience?**

*Delete as appropriate*

Yes - *continue with full equality impact assessment*

~~No - *full equality impact assessment not required*~~

## 3. Research Stage

**Notes:**

- If there is a neutral impact for a particular group or characteristic, mention this in the 'Reasoning' column and refer to evidence where applicable.
- Where there may be more than one impact for a characteristic (e.g. both positive and negative impact), identify this in the relevant columns and explain why in the 'Reasoning' column.
- The Characteristics include a wide range of groupings and the breakdown within characteristics is not exhaustive, but is used to give an indication of groups that should be considered. Where applicable please detail in the 'Reasoning' column where specific groups within categories are affected, for example, under Race the impact may only be upon certain ethnic groups.

## Impact Assessment

| Characteristic | Positive Impact | Negative Impact | Neutral Impact | Not enough information | Reasoning |
|---|---|---|---|---|---|
| **Sex and Gender Re-assignment** – men (including trans men), women (including trans women) and non-binary people. | | | X | | There is no differential treatment on the basis of this protected characteristic. |
| **Race** - Asian or Asian British; Black or Black British; Mixed Race; White British; White Other; and Other | | | X | | There is no differential treatment on the basis of this protected characteristic. This procedure applies a 'Just Culture' approach and evidence demonstrates that this reduces the likelihood of staff from a BAME background being subject to conduct action to the same level as white colleagues. Further detail is included in the Outcome Measures in the Summary Stage of this assessment. |
| **Disability** - disabled people and carers | | | X | | There is no differential treatment on the basis of this protected characteristic. |
| **Age** | | | X | | There is no differential treatment on the basis of this protected characteristic. |
| **Sexual Orientation** | | | X | | There is no differential treatment on the basis of this protected characteristic. |

| Characteristic | Positive Impact | Negative Impact | Neutral Impact | Not enough information | Reasoning |
|---|---|---|---|---|---|
| **Religion or Belief** | | | X | | There is no differential treatment on the basis of this protected characteristic. |
| **Pregnancy and Maternity** | | | X | | There is no differential treatment on the basis of this protected characteristic. |
| **Marriage or Civil Partnership** | | | X | | There is no differential treatment on the basis of this protected characteristic. |
| **Other Groups / Characteristics** - for example, homeless people, sex workers, rural isolation. | | | X | | There is no differential treatment on the basis of this protected characteristic. |

### Sources of information

*Imperial College Disciplinary Procedure*
*Mersey Care NHS Foundation Trust*
*NHS Resolution*
*NHS Employers*

### Consultation with protected groups

*List any protected groups you will target during the consultation process, and give a summary of those consultations*

| Group | Summary of consultation |
|---|---|
| | |

### Consultation with others

*List any other individuals / groups that have been or will be consulted on this policy, service or function.*

- Staff Side
- Trust Alliance Committee Members
- Divisional HR teams
- Trust Management Executive members

## 4. Summary stage

### Outcome Measures

List the key benefits that are intended to be achieved through implementation of this policy, service or function and state whether or not you are assured that these will be equitably and fairly achieved for all protected groups. If not, state actions that will be taken to ensure this.

*The procedure places employee wellbeing at the centre of the procedure and ensures that this is properly considered at all stages. The procedure ensures that there is senior level oversight at all stages and includes a pre-assessment approach to ensure that all cases are reviewed formally reviewed and then signed off by a senior manager before formal conduct procedures can commence. The procedure also introduces an early resolution step which can be applied where the pre-assessment indicates that individual and/or organisational learning would be more appropriate that formal conduct action.*

*OUH WRES data has previously indicated that there is a disproportionate number of BAME staff entering into a formal disciplinary process. The increased level of senior authorisation required before formal action can commence ensures that there is a structured and consistent approach to our Conduct Procedure and should demonstrate a positive impact on our WRES data with all employees in protected groups receiving equitable treatment. This expectation is supported by evidence from other NHS Trusts (including Mersey Care NHS Foundation Trust, Imperial College NHS Foundation Trust and Barts Health NHS Trust) which has demonstrated that this formal structure and early assessment safeguards against a disproportionate impact of conduct procedures on staff with protected characteristics.*

*The revisions to this procedure are taking place within a wider programme of continuing activity to support the implementation of a Just Culture at OUH and the development and embedding of the best EDI initiatives, supported by evidence based research, to reduce and remove any disproportionality in our processes.*

### Positive Impact

List any positive impacts that this policy, service or function may have on protected groups as well as any actions to be taken that would increase positive impact.

*This procedure provides a transparent, fair and consistent approach for dealing with conduct issues. The Just Culture approach should ensure no adverse impact on employees with protected characteristics. As part of monitoring of the application of the procedure the protected characteristics of all staff subject to formal action is monitored and results of the monitoring reported quarterly to the Trust Board.*

### Unjustifiable Adverse Effects

List any identified unjustifiable adverse effects on protected groups along with actions that will be taken to rectify or mitigate them.

*None*

### Justifiable Adverse Effects

List any identified unjustifiable adverse effects on protected groups along with justifications and any actions that will be taken to mitigate them.

*None*

## Equality Impact Assessment Action Plan

Complete this action plan template with actions identified during the Research and Summary Stages

| Identified risk | Recommended actions | Lead | Resource implications | Review date | Completion date |
|---|---|---|---|---|---|
| | | | | | |

## Appendix 2 – Composition of the Hearing Panel

1. The panel to hear the evidence at a formal conduct hearing will consist of:
   1.1. the Chair (manager hearing the case);
   1.2. a Human Resources representative;
   1.3. a manager with relevant experience to advise the Chair, if the matter relates to a professional issue;
   1.4. a Non-Executive Director, where the hearing concerns staff directly accountable to the Chief Executive Officer.
2. Any member of the panel may ask questions throughout the conduct hearing.
3. The Trust views a decision to dismiss an employee as being exceptional. In cases where the hearing outcome may potentially result in dismissal, the role of the Chair will be restricted to those with the authority to act as dismissing officer. These are as follows:
   3.1. Chief Executive Officer
   3.2. Chief Officers
   3.3. Directors
   3.4. Deputy Directors
   3.5. Divisional Directors of Nursing
   3.6. Divisional Directors of Operations
4. If a hearing might be postponed as a result of a dismissing officer not being available to attend a hearing, the dismissing officer may ask a manager with an appropriate level of seniority to chair the hearing. Should the Chair decide that dismissal is the appropriate action, this decision must be ratified by the dismissing officer.
5. The dismissing officer should not normally be the employee's immediate manager.

## Appendix 3 - Behaviours the Trust Considers to be Misconduct

1. Misconduct is unacceptable and improper behaviour which may breach the Trust's policies but does not normally warrant dismissal unless repeated after due warning.
2. Examples of misconduct could include:
    2.1. Refusing or failing to carry out a reasonable management instruction.
    2.2. Unsatisfactory attendance at work, e.g. unauthorised absenteeism, lateness, leaving work without permission, overstaying breaks.
    2.3. Conduct, which disrupts the work of others.
    2.4. Failure to observe the Trust's procedures for recording of working time and attendance, reporting of sickness and time off work.
    2.5. Failure to conform to agreed working practices.
    2.6. Failure to take reasonable care of Trust property.
    2.7. Failure to act in accordance with the Trust's values.
    2.8. Using Trust property, equipment or transport for private use without authorisation.
    2.9. Failure to comply with the Trust's no smoking policy.
    2.10. Failure to comply with any other Trust policy.
    2.11. Misuse of the Internet, email, or other Trust facilities.
    2.12. Recording and/or personally storing recordings of conversations or meetings with colleagues, patients, or third parties without their knowledge and/or consent
3. Consistently failing to demonstrate the behaviours and/or values the Trust expects of its staff. The above are examples and are not exclusive or exhaustive.
4. Dependent upon the degree and circumstances of any of these examples, they might constitute gross misconduct.

## Appendix 4 - Behaviours the Trust Considers to be Gross Misconduct

1. Gross misconduct is misconduct of such a serious nature that it fundamentally breaches and destroys the contractual relationship between an employer and an employee. It is an act (or an omission), which makes any further working relationship and mutual trust impossible. If on completion of a disciplinary process, it is concluded gross misconduct has taken place, the result will normally be dismissal without notice (i.e. summary dismissal). Gross misconduct does not always automatically mean summary dismissal; this must be reasonable taking into account any mitigating factors.
2. If an employee is believed to have committed an act of gross misconduct, advice should be sought immediately from HR.
3. Examples of gross misconduct include, but are not limited to:
    - 3.1. A serious neglect of duty and responsibility.
    - 3.2. Harassment, bullying or any act of discrimination.
    - 3.3. Theft or unauthorised removal of property belonging to the Trust, patients or other members of the general public.
    - 3.4. Bringing the Trust into disrepute.
    - 3.5. Fraudulently obtaining money, property, confidential information or material advantage from the Trust.
    - 3.6. Use of false documents including identity document, qualifications and references.
    - 3.7. Unauthorised entry into computer records.
    - 3.8. Malicious and vexatious claims of bullying and harassment.
    - 3.9. Malicious and vexatious claims under the Freedom to Speak Up Policy.
    - 3.10. Deliberate falsification of official records.
    - 3.11. The submission of fit notes not genuinely issued by a General Practitioner (repayment of sick pay may also be sought and/or referral to the Local Counter Fraud Specialist/Anti-Crime Specialist for investigation).
    - 3.12. Sharing of smart cards, network login details or passwords with another individual where not permitted by Trust policy or procedure.
    - 3.13. Deliberate falsification of claims for earnings and expenses.
    - 3.14. Assault or attempted assault or physical/sexual violence.
    - 3.15. Abusive behaviour towards patients, visitors or colleagues.
    - 3.16. Falsification of timesheets and other pay-related documents.
    - 3.17. Malicious damage to Trust property.
    - 3.18. Failure to comply with departmental rules or regulatory body frameworks/codes of conduct.
    - 3.19. Serious breaches of confidentiality.
    - 3.20. Taking photos of patients in any setting, without obtaining prior informed consent, gained through completing a patient consent form.
    - 3.21. Inability to work due to being under the influence of alcohol and/or illegal substances.
    - 3.22. Negligence.

3.23. Serious breach of health and safety rules and procedures.

3.24. Fraudulent misuse of the Trust's name or property.

3.25. Serious failure to comply with any Trust procedure or policy.

4. The above examples are not exclusive or exhaustive and offences of a similar nature will be dealt with accordingly.

5. Where appropriate, disciplinary outcomes will be notified to the appropriate professional body, which may consider action in relation to its own professional code of conduct.