Bundle Remuneration & Terms of Service Committee 22 July 2021

1 R21.46 Apologies

2 R21.47 Declarations of Interests

3 R21.48 Draft minutes of previous meeting 22.4.21 for approval and matters arising

R21.48 Minutes RATS 22.4.21 v0.01 draft.doc

4 R21.49 Action log

R21.49 RaTS Summary Action log Public_live document Updated 24 5 21.docx

5 R21.50 Matters considered in private at the last meetings, to be noted in public:Harmonisation of pay for managed practices;Tribunal Report; Senior Interim Manager Update; Upholding Professional Standards in Wales; NHS (Performers Lists) (Wales) Regulations 2004 report; Professional Standards Case Management Update Report; Executive Director Appointments and Changes; Performance and Development Review of CEO and Executive Directors; Remuneration Report 20/21

6 R21.51 Nursing and Midwifery Council (NMC) Registration, Revalidation and Fitness to Practise Annual Report - Anne-Marie Rowlands to attend

The Committee is requested to note the content of the report and the processes in place to provide assurance with regard to NMC registration, revalidation and fitness to practise within BCU.

R21.51 Nursing and Midwifery Council (NMC) Registration Revalidation and Fitness to Practise Annual Report.docx

7 R21.52 GMC Revalidation Update 2020 - Arpan Guha

1\. The Committee is asked to note this update
2\. The Committee is asked to note the future actions\, scrutiny and assurance processes required as outlined in this briefing\.

R21.52 GMC_revalidation_FP_May_2021 (002).pdf

8 R21.53 All Wales Policy Update - Sue Green

The Committee is asked to note the approved policies / procedures

R21.53 2021-_07_22 RTS Committee - Policy Update report SG Comments.docx

R21.53.1 Respect and Resolution Policy FINAL April 2021.pdf

R21.53.2 WP62 - BCUHB Dress Code April 2021.pdf

R21.53.3 WP4A - All Wales Raising Concerns procedure for NHS Staff.pdf

9 R21.54 Any other business

10 R21.55 Date of next meeting - 21.10.21

11 R21.56 Resolution to exclude the Press and Public

12 PRIVATE SECTION

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Remuneration & Terms of Service Committee (R&TS)

Minutes of the Meeting held on
22.4.21 via Teams

Present: Mark Polin Medwyn Hughes Jackie Hughes Lucy Reid	 Health Board Chair Independent Member (IM) Independent Member Health Board Vice Chair
In Attendance: Louise Brereton Sue Green (SG) Liz Jones (LJ) Jo Whitehead	 Board Secretary Executive Director of Workforce & Organisational Development (OD) Assistant Director, Corporate Governance Chief Executive

Agenda Item	Action
R21.17 Apologies Arpan Guha.	
R21.18 Declarations of interests None.	
R21.19 Draft minutes of previous meeting held on 1.2.21 The minutes were approved as an accurate record.	
R21.20 Summary action log R21.20.1 The action log was reviewed and updated accordingly.	
R21.21 Matters considered in private at the last meeting, to be noted in public It was noted that Raising concerns: Speak Out Safely progress and proposal; Performance & Development Review - Executive Directors; Executive and senior appointments had been discussed at the last meeting.	
R21.22 Draft R&TS Committee annual report 2020/21 R21.22.1 The Executive Director of Workforce & OD presented the draft report and	

highlighted the Committee's priorities for the coming year. These were Executive and senior employees' objective setting and performance management, professional standards and Performers List reporting, compliance monitoring, employee relations, Speak out Safely reporting, pay harmonisation and a focus on changes relating to the overall operating model of the organisation. R21.22.2 An IM commented that some of RAG ratings needed to be revisited, suggesting that the objective to '*monitor compliance with issues of professional registration including the revalidation processes'* should be assessed as amber due to inaccuracies and gaps highlighted during the course of the year, such as the omission of allied health professionals. This meant that the Committee was only partially assured. The IM added that the Upholding Professional Standards in Wales (UPSW) objective should be scored as red as reports received had not been comprehensive and had contained errors, with inadequate information on progress. It was agreed that the narrative column should read '*reports are being developed but are not yet regularly presented to the Committee'.* R21.22.3 In respect of whistleblowing and Safe Haven, the IM felt that the reports that had been considered did not provide sufficient assurance to be rated green as there was little information provided on actions and lessons learnt. In addition, a review of whistleblowing highlighted gaps requiring an overhaul of the process. Therefore, the IM suggested that the objective should be amber. R21.22.4 A debate ensued regarding the most appropriate forum for consideration of issues relating to UPSW. An IM stated that the R&TS Committee was the appropriate forum, whether the issues were part of the agenda or discussed at the end of meetings. The Chair queried whether the Committee was now sufficiently focused on the issue of very senior managers since their inclusion in the terms of reference. He asked how far the Committee was reaching beyond the Executive. The Executive Director of Workforce & OD stated that information on posts established had been submitted to the Committee, although the number of changes at Executive level had made it challenging to cover everything. However, she felt there was scope to go beyond what had been done to date, and she agreed to build this aspect in for the future. She added that the lines had become blurred over the years in terms of what information was required to be submitted to the Committee compared to that which was simply requested. She emphasised the need to ensure reports do what they need to do. R21.22.5 It was agreed to circulate an amended draft R&TS Committee annual report for approval outside the Committee.	SG LJ
R21.23 National terms and conditions, policy and pay update The Executive Director of Workforce & OD outlined the temporary changes that had been made to Agenda for Change and Medical & Dental terms and conditions, to support flexibility during the pandemic. The changes covered sickness absence, overtime payments and a one-off NHS bonus payment. These were noted, and an extension until 31.5.21 was approved in respect of the temporary changes that were made at all Wales level to Consultant and SAS pay rates from 1.4.21. An IM commented that there was inequity as regards the cessation of enhanced overtime	

arrangements for Agenda for Change staff on 31.3.21. In response to a question from the Chair, the Executive Director of Workforce & OD explained that modelling and costing of the impacts of the annual leave carry-over had taken place. Rostering KPIs were used for levelling out, therefore there would be no significant pockets of impact this year or next. In response to an IM regarding the quantum of the enhanced overtime, the Executive Director of Workforce & OD explained that a review was underway as part of the year end process. The intention was then to ask managers to identify any benefits.	
R21.24 Any other business None.	
R21.25 Date of next meeting The next routine meeting was scheduled for 22.7.21.	
R21.26 Resolution to exclude the press and public and move to private session The Committee moved into private session.	

Remuneration and Terms of Service Committee

Summary Action Plan - Public

Officer	Minute reference and action agreed	Timescale	Latest update position	Revised timescale
20.7.20:				
S Green	R20.37.3 – Re. high profile disciplinary and tribunals that could threaten the reputation of the Board; Executive Director of Workforce & OD to work up a proposal on the parameters in respect of disciplinary and employment tribunal cases.	October meeting	Underway but delayed. Report to be submitted to the next meeting. Update 25.1.21: To be submitted to Committee at its next meeting in April 2021 Update 15.4.21 – Report on Agenda for meeting on 22.4.21 (private session in light of content)	Closed
6.10.20:				
S Green	R20.66.2 [Health Care Professions Council (HCPC) and General Pharmaceutical Council Wales (GPhC) Professional Registration Report 2019-2020]: An Independent Member …asked if such matters would feed through the Director of Governance role in future... the matter would be discussed outside the meeting, as further thought also needed to be given to the role of the R&TS Committee in the timely reporting	30.12.20	Update 25.1.21: Consideration being given to whether this should be incorporated into the "people" governance/delivery structure. Committee comments shared with the Interim Director of Governance. Update 1.2.21 – this has been built into ongoing conversations; the issue of establishing a 'people' committee or not is close to being resolved via re-purposing within the existing committee structure. An IM reminded the Committee that the workforce is wider than those who are directly employed. Action	Closed

	and escalation of significant issues that might impact on the Health Board's reputation. Other registration bodies such as the Nursing & Midwifery Council (NMC) would also be incorporated into this thinking.		remains open pending the conclusion of the 'people' committee issue. Update 15.4.21 – the matter of "no surprises" is addressed in the report on professional standards included on Agenda for the meeting 22.4.21	
S Green	R20.67.3 [Case Management - Professional Standards Review]: the Executive Director of Workforce & OD offered to circulate to Committee members the detail behind the numbers listed as cases over 24 weeks, with particular reference to a comparison with last year, the proportion of the workforce involved and the reasons for the delays.	30.11.20	Update 25.1.21: Delayed due to COVID response. To be circulated by end of February at the latest. Update 1.2.21 - Tribunal reports are not being brought before R&TS currently (the Committee only sees cases being dealt with internally); SG will draft a paper setting out the scope of what a report on this matter might include going forward. This will be circulated outside the Committee as it is not technically part of R&TS terms of reference. A fuller report containing the detail can then be brought to the April meeting. Update 15.4.21 – Report on Agenda for meeting on 22.4.21 (private session in light of content)	Closed
~~M Baker (Lead Manager, OMD)~~ S Green / A Guha	R20.69.4 [Annual Raising Concerns/Safe Haven report 2018/19]: The Independent Member reiterated that she wished to understand the outcomes, lessons learnt and actions taken in relation to the specific cases in the report – not simply receive a description of process. The Lead Manager agreed to circulate additional information after the meeting.	30.11.20	Chased up 10.11.20, Lead Manager responded 10.11.20 to say that the action would be completed. Not received, chased up again 25.1.21. Lead Manager responded: response was delayed due to her sickness absence and now due to Covid-19 redeployment. Sue Green will link with Arpan Guha to close this – remains open Update – 15.4.21 – Suggest Action superseded following review of Raising concerns and revised Speak Out Safely process to be launched 30th April 2021	Closed

1.2.21:				
L Brereton	R21.3a.1 RE Action R20.66 (Health Care Professions Council (HCPC) and General Pharmaceutical Council Wales (GPhC) Professional Registration Report 2019-2020)... The Board Secretary suggested that a report running from January to January would provide a better picture in future, and she agreed to ask the Executive Director of Therapies and Health Science if the reporting timeframe could be amended.	28.2.21	A Thomas was asked on 24.2.21 if the reporting timeframe could be amended. Following discussion between AT and LB, it was decided that there is no advantage to changing the reporting period to a calendar year as there would potentially still be over year end issues. In addition there would be a need to change the reporting period for other similar documents e.g. Nursing and Medical to align; all other reporting for the organisation is based on the financial year.	Closed
22.4.21				
S Green	R21.22 R&TS Committee Annual Report: Ensuring sufficient focus on the issue of very senior managers since their inclusion in the terms of reference… scope to go beyond what had been done to date - build this aspect in for the future.	8.7.21	Prompt added to the committee cycle of business, to ensure this aspect is addressed in future.	Closed
L Jones	R21.22.5 Circulate an amended draft R&TS Committee annual report for approval outside the Committee.	21.5.21	Circulated 19.5.21 Approved	Closed

V37 9.6.21

Cyfarfod a dyddiad: Meeting and date:	**Remuneration and Terms of Service Committee 22nd July 2021**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Nursing and Midwifery Council (NMC) Registration, Revalidation and Fitness to Practise Annual Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Mrs. Gill Harris, Executive Director of Nursing and Midwifery
Awdur yr Adroddiad Report Author:	Mrs. Anne-Marie Rowlands, Associate Director Professional Regulation
Craffu blaenorol: Prior Scrutiny:	Mrs. Gill Harris, Executive Director of Nursing and Midwifery
Atodiadau Appendices:	None attached

Argymhelliad / Recommendation:

The Committee is requested to note the content of the report and the processes in place to provide assurance with regard to NMC registration, revalidation and fitness to practise within BCU.

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**	√	**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						**No**	

Sefyllfa / Situation:

The purpose of this report is to update the Committee on the Health Board's position in meeting statutory NMC registration and revalidation requirements for the period from January to December 2020

Cefndir / Background:

The NMC maintain a register of nurses, midwives and nursing associates (in England) who meet NMC standards, and have in place clear and transparent processes to investigate those who fall short of NMC standards. A nurse, midwife or nursing associate is fit to practise when they have the skills, knowledge, health and character to undertake their job safely and effectively.

The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates (NMC, 2018) sets out the standards that nurses, midwives and nursing associates must uphold in order to be registered, and maintain their registration, in the UK. The NMC revalidation process requires every nurse, midwife and nursing associate to demonstrate every three years that they practise safely and live up to the standards set out in the Code.

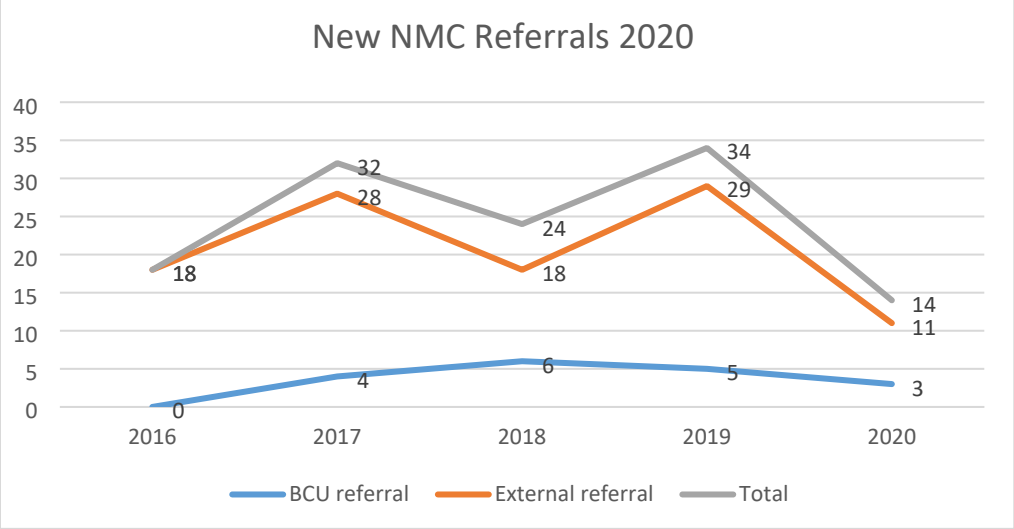
Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications
This report aligns to the strategic goal to support, train and develop our staff to excel and improve the safety and outcomes of care to match the NHS's best. It is is linked to the well-being objective to improve the safety and quality of all services.

Fitness to Practise (FTP)
NMC FTP processes require concerns to be addressed by the employer wherever possible and appropriate to do so. However, if concerns cannot be resolved locally or are serious enough to require immediate regulatory action, anyone can raise concerns with the NMC, who then decide on the required action to protect the public. All NMC referrals are centrally coodinated on behalf of the Executive Director of Nursing and Midwifery, who approves all suspensions and employer referrals.

In 2020 the number of new referrals was 14, which represents a decrease on previous years as shown in Graph 1. This figure represents all those referred whether substantive, bank or agency.

Graph 1: NMC referrals



As of December 2020, BCU has a rate of three referrals for every 1000 registrants in comparison to the UK wide position of eight referrals to every 1000 registrants (Source: NMC Annual FTP Report 2019 – 2020).

The source and reason for BCU NMC referrals is included in Table 1 below.

Table 1: Source and reasons for Referrals

Referral Source	Number	Reason
External - Patient/Public	7	Patient/family not satisfied with care, giving false information, patient care and attitude of staff,
Employer - BCU	3	Falsification of records, behaviour and health, medication theft
Other (Police, self, ex employer)	4	Behaviour out of work, Safeguarding issues,
Total	14	

The NMC Annual FTP Report 2019 – 2020 reports the top three allegations nationally that are subsequently proven are 1. patient care (Diagnosis, observation, assessment , Inappropriate or delayed response to negative signs, deterioration, or incidents, patient handling); 2. Record keeping (patient/client and medication); 3. Prescribing and medicines management (refusing or not administering, prescribing and incorrect medication). Further work will be undertaken in 2021 on themes and learning from NMC referrals and FTP concerns managed locally.

NMC Hearing Outcomes

Due to CoVid, the NMC postponed hearings for many months. Of the new referrals in 2020, six closed in 2020 with no further action and two closed in 2021. Six cases remain within NMC processes. There also remain fourteen cases open from referrals made from 2014 onwards which are progressing through NMC processes.

Registration and Revalidation

The Health Board has a combination of local and corporate systems for notification of registration and revalidation expiry dates. These include:

- NMC register live interface to Electronic Staff Record (ESR).
- Registrant and manager ESR advance notification (1, 3 and 6 months) of expiry dates.
- Corporate Nursing monthly notifications to Directors of Nursing and other Heads of Service
- Workforce and Organisational Development review and address or escalate NMC error notifications

In addition, the registrant is sent direct notifications by the NMC in advance of their annual renewal and revalidation date.

NMC lapses

During 2020, the NMC automatically extended revalidation dates to allow additional time during the CoVid pandemic. Assurance that registrants had revalidated in line with the extension period were reliant on good communication between the registrant and their line manager as NMC/ESR revlidation dates could not be updated to reflect the extension period. During 2020 there has been an increase in lapses as shown in Graph 2 and Table 2.

Graph 2: Lapses 2015 - 2020

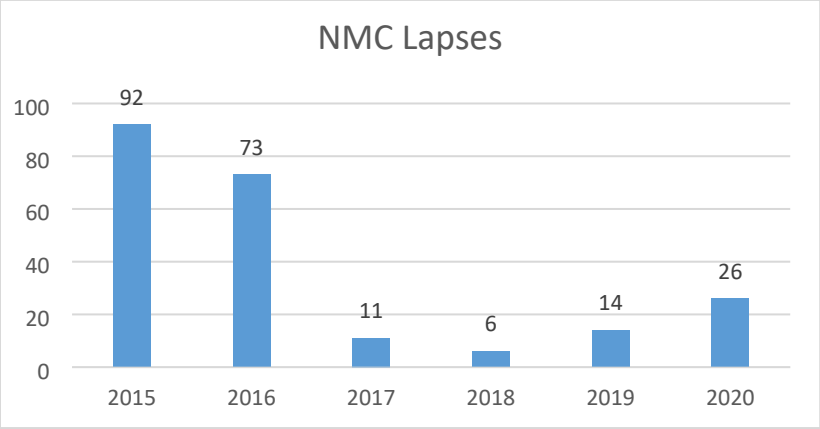


Table 2: Reason for Lapses

Area	*Number of lapses*	*Reason*
Temporary Staffing	18	Not worked bank shifts and leaver
Divisions	8	Direct Debit failure, revalidation extension and missed deadline, registrant didn't submit within deadline, off sick/maternity leave

A root cause analysis (RCA) is completed for lapses so that trends and learning can be identified and action taken to address. The Temporary Staffing team, with the support of the Associate Director Professional Regulation have reviewed their internal NMC processes and quality and content of RCAs submitted if a laspe occurs.

NMC Temporary Register CoVid 19.

Due to the CoVid outbreak, the Government introduced emergency legislation, which enabled the NMC to temporarily register fit, proper and suitably experienced professionals. A CoVid 19 Nursing and Midwifery Council Temporary Register Governance Framework is in place to ensure registrants are safe and competent to practice in line with NMC and Welsh Government requirements. The framework is currently being reviewed and updated. As of 29th June 2021 there are 20 registrants on the Temporary Register working within BCU. Additionally 7 nurses have converted to the full NMC register.

Opsiynau a ystyriwyd / Options considered

Outlined within body of report

Goblygiadau Ariannol / Financial Implications

In line with changes within Wales (NHS Employers 2020), NU04 BCU Registration and Revalidation Procedure was approved at Workforce Policies Group and now allows registrants to work in a non registrant role, determined on a risk assessment basis. However if additional registrants were required to maintain a safe roster, full time costs for a band 5 mid-point on bank for 2 weeks would be £2,680.50 and 4 weeks costs would be £5,361.00.

Dadansoddiad Risk / Risk Analysis

The NMC Temporary CoVid register is on the Risk register (Risk 3243) with a score of six and will remain open until the NMC announce closure of the Temporary Register. With respect to registrants lapsing, the main risk is the loss of the registrant to the workforce, which may affect overall skill mix and staffing within that team. The service manager would ensure that all reasonable steps are taken to maintain the nurse staffing level and that mitigating actions are sufficient to maintain a safe service to both service users and staff.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

The Nursing and Midwifery Council (NMC) is the regulatory body for nurses, midwives and specialist community public health nurses. The Health Board has a statutory responsibility to safeguard the health and wellbeing of the public by making sure that all practising nurses and midwives have the required NMC registration, skills, knowledge, good health and good character to do their job safely and effectively.

Asesiad Effaith / Impact Assessment

An impact assessment is not considered necessary for this report. Due regard has been taken of the sensitive information within the report and provided as an overall summary to avoid identification of registrants. An Equality Impact Assessment has been completed for NU04 BCU Registration and Revalidation Procedure in line with policy requirements.

References

The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates (NMC, 2018) https://www.nmc.org.uk/standards/code/

NMC Annual Fitness to Practise Report (2019 - 2020) https://www.nmc.org.uk/globalassets/sitedocuments/annual_reports_and_accounts/ftpannualreports/2019-2020-annual-fitness-to-practise-report.pdf

COVID 19 Nursing and Midwifery Council Temporary Register Governance Framework http://howis.wales.nhs.uk/sitesplus/documents/861/C19-CN-001%20-%20CoVid%2019%20Nursing%20and%20Midwifery%20Council%20Temporary%20Register%20-%20v1%20-%2009.06.20.pdf

Cyfarfod a dyddiad: Meeting and date:	**Remuneration & Terms of Service Committee – 22.7.21**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	GMC Revalidation Update 2021
Cyfarwyddwr Cyfrifol: Responsible Director:	Prof Arpan Guha, Executive Medical Director & Responsible Officer
Awdur yr Adroddiad Report Author:	Mrs Sarah Tyler, Revalidation Manager
Craffu blaenorol: Prior Scrutiny:	Finance and Performance Committee
Atodiadau Appendices:	(1 appendix detailing appraisal compliance).

Argymhelliad / Recommendation:

1. The Committee is asked to note this update
2. The Committee is asked to note the future actions, scrutiny and assurance processes required as outlined in this briefing.

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	√

Sefyllfa / Situation:

Betsi Cadwaladr University Health Board (BCUHB) has a duty to ensure all professional practitioners working for the Health Board (HB), hold current registration from their professional bodies to comply with the requirements of their contract of employment.

This paper provides an update on the appraisal compliance for doctors attached to BCUHB for the purposes of Revalidation.

Cefndir / Background:

Each doctor is required to be connected to a Designated Body (DB). This is the organisation that the doctor spends the majority of the year working for. The DB is responsible for making the recommendation for revalidation and providing the means to undertake an appraisal.

Health Education & Innovation Wales is responsible for making recommendations for those doctors enrolled in a training programme. Agencies are responsible for making recommendations for those doctors working in BCUHB through agencies. Further detail is provided in the appendices.

The General Dental Council (GDC), have not yet confirmed their plans for revalidation and appraisal of Dentists, but advised that those who are currently participating in local appraisal processes to continue to do so.

Asesiad / Assessment & Analysis

Strategy Implications
The employment policies: WP1, WP1a and WP1a Appendix 4 require all doctors to have a current licence to practise. Additionally BCUHB terms and conditions of employment require registered doctors to undertake an annual appraisal in line with professional requirements.
This also links with Workforce Policy; WP23, Procedure for the Checking of Registration and Qualification.

Wellbeing of Future Generations Act:
Revalidation and appraisal will ensure doctors are able to continue to work, are keeping up to date and fit to practice now and in the future.

Financial Implications
There are no additional financial considerations to be considered which have not been budgeted for. There are staffing cost implications and also an out lay for the provision of the GMC required Multi Source Feedback (MSF) which is procured at an NHS Wales level.

Risk Analysis
It is WOD's responsibility to check that all newly appointed doctors have a current licence to practice. The Revalidation team are responsible for ensuring doctors are supported and reminded to participate in the annual appraisal process. *Mitigating actions currently in place include:*

- Provision of monthly figures on appraisal compliance to the Board through the Integrated Quality & Performance Report.
- Provision of monthly figures to the Office of the Medical Director for the monthly business meeting.
- Provision of Monthly figures and breakdown of breaches or exceptions to Hospital Management Teams for accountability meetings.
- Provision of Monthly figures to Workforce for inclusion in the Dashboard
- Escalation to Clinical Leads if doctors within their teams have not completed an annual appraisal.
- For Primary Care, GP reports detailing exceptions and potential issues are forwarded to the Revalidation team by the GP Unit in Cardiff so that we are able to monitor compliance closer and manage any potential problems

Legal and Compliance
In order to maintain a licence to practice and demonstrate engagement in revalidation, the GMC requires all licensed doctors to undertake an annual appraisal in line with requirements set out in the Good Medical Practice and Good Medical Practice Framework. This has been in legislation since December 2012. It is the individual doctor's responsibility to ensure that they are registered to practice and participate in the appraisal process every 9 – 15 months The annual compliance of appraisal and number and reason for deferral recommendation has been identified as the KPI.

Impact Assessment
All Wales EqIA has been carried out by NHS Wales.

Appendix 1. GMC Revalidation update 2020

1. Situation

Betsi Cadwaladr University Health Board (BCUHB) has a duty to ensure all professional practitioners working for the Health Board (HB), hold current registration from their professional bodies to comply with the requirements of their contract of employment.

The General Medical Council (GMC) is the regulatory body for practising doctors in the UK. The GMC maintains the List of Medical Practitioners, which is a public record of all doctors.

Revalidation and the maintenance of a licence to practise provides assurance to patients, employers and the public that a person is fully qualified, trained, capable and safe in the area of their practice. Following a number of high profile legal cases, Revalidation also aims to provide patients with greater confidence and trust in the medical profession.

2. Background

The Executive Medical Director (known as the Responsible Officer or RO) at BCUHB will, over a five year period, make a recommendation to the GMC for in excess of 1500 doctors. This is a legal obligation. In BCUHB this responsibility has been delegated out to the Deputy Responsible Officer with input from the Hospital, Area and GP Medical Directors as they have a greater understanding of the doctors in their area and link directly with Clinical Governance processes.
There are three possible recommendations available to the RO which can be made up to 90 days before the due date:

- Positive recommendation,
- Deferral due to either ongoing local process or insufficient information,
- Recommendation of non-engagement.

It is the recommendation of non-engagement that can lead to a loss of licence to practice.

Where doctors are not engaged in the appraisal process and a recommendation of non-engagement is made, the GMC will carry out an investigation which can take some time to complete. Throughout this period the doctor is still able to continue to work. Once the GMC has decided to revoke the licence to practice, the doctor is unable to work and is addressed through the Workforce Policies and Procedures group with staff side colleagues including Medical Directors. Doctors are able to reapply to the GMC for their licence to practice. This tends to be a lengthy process with no specific timescale attached.

NHS organisations are responsible for managing the Medical Appraisal process at local level and to have in place quality assurance systems that will stand up to close inspection/scrutiny when called upon to do so. The appraisal process along with local

clinical governance processes supports the mechanism by which the RO is able to recommend the non-training grade doctors in BCUHB for Revalidation. GP appraisal is managed by the GP unit at HEIW.

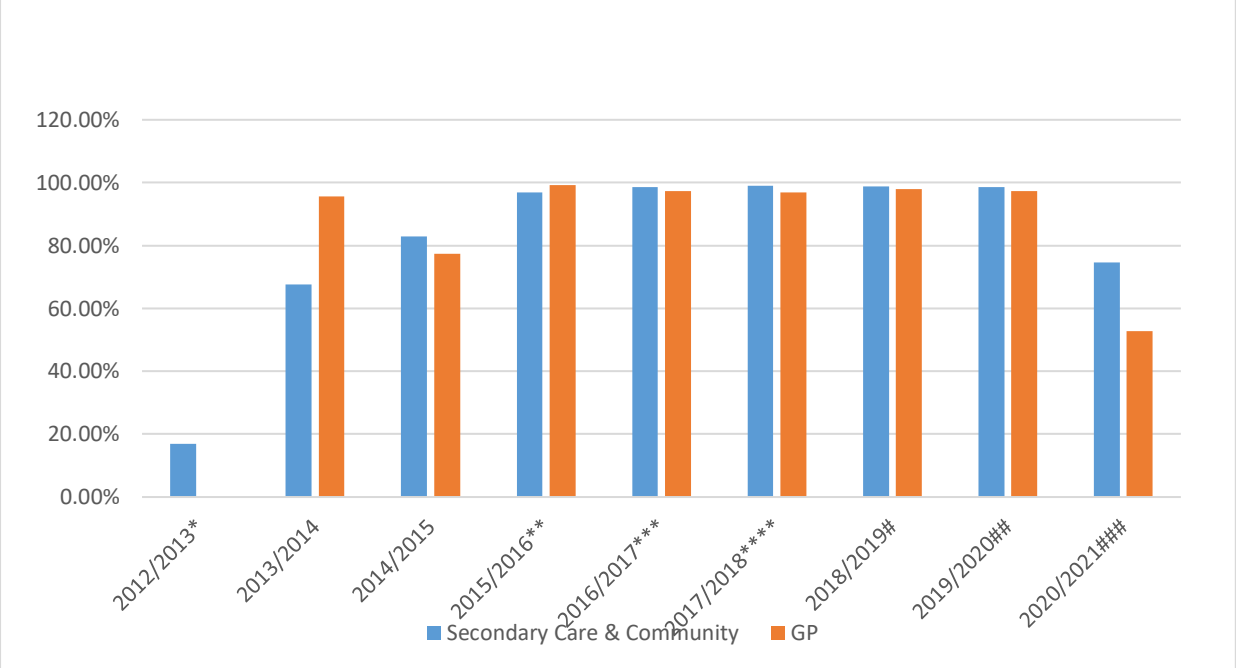
BCUHB have a Revalidation Team, which consists of one Manager, who oversees appraisal and revalidation across BCUHB, a Deputy Manager and two Medical Appraisal Support Officers who support doctors with the appraisal process and are based at each acute site.

To ensure compliance of annual appraisal, the revalidation team utilise the All Wales Appraisal System, MARS, ESR and information from the GMC. This information is triangulated in a database to give accurate figures of compliance whilst highlighting new starters, leavers. The database enables the team to drill down by site and area to the individual doctor, which can be, where appropriate, escalated up to a specific Medical Director.
All Medical staff that work as bank or have 0 hours ad hoc contract that have not worked for three months or more have not given notice of their intention to leave employment are now removed from our staffing system through MEDACS. We are notified of those doctors who change posts to capture those moving in and out of training.

3. Assessment

The appraisal year typically runs from 1st April to 31st March. Since revalidation started in December 2012, the compliance in the appraisal process for secondary care & community doctors has significantly increased as shown in the graph below.

Graph 1: Appraisal Compliance at 15 months March 2021



* No data available for GPs **As at 25th Jan 2016 *** As at 26th Jan 2017 ****As at 29th Mar 2018 # As at 29th Mar 2019 ## As at 31st March 2020 ### As at 31st March 2021

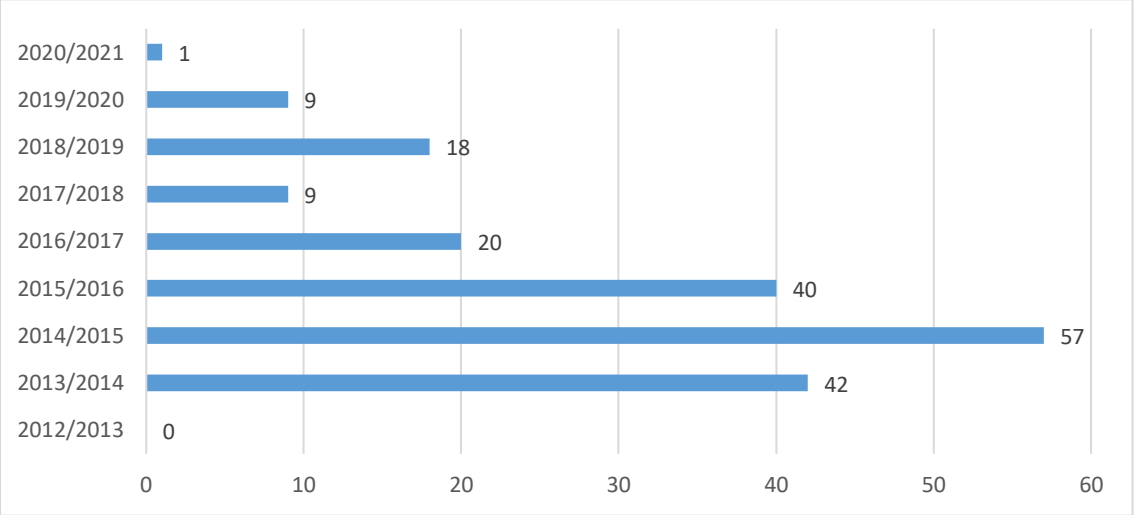
Over the last revalidation cycle there was a steady increase in the 15 month appraisal compliance for secondary care. Now we are in the second cycle of revalidation, the 15 month compliance has seen a plateau.
It is worth noting that appraisals scheduled for the appraisal year 2020/2021 has seen significant disruption due to COVID 19. In recognition of the extra pressures on clinical time during the pandemic, the Chief Medical Officer (CMO) for Wales authorised an approved missed appraisal for those doctors due an appraisal in the year 2020/2021. An approved missed appraisal is defined as the postponement of an appraisal for 12 months which has been authorised and logged by the HB and or RSU. The current 15 month compliance reflects this.

Excluding exceptions such as approved missed appraisal, new starters and those currently on maternity leave, compliance stands at 99.51% for Secondary Care and 100% for Primary Care.
Analysis of the data collected on non-compliance has identified key reasons for not undertaking an appraisal including:

- Approved missed appraisal due to pandemic.
- Long term sickness and maternity leave.
- Bereavement
- Returning to training programme.
- High turnover of doctors on fixed term contracts

Non-compliance within the 15 months is now a rare occurrence. This does represent a breach of statutory requirement and could be regarded as serious/gross misconduct. Therefore when this occurs it is escalated to the local Medical Director and Workforce policy processes may be implemented. If this falls outside of the 90 day revalidation notice period, a request made to the GMC to bring their revalidation date forward by which time the doctor must comply. If this falls within the 90 day notice period a recommendation of non-engagement may be submitted to the GMC.

Graph 2: Deferral recommendation rates



- The graph above depicts a reduction in deferral rates. The single deferral was due to the doctor providing insufficient information. It is likely that deferral recommendations will increase in the future due to the impact the pandemic has had on our workforce. There has been a significant increase in the number of doctors out of practice for long periods of time. This is primarily due to high numbers of doctors shielding, on long term sickness and have had a close family bereavement. These situations require sensitivity and compassion. For the foreseeable future, whilst still satisfying revalidation requirements, the supportive appraisal process will also focus on wellbeing and returning to practice post pandemic.

The GMC have supported doctors during the pandemic by postponing revalidations. Doctors with revalidations due March 2020 to March 2021 have been postponed by 12 months and those due April 2021 – July 2021 have been postponed by 4 months. This will allow more time to collect evidence within an appraisal. All doctors affected by this change have been contacted and are being appropriately supported by the Revalidation Team.

There has been no further late revalidation recommendations submitted to the GMC and is reported within the IQPR along with the monthly GP data.

4. Recommendations

1. The Committee is asked to note this update
2. The Committee is asked to note the future actions, scrutiny and assurance processes required as outlined in this briefing.

Cyfarfod a dyddiad: Meeting and date:	**Remuneration and Terms of Service Committee 22.07.2021**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Policy Update
Cyfarwyddwr Cyfrifol: Responsible Director:	Mrs Sue Green, Executive Director Workforce and Organisational Development
Awdur yr Adroddiad Report Author:	Mrs Sue Green, Executive Director Workforce and Organisational Development
Craffu blaenorol: Prior Scrutiny:	Welsh Partnership Forum for all Wales Policy BCU Policy Group / Local Partnership Forum for BCUHB policy
Atodiadau Appendices:	3

Argymhelliad / Recommendation:

*T*he Committee is asked to note the approved policies / procedures.

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	√

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable	**Y**

EQIAs developed for all policies as core part of development and approval process.

Sefyllfa / Situation:

This paper sets out the policies approved in line with the policy approval mechanism agreed at RaTS Committee 15.5.19.

Cefndir / Background:

An alternative approval process was agreed at RaTS Committee in May 2019 to ensure minimal delay to implementation. It should be noted that following development and subsequent consultation, all policies are taken to Local Partnership Forum / Local Negotiating Committee (Medical and Dental specific policies / procedures) for approval prior to ratification.

Most key policies are developed nationally and approved at Welsh Partnership Forum, and then require ratification locally. In addition, there are local BCUHB policies, which are developed in partnership through the BCUHB policy group. It was previously agreed that amended Wales and

most BCUHB policies should be approved by the Executive Director of Workforce and OD, and circulated to the Committee for information.
New BCUHB policies and amended policies with a significant financial implication, would be submitted to the Committee unless there was an imperative to implement quickly, when Chair's approval would be sought.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

2 policies have been approved by the Executive Director of Workforce and OD:

- New Respect and Resolution Policy (all Wales) which replaces the Grievance Policy and Dignity at Work Policy (both all Wales)
- BCUHB Dress Code Guidelines (revised).
- All Wales Raising Concerns Procedure for NHS Staff (to incorporate Speak out Safely)

A programme of work is underway to make BCUHB policies more user friendly and accessible and this work will be completed by 30 September 2021.

Opsiynau a ystyriwyd / Options considered

N/A

Goblygiadau Ariannol / Financial Implications

N/A

Dadansoddiad Risk / Risk Analysis

The approach in the Respect and Resolution Policy is a significantly different to the legacy policies that it replaces. The risks and opportunties for a diffferent and more productive approach will be monitored through the Task and Finish Group and subsequently the Workforce Partnership Group. A training programme is being rolled out from July onwards.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

Policies comply with legislation

Asesiad Effaith / Impact Assessment

EQIAs are in place for each policy prior to appoval.

RESPECT AND RESOLUTION POLICY

Sections

CONTENTS

RESPECT AND RESOLUTION POLICY

Approved by: Welsh Partnership Forum

Issue Date: April 2021

01

About this policy

01 About this policy

1. About this policy

1.1 We seek to ensure that all employees have access to a policy to help deal with any requests for resolution relating to their employment fairly, constructively and without unreasonable delay.

1.2 We aim to encourage fairness and positive relationships within the workplace. We aim to prevent bullying, harassment and any form of unacceptable behaviour.

1.3 We recognise that a positive working environment and good working relationships have a beneficial impact on employee wellbeing, engagement and patient experience. A positive working environment can also lead to better performance, improved employee retention and reduced stress related sickness absence. Focusing on resolution is good for our organisation, it is good for you and it is good for our patients and service users.

1.4 We recognise conflict and disagreements in the workplace happens but should not always be viewed negatively. When conflict is managed well it leads to healthy, resilient and positive working relationships. We strive for a workplace where everyone can engage with each other constructively and use the toolkit available to seek their own resolution as far as possible.

1.5 If this happens, we will support employees and managers to work together to resolve any issues and conflict constructively and quickly**.**

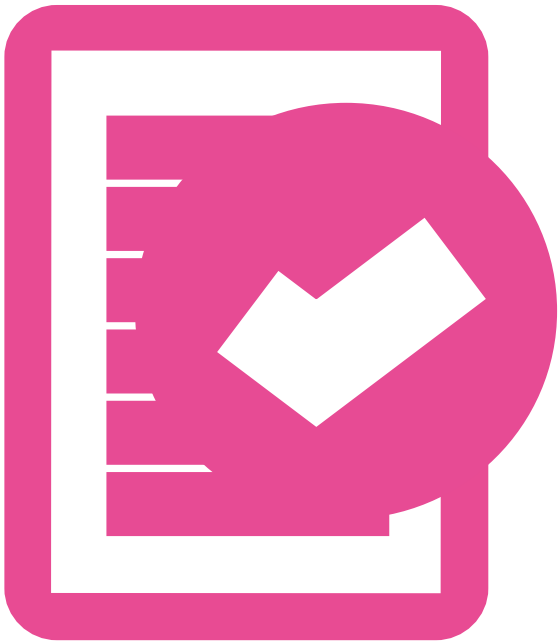
1.6 We commit to resolving issues at the earliest opportunity without resorting to a formal policy. As a last resort it may be necessary to use the formal part of this policy to resolve disputes or issues. This policy sets out our commitment to helping you seek a resolution.

1.7 This policy applies to all employees.

1.8 This policy has been agreed by the Wales Partnership Forum.

1.9 This policy constitutes the formal grievance policy.

1.10 The Core Principles of NHS Wales are central to this policy and apply throughout.



02

Using this policy

2 Using this policy

2. Using this policy

2.1 This Resolution Policy is aimed at securing constructive and lasting solutions to workplace disagreements, conflicts and complaints. Issues that could cause disagreements, conflicts or complaints may include but are not limited to:

(a) terms and conditions of employment
(b) health and safety
(c) work relations
(d) bullying and harassment
(e) new working practices
(f) working environment
(g) organisational change; and
(h) discrimination.

2.2 The status quo at the time you make your request for resolution will normally remain in place throughout the policy.

2.3 Everyone should ensure that issues are dealt with in a fair and consistent way and dealt with quickly and supportively.

2.4 Every workplace in the NHS in Wales should be free from bullying and harassment. We are committed to ensure all staff are treated, and treat others, with dignity and respect.

2.5 This policy covers harassment or bullying which occurs at work and out of the workplace, such as on business trips, at work-related events or online. It covers bullying and harassment by staff (which may include contractors and agency workers) and also by third parties such as patients and visitors to our premises.

03

Informal Resolution

3 Informal Resolution

3. Informal Resolution

3.1 It is our aim that we each take ownership of our relationships so that they are as healthy as possible.

3.2 To help this, a toolkit has been developed which includes these useful approaches:

(a) Reflecting Tips on how we can have healthy relationships
(b) Having a Cuppa Conversation
(c) Discussing with an appropriate leader/manager
(d) Taking part in an independently Facilitated Conversation
(e) Accessing accredited Mediation.

3.3 It is expected that the variety of tools and resources available are used to help resolve the issue(s) prior to raising a formal request for resolution. This can be done with the support of your line manager though this may not always be necessary.

3.4 Most disagreements can be resolved quickly and informally through discussion with your colleagues or line manager. If you feel unable to speak to your manager, for example, because the issue involves them, then you should speak informally to a more senior manager, your Trade Union Representative or a member of Human Resources. If this does not resolve the issue, you should follow the formal part of the policy below.

04

Formal Request for Resolution

4 Formal Request for Resolution

4. Formal Request for Resolution

4.1 This step of the policy constitutes a formal grievance.

4.2 If your issues cannot be resolved informally by using the resources outlined in the toolkit, you should put your request for resolution in writing and submit it to your line manager (or a more senior manager if the issue involves your line manager) or a member of Human Resources.

4.3 Human Resources will appoint someone impartial, of sufficient seniority to consider the request. This appointment usually takes place within seven days of receiving the request. This person will be known as the Chair and will decide on the outcome of your request.

4.4 Your written request for resolution should contain a description of the nature of your issue, including any relevant facts, dates, names of individuals involved and the desired resolution you hope to achieve.
In some situations, we may ask you to provide more information.

4.5 An employee may make a complaint or raise an issue in Welsh and may also respond in Welsh to any allegations made against them and they should be advised of this at the beginning of any proceedings. Any subsequent proceedings should be conducted in Welsh or a simultaneous translation service provided below.

05

Formal Resolution Meetings

5. Formal Resolution Meetings

5.1 The Chair will meet with you to discuss your request for resolution. This should happen within 14 days of the chair being appointed.
The purpose of this meeting is to allow you to explain your issue, explain how you think it should be resolved, enabling a decision to be reached based on the available evidence and representations you have made.
The focus of this meeting will be seeking a resolution.

5.2 Depending on the detail included within your request for resolution the Chair will either explore the issues with you at this meeting and decide on an outcome or will initiate an investigation to enable your request to be considered further.

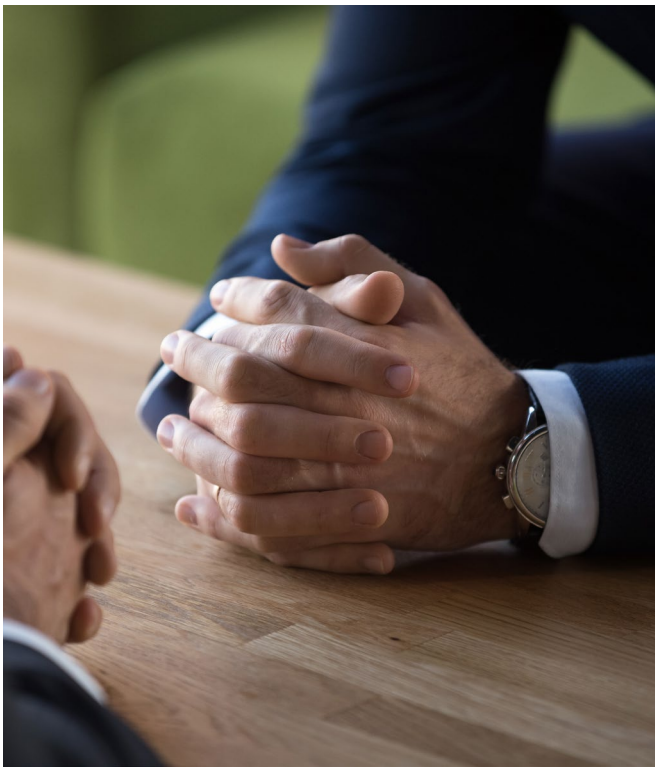
5.3 If a detailed investigation is necessary, the Chair will appoint an investigator. This will normally be an employee of the organisation who is impartial. At this stage, the terms of reference and the timescales will be agreed.

5.4 The level of any investigation required will depend on the nature of the issues involved and will vary from case to case. It may involve interviewing and taking statements from you and any witnesses, and/or reviewing relevant documents.

5.5 The Chair will make a decision based on the information gathered at the formal resolution meeting(s) and with reference to any investigation, if appropriate.

5.6 If it is possible the Chair will provide you with a verbal decision at the end of the meeting. In any event, we will write to you, usually within seven days of the formal resolution meeting, to inform you of the outcome and any further action that is intended to resolve the issues. We will also remind you of your right of appeal.

5.7 An accurate record of the meeting will be made and will be available upon request.



06

Appeals

6. Appeals

6.1 If your issue has not been resolved to your satisfaction you may appeal in writing within 14 days of the date on which the decision was communicated to you in writing.

6.2 We will hold an appeal meeting, normally within one month of receiving your written appeal. This will be dealt with impartially by a more senior person than the Chair who has not previously been involved in the case (although they may ask anyone previously involved to be present where relevant for points of clarification).

6.3 This person will be known as the Appeal Chair. The Appeal Chair will be appointed by Human Resources and will usually be appointed within seven days of the appeal being received. The focus of this meeting, again, will be on seeking a resolution**.**

6.4 We will confirm our final decision in writing within seven days of the appeal meeting. This is the end of the procedure and there is no further appeal.

07

Right to be accompanied

7 Right to be accompanied

7. Right to be accompanied

7.1 You may bring a companion to any investigatory meeting, resolution meeting or appeal meeting to help and support you. The companion may be either a Trade Union Representative or a work colleague.

7.2 At the resolution and appeal meetings your companion may address the meeting to put and sum up your case, respond on your behalf to any views expressed, ask questions and confer with you during the meeting. Your companion should not answer questions on your behalf. You may adjourn and talk privately with them at any time during the meeting.

7.3 All witnesses will also have the right to be accompanied.

08

Collective Request for Resolution

8. Collective Request for Resolution

8.1 This part of the policy applies where more than one employee wishes to invoke the policy on the same issue. This would constitute a formal collective grievance.

8.2 If resolution is required for a collective issue the stages of this policy will be followed in accordance with sections 3 to 7 above.
All employees who are in support of the collective request for resolution will need to be identified on the submission.

8.3 The number of employees attending the formal meeting to represent the collective group will be agreed at the outset (but should not normally exceed three employees plus their companion).

8.4 Where this policy fails to reach a resolution to the collective issue, either side may refer the matter to the Advisory Conciliation & Arbitration Service (ACAS) for advice or conciliation.

09

Overlapping Requests for Resolution and Disciplinary Processes

9 Overlapping Requests for Resolution and Disciplinary Processes

9.Overlapping Requests for Resolution and Disciplinary Processes

9.1 Where you raise a request for resolution during a disciplinary process, the manager will discuss with you and your representative before a decision is made on whether the disciplinary policy should be temporarily suspended in order to deal with the request for resolution. Where the request for resolution and disciplinary cases are related it may be appropriate to deal with both issues concurrently.

9.2 There may be occasions when disagreements or conflict have been resolved using the toolkit however the organisation may feel that a disciplinary process is required where core values or standards have been breached.

9.3 In some circumstances, such as in cases of harassment or discrimination, it may be decided by the Chair that it is more appropriate to suspend the resolution process and progress the matter under the appropriate disciplinary policy.

10

Learning From Events

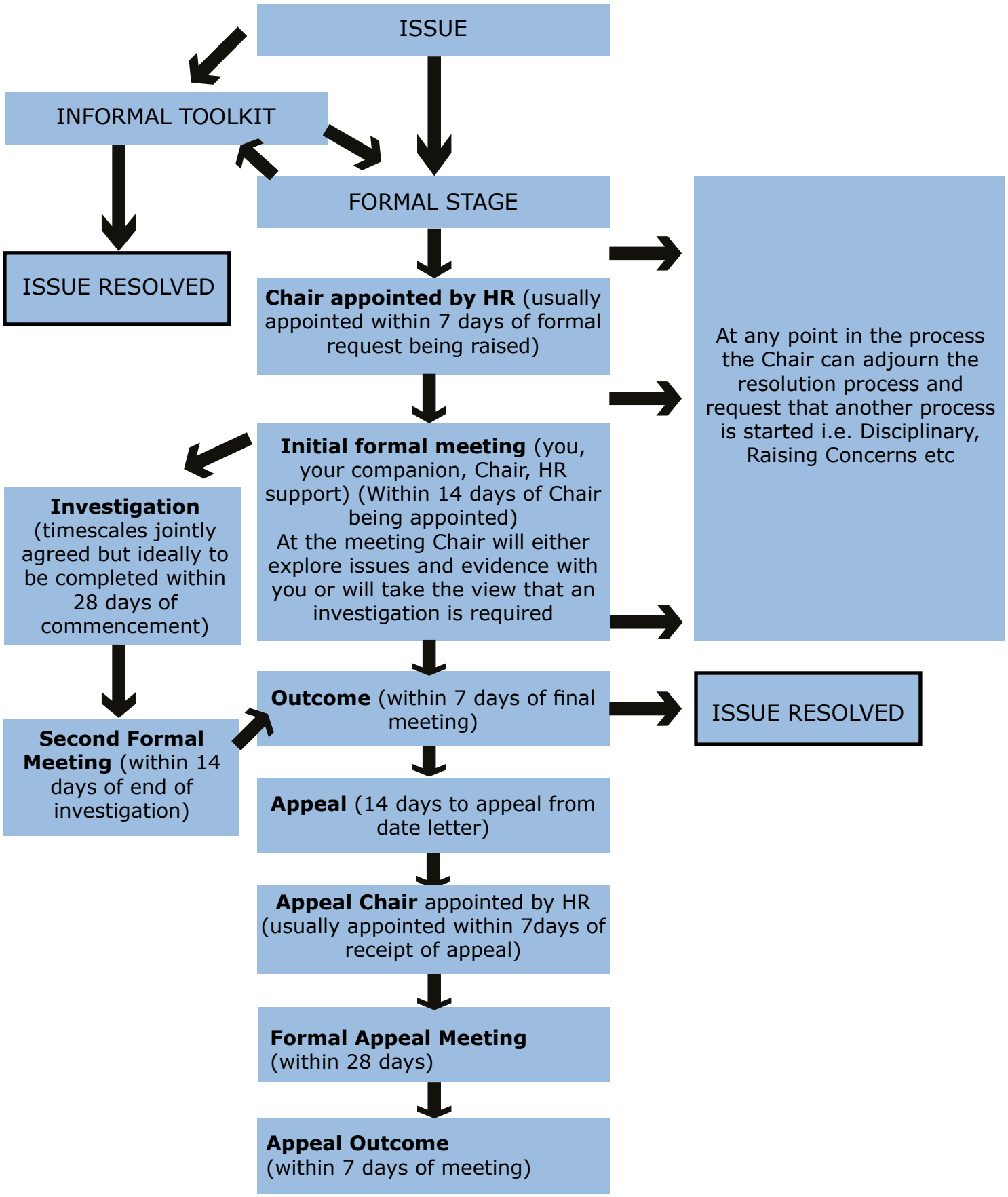
10 Learning From Events

10. Learning From Events

10.1 Where appropriate we will reflect and learn from the resolution process. This stage is not a requirement but is encouraged and may be useful in helping develop healthier working environments and relationships.

10.2 This review should be conducted in partnership where appropriate, with a view to developing and supporting a healthy working culture.
These discussions should be focused on positive outcomes and change (see toolkit).

11 Flowchart



Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Version V0.1
WP62

BCUHB Dress Code Guidelines

Author & Title	Anne-Marie Rowlands, Associate Director Professional Regulation & Education/ Jacqueline Hughes, SOR / Radiographer				
Responsible dept / director:	Gill Harris, Executive Director of Nursing and Midwifery				
Approved by:	Workforce Policies & Procedures Working Group Sue Green – Executive Director of Human Resources				
Date approved:	August 2013				
Date activated (live):	August 2013				
Documents to be read alongside this document:	• All Wales NHS Dress Code • WP6 Code of Conduct (Disciplinary Rules and Standards of Behaviour) • WP9 Disciplinary Policy • Nursing and Midwifery Council Code • Health and Care Professions Council Code • NHS Wales Code of Conduct and Code of Practice for Health Care Support Workers • WP22 Mufti Allowance Procedure • WP8 Equality Diversity and Human Rights Policy				
Date of next review:	February 2024				
Date EqIA completed:	February 2020				
First operational:	August 2013				
Previously reviewed:	No				
Changes made yes/no:					

N.B. Staff must be discouraged from printing this document.
This is to avoid the risk of out of date printed versions of the document.
The Intranet must be referred to for the current version of the document.

Contents

1. Introduction

The BCUHB Dress Code was developed to encompass the principles of inspiring confidence, preventing infection and for the safety of the workforce.

The public expect all healthcare workers to project a professional image. Though not all staff may be required to wear a uniform, the requirement to present a smart, professional image applies to everyone.

Securing the confidence of the public is paramount in delivering exemplary health care services. Evidence has shown that the public is concerned about a number of issues relating to the wearing of NHS uniforms and the comportment of NHS staff.

The evidence base for the BCUHB Dress Code was developed by the Department of Health in England. "Uniforms and Workwear: an evidence-based document on the wearing and laundering of uniforms" was originally published in 2007 and updated in 2010. It is available at http://www.dh.gov.uk/publications.

The wearing of an NHS uniform and/or workplace clothing must address key Health and Safety recommendations:

- Adhere to infection prevention and control protocols especially in relation to hand washing techniques and to minimize potential infection transmission
- the identification of a corporate image for the individual and team
- provide a professional image to promote public confidence
- provide the wearer with mobility and comfort
- be resilient to withstand rigorous laundering
- take into account staff safety in relation to situations involving violence and aggression

The dress code specifies the principles that all NHS staff must adhere to and highlights specific expectations for all staff directly involved in the delivery of clinical services. The dress code applies equally across clinical and non-clinical staff working within the Health Board. This dress code also covers volunteers and temporary staff whilst working on or in our premises

BCUHB recognises the diversity of cultures, religions and disabilities of employees and will take a sensitive approach in relation to dress and uniform requirements. However, priority will be given to health and safety, infection control and quality of care considerations.

2. Policy Statement

These local guidelines are written to support the All Wales NHS Dress Code (Welsh Assembly Government, 2010) which has been developed to encompass the principles of inspiring confidence, preventing infection and safety of the workforce

while also projecting a professional image. They provide local detail and expectations of all staff in BCUHB

3. Scope

The standards outlined in this guideline relate to all staff groups whether or not they are required to wear a uniform during their work. This guideline applies to all permanent, temporary and bank registered and unregistered staff. This dress code also covers volunteers and temporary staff whilst working on or in our premises

4. Roles and Responsibilities

Managers

Managers will ensure that staff comply with the requirements of this dress code by taking the following actions:-

- Ensure that staff for whom they are responsible for are issued with the correct uniform
- Ensure that staff who are not issued with a uniform maintain a professional appearance
- Ensure that any clothing that is provided to protect the Health & Safety of staff is fit for purpose and utilized in accordance with its designated purpose
- Ensure that staff are issued with the same number of uniforms as the number of shifts they are contracted to work each week
- A minimum of two uniforms must be provided
- Undertake regular monitoring of the dress code via spot checks and/or audit
- Ensure all new staff are made aware of this dress code during their Health Board orientation and have local access to it during work time
- Ensure that all staff leaving return their uniforms when leaving.
- Ensure that all uniforms for disposal due to contamination, are cut up, so as to be made un-usable and placed in the Disposal Bin (or clinical waste bin if visibly soiled or contaminated)

Employees

- All staff will ensure that they comply with the dress code and discuss with their manager any individual issues which prevent compliance
- Staff are responsible for ensuring their uniform is clean and in good order.
- If an employee accidentally damages or permanently stains any item of uniform, they must inform their manager as soon as possible so that arrangements can be made for a replacement.
- All staff will ensure that they return their uniform at termination of their employment, as uniforms are the property of the Health Board.
- Renewal of uniforms will be based on the length of time staff have had their uniforms and/or the state of disrepair the uniform is in.
- Requests for new uniforms must be made via agreed divisional /departmental process

5. Principles and Expectations

5.1 Principle 1

All staff will be expected to dress in smart (this is, neat and tidy) clean attire in their workspace.

Expectation:

All staff

- Staff must adhere to the NHS Wales Dress Code principles on the wearing and laundering of uniforms/work attire
- Staff must wear their uniforms/work clothes in a manner that will inspire public confidence
- The special needs of pregnant staff must be assessed and advice obtained from the occupational health department
- The special needs of disabled staff must be assessed and advice obtained from the occupational health department
- The special needs of menopausal staff must be assessed and advice obtained from occupational health when requested (see All Wales Menopause Policy for further advice)
- Staff may wear individual name badges as agreed by their division /department, (a health board design will need to be decided

Staff working in the clinical environment

- Clean uniform/work attire must be worn for each shift/work day
- Clinical staff must have access to a change of uniform must their uniform be contaminated during their shift/work day
- Where staff launder their own uniforms, written instructions must be adhered to which reflect current best practice guidelines (Appendix 2)
- Staff must use additional protective clothing when anticipating contact with blood and/or bodily fluids in line with their local infection prevention and control policies
- Theatre staff must NOT leave the department in theatre scrubs unless in an emergency situation and must change into a fresh set of theatre clothing on return from an emergency.
- Theatre footwear must be regularly decontaminated in line with theatre guidelines.
- Shoes must be wipeable

- Open sandals/flip flops and footwear that cannot be cleaned or absorbent to spillages must not be worn

- Ties, long necklaces, scarfs or ID badges on lanyards or anything that may dangle and may come into contact with the patient must not be worn

- Staff will be asked to remove any item that contradicts bare below the elbows and refusal may result in disciplinary.

- The Hijab, must be worn in a way that the wearer's face remains visible. It must also be worn in such a way that it allows quick release and must be secured by press-studs or Velcro

- Those staff moving into different areas which include high-risk areas must change before entry and/or returning to the area i.e. closed areas for infection prevention/outbreak management.

5.2 Principle 2

All staff will present a professional image in the workplace.

Expectation:

Staff working in the clinical environment

- Staff will wear their hair neatly; medium length/long hair must be tied up off the shoulder and secured

- Staff must not wear jewellery except for a plain wedding ring/Kara/ear studs

- No wrist watches are to be worn under any circumstances in the clinical environment

- Staff with pierced ears may wear one set of stud earrings only

- Staff with new piercings (where the piercing cannot be removed for a specific time period) must cover them with a 'Blue' plaster

- Staff with established body piercings, other than earrings, (one set of studs) must cover them with a 'Blue' plaster when in the workplace

- Staff with beards must keep the beard neatly trimmed. We recommend that staff required to wear FFP3 masks do not grow a beard.

- Staff must not wear false nails and/or nail varnish

- Staff must keep their finger nails clean and short

- Staff must wear footwear that complies with the relevant health and safety requirements, for example, soft soled for reduced noise, low heeled for manual handling and ease of movement, and closed toes for protection

- Staff must wear dark colored footwear e.g. plain black or navy with no bright logos

- For staff in uniform dresses, plain black or natural coloured stockings or tights are to be worn at all times, except during hot weather, when at the discretion of the departmental manager.

- Staff must not wear cardigans/jackets/fleeces or jumpers over their uniforms in the clinical environment

- Staff must not smoke whilst wearing their uniforms

- For staff not required to wear uniform, the wearing of shorts or tracksuits is not allowed (unless participating in sporting activities with service users).

- T-Shirts with logos that may be open to interpretation or cause offence may not be worn.

Non-uniformed female staff must not wear tops, which are low cut or revealing, and skirts must be an appropriate length.

- Staff may be asked to cover up excessive/potentially offensive tattoo designs if it is judged that they are not in line with the spirit of this dress code

- Smart casual dress is usually considered appropriate for a non-clinical setting; work wear must be clean, in a good state of repair, and in keeping with the promotion of a professional image.

5.3 Principle 3

Staff must not socialize outside the workplace or undertake social activities while wearing an identifiable NHS uniform.

Expectation:

Staff working in the clinical environment

- Where changing facilities are available, staff must change out of their uniform at the end of a shift before leaving their place of work

- Where changing facilities are **NOT** available, staff must ensure their uniform is covered up before leaving their place of work.

- Staff must not wear their uniforms in public places, for example, shops (if staff need to enter public places in the course of their duties they must make every effort to cover their uniforms)

- Staff who are permitted to wear a uniform to and from work, or work in the community setting, must cover their uniform when travelling
- Staff must not wear fluffy jumpers.

5.4 Principle 4

All clinical staff must wear short sleeves or elbow-length sleeves in the workplace to enable effective hand washing techniques.

All clinical staff must be bare below the elbows wearing short sleeves or elbow-length sleeves in the workplace to enable effective hand decontamination washing techniques and prevent harm to patients from jewellery and other items, including hand piercings.

Expectation:

Staff working in the clinical environment

- Staff will comply with the above in order to ensure that correct hand hygiene can be performed before contact with patients. BCUHB Hand Hygiene policy can be found on the following link: http://howis.wales.nhs.uk/sitesplus/861/opendoc/463197

5.5 Principle 5

All staff must wear clear identification at all times.

Expectation:

All staff

- Staff must wear identification (for example, a security coded name badge) that includes their title, name and profession at all times, in line with their local policies, for example, a Lone Worker Policy

- Staff identification must be clearly visible

- Staff must not wear lanyards

5.6 Principle 6

Staff who wear their own clothing for work must not wear any clothing that is likely to cause a safety hazard.

Expectation:

All staff

- Staff must not wear any loose clothing that may compromise their health and safety in the work place

- Footwear should be comfortable and practical for the role undertaken

- Clothing must be laundered or cleaned as per Infection prevention and control guidance (Appendix 2).

6. Implementation, Monitoring and Review

The Dress Code will be distributed electronically via divisional operational teams, bulletin, and relevant Health Board policies page. This policy will be reviewed in 3 years.

If a member of staff contravenes this Dress code guideline they will be expected to make right immediately, if this is repeated they will be subject to the BCU Disciplinary Policy (WP9).

7. Equality including Welsh Language

Uniforms can be embroidered with the I Speak Welsh Logo. An equality impact assessment has been completed

8. Well-being of Future Generations

The Dress Code promotes the Well-being of Future Generations Act by ensuring uniforms display the Welsh Language logo so that Welsh speakers are easily identified. Uniforms would also be disposed of in line with Health Board Waste disposable Policy to protect the environment.

9. Resources

Divisions are responsible for the purchasing of uniforms and other work wear essential for staff to safely undertake their role.

10. Training

All new staff as outlined in section 5 will receive a copy of this guideline at Induction

11. Audit

Department managers will undertake regular monitoring of the Dress Code via spot checks and/or audit

12. References

Department of Health (2010) “Uniforms and Workwear: an evidence-based document on the wearing and laundering of uniforms”

Department of Health (2006) Safety First: a report for patients and healthcare managers DoH: London

Health and Safety Commission (2000) Securing Health Together HSE: London

HMSO (1974) Health and Safety at Work Act 1974 HMSO: London

HMSO (1992) Manual Handling Operations Regulations HMSO: London

HMSO (1999) Management of Health and Safety at Work Regulations HMSO: London

HMSO (2002) Control of Substances Hazardous to Health Regulations HMSO: London

HMSO (2002) Personal Protective Equipment Regulations HMSO: London

HMSO (2006) Health Act 2006 Code of Practice HMSO: London

Jacob, G (2007) Uniforms and Workwear. An evidence based for developing local policy Department of Health, London

NHs Borders (2004) Dress Code/Uniforms Policy

Royal College of Nursing (2009) Guidance on uniforms and work wear

Royal College of Nursing (2005) Wipe It Out. RCN Campaign on MRSA. Guidance on uniforms and clothing work in the delivery of patient care Royal College of Nursing: London

13. Appendices

Appendix 1

Supporting information

Good Practice	Rationale	Supporting Information and / or additional comments
Wear short sleeves or roll the sleeves to elbow length before carrying out clinical procedures	Cuffs become heavily contaminated and are more likely to come into contact with patients They may act as a vehicle for transmitting infection Long sleeves or cuffs prevent effective hand washing and compromise patient safety	Some staff working in an outdoor environment, for example, ambulance personnel, paramedics and others delivering emergency care, may be exempt from this requirement
Dress in a manner which is likely to inspire public confidence	People may use general appearance as a proxy measure of competence and professional practice	
Clinical staff who do not wear a uniform must not wear any loose clothing such as unsecured ties, draped scarves, headdress or similar items	This type of clothing may make contact with the patient and their environment during clinical procedures and may be a vehicle for transmitting infection	This type of clothing could have staff safety implications. A risk assessment must be carried out
Where changing facilities **are provided** clinical staff who wear a uniform must change out of their uniform before leaving the workplace. Staff who are permitted to wear a clinical uniform to and from work must have it covered up when travelling	There is no current evidence of an infection risk caused by travelling in uniform, but patient confidence in the health and social care staff may be undermined Staff may be vulnerable to attack if seen off site in uniform	This does not apply to staff who are permitted to travel during the course of their duties, for example, community staff

Good Practice	Rationale	Supporting Information and / or additional comments
Staff must not go shopping, socialising or undertake similar activities in public when in uniform	There is no current evidence of an infection risk from travelling or shopping in uniform, but patient confidence in health and social care staff may be undermined	There is a public perception (as evidenced by the media) that associates staff wearing uniforms with the spread of infection
Wear clear identifiers; uniform and/or, name or identity badge	Patients wish to know who is caring for them. Name badges and uniforms help them to do this	Identification is important to promote patient and client safety
Staff must change as soon as is practical if uniform or clothes become visibly soiled or contaminated with blood or body fluids	Visible soiling or contamination might be an infection risk, and is also likely to affect patient confidence	Organisations must ensure that there is a local arrangement for this
All staff must secure long hair	Patients generally prefer to be treated by staff with tidy hair and a neat appearance Long or unsecured hair may make contact with the patient and their environment during clinical procedures and may be a vehicle for transmitting infection	Long hair must be tied back and off the collar
Staff must be issued with a sufficient number of uniforms to allow them to wear a clean uniform each shift Written instructions must be provided to staff who launder their own uniforms; the guidance must reflect current best practice guidelines	A clean uniform must be worn for each shift A sufficient supply of uniforms for the recommended laundry practice must be provided	Providing staff with clear instructions on the cleaning of uniforms means that uniforms will be processed in line with the current recommendations (Appendix 2) Staff who have too few uniforms may be tempted to reduce the frequency of laundering

Good Practice	Rationale	Supporting Information and / or additional comments
Wrist or hand jewellery must not be worn in the clinical environment	Wrist watches must be removed before performing any clinical procedure and to promote good hand hygiene Hand/wrist jewellery can harbor microorganisms and can reduce compliance with hand hygiene	Centres for Disease Control and Prevention. Guideline for hand Hygiene in Health-Care Settings: Recommendations of the Healthcare Infection Control Practices Advisory Committee and the ICPAC/SHEA/APIC/ IDSA Hand Hygiene Task Force. MMWR 2005; 51 (No. RR-16)
Clinical staff must keep finger nails short and clean Clinical staff must not wear false nails or nail varnish	Long and/or dirty nails can present a poor appearance and long nails are harder to keep clean Long and/or dirty nails may be a vehicle for transmitting infection	Centres for Disease Control and Prevention. Guideline for hand Hygiene in Health-Care Settings: Recommendations of the Healthcare Infection Control Practices Advisory Committee and the ICPAC/SHEA/APIC/ IDSA Hand Hygiene Task Force. MMWR 2005; 51 (No. RR-16)
Footwear worn in the clinical areas must be suitable for purpose and comply with the relevant health and safety requirements	Closed toe shoes offer protection against spills. Soft soles reduce noise, low heeled to comply with manual handling policies	

Appendix 2

Guidance for healthcare staff laundering uniforms / workwear in the home

For staff working in some clinical environments a laundry service is provided by the employing organisation. With the introduction of a national NHS uniform and the instigation of on-site changing facilities for all healthcare staff, the next logical progression will be the reintroduction of laundry services to negate the need for staff to leave the premises with used or contaminated clothing.

Until such services have been reinstated and where currently the employer does not provide such a service it is sensible to issue staff with guidance on how best to launder their uniforms at home.

Such guidance must include:

- Where on-site changing facilities already exist and once they have been made available, staff must remove their uniform on site.

- For transportation, uniforms must be placed in a clear plastic bag or a water soluble bag suitable for use in domestic washing machines*.

- Uniforms must be washed at the hottest temperature suitable for the fabric. A wash for 10 minutes at 60ºC must remove most micro-organisms**.

- Ensure that the machine is not overloaded to allow for optimum wash efficiency and dilution factor.

- Staff must wash their hands after loading the machine.

- Use of biological washing agent is preferable.

- Tumble dry on the hottest temperature as recommended by the manufacturer or air dry thoroughly before ironing on the hottest setting as advised by the manufacturer.

** Plastic bags with a water soluble tie and seam, suitable for use in domestic washing machines, clearly labelled for staff use with instructions printed on them, are now available through a Welsh Health Supplies contract. Ideally, they should be available for the transportation of all uniforms but as a minimum must be considered for use where uniforms are visibly soiled or during an outbreak of disease. The use of such a bag would negate the need for staff to handle the uniform in the home. The whole bag can be placed safely into the machine. On no account must the soluble bags used by hospital laundries be issued to staff even during an outbreak. They are not suitable for use within a domestic machine where the dilution and temperatures reached are not of the magnitude that can be achieved in a commercial setting.

** Employing organisations should take into account the manufacturer's washing instructions during the procurement process for uniforms purchased outside of the national contract.

Version: 5

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

WP4a

Procedure for NHS Staff to Raise Concerns

Date to be reviewed:	June 2024	**No of pages:**	21
Author(s):	Welsh Partnership Forum Business Committee		
Responsible dept / director:	Director of Workforce & Organisational Development		
Approved by:	All Wales Policy- for local adoption		
Date approved:	June 2021		
Date activated (live):	All Wales Policy activated December 2017		

Documents to be read alongside this document:	• Respect and Resolution Policy (WP5) • Code of Conduct (Disciplinary Rules & Standards of Behaviour) (WP6) • Policy for the Protection of Vulnerable Adults (POVA) (SA01) • All Wales Child Protection Policy • Local Counter Fraud & Corruption Policy
Review	**Purpose of Issue/Description of current changes:** All Wales Amendments

Summary: BCUHB is working towards a culture that encourages the raising of any concerns by staff to be embedded into routine discussions on service delivery and patient care, (e.g. problem solving, service review, performance improvement, quality assessment, training and development) as these are the most effective mechanism for early warning of concerns, wrongdoing, malpractice or risks and line managers are accordingly best placed to act on, deal with and resolve such concerns at an early stage

First operational:	November 2013			
Previously reviewed:	February 2018	August 2015	March 2015	
Changes made yes/no:	Yes	Yes	Yes	

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Introduction

The Core Principles of NHS Wales are:

- **We put patients and users of our services first:** We work with the public and patients/service users through co-production, doing only what is needed, no more, no less and trying to avoid harm. We are honest, open, empathetic and compassionate. We ensure quality and safety above all else by providing the best care at all times.
- **We seek to improve our care:** We care for those with the greatest health need first, making the most effective use of all skills and resources and constantly seeking to fit the care and services we provide to users' needs. We integrate improvement into everyday working, by being open to change in all that we do, which also reduces harm and waste.
- **We focus on wellbeing and prevention:** We strive to improve health and remove inequities by working together with the people of Wales so as to ensure their wellbeing now and in future years and generations.
- **We reflect on our experiences and learn:** We invest in our learning and development. We make decisions that benefit patients and users of our services by appropriate use of the tools, systems and environments which enable us to work competently, safely and effectively. We actively innovate, adapt and reduce inappropriate variation whilst being mindful of the appropriate evidence base to guide us.
- **We work in partnership and as a team:** We work with individuals including patients, colleagues, and other organisations; taking pride in all that we do, valuing and respecting each other, being honest and open and listening to the contribution of others. We aim to resolve disagreements effectively and promptly and we have a zero tolerance of bullying or victimization of any patient, service user or member of staff.
- **We value all who work for the NHS:** We support all our colleagues in doing the jobs they have agreed to do. We will regularly ask about what they need to do their work better and seek to provide the facilities they need to excel in the care they give. We will listen to our colleagues and act on their feedback and concerns.

They have been developed to help and support staff working in NHS Wales.

NHS Wales is about people, working with people, to care for people. These Core Principles describe how we can work together to make sure that what we do and how we do it is underpinned by a strong common sense of purpose which we all share and understand.

The NHS is continually under pressure to deliver more services, with better outcomes and maintain and increase quality against the backdrop of significant financial challenge, high levels of public expectation and with a population which is getting older and with increased levels of chronic conditions.
These principles have been developed to help address some of the pressures felt by staff in responding to these demands. They will re-balance the way we work together so we are less reliant on process and are supported to do the right thing by being guided by these principles when applying policies and procedures to the workforce.

As people working within the health service, we will all use them to support us to carry out our work with continued dedicated commitment to those using our services, during times of constant change.

The Principles are part of an ongoing commitment to strengthen the national and local values and behaviour frameworks already established across Health Boards and Trusts.

They have been developed in partnership with representatives from employers and staff side.

The Principles will be used to create a simpler and consistent approach when it comes to managing workplace employment issues.

The safety and wellbeing of patients and service users are seen as the responsibility of everyone involved in the provision of health and social care services. The Betsi Cadwaladr University Health Board and senior management are committed to providing an environment which facilitates open dialogue and communication so as to ensure that any concerns which staff may have are raised as soon as possible.

This procedure refers in the main to 'raising concerns' rather than 'whistleblowing' because the latter has come to denote a sudden, drastic or last resort act which can hold negative connotations.

The Betsi Cadwaladr University Health Board is working towards a culture that encourages the raising of any concerns by staff to be embedded into routine discussions on service delivery and patient care, (e.g. problem solving, service review, performance improvement, quality assessment, training and development) as these are the most effective mechanism for early warning of concerns, wrongdoing, malpractice or risks and line managers are accordingly best placed to act on, deal with and resolve such concerns at an early stage.

It is, however, acknowledged that such processes take time to develop and embed into the organisation and until such time as such a culture exists comprehensively across Betsi Cadwaladr University Health Board that a clear process needs to be in place to guide individuals who wish to raise concerns about a danger, risk, malpractice or wrongdoing in the workplace. This procedure sets out the Betsi Cadwaladr University Health Board's commitment to support individuals who raise concerns as well as setting out the processes for individuals to raise such concerns and to provide assurance on how such concerns will be listened to, investigated and acted upon as necessary.

'Whistleblowing' is the popular term applied to a situation where an employee, former employee or member of an organisation raises concerns to people who have the power and presumed willingness to take corrective action. The types of situation where this will be appropriate are outlined in Appendix 1. "Protected disclosure" is the legal term for whistleblowing and is referenced in the context of describing the protection is afforded to the person raising the concern in the interest of the public (see appendix 2).

The development of this procedure is an ongoing process and is a part of the wider work across NHS Wales to ensure that an open culture exists to provide the highest standards of care and experience across all services. This procedure does not form part of an employee's contract of employment and may need to be amended from time to time.

1. A Commitment to Support Those Who Raise Concerns

1.1 Betsi Cadwaladr University Health Board actively encourages feedback and has a transparent and open approach to listening to and responding to all concerns.

1.2 Betsi Cadwaladr University Health Board aims to ensure that individuals:

- Are fully supported to report concerns and safety issues;
- are treated fairly, with empathy and consideration when raising concerns; and
- have their concerns listened to and addressed, when they have been involved in an incident or have raised a concern.

1.3 Betsi Cadwaladr University Health Board aims to develop and maintain a culture across all parts of the organisation that provides an environment where people feel able to raise concerns and are treated with respect and dignity when raising concerns.

1.4 Safety is at the heart of all care and must be underpinned by a culture which is open and transparent. This leads to increased reporting, learning and sharing of incidents and development of best practice. Betsi Cadwaladr University Health Board recognises that this is the responsibility of everyone involved in the provision of health and social care services. Betsi Cadwaladr University Health Board is committed to working towards ensuring that all individuals are treated in a service which is open to feedback and encourages as well as supports its staff to raise concerns.

1.5 Betsi Cadwaladr University Health Board will ensure that individuals always feel free to raise concerns through local processes and are supported to do so directly with the Betsi Cadwaladr University Health Board*,* their professional regulatory body, professional association, regulator or union.

1.6 Betsi Cadwaladr University Health Board is committed to:-

- Working in partnership with other organisations to develop a positive culture by promoting openness, transparency and fairness;
- Fostering a culture of openness which supports and encourages staff to raise concerns;
- Sharing expertise to create effective ways of breaking down barriers to reporting incidents and concerns early on;
- Exchanging information, where it is appropriate and lawful to do so, in the interests of patient and public safety; and
- Signposting individuals to support and guidance to ensure that they are fully aware of and understand their protected rights under the Public Interest Disclosure Act 1998.

1.7 Betsi Cadwaladr University Health Board will monitor the use of this procedure and report to the Board or a subcommittee, as appropriate.

2. About this Procedure

2.1 The aims of this procedure are:

(a) To encourage staff to discuss concerns and safety issues as soon as possible, in the knowledge that their concerns will be taken seriously and acted upon as appropriate,

(b) To encourage staff to report more serious concerns and suspected wrongdoing as soon as possible, in the knowledge that their concerns will be taken seriously and investigated as appropriate, and where requested that their confidentiality will be respected.

(b) To provide staff with guidance as to how to raise those concerns.

(c) To assure staff that they should be able to raise genuine concerns without fear of reprisals, even if they turn out to be mistaken.

2.2 This procedure applies to all employees, officers, consultants, contractors, students, volunteers, interns, casual workers and agency workers.

3. Raising a Concern

3.1 All healthcare settings and workplaces should encourage ongoing open dialogue and feedback on matters relating to provision of care/service delivery through supervision, team or departmental meetings, staff forums. These ongoing mechanisms are the place where Betsi Cadwaladr University Health Board will actively seek suggestions for improvement and regularly review the safe and effective delivery of services and ways of working.

3.2 All managers will ensure that there is a shared responsibility to focus positively on the quality of service/care, continuous improvement and/or problem solving.

3.3 If concerns are held by an individual or individuals Betsi Cadwaladr University Health Board will ensure that such concerns are addressed and responded to with the outcome being verbally communicated, as a minimum, to the individual or individuals raising the concern.

3.4 More Serious Concerns

Confidentiality

As noted in section 1.3 of this procedure Betsi Cadwaladr University Health Board aims to develop and maintain a culture across all parts of the organisation that provides for an environment where people feel able to raise concerns. It is therefore hoped that all staff will feel able to voice concerns openly under this procedure. However, if an individual wants to raise a concern confidentially this will be respected. It is sometimes difficult however, to investigate a concern without knowing the individual's identity. In such circumstances if it is considered absolutely necessary to share the identity of the person raising the concern this will be discussed with them prior to any disclosure being made, and their permission sought.

Stage 1 – Internal (Informal)

If an individual has a concern about any issue involving malpractice/wrongdoing they are encouraged to raise it first either verbally or in writing with their line manager or the manager responsible for that area of work, unless it relates to fraud or corruption (see paragraph overleaf relating to this issue). They may also wish to involve their Trade Union/Staff Representative. Medical staff should report the issue to their Lead clinician.

It is important to remember that raising a concern is different from raising a personal complaint or grievance and in such circumstances the Respect and Resolution Policy may be appropriate (see appendix 1). If the concern is around the abuse of children or adults with vulnerabilities then the All Wales Child Protection Procedures 2008 and Wales Interim Policy and Procedures for the Protection of Vulnerable Adults from Abuse 2013 should be followed and initiated immediately.

To ensure effective operation of the Procedure for Raising Concerns, Betsi Cadwaladr University Health Board also has an alternative route for issues to be raised where going through the line manager is not appropriate e.g.

- the member of staff feels there is an immediate issue of significant risk to safety which would not be addressed by line management
- the concern raised relates to the conduct or practice of one or more individuals in the line management accountability structures who would normally consider the concern
- the member of staff has strong experiential evidence that the line manager(s) would not address the concern
- the member of staff feels that similar concerns raised in the past had been ignored
- the member of staff feels that the raising of concern would place him/her at risk of harassment or victimisation from colleagues or managers

The alternative route for raising concerns is accessed through Work in Confidence, an independent web-based platform that allows BCUHB staff members to raise concerns and engage in anonymous two-way conversation with either the Speak Out Safely Guardian or a member of the Speak Out Safely Multi-Disciplinary Team. Providing a service that is wholly independent of the Health Board is designed to provide assurances to staff that there is a mechanism to raise concerns in those situations where they may feel unable to report concern through the normal management structure. Work in Confidence is not designed to bypass the normal process for raising concerns; it provides a secure means to raise concerns on those occasions when a member of staff feels it inappropriate to raise the concern through line management. Staff may still utilise the suite of policy and resource options available through the Respect and Resolution Policy where it is deemed this would be more appropriate.

Further information on how to access Work in Confidence can be found on the Speak Out Safely BCUHB intranet page.

Any concerns regarding potential fraud or corruption should be raised initially with the Local Counter Fraud Specialist (LCFS) on 01978 725417 / 01745 448782 x 2236/2238. Alternatively, reports can be made via the Fraud and Corruption Reporting Line or Website. Full contact details are available via the Counter Fraud pages of the Health Board / Trust intranet site.

These concerns will then be managed in line with the Betsi Cadwaladr University Health Board's Counter Fraud Policy and Response Plan.

The individual will be entitled to a verbal response, as a minimum, and where appropriate detail needs to be conveyed a written response to their concern may be appropriate, provided that they have not wished to remain anonymous. The responsibility for providing this response will be either the manager to whom the concern was addressed, or the individual identified to provide such responses in any local processes in place to ensure that concerns can be raised as described in the previous paragraph.

Stage 2 – Internal (Formal)

If, having followed the approach outlined in stage 1, the individual's concerns remain, or they feel that the matter is so serious that they cannot discuss it with any of the above then they can move on to use the more formal steps as follows.

The individual should make their concerns known to an appropriate senior manager in writing. They may also wish to involve their Trade Union/Staff Representative.

When a concern is raised it is helpful to know how the individual considers the matter might be best resolved.

The senior manager will meet with the individual raising the concern within seven working days. The outcome of the meeting will be recorded in writing and a copy given to the individual within seven working days of the meeting.

Once an individual has told someone of their concern, whether verbally or in writing, Betsi Cadwaladr University Health Board will consider the information to assess what action should be taken. This may involve an informal review or a more formal investigation.

The individual will be told who is handling the matter, how they can contact them and what further assistance may be needed. If there is to be a formal investigation the manager to whom they have reported their concern will appoint an Investigating Officer. If an internal investigation takes place this will be undertaken thoroughly and as quickly as possible (usually within 28 days) in light of the matters to be investigated. At their request, the individual will be written to summarising their concern, and setting out how it will be handled along with a timeframe.

Betsi Cadwaladr University Health Board will aim to keep the individual informed of the progress of the investigation and its likely timescale. However, sometimes the need for

confidentiality may prevent specific details of the investigation or any disciplinary action from being disclosed. All information about the investigation should be treated as confidential.

If the matter falls more appropriately within the remit of other W&OD policies, the employees should be advised that they should pursue the matter through the relevant policy and that the Procedure for NHS Staff to Raise Concerns will not be followed (see appendix 1).

Betsi Cadwaladr University Health Board does not expect any individual reporting a matter under this procedure to have absolute proof of any misconduct or malpractice that they report, but they will need to be able to show reasons for their concerns, so any evidence that they have such as letters, memos, diary entries etc. will be useful. These will need to be redacted if they contain any patient identifiable information.

If the alleged disclosure is deemed to be serious enough, then the Betsi Cadwaladr University Health Board may follow the process laid down in the Disciplinary policy and procedure, where the issues raised could relate to individual misconduct, when considering the most appropriate line of action.

The aim of this procedure is to provide an effective process for serious concerns to be raised. If it is concluded that an individual has deliberately made false allegations maliciously or for personal gain, then Betsi Cadwaladr University Health Board will instigate an investigation into the matter in accordance with the Disciplinary policy and procedure.

Subject to any legal constraints, Betsi Cadwaladr University Health Board will inform the individual(s) who raised the concern, of an outline of any actions taken. However, it may not always be possible to divulge the precise action, e.g. where this would infringe a duty of confidentiality of Betsi Cadwaladr University Health Board towards another party.

Stage 3 – Senior Manager

If an individual is either dissatisfied with a decision to only undertake an informal review, or is dissatisfied with the outcome of stage 2 through the mechanisms outlined previously, they should raise their concerns in writing with the Chief Executive, and/or an appropriate Executive Director. If the concern relates to the Chief Executive or Executive Director, concerns should be raised with the Chair. Exceptionally, an individual should proceed directly to this stage as a “Last Resort Escalation” in the unlikely event that having made every attempt to raise a concern through the mechanisms outlined previously there has been little or no attempt to address the matter.

The Chief Executive or Chair (or a nominated representative not previously involved) will meet the individual within 28 working days. Again, the outcome of this meeting will be recorded in writing and a copy given to the individual within seven working days of the meeting.

Stage 4 - Serious or Continued Concerns and Regulatory/Wider Disclosure

The aim of this procedure is to provide an internal mechanism for reporting, investigating and remedying any wrongdoing/inappropriate practices in the workplace. In most cases individuals should not find it necessary to alert external parties.

However, the law recognises that in some circumstances it may be appropriate to report concerns to an external body. It will very rarely if ever be appropriate to alert the media. It is strongly encouraged that an individual seeks advice before reporting a concern to external parties. The independent charity, Public Concern at Work, operates a confidential helpline to support individuals in determining the appropriate course of action. They also have a list of prescribed regulators for reporting certain types of concern. Public Concern at Work's details are included later in this procedure.

All staff have an individual responsibility to safeguard people from harm or suspected harm, by making known their concerns about abuse. Children and adults with vulnerabilities can be subjected to abuse by those who work with them in any setting; all allegations of abuse must therefore be taken seriously and treated in accordance with the All Wales Child Protection Procedures 2008 and Wales Interim Policy and Procedures for the Protection of Vulnerable Adults from Abuse 2013. These procedures may dictate that any investigation should be handled by a partner organisation such as Social Services or the Policy which would take precedence over internal procedures, therefore advice from a safeguarding professional should be sought at the earliest opportunity.

If an individual has followed the above procedure to deal with the matter and still has concerns or if they feel that the matter is so serious that they cannot discuss it in any of the ways outlined previously, then in exceptional circumstances they may wish to contact:-

- The National Fraud and Corruption reporting Line on 0800 028 40 60, or alternatively via the on line reporting facility at www.reportnhsfraud.nhs.uk. (if your concern is about financial malpractice)
- Welsh Government

Betsi Cadwaladr University Health Board hopes that this procedure will provide individuals with the reassurances required to raise any matters of concern internally or exceptionally with the organisations referred to above. However, there may be circumstances where individuals are required under their professional regulations to report matters to external bodies such as the appropriate regulatory bodies, including:-

- ❖ General Medical Council (www.gmc-uk.org)
- ❖ Nursing and Midwifery Council (www.nmc-uk.org)
- ❖ Health and Care Professions Council (www.hpc-uk.org)
- ❖ General Pharmaceutical Council (www.pharmacyregulation.org)

Betsi Cadwaladr University Health Board would rather the matter is raised with the appropriate regulatory body than not at all. Other regulatory bodies may include;

- Health and Safety Executive
- Health Inspectorate Wales
- Wales Audit Office
- Police

(This list is not exhaustive).

If an individual needs further advice they can contact the charity Public Concern at Work on 020 7404 6609 or by email at helpline@pcaw.co.uk. Public Concern at Work can advise individuals how to go about raising a matter of concern in the appropriate way (www.pcaw.co.uk/law/lawregulators.html). Alternatively, the Department of Health also provide a service for NHS and Social Care employees in England and Wales on 08000 724 725 or by email at enquiries@wbhelpline.org.uk.

Appendix 1 - What is whistleblowing?

Whistleblowing is the term used when a member of staff raises a concern about a possible risk, wrongdoing or malpractice that has a public interest aspect to it, usually because it threatens or poses a risk to others (e.g. patients, colleagues or the public).

This may include:

- Systematic failings that result in patient safety being endangered, e.g. poorly organised emergency response systems, or inadequate/broken equipment, inappropriately trained staff;
- Poor quality care;
- Acts of violence, discrimination or bullying towards patients or staff;
- Malpractice in the treatment of, or ill treatment or neglect of, a patient or client;
- Disregard of agreed care plans or treatment regimes;
- Inappropriate care of, or behaviour towards, a child /vulnerable adult;
- Welfare of subjects in clinical trials;
- Staff being mistreated by patients;
- Inappropriate relationships between patients and staff;
- Illness that may affect a member of the workforce's ability to practise in a safe manner;
- Substance and alcohol misuse affecting ability to work;
- Negligence;
- Where a criminal offence has been committed / is being committed / or is likely to be committed (or you suspect this to be the case);
- Where fraud or theft is suspected;
- Disregard of legislation, particularly in relation to Health and Safety at Work;
- A breach of financial procedures;
- Undue favour over a contractual matter or to a job applicant has been shown;
- Information on any of the above has been / is being / or is likely to be concealed

This procedure should not be used for complaints relating to your own personal circumstances, such as the way you have been treated at work. In these cases, the Grievance policy or the Dignity at Work policy should be used as appropriate. Please see illustration below:-

Where do I go to raise a concern…?

Informal Mechanisms

If possible, all concerns should be **raised with your line manager** in the first instance. Raising concerns should be a **positive part of our day to day roles** and a way of **improving services** for our patients, carers and each other.

Mediation is used as a first resort in dealing with **Dignity at Work** issues and can be described as an informal, voluntary process, in which a **neutral person (trained mediator)** helps individuals in dispute explore & understand their differences so they can **find their own solution**.

Incident reporting mechanisms should be used for any unintended or unexpected incident which could or did lead to harm for a patient receiving NHS Care. Where available use the new **electronic reporting system** e-datix (via the intranet or your desktop). **You can also talk** to a member of the **Patient Safety Team** on 03000 840145 or BCU.PatientSafetyIncidents@wales.nhs.uk.

It is important to develop an **action plan** for all concerns, including those raised informally. These action plans should be **monitored and reviewed regularly**.

Formal Mechanisms

Raising Concerns Procedure: Use this to raise concerns about a danger, risk, malpractice or wrongdoing in the workplace. If you can't talk to your manager contact Human Resources, the Board Secretary or your professional lead.

Respect and Resolution Policy: Use this for workplace disagreements, conflicts and complaints. This process emphasises the importance of using informal mechanisms including mediation.

Counter Fraud: Their role is to investigate all aspects of fraud and corruption in the NHS. If you would like to report any suspicions the local counter fraud team can be contacted on 01978 725417/01745 448782 x 2236/2238

Putting Things Right: Use these arrangements if you have a concern to raise as a **member of the public or patient**, rather than as a member of staff. Contact the concerns team on 03000 851234 or BCU.ConcernsTeam@wales.nhs.uk.

Appendix 2 - Protection of those making disclosures

It is understandable that individuals raising concerns are sometimes worried about possible repercussions. Betsi Cadwaladr University Health Board aims to encourage openness and will support staff who raise genuine concerns under this procedure, even if they turn out to be mistaken. In addition, there are statutory provisions for individuals who make what are termed “protected disclosures”.

In law individuals must not suffer any detrimental treatment as a result of raising a concern. Detrimental treatment includes dismissal, disciplinary action, threats or other unfavourable treatment connected with raising a concern. If an individual believes that they have suffered any such treatment, they should inform a member of the Workforce and Organisational Development department, immediately. If the matter is not remedied they should raise it formally using the Respect and Resolution Policy.

Those who raise concerns must not be threatened or retaliated against in any way. If an individual is involved in such conduct they may be subject to disciplinary action. [In some cases, the individual raising a concern could have a right to sue for compensation in an employment tribunal.]

Betsi Cadwaladr University Health Board aims to protect and support staff to raise legitimate concerns internally within the organisation where they honestly and reasonably believe that malpractice/wrongdoing has occurred or will be likely to occur. Staff who make what is referred to as a “protected disclosure”, i.e. a disclosure concerning an alleged criminal offence or other wrongdoing, have the legal right not to be dismissed, selected for redundancy or subjected to any other detriment (demotion, forfeiture of opportunities for promotion or training, etc.) for having done so and the protections are set out in law in the Public Interest Disclosure Act 1998.

If an individual is raising a matter of serious or continued concern the same protection applies as for internal disclosure. This is intended to promote accountability in public life and there is no requirement that such concerns should first be raised with the Betsi Cadwaladr University Health Board although it is preferred that the Betsi Cadwaladr University Health Board should be given an opportunity to resolve the matter first.

lf an individual is raising a matter with a regulatory body defined within the Public Interest Disclosure Act 1998 they will be protected where they honestly and reasonably believe that the malpractice/wrongdoing has occurred or is likely to occur and in addition they honestly and reasonably believe that the information and any allegation contained in it are substantially true. The Public Interest Disclosure (Prescribed Persons) Order 2014 amends the list of prescribed persons and came into force on 1 October 2014 and

applies to disclosures made on or after this date. The new list of prescribed persons in respect of matters relating to healthcare services is set out below:-

Relevant matters	**Prescribed person**
Matters relating to the registration and fitness to practice of a member of a profession regulated by the relevant council and any other activities in relation to which the relevant council has functions.	The Nursing and Midwifery Council, Health and Care Professions Council, General Medical Council, General Chiropractic Council, General Dental Council, General Optical Council, General Osteopathic Council, General Pharmaceutical Council.

For healthcare services in Wales (specifically):

Relevant matters	**Prescribed person**
Matters relating to the registration of social care workers under the Care Standards Act 2000.	Care Council for Wales
Matters relating to: • The provision of Part II services as defined in section 8 of the Care Standards Act 2000 and the Children Act 1989. • The inspection and performance assessment of Welsh local authority social services as defined in section 148 of the Health and Social Care (Community Health and Standards) Act 2003. • The review of, and investigation into, the provision of health care by and for Welsh NHS bodies as defined under the Health and Social Care (Community Health and Standards) Act 2003. • The regulation of registered social landlords in accordance with Part 1 of the Housing Act 1996 (as amended by the Housing (Wales) Measure 2011.	Welsh ministers

If an individual is making a wider disclosure (for example to the police, or an Assembly Member (AM) (other than the Minister for Health and Social Care or a Member of Parliament (MP)) they will be protected only if:

- they meet the above tests for internal and regulatory disclosures;
- they have not made the disclosure for personal gain;
- they have first raised the matter internally or with a prescribed regulatory body unless the matter was exceptionally serious and they reasonably believed they would be victimised if they did so; or
- there is no prescribed regulatory body and it is reasonably believed that there would be a cover up

Public Concern at Work or a Trade Union will be able to advise on the circumstances in which an individual should use this procedure and where they may be able to contact an outside body without losing the protection afforded under the Public Interest Disclosure Act 1998.

Appendix 3 - Betsi Cadwaladr University Health Board - Form WB1 – Recording a concern raised under the procedure

Concern raised by (name):				
Designation				
Ward / Department				
Confidentiality requested:	yes		No	
Nature of concern raised:	Delivery of care/services to patients			
	Vale for money			
	Health and safety			
	Unlawful conduct			
	Fraud, theft or corruption			
	The cover-up of any of the above			
Details of concern raised: (Continue overleaf is necessary)				
Evidence to support the concern (if available):				

(Continue overleaf if necessary)		
Any suggestions from employees as to a resolution?		
How will the matter be handled?	Informal review	
	Internal investigation	
Concern reported to:		
Contact name:		
Designation:		
Telephone no:		
Signed:		
Date:		
N.B. Once completed, this form should be retained on a case file		

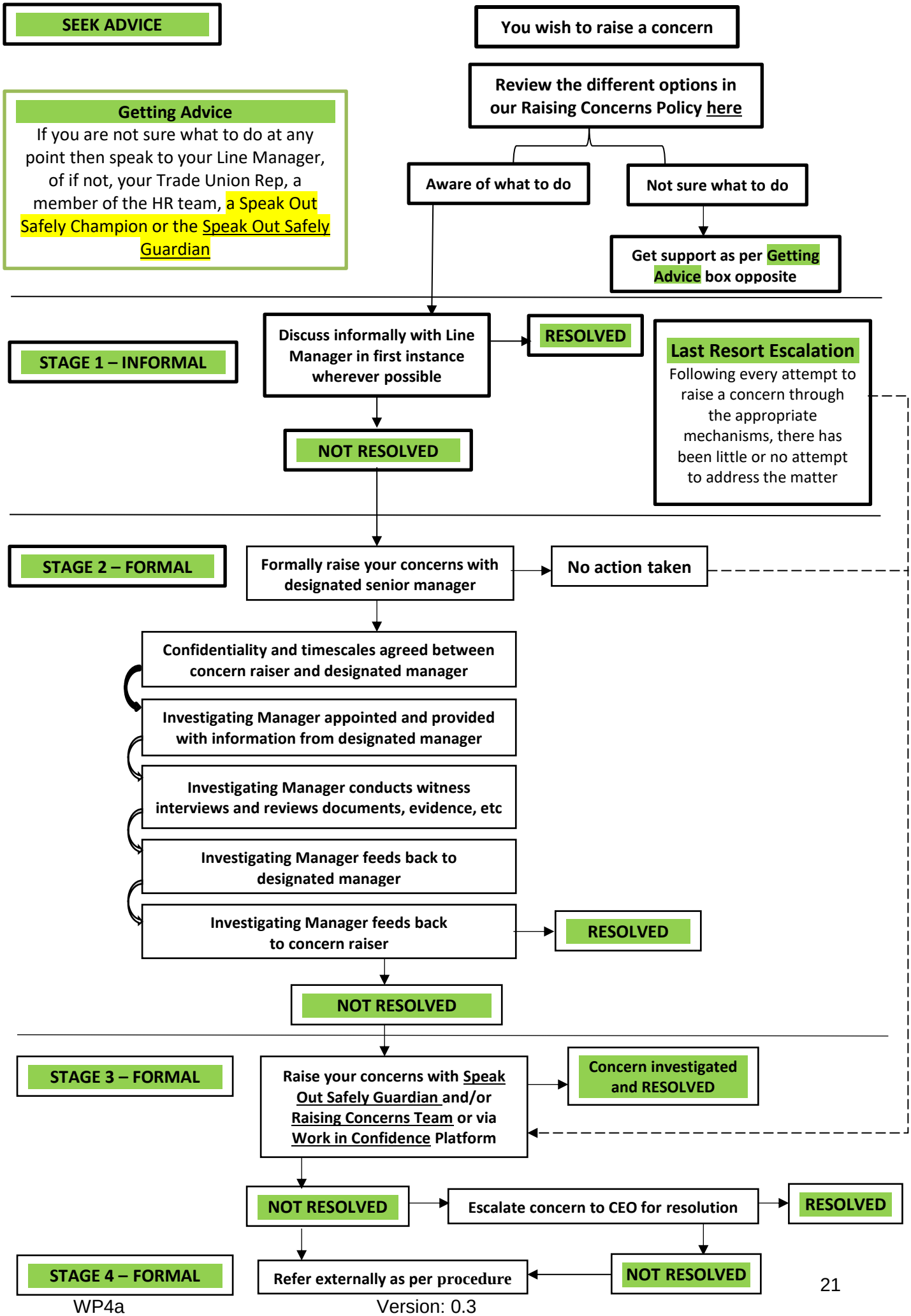
Appendix 4 - Betsi Cadwaladr University Health Board - Form WB2 Concerns Raised Under the Procedure: Summary of findings and outcome of investigation

Concern raised by (name):	
Designation:	
Informal review undertaken by:	
Investigation undertaken by:	
Summary of findings of review / investigation: (continue overleaf if necessary)	
Outcome: Action taken: (continue overleaf if necessary)	
No action taken for the following reasons:	

Further action (if appropriate): (e.g. report the matter to Welsh Government / Regulator)	
Name:	
Signed:	
Designation:	
Date:	
N.B. Once completed, this form should be retained on a case file.	

Appendix 5 – Flowchart of Raising Concerns Process

This flowchart sets out the stages in raising a concern and shows the management levels for internal disclosure. In a small organisation, there may not be more than one or two levels of management to whom you can escalate your concerns. In these cases, you should consider escalating your concern to the regulator or other prescribed person at an earlier stage than is shown on the flowchart.


SEEK ADVICE
You wish to raise a concern
Review the different options in our Raising Concerns Policy here
Getting Advice
If you are not sure what to do at any point then speak to your Line Manager, of if not, your Trade Union Rep, a member of the HR team, a Speak Out Safely Champion or the Speak Out Safely Guardian
Aware of what to do
Not sure what to do
Get support as per Getting Advice box opposite
STAGE 1 – INFORMAL
Discuss informally with Line Manager in first instance wherever possible
RESOLVED
NOT RESOLVED
Last Resort Escalation
Following every attempt to raise a concern through the appropriate mechanisms, there has been little or no attempt to address the matter
STAGE 2 – FORMAL
Formally raise your concerns with designated senior manager
No action taken
Confidentiality and timescales agreed between concern raiser and designated manager
Investigating Manager appointed and provided with information from designated manager
Investigating Manager conducts witness interviews and reviews documents, evidence, etc
Investigating Manager feeds back to designated manager
Investigating Manager feeds back to concern raiser
RESOLVED
NOT RESOLVED
STAGE 3 – FORMAL
Raise your concerns with Speak Out Safely Guardian and/or Raising Concerns Team or via Work in Confidence Platform
Concern investigated and RESOLVED
NOT RESOLVED
Escalate concern to CEO for resolution
RESOLVED
STAGE 4 – FORMAL
Refer externally as per procedure
NOT RESOLVED