

## Agenda

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**09:30 - 09:35** **1. PRELIMINARY MATTERS**  
5 min

**1.1. Welcome & Introductions**

*Dilys Jouvenat, Chair*

**1.2. Apologies for Absence**

*Dilys Jouvenat, Chair*

For Noting

**1.3. Declarations of Interest**

*Dilys Jouvenat, Chair*

For Noting

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**09:35 - 09:45** **2. CONSENT AGENDA**  
10 min

**2.1. Items for Approval**

**2.1.1. Unconfirmed Minutes of the Meeting held on 8th February 2023**

*Dilys Jouvenat, Chair*


For Approval


 2.1.1 Unconfirmed Minutes 8.2.23 PC Committee 10th May 2023.pdf (12 pages)

**2.1.2. Amendment to the Standing Orders Schedule 35 - Revised Terms of Reference**

*Assistant director of Governance & Risk*

For Approval

 2.1.2a Amendment to the Standing Orders Schedule 3.5 PC ToR's Cover Report PC Committee 10th May 2023.pdf (2 pages)

 2.1.2b Appendix 1 Schedule 3.5 - PCC ToR (revised) PC Committee 10th May 2023.pdf (10 pages)

**2.1.3. Policies**


*Karen Wright, Assistant Director of Workforce & OD*

For Approval

 2.1.3 Policy Cover Paper PC Committee 10 May 2023.pdf (5 pages)

 2.1.3a Appendix 1 Relocation Expenses Policy final.pdf (9 pages)

 2.1.3b Appendix 2 LD Policy final.pdf (13 pages)

 2.1.3c Appendix 3 Staff Bank Policy Final.pdf (20 pages)

 2.1.3d Appendix 4 Death In Service final.pdf (17 pages)

 2.1.3e Appendix 5 Honorary Contract Procedure Final.pdf (13 pages)

## 2.2. Items for Noting

### 2.2.1. Community Nursing National Specification for Wales

*Greg Padmore-Dix, Director of Nursing & Midwifery*

For Noting

- 📄 2.2.1 Letter from CNO and Alex Slade - National Community Nursing Specification PCC 10 May 2023.pdf (2 pages)
- 📄 2.2.1a Letter from CNO and Alex Slade - National Community Nursing Specification (Appendix 2 \_National Community Nursing Specification v1 Jan 23).pdf (30 pages)
- 📄 2.2.1biNational Community Nursing Specification Appendix 1 page 1 Overview.pdf (1 pages)
- 📄 National Community Nursing Specification Appendix 1 page 2 Self Assessment.pdf (4 pages)

### 2.2.2. Action Log

*Dilys Jouvenat, Chair*

- 📄 2.2.2 Action Log PC Committee 10 May 2023.pdf (3 pages)

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## 09:45 - 09:45 3. MAIN AGENDA

0 min

### 3.1. Matters Arising Not Otherwise Contained on the Action Log

*Dilys Jouvenat, Chair*

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## 09:45 - 12:25 4. INSPIRING PEOPLE

160 min

### 4.1. Overview and Ambitions for the Strategic Equality Plan (2 Hours) - This will be presented on the day

*Michelle Hurley-Tyers*

To Endorse

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## 12:25 - 12:30 5. OTHER MATTERS

5 min

### 5.1. Committee Highlight Report to Board

*Dilys Jouvenat, Chair*

### 5.2. Forward Work Plan

*Dilys Jouvenat, Chair*

- 📄 5.2 Forward Plan PC Committee 10 May 2023.pdf (4 pages)

### 5.3. Any Other Urgent Business

*Dilys Jouvenat, Chair*

### 5.4. How Did We Do Today?

*Dilys Jouvenat, Chair*

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12:30 - 12:30  
0 min

## 6. CLOSE OF MEETING - DATE AND TIME OF NEXT MEETING

*Dilys Jouvenat, Chair*

9th August 2023 at 9.30 am



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Cwm Taf Morgannwg  
University Health Board

## People & Culture Committee

Held on 8 February 2023 at 09:00 am

At Ty Hwb, Royal Glamorgan Hospital Site, Llantrisant

### Present:

- Dilys Jouvenat - Independent Member (Chair)
- Mel Jehu - Independent Member
- Nicola Milligan - Independent Member
- Jayne Sadgrove - Health Board Vice Chair (Observing)

### In attendance

- Hywel Daniel - Executive Director for People
- Greg Padmore - Executive Director of Nursing & Midwifery
- Dix
- Helen Watkins - Deputy Director for People
- Michelle Hurley - Assistant Director of OD & Wellbeing
- Tyers
- Karen Wright - Assistant Director of Policy, Governance & Compliance
- Clare Wright - Strategic Lead for Wellbeing
- Natalie Price - Assistant Director, Strategic Workforce Planning
- Cally Hamblyn - Assistant Director for Governance & Risk
- Richard Hughes - Deputy Director of Nursing
- Suzanne Hardacre - Director of Midwifery
- Sara Mason - Head of People for Primary Care, Mental Health, Children and Families
- Nick Carter - Head of People Development
- Siobhan Flynn - Graduate (in-part)
- Matthew Kvedaras - Graduate (in-part)
- Shannon Wills - Graduate (in-part)
- Kathrine Davies - Corporate Governance Manager

### 02.23.1

### PRELIMINARY MATTERS

### 02.23.2

### Welcome & Introductions

The Chair welcomed everyone to the meeting including Nick Carter, Head of People Development and the Graduate Scheme delegates – Matthew Kvedaras, Siobhan Flynn, and Shannon Wills who were attending to provide a presentation to the Committee.

### 02.23.3

#### **Apologies for Absence**

Apologies for absence were received from Lynda Thomas, Independent Member, Dom Hurford, Executive Medical Director and Kay Chandler, Graduate Manager and OD Support.

### 02.23.4

#### **Declarations of Interest**

No declarations of interest were received.

### 02.23.5

#### **CONSENT AGENDA**

The Chair explained that to ensure a focus on business critical activity and discussions, the Health Board is continuing to use the consent agenda process. This enabled questions on any of the items under the Consent Agenda to be invited in advance of the meeting which were then put to the relevant officer lead.

The Chair asked if anyone wished to comment further on the consent agenda items or move any of the items to the main agenda for discussion. There were no such requests.

### 02.23.6

#### **ITEMS FOR APPROVAL**

##### **Minutes of the People & Culture Committee held on the 9 November 2022**

Resolution: The minutes were **RECEIVED** and **CONFIRMED** as an accurate record.

##### **Committee Annual Cycle of Business 2023-23**

Resolution: The Annual Cycle of Business was **APPROVED**.

##### **Employee Wellbeing Policy**

Resolution: The Policy was **APPROVED**.

##### **Reference Policy**

Resolution: The Policy was **APPROVED**.

#### **ITEMS FOR NOTING**

##### **Anchor Institution Steering Group Highlight Report**

Resolution: The Highlighted report was **NOTED**.

##### **Action Log**

Resolution: The Action Log was **NOTED**.

## MAIN AGENDA

### 02.23.7

#### **Graduates Scheme Presentation**

The Chair thanked N. Carter and Graduate colleagues for providing an interesting insight into the graduate scheme and for sharing their individual experiences.

M. Jehu asked the graduates to reflect on their learning in terms of decision making and leadership over the last two years. M. Kvedaras reflected that he considered that there was positive decision making with colleagues engaged and committed to making a difference. He further commented that communication is key to cascading decisions and that he sees this as an example of good leadership.

S. Wills added that from her experience she has found 121 meetings with leaders helpful in understanding the accountability around decision making and embedding the values of the Health Board.

K. Wright queried whether Welsh Language was part of the core programme or an area that they had chosen for themselves, noting that Health Education and Improvement Wales offer a beginners level in Welsh Language which might benefit future leaders. S. Wills considered that this would be of support particularly reflecting upon when she had been in medicine where Welsh had been spoken.

H. Daniel thanked the Graduates for presenting and reflecting on their placements at the Committee. He added that it had been very encouraging to listen to the feedback around leadership and that this now evokes a question on how to provide opportunities to support and shape further leadership and culture activity.

M. Hurley-Tyers embraced the learning from the presentation and also recognised the work that K. Chandler undertakes in relation to the graduate scheme and pastoral work.

Resolution: The Presentation was **NOTED**.

## GOVERNANCE

### 02.23.8

#### **Organisational Risk Register**

C. Hamblyn presented the report, which provided the latest iteration of the Risk Register containing matters with a score of 15 or above which had been assigned to the Committee for scrutiny.

H. Daniel referred to the work they were undertaking with KPMG developing a strategy for workforce planning, along with a more structured clear articulation of mitigation and would update the Committee on the more specific speciality risks as they move through the planning cycle. It was agreed that a presentation will be received at a future Committee meeting.

C. Hamblyn advised that a workshop with Executive Leads was held in January 2023 to review the Organisational Risk Register in terms of consistency of risk scoring, robustness of narrative and review of actions being taken to mitigate risks.

J. Sadgrove referred to the risks that were consolidated with Quality & Safety Committee and advised that they were requiring an update and in particular Risk 4722 where the dates had expired. C. Hamblyn advised that she would take this action away and liaise with the relevant risk owners.

Resolution: The Committee reviewed the Risk Register and **NOTED** the report.

Action: To receive an update from mental health colleagues on Risk 4722 and to update the consolidated risks with the Quality and Safety Committee.

### 02.23.9

## INSPIRING PEOPLE

#### **Equality, Diversity & Inclusion (EDI)**

M. Hurley-Tyers presented the overarching report and the two attachments as follows:

- **Annual Equality Plan 2022-23**
- **Gender Pay Gap Report**

H. Daniel referred to the Gender Pay Gap Report and advised that they were now delving into the 'so what' and drew attention to next steps and development areas.

M. Hurley-Tyers added that the team were working with an additional dashboard to provide a more transparent approach on how data is presented and engaging with with the new Women's Network, in order to explore what those targeted areas could look like. She added that this would be discussed fully at the May meeting of the Committee when they would also be discussing ambitions for the Strategic Equality Plan along with the work of the networks.

J. Sadgrove thanked M. Hurley-Tyers for the report and commented that lots of positive work was being undertaken. She referred to the both reports and advised that there was a tendency to use single data points, particularly in relation to equality and gender pay gaps and that they should be using three data points so that they could see the progress and data from other organisations in relation to learning from comparative data. She added that they were not seeing occupational segregation which could play a significant part in obscuring the data with the nurse population predominantly female. J Sadgrove also queried how this would be addressed going forward.

J. Sadgrove further referred to the table on page 6 of the report where it had referenced the proportionate amount of staff receiving a Commitment Bonus and queried if the Consultants were the only relevant employees. She also drew attention to page 7 where it referred to quartiles and queried whether doing this by grade might provide a more robust picture.

In response, H. Daniel advised that in relation to the comparator of the data that there were two points of data in more than one report. The gender pay gap had narrowed and they were going to develop a plan that would outline what they were dealing with and this would then be brought back to the Committee highlighting the further detail.

M. Jehu referred to page 6 of the Annual Equality Report and queried what networks were being referenced in terms of promoting staff networks to encourage confidence in the workplace. M. Hurley-Tyers advised that they were their own specific networks such as Race Equality, LGBT, Women's Network and Disabled Network, all of which had terms of reference and actions plans with an Executive sponsor.

Resolution: the Committee **NOTED** the reports.

## 02.23.11

### **Overview and Ambitions for the Strategic Equality Plan**

M. Hurley-Tyers presented the report that outlined to the Committee the emerging strategic approach to Equality, Diversity and Inclusion and the activities undertaken to date to support this approach and the plan for developing a proposed SEP for 2023-27.

The Committee **noted** that the May 2023 meeting would focus on a deep dive into the Strategic Equality Plan (SEP). It was highlighted that the LGBTQ+ Action Plan for Wales had been launched that day and the team were planning to present to the Committee on the process underway for re-setting the ambitions for Equality, Diversity and Inclusion (EDI).

H. Daniel advised that following the deep dive in May they would spend the next few months re-designing the SEP and their strategic ambitions.

N. Milligan commented on the significant amount of work underway and referred to the need to ensure meaningful engagement learning from previous experiences. M. Hurley-Tyers recognised the amount of work to do in this area with a relatively small team.

In response, N. Milligan advised that they needed to put these changes into action. H. Daniel advised that they would shortly be losing their Lead for EDI who would be taking up another post, and wished her well. He added that this could present a capacity risk whilst they undergo the recruitment for this post.

M. Jehu reminded colleagues that in making these changes it was not just the responsibility of the People Directorate as everyone needs to own their part in leading and promoting this important agenda. M. Hurley-Tyers advised that they were working closely and in partnership with their nursing colleagues, however, there was room for improvement in this area.

G. Dix, agreed with the comments made by M. Jehu and advised that they could further socialise the networks.

Resolution: The Committee **SUPPORTED** the emerging strategic approach to ED&I, the activities undertaken to date to reinforce this approach, and the plan for developing and consulting on the draft SEP for 2023-27, and

**AGREED** to receive a further deep-dive to be carried out in May 2023 at the next People and Culture Committee on the revised SEP and ongoing plans for ED&I.

## 02.23.12

### **PRINCE CHARLES HOSPITAL (PCH): Progress on Cultural Transformation and Improvement work**

R. Hughes provided a presentation to the Committee on the progress with the PCH Culture Transformation and Improvement work.

N. Milligan referred to the work they had undertaken with the Emergency Department and commented that there was clearly improvements moving forward. She referred to Theatres and queried whether they would be able to recruit and retain enough staff within this area and advised that it would be good to see a review of the survey to get a general feel of how things were improving. R. Hughes advised that productivity had increased significantly and was giving the team in theatres a purpose.

R. Hughes advised that theatres were slightly more advanced however, there was still further improvement needed in the Emergency Department .

J. Sadgrove referred to the fact that the Improvement Board had now been stood down and queried whether this Committee along with the Quality & Safety Committee would receive a reflective report on lessons learned and how they would be applied across the organisation.

In response, R. Hughes advised that the Improvement Board remained active and engaged within the Care Groups, noting that it had transitioned into something different with tangible benefits in terms of quality and safety.

N. Milligan requested that the Theatres Newsletter was circulated to the Committee.

D. Jouvenat commented that it was pleasing to see the Electronic Staff Record (ESR) compliance had increased.

Resolution: The Committee **NOTED** the Presentation.

Action: To circulate the Theatres Newsletter to Members of the Committee.

## 02.23.13

### **Maternity & Neonates: Progress on Cultural Transformation and Improvement work**

S. Hardacre provided a presentation to the Committee on the culture transformation work undertaken to date.

N. Milligan commented that there were still some areas to address but they were not unique and were reflective across the Health Board. She added that she was really pleased to see the investment in the Health Care Support Workers (HCSW) and the potential for them to move into different areas and pathways. She expressed concerns on the the ability to raise a concern anonomously and how would this be effectively managed if you did not know who had raised the concern. S. Hardacre advised that this had occurred recently but they were fortunate to have C. Wright supporting the team through the wellbeing pathways.

H. Daniel advised that with regard to the mention of repeating the survey he wondered whether there was something they could do to avoid survey fatigue.

M. Jehu acknoweldged the amount of work that had been undertaken, however, he reflected on the journey in terms of visible leadership, trust and confidence within the communities and how bullying could be eradicated and queried what was being done to learn from the past and mitigate these risks in the future.

S. Hardacre, in response, advised that that there were drop in sessions and the senior managers were now based on the unit and working clinically. They were still dealing with some of the legacy issues and there was further work to do to achieve a consistent management approach.

N. Milligan advised that people were not fully aware of the roles of a manager and that they were not always visible and she suggested that perhaps the role needed to be communicated to staff. She added that from a trade union perspective, they continued to receive a number of calls from staff in relation to bullying, however, there was a noticeble reduction from what was previously being received. S. Hardacre advised that band 7 staff had a responsibility to lead by example in the clinical setting, however, there was still lots more work to do in relation to training and development.

Resolution: The Committee **NOTED** the Presentation.

#### **02.23.14 Employee Relations (ER) Update**

K. Wright presented the report providing a formal update in respect of ongoing Employment Relation cases and trends within the Health Board for the period October - December 2022.

M. Jehu commented that he was delighted to see that the numbers were decreasing and congratulated the team. He queried what was the longest time they were waiting as some of these cases could take such a long time to conclude. K. Wright advised that there were currently five lengthy cases and she would be able to provide the detail outside of the meeting.

H. Daniel suggested that further advice be sought from the Information Governance Team in order to consider presenting data where numbers fell below 5. C. Hamblyn advised that they could refer to the Information Governance Team on this matter.

J. Sadgrove endorsed the comments that M. Jehu had made and agreed that significant improvements had been made over the last couple of years. She added that it was pleasing to note that counter fraud and police cases were now integrated and that the Audit and Risk Committee received regular counter fraud reports.

Resolution: The Committee **NOTED** the report.

Action: To refer the request for the data on the five cases to the Freedom of Information Team.

#### **02.23.15 Disclosure and Barring Service (DBS) Assurance Report**

K. Wright presented the report that provided the Committee with an update on the Actions taken regarding: improvements to the compliance of DBS checks.

J. Sadgrove commented whether making this a managerial responsibility to ensure that staff had their DBS in place would help to take the pressure off the team. K. Wright advised that currently there were no consequences for staff in not responding to the team and if they did not receive a response they would escalate to the manager.

**Resolution:** The Committee:

**NOTED** the content of the report and the actions taken to date to try to improve the compliance of DBS checks among those employees who historically do not have this information on their ESR record.

**NOTED** the Health Board has robust processes in place to ensure new employees that require a DBS check have this evidence on their ESR record.

## 02.23.16

### **Strategic Workforce Planning & Retention**

N. Price presented the report that updated the Committee on the approach to the recruitment and retention work and provided a presentation on Nurse Retention.

N. Milligan referred to the age of leavers and that the younger leavers were at the same level as staff retiring. She queried why they were not retaining their skilled knowledge to support younger staff and also with regards to the lack of career progression for staff, recognising the risk of managers losing skilled staff.

J. Sadgrove agreed with N. Milligan's comments and queried whether there was a career break policy that allowed staff to leave and undertake training and then return. N. Price confirmed that they did have a policy which would benefit from increased awareness.

Resolution; the Committee **NOTED** the report and presentation and **SUPPORTED** the approach to developing a Retention Steering Group which will develop a programme of retention activities to minimise turnover.

## 02.23.17

### **Workforce Metrics Report**

N. Price presented the report which provided the Committee with the key workforce metrics for the period October - December 2022, with historic trends shown as appropriate.

N. Milligan drew attention to the return to work compliance data which was quite low. S. Mason advised that she would revisit the data outside of the meeting.

M. Jehu advised that the narrative in the cover report was helpful, however, he suggested that it would be beneficial to see outcomes and actions in future reports.

Resolution: The Committee **NOTED** the report.

Action: Data on return to work compliance to be reviewed outside of the meeting.

Action: Outcomes and actions to be included in future reports.

## **SUSTAINING OUR FUTURE**

### **02.23.18**

#### **Outcome of the Wellbeing Survey**

C. Wright provided a presentation to the Committee on the outcome of the Staff Wellbeing Survey.

D. Jouvenat referred to the financial issues and queried whether they had considered referring staff to the Citizens Advice Bureau (CAB) who provided excellent support. C. Wright advised that they were arranging for the CAB to see staff in an outreach and this was contained within their signposting information.

H. Daniel thanked C. Wright for her leadership in designing this service and advised the Committee that she had been shortlisted for a UK and Welsh award. He added that they were leading the way in this work and would be having further conversations on an Executive level with regard to further investment to continue to focus on the wellbeing of staff.

Resolution: The Committee **NOTED** the Presentation.

## **OTHER MATTERS**

### **02.23.19**

#### **Committee Highlight Report to Board**

The Chair suggested that the highlight report be developed by the Governance Team and approved by herself and H. Daniel as the Executive lead for the Committee.

### **02.23.20**

#### **Committee Forward Work Plan 2021-22**

Members were asked that if they had any suggestions to be added to the forward work plan to relay to the Governance Team within the next 10 days, so that they could be logged and put forward for discussion at the next agenda planning session.

### **02.23.21**

#### **Any Other Urgent Business**

The Chair advised the Committee that the Terms of Reference would need to be revised to amend some of the titles and

membership of the Committee. The Chair requested that this could be undertaken via Urgent Chairs Action outside of the meeting for the Committee to Endorse for Board Approval at the March 2023 Board Meeting. This was **AGREED**.

Action: Revised Terms of Reference to be circulated outside of the Committee via Urgent Chairs Action for the Committee to Endorse for Board Approval.

## **02.23.22**

### **How did we do today?**

A discussion was held to evaluate the meeting. The Committee felt that the meeting had considered their values and had run slightly over time but for good reason and that they had acted within their values and had received sufficient assurance.

M. Jehu encouraged attendees to ensure they fed back to the Committee on any concerns they may have on how the meeting is conducted.

### **DATE AND TIME OF NEXT MEETING**

The next meeting would be held on 10 May 2023 as an in-person meeting at Ty Hwb, Llantrisant



<b>AGENDA ITEM</b>
2.1.2a

**PEOPLE AND CULTURE COMMITTEE**

**AMENDMENT TO STANDING ORDERS – SCHEDULE 3.5**

<b>Date of meeting</b>	10 <sup>th</sup> May 2023
<b>FOI Status</b>	Open/Public
<b>If closed please indicate reason</b>	Not Applicable - Public Report
<b>Prepared by</b>	Kathrine Davies, Corporate Governance Manager
<b>Presented by</b>	Cally Hamblyn, Assistant Director of Governance & Risk
<b>Approving Executive Sponsor</b>	Cally Hamblyn, Assistant Director of Governance & Risk
<b>Report purpose</b>	ENDORSE FOR BOARD APPROVAL

<b>Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)</b>		
<b>Committee/Group/Individuals</b>	<b>Date</b>	<b>Outcome</b>

<b>ACRONYMS</b>	
SO	Standing Orders

**1. SITUATION/BACKGROUND**

1.1 The Cwm Taf Morgannwg University Health Board Standing Orders form the basis upon which the Health Board’s governance and accountability framework is developed and, together with the adoption of the Health Boards Standards of Behaviour Policy is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.



1.2 All Health Board members and officers must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content.

**2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)**

2.2 **Standing Orders – Schedule 3.5 People & culture Committee Terms of Reference.** The Terms of Reference are included at Appendix 1. Proposed changes are identified in **red**. The Committee is asked to endorse for Board approval.

**3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE**

3.1 If endorsed, the Standing Orders will be presented to the Board for approval at their meeting to be held on 25<sup>th</sup> May 2023.

**4. IMPACT ASSESSMENT**

<b>Quality/Safety/Patient Experience implications</b>	There are no specific quality and safety implications related to the activity outlined in this report.
<b>Related Health and Care standard(s)</b>	Governance, Leadership and Accountability
<b>Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.</b>	No (Include further detail below)
	Not required
<b>Legal implications / impact</b>	There are no specific legal implications related to the activity outlined in this report.
<b>Resource (Capital/Revenue £/Workforce) implications / Impact</b>	There is no direct impact on resources as a result of the activity outlined in this report.
<b>Link to Strategic Goals</b>	Improving Care

**5. RECOMMENDATION**

5.1 The Committee is asked to **ENDORSE** for Board Approval:

- The amendments to the Health Board’s Standing Orders as outlined in section 2 of this report.

## Schedule 3.5

### BOARD COMMITTEE ARRANGEMENTS

This Schedule forms part of, and shall have effect as if incorporated in the  
University Health Board Standing Orders

## PEOPLE & CULTURE COMMITTEE

### Terms of Reference & Operating Arrangements

*Reviewed April 2023 – Pending Approval*

**Last Reviewed: 8 February 2023**  
**Approved by Health Board: 30 March 2023**

## INTRODUCTION

The Cwm Taf Morgannwg University Health Board (CTMUHB) Standing Orders provide that “The Board may and, where directed by the Welsh Government must, appoint Committees of the Board either to undertake specific functions on the Board’s behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board’s commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees”.

In accordance with Standing Orders (and the CTMUHB scheme of delegation), the Board shall nominate a committee to be known as the **People & Culture Committee**. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set out below.

## CONSTITUTION & PURPOSE

The role of the People and Culture Committee is to advise the Board on all matters relating to staff and workforce planning of the Health Board, and enhance the environment that supports and values staff in order to engage the talent and nurture the leadership capability of individuals and teams working together to drive the desired culture throughout the health service to deliver safer better healthcare.

The Committee will also provide advice and assurance to the Board in relation to the direction and delivery of the organisational development and other related strategies to drive continuous improvement and to achieve the objectives of the Health Board’s Integrated Medium Term Plan (IMTP).

## SCOPE AND DUTIES

The Committee will, in respect of its provision of advice and assurance:

### **Culture & Values:**

- Agree and oversee a credible process for assessing, measuring and reporting on the “culture of the organisation” on a consistent basis over time.
- Oversee the coherence and comprehensiveness of the ways in which the Health Board engages with staff and with staff voices, including the staff survey, and report on the intelligence gathered, and its implications.

- Oversee the development of a person-centred open and learning culture that is caring and compassionate, which nurtures talent and inspires innovation and excellence;
- Seek assurance that there is positive progress on equality and diversity, including shaping and setting direction, monitoring progress and promoting understanding inside and outside the Health Board.
- Promote staff engagement and partnership working.
- Ensure the organisation adopts a consistent working environment which promotes staff well-being, where people feel safe and are able to raise concerns, and where bullying and harassment are visibly and effectively addressed.
- Supporting the enhancement of collaborative working relationships across the Health Board between professions and other stakeholders including representative bodies and regulators to improve culture.

### **Organisational Development & Capacity:**

- Ensure the systems, processes and plans used by the Health Board have integrity and are fit for purpose in the following areas:
  - strategic approach to growing the capacity of the workforce
  - analysis and use of sound workforce, employment and demographic intelligence
  - the planning of current and future workforce capacity
  - effective recruitment and retention
  - new models of care and roles flexible working
  - identification of urgent capacity problems and their resolution
  - continuous development of personal and professional skills
  - talent management
- Review plans for ensuring the development of leadership and management capacity, including the Health Board's approach to succession planning.
- Receive and consider people & Organisational Development strategies providing assurance to the Board that all strategic developments are informed by the Sustainable Development Principle as defined by the Well-being of Future Generations (Wales) Act 2015.

## Performance Reporting

- Seek assurances that governance (including risk management) arrangements are appropriately designed and operating effectively to ensure the provision of high quality, legal and safe workforce practices, processes and procedures.
- Scrutinise risks on the Organisational Risk Register that fall within the remit and control of the Committee.
- Advise the Board on aligning service, workforce and financial performance matters into an integrated approach in keeping with the Health Board's commitment to the Sustainable Development Principle defined by the Well-being of Future Generations (Wales) Act 2015.
- Ensure there is an effective planning and performance management cycle that meets the needs of the Board in delivering the Health Board's people and organisational development objectives.
- Scrutinise workforce and organisational development performance issues and key performance indicators and the associated plans to deliver against these requirements, achieved by establishing a succinct set of key performance and progress measures (in the form a performance dashboard) relating to the full purpose and function of the Committee, including:
  - The Health Board's strategic priorities on people
  - organisational culture
  - strategies to promote and protect staff Health & Wellbeing
  - workforce utilisation and sustainability
  - recruitment, retention and absence management strategies,
  - strategic communications
  - workforce planning
  - plans regarding staff recruitment, retention and remuneration;
  - succession planning and talent management;
  - staff appraisal and performance management.
  - Training, development and education
  - Management & leadership capacity programmes
  - **Veterans**
- Ensure the credibility of sources of evidence and data used for reporting to the Committee, in relation to the Committee's purpose and function.

- Ensure there is an effective system in place to consider and respond in a timely manner to workforce and organisational development performance audits received across the organisation and an effective system in place to monitor progress on actions resulting from such audits.
- Monitor and scrutinise relevant internal and external audit reports, management responses to action plans.
- Consider and ratify Welsh Government Workforce & Organisational Development policies, procedures and initiatives prior to implementation across the Health Board.

### **Statutory Compliance**

Ensure, on behalf of the Board, that current statutory and regulatory compliance and reporting requirements are met, including:

- Equality & Diversity Legislation
- Welsh Language Standards
- Wellbeing of Future Generations Act
- Consultation on service change
- Mandatory and Statutory Training
- **Armed Forces Covenant**

### **DELEGATED POWERS**

Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of its organisation.

The People & Culture Committee has a key role in assisting the Board to fulfil its oversight responsibilities in areas such as the Health Board's Culture, Organisational Development Strategy, its Values and Behaviours Framework to ensure it is appropriate and operating effectively.

### **AUTHORITY**

The Committee is authorised by the Board to:

- Investigate or have investigated any activity within its terms of reference. It may seek relevant information from any:

- employee (and all employees are directed to cooperate with any legitimate request made by the Committee), and
  - Any other committee, or group set up by the Board to assist in the delivery of its functions.
- obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board’s procurement, budgetary and other requirements
- approve policies relevant to the business of the Committee as delegated by the Board.

### **Sub Committees**

The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee business. At this stage, no sub-committees/task and finish groups have been established.

## **ACCESS**

The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

## **MEMBERSHIP**

### **Members:**

A minimum of **(4)** members, comprising

Chair                      Independent Member of the Board

Vice Chair                Independent Member of the Board

Members                 Two Independent Members of the Board (one of which is the Staff side representative)

### **Attendees**

- Executive Director for People (Committee Executive Lead)
- Executive Director of Nursing, Midwifery & Patient Care
- Executive Medical Director
- **Deputy Chief Operating Officer (in their absence nominated Care Group Lead)**
- Executive Director of Therapies and Health Sciences
- Director of Improvement & Innovation

- Representative from the Care Groups
- Director of Corporate Governance / Board Secretary or their Deputy
- Staff side representatives (nominated by Local Partnership Forum)

### **By Invitation:**

- Other Directors / Health Board Officers may be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that Director.
- The Committee may also co-opt additional independent external members from outside the organisation to provide specialist skills, knowledge and experience.

### **Secretariat**

The Director of Corporate Governance / Board Secretary will determine the secretarial and support arrangements for the Committee.

### **Member Appointments**

The membership of the Committee shall be determined by the Chair of the Board, taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

Members shall be appointed for a maximum of three consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

The Board shall ensure succession planning arrangements are in place.

### **Support to Committee Members**

The Director of Governance / Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to committee members on any aspect related to the conduct of their role, and
- Co-ordinate the provision of a programme of organisational development for committee members as part of the overall Health Board's Organisational Development programme developed by the Executive Director of Workforce & Organisational Development

## **COMMITTEE MEETINGS**

### **Quorum**

Page 7 of 10

GC01 – Standing Orders – Schedule 2 – Board Committee Terms of Reference – People & Culture Committee

Approved: 30.03.2023

A quorum shall be two Independent Members one of whom must be the Chair or in the absence of the Chair, the Vice Chair and the staff side representative Independent Member.

### **Frequency of Meetings**

Meetings shall be held no less than four times a year, and otherwise as the Chair of the Committee deems necessary.

The Committee will arrange meetings to fit in with key statutory requirements during the year consistent with the CTMUHB's annual plan of Board Business.

### **Withdrawal of individuals in attendance**

The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

### **Circulation of Papers**

The Director of Governance / Board Secretary will ensure that all papers are distributed at least **7** calendar days in advance of the meeting.

## **REPORTING AND ASSURANCE ARRANGEMENTS**

The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity and the submission of written highlight reports throughout the year;
- bring to the Board's specific attention any significant matters under consideration by the Committee
- ensure appropriate escalation arrangements are in place to alert the CTMUHB's Chair, Chief Executive or Chairs of other relevant committees of any urgent / critical matters that may affect the operation and / or reputation of the organisation.

The Committee shall provide a written, annual report to the Board on its work in support of the Annual Governance Statement specifically commenting on the adequacy of the assurance arrangement, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Committees self-assessment and evaluation.

The Board may also require the Committee Chair to report upon the activities at public meetings or to community partners and other stakeholders, where this is considered appropriate e.g. where the Committee's assurance role relates to a joint or shared responsibility.

The Director of Corporate Governance / Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

## **RELATIONSHIP WITH THE BOARD AND ITS COMMITTEES/GROUPS**

Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of its organisation.

The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.

The Committee, through the Committee Chair and members, shall work closely with the Board's other Committees including joint committees/Advisory Groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business; and
- sharing of information

In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

The Committee shall embed the corporate goals and priorities through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

## **APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS**

The requirements for the conduct of business as set out in the CTMUHB Standing Orders are equally applicable to the operation of the Committee, except in the area relating to the Quorum.

## **CHAIR'S ACTION ON URGENT MATTERS**

There may, occasionally, be circumstances where decisions which normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board, after first consulting with one other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

## **REVIEW**

These Terms of Reference shall be adopted by the Committee at its first meeting and subject to review at least on an annual basis thereafter, with approval ratified by the Health Board.



<b>AGENDA ITEM</b>
2.1.3

<b>PEOPLE &amp; CULTURE COMMITTEE</b>
---------------------------------------

<b>WORKFORCE AND ORGANISATIONAL DEVELOPMENT POLICIES</b>
--

<b>Date of meeting</b>	10/05/2023
<b>FOI Status</b>	Open/Public
<b>If closed please indicate reason</b>	Not Applicable - Public Report
<b>Prepared by</b>	Claire Nicholas, Head of Policy, Compliance and Agenda for Change
<b>Presented by</b>	Karen Wright, Assistant Director of Policy, Governance and Compliance
<b>Approving Executive Sponsor</b>	Executive Director for People
<b>Report purpose</b>	FOR APPROVAL

<b>Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)</b>		
<b>Committee/Group/Individuals</b>	<b>Date</b>	<b>Outcome</b>
Local Partnership Forum	21/03/2023	ENDORSED FOR APPROVAL

<b>ACRONYMS</b>	
CTMUHB	Cwm Taf Morgannwg University Health Board
L&D	Learning and Development
PPRG	People Policy Review Group



## **1. SITUATION/BACKGROUND**

**1.1** The purpose of the report is to present the People policies set out below.

## **2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)**

### **2.1 People Policy Review Group Policy**

The People Policy Review Group (PPRG) has developed the following policies, procedures and guidance in partnership. The group is accountable to the Local Partnership Forum. The PPRG is responsible for developing and reviewing policies and procedures and where appropriate, endorsing them for approval following the consultation process.

During February and March 2023, the following policies, procedures and guidance were signed off by the PPRG. They were presented to the Local Partnership Forum for their consideration on 21<sup>st</sup> March 2023, where they were endorsed for approval by the People and Culture Committee:

### **2.2 Relocation Expenses Policy**

The policy sets out the available provisions for financial assistance, which may be available to newly appointed or existing employees who incur removal expenses, due to their recruitment, promotion or transfer at the request of the Health Board, because of organisational change.

A review of the policy has been undertaken and now includes provisions for appointees moving from abroad, to take up a post. The previous policy did not include this provision, which made the Health Board less attractive and competitive in the NHS Wales recruitment market.

The new policy also streamlines the approval for payment process, which will pass from the Senior Medical Workforce Manager / Assistant Director of Policy, Governance and Compliance to the appropriate Care Group Director of Operations / Corporate Director.

The payment of relocation expenses will also be processed and paid in a much more efficient way, using e-Expenses. (Attached as 2.1.3a Appendix 1).

## **2.3 Learning and Development Policy**

The policy sets out the organisation's Learning & Development (L&D) approach, providing guidance to both staff and line managers relating to the accessibility of learning opportunities and attendance requirements relevant to learning.

Previously referred to as the 'Study Leave', this new and revised policy is more holistic and references a broader range of L&D matters, including core learning, attendance, study leave and funding arrangements, including the recovery of fees in certain circumstances. (Attached as 2.1.3b Appendix 2).

## **2.4 Staff Bank and Agency Worker Policy**

The revised Staff Bank and Agency Worker Policy replaces the current Staff Bank Policy for Nursing Staff. The revised policy covers all staff groups (with the exception of medical and dental staff), who are registered or wish to join the Health Board's Staff Bank. It also sets out the process, which managers must adhere to should they need to utilise a casual workforce, to support the delivery of their services.

The aim of the policy is to ensure all bank and agency workers receive and maintain appropriate induction, mandatory and statutory training and orientation to areas and departments, to enable them to work safely and within their scope of practice. It will also help to manage all bank and agency workers in a transparent, consistent and fair manner, in line with their Terms of Engagement, Manager's Staff Bank Guidance, Bank Register Principals and the ACAS Code of Practice.

The policy also outlines the responsibilities of Ward and Departmental Managers in the engagement of bank and agency workers. (Attached as 2.1.3c Appendix 3).

## **2.5 Death in Service Guidelines for Managers and Staff**

The Death in Service Guidelines for Managers and Staff supports managers in taking the appropriate actions due to the sad event of the death of a colleague. The guidelines assist the manager in making sure the situation is dealt with compassionately and effectively, to prevent any additional distress for the colleague's bereaved family, work colleagues and friends.

The guidelines outline the process to be followed to ensure the pay and death in service benefit arrangements (if applicable) are managed in a sensitive and timely manner.

The guidelines also outline the wellbeing services available to support managers and employees to deal with the loss of a colleague / friend. (Attached as 2.1.3d Appendix 4).

## 2.6 Honorary Contracts Procedure

This is a new procedure, the purpose of which is to ensure the correct process is followed when a manager is required to issue an honorary contract to an individual.

The procedure defines the lines of responsibility and accountability for individuals who work in CTMUHB, but who are not employees of the Health Board.

The procedure ensures that individuals are engaged through a fair, open and transparent procedure that satisfies legal and NHS Wales Employer requirements. (Attached as 2.1.3e Appendix 5).

## 3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

- 3.1** The above policies and procedures meet all legal and contractual obligations and reflect best practice. The above policies have been developed in partnership with trade union colleagues.

## 4. IMPACT ASSESSMENT

<b>Quality/Safety/Patient Experience implications</b>	There are no specific quality and safety implications related to the activity outlined in this report.
<b>Related Health and Care standard(s)</b>	Staff and Resources If more than one Healthcare Standard applies please list below:
<b>Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.</b>	Yes



	Available from Claire Nicholas, Head of Policy Compliance and A4C
<b>Legal implications / impact</b>	Yes (Include further detail below)
	There could be legal implications if the policies are not adhered to, as identified, if applicable, within the relevant policies.
<b>Resource (Capital/Revenue £/Workforce) implications / Impact</b>	There is no direct impact on resources as a result of the activity outlined in this report.
<b>Link to Strategic Goals</b>	Sustaining our Future

## 5. RECOMMENDATION

- 5.1** The People and Culture Committee is asked to **APPROVE** the Policies and Procedures for implementation across the Health Board.

## Relocation Expenses Policy

<b>Document Type:</b>	Non Clinical Organisational Wide Policy
<b>Reference:</b>	People41
<b>Author:</b>	People Policy Review Group
<b>Executive Sponsor:</b>	Executive Director for People
<b>Approved By:</b>	
<b>Approval / Effective Date:</b>	(00/00/0000)
<b>Review Date:</b>	(00/00/0000)
<b>Version:</b>	2

### Target Audience:

<b>People who need to know about this document in detail</b>	Care Group Service, Clinical Service Group Managers
<b>People who need to have a broad understanding of this document</b>	Senior Managers
<b>People who need to know that this document exists</b>	Employment Candidates, Employees of Cwm Taf Morgannwg University Health Board and its hosted organisations.

### Integrated Impact Assessment:

<b>Equality Impact Assessment Date &amp; Outcome</b>	21/02/2023 This policy has been screened for relevance to Equality. No potential negative impact has been identified.
<b>Welsh Language Standard</b>	Yes - If Standard 82 applies you must ensure a Welsh version of this policy is maintained.
<b>Date of approval by Equality Team:</b>	Awaiting sign off
<b>Aligns to the following Wellbeing of Future Generation Act Objective</b>	Co-create with staff and partners a learning and growing culture



**Disclaimer:**

If the review date of this Policy has passed, please ensure that the version you are using is the most up to date version either by contacting the author or email [CTM\\_Corporate\\_Governance@wales.nhs.uk](mailto:CTM_Corporate_Governance@wales.nhs.uk)

**CONTENTS PAGE**

<b>Section Number</b>	<b>Sub Heading</b>	<b>Page Number</b>
1	Policy Statement	3
2	Scope of Policy	3
3	Aims and Objectives	3
4	Responsibilities	3
5	Criteria and Compliance	4
6	Relocation Costs eligible for reimbursement	6
7	Claiming Expenses	7
8	Repayment of Expenses	7
9	Right of Review/Appeal	8
10	Equality Impact Assessment Statement	8
11	References	8
12	Getting Help	8
13	Related Policies	8
14	Information, Instruction and Training	9
15	Main Relevant Legislation	9

## **1. POLICY STATEMENT**

This policy ensures where an individual may need to relocate to take up their employment, financial assistance may be provided, at the discretion of the Health Board.

This policy sets out the scope and level of financial assistance, which may be offered towards relocation expenses, the eligibility criteria and the process to be followed for claiming reimbursement.

## **2. SCOPE OF POLICY**

This policy sets out the available provision for financial assistance, which may be available to newly appointed or existing employees who incur removal expenses, as a consequence of recruitment, promotion or transfer at the request of the Health Board, as a result of organisational change.

It shall apply to all Health Board staff groups, who meet the eligibility criteria, with the exception of:

- Medical and dental staff in training i.e. those who are now employed by NWSSP as the Single Lead Employer (SLE) and are covered by a separate policy, issued by the Postgraduate Dean, where relocation expenses are paid to them by the SLE;
- Medical and nursing staff recruited in collaboration with a recruitment agency, where the Health Board has agreed a specific relocation package, prior to the implementation of this relocation policy. Although a different package applies to these staff, claims can still be made using e- Expenses as described in section 7 below; and
- When the Health Board takes part in an all Wales recruitment campaign, such as that for medical staff, in association with the British Association of Physicians of Indian Origin (BAPIO) and a single relocation package is agreed outside of the Health Board's relocation policy, claims can still be made using e-Expenses as described in section 7 below.

## **3. AIMS AND OBJECTIVES**

To achieve excellence in the provision of services to the population of Cwm Taf Morgannwg, the Health Board aims to attract employees of the highest calibre. To attract employees from across the United Kingdom and internationally, it will, as appropriate offer and provide a relocation package, in accordance with the provisions set out in this policy.

## **4. RESPONSIBILITIES**

The newly appointed employee is required to apply for a relocation package immediately upon receipt of their unconditional offer of employment.

The determination of eligibility for relocation expenses shall be the decision of the appointing manager line manager, who will make this decision on the basis of the criteria laid out in this policy. Managers do not have the discretion to decline relocation expenses to anyone deemed eligible.

This policy should be read by the employee, in conjunction with HM Revenue and Customs (HMRC) regulations (see link [HMRC Expenses and Benefits Relocation](#)). It is the responsibility of the employee to seek advice from HMRC if they are unsure of the tax liabilities of their relocation package.

Eligible employees must have incurred the expenses related to their relocation for which they make a claim. All financial expenses relating to the employee's move are their responsibility. Therefore, they must ensure they have sufficient funds to meet those expenses, as the Health Board will only reimburse eligible expenses incurred, subject to production of original receipts, accompanied by the three quotes where applicable. The Health Board will not process or reimburse claims without an original receipt nor will they pay a supplier directly, as this is the responsibility of the employee.

The newly appointed employees must declare in the relocation application form, the expenses they may incur as a result of their relocation, which are not recoverable in full or part from another sources e.g. through a partner's employer either within the NHS or another employer. Should the appointee's partner be in receipt of a separate relocation package, the Health Board will reduce the amount of the agreed relocation maximum limit, to take account of this. Employees should be aware that claiming twice for a relocation package will be considered fraud and the matter will be referred to the NHS Counter Fraud Service. The Health Board may also invoke disciplinary action against the employee.

The employee must obtain a minimum of three quotes for any removal expenses claimed, as the Health Board will only reimburse the cheapest quote.

The employee must make and submit all eligible claims related to their relocation within three months of incurring the expenditure. The Health Board will ensure these are paid within one calendar month of receipt.

Employees with enquiries regarding their relocation package claim(s) must direct these to the line manager in the first instance and then the Expenses Team ([nwssp.expenses@wales.nhs.uk](mailto:nwssp.expenses@wales.nhs.uk)) once the claim has been signed off.

Guidance on the interpretation of the policy should be addressed to the appropriate Head of People or Deputy Head of People, or the Senior Medical People Manager.

## **5. CRITERIA AND COMPLIANCE**

### **5.1 Overview**

Relocation expenses will be approved by the line manager followed by agreement by the appropriate Care Group Service Director / Corporate Director .

The upper limit for claims under this policy will be £8,000 or 20% of gross basic salary, whichever amount is lowest.

Prospective and appointed employees must confirm eligibility for reimbursement of any relocation expenses before incurring expenditure for which a claim may be made under this policy.

## 5.2 Criteria

A relocation package cannot be agreed with an employee taking up a temporary contract of a duration of less than one year. Where a temporary contract is for a period between one and two years, a limited relocation package may be offered as outlined in Section 8 below. Temporary contracts in excess of two years will be treated in the same way as substantive posts.

In the case of locum Medical and Dental Staff, they are entitled to claim travelling expenses, in line with Paragraph 289 of the Medical and Dental Staff Handbook.

Where an employee is required to be readily available for work e.g. work on an on-call rota, their entitlement to a relocation package will be subject to them moving to a permanent home (rented or purchased) within a reasonable (as agreed with Clinical Director / Head of Service) travelling distance of their new work base.

Relocation expenses are offered to an employee regardless of whether they choose to rent or purchase a property. Employees who choose to rent may however be liable to pay tax on the agreed relocation amount. Relocation expenses will be reimbursed on a property only once.

The employee will be required to pay any tax liabilities, which may arise from receiving relocation expenses.

Should the Health Board be subject to service reconfiguration, and an existing employee's base is changed, relocation may be appropriate in line with the

[Organisational Change Policy](#) and the principles within this policy.

In exceptional circumstances, where a fixed term contract is approved for a duration of longer than 12 months, the Care Group Service Director / Corporate Director has discretion to approve relocation expenses, without the requirement for repayment.

Relocation expenses claims must be submitted within 12 months of the employee's commencement date with the Health Board. Any requests to vary this duration must be submitted by the employee in writing, to their Care Group Service Director / Corporate Director.

All claims must be submitted as they are incurred, but no later than three months after the relocation has been completed.

Relocation expenses will not be paid if the employee already owns or rents a property within fifty miles of the employee's Health Board base.

All claims must be accompanied by original receipts.

All expense claims must be processed via the e-expenses system (see [E-Expenses Guide](#)).

All expenses claimed must reflect the actual expenses incurred in relation to the employee's relocation.

Relocation expenses cannot be paid where an employee has no intention of selling their existing owned property to buy a similar property to be within commuting distance of their Health Board workplace.

In circumstances where an employee is moving from rented accommodation to purchased accommodation, the employee will only be entitled to receive the costs of relocation of furniture and effects from the rented property to the purchased property.

Any misleading or false statements or claims could result in referral to the Counter Fraud Team and invoke the Disciplinary Policy.

Relocation expenses will be reimbursed on the property only once. If a spouse or partner is also relocating to this area and is receiving a relocation package from their employer, the expenses that will be paid by the Health Board will be reduced to take account of this. Employees are required to sign declaration to this effect.

## 6. RELOCATION COSTS ELIGIBLE FOR REIMBURSEMENT

HMRC rules state:

*"If your employer helps to you to move home because of your job, any payments you receive, or any goods and services provided to you, are treated as part of your earnings for tax and National Insurance (NI) purposes. However, the first £8,000 of any help you get from your employer is exempt from tax and NI as long as certain conditions are met. Excess travel, which is paid at the public transport rate will be subject to tax."*

The Payroll Department determines which expenses are taxable and which are not in accordance with HMRC rules.

### 6.1 Allowable expenses

- Legal and associated fees (such as estate agents fees, land registration, survey costs and stamp duty) on sale and purchase of a property;
- House contents removal costs;
- Storage of furniture costs;
- Travel expenses related to relocation, including from outside the United Kingdom;
- Continuing commitments allowance – see below; and
- Immigration related expenses, i.e. visa fees and health surcharge.

All of the above expenses will be reimbursed within the maximum limit of the policy / agreed relocation package amount.

Where an employee is moving **from rented accommodation to purchased accommodation** they will only be entitled to claim the costs of moving furniture and effects from the rented property to the purchased property. The employee cannot claim any other relocation expenses associated with the purchase of the property.

### 6.2 Continuing commitments allowance

This allowance is payable when an employee has moved to the new area before having sold their property in their old area. The total amount of commitment for each property will be calculated and the lower amount will be reimbursed.

Where the Health Board agrees with the employee that they **may occupy rented accommodation**, as either a temporary or longer-term **alternative to moving from owner occupied property**, the relocation package may be used to meet the costs of such accommodation for a maximum period of twelve months. This agreement will be subject to this expenditure being part of the overall £8,000 / or agreed relocation package limit.

In exceptional circumstances with the approval of the Executive Director / Deputy Director for People, the above period of time may be extended, depending on the employee's individual circumstances.

When renting accommodation, the relocation package may be used for the following:

- Monthly rent;
- Mileage from rented accommodation to home on weekly basis, up to a maximum of 1 year.; and
- Cost of removal of furniture and effects.

### 6.3 Non-allowable expenses

Relocation schemes of commercial relocation companies; Bridging loan finance; items of a capital nature e.g. building work or improvements to the property nor will it reimburse repairs to, or replacement of, fixtures or fittings or garden items including fences, sheds and walls; Council Tax; Advance of salary; Professional body fees, e.g. GMC, GDC, NMC fees and memberships, e.g. Royal Medical Colleges as these are incurred by staff not relocating home to work in CTM; expenses of any kind relating to family members, even dependents.

## 7. CLAIMING EXPENSES

Applications must be submitted to the expense department via the link below [Application for Relocation Expenses \(Excluding Training Grade Doctors\)](https://forms.office.com/Pages/ResponsePage.aspx?id=uChWuyjjgkCoVkM8ntyPrjIXYRhKFypFtPSxgNT3cPRUREJBREhSMUZZSUowODdHSDFDWE0xTzRBSS4u)  
<https://forms.office.com/Pages/ResponsePage.aspx?id=uChWuyjjgkCoVkM8ntyPrjIXYRhKFypFtPSxgNT3cPRUREJBREhSMUZZSUowODdHSDFDWE0xTzRBSS4u>

**Please note all submissions must be from the approving manager and not the employee.**

Once the employee's account has been enabled with the relevant permissions, the employee will be sent an email advising them how to claim their expenses.

## 8. REPAYMENT OF EXPENSES OCCURRED

In the event an employee leaves the employment of the Health Board within two years of the date of taking up their posts, a proportion of the total expenses claimed and reimbursed will be repayable to the Health Board. Repayment will be based on the percentage set out in the table below:

<b>Period of Service (from date of appointment)</b>	<b>Amount to be Repaid (as a percentage of the total expenses claimed and reimbursed)</b>
0 – 6 months	100%
6 – 12 months	75%
12 – 24 months	50%

Should an employee leave the employment of the Health Board, within the above timescales, the Organisation will seek to deduct, in full, the repayment from the employee's final salary.

The Health Board will reclaim expenses paid to an employee who decides not to proceed with a relocation. The manager should discuss the matter with the Executive Director / Deputy Director for People, who will make the final decision on the amount of money to be repaid, based on the circumstances, on a case by case basis.

The Health Board reserves the right to reclaim relocation expense reimbursed to an employee, should they not relocate within two years of their appointment date.

Repayment as set out above will be enforced in all cases, unless there are exceptional circumstances and agreed by the Executive Director / Deputy Director for People.

It is the responsibility of the line manager to notify the e-expense department of any overpayments to be recovered.

## **9. RIGHT OF REVIEW / APPEAL**

Should an employee believe they have been treated unfairly, in respect of their relocation application or approved financial package, they may submit a request to have their concerns reviewed, in accordance with the [Appeals Procedure when not detailed in the HR Policy](#).

## **10. EQUALITY IMPACT ASSESSMENT STATEMENT**

This policy has been screened for relevance to Equality. No potential negative impact has been identified.

## **11. REFERENCES**

This policy mirrors the HMRC rules and guidance in respect of relocation expenses and benefits.

## **12. GETTING HELP**

The People Services Team will assist with the interpretation of this policy and resolution of problems and other special situations.

## **13. RELATED POLICIES**

The following policies are relevant:

- All Wales Disciplinary Policy;
- All Wales Organisational Change Policy;

- Appeals Procedure when not detailed in the People Policy; and
- Recruitment and Selection Policy.

#### **14. INFORMATION, INSTRUCTION AND TRAINING**

The People Services Team will provide managers with coaching, to support them to fairly and consistently implement this policy.

#### **15. MAIN RELEVANT LEGISLATION**

This policy should be read in conjunction with the HM Revenue and Customs (HMRC) regulations.

It is the responsibility of the new employee to seek HMRC advice if they are unsure of the tax liabilities in respect of their relocation package.

## LEARNING & DEVELOPMENT POLICY

<b>Document Type:</b>	Learning & Development Policy
<b>Reference:</b>	People67
<b>Author:</b>	Nick Carter, Head of People Development
<b>Executive Sponsor:</b>	Executive Director of People
<b>Approved By:</b>	
<b>Approval / Effective Date:</b>	(00/00/00)
<b>Review Date:</b>	(00/00/00)
<b>Version:</b>	1.0

### Target Audience:

<b>People who need to know about this document in detail</b>	Author/Owners of this procedure.
<b>People who need to have a broad understanding of this document</b>	Board Members, Management Board, Senior Leaders, Board Committees.
<b>People who need to know that this document exists</b>	Employees, Bank Staff and Agency Workers of Cwm Taf Morgannwg University Health Board and its hosted organisations.

### Integrated Impact Assessment:

<b>Equality Impact Assessment Date &amp; Outcome</b>	25/08/2022 No Concerns Raised
<b>Welsh Language Standard</b>	Yes - If Standard 82 applies you must ensure a Welsh version of this policy is maintained.
<b>Date of approval by Equality Team:</b>	25/08/2022
<b>Aligns to the following Wellbeing of Future Generation Act Objective</b>	Co-create with staff and partners a learning and growing culture



### Disclaimer:

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## **CONTENTS PAGE**

<b>Section Number</b>	<b>Sub Heading</b>	<b>Page Number</b>
1	Policy Statement	3
2	Scope of Policy	3
3	Aims and Objectives	3
4	Responsibilities	4
5	Implementation/Policy Compliance	4
6	Funding and costs of training	9
7	Equality Impact Assessment	11
8	Getting Help	11
9	Appendix A – Application for Supported Learning and Development	12

## 1. POLICY STATEMENT

Cwm Taf Morgannwg University Health Board (hereafter "the Health Board") is committed to the continuing investment in education, training and development of all staff to create a culture of learning that enhances our work environment, professional competence, and quality of our services.

## 2. SCOPE OF POLICY

This policy and procedure applies to all staff groups employed by CTM UHB, this includes part time, full time staff and those on fixed term contracts. However, excludes Medical and, Dental staff and Executive Directors.

## 3. AIMS AND OBJECTIVES

To provide clear advice, support and guidance to managers and staff regarding their role(s) in managing learning & development activity and the subsequent management of processes related to study leave and reclaiming of course fees (as applicable) should these staff leave the Health Board.

### Principles

The policy is based on the following guiding principles, which should be taken into consideration when facilitating learning and development activity.

1. We are all supported in our learning and development, balancing individual needs with the requirements of the Health Board.
2. Learning is at the very heart of our development and in the true spirit of our values, we listen, learn and improve.
2. We are all responsible for our own career, recognising our managers have an important role to play in supporting and developing their staff and team members.
3. Some technical / specialist roles may require specific Continuing Professional Development (CPD) to maintain a licence to practice. It is the responsibility of these staff members to ensure they achieve the required level.
4. There is a formal process for requesting time off for training, which should be followed.
5. The Core Learning requirements of all staff should be reviewed on a regular basis, typically when they commence working in a new role, or when their responsibilities change.

## **4. RESPONSIBILITIES**

### **4.1 The Learner**

You are in control of your learning. It is your personal responsibility to ensure you take the opportunities available, to progress your own development.

You will ensure you are engaged in your learning, applying our values of respect at all times when working with our trainers and external learning partners.

You will ensure that you are compliant and up to date with all Core Learning, prior to applying for courses or external qualifications. You will actively engage in learning and development discussions, noting your achievements and progress within Your Conversation (PDR) and maintain and update ESR with your learning activities.

Upholding our values where we listen, learn and improve, you will provide opportunities to bring any learning back into the workplace and share good practice.

### **4.2 The Manager**

You will ensure that all staff have equal access to all learning and development opportunities. Through Your Conversation (PDR) you will regularly review staff member's learning and development requirements. During your discussions you can agree the undertaking of internal/external courses and qualifications acknowledging that they should be up to date with their Core Learning. However, it is recognised that this may not be the case for many reasons and should not prevent staff from undertaking further learning and development. You are required to ensure you're your staff make all reasonable attempts to complete core training and you discuss and offer them with support to address this.

You will ensure all new staff complete their Corporate Welcome Induction within their first week of employment. This will be followed by their local induction (reception) on the first day of employment. You will also regularly access ESR to review your team member's training requirements to ensure they are correct and applicable to the role.

## **5. IMPLEMENTATION/POLICY COMPLIANCE.**

### **5.1 What is Learning and Development?**

Learning and development activities include:

- Structured training/learning, including E-Learning and face-to-face training provided either internally or externally.
- Core learning (statutory and mandatory training).
- Vocational qualifications such as Apprenticeships and National Vocational Qualifications.
- Internal development opportunities such as Leadership and Management Programmes.
- Tools and processes to engage employees in their personal and professional development (e.g. Your Conversation (PDR)).
- Social learning, such as coaching, mentoring, experiential opportunities and shadowing.
- Self-directed learning / development such as observation, reading time and study for examinations/assessments.
- Academic courses.
- Attendance of relevant conferences, seminars and webinars.
- **Learning and Development at Cwm Taf Morgannwg University Health Board**

Learning and development can take many forms and is not achieved just by completing a training course. Research shows for adults the most effective learning, (around 70%), is obtained on-the-job through job related experience, 20% through interactions with others providing learning opportunities and 10% via formal learning opportunities, such as classroom and online learning.

Examples of the different types of learning and development are shown below and managers and their staff should discuss these opportunities on a regular basis. Training needs can be identified at any time, but a useful time to discuss staff need is during the Your Conversation (PDR) discussion.

- **70%: On-the-job**

Learning and development on the job can be the most beneficial because it enables individuals to discover and refine their job-related skills, make better more informed decisions, address challenges and interact with influential people, such as managers and mentors within the work setting. We can also learn from each other's mistakes and receive immediate feedback on our performance. Examples include:

- On-job development, including exposure to particularly challenging situations;
- Project work;
- Work shadowing;
- Secondments.

- **20%: Informal Learning**

Informal training takes place when we learn from others through a variety of activities, which include social learning, coaching, mentoring, collaborative learning and other methods of interaction with peers. Encouragement and feedback are prime benefits of this valuable learning approach. Examples include:

- Receiving regular feedback from managers / peers;
- Coaching and mentoring;
- Networking;
- Personal learning, including reading and research.

- **10%: Formal Learning**

The health board has a broad range of formal training courses offered under a series of subject areas including:

Leadership and Management / interpersonal skills courses; further education courses; and professional development events. We have a dedicated [Learning and Development Opportunities](#) brochure where you can find the most up to date professional learning opportunities available within the health board. You may also consider exploring what learning may be available within your own professional area, department or service.

- **Your Conversation (Personal Development Review PDR)**

All employees should have an annual Your Conversation (PDR). For information that is specific to the Your Conversation process refer to the [Your Conversation Reviewers Guidance](#).

- **Core Learning**

This is learning activity, which the health board is required by statute to provide, or which it deems essential to ensure patient and employee safety. For all [Core Learning activities](#), study time must be allocated to employees to allow them to practice safely within the health board and their role.

Learning and development work with relevant subject matter experts to identify the Core Learning requirements and upload them to ESR.

It is the responsibility of the employee to check what core learning training they have to undertake for their role and to complete the training within the required timescales. The manager is also able to provide this information (if it has not been given). It is the responsibility of the manager to ensure that employees are allocated appropriate time to complete training and to ensure they have completed it.

The core learning training requirements of all employees should be reviewed on a regular basis, typically when they commence working in a new role, or when their responsibilities change.

- **Core Learning Appeals**

If an employee's training requirements are not appropriate or they determine them to be incorrect, they should discuss them with the manager, who, if necessary, can complete an appeal on their behalf. When doing so, they need to consider all employees that are covered by the ESR position.

The appeal process is available via the following [Link](#).

- **Mandating Core Learning**

The health board's approach is to avoid mandating training, unless there is sufficient evidence to show mandating the required training will have an essential clinical or organisational benefit. Where mandating training is proven to have sufficient impact and value, the following actions should be taken:

- Sponsors (those who wish to mandate the training) will be required to nominate a dedicated person or persons who will act as the Subject Matter Expert (SME).
- The SME will need to demonstrate that the training will be promoted in such a way to ensure employees who are required to complete the training do so within 60 days of the training being available.
- SME's will be required to provide regular updates on learning performance and where compliance is below 85%, provide remedial action plans to improve engagement and increase compliance performance.
- SME's will be required to engage in Core Learning Steering Groups and ensure any training coordination is administered effectively.
- L&D will support all SME's to provide relevant training and managing positions to ensure training requirements are updated regularly.

- **Time Off for Learning**

You are in control of your learning. It is your personal responsibility to understand what you are committing to prior to commencing the learning, ensuring you have sufficient time and capacity to complete all elements of the learning programme.

- **Annual Leave**

If the employee has been required to attend mandatory training during a period of pre-booked annual leave, the annual leave may be cancelled (if mutually agreed) to attend. The annual leave can then be taken at another time.

- **Study Leave**

Type of Study Leave	Examples	Funding
<p>1. Training that is mandated by the Health Board.</p> <p>2. Training that is essential to the performance of the job / role.</p> <p>3. Training essential by statute.</p> <p>4. Training where there is significant benefit to the Health Board and the individual staff member.</p> <p>5. Training where staff are requested by the Health Board to attend.</p>	<ul style="list-style-type: none"> <li>• Fire Safety</li> <li>• Health, Safety &amp; Welfare</li> <li>• Violence &amp; Aggression</li> <li>• Welsh Language</li> </ul>	<p>100% travelling expenses, fees, accommodation, time to attend</p>
<p>Study that is of mutual benefit to both the individual staff member and the Health Board and forms part of their PDR personal development plan.</p>	<ul style="list-style-type: none"> <li>• Attainment of a qualification, which is relevant to their post but not essential</li> </ul> <p>*Not applicable to staff employed on a fixed term contract, as it cannot be guaranteed they will be able to remain in the employment of the Health Board for a continuous period of 2 years following the completion or end of their course.</p>	<p>Up to 80% travelling expenses, fees, accommodation, time to attend, by agreement with the line manager.</p>
<p>Study that is more beneficial to the staff member, but of little relevance to their role or the Health Board.</p>	<ul style="list-style-type: none"> <li>• Attending a course of professional interest but not directly relevant to their role.</li> </ul>	<p>No contribution towards travelling expenses, fees, accommodation. Time to attend would be at discretion of manager.</p>

- **Cancellation and Non-attendance**

As a university health board, we make every effort to provide our employees with learning and development opportunities. All parties should work together as one team to ensure that cancellations and non-attendance are minimalised.

Every effort should be made to attend scheduled learning and development/training activities; however, it is understood that employees may not be able to attend scheduled training due to unforeseen circumstances.

Examples of reasonable justification for cancellation or non-attendance at planned learning and development / training may be sickness absence, emergency / special leave circumstances or bereavement.

It is the responsibility of the employee to cancel any scheduled learning and development / training at the earliest opportunity and re-book as appropriate. For in-house learning and development / training booked through ESR the employee **must** cancel their place using [this guide](#). If the learning and development / training is not hosted on ESR the employee must make every effort to contact the training provider directly via email or telephone.

If the employee cannot cancel the scheduled learning and development / training through ESR or by contacting the training provider, they must inform their line manager who will assume responsibility for undertaking these actions on their behalf.

If it is found that the employee has not attended any learning and development / training and has failed to inform the training provider, the line manager must ensure appropriate action is taken. Line managers can seek support from the People Services Team for further advice.

Non-attendance of learning and development / training, which is not for reasonable circumstances may result in the department budget being deducted for any financial loss incurred. These fees will be subject to the training provider and /or Head of Learning & Development discretion and claimed back up to the value of the cost of the learning and development / training offered.

## **6. Funding & Costs of Training**

### **6.1 Funding Arrangements**

Where courses are not being self-funded or other funding cannot be arranged to cover the full cost of the course, employees may request for the relevant department to fund the full or partial cost of the course.

There is no central budget for learning and development activity and the payment of course fees. Managers should consider the principles of access to learning for all, relevance of the course in meeting the health board's objectives and ensure that staff are treated equitably in any allocation of funding.

### **6.2 External Funding**

All efforts will be made by the Learning & Development Team to explore opportunities to draw on external funding to assist employees in funding learning opportunities.

When accessing external funding, the health board is subject to stringent criteria and employees will need to evidence they meet this criteria prior to commencing their learning. Employees should seek the advice of the L&D Team in the first instance, to check whether funding is available for their chosen course.

### **6.3 Self-Funding**

Where an employee is self-funding an education programme, approval does not need to go through the L&D Team. Any applicable study leave would need to be negotiated at a local level with their manager.

### **6.4 Examination Fees**

Unless otherwise stated or agreed, it is the responsibility of the employee to cover examination fees.

### **6.5 Welsh Language**

The health board encourages all employees to explore opportunities to learn more about the Welsh Language. If an employee member wishes to learn Welsh or improve their confidence to use Welsh, the Welsh Language Standards require the organisation to provide them with the opportunity to do so, free of charge and during working hours.

Managers are required to support staff to learn / improve their confidence in speaking Welsh. They should contact the Welsh Language Services Team, who will signpost them to the provisions available and information on how this will be funded.

### **6.6 Textbooks and Equipment**

It is an employee's responsibility to ensure appropriate textbooks and equipment are available to support their study. When employees are unable to obtain the necessary books or equipment through sources such as the college or local library, assistance may be granted to purchase course text books and equipment within the overall agreed level of financial assistance. Receipts for these approved purchases must be produced.

Libraries within the health board offer a range of textbooks and resource materials to support a wide range of programmes. Prior to purchasing textbooks and resources, staff should speak with their local health board library to check availability or whether the texts can be purchased through the library service.

### **6.7 Reclaiming Expenses**

All learning /development associated expenses must be reclaimed using the health board's e-expenses process and system.

## 6.8 Payback Periods

The following payback period does not apply to employees in receipt of financial assistance who are made redundant (including voluntary redundancy); or whose employment is terminated on the grounds of medical incapacity.

Employees in receipt of financial assistance, whether they successfully complete their course or not, are expected to remain employed with the health board for a continuous period of 2 years, following the completion or end of their course. The health board will not fund fixed term employees to attain a qualification, which will benefit them, but not the organisation in the long-term. Managers should note that fixed term contracts should not usually exceed a period of two years

Where an employee does not remain employed by the health board for a continuous 2 year period following the completion / end of their course, due to resigning or having their employment terminated on the grounds of their conduct or capability, the employee must repay the whole or a proportion of the financial assistance on the following basis;

<b>Length of employment following completion of course</b>	<b>Proportion of financial assistance to be repaid</b>
Up to 6 months	100%
Between 6 and 12 months	75%
Between 12 and 18 months	50%
Between 18 and 24 months	25%
Greater than 24 months	0%

Employees must be made aware of the above pay back provision before they undertake the learning. They will be required to sign an agreement confirming they understand the potential pay back implications.

## 6.9 Recording Learning on ESR

On successful completion of a training course, employees should record the relevant competency on ESR, within 14 days of attendance.

## 7. EQUALITY IMPACT ASSESSMENT STATEMENT

This policy has been screened for relevance to equality. No potential negative impact has been identified.

## 8. GETTING HELP

For further information or guidance in relation to this policy please contact a member of the L&D Team.

## Appendix A

### APPLICATION FOR SUPPORTED LEARNING AND DEVELOPMENT

#### SECTION 1: APPLICANT AND COURSE DETAILS

Name: Click or tap here to enter text. Position: Click or tap here to enter text. Department: Click or tap here to enter text.
Contact Email: Click or tap here to enter text.
Title of Course: Click or tap here to enter text.
Date of Course: Click or tap to enter a date.
Duration of Course: Click or tap here to enter text.
Course Provider: Click or tap here to enter text. Course Venue / Location: Click or tap here to enter text.

Brief Details of Course Content:  
Click or tap here to enter text.

Is this relevant to your performance review and Your Conversation (Personal Development Plan)? Choose an item.

If 'NO' – reason for application: Click or tap here to enter text.

Objectives and evaluation process agreed (see Part B, Sections 4 and 5)? YES/NO

TO BE COMPLETED BY APPLICANT			AUTHORISATION TO BE COMPLETED BY BUDGET HOLDER				
	Estimated £ Expenses	Expenses to be Claimed	% Expenses Approved	£ Expenses Approved	Cost Centre	Signature of Authorising Officer	Comments
Course / Conference Fee	£	£	%	£			
Examination Fee	£	£	%	£			
Travelling	£	£	%	£			
Subsistence	£	£	%	£			
Other	£	£	%	£			
TOTAL	£	£	%	£			
Number of Days Leave Applied For:		days	days	Number of Days Leave Approved			

**SECTION 2: AUTHORISATION**

**Applicant:**

1. I confirm that if learning/development is approved I will not unreasonably withdraw and I will discuss issues of potential withdrawal with my line manager.
2. It is my intention to remain employed within Cwm Taf Morgannwg University Health Board for two years following completion of my course. Should I leave within two years, I will be liable to costs as outlined in the Payback section of this policy.
3. I accept that I will be expected to repay in full any unavoidable costs committed by Cwm Taf Morgannwg University Health Board and as a funded student I hereby give permission for my sponsor (CTMUHB) to be notified of the final result of any learning / development undertaken.

Signature: Click or tap here to enter text. Name: Click or tap here to enter text. Date: Click or tap to enter a date. \_\_\_\_\_

**Authorising Officer:** The application has / has not been approved and objectives have been detailed on 'Part B' of this form

Signature: Click or tap here to enter text. Name: Click or tap here to enter text. Date: Click or tap to enter a date.

If application is not approved please state reason why: Click or tap here to enter text.

**PART B**

**SECTION 3: OBJECTIVES & EVALUATION**

AGREED OBJECTIVES (To be completed prior to attendance at course / conference). State the benefits likely to be achieved as a result of attending this course.	EVALUATION (To be completed by the Manager and Applicant following completion of the course / conference)		
	Objectives Met?		
	FULLY	PARTIALLY	NOT AT ALL
Date and Time of Evaluation Meeting: Click or tap to enter a date.			

# Staff Bank and Agency Worker Policy

<b>Document Type:</b>	Non Clinical Organisational Wide Policy
<b>Ref:</b>	People25
<b>Author:</b>	Sarah Quirk, Staff Bank Manager
<b>Executive Sponsor:</b>	Executive Director for People
<b>Approved By:</b>	Choose an item.
<b>Approval / Effective Date:</b>	(00/00/0000)
<b>Review Date:</b>	(00/00/0000)
<b>Version:</b>	

## Target Audience:

<b>People who need to know about this document in detail</b>	Author/Owners of this procedure.
<b>People who need to have a broad understanding of this document</b>	Board Members, Management Board, Senior Leaders, Board Committees.
<b>People who need to know that this document exists</b>	Employees, Bank Staff and Agency Workers of Cwm Taf Morgannwg University Health Board and its hosted organisations.

## Integrated Impact Assessment:

<b>Equality Impact Assessment Date &amp; Outcome</b>	10/03/2022 No potential negative impact has been identified.
<b>Welsh Language Standard</b>	Yes - If Standard 82 applies you must ensure a Welsh version of this policy is maintained.
<b>Date of approval by Equality Team:</b>	10/03/2022
<b>Aligns to the following Wellbeing of Future Generation Act Objective</b>	Ensure sustainability in all that we do, economically, environmentally and socially



**Disclaimer:**

If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or [CTM\\_Corporate\\_Governance@wales.nhs.uk](mailto:CTM_Corporate_Governance@wales.nhs.uk)

**CONTENTS PAGE**

<b>Section Number</b>	<b>Sub Heading</b>	<b>Page Number</b>
1	Policy Statement	3
2	Scope of Policy	3
3	Aims and Objectives	3
4	Responsibilities	3
5	Recruitment	4
6	Appointment and Induction	8
7	Training	8
8	Professional Registration	9
9	Allocating Shifts	9
10	Identification of Bank and Agency Workers on Shift	11
11	Cancellation of Shifts by Bank Workers	12
12	Cancellation of Shifts by Agencies	12
13	Cancellation of Shifts by Wards / Departments	13
14	Working Time Regulations	13
15	Management of Bank Staff	14
16	Equality Impact Assessment Statement	17
17	References	17
18	Getting Help	17
19	Related Policies	17
20	Information, Instruction and Training	18
21	Main Relevant Legislation	18
Appendices	Appendix 1 Bank Registration Form	19
	Appendix 2 Request for Bank External Recruitment Form	19
	Appendix 3 Expression of Interest Request Form	19
	Appendix 4 NHS Wales Agency Worker Placement Checklist	19
	Appendix 5 Ward Induction Checklists	19
	Appendix 6 Agency Booking Escalation Process	20
	Appendix 7 On Contract Agency Request Forms	20
	Appendix 8 Off Contract Agency Request Forms	20
	Appendix 9 Bank Register Principals	20

Ref: People25

Policy Title: Staff Bank and Agency Worker Policy

Page Number: 2

## **1. POLICY STATEMENT**

This policy sets out the operational process of ensuring the engagement and management of all bank and agency workers engaged with Cwm Taf Morgannwg University Health Board (CTMUHB), following a robust process; this does not include Medical and Dental Workers.

It will ensure all bank and agency workers receive and maintain appropriate induction, mandatory and statutory training and orientation to areas and departments to enable them to work safely and within their scope of practice. It will further ensure that all bank and agency workers are managed in a transparent, consistent and fair approach in line with Terms of Engagement, Manager's Staff Bank Guidance, Bank Register Principal and the ACAS Code of Practice.

The policy also outlines the responsibilities of ward and departmental managers in the engagement of bank and agency workers.

All managers are expected to familiarise themselves with the content of this policy. The existence of this policy and its provisions will be brought to the attention of bank and agency workers through induction programmes, via intranet pages and other relevant methods.

## **2. SCOPE OF POLICY**

This policy applies to staff and agency workers engaged by the health board, with the exception of medical and dental workers and all wards / departments who utilise a casual workforce to support the function and delivery of their services.

This policy sets out the standards, which will be implemented across the health board and it should be read in conjunction with the Recruitment and Selection Policy, Nursing and Midwifery Rostering Policy and All Wales Agency Consolidated Contract.

## **3. AIMS AND OBJECTIVES**

The aim of Health Board Staff Bank is to establish a casual workforce of competent bank workers including, though but not exclusively; Registered nurses, healthcare support workers (HCSWs), Allied Healthcare Professionals, Administrative and Clerical and facilities workers, who can be called upon to support the substantive workforce, in the event of absence, vacancies or increased workload pressures. The contribution of all workers enrolled on the Staff Bank Register is recognised and the health board is committed to equality in all aspects of their engagement.

## **4. RESPONSIBILITIES**

The Staff Bank Team are responsible for

- Ensuring fair and transparent processes are followed, as underpinned by the ACAS Code of Practice and as set out in the Bank Register Principles.

Ref: People25

Policy Title: Staff Bank and Agency Worker Policy

Page Number: 3

- Supporting ward / departmental managers in relation to filling vacant shift with bank and agency workers;
- Developing and implementing operational procedures and safe systems of work;
- Assisting in the production and training of staff to run management reports on shift fill rates, usage, and trend analysis and performance indicators, to enable effective monitoring and management of the temporary staffing resource;
- Undertaking regular review of Staff Bank Register, and where applicable remove Bank Workers from the Staff Bank Register;
- Managing the relationships with supplying agencies, in line with the All Wales Agency Nursing Supply Consolidated Contract;
- Recruiting bank workers who will be organised to meet the demands of the Service. The intention is to maintain the optimum number of workers on the Staff Bank Register to respond to the needs of the organisation; and
- Processing shifts for agency payment and act as a gateway between ward / departmental managers and nurse agencies with any issues.

Ward / department managers are responsible for

- Ensuring rosters are managed in line with the Roster Policy;
- Ensuring unfilled shifts are appropriately escalated in line with the Bank and Agency Booking Escalation Process;
- Ensuring shifts are checked and finalised daily, following reconciliation with Ward Attendance Sheet/Book;
- Checking identification documents of the bank and agency worker at the start of the shift, and ensuring these correlate with Health Roster;
- Completing and returning Ward Induction Checklists and return to Staff Bank Office for retention; and
- Not engage directly with nurse agencies regarding supply and refer to Staff Bank Office Team.

Bed / site managers are responsible for

- Co-ordinating bank and agency cover arrangement outside of office hours; and
- Ensuring rosters are managed in line with the Roster Policy.

## 5. RECRUITMENT

### 5.1 Recruitment

The health board aims to recruit workers to the staff bank internally from our employee and student workforce as well as from external recruitment sources.

All engaged bank staff will be issued with a Terms of Engagement, Staff Bank Induction Booklet and Employee Online (EOL) link to book shifts and view roster. They will also be set up with an All Wales Nadex account and ESR self-service account.

Ref: People25

Policy Title: Staff Bank and Agency Worker Policy

Page Number: 4

Staff Bank only workers will sit under Staff Bank hierarchy on ESR.

## 5.2 Internal Recruitment

Substantive employees already employed by the health board are required to be formally registered with the Staff Bank, if they wish to undertake staff bank work. They must complete an internal Bank Registration Form (**Appendix 1**). A supporting statement from their substantive line manager must also be obtained, and submitted along with the completed Bank Registration Form. These forms are available from the Staff Bank Office.

Substantive employees undertaking bank shifts must only select bank shifts relevant to their skill set, role and grade. Restrictions are in place on the Health Roster to ensure workers can only pick up shifts within their relevant skill set. No advertisement is required in these situations.

Employees suspended or currently certified unfit to work will not be eligible to register with the Staff Bank, and therefore will be unable to work bank shifts.

## 5.3 External Recruitment

All external recruitment will be managed via Trac in compliance with the NHS Employer's Recruitment Standards and the health board's Recruitment and Selection Policy, to ensure the process is managed in a fair, consistent and legally compliant way. The process will be transparent and accountable throughout.

The Staff Bank will promote equal opportunities to protect the rights of those with protected characteristics. Discrimination will be avoided and not tolerated in any aspects of recruitment and selection. Applications are welcome in both Welsh and English, and will be treated equally. Applications are welcomed from candidates from protected groups.

Equality of opportunity will be monitored as part of the Annual Strategic Equality Plan, which will be reported to the health board's People and Culture Committee. This reporting may result in a recommendation to take positive action in relation to underrepresented groups.

Appointments will be made on merit against criteria specified in the job description and person specification, which have been approved via the health board's job evaluation process.

All appointments will be subject to completion of appropriate pre-employment checks, including references, occupational health clearance, Disclosure and Barring Service (DBS) checks, and eligibility to work in the UK, qualifications and professional registration, as appropriate to the post.

The Staff Bank's Recruitment Team will act as the recruiting manager for all external recruitment, with NWSSP Recruitment Services undertaking the recruitment administration function, as with substantive recruitment (advertising posts, interview set up, undertaking all pre-engagement checks, recruiting Bank staff, issuing All Wales Bank Worker Terms of Engagement and Staff Bank Induction Booklet.?

Examples of Bank Recruitment Campaigns are listed below:

- On a rolling basis;
- For periodic campaigns;
- In response to ad hoc requests and specific demand (for advertisement); and
- For the recruitment of nursing students onto the Staff Bank.

The Staff Bank Recruitment Team is responsible for the creation of the vacancy request on Trac, ensuring all corresponding advertisements meet the prevailing vacancy standards including:

- All advert wording must be in line with the Recruitment and Selection Policy;
- The job description must be a "Bank Only" version and contain the unique CAJE reference number in line with the job evaluation process;
- The vacancy must have a cost centre and position number;
- The position number must be part of the advertisement filing system;
- Vacancy Scrutiny Panel (Appendix 2) Workforce Information Team and Agenda for Change Team must approve all Bank vacancies prior to it being advertised by NWSSP Recruitment Service.

External applicants will be invited to apply via Trac or NHS Jobs. Other sites, linked via Trac's interfaces, will divert the applicant to one of these sites. No other forms of applications will be accepted.

All applicants will undergo shortlisting process, and shortlisting decisions will be made on merit against the specific criteria in the job description and person specification. Candidates will be invited to attend interview (with the exception of nursing students).

All internal and external recruitment to the Staff Bank will be in line with the health board's recruitment processes, including shortlisting against a matched job description and person specification.

Bank workers can only claim travel expenses if there is a requirement to travel as part of their bank duties, e.g. health visiting, district nursing. It is the responsibility of the manager of the area engaging the bank work, to set up a SEL account and authorise any travel expenses.

#### **5.4 Specific demand without advertisement**

In circumstances where a manager has already identified a demand to utilise bank workers and has already undertaken the selection process, they must notify the Staff Bank Recruitment Team and provide the candidate's details, approved job description and person specification (must have a health board CAJE reference number) and cost centre.

The job description and person specification will be amended by the Agenda for Change Team to align with the bank worker criteria. The substantive and the bank versions of the job description and person specification will be stored together. Only the Agenda for Change Team will be able to amend any information contained within the job description and person specification, including the unique CAJE reference number.

A vacancy must still be created on Trac, following the same process as external recruitment. A hidden link will be set up and issued to the candidate(s) to apply. The candidate(s) will undergo full pre-employment checks and must not undertake bank shifts until the full recruitment process has been completed. This process is used for specialised areas and will not supersede normal bank worker recruitment programmes.

The manager must also ensure the ward / department is set up with Health Roster to ensure the bank shifts are allocated and finalised for payment.

Dependent on requirements, "Expression of Interest" posts can be placed on the Staff Bank Facebook page to attract the existing Bank workforce to apply for the role. The manager must complete the Expressions of Interest Request Form (**Appendix 3**) and provide a point of contact. The duties and banding on the Expression of Interest post must be in line with an approved job description and person specification (must have a CAJE reference number).

It is advised that ward / department managers undertake suitability interviews and confirm the bank status of the worker prior to their engagement.

#### **5.5 Leave and Return (to a Bank Only Position)**

Health board employees who are leaving to take up a position in another organisation or retire, are encouraged to join the CTM Staff Bank. These employees should follow the process set out in Section 5.2 above. If they wish to join after they have left the employment of the health board, they must apply following the process set out in Section 5.3 above.

For employees who already hold a bank position and wish to remain on the Staff Bank Register, they must inform the Staff Bank Office when they tender their resignation, to activate the leave and return process. This will facilitate their smooth transition to becoming a bank only worker.

A new assignment number will be issued and ESR self-service account set up for those implementing the leave and return process. They will not be

permitted to undertake a bank shift until the leave and return process has been completed.

## 5.6 Engagement of Agency Workers

To meet the demands of service the health board will engage agency workers. To enable agency workers to undertake shifts within the health board the Staff Bank Booking Team must receive an NHS All Wales Agency Worker Placement Checklist (**Appendix 4**). Nursing agencies must be approved to supply agency staff to the health board.

The Staff Bank Booking Team will review the All Wales Check List to ensure that it is correctly completed, and that there are no restrictions, prior to registering the agency worker on the system. Any concerns will be escalated to the Clinical Lead Nurse or Staff Bank Manager.

Agency Workers are then assigned a post to enable the Agency to book shifts.

During out of hours the bed management / manager should inform the Staff Bank Booking Team of any engagement with agency workers, to ensure the relevant documentation has been received and all checks have been undertaken and are satisfactory.

## 6. APPOINTMENT AND INDUCTION

All new bank workers who do not hold a substantive post within the health board will need to book an appointment with the Staff Bank Recruitment Team to

- Complete New Appointment Form (NAF);
- Obtain uniform as per the All Wales NHS Dress Code;
- Complete ID badge form; and
- Complete IT new user form.

Substantive employees who also undertake bank shifts will be expected to wear the appropriate grade uniform to the shift they will be undertaking.

It is the responsibility of the ward / department manager to ensure all bank and agency workers new to the area have an induction and for the Ward Induction Checklist (**Appendix 5**) to be completed and returned to the Staff Bank Office.

## 7. TRAINING

All bank workers will undertake Corporate Induction and Manual Handling ([000 NHS Wales - Manual Handling](#)) training.

With the exception of the nurse students, bank workers recruited as healthcare support workers (HCSW) will also be required to undertake the HCSW Framework Programme, manual handling training, followed by 3 x 12 hour shadow shifts. Following successful completion and verification of the above, bank HCSWs will be able to pick up shifts on the Bank via EOL.

Submission of the HCSW assessment workbook is mandatory for all such bank recruits. Should there be a delay in their submission; a restriction will be placed on their record, preventing them from picking up HCSW bank shifts.

Ref: People25

Policy Title: Staff Bank and Agency Worker Policy

Page Number: 8

All Bank HCSWs will receive payment for all training, including shadow shifts following completion of their first bank shift.

For all other bank workers any additional or alternative training that is identified will be arranged under the guidance of the ward / department manager and depending on the nature of the training required it may need to be completed prior to commencement of work.

It is mandatory for all staff enrolled on the staff bank to undertake all mandatory and statutory training, including the completion of e-learning packages. It is the responsibility of the bank worker to ensure they remain in compliance with all mandatory and statutory learning requirements. The Staff Bank Office will monitor compliance, and failure to remain in compliance may result in their removal from the Staff Bank Register.

Training is provided free of charge for all bank workers, though time to attend to training is unpaid, unless the ward / department manager has an agreement in place to pay for it out of their budget.

## **8. PROFESSIONAL REGISTRATION**

Should a bank worker's role require professional registration or revalidation they are solely responsible for ensuring their compliance in accordance with their Professional Codes. The bank worker upon request must produce proof of their compliance.

The Bank Clinical Lead Nurse will monitor the records of bank worker's registration and revalidation. They will remind workers whose certification is due for renewal / revalidation of the requirement and update the renewal dates on Health Roster.

In line with the All Wales Agency Nursing Service Consolidated Contract, agencies must provide professional registration and revalidation information and renewal updates to the Staff Bank Booking Team along with proof on request.

Failure to maintain compliance will result in a restriction being placed on the bank or agency worker's record on the e-system. The matter escalated as a concern, to the Bank Clinical Nurse Lead and it may result in their removal from the staff bank register.

## **9. ALLOCATING SHIFTS**

The health board currently utilises Allocate software products:

- Health Roster (used for the production of rosters and enables unfilled shifts to be identified for bank / agency fill);
- Bank Staff (e-system used by the Bank Office Team and approved on-contract agencies to fill shifts); and
- EOL (web-based system that enables Bank Staff to book shifts and view their roster).

Ref: People25

Policy Title: Staff Bank and Agency Worker Policy

Page Number: 9

The above three E-Systems interface, to provide up to date information on filled and unfilled shifts on the rosters.

On completion of a staff roster, roster managers must follow the Bank and Agency Booking Escalation Process (**Appendix 6**). They must initially attempt to fill any vacant shifts with existing substantive staff, assigning under and over contracted hours.

Following this, any remaining vacant shifts will be made available to the bank workforce. This will enable bank workers to pick up shifts via EOL, in accordance with their skill and competency.

If the shift remains vacant, it will be made available to bank workers engaged on the Collaborative Bank Partnership. At this point, rosters should be reviewed and any unfilled shifts can be offered as overtime as per the Overtime and Additional Hours Policy.

Two weeks before date of shift, any unfilled registered shifts are escalated to nursing agencies on the All Wales Agency Consolidated Contract, who engage with the health board to supply agency nurses. For unregistered shifts, these may be escalated 24 hours prior to the shift date, with authorisation from the heads of nursing. Approved authorisation forms must be submitted to the Bank Office Booking Team to escalate unfilled HCSW shifts to agency (**Appendix 7**).

Nurse agencies are able to book direct via the e-system portal. Once this has been agreed with the Clinical Lead Nurse / Staff Bank Manager. If necessary, the Staff Bank Booking Team will contact agencies to request agency workers to fill shifts at short notice.

In extreme circumstances, unfilled shifts may be offered to agencies not on the All Wales Agency Nursing Supply Consolidated Contract. This is subject to review of staffing levels, acuity and completion of the off contract authorisation form. The Staff Bank Booking Team will only action requests when the approved authorised paperwork has been submitted (**Appendix 8**).

The bed / site managers will co-ordinate any unfilled shifts required out of hours and when the Staff Bank Office is closed.

The bed / site managers will be responsible for advising the Staff Bank Booking Team of all bookings made outside office hours and when the Staff Bank Office is closed. The bed / site manager, to enable finalisation of shifts by the ward manager, must enter this information onto Health Roster.

The bed / site managers are responsible for updating Health Roster with any changes made out of hours including redeployment of bank or agency workers to other ward / departments.

All unfilled shifts will remain visible to ward / department managers via Health Roster and if the shift remains unfilled, it will be the responsibility of the ward / department manager to consider other options to cover the unfilled shift.

Should staffing levels remain insufficient, redeploying workers or employees from other clinical areas should be considered. It should be noted, bank and agency workers may be asked to change their area of work / location at short notice, where they have the appropriate skills and competencies to work safely. Should they decline to be moved to another ward / department it may result in them leaving the shift early.

Before deploying staff from another clinical area to cover staff shortages, the manager must consider the skills and competencies required the acuity of the patients, continuity of care etc. The assessment of need will determine the appropriateness of redeploying bank or agency workers (in the first instance) or substantive employees, to ensure the best and safest patient care in all areas.

It is the responsibility of the ward / department manager to update Health Roster, in real time regarding re-deploying workers who have been moved to a new area. This is important to enable the correct finalisation of the shift payment.

It is the ward / department manager's responsibility to ensure Rosters are up-to-date and accurate; this includes allocating bank or agency workers to vacant shifts not on the system.

All Bank and Agency shifts must be finalised to ensure workers are paid.

Where bank workers do not receive payment for shifts due to ward / department managers not finalising shifts in time for the payroll runs, queries related to pay will be reverted to them. Likewise, it is the responsibility of the ward / department managers to notify the Staff Bank Booking Team of any changes to requests for cover, as soon as possible.

Please be aware that bank workers **MUST NOT** manage or swap shifts through the Staff Bank Facebook page. Bank workers must not book shifts through the closed Facebook page, this method will not be accepted.

## **10. IDENTIFICATION OF BANK AND AGENCY WORKERS ON SHIFT**

The ward / department manager in charge of the shift is responsible for all employees and workers on duty for the duration of that shift.

At the start of each shift, where bank or agency workers report for duty, their photograph identification must be checked. In the case of a registered nurse, their PIN must also be viewed. There is no requirement to check the PIN with the NMC, as the Staff Bank Booking Team do this at the point of registration.

If there is a discrepancy in the checking of the identification the ward / department manager is required to escalate their concern to the Staff Bank Office. Out of hours, such concerns must be escalated to the bed / site manager.

The Ward Induction Checklist must be completed and returned to the Staff Bank Booking Team for all bank and agency workers new to the ward / department.

Ref: People25

Policy Title: Staff Bank and Agency Worker Policy

Page Number: 11

## 11. CANCELLATION OF SHIFTS BY BANK WORKERS

Bank workers **MUST** notify the Staff Bank Booking Team if they are unable to undertake a booked shift, giving a minimum of four hours' notice, to provide sufficient time to source a replacement. If the Bank Worker does not inform the Staff Bank Booking Team and they fail to attend a shift, this will be classed as a 'Did Not Attend' (DNA). All cancellations and DNAs are recorded and monitored.

Bank workers who repeatedly cancel or DNA shifts will be asked to attend an appointment with the Clinical Lead Nurse and / or the Staff Bank Manager to discuss the matter. Until this meeting is held, a restriction will be placed on their EOL account and no further bank shifts will be offered to them.

Any concerns about this process should be raised with the Clinical Lead Nurse / Staff Bank Manager. The Clinical Lead Nurse / Staff Bank Manager will explain the monitoring and escalation process should there be no improvement in the cancellation or DNA rate:

- Restriction of EOL account for 2 weeks; and
- Potential removal from Staff Bank Register.

Bank workers, who have not actively booked shifts or have refused shifts for a 6-month period, may be removed from the Staff Bank Register. Please note that this excludes bank workers who are nursing students on placement / studying or those on maternity, parental, adoption leave or long-term sickness absence.

All cancellation reasons must be recorded on the e-system accurately by either the ward / department manager or the Staff Bank Booking Team.

The Staff Bank Booking Team will update Health Roster with cancellations and inform the ward / department manager, where possible, of those made at short notice. All cancelled shifts will immediately be made available via EOL for bank workers and agency nurses to fill.

The Staff Bank Booking Team will endeavour to contact bank workers and agencies to provide short notice availability to fill the shift, unless the ward / department manager is able to source a suitable replacement.

Outside of office hours, the bank workers must contact the bed / site manager. The bed / site manager will inform the ward / department manager whether or not a replacement can be found.

## 12. CANCELLATION OF SHIFTS BY AGENCIES

Agencies must notify the Staff Bank Booking Team as soon as they are aware that an agency worker is not able to attend a booked shift. If the agency is not able to provide a suitable replacement, the shift will be made available to other on-contract agencies.

Agency workers who cancel or DNA for a shift repeatedly, may no longer be offered shifts by the health board. If it is deemed the agency is at fault of "ghost

booking” shifts the health board may disengage with that agency, escalating the matter to the All Wales Commodity Officer for investigation.

### **13. CANCELLATION OF SHIFTS BY WARDS / DEPARTMENTS**

The ward / department is entitled to cancel booked shifts, with reasonable notice (more than four hours before the commencement of shift). If this notice is provided the bank worker will not be entitled to receive pay for the cancelled shift. It is the responsibility of the ward / department manager to cancel and remove the shift from Health Roster.

It is the responsibility of all bank and agency workers to review bookings to ensure they are still required to be worked in the ward / department, prior to arriving on shift.

If notice of the cancellation is less than four hours, bank and agency workers may be entitled to be paid for the minimum shift, unless the ward / department are able to find them suitable alternative work in compliance with their skill set. In these circumstances, the worker will be paid for any alternative work completed.

It is accepted, at times staffing requirements alter and should there be a surplus to staffing requirements after arrival on the ward / department the bed / site manager must be contacted to organise reallocation. Alternatively, if there are insufficient staffing numbers to meet demand, the respective ward / department manager may be asked to redeploy staff on a temporary basis. Consideration of bank / agency worker and substantive employee skills and competencies will be taken into account, prior to any temporary redeployment, to ensure the best and safest patient care.

If alternative work is found for the worker and this work is refused, they will not be entitled to the four hours’ pay.

If, after review of staffing level and acuity, there is no longer a requirement for the bank / agency workers, it is the responsibility of the ward / department manager to cancel the shift on Health Roster.

### **14. WORKING TIME REGULATIONS**

It is the responsibility of the worker to disclose to their manager any other employment, NHS or private, which may affect their compliance while working within the health board. This information will be noted upon their enrolment to the Staff Bank Register.

Health Roster has been developed to ensure all Working Time Regulations (WTR) and rostering rules are built into the system. It is the responsibility of the ward / department manager to ensure all rosters are kept up-to-date and accurate, as this prevents any working time violations by bank or agency workers.

Bank and agency workers must adhere to the WTRs and will not be permitted to work a total of more than 48 hours per week, unless the WTR Opt-out Form is completed. In any event bank and agency workers will not be permitted to work in excess of 60 hours per week, regardless of the completion of a Working Time Regulations Opt-out Form.

Ref: People25

Policy Title: Staff Bank and Agency Worker Policy

Page Number: 13

## **15. MANAGEMENT OF BANK STAFF**

### **15.1 Remuneration and Payment**

All bank workers will be paid for hours worked, and will be paid monthly in line with the payroll schedule. Bank workers are able to download the Wage Stream App, which allows access to draw down, up to a maximum of 50% of their bank payments in respect of finalised worked shifts.

Payment will be made by direct transfer to the workers bank or building society Account. Staff with a substantive post within CTMUHB will be paid as per their substantive pay period. All payslips will be available via ESR Self Service only.

The hourly payment for a shift will be paid at the Agenda for Change Band for the role / duties that are undertaken.

Incremental increases will be awarded after a bank worker has complete 488 hours of work and at least 12 months' service has passed since their commencement date. Bank workers will not be entitled to receive more than one pay increase in any 12-month period.

Agency workers will not be paid directly. Payment will be made to the relevant agency via e-billing through Health Roster. All wards / departments must have an attendance sheet / book and agency shifts should be finalised in accordance with this, at the end of each shift. Any discrepancy in relation to non-payment or incorrect payment from the agency will be forward to the ward / department manager to rectify.

In line with the Nursing and Midwifery Roster Policy, it is the responsibility of the Ward / department manager to ensure the rosters are up-to-date and shifts for bank and agency workers are finalised for payment. This includes placing shifts on the roster and allocating bank and agency workers.

All ward / department managers will be notified either by the E-Rostering Team or Staff Bank Invoice Team of any unfinalised shifts. If shifts remain unfinalised, the Bank Staff Team will escalate the matter.

### **15.2 Non-Entitlements for Bank Workers**

Bank workers have

- No right to be offered any /or regular work, and the availability and nature of work depends on clinical area /placement requirements;
- No Occupational Sick Pay (bank workers may however, be eligible to receive Statutory Sick Pay, if they meet the relevant criteria for the scheme); and

- No Occupational Maternity Pay (bank workers may however, be eligible to receive Statutory Maternity Pay. if they meet the relevant criteria for the scheme).

### **15.3 Maternity Leave**

It is the responsibility of the worker to notify the Clinical Nurse Lead and /or the Staff Bank Manager if they are pregnant, and to arrange for them to undertake a risk assessment.

Following maternity leave, the worker must complete a Return to Work New Mother's Assessment in conjunction with Clinical Lead Nurse and / or the Staff Bank Manager.

### **15.4 Sickness Absence**

If a bank worker is unable to present for a booked shift due to sickness, they must inform the Staff Bank Booking Team as soon as possible, to ensure the shift is made available to the bank workforce via EOL and agencies (if applicable). If the bank shift is being filled by a substantive employee, they are also required to notify their line manager of their absence.

The Staff Bank Booking Team will inform the ward / department manager that the shift has been cancelled and has been made available for filling.

Out of hours, the bank worker must contact the ward / department manager if they are unable to attend for a booked shift.

Bank Workers who have been signed off work sick are required to provide a Fitness to Work Note, signed by their GP to the Staff Bank Booking Team. A scanned copy of the Fitness to Work note will be sent to Payroll where it will be determined whether the bank Worker is entitled to Statutory Sick Pay. If they are not eligible, the original Fitness to Work note will be sent by Payroll to the Department of Work and Pensions. A copy will also be saved in the worker's e-Personal File.

On receipt of the Fitness to Work note a restriction will be placed on the bank worker's record, as bank shifts cannot be offered to them until they are deemed fit to return to work. Once the bank worker is deemed fit to pick up bank shifts, it may be necessary for a discussion to take place with them, prior to offering them shifts to ensure they are fully recovered or whether they require any adjustments etc.

Bank Workers can be referred and self-refer to Occupational Health and / or Wellbeing Services.

Bank workers are able to access the health board's Wellbeing services and those outlined in the Recruitment and Retention of Disabled Staff Policy, including completion of the Empowerment Passport.

### **15.5 Pension**

Bank Workers may automatically join the NHS Pension Scheme if they are eligible. If they are not eligible they will be automatically enrolled into the nominate pension provider, the Government National Employment Savings Trust (NEST).

### **15.6 Management of concerns raised in relation to Bank Workers**

Any concerns identified during a bank worker's engagement regarding their performance, capability or conduct must be brought to their attention by the ward / department manager immediately and discussed with them. Matters of concern must also be raised with the Clinical Lead Nurse and /or the Staff Bank Manager. Where necessary, concerns should be recorded via Datix or referred to the Safeguarding Team.

Dependent on the nature of the incident / concern, bank shifts will not be offered until an investigation has been completed and the outcomes agreed. This may result in removal of the worker from the Staff Bank Register.

A fair process must be followed, as underpinned by the ACAS Code of Practice on disciplinary matters and as set out in the Bank Register Principles (**Appendix 9**).

The Clinical Lead Nurse and /or the Staff Bank Manager will seek advice and guidance from the People Services Team and Lead Nurse for Professional Practice and Quality Assurance, if required.

### **15.7 Management of concerns raised in relation to Agency Workers**

The process set out in 15.6 above will be followed.

Following investigation, a decision will be made regarding any further action required. This may range from no further action, provision of additional training or non-engagement with the agency worker. The health board has full, unfettered discretion to deem who should be offered shifts via an agency. Should non-engagement be the outcome, a restriction will be placed on the e-system to prevent the worker being offered future shifts by the health board.

### **15.8 Removal (de-registration) of Bank Only Workers**

No bank worker has the entitlement to be registered on the Staff Bank Register.

Removal (de-registration) from the Staff Bank Register will occur if a worker has not actively booked a shift, or has refused shifts for a 6 month period. This does not apply to those Bank Workers who are nursing students or who are on maternity/paternity/adoption or sickness leave.

Removal from the Staff Bank Register will also be considered if there is a conduct or other reason that would deem the bank worker unsuitable to remain on the Staff Bank Register. Noting the health board must take into account the Equality Act 2010 and any protected characteristics under the said Act before any removal from the Staff Bank Register, seeking further advice if necessary.

An online Termination Form must be completed for Payroll, and the worker's Health Roster account must be closed. Where possible, the worker must return their identification badge and their uniform to the Staff Bank Office.

## 16. EQUALITY IMPACT ASSESSMENT STATEMENT

This policy has been screened for relevance to equality. No potential negative impact has been identified, apart from referencing the Empowerment Passport.

## 17. REFERENCES

- All Wales Consolidated Contract 2021;
- All Wales Bank Worker Terms of Engagement;
- Bank Register Principals;
- Advisory Conciliation and Arbitration Service (ACAS) Code of Practice;
- The Code: Standards of conduct, performance and ethics for nurses and midwives NMC publication 2008.

## 18. GETTING HELP

The Staff Bank Office is located at Pontypridd Cottage Hospital, The Common, Hospital Road, Pontypridd, CF37 4AL. Opening hours are Monday to Friday 8am-4pm, Weekends and Bank Holidays 9am-1pm.

On Christmas Day, Boxing Day, New Year Day and Easter Sunday the Staff Bank Office is closed.

Contact details:

- **Telephone:** 01685 726900
- **E-mail:** [CTT\\_StaffBank@Wales.NHS.UK](mailto:CTT_StaffBank@Wales.NHS.UK)
- **SharePoint:** The Staff Bank page can be accessed from the "Sites" tab on the front page of the intranet.

## 19. RELATED POLICIES

- All Wales Agency Consolidated Contract
- Advisory Conciliation and Arbitration Service (ACAS) Code of Practice
- Nursing and Midwifery Roster Policy
- Occupational Health and Wellbeing Policy
- NHS Employers Recruitment Standards

Ref: People25

Policy Title: Staff Bank and Agency Worker Policy

Page Number: 17

- All Wales Dress Code and Uniform Policy
- Overtime and Additional Hours Policy

## **20. INFORMATION, INSTRUCTION AND TRAINING**

All managers are expected to familiarise themselves with the content of this policy. The existence of this policy and its provisions will be brought to the attention of bank and agency workers through induction programmes, via our SharePoint page and other relevant communication methods.

## **21. MAIN RELEVANT LEGISLATION**

- Freedom of Information Act 2000
- General Data Protection (GDPR) and the Data Protection Act 2018
- Health and Safety at Work Act 1974
- Working Time Regulations 1998
- New and Expectant Mothers at Work 2002
- Agency Worker Regulations 2011

**APPENDIX 1**

BANK REGISTRATION FORM



New Registration  
Form - Substantive F

**APPENDIX 2**

REQUEST FOR BANK EXTERNAL RECRUITMENT FORM



Request for Bank  
External Recruitmen

**APPENDIX 3**

EXPRESSION OF INTEREST REQUEST FORM



Expressions of  
Interest.docx

**APPENDIX 4**

NHS WALES AGENCY WORKER PLACEMENT CHECKLIST



NHS Wales Agency  
Worker Placement C

**APPENDIX 5**

WARD INDUCTION CHECKLISTS



Community Bank WARD INDUCTION  
INDUCTION CHECKLICHECKLIST Final Ver:

## APPENDIX 6

### BANK AND AGENCY BOOKING ESCALATION PROCESS



Bank and Agency  
Booking Escalation

## APPENDIX 7



Form 1 - In Hours  
HCSW Agency Requ



Form 2 - Out of  
Hours Off HCSW Co

## APPENDIX 8

### OFF CONTRACT AGENCY REQUEST FORMS



Form 2 - Out of  
Hours Off Contract



Form 1 - In Hours  
Off Contract Agency

## APPENDIX 9

### BANK REGISTER PRINCIPALS



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Principles.docx



**GIG**  
CYMRU  
**NHS**  
WALES

Bwrdd Iechyd Prifysgol  
Cwm Taf Morgannwg  
University Health Board

## Death in Service Guidelines for Managers and Staff

<b>Document Type:</b>	Non Clinical Procedure
<b>Ref:</b>	People62
<b>Author:</b>	Karen Wright, Assistant Director of Policy, Governance and Compliance
<b>Executive Sponsor:</b>	Executive Director for People
<b>Approved By:</b>	Choose an item.
<b>Approval / Effective Date:</b>	
<b>Review Date:</b>	
<b>Version:</b>	V2

### Target Audience:

<b>People who need to know this document in detail</b>	Executive Directors, Senior Managers and managers
<b>People who need to have a broad understanding of this document</b>	All managers and staff
<b>People who need to know that this document exists</b>	All managers and staff

### Integrated Impact Assessment:

<b>Equality Impact Assessment Date &amp; Outcome</b>	17/04/23 No negative impact.
<b>Welsh Language Standard 82</b>	Yes - If Standard 82 applies you must ensure a Welsh version of this policy is maintained.
<b>Date of approval by Equality Team:</b>	Awaiting sign off
<b>Aligns to the following Wellbeing of Future Generation Act Objective</b>	Ensure sustainability in all that we do, economically, environmentally and socially



If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or [CTM\\_Corporate\\_Governance@wales.nhs.uk](mailto:CTM_Corporate_Governance@wales.nhs.uk)

	<b>Death in Service Guidelines for Managers and Staff</b>	<b>Page</b>
1	Guideline Statement	4
2	Scope of the Guidelines	4
3	Employee Death in Service – Not Work Related	4
4	Employee Death in Service – Work Related Accident / Incident	4
	4.1 Accident / Incident in Normal Working Hours	4
	4.1.1 Immediate Actions	4
	4.1.2 Internal Reporting and Other Actions	5
	4.2 Accident / Incident Out of Hours	6
	4.2.2 Internal Reporting and Other Actions	6
5	Roles and Responsibilities	6
	5.1 Chief Executive	6
	5.2 Manager	7
	5.2.1 The Next of Kin Aspects	7
	5.2.2 The Colleague / Patient Aspects	8
	5.2.3 The Administration Aspects	9
	5.3 The People Directorate / People Services Team	9
	5.4 The Payroll and Pensions Department	10
	5.5 The Wellbeing Service	10
	5.5.1 Bereavement Wellbeing Resources	11
	5.6 Multi-faith Chaplaincy Support	11
6	Communication of a Colleague's Death	11
	6.1 Letter of Condolences from the Chief Executive	12
7	Completion of the Online Payroll Form to End Employment	12

	7.1 Payment of the Final Salary	12
	7.2 Payment of NHS Pension Benefits	12
8	Attendance at the Colleague's Funeral Service	13
9	Training Implications	13
10	Review, Monitoring and Audit Arrangements	14
11	Implementation Responsibilities	14
12	Retention or Archive	14
13	Non Compliance	14
14	Equality Impact Assessment Statement	14
	Appendices	
	Appendix 1 – Template Letter of Condolences from the Line Manager	15
	Appendix 2 – Death in Service Flowchart	16

## **1. GUIDELINE STATEMENT**

This guidance is to support managers in taking the appropriate actions due to the sad event of the death of a colleague. It is essential that the manager deals with the situation compassionately, sensitively and effectively, to prevent any additional distress for the colleague's bereaved family (next of kin), work colleagues and friends.

The guidelines will assist the manager to take all of the necessary steps in respect of agreeing communications with the family, colleagues, patients (where applicable) as well as ensuring the pay and death in service benefit arrangements (if applicable) are managed in a sensitive and timely manner.

The guidelines also outline the wellbeing services available to support managers and employees to deal with the loss of a colleague / friend.

## **2. SCOPE OF THE GUIDELINES**

The guidance applies to Health Board employees that die in service. The key principles in the guidance may also be considered and adopted for use for other staff, such as volunteers, agency and bank workers.

## **3. EMPLOYEE DEATH IN SERVICE – NOT WORK RELATED**

Occasionally an employee will die unexpectedly or due to an ill health condition, while still an employee of the Health Board. Where an employee dies in these circumstances, the manager should refer to Section 5 of the guidance onwards.

## **4. EMPLOYEE DEATH IN SERVICE – WORK RELATED ACCIDENT / INCIDENT**

In the rare but sad event of an employee dying in work as the result of a workplace accident or incident, the most senior person at the scene, or to come onto the scene must follow the process set out below:

### **4.1 Accident / Incident in Normal Working Hours**

#### **4.1.1 Immediate Actions**

- Make contact with the emergency services by telephoning 999 informing them of the location and nature of incident / accident and that there has been a fatality;

- Ensure the immediate safety and care of people involved i.e. other colleagues, staff, patients, visitors etc.;
- Ensure the scene is kept secure and any evidence is not touched or moved (there may be an external as well as an internal investigation depending on the circumstances of the accident / incident). If necessary and possible, lock any access points or cordon off the area and put up signs clearly stating that no-one is permitted to enter the area;
- Record the names and contact details of eyewitnesses;
- Make notes to assist with the completion of the DatixWeb Incident Report Form.
- The senior person at the scene should telephone the Site Manager and the Care Group Director to inform them of the situation and the actions taken to date.
- Advise the Health Board not to make any comment / share any information on social media or respond to media approaches, as detailed in the [Media Enquiries Protocol](#) and the [Media Handling Protocol](#).

#### **4.1.2 Internal Reporting and Further Actions**

The Care Group Director must:

- Identify any further action required, by whom and instigate it. Contact must be made with each Care Group Director and a lead agreed if the accident / incident concerns more than one Care Group.
- Contact the relevant Head of Service (or, in their absence, nominated deputies) and the Head of Health, Safety & Fire, to relay a synopsis of the accident / incident and obtain any immediate advice.
- Obtain the next of kin details from the relevant manager / People Services Team to inform them of the accident / incident and to ensure they are kept fully apprised of the situation, including which hospital their loved one has been taken.
- Ensure there is appropriate and immediate support for the staff involved in or witness to the accident / incident. The People Directorate Wellbeing Service will be able to advise what support is available, in the first instance. Following the accident incident, it may be appropriate to signpost the staff involved to the Health Board Wellbeing Services (see Section 5.5 below).
- Obtain eyewitness statements from those involved or who witnessed the accident / incident, as a matter of urgency.
- Ensure the DatixWeb Incident Report Form is fully completed by the senior person on the scene within 24 hours of the accident / incident, using any notes taken immediately after the accident / incident.
- Brief the Chief Executive and consider the need for external reporting, including to the Welsh Government as a "No surprises event".
- Inform the Communications and Engagement Department of the accident / incident, to enable the preparation for any media / public interest statement.

- To determine whether the matter should be reported to the Health and Safety Executive and commission the Head of Health, Safety & Fire to oversee a comprehensive initial investigation and analysis of the accident / incident.

## **4.2 Accident / Incident Out of Hours**

The most senior person first on the scene must follow the process set out in *section 4.1.1. (Immediate Actions)* above, including notifying the on-call Site Manager of the accident / incident and the action being taken.

### **4.2.1 Internal Reporting and Further Actions**

The on-call Site Manager will:

- Notify the Executive Director on-call of the accident / incident and discuss the action already being taken and to be taken;
- Will organise contact with the senior staff on the scene to ensure that all appropriate actions are taken, prior to commencement of the next working day; and
- Follow the additional steps outlined under the 'Normal Working Hours' procedure, set out in Section 4.1 above, which have not already been actioned.

The Executive Director on-call will:

- Make the necessary arrangements to inform and keep the deceased colleague's next of kin fully apprised of the situation.
- Contact the Chief Executive and discuss whether to contact the designated on-call Professional at the Welsh Government, to report the accident / incident as an "Early Warning Notification".
- Contact the Care Group Director and Head of Health, Safety & Fire early the next working day to inform them of the accident / incident.
- Determine whether the matter should be reported to the Health and Safety Executive they will commission the Head of Health, Safety & Fire to oversee a comprehensive initial investigation and analysis of the accident / incident

## **5. ROLES AND RESPONSIBILITIES**

### **5.1 The Chief Executive**

To express their sympathy on behalf of the Health Board to the deceased colleague's next of kin. The Communication and Engagement Team will draft the letter of

condolences on the Chief Executive's behalf, using information provided by the manager.

## **5.2 The Manager**

To ensure all calls, correspondence and matters relating to the death of the colleague are managed in a sensitive, compassionate and confidential manner, always respecting the wishes of the family and colleagues.

The manager may, in addition to the Chief Executive also send a letter of condolences to the confirmed next of kin on the behalf of their team and colleagues (see template letter Appendix 1). They may also wish to consider sending flowers, if appropriate.

### **5.2.1 The Next of Kin Aspects**

- Ascertain from ESR the details of the deceased colleague's next of kin and contact details. **N.B.** The next of kin may contact the manager to inform them of the death of their loved one.
- Ascertain whether the next of kin has a preferred language and / or any communication needs.
- Agree the how and frequency of contact with the next of kin, respecting their wishes.
- Inform the next of kin of the arrangements being made to pay the final salary and any pension benefits to which they may be entitled.
- Make the next of kin aware they may be able to claim a 'death benefit', if their loved one was a member of a trade union/professional organisation.
- Respond promptly and appropriately to the requests of the next of kin, bearing in mind the need to be respectful and considerate towards any religious or cultural beliefs or practices.
- Determine whether the family would like the Health Board to pay tribute to their loved one (see Communication Section 6).
- Should there be no next of kin contact details available for the deceased colleague, the manager should send a letter of condolence to the deceased colleague's home address. They should include their contact details and invite the family / next of kin to contact them should they have any queries relating to their final salary and pension entitlements (see Appendix 1).
- Inform the next of kin that they will be supported in any media interest that may arise in the instance that the death occurred as the result of an incident / accident on site. This support will be in an advisory capacity and will include social media handling. The support provided by Communication and Engagement Team will be determined by the specific circumstances of the

death and the reaction to and the relationship with the Health Board and the bereaved family.

### **5.2.2 The Colleague / Patient Aspects**

- Deciding how, when and where to inform colleagues of the death, ensuring the information is communicated in a timely, sensitive and compassionate manner. Where possible, inform those who had a close relationship with the deceased colleague separately.
- Show compassion towards colleagues and teams, recognising the range of reactions that colleagues and teams may display (upset, sadness, anger, becoming withdrawn, feelings of being unable to cope). These emotions may be displayed immediately or take a few days, weeks or months. They may be triggered by an event or the anniversary of the death. It is therefore important that the manager talks regularly to the staff within their team (on a group and individual basis) to check how they are feeling and coping. Talking is often the best way to help support each other through sad and difficult times.
- Put in place arrangements to cover essential service provision where individuals are too distressed to cover their duties following the news of their colleague's death.
- Consider the emotional support needed following receipt of the sad news. It's vital that the manager includes themselves in this consideration. Advice can be sought from the Wellbeing Service Team as required (see Section 5.5 below).
- Consider the wishes of the team and individuals to help them grieve in their own way and remember their colleague, being mindful of the next of kin's wishes.
- Advise the team not to share information publicly as this may usurp the bereaved family's communications and wishes e.g. do not set up a 'Go Fund Me' page, or place the information on social media.
- Discuss with the team the family's wishes in relation to sending condolences and / or flowers to the family.
- Keep the team up to date regarding the family's wishes in respect of the wake and funeral arrangements.
- Put appropriate service cover arrangements in place to enable colleagues to attend the funeral service, should this be in accordance with the wishes of the next of kin.
- There may be occasions upon which the deceased colleague has numerous contacts across the service / organisation. Consideration should be given to using other forms of notification, such as internal social media notification if it is not possible to let all these contacts know individually. The Communication and Engagement Team can manage this.

- Decide whether / how patients of the deceased colleague should be informed and offered support if required.

### **5.2.3 The Administrative Aspects**

- Contact the People Services Team to obtain any advice or support required to manage any aspects of the death in service process.
- Complete and submit the [Payroll Form to end employment](#) (See Section 7 below) immediately, to ensure the pay is not transferred into the deceased colleague's bank account until the final payments can be accurately calculated.
- Email the Payroll Department with the details of the deceased colleague and their next of kin to ensure timely initiation of final salary payment and administration of the Pension Scheme benefits (if applicable).
- Sensitively organise the collection of the deceased colleague's personal belongings, making an itemised list, to help to respond to any next of kin queries in the future. Should the manager be unable to deliver them personally to the next of kin, following the funeral they should arrange for them to be sent via recorded delivery postal delivery.
- The itemised personal belongings list is to be filed on the deceased colleague's personal file, prior to it being closed and archived.
- Sensitively discuss and organise the collection of any Health Board property from the next of kin following the funeral, without subjecting them to any undue pressure. It may be helpful to provide the next of kin with a list of the items.
- Arrange the removal of the deceased colleague's details from all department and team email distribution lists, telephone directories, rotas etc.
- Inform the Occupational Health Department of the colleague's death, by sending them an email to [CTT\\_Occupationalhealth@wales.nhs.uk](mailto:CTT_Occupationalhealth@wales.nhs.uk).

## **5.3 The People Directorate and People Services Team**

- The Care Group Head of People / Deputy Head of People will arrange for a member of the People Services Team to coach the line manager in the practical application of the guidance, should they require such assistance.
- The Head of People / Deputy Head of People will support the manager (if required) at meetings with the deceased colleague's next of kin or colleagues.
- Notify the Medical Workforce Manager if the deceased is a medical or dental employee.
- In the event that there is no identified next of kin, the Head of People / Deputy Head of People will support the line manager to make reasonable enquiries to try

to identify the next of kin, based on information available on the deceased colleague's personnel record.

#### 5.4 The Payroll and Pensions Department

- Ensure the processing and pay and pension is managed in a sensitive, compassionate and timely manner.
- Ensure all payments are paused until receipt of the completed online [Payroll Form to end employment](#) to ensure the final salary is calculated accurately.
- Ensure payments for any salary sacrifice schemes are stopped,
- Ensure all telephone calls, correspondence and matters relating to the death of the colleague are managed in a sensitive, compassionate and confidential manner.
- Ensure a copy of the end of employment paperwork is forwarded to the Pensions Officer, to initiate the NHS Pension Process in conjunction with the NHS Pension Agency;
- Liaise with the deceased colleague's manager and next of kin to keeping them informed of any Pension process issues or dealing with any queries.

#### 5.5 The Wellbeing Service

- The Wellbeing Service will provide appropriate professional emotional wellbeing support, if required following the sad death of a colleague. This may be individual support or in some circumstances group support etc.
- **Noting:**
  - The death of a colleague will understandably have a significant impact on their team, colleagues and friends. Grief is a normal reaction to loss and in many cases the most supportive action in the immediate days following the death is peer support rather than professional help.
  - The emotional support required will vary depending on the closeness of relationships and the circumstances of the colleague's death.
  - In the early days following a colleague's death, it may be appropriate to signpost team members to wellbeing information via the [Employee Wellbeing Service or wellbeing Service](#).
  - If a member of staff feels that their grieving is prolonged or that the intensity of their emotions have not reduced with time, they can refer themselves for support. They can access wellbeing support and counselling via the Health Board's, free, confidential and impartial Employee Assistance Scheme. The service provides access to qualified professionals 24 hours a day, 7 days a week, 365 days a year. Employees can access the service by telephoning **03303 800658** (calls charged at local rates). To find the full range of services available, visit [vivup.co.uk](http://vivup.co.uk)

- If an aspect of a colleague's death has left a staff member experiencing psychological trauma, they can self-refer themselves to the counselling service via [vivup.co.uk](http://vivup.co.uk) or by telephoning **03303 800658** (calls charged at local rates).

### **5.5.1 Bereavement Wellbeing Resources**

- ↗ [CTM Support Following a Bereavement - Signposting Poster.](#)
- ↗ [ACAS: Managing Bereavement in the Workplace A Good Practice Guide](#)
- ↗ [Cruse: Grief in the Workplace](#)
- ↗ [Dying to Work Charter](#)
- ↗ [NHS Business Services Authority: Pensions Survivors Guide](#)
- ↗ [NHS Wales Direct: Bereavement Guide](#)
- ↗ [Public Health Wales: A Resource for People Bereaved Though Suicide or Other Unexplained Death](#)

### **5.6 Multi-faith Chaplaincy Support**

Pastoral and spiritual support is accessible via our Multi-faith Chaplaincy Service. This service is available to both employees and the deceased colleague's family. The service is available 24/7 and is accessible via the main hospital switchboard.

Further information is available via the [Chaplaincy and Spiritual Care Service Home Page](#).

## **6. COMMUNICATION OF THE COLLEAGUE'S DEATH**

The manager should liaise with the deceased colleague's family to establish whether they would like the Health Board to pay tribute to them. The manager should establish:

- What is the family's preferred language and communication methods, including any specific communication needs?
- Would the family like the Health Board to pay tribute to their loved one?
- If yes, would they prefer any communications to be internal only (i.e. staff of the Health Board) or would they support the Health Board doing something externally as well, for example on our social media and our website?

- Would they wish to provide a photograph of their choice and for this to be shared as part of the communications?
- Is there any other information they would like the Health Board to include about their loved one?
- Would they like us to invite colleagues to hold a minute's silence and is there a particular day or time they would like us to do this.

If the family would like the Health Board to pay tribute to their deceased family member, the manager should make contact with the Communications and Engagement Team, to enable them to make the necessary arrangements. The Team will also require the following information from the manager:

- The deceased colleague's, age, job title, team, department and place of work.

### **6.1 Letter of Condolences from the Chief Executive**

The manager must notify the Chief Executive's Office of the sad death of their colleague. The Communication and Engagement Team, using the information provided by the manager, will draft the letter of condolence for the Chief Executive to be sent to the deceased colleague's family.

## **7. COMPLETION OF THE ONLINE FORM TO END EMPLOYMENT**

- Upon notification of the death of a colleague, the manager must immediately complete the online [Payroll Form to end employment](#). The manager must also identify on the form that the ending of employment is due to "Death in Service" and ensure that any outstanding leave owed is included on the form. There is no deduction from the final salary payment in respect of any excess annual leave taken.
- The immediate completion of the form is necessary to ensure the Payroll Department stops any payments following the confirmed date of death and avoid any under or overpayment of salary, which can be upsetting for the next of kin.

### **7.1 Payment of Final Salary**

Based on the information provided on the [Payroll form to end employment](#), the Payroll Department will calculate any final payment due to the deceased colleague's next of kin.

### **7.2 PAYMENT OF THE NHS PENSION BENEFITS**

**N.B.** NHS Pension Benefits are only payable to employees who were a member of the NHS Pension Scheme on the date of their death.

The manager must contact the NWSSP Pensions Officer, Jacky O'Grady who deals with the administration of pension benefits to inform her of the death of their colleague. Jacky O'Grady can be contacted via email: Jacky.O'Grady@wales.nhs.uk or by telephoning 02920 903 812.

To ensure any pension and dependant entitlement is processed in a timely manner the manager must provide the Pensions Officer with the following information:

- **Email Title** – Death in Service of Colleague
- Name of the deceased colleague;
- Payroll number;
- Confirmed date of death;
- Details of Next of Kin – Name, relationship to deceased, home address, telephone number and email address, if available;
- Request them to process the pension benefits.

If the deceased colleague was a member of the NHS Pension Scheme, the Pensions Officer will liaise with the next of kin and the NHS Pensions Agency, to complete the pension administration process.

If the deceased colleague was not a member of the NHS Pension Scheme, the Payroll Pensions Officer will inform the manager. The manager will be asked to contact the next of kin, to advise them of the fact and inform them that should they have any queries regarding the pension benefits they should contact the NHS Pension Agency Contact Centre on 0300 330 1346 or write to them via NHS Pensions, PO Box 2269, Bolton, BL6 9JS.

## **8. ATTENDANCE AT THE COLLEAGUE'S FUNERAL SERVICE**

In the event of the sad death of one of our colleagues, the Health Board would wish to show support to the family by attending the funeral service. The manager should discuss attendance at the funeral service with the next of kin to determine whether they wish work colleagues to attend and if so how many.

In accordance with the All Wales Special Leave Policy, should the bereaved family wish work colleagues to attend the funeral, paid bereavement leave will be granted.

## **9. TRAINING IMPLICATIONS**

All managers and staff should be aware of this policy via internal mechanisms such as SharePoint and Team Briefings.

#### **10. REVIEW, MONITORING AND AUDIT ARRANGEMENTS**

This policy will be reviewed every 3 years. Additional reviews may be required if any changes are made to legislation or national Terms and Conditions of Service.

#### **11. IMPLEMENTATION RESPONSIBILITIES**

The People Directorate and managers of staff have overall responsibility for implementing and monitoring this policy. The People Directorate has responsibility for ensuring Executive Directors, senior managers, line managers and employees are aware of their responsibilities in accordance with this policy.

#### **12. RETENTION OR ARCHIVING**

The Executive Director for People will ensure that copies of this policy are archived and stored in line with Health Board's Records Management Policy, and are made available for reference purposes, should any situation arise where they are required.

#### **13. NON CONFORMANCE**

All managers and employees within the scope of this policy are required to comply with this policy, failure to comply with the policy is a serious offence and could result in disciplinary action. Any deliberate misuse or abuse of this policy will be regarded very seriously and could lead to disciplinary action or dismissal.

#### **14. EQUALITY IMPACT ASSESSMENT STATEMENT**

This policy has been subject to a full Equality Impact Assessment and no implications were found.

Consider whether the letter should be in Welsh / English / other language / braille or other method

[NEXT OF KIN TITLE, NAME, SURNAME]  
[ADDRESS 1]  
[ADDRESS 2]  
[ADDRESS 3]  
[POSTCODE]

Dear [NEXT OF KIN NAME]

I was truly saddened to hear of the passing of [DECEASED EMPLOYEE'S NAME] on [DATE] they will be dearly missed in the [NAME OF THE DEPARTMENT] department.

[DECEASED EMPLOYEE'S NAME] was [INSERT A PARAGRAPH ABOUT THE DECEASED EMPLOYEE AND THEIR CONTRIBUTION TO WORK AND THE TEAM]. I have spoken to some of [DECEASED EMPLOYEE'S NAME] colleagues today and I know they were a dedicated and well-respected member of the team in the department.

[DECEASED EMPLOYEE'S NAME] will be particularly missed by [NAMES OF CLOSEST COLLEAGUES] who have asked me to pass on their sincere condolences to you.

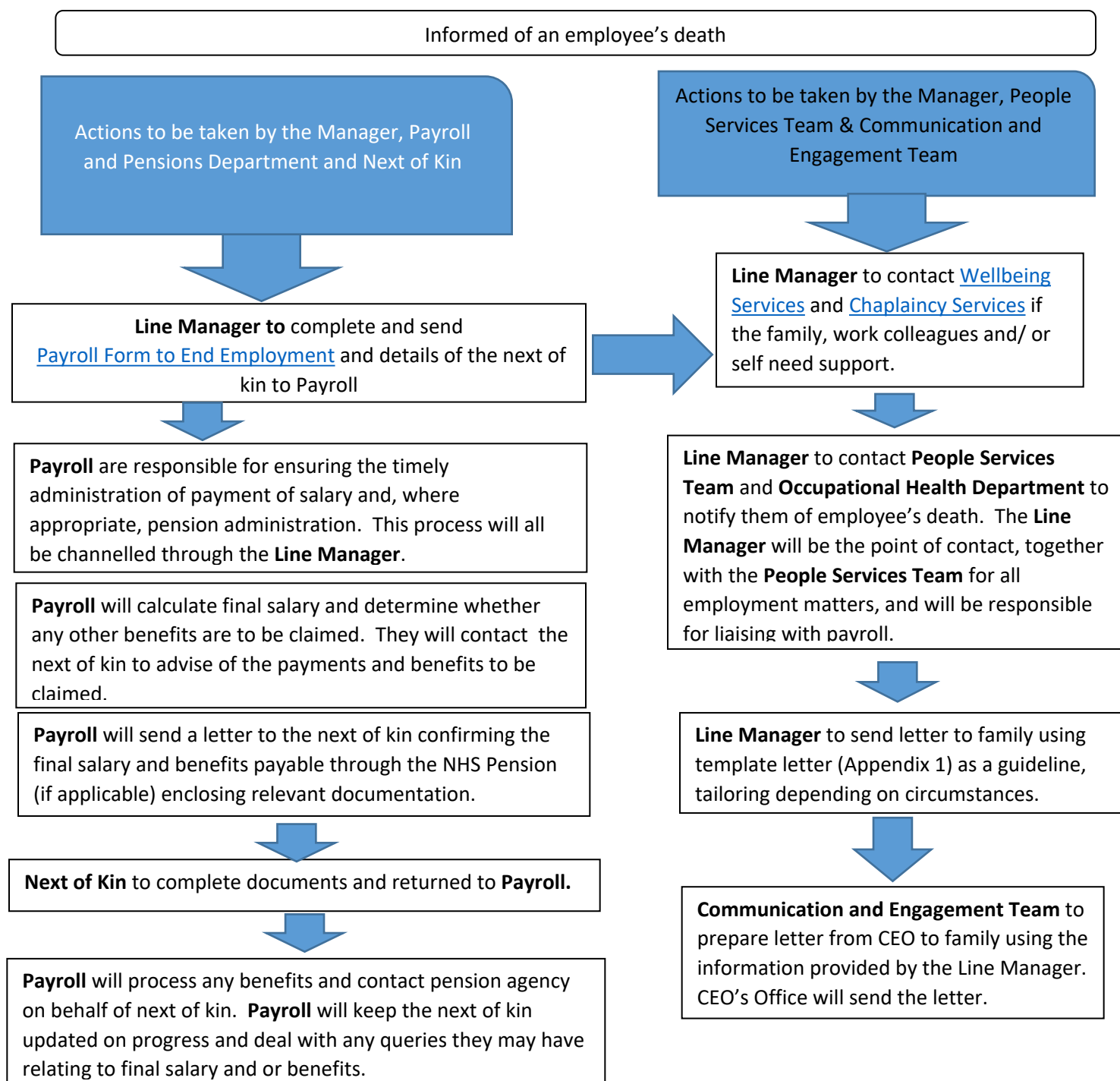
**[INSERT THE PARAGRAPH BELOW ONLY IF THE NEXT OF KIN NEEDS TO BE IDENTIFIED]** Unfortunately, [DECEASED EMPLOYEE'S NAME] did not provide the Health Board with details of their next of kin. To assist me to make the necessary arrangement in respect of [DECEASED EMPLOYEE'S NAME] final payment of salary and pension entitlements (if eligible), it would be helpful if a member of the family could contact me, to provide me with this information.

In the meantime, if there is anything I can do to assist you and the family at this very sad and difficult time, please do not hesitate to contact me on the following [PHONE NUMBER] or via my email address [XXX.XXX@wales.nhs.uk]. You and your family are in our thoughts at this time.

Yours sincerely

Line Manager

## Appendix 2



Ref: **WOD62**

Policy Title: Death in Service Guidelines for Managers and Staff

Page Number

Ref: **WOD62**

Policy Title: Death in Service Guidelines for Managers and Staff

Page Number

# Honorary Contract Procedure

<b>Document Type:</b>	Non Clinical Procedure
<b>Ref:</b>	People69
<b>Author:</b>	Workforce Policy Review Group
<b>Executive Sponsor:</b>	Executive Director for People
<b>Approved By:</b>	Choose an item.
<b>Approval / Effective Date:</b>	(00/00/0000)
<b>Review Date:</b>	(00/00/0000)
<b>Version:</b>	1

## Target Audience:

<b>People who need to know this document in detail</b>	Authors/owners of policies, procedures and written control documents
<b>People who need to have a broad understanding of this document</b>	Board Members, Management Board. Senior Leaders. Board Committees.
<b>People who need to know that this document exists</b>	All managers and staff involved in the requesting and issuing of an Honorary Contract.

## Integrated Impact Assessment:

<b>Equality Impact Assessment Date &amp; Outcome</b>	27/02/2023 This policy has been screened for relevance to Equality. No potential negative impact has been identified.
<b>Welsh Language Standard 82</b>	Yes - If Standard 82 applies you must ensure a Welsh version of this policy is maintained.
<b>Date of approval by Equality Team:</b>	Awaiting sign off
<b>Aligns to the following Wellbeing of Future Generation Act Objective</b>	Co-create with staff and partners a learning and growing culture

## Policy Approval Route:

Where	When	Why

**Disclaimer:**

If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or [CTM\\_Corporate\\_Governance@wales.nhs.uk](mailto:CTM_Corporate_Governance@wales.nhs.uk)

**CONTENTS PAGE**

	<b>Honorary Contracts Procedure</b>	<b>Page</b>
1	Policy Statement	3
2	Scope	3
3	Aims and Objectives	3
4	Legislative and NHS Requirements	3
5	Principles	4
6	<u>Procedure</u>	5
	6.1 Occupational Health Check	5
	6.2 Disclosure and Barring Service (DBS) Check	5
	6.3 Professional Registration	6
	6.4 Process for issuing Honorary Contract	6
	6.5 Start Date	7
	6.6 Access to CTMUHB Information Systems	7
	6.7 Termination of Honorary Contract	7
7	Training Implications	8
8	Review, Monitoring and Audit Arrangements	8
9	Managerial Responsibilities	8
10	Retention/Archiving	8
11	Non Conformance	8
12	Equality Impact Assessment Statement	8
13	<u>Appendices</u>	
	Appendix 1 - Honorary Contract Proforma	9
	Appendix 2 - DBS Eligibility Form (ALGORITHM)	12

## **1. POLICY STATEMENT**

An honorary contract is a written agreement issued to authorised individuals, who are not employees of Cwm Taf Morgannwg University Health Board (CTMUHB), where the individual is required to perform a particular function, within a specified remit. Without an honorary contract the individual will not be covered by the NHS Indemnity Scheme.

## **2. SCOPE OF POLICY**

This procedure applies to all CTMUHB staff involved in the requesting, approving, issuing, and monitoring of honorary contracts.

## **3. AIMS AND OBJECTIVES**

The purpose of this procedure is to ensure the correct process is followed when a manager is required to issue an honorary contract to an individual.

This includes responsibility for checking the DBS requirements of the role, arranging for an ad hoc DBS check to be undertaken, if required, as well as checking an individual's Occupational Health status and complete an Occupational Health questionnaire, if required.

This procedure will also ensure that information concerning individuals in receipt of an honorary contract are accurately recorded and maintained by the People Services Department (Agenda for Change, AfC) or Medical Workforce (Medical and Dental, M&D).

The aim is to create an honorary contract procedure which:

- Defines lines of responsibility and accountability for individuals who work in CTMUHB, but who are not employees of CTMUHB;
- Ensures that honorary contract workers are engaged through a fair, open and transparent procedure that satisfies all legal requirements; and
- Is compliant with NHS Employer's requirements.

## **4. LEGISLATIVE AND NHS REQUIREMENTS**

- All Wales Policy on Insurance NHS Indemnity and Related Risk Management for Potential Losses and Special Payments (Welsh Risk Pool, 2015);
- NHS Employment Checks Standards; and Employment Guidance.

In addition to its core workforce, CTMUHB will from time to time, engage the services of individuals, who are not paid employees, to carry out regular or ad-hoc work, on behalf of the Health Board. Occasions often arise when an individual from an external organisation wishes to work within CTMUHB in an unpaid capacity, for example, to gain work experience or shadow experienced staff.

Ref: People69

Policy Title: Honorary Contract Procedure v 1

Page Number: 3

CTMUHB recognises its obligation to promote careers in healthcare and offers work experience arrangements and unpaid placements to individuals, for a specific purpose, via the honorary contract process. In these, circumstances, where the individual concerned is not employed directly by CTMUHB, an honorary contract must be established.

Issuing an honorary contract does not imply the creation of an employer /employee relationship and is for the purpose of granting licence to an individual to conduct certain activities and use certain Health Board facilities and resources. The most important feature of an honorary contract, however, is the indemnity provided by the Health Board, in respect of liabilities, particularly liability in respect of medical negligence (where applicable).

## 5. Principles

The principle of this procedure is to protect patient / service user safety by setting out the process to be followed, to ensure that all appropriate checks are carried out in accordance with NHS Employment Checks Standards and Employment Guidance and best practice. In addition, it places an obligation on the Health Board and individuals to be aware of their duty of care to patients, the general public and work colleagues.

This procedure aims to clarify the correct procedure to be followed when confirming honorary contract arrangements. It is important to note that an individual **will not be covered under the Health Board's insurance policies**, and **will not be indemnified** if an honorary contract has not been issued. Therefore, no individual should be allowed to participate or shadow/observe in a department etc. without an honorary contract being in place.

Individuals eligible for issue of an honorary contract include:

- Return to Practice Students;
- A nurse or other clinical practitioner from another Health Board / NHS Trust undertaking further clinical experience;
- Individuals working for another Health Board / NHS Trust, following through a patient's treatment while in hospital;
- Clinicians, principally but not solely Medical and Dental staff, employed by another NHS organisation or University (in or outside Wales) carrying out duties within CTM but not employed by CTM while doing so.
- Third sector staff;
- Work experience /shadowing /observing individuals, regardless of placement period; and
- Elective placements or similar shadowing for current university or health education institution students, where there is no service level agreement in place.

This procedure does not cover:

- Volunteers recruited directly by CTM Volunteer Service; for further information refer to the Health Boards Volunteer Service guidelines / policy and webpage [Volunteering for Us - Cwm Taf Morgannwg University Health Board \(nhs.wales\)](http://nhs.wales)
- Workers covered under a service level agreement between the Health Board and a third party provider e.g. contractors;
- Staff covered under a service level agreement between the Health Board and a university or health education institution;
- Trainee M&D staff employed by NWSSP (Velindre NHS Trust) while being hosted by CTM.
- Temporary staff employed through the staff bank or an agency.
- Work Experience requests from schools or sixth form colleges.  
For these types of requests please email:  
CTM.Workexperience@wales.nhs.uk

## 6. Procedure

### 6.1 Occupational Health Checks

All posts will require an occupational health check, to ensure that the individual is medically fit to undertake the placement safely on a Health Board site. For Medical and Dental staff, this would not be required if confirmation is received from their current substantive employer that they have been cleared by their own Occ Health Dept to the correct level (eg Patient Contact / EPP).

### 6.2 Disclosure and Barring Service (DBS) Check

All honorary contract holders who will come into contact with children or vulnerable adults in the course of their placement with the Health Board must have had a satisfactory DBS check, prior to commencing.

It is the responsibility of the manager to ensure that the honorary contract holder is suitable to undertake the role for which the contract is being issued, therefore, prior to commencement the manager must check to establish whether the proposed honorary contract holder's employer/education provider has undertaken a DBS Check.

Where the current employer/education provider has undertaken a DBS Check they must be asked to provide the disclosure number, date and level of check undertaken. N.B. most students are now part of the DBS Update Service, which allows an individual's status to be checked on-line.

If a DBS check has **not** been undertaken by the proposed honorary contract holder's employer/education provider the manager must request an appropriate level, ad hoc DBS Check from the Recruitment Department (NWSSP) by using the [Adhoc DBS request form SE .docx \(sharepoint.com\)](#) and send to the following Recruitment Department (NWSSP) email account: [recruitment.servicese@wales.nhs.uk](mailto:recruitment.servicese@wales.nhs.uk).

Ref: People69

Policy Title: Honorary Contract Procedure v 1

Page Number: 5

The DBS Eligibility Form (Appendix 2) can be used to determine what level of DBS check is required and must be completed and attached to every Honorary Contract Proforma. For M&D staff, Medical Workforce will arrange a DBS check if required

### **6.3 Professional Registration**

The Health Board has a Professional Registration Policy, which requires honorary contract holders to provide evidence of their professional registration and qualifications, where appropriate, prior to commencing their placement.

It is the responsibility of the individual to ensure that they maintain their registration such as is necessary to enable them to practise their profession within the Health Board.

Where appropriate, the Health Board manager will be required to verify the individual's profession registration with their employer/university, prior to commencement of their duties/placement.

### **6.4 Process for Issuing Honorary Contract**

Where it is indicated that the work of the individual will involve an element of research please contact the Health Board's Research and Development Department [CTMUHB\\_RD@wales.nhs.uk](mailto:CTMUHB_RD@wales.nhs.uk) who will advise on the process to be followed.

For all other types of Honorary Contacts:

The manager is required to complete an Honorary Contract Proforma (Appendix 1), and to send it to the People Services Department (AfC) or Medical Workforce (M&D) to process. The manager must also attach a list of key duties or the job description the individual will be expected to undertake, as part of their honorary contract arrangement.

This proforma must identify:

- the full name and address of the individual to whom the honorary contract is to be issued to;
- post title/nature of post and honorary contract start and finish dates; (the maximum duration of a contract is 3 years)
- identify to whom the individual will be responsible/report to;
- make sure an Occupational Health check is undertaken (or has been undertaken previously by the individual's employer for M&D)
- whether a Disclosure and Barring Service Check and at which level is required, or has been undertaken previously by the individual's employer/education provider.

A DBS Eligibility Form (Appendix 2) must be completed and attached to every Honorary Contract Proforma.

Ref: People69

Policy Title: Honorary Contract Procedure v 1

Page Number: 6

The manager must ensure that the same departmental induction for substantive staff is followed for honorary contract holders, on their first day of working on a Health Board site. This should cover key areas such as fire responses, car parking and other key health and safety considerations.

The manager must ensure that an honorary contract holder obtains a staff ID badge from the Facilities Department. Honorary contract holders should only have access to those areas where they are required to work.

The manager must ensure that an honorary contract holder is provided with any PPE/uniform required for their role, as applicable.

The People Services Department will record the details contained in the proforma, draft the honorary contract and send it to the individual.

## **6.5 Start Date**

It is the responsibility of the manager to ensure that the required pre-honorary contract checks have been satisfactorily completed, before the individual is allowed to commence work.

Honorary contract holders will not be remunerated (directly by CTM) for any work that they undertake during this agreed period. The duration of an honorary contract must be reviewed every 3 years.

## **6.6 Access to Health Board Information Systems**

Security of information systems is important and access can only be granted to fully identified, system trained individuals that have the correct permissions.

Before an honorary contract holder can be given access to an information system e.g. Outlook, Myrddin etc. the manager must complete the processes for the individual to:

- Be issued with a NADEX number;
- Undertake the required level of training for the IT system(s);
- Sign an IT security declaration form; and
- Have a system password.

The honorary contract holder cannot access any system until the above processes are in place. They cannot use another member of staff's password, regardless of their seniority.

## **6.7 Termination of Honorary Contract**

The manager must inform the People Services Department (AfC) or Medical Workforce (M&D) immediately should the honorary contract cease prior to its planned expiry date.

At the end of the honorary contract, the manager should confirm with the People Services Department (AfC) or Medical Workforce (M&D) that the arrangement has ended, to ensure that accurate records are maintained.

The manager should also ensure that any items belonging to the Health Board e.g. PPE, uniform, staff ID badge, laptop etc. are returned to them before the individual leaves.

The manager must also ensure that IT are also informed when an honorary contract holder leaves, to remove their NADEX account and access to IT systems, if applicable.

## **7. Training Implications**

Any training implications in the implementation of this procedure will be provided as required.

## **8. Review, Monitoring and Audit Arrangements**

This procedure will be reviewed every 3 years. Additional reviews may be required if any changes are made to legislation, policy or terms and conditions of service.

## **9. Managerial Responsibilities**

Managers have overall responsibility for ensuring that this procedure is implemented and monitored effectively. They must also ensure that all of their honorary contract holders are aware of their responsibilities in accordance with this procedure.

## **10. Retention/Archiving**

The Executive Director for People will ensure that copies of this procedure are archived and stored in line with the Health Board's Records Management Policy and are made available for reference purposes, should any situation arise where they are required.

## **11. Non Conformance**

All managers and honorary contract holders are expected to comply with this procedure. Failure to comply with the procedure is a serious offence and could result in disciplinary action.

## **12. Equality Impact Assessment Statement**

This policy has been screened for relevance to Equality. No potential negative impact has been identified.

## **Appendix 1**

### **Guidance for completing the Honorary Contract Request Proforma**

**Please ensure that you complete ALL sections of this form in full, in clear and legible handwriting.**

Incomplete forms will not be actioned and will be returned to the relevant manager for completion. This will result in a delay in issuing the new contract, and may also delay the honorary contract holder's start date.

Please note the following:

- All honorary contracts must have an end date (the duration of an honorary contract must be reviewed every 3 years).
- If an extension to a contract is required, a duplicate form will need to be completed and sent to the People Services Department before for the expiry of the initial honorary contract.
- Honorary contracts will not be issued until Occupational Health clearance has been confirmed.
- If the post requires a DBS check, it is the responsibility of the Manager to obtain confirmation from the individual's employer/education provider that the check has taken place, including the disclosure number, date and level of check undertaken.
- A completed DBS Eligibility Checklist must be attached to the Request Form.
- If a DBS check is required, but has not been previously undertaken, this must be completed and clearance provided prior to an honorary contract being issued.
- All Honorary Contract requests must be signed and authorised by a manager of the Health Board, who will be responsible for the supervision of the honorary contract holder.

**When complete if the request is for a Medical and Dental then the form should be returned to [CTT\\_MedicalRecruitment@wales.nhs.uk](mailto:CTT_MedicalRecruitment@wales.nhs.uk)**

**All other request forms should go to the People Services Department and uploaded via the attached link [People Services \(office.com\)](#)**

**The request must be received at least 2 weeks before the proposed honorary contract start date.**



Section 1: Reason for Honorary Contract Request (please tick the appropriate box(s))						
Access to IT/IG Systems (please provide further info below)*	Work Involves direct patient contact (including Volunteer work)		Observation Placements	Research	Extension to existing Honorary Contract	
Assisting/Leading non-invasive surgical procedures	Assisting/Leading invasive surgical procedures					
*Does the IT access include access to Patient Identifiable Data – Yes / No						
Section 2: Personal Details						
Title: Mr / Mrs /Miss /Ms / Dr / Prof:			Surname:			
Forename:				Date of Birth:		
Address:						
Postcode:						
Email Address:						
Employing Organisation or University:						
Professional Registration Body:						
Professional Registration No:					Expiry Date:	
Section 3: Post/Placement Details						
Title:		CTMUHB Site:				
Dept:		Clinical Service Group:		Care Group:		
Contract Start Date:			Contract End Date:			
Does the post require a DBS check?		Yes / No	* Does the post holder have a current check?		Yes /No	
<i>*If <b>yes</b> please ensure current check has been undertaken and provide details of the check below – please see Honorary Contract Guidance Notes. If <b>no</b> a new DBS check must be completed and clearance provided prior to an honorary contract being issued.</i>						
Disclosure Number:		Date:		Level of Check:		
Please provide brief details of the work the honorary contract holder will be undertaking: (if appropriate, please attach the relevant job description to this form)						
Section 4: Declaration (to be signed by Honorary Contract Holder)						
Medical and Dental only – I confirm I give consent for my pre-employment checks, including Occupational Health to be requested from my current employer.				Yes/No		



I confirm the Occupational Health questionnaire has been completed and forwarded to CTT\_Occhealthnewstart@wales.nhs.uk

Date sent to Occupational Health:

**I confirm that the information provided on this form including DBS information is correct.**  
**I confirm that I will contact the People Services Department or Medical Workforce immediately should my honorary contract cease prior to the expiry date.**

Honorary Contract Holder's Signature: .....  
Print Name: ..... Date: .....

**Section 5: Authorisation (to be completed by Manager)**

**As the authorising supervisor, I agree to take full responsibility for the day-to-day supervision of the above named individual and their work. I confirm that the work they will be undertaking is appropriately approved and all relevant checks have been undertaken. I will ensure that they are fully informed of the relevant CTMUHB policies e.g. Data Protection, Health and Safety, Email/Internet etc.**

**I confirm that I will inform the People Services Department or Medical Workforce immediately should the honorary contract cease prior to its expiry date.**

Manager's Signature: ..... Job Title: .....  
Print Name: ..... Dept/ILG: .....  
Tel No/Extension No: ..... Date:.....

**Section 6: People Services Department/Medical Workforce**

Date Request Received: .....  
Name of person dealing with request: ..... Date: .....  
Confirmation that DBS and Occupational Health Clearance has been received by Manager if applicable: .....  
Date Honorary Contract issued: .....  
If Research related send copy to [CTMUHB\\_RD@wales.nhs.uk](mailto:CTMUHB_RD@wales.nhs.uk), date sent: .....

People Services Department/Medical Workforce Comments/Notes

## Appendix 2

### DBS ELIGIBILITY ALGORITHM

To establish if this post is lawfully eligible for a DBS check, and to identify the level of checks required, please answer Sections A and B.

<b>A</b> Please read the descriptions below and place an X against the <b>ONE</b> activity that applies to this post:		
Description of Activity	Select <b>ONE</b>	RECRUITMENT USE Type of Disclosure
1. Post holder is a health care professional <sup>1</sup> providing health care <sup>2</sup> to an adult <sup>5</sup> and/or child <sup>5</sup> , even if done only once <i>E.g. NMC, HCPC, Royal Pharmaceutical Society, General Pharmaceutical Council (inc. registered laboratory staff and Pharmacists)</i>	<input type="checkbox"/>	Enhanced <b>and</b> appropriate barred list check(s)
2. Post holder provides health care <sup>2</sup> to an adult <sup>5</sup> and/or child <sup>5</sup> under the direction or supervision of a health care professional, even if done only once	<input type="checkbox"/>	Enhanced <b>and</b> appropriate barred list check(s)
3. Post holder provides personal care to an adult <sup>5</sup> or child <sup>5</sup> , even if done only once. <i>E.g. HCSW, Porter transporting patients, etc</i> <b>or</b> Post holder is a social care worker providing social work which is required in connection with any health care or social services to an adult <sup>5</sup> who is a client or potential client, even if done only once	<input type="checkbox"/>	Enhanced <b>and</b> appropriate barred list check(s)
4. Post holder undertakes the following activities unsupervised: teach, train, instruct, care for or supervise children <sup>5</sup> , or provide advice/guidance on well-being, or drive a vehicle only for children <sup>5</sup> ; with likely direct bearing on the quality of care <sup>3</sup> .	<input type="checkbox"/>	Enhanced <b>and</b> <b>Childrens</b> barred list check
5. Post holder manages people engaging in any of the above activities in a day to day basis.	<input type="checkbox"/>	Enhanced, <b>no</b> barred list checks
6. Post holder has opportunity for any form of contact with children <sup>5</sup> in the same Children's Hospital (formerly a specified place) but is not providing health care or other types of regulated activity and has no direct bearing on the quality of care.	<input type="checkbox"/>	Enhanced, <b>no</b> barred list checks
7. Post holder has access <sup>4</sup> to persons in receipt of health care services in the course of their normal duties but is not providing health care or other types of regulated activity and has no direct bearing on the quality of care	<input type="checkbox"/>	Standard, <b>no</b> barred list checks
8. Post holder is supervised by a health care professional <sup>1</sup> and undertakes diagnostic tests and/or investigative procedures <i>E.g. non-registered laboratory staff</i>	<input type="checkbox"/>	Standard, <b>no</b> barred list checks
9. The role does not meet any of the above <i>(If you select this activity you may ignore Section B)</i>	<input type="checkbox"/>	Post not eligible for a DBS check

<b>B</b> To establish the age of your <b>PATIENTS</b> and the post holders level and frequency of contact with your patients, please select the relevant options below for both age groups: <i>NB: This section relates to patient access only. Friends, relatives or children accompanying a patient do not dictate the level of a DBS check and should <u>not</u> be taken into consideration.</i>						
Age of Patients	Frequency of Contact			Type of Contact <sup>6</sup>		
<b>Aged 17 yrs or under</b>	<input type="checkbox"/> Never	<input type="checkbox"/> Possible	<input type="checkbox"/> Frequent	<input type="checkbox"/> Direct	<input type="checkbox"/> Indirect	<input type="checkbox"/> N/A
<b>Aged 18 yrs or over</b>	<input type="checkbox"/> Never	<input type="checkbox"/> Possible	<input type="checkbox"/> Frequent	<input type="checkbox"/> Direct	<input type="checkbox"/> Indirect	<input type="checkbox"/> N/A

- <sup>1</sup> "health care professional" means a person who is a member of a profession regulated by a body mentioned in [section 25\(3\) of the National Health Service Reform and Health Care Professions Act 2002](#).
- <sup>2</sup> "Health care" includes all forms of health care provided for individuals, whether relating to physical or mental health and includes palliative care. This includes diagnostic tests and investigative procedures. "Health Care" also includes procedures that are similar to forms of medical or surgical care that are not provided in connection with a medical condition, e.g. taking blood from a blood donor or cosmetic surgery.
- <sup>3</sup> A "direct bearing on the quality of care" suggests that the actions of Post holders could foreseeably directly affect the type, quality or extent of prevention, diagnosis or treatment of illness or foreseeably cause injury or loss to an individual to whom the organisation has a duty of care.
- <sup>4</sup> "Access" relates to where individuals will have in-person, direct contact with patients e.g. reception, observation, interviews, focus groups, etc.
- <sup>5</sup> An adult is anyone aged 18 years or older. A child is anyone under the age of 18 years old.
- <sup>6</sup> Direct Contact is face-to-face contact, but not necessarily physical contact. Indirect Contact is contact, for example, by telephone, access to medical notes, etc.



Llywodraeth Cymru  
Welsh Government

Sue Tranka  
Prif Swyddog Nyrsio  
Chief Nursing Officer  
Cyfarwyddwr Nyrs GIG Cymru  
Nurse Director NHS Wales

Alex Slade  
Director of Primary Care and Mental Health  
Cyfarwyddwr O Gofal Sylfaenol Ac Iechyd Meddwl

To: Chief Executive Officers  
Vice Chairs  
Executive Directors of Nursing  
Directors of Primary Care

25 January 2023

Dear Colleagues,

### National Community Nursing Specification

The Programme for Government (June 2021) sets out the ten well-being objectives that the government will use to maximise its contribution to the seven long-term well-being goals and the steps we will take to deliver them. A key objective is to provide effective, high quality and sustainable healthcare through a number of actions including delivering better access to doctors, nurses, dentists, and other health professionals.

During 2021-2022, the National Primary Care Board has overseen a significant piece of work, led by the Strategic Programme for Primary Care, to develop a [National Community Nursing Specification](#). We are delighted to launch this specification, the first of its type in Wales, which is enclosed and it can be found in the [Community Infrastructure Toolkit](#). The specification outlines the minimum requirements of how community nursing services (including district nurses, general practice nurses and specialist nurses) work together and with other members of the multi professional team, to meet the needs of people aged 16 and over. This will;

- **Standardise** care where possible to reduce variation and raise quality
- **Simplify** systems and processes to make people's experience better and nurses working lives easier
- **Promote collaboration** with other nurses and professionals around the person

To help achieve the ambitions of the specification, we set out below some key milestones for 2023-24.

### Key Milestones 2023-24

#### By 31<sup>st</sup> March 2023

- Health Boards undertake the [National Community Nursing Specification self- assessment](#) and develop a locally owned action plan which outlines how community nursing services will start to meet the requirements of the National Community Nursing Specification. This should be submitted to Paul Labourne ([paul.labourne@wales.gov.uk](mailto:paul.labourne@wales.gov.uk))
- The self assessment to be shared with the Strategic Programme for Primary Care and health boards to identify any national support required.



BUDDSODDWR MEWN POBL  
INVESTOR IN PEOPLE

Parc Cathays, Caerdydd CF10 3NQ Cathays Park, Cardiff CF10 3NQ  
Epost/Email: [QualityAndNursing@gov.wales](mailto:QualityAndNursing@gov.wales)

April - May 2023

- Increase end of life care capacity (this is subject to confirmation of funding and will be clarified in February)

By 30<sup>th</sup> June 2023

- Clear supervision offer to District Nurses, Specialist Nurses and General Practice Nurses in Health Board Managed practices, of a **minimum** of one restorative supervision session every six months.

By 30<sup>th</sup> September 2023

- Implementation of a two hour, 72 hour and 10 working day response to referrals, by District Nursing Teams and Community Specialist Nursing Teams.
- Direct referrals to District Nursing Services out of hours from Urgent Care Services including OOH GP, 111 and WAST Clinical Support Desk clinicians and Paramedics where direct referral pathways exist, are in place.
- Implementation of a frailty score across all community nursing services

By 31<sup>st</sup> October 2023

- District Nursing capacity on Saturday and Sunday daytime is at a minimum of 60% of the usual weekday DN capacity
- All Health Boards are able to provide access to overnight District Nursing Services for people

November- December 2023

- Health Boards to refresh self-assessment and identify any actions to be included in subsequent IMTP for 2024

I trust you will do all you can to enable and support the achievement of the above milestones, which will help ensure care provided by community nursing services is safe, effective, person centred, timely, efficient and equitable in line with the [Quality and Safety Framework: Learning and Improving \(gov.wales\)](#) This in turn will provide benefits to the wider system, including prevention of inappropriate attendances at emergency depts and hospital admissions, timely hospital discharges and retention of community nurses. All of which aligns to the Accelerated Cluster Development Programme and the Six Goals for Urgent & Emergency Care Programme.

Should you have any queries or would like local specific discussions on the implementation of the Community Nursing Specification and the delivery of the milestones, please contact Chiquita Cusens, National Lead Nurse for Primary and Community Care ([chiquita.cusens@wales.nhs.uk](mailto:chiquita.cusens@wales.nhs.uk)).

Yours sincerely



**CHIEF NURSING OFFICER  
NURSE DIRECTOR NHS WALES  
PRIF SWYDDOG NYRSIO  
CYFARWYDDWR NYRS GIG CYMRU**



**DIRECTOR OF PRIMARY CARE AND  
MENTAL HEALTH  
CYFARWYDDWR O GOFAL SYLFAENOL  
AC IECHYD MEDDWL**



# National Community Nursing Specification

Overarching principles, characteristics, and functions of Community Nursing in Wales

October 2022

## Executive Summary

The National Community Nursing specification outlines at a strategic level the overarching principles, characteristics, and functions of Community Nursing in Wales for individuals aged 16 and over. The experience of individuals and families using or accessing community nursing services are at its centre, via the use of core principles focused on providing person centred, preventative, safe and effective services. Its aims are:

<b>Standardise</b> care where possible to reduce variation and raise quality	Sets out key principles	<a href="#">Section 4</a>	→	<b>Improved experience for person and their health &amp; well-being</b>  <a href="#">Section 13</a>
	Sets out working hours for District Nursing services & response times	<a href="#">Section 5</a>		
	Identifies key skills and knowledge for Community Nurses	<a href="#">Section 7</a>		
<b>Simplify</b> systems and processes to make people's experience better and nurses working lives easier	Access for other health & care services	<a href="#">Section 5</a> & <a href="#">Section 6</a>	→	
	Reduces Variation	<a href="#">Section 9</a>		
	Improves Quality	<a href="#">Section 6</a> & <a href="#">Section 9</a>		
	Values Nurses	<a href="#">Section 11</a>		
<b>Collaboration</b> with other nurses and professionals around the person	Improving Communication	<a href="#">Section 10</a>	→	
	Role of Community Nurses as clinical leaders	<a href="#">Section 8</a>		
	Opportunities for new ways of working & nursing models	<a href="#">Section 12</a>		

The specification is not able to comprehensively cover all areas of practice and specialism that Nurses working in the Community provide. Therefore, this specification focuses on General Practice Nurses, Specialist Nurses and District Nurses and their teams.

**Collectively these groups are referred to as Community Nursing Services and Community Nurses or Nurses, within this specification.**

Community Nursing Services do not work alone and are an essential part of the wider nursing team, multi professional team and health and social care system.

Standardising key elements of Community Nursing Services will promote greater collaborative working between nurses and understanding of community nurse's role and value within the wider multi professional team. This will be important as traditional role boundaries change and nurses increasingly work in new models of care to meet the challenges of our health and social care system.

The specification promotes Community Nurses to come together to review the way they work across pathways for people aged 16 and over. It encourages nurses to think about different models of working, how to share and learn from one another and advocates for a move towards a preventative population-based approach to support the people they care for.

Recognising the value Community Nurses offer, the specification outlines how nurses should be enabled to lead and support research and service improvements, have clear development and career pathways and be supported via access to regular clinical supervision.

Community Nurses offer strong clinical leadership and governance to their services and the wider health and care team. This, alongside a consistent approach to the way they work, will enable nurses to further lead, develop, and/or support current and new services, to meet the ambitions of the Primary Care Model for Wales.

## Contents

Executive Summary.....	2
1. Introduction.....	4
2. Definition of Community Nursing .....	4
3. Strategic Context of Nursing in Wales .....	6
4. Community Nursing Principles.....	7
4.1 Person centred .....	7
4.2 Preventative and Population health focused .....	7
4.3 Skilled workforce .....	8
4.4 Whole system pathway.....	8
4.5 Technology enabled .....	9
4.6 Safe, Effective and Value based.....	9
5. Key Characteristics of a Community Nursing Workforce.....	10
5.1 Operational Standards.....	10
5.2 Response times.....	11
5.4 Clinical Recording Keeping .....	12
5.5 Use of Technology .....	12
5.6 Place of care.....	12
6. Specific Clinical Considerations.....	13
7. Scope of practice.....	16
8. Leadership & Management Skills .....	19
9. Organisation of Care .....	19
10. Communication.....	22
10.1 Person Specific Communication .....	22
10.2 Professional & Team Communication:.....	23
11. Workforce learning and development.....	23
12. Community Nursing Models of Care.....	25
13. Quality and Outcomes.....	26
14. Glossary of Terms.....	29
Appendices.....	30
Appendix 1: Self-assessment form which covers all key aspects (i.e. sections 4 – 12) of the National Community Nursing Specification .....	30

# 1. Introduction

1.1 The National Community Nursing Specification outlines at a strategic level the overarching principles, characteristics and functions of Community Nursing in Wales for individuals aged 16 and over.

1.2 The National specification aims to;

- **Standardise** care where possible to reduce variation and raise quality
- **Simplify** systems and processes to make people’s experience better and nurses working lives easier
- **Promote collaboration** with other nurses and professionals around the person

1.3 The specification recognises that the needs of local populations will require nurses with different skills in order to meet those needs. However, **the totality of the service** offered by Community Nursing, should embed the key characteristics, principles and functions outlined here.

1.4 This will ensure there is a consistent approach to the provision of Community Nursing Services which;

- has the experience of individuals and carers using or accessing community nursing services at its centre. This will be via the use of key principles focused on providing person centred, preventative, safe and effective services
- recognises the value and contribution Community Nursing offers to individuals, local communities and health and care professionals across primary, community and secondary care.
- promotes closer working and a clearer understanding of each other’s roles, creating more resilient and effective relationships between, generalist, specialist, advanced and consultant Nursing practitioners, who provide episodes of care within the community setting
- reduces variations in the service provided to individuals and carers and to those services or professionals that interface with them

1.5 Community Nursing Services will need to be able to demonstrate how they are achieving the National Community Nursing Specification and its outcomes. A self-assessment tool and measures to demonstrate how the outcomes of this specification will be achieved are included in section 13. Together these will support Community Nursing Services to understand how their services currently meet the principles, characteristics and functions set out in this specification and the actions required to achieve these.

## 2. Definition of Community Nursing

2.1 Community Nursing can be defined as any nurse working in the community, providing care, treatment and support to individuals. Community nursing covers a breadth of generalist and specialist nurses who work within local communities; see figure 1. For the purposes of the specification, these are grouped in the following way, recognising there can and will be, multiple interfaces between nurses based on an individual’s nursing needs;

<b>Generalist Nurses</b>	General Practice Nurses District Nurses and their teams
<b>Specialist Nurses</b>	Disease Specific Specialist Nurses who work with a group of individuals with a specific condition e.g., Diabetes Specialist Nurses, Heart Failure Nurses, Chronic Obstructive Pulmonary Disease (COPD) Nurses
	Practice Specific Specialist Nurses who work within a specific area of practice, but see individuals with a range of need e.g., Prison Health Nurses, Homeless & Inclusion Nurses, Intermediate Care Nurses, Palliative Care Nurses
<b>Specialist Nursing Branches and/or Specialist Community Public Health Nurses</b>	Community Children’s Nurses, Community Mental Health Nurses, Learning Disability Nurses, Health Visitors, School Nurses, Community Midwives, Occupational Health Nurses
<b>Significant other groups of Nurses</b>	Care Home Nurses, Dental Nurses

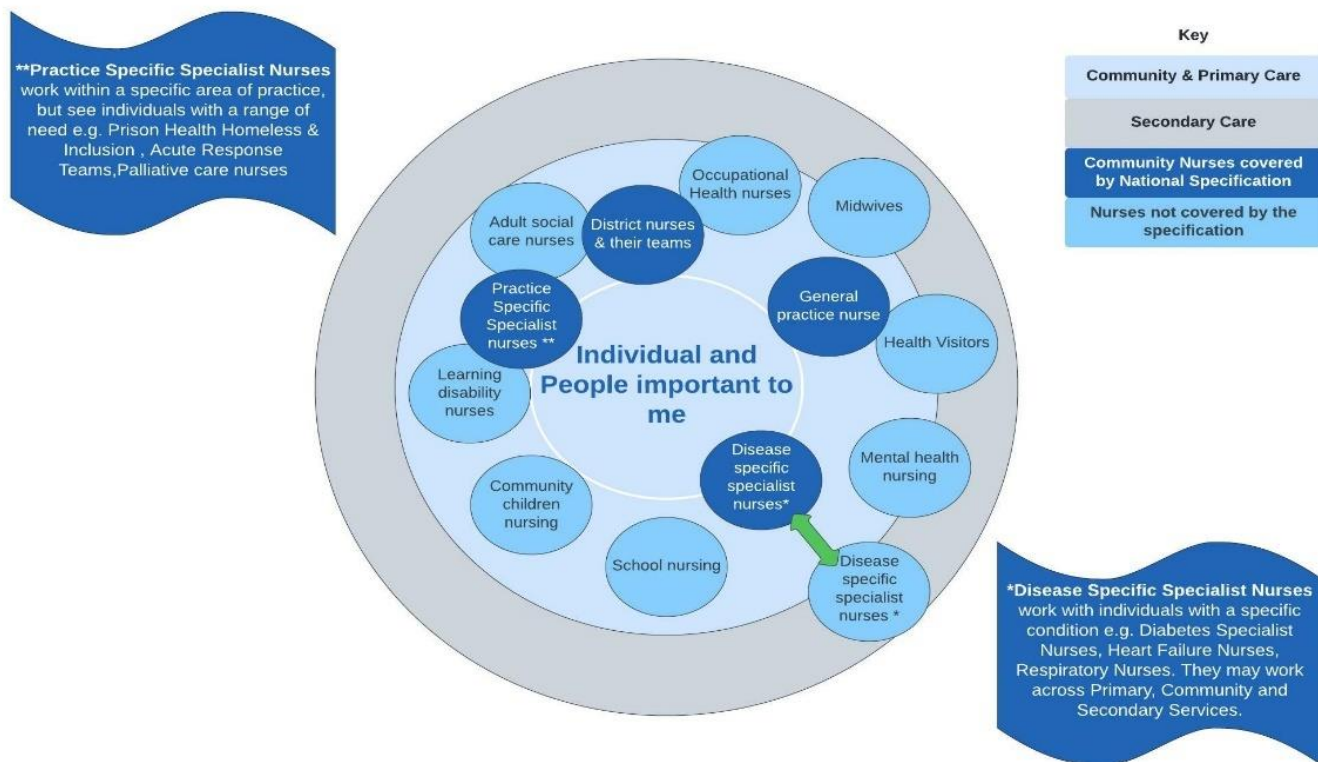


Figure 1 – Community nursing

2.2 In addition, the Community Nursing family consists of a variety of roles and levels of expertise.

- Health Care Support Workers including Assistant Practitioners
- Registered Nurses
- Advanced Nurse Practitioners
- Consultant Nurses
- Nurse Leaders/Managers

2.3 Nurses are integral to supporting people and are key to effective partnership working with other members of the health and care workforce. They have a wealth of varied skills, knowledge and expertise covering individual nursing needs from pre conception to birth, through childhood to adulthood and at the end of life. All nurses throughout an individual's life journey, play a valuable part in empowering and supporting individuals and their families at home, in education and at work.

**However, for the purposes of this specification, Nurses who fall under the Specialist Nursing Branches, Specialist Community Public Health Nurses and Significant other groups are not included here.**

This is due to either the specialist area of practice they provide, which the specification would not be able to fully cover, or that their area of practice falls outside the age remit of the specification, which is 16 years and over. While some nurses will have significant interfaces between children and adult services, this is covered within 'Transition' in section 6.

2.4 Community Nursing Services will also work within the wider context of Multi Professional Teams. This may be as a standalone service which collaborates with other professionals, as a key part of a multi professional team or within an integrated service. The inclusion or exclusion of any Nurses within this specification, is not intended to prevent Nurses from collaborating together, either with each other or within the wider health and social care system, to meet individuals and local populations nursing needs.

**2.5** The National Specification for Community Nursing focuses specifically on the three following groups;

- **District Nursing Services** are a nurse led service run by a District Nurse team leader who holds an NMC recordable specialist practitioner qualification (QNI 2022), providing leadership and expertise that focuses on care in the home. District Nurses and their teams are an integral part of the multi-professional primary care team. These teams take a public health approach, caring for a designated population, aligned within a cluster, promoting independence, safety, quality and experience with the ethos of home being the best and first place of care.
- **General Practice Nurses** (GPN's) work within a General Practice setting where they autonomously assess individuals and provide evidence-based care and treatment to individuals of all ages, presenting with a wide range of health conditions. These include individuals experiencing a short-term illness, management of chronic conditions, as well as supporting those who are palliative. GPN's play an important part in enabling people of all ages to stay well by providing screening and health promotion, as well as delivering care and treatment for acute and chronic illness. They also provide vaccinations and immunisations, contraceptive and sexual health services, wound care and support General Practitioners with minor surgery.
- **Specialist Nurses** play an important role in commencing and optimising treatments, educating the person on their condition and helping the person to stay well. They are an integral part of the enhanced multi-professional primary care team, specialising in a particular area of practice or health condition. Specialist nurses may work *autonomously* either alone or as part of a multi professional team.

There are significant interfaces between District Nursing Services, Specialist Nurses and General Practice Nurses in the Community and the people they provide care, support and treatment to. The National Specification *does not require these groups to operate in the same way*, but rather as a totality, to ensure they work in partnership regardless of the organisation they are employed by, to support the [underlying principles](#) (section 4) of Community Nursing and the provision of high quality, seamless and coordinated care.

### 3. Strategic Context of Nursing in Wales

**3.1** Community Nursing Services are central to achieving the ambitions of ['A Healthier Wales's \(2019\)](#) and the [Social Services and Well-being \(Wales\) Act \(2014\)](#) which collectively focus on people at the centre, enabling health and well-being through prevention of illness, delivered through partnership and co-operation. They form a significant part of the multi professional team and cluster working, essential components in achieving the [Primary Care Model for Wales \(2019\)](#) and ambitions of the [Six Goals for Urgent and Emergency Care](#), supporting care closer to home.

**3.2** Community Nurses play an important part in improving health and social care outcomes and delivering equitable, person centred quality services that recognise the needs of its population, addresses inequalities and adopt an anti-racist approach ([Anti-racist Wales Action Plan 2022](#)). These are three of the five [CNO's priorities for Nursing \(2022\)](#) and are also reflected in the learning from the [Evaluation of the Neighbourhood District Nursing Pilots and recommendations \(2020\)](#).

**3.3** Community Nurses provide strong compassionate clinical leadership within the health and social care system and are ideally placed to develop and lead services using a [Value Based Health Care](#) approach to achieve the principles of [Prudent Health Care \(2016\)](#).

**3.4** The development of the Community Nursing Workforce therefore, which is underpinned by the [Health and Social Care Workforce Strategy \(HEIW 2020\)](#), and the [Digital Strategy for Wales \(2022\)](#) will be essential in realising the ambitions of these national strategies and the significant transformation required to do so.

## 4. Community Nursing Principles

The following principles, based upon National Strategies including 'A Healthier Wales's (2018) and developed in discussion with Nurses must underpin how community nursing services work:

4.1 Person centred	4.2 Preventative and Population health focused
<ul style="list-style-type: none"> <li>• Community Nursing services support individuals to understand their physical, mental, sensory health and emotional wellbeing needs.</li> <li>• Community Nursing services enable individuals to make decisions based on 'what matters to me', using a co productive personalised care planning approach.</li> <li>• Community Nursing Services recognise the cultural rights and practices of the people they support. This includes ensuring individuals have access to information about their condition and treatment in the language of their choice.</li> <li>• Community Nursing Services are able to make an active offer of Welsh and English to all individuals seen.</li> <li>• All individuals have access to information about their condition and treatment in the language of their choice.</li> <li>• Individuals are enabled to take responsibility for their health and well-being through self-management of their conditions and are empowered to make decisions to achieve their outcomes.</li> <li>• Community Nursing Services recognise the rights of individuals to make decisions which to others may appear risky, whilst enabling them to live safely within families and communities.</li> <li>• All individuals should receive equitable levels of access, treatment or support regardless of where they live, their ethnicity or whether their need is due to a physical or mental health condition.</li> <li>• Community Nursing Services should be designed to provide a holistic approach recognising the individual and their networks, promoting choice and independence.</li> <li>• Consistent treatment, support and continuity of care, is delivered where ever possible by small groups of nurses who know the individual well.</li> </ul>	<ul style="list-style-type: none"> <li>• Nurses working in community nursing services at each contact, offer opportunities for individuals to better understand, maintain and improve their health and wellbeing.</li> <li>• Nurses take a biopsychosocial approach to interventions, that recognises the individual as a whole and how other factors may impact upon both the individual's health and wellbeing and the choices they make.</li> <li>• Nurses understand their local population's needs and there is active collaboration, engagement and clear referral pathways with other community services and organisations, at neighbourhood and/or cluster level.</li> <li>• Community Nursing services are supported to access risk stratification software alongside local population data, to understand the nursing needs of local residents</li> <li>• Nurses work collaboratively with members of the wider Nursing community and multi professional team, to identify opportunities for preventative services and early interventions.</li> <li>• Community Nursing Services are empowered to shift from a focus on ill health to one of prevention, maintenance and improving health and wellbeing.</li> <li>• Community Nursing services consider how they support and recognise opportunities to maintain and improve the health and wellbeing of carers they have contact with. This may include signposting carers and/or supporting them to access support through collaborative working with others.</li> </ul>

### 4.3 Skilled workforce

- Nurses working within community nursing services are developed to provide holistic care, which has advocacy and compassion at its core.
- Nurses are enabled to obtain, understand and use local population data to identify the skills required to support the health and wellbeing needs of their population.
- Nurses use behavioural and motivational techniques to enable individuals to stay well and take responsibility for their health and wellbeing, including the management of any long-term conditions.
- Access to training should where ever possible, be part of a multi professional offer. This allows community nurses to learn alongside colleagues from different professionals, recognising that community nurses work and support individuals as part of a wider multi professional team.
- Community Nursing Services have a clear career and development pathway which enable nurses to work effectively to the full remit and opportunities offered by the nurse's job description and which is responsive to the changing needs of its population.
- Nurses have access to restorative supervision which offers opportunities for nurses to reflect on their practice, identify development needs and facilitate wellbeing and person-centred care via advocacy.
- The development needs of Nurses should be considered and delivered across the traditional boundaries between practice, district and specialist nurses, enabling nursing care that is seamless and coordinated across organisational and nursing interfaces. This ensures consistent practices particularly in regard to management of long-term conditions and increased understanding of roles.
- The specialist nature of the breadth of Nurses who practice up to advanced and consultant level within Community Nursing should be recognised via the offer of specialist advanced practice programmes, including the specialist practice qualification (SPQ). This enables Nurses to make high-level decisions (Hill 2020) and supports prevention of unnecessary hospital admission (Kraszewski and Norris 2014; Barrett et al 2007).
- All Nurses should have opportunities to develop compassionate leadership, with Nurses responsible for teams being offered additional training in case management, coordination of care, coaching, mentoring, clinical supervision, change management and negotiation.
- To enable this, all Community Nurses, require access to dedicated continuous professional development time and access to funding.

### 4.4 Whole system pathway

- Community Nursing Services work collaboratively as part of a whole system multi professional pathway, which has a co productive and preventative approach, based on population needs and underpinned by shared visions and goals.
- Community Nursing services have access to shared electronic systems which allow for greater integration and coordination of care across and between other health/care professionals and services within their cluster or neighbourhood. This is essential for safe joint working, coordination, timely sharing of information and preventing nurses from duplicating record keeping.
- Community Nursing services are responsive to individuals urgent nursing needs, maximising opportunities for working across traditional boundaries such as employer, profession or location.
- Community Nursing Services response to nursing need, is based on ensuring care provided to the individual is at the right time, by the right person with the right skills.
- Community Nursing services and their representatives are a core part of any development of services, advocating for a whole system partnership approach within their Neighbourhoods or Clusters.
- This recognises the skills Nurses have in identifying, planning, leading, influencing, coordinating and delivering person centred services, at neighbourhood, cluster and regional level, based on local population needs.
- Specialist Nurses are an integral part of community nursing services and wider multi professional team. Specialist Nurses should be supported and permitted to develop their services within the context of seamless integration.
- Alongside their traditional roles, Specialist Nurses should be enabled to work with local populations, primary and community services, 111 and out of hours services, on identifying preventative and public health approaches to meet the local population's needs.

#### 4.5 Technology enabled

- The use of technology can support and empower some individuals to understand their condition, to recognise when their condition may be changing and to seek advice and support in a timely way. This can enable individuals to have choice in how and where their care is provided, to stay well and to prevent unnecessary contact and attendances with health and care professionals.
- Community Nursing Services use technology to work across organisational and professional boundaries to support timely, safe and effective clinical assessment/ diagnosis and individualised care, treatment and wellbeing, during face-to-face visits or via remote consultations.
- Community Nurses have access to information in the persons preferred language of choice and support for individuals to use technology.
- The use of technology to support individuals, is always balanced with the rights of individuals to refuse this and the acknowledgement that some individuals may not have the financial means, ability, access to devices, or desire to use digital technology.
- Community Nurses have access to electronic clinical records and/or integrated records where available and the use of scheduling systems where they have demonstrated benefit.
- Community Nursing services are enabled by handheld digital infrastructure and the ability to remotely connect with and access systems across primary and secondary care. This will allow Community Nurses to flexibly carry out their role regardless of setting.
- Community Nursing services should consider how Technology Enhanced Care Services (TECS) including telecare, telehealth, telemedicine and mhealth can be used to support individuals to monitor or manage their care within the areas of their practice.
- The use of apps, remote health monitoring systems or environmental/personal sensors, which can alert to changes in health or risk of harm are used, supporting community nurses to take preventative actions.

#### 4.6 Safe, Effective and Value based

- Community Nursing services provide safe, timely, dignified, individualised, consistent and effective, evidence-based nursing care, which provides value for money, based on prudent healthcare principles and a value-based approach.
- Community Nurses are enabled to work together to ensure their generalist and specialist skills and ways of working, are able to consistently evolve to meet the changing needs of their population. This will ensure Nurses unique contribution to the care they offer to individuals and benefits to the wider multi professional team, are recognised and valued.
- Community Nursing services have a service improvement and research strategy which supports nurses at all levels to identify, participate or lead quality and/or research initiatives. This is essential to developing, improving and increasing the quality of care and outcomes for individuals.
- Community Nurses across primary, community and specialist nursing are supported to learn from one another, explore what works well and use innovation to improve and transform practice.
- Community Nurses are able to demonstrate through the use of individual outcomes and population health data, how they are contributing towards people's health and wellbeing both within their own remit of practice and as part of a multi professional team.
- Community Nursing Services have access to tools and data which supports their understanding of the capacity, demand, acuity and complexity of individuals seen, to ensure nurses can meet people's needs in a safe and timely manner.
- Community nursing services share information including across organisational boundaries, where it will benefit wider understanding of the needs and demands of a population within a neighbourhood or cluster.

## 5. Key Characteristics of a Community Nursing Workforce

### 5.1 Operational Standards

#### Working Hours

**5.1.1 District Nursing Services** as the core nursing service for the community, must operate a **7 day service that is available 24 hours a day**. District Nursing Teams should as a **minimum** be of a **sufficient and consistent** level across the 7 day period to meet the nursing needs of the local population. This includes how District Nursing services support out of hours services, including urgent discharges from hospital e.g., for individuals who wish to die at home and admission avoidance.

The difference in capacity between 'in hours' i.e., Monday to Friday 8 – 5 pm and the weekend **should be no less than 80% of District Nursing Capacity Monday to Friday**. Ensuring there is a robust District Nursing workforce over the weekend is essential, as these teams form the underpinning core of nursing availability throughout the 24-hour period.

This will promote a consistent approach, reducing unwarranted variation between District Nursing Services in Wales and key services including secondary care, Welsh Ambulance Service Trust (WAST) and GP out of hours.

The ability to access support during the evening, at weekends or overnight can often make the difference between a person being able to stay at home when unwell, or being admitted to a hospital. District Nursing Services as a 24/7 service, should be supported to review how they work together with other community nurses such as those in intermediate care teams or acute response teams, where available, as well as third sector provision e.g., hospices, local authorities and domiciliary care.

A collaborative approach which brings services together out of hours including overnight, has multiple benefits. For the individual it can help them to stay at home when e.g., unwell preventing deterioration, or in crisis e.g., due to carer breakdown, or at the end of life. For services, nurses and professionals, it can reduce calls to other out of hour's services, provide clinical support and governance and support lone working.

The recognition of District Nursing Services as one of the three central components of community nursing in clusters, is essential to support the ambition of a District Nursing service with its focus on prevention, what matters to me, self-care where possible and enabling care and treatment at home.

**5.1.2 General Practice Nursing** (GPN) services operate mainly Monday to Friday, although this varies between GP practices. Treatment or care provided by practice nurses, which needs to be continued at weekends, will require nurses across primary and community care to work together to provide wrap around care for the individual. This may mean reviewing current pathways, skills and ways of working to ensure individuals do not experience a reduction in service or quality, due to different services operating hours. Developing communication opportunities for community nurses to come together in person or virtually to review ways of working is essential.

**5.1.3 Specialist Nurses** – Services may operate a variety of working hours dependent on the way they have been previously developed and commissioned. Wherever possible and if appropriate to the needs of the population they are working with, access to specialist advice for community nurses should be available across the 7-day period during core working hours i.e., 9.00 – 5.00 pm.

This may mean utilising opportunities such as technology to support access to specialist nurses, specialist nurses working across clusters, promoting the use of personalised care plans and/or specialist advice being available from the wider multi professional team. This recognises the increasing complexity of people supported in community settings and the emphasis on enabling people to remain in their own homes and increasing other community nurses' confidence, knowledge and skills.

Specialist Nurses risk being isolated at weekends and consideration of how specialist nurses work in partnership and stay in touch with other specialist nurses and professionals over the weekend should be

reviewed. This could include co-locating District Nursing and Specialist Nursing Services together out of hours and would help reduce the risks associated with lone working and improve efficiency.

**5.1.4 Access to Community Nursing Services** should be easy, both to access and to understand how to do so for individuals and professionals. Single Access Points can be a way of achieving this particularly for District Nursing Services and/or Specialist Nurses. For example, single access points for Palliative Care Nurses and District Nurses and their teams can prevent duplication of effort, ensuring individuals receive a timely response from the right nurse with the right skills, particularly for those individuals at the end of life.

Access to services both in and out of hours for urgent referrals should be direct to the service, rather than via another professional. Referrals to Community Nursing Services out of hours from Urgent Care services including OOH GP, 111 services and the Welsh Ambulance Service Trust (WAST) Clinical Support Desk clinicians and Paramedics where direct referral pathways exist, must be direct to ensure a timely response.

Self-referrals by **individuals known** to community nursing services, particularly specialist nursing services should be in place and the arrangements of how individuals can self-refer, clearly communicated upon admission to the service.

## 5.2 Response times

**The section below refers to all Community Nursing Services unless specified otherwise.**

The way community nursing services organise themselves to achieve the two hour urgent response may vary, according to local population need and organisation of services. The definitions for response times below are intended as guidance only, as determination of these should be based on the **professional's clinical judgement**.

**Urgent** - *an urgent nursing need which is likely to result in a hospital attendance or admission if the person is not seen within 2 hours*

### 5.2.1 District Nursing Services and Specialist Nurses:

To enable people to receive timely care at home, preventing unnecessary attendances or admission to hospital, specialist and district nursing services must be able to respond to urgent calls within a two-hour period. This response may consist of a face to face, telephone/video triage or consultation, resulting in a management plan which meets the individual's needs.

Individuals who are in the last few weeks/days of life must receive an **urgent response** to calls regarding the management of distressing symptoms and/or significant changes in the person's condition. **This response may consist of an initial triage call and/or a face-to-face visit**, resulting in a management plan which meets the individual's needs.

A proactive approach between professionals and organisations across community/practice settings is key to maximise anticipatory planning and reduce urgent issues which could have been anticipated. The reviewing of such occurrences in team/multi professional meetings should be encouraged to understand the reasons for these issues, if they could have been prevented and if any changes to practice/pathways are required.

**Where clinically triaged and agreed with the referrer**, a response of longer than 2 hours may be agreed up to a maximum response time of 4 hours for a face-to-face visit. This decision must be clearly communicated to the individual or carer/family and documented within the clinical record.

Community Nursing Services may develop specific teams to support the achievement of an urgent response. However, this should not prevent the wider community nursing workforce from developing skills or knowledge that enable them to respond to an individual's changing condition at home. Equally, the development of any such teams should not result in duplication, or overlap of provision.

**5.2.2 Non-Urgent** - Individuals identified as requiring non urgent nursing care must receive a face to face visit within 72 hours, unless after clinical triage and discussion with the referrer a longer response is agreed. This decision must be clearly communicated to the individual or carer/family and documented within the clinical record.

**Non Urgent** - *the individual is able to wait for a nursing intervention for up to 72 hours (including weekends & bank holidays)*

**5.2.3 Planned** - Individuals identified as requiring planned nursing care

**Planned** – *the individual is able to wait for a nursing intervention for up to ten working days*

should receive a face to face visit within 10 working days, unless after clinical triage and discussion with the referrer a longer response is agreed. This decision must be clearly communicated to the individual or carer/family and documented within the clinical record.

The allocation of visits must be supported via a scheduling system for District Nursing services and should be considered for specialist nursing services. Scheduling systems can support the safe and timely allocation of visits, and support recording of response times, promoting ‘the right nurse with the right skills, at the right time’ approach. Services will also need to consider how this information is shared with the wider multi professional team, to prevent duplication of visits and the best use of staffing resources. This should also include how services can work together to meet the above response times.

## 5.4 Clinical Recording Keeping

Community nursing services have electronic clinical systems in place to record their nursing care, either during or immediately after providing care. To achieve this Community Nurses will require a robust mobile digital infrastructure, which allows access to relevant clinical systems. This supports timely nursing practice, clinical safety and prevents duplication of recording information, ensuring high quality and effective care.

Community Nursing Services must have a clear plan to support the development of integrated records and information governance and sharing arrangements, which may be across a range of professionals, organisations and boundaries.

## 5.5 Use of Technology

Community Nursing Services should utilise technology where possible, to support their interactions with individuals and other professionals. This should include how information is shared back into the individual’s main clinical record.

Examples of such technology may include the use of video consultations, e scheduling systems, remote telephone/photo/messaging consultation software, as well as telecare/telehealth technology. The use of technology to support individuals, must always be balanced with the rights of individuals to receive services/resources in their language of choice, the right to refuse and recognition that not every individual may have the financial means, ability or desire to use digital means.

Where scheduling tools are used, nurses with Welsh language skills are identified within the system and are actively matched to individuals who have requested Welsh Speakers. Where the active offer of Welsh cannot be supported, this should be recorded. This allows for the identification of gaps in Welsh language skills and future planning of how the active offer of Welsh can be achieved.

## 5.6 Place of care

**5.6.1** Community Nursing Services may be carried out in a variety of locations including GP practices, clinic settings, care homes, settings in community hospitals or health centres and in the person’s own home. Individuals who are able to access settings outside their home for their nursing care, should be encouraged by services and professionals to do so. Regardless of the place a person with nursing needs is seen, the treatment, support and advice provided, must be based on evidence based guidelines and ensure equity in the provision of care.

**5.6.2** District Nursing Services specifically focus on people who are unable to access settings outside their home, i.e., those who are termed as housebound. However, some individuals who are not housebound, may

need to receive nursing care in their own home due to illness, significant frailty or another medical condition which would put them at risk e.g., individuals who are immunocompromised.

**5.6.3** Community Nursing services and General medical services work together with statutory and non-statutory services to ensure individuals who are unable to leave their home due to a lack of transport, are able to access nursing services in other settings. Social isolation has a significant impact on a person's health and wellbeing ([Connected Communities 2020](#)) and a lack of transport should not be a barrier to accessing any service, or the wider community.

**5.6.4** Alternative care settings - Individuals may be supported long term within a care setting where there are care workers available. This is the person's own home and individuals are entitled to access the same level of nursing support that is available to any person living in a community setting.

Where an individual lives in a care setting with access to registered nurses, Community Nursing Services may need to provide additional support **where there is a risk to an individual's health and wellbeing**, including risk of unnecessary admission to hospital. In these circumstances, Community Nursing services should work together with other members of the multi professional team, to provide wrap around care for that individual and to support the care home workforce.

**5.6.5** As Cluster working becomes further developed and embedded, the traditional boundaries between where and how GPN's, DN Services and Specialist Nurses work, may become more blurred. This allows greater opportunity for the nursing workforce to work across place and organisational boundaries focusing on who the right nurse is to meet the person's needs, rather than on traditional organisational boundaries.

To achieve this, Nurses within clusters and across different organisations must be enabled to come together to review current pathways and ways of working. This will ensure Nurses offer the best service to the individual promoting equity and consistency of outcomes, alongside best use of resources. This may be as part of the professional collaboratives and/or the bi monthly community nursing meetings, **as outlined in section 10.3.**

Where opportunities to develop changes to pathways exist, there needs to be clear structures and processes in place to ensure work is fairly distributed across the totality of the nursing workforce. This must be demonstrated by measures which confirm the benefits, outcomes and experience for both individuals, Nurses, and the wider health and social care system.

## 6. Specific Clinical Considerations

**6.1 Frailty Tools** - Community Nursing Services use an evidence-based frailty tool, which may be electronic e.g., Clinical Frailty Scale App. This allows for consistent identification and assessment of frailty. Where required, community nurses should work as part of the wider multi professional team to help complete a Comprehensive Geriatric Assessment (CGA), leading to the development of a personalised care plan. The completion of a CGA, may be led and coordinated by any professional who has had additional training in carrying out a CGA.

**6.2 Rehabilitation following illness** - Community Nursing Services have the necessary skills and knowledge to support individuals, to regain everyday life and activities following illness. This approach as part of the wider multi professional offer to rehabilitation and recovery, is important in ensuring individuals are able to self-care and manage their needs independently where ever possible.

**6.3 Management of urethral and suprapubic catheters** –District Nursing Services as the core community nursing service, possess the relevant clinical skills and expertise to manage urgent situations concerning catheters, including blocked catheters, **where they meet the criteria for community change/insertion.**

Community Nursing Services should be available to respond to urgent requests from individuals and/ or other agencies e.g., WAST/111/OOH GP's regardless of whether the individual normally accesses DN services or not. A person with a blocked catheter where urine is not bypassing and **where they meet the criteria for community change/insertion** should be able to make direct contact with a DN service and be seen within 2 hours, unless following clinical triage it is decided they need referral to another service, or do not require

an immediate response. This decision must be clearly communicated to the individual or carer/family and documented within the clinical record.

**6.4 Wound Management** – Nurses within Community Nursing Services will have varied levels of knowledge and skills on wound management dependent on their role and area of practice. However, all registered nurses should have the ability to undertake simple wound management including;

- Removal of sutures or clips
- Post-operative wound management e.g., checking of wound and reapplying dressings
- Dressing/redressing of simple non-complex wounds
- Identification of venous/arterial ulcers
- Identification of static or deteriorating wounds
- Identification and management of pressure damage

Complex wounds where nurses require additional training and assessment of competency and/or oversight by Tissue Viability Nurses e.g., negative pressure wound therapy, larvae therapy or compression bandaging, may be delivered in full or part by a range of community nursing services in order to meet the individuals and/or local population needs. This may include referral to local community clinics, rather than the person being seen at home or in a GP practice.

*Where an individual's care is shared between different community nursing services, communication systems and processes must be in place, to ensure care is seamless and prevents duplication.*

**6.5 Transition** - Individuals with complex health and wellbeing needs including those with life limiting conditions and their families who require transfer from children services to adult services, can often experience difficulties during this process.

It is essential that Adult Community Nursing Services follow best practice outlined within the [All Wales Transition and Handover Guidance \(2022\)](#). Working collaboratively with education, housing, care providers and other members of the multi professional team and community, is essential to empowering young people to take responsibility for their health. This will need to be supported by the collaborative development of comprehensive personalised care plans and packages of support and the continuation of existing pathways, particularly for individuals at the end of life.

Transition may also include individuals who are moving into a new locality, or to a different support setting. For example, individuals moving from learning disability services, such as supportive living to care homes.

Discussions between services e.g., between children and adult services or between different providers within adult services on how best to do this, should start as early as possible. This may include sharing policies, guidance and training via children services or specialist adult services, to enable community nurses to develop the skills required to support the individual.

**6.6 End of Life Care** - Individuals who are at the end of life and whose choice of place of care and death is home and their carers/families, must be able to make prompt and direct contact with Community Nursing services for timely advice and support. In turn, Community Nursing services must be able to directly access 24/7 specialist palliative care advice, and understand how their local services provide this support. This is particularly important during the evening and overnight when the availability of other health professionals will be reduced.

Community Nursing Services must ensure a proactive and personalised care planning approach is taken to support individuals in the last days of life and their families. This should include, for example, daily district nurse review and co-ordination of care and support as needed, as well as rapid access to equipment. There should be 24/7 access to and administration of anticipatory (Just in Case) medications to prevent or reduce delays in managing symptoms and facilitated access to specialist palliative care advice and support in a timely way as required. Where appropriate, and in collaboration with the GP and the family, care should be guided by the All Wales Care Decisions Guidance for the last days of life.

Care to the person and their families extends to after an individual dies. This means Community Nursing Services, alongside other members of the multi professional team, should be able to provide timely

verification of expected death to people seen by their service and be able to signpost carers/family members to practical advice and bereavement support as required.

In order to ensure value-based health and care at the end of life, community nursing services leads need to demonstrate safe and effective care in line with recommendations and metrics endorsed by the National Programme Board for Palliative and End of Life Care and in line with the Quality Statement for Palliative and End of Life Care.

## 7. Scope of practice

GPN's, DN's and Specialist Nurses provide nursing care, treatment and support across a wide area of nursing practice. While Nurses scope of practice will vary according to the skills, knowledge, ability and registration status of the Nurse, there are some fundamental areas which are common to all. A summary of these areas for all DN's, GPN's, Specialist Nurses and Health Care Support Workers are outlined below. This is **not meant to be an exhaustive list** and the principles of collaborative working providing the right person with the right skills at the right time, remains central to supporting individuals.

Fundamental Areas of Practice & Skills for All Registered Community Nurses and Health Care Support Workers
Person Centred Approach's & What matters to me conversations
Communication skills including respectful communication, empathetic listening, protecting privacy & promoting autonomy
Human rights & Equality & Diversity training
Keeping People Safe (safeguarding & self-neglect) and addressing essential needs e.g., nutrition, personal hygiene, sensory health needs, in a sensitive manner
Understanding of Mental Capacity/Consent & Lasting Powers of Attorney
Making Every Contact Count
Working safely in the Community/Community Settings
Multi Professional Team working including working virtually to develop and maintain collaborative working
Digital skills to enable the use of Technology & mobile working
Undertaking observations i.e., BP, Pulse, Respiratory Rate, Temperature, BP, Pulse, Respiratory Rate, Height, Weight & Completion of NEWS Cymru
Pressure Area Care
Mental Health Awareness
Use of SBAR to communicate concerns
Care of Self & Colleagues
Understanding of clinical audit

Fundamental of Practice for All Registered Community Nurses and Dependent on Role, Health Care Support Workers		
Non-complex wound care	Recognising Frailty	Prevention of illness & Promoting health, self-care & wellbeing
Dementia care training including understanding, recognising and managing dementia-related conditions	Promotion of Continence	Principles and understanding of enabling independence & rehabilitation
Understanding wider determinants of health	Management and resolution of Conflict	

While the following are considered fundamental for **All** registered nurses working within community nursing services, the level of knowledge and skills in these areas may vary according to the area of practice.

Fundamental Areas of Practice for All Registered Community Nurses		
Understanding Population Needs data	Health Promotion Skills including promotion of self-care	Prevention of hospital admission including recognition of the deteriorating person
Immunizations specifically flu, covid-19, pneumococcal	Knowledge of Long term condition management	Knowledge of palliative and end of life care, including verification of Expected Death
Advanced Care Planning/Future Discussions	Wound management - simple wounds	Supporting hospital discharge
Early identification / Screening / Risk reduction / Education and support	Use of technology and mobile applications to help provide advice/assessment of need, monitor health and support self-management	Behaviour change strategies
Integrated collaborative decision making	Holistic assessment Skills & critical thinking skills	Advanced communication skills
Management of risk	Management of safeguarding and self-neglect	Compassionate leadership
Mentorship and/or supervision and or /assessor skills for students and others	Prudent healthcare & Value based healthcare	Knowledge of Quality and service development improvements to demonstrate value of the service
Understanding how to use data to inform practice	Understanding of health inequalities and needs of vulnerable groups	How to use outcome measures to influence and change practice
Knowledge and Understanding of the impact of health on work and work on health	Continuing Health Care Framework and Decision Support Tools in Community & Primary Care	Motivational interviewing
Understanding of Clinical Governance in the context of working in multi professional/integrated services	Understanding of Commissioning process and development of shared budgets on nursing practice	Liberty Protection Safeguards (LPS)

The areas identified below are a small element of the skills and knowledge required to practice at an advanced level. Nurses who work in advanced clinical roles e.g., Advanced Nurse Practitioners, or Consultant Nurses, must have a clear scope of practice and job description which clearly outlines how the 4 advanced pillars of clinical practice below are met;

- Clinical care,
- Leadership and management
- Facilitation of learning and evidence
- Research and development

Fundamentals of Advanced Clinical Practice (Educated to Master's level or equivalent)		
Clinical Assessment and Diagnostic Reasoning	Mental Health and well being	Autonomous practice
Leadership & Critical thinking skills	Practice improvement initiatives and/or Strategic Service Development	Evidence, Research & Development
Facilitating Learning	Detailed understanding of self as a crucial component of the therapeutic relationship and regard i.e., Transactional v Relational care	Non-Medical Prescribing or Supplementary Prescribing, dependent on role
Specialist Practice Qualification (SPQ), if relevant to role	Population Risk Stratification	Comprehensive awareness of own values, biases and prejudices

Community nursing services will need processes in place to pro-actively identify and develop skills, reflecting the needs of their local population. Further information on specific competencies and skills for DN and GPN's which may be helpful, can be accessed below;

- [District Nursing and General Practice Nursing Service Education and Career Framework](#) (Health Education England 2015)
- [An NHS Wales Competence Framework for Nurses working in General Practice](#)
- [Framework for Advanced Nursing, Midwifery and Allied Health Professional Practice in Wales](#)

## 8. Leadership & Management Skills

Community Nursing Services will enable nurses to develop and work as compassionate leaders. Compassionate leadership supports Nurses to work within organisational cultures where Nurses are safe to challenge, to be authentic, to lead by example, share their ideas and support quality initiatives working with others to improve care for the individual.

The Health and Social Care system is constantly evolving and Nurses need to be developed to lead and support transformational ways of working.

To achieve this Nurses should be enabled to develop and/or enhance existing skills and knowledge in coaching and mentoring, influencing negotiation, partnership working and decision making. This will empower Nurses to provide clinical leadership, acting as strong advocates, working collaboratively with others to develop care pathways that enable, self-care, enhance an individual's health and wellbeing and which deliver the best outcomes for people.

A variety of resources and clinical leadership programmes can be accessed via the [- Gwella HEIW Leadership Portal](#)

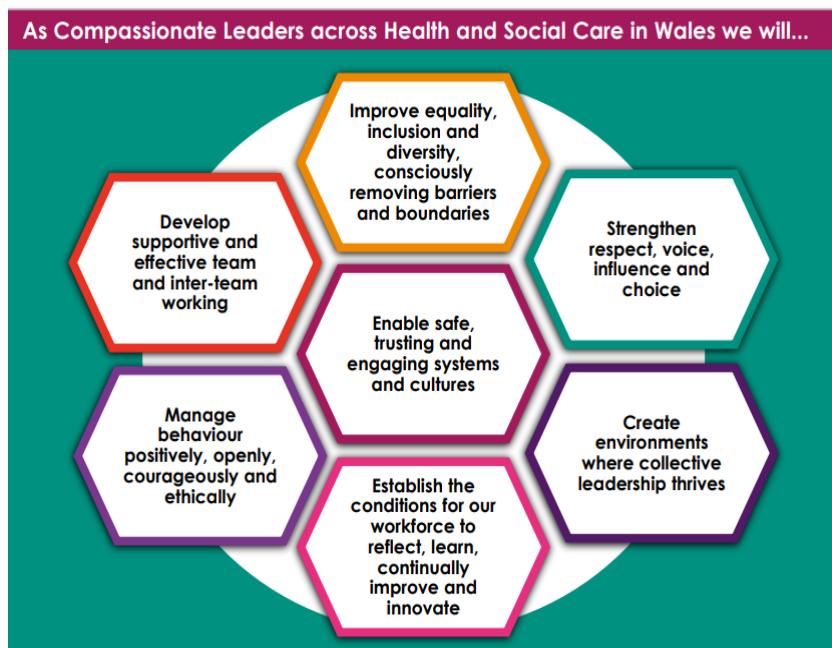


Figure 2 [Compassionate Leadership Principles - Gwella HEIW Leadership Portal for Wales](#)

## 9. Organisation of Care

9.1 Community nursing services are be able to demonstrate how collaborative working underpinned by shared IT systems, shared protocols, guidance, pathways and standard operating procedures is working within and across clusters. This must be in conjunction with the use of shared person reported outcomes and experience measures, which will allow nurses to evaluate the care they provide and identify areas for improvement.

**Capacity** – the availability of nurses and their skills within the cluster to meet the needs of the population they see.

**Demand** – the nursing needs of individuals within a cluster. These may be actual needs or anticipated needs based on local population need and/or local knowledge. This should take account of new housing developments, including new care homes or sheltered housing facilities.

The development of any new community services with nursing must consider any actual and possible impacts on current community nursing services, including duplication of care, impact on seamless care and impact on individuals and families.

Community Nursing Services need to be able to show how capacity and demand are identified and managed, to minimise any impacts on the ability to deliver safe, effective and responsive nursing care or treatments to individuals.

Tools which can help describe the complexity and/or acuity of individual's needs and which can provide additional assurance on how those needs are met, should be considered where available.

**9.2** Community Nursing Services are able to demonstrate how they meet the requirements of recognised evidence-based guidance including;

- those related to workforce e.g. [Nurse Staffing Levels \(Wales\) Act 2016 \(legislation.gov.uk\)](#) or [Royal College of Nursing, Nursing Workforce Standards](#)
- National policy and/or guidance from profession specific organisations and/or clinical standards/guidelines.

**All Nurses** in Community Nursing Services have **sufficient time allocated** to care sensitively for people through;

- 'What matters to me' conversations with individuals
- Holistic assessment of an individual's needs, which incorporates a preventative/educational approach
- Completion of clinical records including care planning, assessment and review of outcomes
- Completion of activities required to support the individual and/or their family e.g., referrals
- Travel time - dependent on role/service

The time allocated, may be reflective of the Nurse's area and level of practice.

**9.3** All Community Nursing services have clearly defined escalation measures which outline when demand for nursing care has exceeded capacity and the measures to be taken to ensure nursing care and treatment remains safe, effective and responsive.

Indicators of 'red flags' or areas of concern for any Community Nursing Service, which should be set out within escalation tools include;

- Inability to review individuals within usual working standards for that area of practice
- Deferring home visits which have the potential to negatively impact on an individual's health or wellbeing, every day or most days
- Inability to visit or see any individual with an urgent need, that may result in attendances at Urgent or Same Day Emergency Care services, OOH services, ED attendance and/or admission
- Inability to support people who are at the end of life in their preferred place of care – this may include delayed discharges from hospital or hospices
- High staff turnover and high sickness levels – which may include wider members of the multi professional team, recognising the impact this may have on community nursing services
- Nurses expressing concerns about their own and/or colleagues wellbeing e.g., due to missed breaks, staying over paid hours, being asked to do extra shifts
- Nurses expressing concern that in their **professional judgement**, there is a risk of unsafe care and treatment, which may result in avoidable harm to individuals

**9.4** There should be clear systems in place for how changes in demand and capacity are escalated to senior nurses, GP's, cluster leads and other health and care professionals within the cluster. This should include how escalation is responded to, the outcomes of actions taken and how this is fed back to Nurses.

**9.5** There may be exceptional circumstances where demand vastly exceeds capacity within Community Nursing Services e.g., during a pandemic. In these circumstances, nurses may be working in situations where staffing levels are below the usual standard for that area, where only individuals with the greatest nursing need are seen and where care delivered to individuals is at risk of being compromised.

It is essential that Community Nursing Services work together in these circumstances to support those individuals with the greatest nursing needs. This may mean working outside a nurse's usual area of practice, in unfamiliar environments or across organisational boundaries.

In addition, to escalation measures used by Community Nursing Services to support increased demand there should be;

- Clear policies on how Nurses are moved between areas and organisations
- Identification of any additional training/support required for Nurses to safely carry out nursing care, if

- working in different settings or areas of practice
- Decision support tools to assist Nurses in identifying which individuals are prioritised
- Additional access to emotional well-being support

**9.6** District Nursing Services as the core nursing service 24/7, 365 days a year, have caseloads which are manageable and which meet the recommendations outlined in the Queens Nursing Institute's (QNI) ['Workforce Standards for the District Nursing Service' \(2022\)](#) and the [Welsh Audit Office's District Nursing Services in Wales - A checklist for Board Members](#). This includes considering if mitigating actions are required, based on the Nurses professional judgement where;

- caseloads **per whole time equivalent registered nurse** exceed 150 people
- number of visits exceed 9-10 **per registered nurse, per shift**

**The QNI workforce standards highlight how the above factors have an effect of increasing the amount of work left undone, resulting in delays in care being provided to individuals.**

To ensure there is sufficient time to carry out the full nursing process the QNI Workforce Standards (2022) recommend a Registered Nurse home visit should be scheduled for a minimum of 30 minutes.

While other professionals may visit people on a DN caseload, the individual should be assessed by a registered nurse at least **every fourth visit, or every 6 months**, whichever is sooner, so the full nursing process can be carried out.

**9.7** In situations where the number of visits exceed 9-10 per registered nurse, per shift, additional factors that may need to be considered by the DN Team Leader are;

- The location of visits e.g., a nurse visiting a residential home where they may carry out multiple visits within that setting
- Acuity and complexity of the individuals being seen
- Demand and capacity data from a scheduling system
- Escalation level of the team, service and wider health and social care system.

Following assessment of these additional factors, the DN Team Leader or Deputy, in conjunction with a Senior Nurse may need to increase the number of visits that registered nurses are asked to complete for **that shift**.

**9.8.** Where visits for Registered Nurses exceed 9-10 per shift in a team on most days (i.e., 4 or more days in a 7 day period), a review of demand and capacity data for that DN team and the wider DN Nursing Service, is undertaken and an action plan with clear timescales developed. The review should include opportunities for safe skill mixing and opportunities to streamline /improve ways of working with the wider multi professional team.

Increasing visits above 9-10 per registered nurses per day have an effect of increasing the amount of work left undone, resulting in delays in care being provided to individuals (QNI Workforce Standards 2022).

Scheduling systems are designed to help Community Nursing Services schedule visits by allocating individuals to the right nurse with the right skills. While an **indicative length of time** is used for scheduling, this time can be revised by a registered nurse. Scheduling tools are not designed to replace a registered nurse's professional judgement, or prevent sufficient time being allocated to enable nurses to carry out care sensitively.

**9.9** DN and Deputy team leaders, along with caseload holders, are supported to undertake additional training such as the Specialist Practice Qualification (SPQ), or a post registration community nursing degree. This is because of the clear evidence base demonstrating the benefits the SPQ provides to people seen by the service.

**9.10** To promote the continuity of an individual's care, each DN team within a cluster should have a staffing complement of no greater than 15 staff / 12 WTE. This needs to include a 26.9% uplift for staffing and at least 15 hours administration support per week per DN team.

**9.11** DN teams are structured so they are coterminous with the cluster and have a distinct and identifiable geographical neighbourhood, zone or district within the cluster. If the anticipated nursing needs of the local population are increasing and the above recommendations cannot be met, an exploration of the need for additional registered nurses or DN team (where large team size is becoming an issue) must be considered. The use of professional judgement, [Interim District Nurse Staffing Principles](#) and local knowledge of factors which may influence DN services, must be included in this assessment.

**9.12** Any assessment should include the benefits, disadvantages and risks to the local population, the DN nursing workforce, the wider community nursing workforce and relationships with GP practices and other health professionals. The outcomes of any risk assessment and decision are clearly communicated with all key stakeholders.

## 10. Communication

Communication with individuals using community nursing services and their carers and/or significant others is essential. This allows for individuals to fully participate in decisions about their care and to take part in the management of their nursing needs where appropriate.

To ensure individuals nursing needs are managed safely, timely communication between nurses within clusters as well as GP's, Allied Health Professionals (AHP's) and other members of the multi professional team is essential.

Each GP practice should be aware of members of the DN teams and Specialist Nurses, who provide services to individuals registered at their practice. This will help prevent delays in sharing clinical information between nurses and other professionals involved in the person's care.

Technology should be available to support effective communication between nurses, and the wider multi professional team. This needs to be enabled by identified time within the working day, for nurses to attend multi professional meetings and/or have discussion with individuals and their carers where required.

### 10.1 Person Specific Communication

**10.1.1** Community Nursing services are part of regular multi professional meetings in line with best practice, which as a minimum should allow for clinical discussion, review and management of individuals who;

- Have a deteriorating condition, significant frailty or complex health/mental health needs which may result in an unplanned admission or attendance at hospital,
- Have a deteriorating condition, significant frailty or complex health/mental health needs that have resulted in an unplanned admission or attendance at hospital within the past 5 days
- Are considered to be in the last year, months or days of life and have palliative care needs
- Have complex needs that require a multi professional approach
- Are at significant risk of harm due to safeguarding or self-neglect
- Have a condition that is at risk of deteriorating or has deteriorated, resulting in an individual being unable to carry out their work role.

Multi professional meetings can play an important part in developing effective working relationships between members of the multi professional team and where possible, should be used as an opportunity for shared reflection and learning.

**10.1.2** For individuals, discussed at multi professional meetings, a named coordinator should be agreed by the team, to support seamless working and prevent duplication. The coordinators details must be shared with the individual, carer and wider members of the multi professional team as appropriate.

## 10.2 Professional & Team Communication:

**10.2.1** There is a Community Nurses meeting at cluster level **every two months**, which allows for GPN's, DN's and Specialist Nurses along with nurses from Specialist Nursing Branches, Specialist Community Public Health Nurses and Significant other groups of Nursing to;

- Have opportunities for networking, including identification of challenges and opportunities
- Support discussion of practice e.g., via case studies, and/or changes in practice based on new research, and/or clinical practice recommendations e.g., NICE
- Identify, carry out and review service improvements and/or research
- Review data from experience and outcome measures
- Provide opportunities for informal/formal education opportunities
- Review current pathways and/or develop new pathways and ways of working in light of local population and outcome data
- Develop collaborative leadership including greater understanding of roles and contribution to local population needs,
- Develop effective working relationships,
- Share learning from compliments/complaints and incidents

**10.2.2** At a maximum of six monthly intervals, this meeting should be attended by Cluster leaders, representatives from GP practices, Senior Nurses and members of the wider health and care team, to ensure any learning, development or innovation from the Community Nurses meeting is shared and evaluated.

**10.2.3** Nurses from Community Nursing Services should be either part of a Professional Nursing Collaborative, or know how to raise anything they wish to, to their local Professional Nursing Collaborative.

The Professional Nursing Collaborative may be part of the two monthly community nurses meeting or a separate meeting. However, if the professional collaborative is part of the two monthly meeting, it is essential that there is a broad nursing membership representation to meet the objectives of the collaborative's core work.

**10.2.4** It is **essential** that Community Nurses are supported by their employers and organisations to network together, as this offers a way for Community Nurses to innovate, build meaningful working relationships and review current ways of working. Ensuring nurses have the time to do this should result in reduced duplication, release time and improve individuals experience and outcomes.

**10.2.5** Community Nurses have a system in place where they can come together on a daily basis to;

- Provide support to one another
- Discuss concerns and/or changes in individual's condition
- Review outstanding work and/or new referrals
- Have a meal break

## 11. Workforce learning and development

**11.1** Community nursing services have a workforce plan which includes how nurses are;

- Recruited into the service, including positive recruitment strategies aimed at groups that may be under represented within the local nursing workforce.
- Developed in line with population needs, recognising the skills needed by the nursing workforce, including the development of advanced clinical practice roles, specialist practice qualifications (SPQ) and consultant roles.
- Retained via clear succession planning and development opportunities for nurses at all levels of practice, including access into registered nurse training for health care support workers and into lead clinical or professional nurse roles within the cluster and/or community services.

- Enabled to have a structured career pathway aimed at promoting a lifelong career within community nursing. This should include opportunities for nurses to maintain their clinical skills in senior operational/management roles.
- Supported to have well balanced, reasonable job plans which permit a sense of a job well done and accomplishment.

**11.2** Community Nursing Services have an understanding of the reasons why nurses leave, e.g., via the use of exit interviews, which is used to review and inform their work force plan

**11.3** Community Nursing Placements are offered across District Nursing Services, General Practice Nursing and Specialist Nursing Services. This supports student nurses to develop a better awareness of the types of nursing available in community settings and supports future recruitment.

**11.4** Community Nursing Services ensure there are sufficient clinical assessors and supervisors in line with the [NMC 'Standards for student supervision and assessment'](#) as well as Practice Education Facilitators to support;

- student nurse placements
- newly qualified nurses
- nurses returning to practice
- nurses undertaking specialist practice qualifications
- nurses undertaking advanced clinical practice.
- nurses undertaking Non-Medical Prescribing

**11.5** Community nursing services have a clinical supervision model in place which provides a structured and protected session at least every 8 weeks. In addition, at least every 6 months there should be a session with a nurse who has received additional training in restorative supervision. This can reduce stress and burnout, improve wellbeing and job satisfaction as well as improving relationships and team dynamics<sup>1</sup>. Clinical Supervision may be offered individually, in groups or a mixture of both. Restorative supervision sessions may also occur at other times in the year for example following a change in role, at times of stress<sup>2</sup> or after a critical incident.

**11.6** Each Community Nurse has dedicated time of at a minimum, 4 hours, per 4 week period to undertake quality initiatives. This may consist of clinical audits, development of service improvement initiatives, research or time for writing articles for publication. This dedicated time is essential to support the principle of safe, effective and value-based care.

**11.7** Each Community Nurse has a minimum 5% of their working hours during a year, allocated as non-mandatory professional development time. This enables continuous development for nurses which is essential for the provision of safe care.

**11.8** Each Community Nurse has an opportunity yearly to discuss with their line manager their professional development, to ensure they are able to meet the requirements of their role and the NMC's revalidation requirements.

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<sup>1</sup> Petit, A. Stephen, R (2015) [ihv literature-review\\_v9.pdf \(wordpress.com\)](#)

<sup>2</sup> [clinical-supervision-for-midwives-in-wales.pdf \(gov.wales\)](#)

## 12. Community Nursing Models of Care

**12.1** General Practice Nurses, District Nurses and their teams and Specialist Nurses by the nature of their roles and scope of practices will have both generalist and specialist skills. This breadth of skills allows for opportunities to consider different ways of working across neighbourhoods, clusters and primary/secondary care and as part of the wider multi professional team, **while still recognising the value each of these nursing groups bring.**

**12.2** Community Nursing Services should be enabled and supported to consider alternative ways of collaborative working which cross traditional organisational boundaries. Examples of this may be;

- Cluster based roles such as consultant nurses who can support both community nurses and other members of the multi professional team
- Shared posts such as DN/GPN team leader roles
- Specialist Nurses who are based in secondary care being aligned with Primary and Community Nursing Services, enabling and developing preventative services where this adds value
- Occupational Health Nurses working alongside and/or aligned with Community Nursing Services at an individual practice or Cluster level
- Community Nursing Hubs
- Community Nurse Led Services, e.g., Nurse Led Family Practices, Nurse Led Ward rounds
- Rotational Nurse posts between Community Nursing Services, secondary care and/or OOH/111/WAST, promoting greater understanding of roles, experience and management of risk
- Specialist Nurses employed in Community Nursing Services, and/or as part of the wider multi professional team rather than secondary care, with a proactive in reach offer to secondary care.
- Collaborative working with Volunteers or voluntary organisations building on current good practice for example, Leg Clubs, Home from hospital schemes and trained volunteers supporting people at end of life.
- Development of new and/or shared pathways between Community Nursing Services which operate over extended service times e.g., evenings/weekends and in alternative settings, to meet the needs of hard to reach groups.
- Development of shared pathways between Community Nursing Services across Health Board boundaries, ensuring care and access to Community Nursing is standardised.

**12.3** Where opportunities to develop new models of working exist, this is demonstrated by measures which confirm the benefits, outcomes and experience for both individuals, Nurses and the wider health and social care system.

## 13. Quality and Outcomes

Community Nursing Services need to be able to demonstrate how they are achieving the National Community Nursing Specification. This includes how Community Nursing meets the needs of individuals, benefits nurses, benefits the system and enables quality, safety, effectiveness and efficiency. The outcomes outlined below provide a [value based approach](#) to improving the experience and outcomes of people who have nursing needs and supports the ambitions of the [National Clinical Framework](#), of a learning health and social care system, where collaborative working, local ownership and innovation is key.

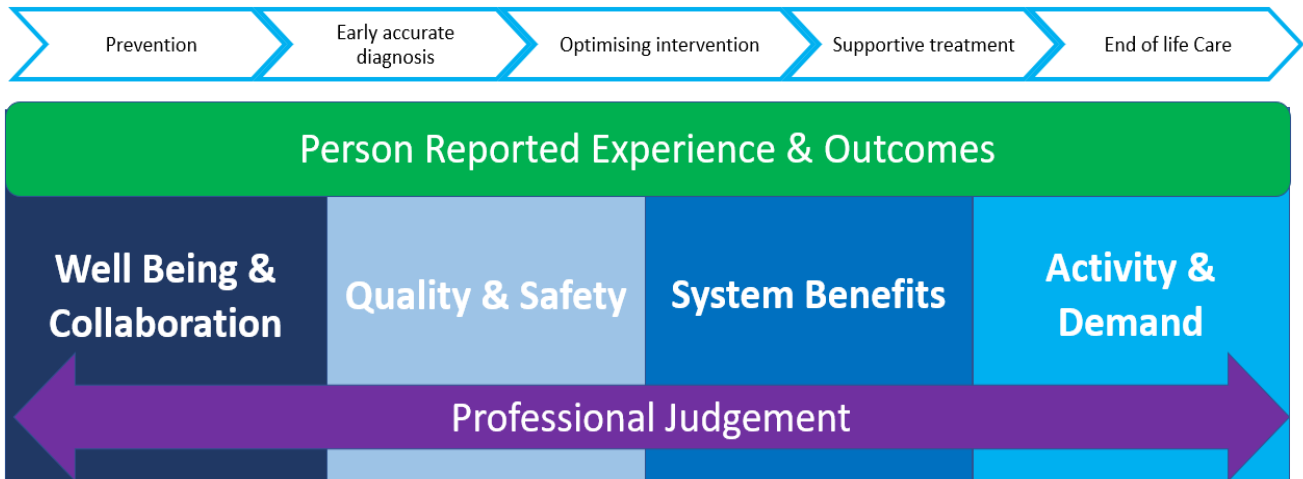


Figure 3 Quality & outcome measures

Demonstration of achievement of the National Community Nursing Specification will be achieved via a two-part process, which should be completed on a 12-month basis, or after any significant transformation of Community Nursing Services and shared with Executive Directors of Nursing.

The two-part process consists of;

1. Completion of the Self-assessment form which covers all key aspects (i.e., sections 4 – 12) of the National Community Nursing Specification – See Appendix 1
2. Feedback from Community Nurses, Person reported outcomes and experience measures and data as below;

Person Reported Experience & Outcomes		
What do we want to achieve?	How will we know?	Outcomes
Individuals are able to share their experience of care within Community Nursing Services	Use of core service user questions to understand individuals experience of care	Individuals accessing Community Nursing Services have a good experience
Individuals are able to inform how Community Nursing Services provide their care, treatment or support	Examples of how Community Nursing Services have acted on feedback e.g., 'you said, we did'	

Wellbeing and collaboration		
What do we want to achieve?	How will we know?	Outcomes
<p>Access to restorative supervision for Nurses via dedicated time</p> <p>Increased understanding of Nurses own role, value &amp; contribution</p> <p>Ownership of how Nursing is provided in neighbourhood/cluster via use of data which informs and supports practice</p> <p>Development of shared skills, pathways and ways of working which may be outside traditional models</p> <p>Clear career pathway and succession planning for Nurses</p> <p>Sufficient clinical assessors and supervisors to support Nurses</p> <p>Daily handovers/briefings for Nurses</p>	<p>Feedback from Nurses via professional collaboratives and survey</p> <p>Involvement in Professional Collaboratives and/or Community Nursing meetings</p> <p>Self-assessment tool</p>	<p>Nurses have access to restorative supervision via dedicated time</p> <p>Nurses feel included in how changes to services are agreed at their neighbourhood/cluster level</p> <p>Nurses understand the career opportunities that exist within their chosen area of practice</p> <p>Nurses are supported during professional development activities by adequately trained and prepared supervisors/assessors</p> <p>Nurses have a daily meeting with their immediate team/colleagues, where they are able to discuss peoples care &amp; treatment, any concerns and receive support</p>

Quality & Safety		
What do we want to achieve?	How will we know?	Outcomes
<p>Increased time to provide care – % time spent 'face to face' (actual or virtual)</p> <p>Ability to access clinical systems for Nurses necessary for role</p> <p>Access to SPQ and/or other training required to undertake role</p> <p>Ability to undertake research and quality improvement initiatives via dedicated time</p> <p>Clear escalation routes for all Nurses and areas of practice, underpinned by Nurses professional judgement</p> <p>Use of digital solutions to support practice including e scheduling</p> <p>Use of Multi professional meetings and agreed frailty tools</p>	<p>Feedback from Nurses via professional collaboratives and survey</p> <p>Data from scheduling systems where available</p> <p>Access rates to advanced clinical practice programs including Specialist Practitioner Qualifications</p> <p>Number of services where frailty tools are in place</p> <p>Self-assessment tool</p>	<p>Nurses report they have time to provide holistic care</p> <p>Community Nursing Services can demonstrate how much time Nurses spend with the people they care for</p> <p>Nurses have access to clinical systems and digital means</p> <p>Nurses are able to access the training they require for their role</p> <p>Nurses are able to develop, support or lead research and service improvement initiatives</p> <p>Nurses use a standardised approach to the identification of frailty</p>

## System Benefits

What do we want to achieve?	How will we know?	Outcomes
<p>Consistency of provision and reduction in variation: access to services in &amp; out of hours, pathways e.g., catheter care</p> <p>Sustainability of core 24/7 District Nursing services –weekend staffing is a minimum of 80% of the usual staffing available Monday – Friday.</p> <p>Retention of experienced nurses</p> <p>Attraction of community nurses – new to practice, change of practice area, international and returning to practice</p>	<p>% of people with a urethral or suprapubic catheter who attend an Emergency Department (ED)</p> <p>Self-assessment tool</p> <p>Workforce retention, recruitment and vacancy information</p>	<p>People who have a urethral or supra pubic catheter are able to access District Nursing services or an alternative community nursing provision 24/7</p> <p>People with nursing needs are able to access District Nursing Services 24/7,</p> <p>Nurses choose to work and stay in community and primary care services</p>

## Activity & Demand

What do we want to achieve?	How will we know?	Outcomes
<p>Reduced hospital attendances/admissions</p> <p>Reduced hospital length of stay</p> <p>Ability to consistently discharge 7 days a week</p> <p>Ability to meet response times; Urgent 2 hours; Non-Urgent within 72 hours; Planned within 10 days</p>	<p>Use of Healthy Days at Home Measure to indicate areas of high attendances at ED/Hospital</p> <p>Codes in use which relate to delays due to Nursing within Pathways of Care Delays</p> <p>Data from scheduling systems where available</p>	<p>Individuals do not attend ED or hospital unnecessarily</p> <p>Individuals with nursing needs do not have their discharge delayed due to a lack of Community Nursing Services.</p> <p>Community Nursing Services are able to accept discharges from hospitals 7 days a week</p> <p>Individuals with a nursing need are seen in line with agreed response times</p>

## 14. Glossary of Terms

- **Active collaboration and engagement** - may consist of;
  - Building understanding and relationships on a locality basis.
  - Working with voluntary sector partners to co-produce solutions to identified needs or gaps in care provision.
  - Involving volunteers. e.g., through voluntary or statutory bodies, (WCVA, 2022)
- **Cluster:** “A cluster brings together all local services involved in health and care across a geographical area, typically serving a population between 25,000 and 100,000”. ([ACD Toolkit](#))
- **Neighbourhood:** a defined geographical area within a larger community
- **Non-Urgent** - the individual is able to wait for a nursing intervention for up to 72 hours (including weekends & bank holidays)
- **Planned** – the individual is able to wait for a nursing intervention for up to ten working days
- **Professional Nursing Collaboratives** - are networks of professionals with shared expertise working together to use their unique skills to assess the population needs of the local residents where they work.
- **QNI Nursing Process:** The process by which registered nurses assess, plan, implement and evaluate care. Although this can be delivered by many members of the team, the Registered Nurse remains responsible for the nursing process ([QNI 2022](#))
- **Technology Enabled Care (TEC)** - [Technology Enabled Care Services \(TECS\)](#) - offers a way to do more with less, care closer to home and delivers benefits to people and workforce. Examples of TEC projects in Wales can be found here; [TEC Cymru | Digital Health Wales](#)
- **Urgent** - an urgent nursing need which is likely to result in a hospital attendance or admission if the person is not seen within 2 hours
- [Value-Based healthcare](#) - focuses on meeting the goals of the people seen and helps manage expectations throughout their care or treatment. It includes, improving how people are involved in decision making, avoiding any unnecessary variation in care and becoming more creative to determine where resources are best spent for improved person outcomes.
- **Work left undone:** The work that nurses and support workers do not have time or resources to do, but impact on direct patient care or the organisation of care (for example making referrals) ([QNI 2022](#))

## Appendices

### Appendix 1: Self-assessment form which covers all key aspects (i.e. sections 4 – 12) of the National Community Nursing Specification



Appendix 1 Self  
Assessment Form.xls

## National Community Nursing Specification

This self-assessment tool has been developed to enable Community Nursing Services to understand how their nursing services currently meet the principles, characteristics and functions set out in the specification and the actions required to achieve these.

Key	
<b>Essential:</b> provides a value based approach to improving the experience and outcomes of people who have nursing needs, ensuring consistency, reducing variation and benefiting nurses and the wider health and social care system.	<b>Recommended:</b> supports the ambitions of the National Clinical Framework, of a learning health and care system, where collaborative working, local ownership and innovation is key.

Issue/Severity Rating (RAG)	Description
<b>Red</b>	Risk rating should align with Health board risk management
<b>Amber</b>	
<b>Green</b>	

National Community Nursing Specification

Section	Links to outcome; Well being & Collaboration; Quality & Safety; System Benefits; Activity & Demand or All	Applies to: All Nurses, District Nursing Services (DNS), General Practice Nurses (GPN) or Specialist Nurses (SN)	Essential or Recommendation	Requirement	Self assessment - fully compliant, partially compliant, not compliant	Level of risk (RAG)	Actions required/or planned
4. Community Nursing Principles	Well being & Collaboration; Quality & Safety; System Benefits; Activity & Demand	All	Essential	Community Nursing Principles underpin the way community nursing services operate and are;			
				4.1 Person centred			
				4.2 Preventative and Population health focused			
				4.3 Skilled workforce			
				4.4 Whole system pathway			
				4.5 Technology enabled			
5. Key Characteristics of a Community Nursing Workforce - Operational Standards	Quality & Safety; System Benefits; Activity & Demand	DNS	Essential	5.1.1 Working hours DN services operate a 7 day service that is available 24 hours a day			
			Essential	5.1.1 Working hours difference in capacity between 'in hours' i.e. Monday to Friday 8 – 5 pm and the weekend <i>should be no less than 80% of District Nursing Capacity Monday to Friday</i> .			
			Recommended	5.1.1 Working hours DN services as a 24/7 service, together with other community nurses such as those in intermediate care teams or acute response teams, as well as third sector provision e.g. hospices, local authorities and domiciliary care should be supported to review to provide ways to support people to stay at home when unwell			
		GPN	Essential	5.2.1 GPN's Treatment or care provided by practice nurses, which needs to be continued at weekends, is supported by nurses across primary and community care working together to provide wrap around care for the individual. This may mean reviewing current pathways, skills and ways of working			
			Recommended	5.2.2 Specialist Nurses Wherever possible and if appropriate to the needs of the population they are working with there is access to specialist nurse advice or from other members of the multi professional team across the 7 day period during core working hours i.e. 9.00 – 5.00 pm.			
		SN	Essential	5.2.2 Working hours Specialist Nurses risk being isolated at weekends There are systems in place to support specialist nurses to work and stay in touch with other specialist nurses and professionals over the weekend. This could include co-locating DN and Specialist Nursing Services together out of hours			
			Recommended	5.2.3 Access to Community Nursing Services is easy, both to access and to understand how to do so for individuals and professionals. This could include the use of Single Access Points particularly for District Nursing Teams and/or Specialist Nurses			
		DNS & SN	Recommended	5.2.3 Access to services both in and out of hours for urgent referrals should be direct to the service, rather than via another professional			
		DNS	Essential	5.2.3 Access Self-referrals by individuals known to community nursing services should be in place			
		All	Recommended	5.3 Response Times There is a 2 hours Response to Urgent nursing needs			
		All	Essential	5.3 Response Times There is a 72 hour response to Non urgent nursing needs (including weekends & bank holidays)			
			Essential	5.3 Response Times There is a 10 working day response to Planned nursing needs			
			Essential	5.4 Clinical Record Keeping Community nursing services have electronic clinical systems in place to record their nursing care, either during or immediately after providing care			
			Recommended	5.4 Clinical Record Keeping Where possible nurses are supported to enable the viewing of other relevant clinical records to support timely nursing practice, clinical safety and prevent duplication of recording information			
			Essential	5.4 Clinical Record Keeping There is a plan in place to support development of integrated records			
			Recommended	5.5 Use of technology Technology is used to support interactions with individuals and other professionals. This includes how information is shared back into the individual's main clinical record.			
			Essential	5.6.1 Place of care Treatment, support and advice is based on evidence base guidelines and equity in the provision of care., regardless of where the person is seen.			
			Essential	5.6.3 Place of care Individuals who are unable to leave their home due to a lack of transport, are supported to access nursing services in other settings.			
			Essential	5.6.4 Place of care Alternative care setting, the community nursing services should work together with other members of the multi professional team to provide wrap around care for that individual and to support the care home workforce, where there is a risk to an individual's health and wellbeing, including risk of unnecessary admission to hospital			
			Essential	5.6.5 Collaborative working across organisations and boundaries Nurses within clusters and across different organisations are enabled to come together to review current pathways and ways of working.			
All	Essential	5.6.5 Collaborative working across organisations and boundaries Any changes to the way GPN's, DN Services and Specialist Nurses work include clear structures and processes to ensure work is fairly distributed across the totality of the nursing workforce. This must be demonstrated by measures which confirm the benefits, outcomes and experience for both individuals and nurses.					
	All	Essential	6.1 Frailty Tools - Community Nursing Services use an evidence based frailty tool e.g. Clinical Frailty Scale App, which allows for consistent identification and assessment of frailty				
		Recommended	6.1 Frailty Tools - community nurses work as part of the wider multi professional team to help complete a Comprehensive Geriatric Assessment (CGA).				
		Essential	6.2 Rehabilitation following illness - Community Nursing Services have the necessary skills and knowledge to support individuals to regain everyday life and activities following illness.				
	DNS	Essential	6.3 Management of urethral and suprapubic catheters DN services should be available to respond to urgent requests from individuals and/ or other agencies e.g. WAST/111/OOH GP's regardless of whether the individual normally accesses DN services or not.				
	DNS	Essential	6.3 Management of urethral and suprapubic catheters A person with a blocked catheter where urine is not bypassing and where they meet the criteria for community change/insertion should be able to make direct contact with a DN service and be seen within 2 hours, unless following clinical triage it is decided they need referral to another service, or do not require an immediate response.				
	Essential	6.4 Wound Management All registered nurses should have the ability to undertake simple wound management including;					
		· Removal of sutures or clips					
		· Post-operative wound management e.g. checking of wound and reapplying dressings					
		· Dressing/redressing of simple non-complex wounds					
· Identification of venous/arterial ulcers							
· Identification and management of pressure damage							

6. Specific Clinical Considerations	Well being & Collaboration; Quality & Safety; System Benefits;	All	Recommended	6.4 <b>Wound Management</b> Complex wounds where nurses require additional training and assessment of competency can be delivered in full or part by a range of community nursing services. This may include referrals to local community clinics, rather than the person being seen at home or in a GP practice			
			Essential	6.5 <b>Transition</b> Adult Community Nursing Services work collaboratively together in conjunction with education, housing and others members of the multi professional team and community to understand and develop comprehensive packages of support to meet these individual's needs			
				6.5 <b>Transition</b> Adult Community Nursing Services follow best practice outlined within the All Wales Transition and Handover Guidance (2022).			
				6.5 <b>Transition</b> Transition Discussions between children and adult services or between different providers within adult services start as early as possible. This may include sharing policies, guidance and training via children services, to enable community nurses to develop the skills required to support the individual.			
				6.6 <b>End of Life Care</b> Individuals who are at the end of life and whose choice of place of care and death is home and their carers/families, must be able to make prompt and direct contact with Community Nursing services for timely advice and support			
				6.6 <b>End of Life Care</b> Community Nursing services must be able to directly access 24/7 specialist palliative care advice,			
				6.6 <b>End of Life Care</b> Community Nursing Services ensure a proactive and personalised care planning approach is taken including, daily district nurse review, co-ordination of care and support as needed and rapid access to equipment.			
				6.6 <b>End of Life Care</b> Community Nursing services have 24/7 access to and administration of anticipatory (Just in Case) medications			
				6.6 <b>End of Life Care</b> Where appropriate, and in collaboration with the GP and the family, care should be guided by the All Wales Care Decisions Guidance for the last days of life.			
				6.6 <b>End of Life Care</b> End of Life Care Community Nursing Services, alongside other members of the multi professional team, should be able to provide timely verification of expected death to people seen by their service and be able to signpost carers/family members to practical advice and bereavement support as required.			
6.6 <b>End of Life Care</b> Community Nursing services demonstrate safe and effective care in line with recommendations and metrics endorsed by the National Programme Board for Palliative and End of Life Care							
7. Scope of practice	Quality & Safety; System Benefits;	All	Essential	There are systems in place to ensure all Nurses are able to achieve the Fundamental Areas of Practice for All Registered Nurses and Health Care Support Workers according to level of knowledge and skills required in the nurses area of practice			
				There are systems in place to ensure all Nurses are able to achieve the Fundamental Areas of Practice for All Registered Community Nurses according to level of knowledge and skills required in the nurses area of practice			
				Nurses who work in advanced clinical roles e.g. Advanced Nurse Practitioners, or Consultant Nurses, must have a clear scope of practice and job description which clearly outlines how the 4 advanced pillars of clinical practice below are met;			
				· Clinical care,			
				· Leadership and management			
				· Facilitation of learning and evidence			
· Research and development							
There are systems in place to ensure all Nurses working as advanced practitioners, are able to achieve the Fundamentals of Advanced Clinical Practice							
8. Leadership and Management Skills	Well being & Collaboration; Quality & Safety; System Benefits;	All	Essential	Community Nursing Services enable nurses to develop and work as compassionate leaders.			
			Recommended	Nurses are encouraged to develop and/or enhance existing skills and knowledge in coaching and mentoring, influencing and negotiation, partnership working and decision making.			
9. Organisation of Care	Well being & Collaboration; Quality & Safety; System Benefits;	All	Essential	9.1 Community nursing services demonstrate how collaborative working underpinned by shared IT systems, shared protocols, guidance, pathways and standard operating procedures is working within and across clusters.			
				9.1 Community nursing services use shared person reported outcomes and experience measures, which will allow nurses to evaluate the care they provide and identify areas for improvement.			
				9.1 The development of any new community services with nursing consider any actual and possible impacts on current community nursing services, including duplication of care, impact on seamless care and impact on individuals and families.			
				9.1 Community Nursing Services are able to show how <b>Capacity</b> and <b>Demand</b> are identified and managed, to minimise any impacts on the ability to deliver safe, effective and responsive nursing care or treatments to individuals.			
				9.2 Community Nursing Services demonstrate how they meet the requirements of recognised evidence based guidance including those related to workforce			
				9.2 All nurses in Community Nursing Services have sufficient time allocated to them which is reflective of the nurse's area and level of practice, to allow for;			
				· 'What matters to me' conversations with individuals			
				· Holistic assessment of an individual's needs, which incorporates a preventative/educational approach			
				· Completion of clinical records including care planning, assessment and review of outcomes			
				· Completion of activities required to support the individual and/or their family e.g. referrals			
				· Travel time - dependent on role/service			
				9.3 All community nursing services have clearly defined escalation measures which outline when demand for nursing care has exceeded capacity and the measures to be taken to ensure nursing care and treatment remains safe, effective and responsive			
				9.3 The Escalation tool includes the following indicators or 'red flags':			
				· Inability to review individuals within usual working standards for that area of practice			
				· Deferring home visits			
				· Inability to visit or see any individual with an urgent need,			
				· Inability to support people who are at the end of life in their preferred place of care			
· High staff turnover and high sickness levels							
· Nurses expressing concerns about their own and/or colleagues wellbeing							
· Nurses expressing concern that in their <b>professional judgement</b> , there is a risk of unsafe care and treatment, which may result in avoidable harm to individuals							
9.4 There are clear systems in place for how changes in demand and capacity are escalated to senior nurses, GP's, cluster leads and other health and social care professionals within the cluster. This includes how escalation is responded to, the outcomes of actions taken and how this is fed back to Nurses.							
9.5 There may be exceptional circumstances where demand vastly exceeds capacity within Community Nursing Services e.g. during a pandemic. In addition, to escalation measures used by Community Nursing Services to support increased demand there should be;							

Activity & Demand	DNS	Essential	Clear policies on how nurses are moved between areas and organisations			
			Identification of any additional training/support required for nurses to safely carry out nursing care if working in different settings or areas of practice			
			Decision support tools to assist nurses in identifying which individuals are prioritised			
			Additional access to emotional well-being support			
			<b>9.6</b> DN teams have manageable caseloads which meet the recommendations in the QNI Workforce standards for the District Nursing Service (2022) including;			
			· caseloads per whole time equivalent registered nurse exceed 150 people			
			· number of visits exceed 9-10 per registered nurse, per shift			
			<b>9.6</b> To ensure there is sufficient time to carry out the full nursing process a Registered Nurse visit should be scheduled for a minimum of 30 minutes.			
			<b>9.6</b> To ensure there is sufficient time to carry out the full nursing process a Registered Nurse visit should be scheduled for a minimum of 30 minutes. While other professionals may visit people on a DN caseload, the individual should see a registered nurse at least every fourth visit, so the full nursing process can be carried out.			
			<b>9.6</b> An individual on a DN caseload should see a registered nurse at least every fourth visit, or every 6 months, whichever is sooner, so the full nursing process can be carried out			
			<b>9.7</b> Where the number of visits per day exceeds 9-10 visits, per registered nurse, per day, additional factors influencing the number of visits may need to be considered by the DN Team Leader. E.g.; location of visits; Acuity and complexity of the individuals being seen; Demand and capacity data from a scheduling system; Escalation level of the team, service and wider health and care system. This may result in the DN team Leader in conjunction with a Senior Nurse increasing the number of visits that registered nurses are asked to do for that shift.			
			<b>9.8</b> Where visits for Registered Nurses exceed 9-10 per day in a team on most days (i.e. 4 or more days in a 7 day period), a review of demand and capacity data for that DN team and the wider DN Nursing Service, is undertaken and an action plan with clear timescales developed.			
			<b>9.9</b> DN deputy and team leaders along with caseload holders, have a Specialist Practice Qualification (SPQ) or a post registration community nursing degree			
<b>9.10</b> Each DN team within a cluster has a staffing complement of no greater than 15 staff / 12 WTE. This includes a 26.9% uplift for staffing and at least 15 hours administration support per week per DN team.						
<b>9.11</b> DN teams are structured so they are coterminous with the cluster and have a distinct and identifiable geographical neighbourhood, zone or district within the cluster. If the population's nursing needs are increasing and QNI workforce standards (2022) can not be met, there should be consideration of additional registered nurses or DN team (where large team size is becoming an issue).						
<b>9.12</b> Changes to the DN service include the benefits, disadvantages and risks to the local population, the DN nursing workforce, the wider community nursing workforce and relationships with GP practices and other health professionals. The outcomes of any risk assessment and decision is clearly communicated with all key stakeholders.						
10. Communication	All	Essential	<b>10</b> There are effective systems in place to support timely communication with individuals and their carers and between Nurses, GP's and members of the wider multi professional team. This is supported by the use of technology including planned time to attend meetings/speak with individuals and their carers.			
			<b>10</b> Each GP practice should be aware of the members of the DN team and specialist nurses who provide services to individuals registered at their practice.			
			<b>Patient Specific Communication</b>			
			<b>10.1</b> Community Nursing services are part of regular multi professional meetings in line with best practice, which as a minimum should allow for clinical discussion, review and management of individuals who;			
			· Have a deteriorating condition, significant frailty or complex health/mental health needs which may result in an unplanned admission or attendance at hospital,			
			· Have a deteriorating condition, significant frailty or complex health/mental health needs that have resulted in an unplanned admission or attendance at hospital within the past 5 days			
			· Are considered to be in the last year, months or days of life and have palliative care needs			
			· Have complex needs that require a multi professional approach			
			· Are at significant risk of harm due to safeguarding or self-neglect			
			· Have a condition that is at risk of deteriorating, or has deteriorated resulting in an individual being unable to carry out their work role.			
			<b>10.1.2</b> Individuals discussed at multi professional meetings have a named coordinator agreed by the team, to support seamless working and prevent duplication. The coordinators details are shared with the individual, carer and wider members of the multi professional team as appropriate.			
			<b>Professional &amp; Team Communication</b>			
			<b>10.2</b> There is a Community Nurses meeting every two months, which allows for GPN's, DN's and Specialist Nurses along with nurses from Specialist Nursing Branches, Specialist Community Public Health Nurses and significant other groups of nursing to;			
· Have opportunities for networking including identification of challenges and opportunities						
· Support discussion of practice e.g. via case studies, and/or changes in practice based on new research, and/or clinical practice recommendations e.g. NICE						
· Identify, carry out and review services improvements and/or research						
· Review data from experience and outcome measures						
· Provide opportunities for informal/formal education opportunities						
· Review current pathways and/or develop new pathways and ways of working in light of local population and outcome data						
· Develop collaborative leadership including greater understanding of roles and contribution to local population needs						
· Develop effective working relationships,						
· Share learning from compliments/complaints and incidents						
<b>10.2.2</b> At a maximum of six monthly intervals, this meeting should be attended by Cluster leaders, representatives from GP practices, Senior Nurses and members of the wider health and social care team, to ensure any learning, development or innovation from the Community Nurses meeting is shared and evaluated.						
<b>10.2.3</b> Nurses from Community Nursing Services are either part of a Professional Nursing Collaborative, or know how to raise anything they wish to, to their local Professional Nursing Collaborative. The Professional Nursing Collaborative may be part of the two monthly community nurses meeting or a separate meeting.						
<b>10.2.4</b> Community Nurses are supported by their employers and organisations to network together,						
<b>10.2.5</b> Community Nurses have a system in place where they can come together on a daily basis to;						
· Provide support to one another						
· Discuss concerns and/or changes in individual's condition						
Well being & Collaboration; Quality & Safety; System Benefits;	Essential	Essential				

				· Review outstanding work and/or new referrals			
				· Have a meal break			
11. Workforce learning and development	Well being & Collaboration; Quality & Safety; System Benefits;	All	Recommended	11.1 Community nursing services have a workforce plan which includes how nurses are;			
				· Recruited into the service, including positive recruitment strategies			
				· Developed in line with population needs, recognising the skills needed by the nursing workforce, including the development of advanced clinical practice roles, specialist practice qualifications and consultant roles.			
				· Retained via clear succession planning and development opportunities for nurses at all levels of practice, including access into registered nurse training for health care support workers and into lead clinical or professional nurse roles within the cluster and/or community services.			
				· Enabled to have a structured career pathway aimed at promoting a lifelong career within community nursing. This should include opportunities for nurses to maintain their clinical skills in senior operational/management roles.			
				· Supported to have well balanced, reasonable job plans which permit a sense of a job well done and accomplishment.			
			Essential	11.2 Community Nursing Services have an understanding of the reasons why nurses leave, e.g. via the use of exit interviews, which is used to review and inform their work force plan			
				11.3 Community Nursing Placements are offered across the DN, GPN and Specialist Nursing Services. This supports student nurses to develop a better awareness of the types of nursing available in community settings and supports future recruitment.			
				11.4 Community Nursing Services should ensure there are sufficient clinical assessors and supervisors in line with the NMC 'Standards for student supervision and assessment' as well as Practice Education Facilitators to support;			
				· student nurse placements			
				· newly qualified nurses			
				· nurses returning to practice			
				· nurses undertaking specialist practice qualifications			
				· nurses undertaking advanced clinical practice.			
Recommended	11.5 Community nursing services have a clinical supervision model in place which provides a structured and protected session at least every 8 weeks.						
	11.5 Community Nursing Services offer at least every 6 months a session with a nurse who has received additional training in restorative supervision.						
	11.6 Each Community Nurse has dedicated time of at least, 4 hours, per 4 week period to undertake quality initiatives. This is essential to support the principle of safe, effective and value based care.						
	11.7 Each Community Nurse has a minimum 5% of their working hours during a year, allocated as non-mandatory professional development time. This enables continuous development for nurses which is essential for the provision of safe care.						
Essential	11.8 Each Community Nurse has an opportunity yearly to discuss with their line manager their professional development to ensure they are able to meet the requirements of their role and the NMC's revalidation requirements.						
12. Community Nursing Models	Quality & Safety; System Benefits;	All	Recommended	12.2 Community Nursing Services should be enabled and supported to consider alternative ways of collaborative working which cross traditional organisational boundaries.			
			Essential	12.3 Where opportunities to develop new models of working exist, this must be demonstrated by measures which confirm the benefits, outcomes and experience for both individuals and nurses			

<b>ACTION LOG: PLANNING, PEOPLE &amp; CULTURE COMMITTEE</b>					
<b>Minute Reference</b>	<b>Date of Meeting Action Originated</b>	<b>Issue</b>	<b>Lead Officer</b>	<b>Timescale for Action to be completed</b>	<b>Status of Action</b> (as at 02.05.23)
02.23.08	February 2023	<p><b>Organisational Risk Register</b></p> <p>To receive an update from mental health colleagues on Risk 4722 and to update the consolidated risks with the Quality and Safety Committee.</p>	Assistant Director of Governance & Risk	May 2023	<p><b>Completed</b></p> <p>This risk was de-escalated from the organisational risk register in March 2023. The rationale for the score reduction is that the service area can now report that there is a Consultant Responsible Clinician for 3 areas, with CD Responsible Clinician for 1 area. Community Consultants are stable and set to improve with appointments in early February (Locum).</p> <p>Risk to be monitored by the MH and LD Care Group.</p>
02.23.12	February 2023	<p><b>PCH Progress on Cultural Transformation and Improvement work</b></p> <p>To circulate the Theatres Newsletter to Members of the Committee.</p>	Governance Team	February 2023	<p><b>Completed</b></p> <p>Newsletter circulated via email following meeting.</p>

## Agenda Item 3.1

02.23.14	February 2023	<b>Employee Relations (ER) Update</b> To refer the request for the data on the five cases to the Freedom of Information Team.	Assistant Director of Workforce and OD	May 2023	<b>Update to be provided at meeting.</b>
02.23.17	February 2023	<b>Workforce Metrics Report</b> Data on return to work compliance to be reviewed outside of the meeting	Assistant Director, Strategic Workforce Planning'	May 2023	<b>Completed</b> The compliance reviewed by Head of People and Independent Member and it was confirmed that the figures had been for November 22. More recent figures were provided along with details on the plan going forward.
02.23.17	February 2023	<b>Workforce Metrics Report</b> Outcomes and actions to be included in future reports	Assistant Director, Strategic Workforce Planning'	May 2023	<b>Completed</b> Detail to be included in the report to be received in August 2023 and all reports moving forward.
08.22.11	August 2023	<b>BAME Story</b> Discussions to be held outside of Committee in relation to how the health board could support the Network in terms of the time and resource required to dedicate to this activity.	Director for People	November 2022	<b>In Progress</b> An update will be provided at the February Committee meeting which includes work with the networks. In May 23 a more extensive equality, diversity and inclusion

## Agenda Item 3.1

					session will be held which will include the contribution of our staff networks, further to our review of action plans and terms of reference with each network.
05.22.9	May 2022	<b>Disclosure &amp; Barring Service</b> Further update to be provided to the Committee at a future meeting.	Assistant Director, Workforce & OD	November 2022	<b>Complete</b> Report received at February 2023 meeting.

### COMPLETED ACTIONS

11.22.8	November 2022	<b>Organisational Risk Register</b> Outputs and timescales for delivery in relation to the Task and Finish Group aligned to risk 4080 to be provided for the next meeting through the relevant Executive Lead.	Medical Director/Director for People	February 2023	<b>Complete</b> Most recent update for this risk is set out in the appendix to agenda item 3.2.1 – Organisational Risk Register for February 23 Committee meeting.
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<b>PEOPLE &amp; CULTURE COMMITTEE- FORWARD WORK PLAN 2023/24</b>				
<b>Origin of Request</b>	<b>Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)</b>	<b>Item Title</b>	<b>Lead Officer</b>	<b>Intended Meeting Date</b>
Requested at agenda planning for February 23 meeting.	Additional item	Overview and Ambitions for the Strategic Equality Plan – Deep Dive	Assistant Director of OD and Wellbeing	10 May 2023
Requested at agenda planning for May 23 meeting now deferred to August 2023	Deferred Item	Staff Recognition Programme	To be confirmed	9 August 2023
Requested via email.	Additional Item	Anchor Organisation Activity Report	Tom Powell	9 August 2023
Requested via Email	Deferred Item	Armed Forces Covenant	To be confirmed	9 August 2023

### **Completed Activity from the Forward Work Programme**

Deferred from November 2022 meeting.	Additional Item	Employee Wellbeing Policy	Assistant Director of Policy, Governance & Compliance	8 February 2023 - <b>Completed</b>
Requested at agenda planning for November	Additional item	Equality Annual Report	Assistant Director of Policy,	8 February 2023 - <b>Completed</b>

meeting to add to forward plan			Governance & Compliance	
Requested at agenda planning for November meeting to add to forward plan	Additional item	Gender Equality Report	Assistant Director of Policy, Governance & Compliance	8 February 2023 – <b>Completed</b>
Requested at agenda planning for November meeting to add to forward plan	Additional Item	Outcome of the Staff Wellbeing Survey	Assistant Director of OD and Wellbeing	8 February 2023 - <b>Completed</b>
Requested at agenda planning for November meeting to add to forward plan	Additional Item	PCH: Progress on Cultural Transformation & Improvement Work	Richard Hughes	8 February 2023 – <b>Completed</b>
Requested at agenda planning for November meeting to add to forward plan	Additional item	Maternity & Neonates: Progress on Cultural Transformation & Improvement Work	To be confirmed	8 February 2023 – <b>Completed</b>
Requested at agenda planning for February 23 meeting.	Additional Item	Overview and Ambitions for the Strategic Equality Plan	Assistant Director of OD and Wellbeing	8 February 2023 – <b>Completed</b>

Requested at agenda planning for November 22 meeting	Additional Item	Ratification of Chairs Action – Nursing & Midwifery Rostering Policy	Assistant Director of Policy, Compliance & Governance	9 November 2022 - <b>Completed</b>
Requested at agenda planning for November 22 meeting	Additional Item	Industrial Injury Policy	Assistant Director of Policy, Compliance & Governance	9 November 2022 - <b>Completed</b>
Requested via email	Additional Item	Alternative Pension Payment Contributions for Medical and Dental Staff	Assistant Director of Policy, Compliance & Governance	9 November 2022 - <b>Completed</b>
Action arising from August 22 meeting	Additional Item	Outcome of Committee Self Effectiveness Survey	Director of Corporate Governance	9 November 2022 - <b>Completed</b>
Requested at agenda planning for November 22 meeting	Additional item	Pathology: Cultural transformation & Improvement Work	Clinical Service Group Manager, pathology	9 November 2022 - <b>Completed</b>
Requested at agenda planning for November 22 meeting	Additional Item	Maternity & Neonates; Cultural Transformation & Improvement Work	Care Group Nurse Director	9 November 2022 - <b>Completed</b>
Requested at agenda planning for November 22 meeting	Additional Item	Nursing Workforce Update	Deputy Director for People	9 November 2022 - <b>Completed</b>
Requested at agenda planning for	Deferred item	Medical Staffing Value & Efficiency Progress Report	Medical Director	9 November 2022 - <b>Completed</b>

August 22 meeting deferred to November 22				
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