East Sussex Healthcare
NHS Trust

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FOI REF: 24/390

25th July 2024

FREEDOM OF INFORMATION ACT

I am responding to your request for information under the Freedom of Information Act. The answers to your specific questions are as follows:

1. Copies of all trust policies related to violence by patients and/or their visitors against staff. Please include all policies related to the following:

a) Any physical, verbal, or sexual aggression, assault, or stalking.

b) Violence both experienced and witnessed by staff.

c) Any separate policies for different types of violence, different staff groups, or

Whilst the Trust holds the information requested, it is applying a Section 31(1)a exemption because disclosure of this information under the Act would, or would be likely to, prejudice the prevention or detection of crime.

The Trust considers that the release of the information could enable individuals to use the information to their advantage, which could make the Trust more vulnerable to crime.

In applying the exemption consideration has been given to the public interest in enabling scrutiny of public sector decision making and the general public interest in accountability and transparency.

In this instance, we consider that the public interest in preventing the prejudice outweighs the public interest in disclosure due to the significant impact successful violence against staff can have.

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2. Copies of all trust policies/procedures related to the following post-violence measures, if not included within the above (1):

a) Immediate sanctions for aggressor(s) (e.g. discharge)

Section 31(1)a applied, please refer to question 1.

b) Processes for incident reporting

Please see attached the Trust's Incident Reporting and Management Policy.

c) Processes for debrief with staff member(s) and/or aggressor(s)

Section 31(1)a applied, please refer to question 1.

d) Follow-up with aggressor(s) (e.g. accountability letter, behaviour contract)

Section 31(1)a applied, please refer to question 1.

e) Counselling or similar longer-term psychological support for staff member(s)

Please see attached the Trust's Psychological Wellbeing and Safety of Staff Policy.

f) Incident investigation (e.g. root cause analysis) and feedback to relevant parties

Section 31(1)a applied, please refer to question 1.

g) Longer-term sanctions for aggressor(s) (e.g. card system)

Section 31(1)a applied, please refer to question 1.

h) Examples of processes for tailored management plans for patients with a known history of aggressive behaviour (including use of a flag/alert system)

Section 31(1)a applied, please refer to question 1.

i) Staff sickness absence and/or returning to work following work-related injury

Please see attached the Trust's Sickness Management Procedure.

According to our Freedom of Information Policy we only release the names of staff on Grade 8a and above. We have, therefore, redacted the names of staff below that grade, and also members of staff that have left the Trust, from the attached policies provided as above.

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I can confirm that we hold this information, but it is exempt under section 40(2) of the Freedom of Information Act 2000 – Personal Information of third parties. This is because this information may allow the identification of individuals and disclosure would breach the principles of the Data Protection Act.

This is an absolute exemption and there is, therefore, no requirement to consider the public interest.

3. **The trust's most recent self-assessment against the NHS Violence Prevention and Reduction (VPR) Standard, including evidence showing the criteria have been met for each indicator. The compliance assessment template can be found in the VPR Standard published by NHS England, available here (template on pages 7-14):** https://www.england.nhs.uk/publication/violenc e-prevention-and-reduction-standard/

Please see the attached document and note the following:

We are working towards absolute indicators in all areas. Evidence of reaching those absolute indicators is sort analysed and KPi indicators, which are set and agreed, sit behind each of the standards and is reviewed every 2 months. We will not turn green until all of those absolute indicators are met and formalised.

If I can be of any further assistance, please do not hesitate to contact me.

Should you be dissatisfied with the Trust's response to your request, you have the right to request an internal review. Please write to the Freedom of Information Department (esh-tr.foi@nhs.net), quoting the above reference, within 40 working days. The Trust is not obliged to accept an internal review after this date.

Should you still be dissatisfied with your FOI request, you have the right of complaint to the Information Commissioner at the following address:

The Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire SK9 5AF

Telephone: 0303 123 1113

Yours sincerely

Freedom of Information Department
esh-tr.foi@nhs.net

East Sussex Healthcare
NHS Trust

Sickness Management Procedure

Document ID Number	57
Version:	V3
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Name of author and title:	[redacted], HR Advisor
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Target audience:	All staff
CQC Fundamental Standard:	Good Governance
Compliance with any other external requirements (e.g., Information Governance):	ACAS
Associated Documents:	Annual Leave Policy Disciplinary Procedure Work Life Balance & Special Leave Policy Incident Reporting and Management Procedure for Maintaining High Professional Standards (MHPS) in the modern NHS Psychological Wellbeing & Safety Policy Substance Misuse Supporting Staff Involved in Incidents, Complaints and Claims Ending Employment Including Retire and Return

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Please be advised the Trust discourages retention of hard copies of procedural documents and can only guarantee that the procedural document on the Trust website is the most up to date version

Version Control Table

Version number and issue number	Date	Author	Reason for Change	Description of Changes Made
V2	December 2017	[redacted], HR Manager	Periodic review	Minor adjustments in main body Changes to pay terms and conditions in Appendix G as per pay agreement
V2.1	December 2017	[redacted], HR Manager	Periodic Review	Minor adjustments to Appendix B Sickness Reporting Form
V2.2	December 2022	[redacted]	Extension for review date due to extensive review	Extended review date from May 2022 to March 2023
V2.3	March 2023	[redacted]	Extension for review date due to extensive review	Extended review date from March 2023 to May 2023
V3	November 2023	[redacted], HR Advisor	Periodic Review	Change to title from Attendance management

Consultation Table

This document has been developed in consultation with the groups and/or individuals in this table:

Name of Individual or group	Title	Date
Sammi Foy	Occupational Health Manager	March 2023
Liz Lipsham	People Potential Manager	March 2023
Operational HR		March 2023
WPPG		April 2023

This information may be made available in alternative languages and formats, such as large print, upon request. Please contact the document author to discuss.

Table of Contents

1. Introduction

The Trust recognises that the health and well-being of staff is vital for ensuring that it can provide effective patient care and continually improve the quality of services for patients. The Trust approach to staff health and well-being is centred on prevention, promotion of positive health and, where sickness occurs, enabling staff to return to work safely as soon as is appropriate.

Our People Strategy (People Strategy (esht.nhs.uk)), which is based on the NHS People Plan (NHS England » NHS People Plan), prioritises a culture that supports and grows our people.

Looking after our people means creating a positive, engaging working environment and keeping colleagues safe and healthy – both physically and psychologically. It is everyone's responsibility to contribute to an inclusive culture where all colleagues feel that they are treated according to trust values and demonstrate those values in our own compassionate behaviour, to inspire each one of us to thrive and develop to our full potential.

2. Purpose

The purpose of this policy is to provide clear guidance to managers and staff in managing sickness absence so that they are aware of their obligations and responsibilities in relation to attendance, health, and wellbeing.

2.1. Rationale

The Trust aims to strike a reasonable balance between the needs of our services and of employees who are absent from work because of sickness. It recognises that staff should be supported when they are unable to work because of their health or other reasons. The Trust's ability to deliver cost effective patient care is adversely affected when staff are absent, and therefore the Trust has a responsibility to follow appropriate and reasonable measures when dealing with absence, including sickness absence.

2.2. Principles

2.2.1 Where employees are unable to attend work due to health issues, any absence will be managed sympathetically and sensitively.

2.2.2 Should an employee's health prevent them from providing a regular and reliable attendance at work the processes set out in this procedure will ensure support is given with an aim of considering the Trust's ability to support their ongoing employment.

2.2.3 When managing staff absence all those involved will be expected to adhere to strict rules of confidentiality as would be applied with the handling of medical records. Any breach of confidentiality by any part, will be dealt with potentially under the Trust's Disciplinary Procedure.

2.2.4 Should staff need to have their sickness absence managed formally, they will be required to attend any formal meetings as laid out within this policy. In that event staff will be given five working days' written notice and advised of their entitlement to be accompanied by either a colleague who is an employee of the Trust or represented by a full time or lay Trade Union officer.

2.2.5 If an employee fails to attend a formal meeting without notification the meeting will be reconvened within 10 working days, unless both parties agree otherwise. If the reconvened meeting is not attended by the employee or their nominated representative, it may proceed in their absence.

2.2.6 Working in any capacity whilst on sick leave or claiming sick pay when a staff member is fit to work is not permitted. This will be regarded as dishonest conduct and will be dealt with in line with the Trust's Disciplinary Procedure. In addition, if there are reasonable grounds to suspect abuse of the sick pay system, the Trust's Local Counter Fraud specialists (LCFS) may investigate and take action, in line with the Counter Fraud Policy.

2.3. Scope

This procedure applies to all staff employed by East Sussex Healthcare NHS Trust. For Medical staff, this policy should be applied in conjunction with the Maintaining High Professional Standards Policy.

3. Definitions

Episode of sickness:	Any period of absence due to sickness, regardless of duration including where linked should an early return be unsuccessful.
Fit note:	Is a medical certificate usually provided by the employees General Practitioner and is used for periods of sickness of eight+ calendar days.
'Open' fit note:	A fit note which specifies a period to refrain from work but does not specify a return date.
'Closed' fit note:	A fit note which specifies an exact return to work date Fit notes may indicate workplace adjustments.
Self-certification:	Absence of between one – seven calendar days
Working days:	Monday-Friday
Frequent Sickness Absence:	Any occurrence of sickness absence will be considered as frequent. Absence from the eighth calendar day must be covered by a Fit Note
Long-Term Sickness Absence:	Any one occurrence of sickness absence which lasts 28 days or more, which may be due to an underlying health condition/Disability.
Formal Review / Meeting:	A review meeting held at any Stage of Frequent or Long-term absence.
6 / 12 month rolling period:	The 6 /12-month period immediately before each episode of sickness absence

Reasonable adjustments:	Adjustments made to working arrangements or physical aspects of the workplace, due to a health condition or disability, to ensure staff are not put at a disadvantage compared to other staff. This includes those who may require temporary adjustments in order for them to reintegrate back to work following absence or to avoid absence occurring.
Statutory Sick Pay (SSP)	is paid in accordance with rules determined by the Department for Work and Pensions
Occupational Sick Pay	is paid in accordance with NHS terms and conditions of employment.

4. Accountabilities and Responsibilities

4.1 Chief Executive and Directors

Chief Executive and Directors have ultimate responsibility for ensuring that the processes and procedures set out in this document are applied consistently.

4.2 Line Managers' responsibilities

Managers should act reasonably, fairly, consistently and, sympathetically in dealing with absence, through the needs of individuals' specific requirements to achieve good attendance and sustain service delivery. Obligations include:

4.2.1 Ensure they are fully conversant with this policy and linked policies.

4.2.2 Ensure all staff are aware of who they should report absence to, and the required procedure.

4.2.3 Ensure reported absences are documented using Sickness Reporting Form

4.2.4 Promote healthy work practices and take preventative actions to mitigate risks to health; this can be achieved through completion of relevant risk assessments.

4.2.5 Ensure that accurate records of all absences are recorded on ESR/ E-rostering promptly to assist discussions with the employee.

4.2.6 Maintain strict confidentiality of their employees' sickness absence, whilst not to the detriment of seeking out appropriate services with the intention of supporting their staff member. Unauthorised disclosure will be treated in the same manner as for any other medical record.

4.2.7 Conduct return to work discussions with employees on their return from a period of absence on the day of their return. This can be carried out by a designated colleague if the line manager is not available. The Sickness Reporting Form should be used to document this discussion and any necessary follow up action. This should be retained on the staff members confidential personal file.

4.2.8 Monitor attendance and maintain agreed regular contact with employees when they are absent in order to better support and facilitate their return to work.

4.2.9 Arrange a referral to Occupational Health using the Management Referral Form. Support the employee to either attend an appointment or help identify a confidential space for the employee to undertake an OH telephone assessment.

4.2.10 Where appropriate make reasonable adjustments for staff who require this to enable them to have access to work or support a reduction in sickness absence due to a disability or health condition. This may include, making physical changes to premises, providing equipment, or changing work patterns. Where adjustments are not feasible within the staff members substantive role or areas, redeployment on a temporary or permanent basis should be considered.

With the agreement of the employee, complete a (Dis) Ability and Health passport to better understand and facilitate support and/or adjustments within the workplace. Further information can be found on the Trust's HR Solutions Extranet.

4.2.11 Contact the Local Counter Fraud Specialists for advice if there is a suspicion that an employee has taken sick leave dishonestly. Ensure you do not discuss your concerns with the colleague or others and seek additional support from HR.

4.2.12 Inform Temporary Workforce Services of decisions to place restrictions on bank working.

4.2.13 Participate in training on Sickness Management Procedures.

4.3 Employee's responsibilities

4.3.1 Ensure they understand the content of this policy and co-operate fully with absence procedures.

4.3.2 Take appropriate care of their own health, safety and well-being and access the range of support and resources available to them via the Trust.

4.3.3 Offer regular and reliable attendance at work in accordance with their contracted hours and in a fit state to carry out their duties.

4.3.4 Report their absence on the first day to their manager or designated person within their department in accordance with agreed departmental procedures. This should be directly, in person, by telephone and not by other electronic means such as email or text message

4.3.5 If the absence is due to an incident at work the employee should inform the line manager and complete an incident form at the time of the injury

4.3.6 Report fitness to return to work as soon as it is known to their Line Manager or designated person within their department, whether they are expected to attend work on that day or whether it is a rostered day off. Failure to do so may result in an increase in absence calculations.

4.3.7 Participate in Return-to-Work discussions and sign the Sickness Reporting Form.

4.3.8 Comply with sickness certification arrangements. Failure to provide the correct documentation in a timely fashion may jeopardise entitlement to sick pay

4.3.9 Attend review / contact meetings with their Manager in line with the provisions of this procedure

4.3.10 Keep in regular contact with their manager, and discuss Fit Note adjustments and return to work plans as appropriate

4.3.11 Attend Occupational Health appointments as requested. Should employees choose not to engage with Occupational Health, it will not be possible to manage any absence with due regard to their health needs.

4.3.12 Cooperate with regards to possible implementation of any adjustments to job duties hours or working conditions resulting from recommendations made by a medical practitioner or the Occupational Health Department. Notwithstanding the fact that a Fit Note is not binding on the Trust

4.3.13 Employees must not carry out any work while on sick leave unless specifically authorised by the Trust, this includes, but is not exclusive to, any employment outside of the Trust; self-employment and voluntary work.

4.3.14 Take responsibility to help their own recovery, and not undertake any activity whilst absent from work through sickness which could hinder their recovery and subsequent return to work, e.g. taking part in sports or other activities which may aggravate their illness. However, it is acknowledged that undertaking of some activity whilst absent can aid recovery from sickness. Staff can gain advice from Occupational Health if they are uncertain about this.

4.3.15 Inform their line manager if they are making plans to travel abroad whilst on sick leave. Consideration will then be taken regarding the appropriateness of the planned travel based on medical evidence provided their GP.

4.3.16 Do not Bank work or any hours in addition to contracted hours is not permitted during period of sick leave, when or a phased return or advised whilst under a formal absence process.

4.4 Human Resources Department

4.4.1 HR Business Partners and HR Solutions will help ensure that this policy is understood and implemented consistently by managers, staff and trade union representatives. They will also advise on specific cases, particularly where formal action is taken.

4.4.2 The HR Information Team will produce monthly sickness absence reports listing those employees who have triggered a review under this procedure to Departments / Clinical Units and line managers.

4.4.3 HR Business Partners will analyse sickness absence reports to enable trends/hot spots to be identified within particular departments.

4.4.4 Where appropriate HR Advisors may make home visits to staff with their line manager, e.g., to explain sick pay entitlements or ill health retirement provisions.

4.4.5 General HR guidance and template documents can be accessed on the Trust's HR Solutions Extranet.

4.5 Occupational Health Service

4.5.1 Occupational Health (OH) provide specialist advice and guidance to staff and managers on receipt of a referral, and to liaise with employees GPs or Medical Specialists to provide an informed, comprehensive assessment of the employee's fitness for work. It should be noted that contact with GPs or Medical Specialists can only be undertaken with written consent from the employee. Any such reports when received remain within the employees confidential Occupational Health record for which only the staff member and Occupational Health personnel have access.

4.5.2 OH will manage referrals and advise staff and line managers of appointments made.

4.5.3 OH will advise managers of any non-attendance / cancellations or postponements of appointments.

4.5.4 Following an OH consultation with the staff member and pending their consent, OH will provide line managers with a written report. This report will advise on the employee's likelihood of returning to work, timescales and highlight any adjustments which need to be considered to facilitate a return to work or otherwise.

4.5.5 Should employees choose not to engage with Occupational Health or decline their consent for an OH report to be shared with their manager, gain access to a GP or specialist report, it will not be possible to manage their absence with due regard to their health needs.

5. Procedures and Actions to Follow

Notification of Absence

5.1 Reporting Absence

5.1.1 Employees must report absence in line with the departmental arrangements but no later than within one hour of their start time or as soon as possible on the first day they are unfit for work to their line manager or designated person within their department. Early notification is preferable to enable arrangements to be made to cover shifts or duties.

5.1.2 All absences must be reported via telephone. Text messaging, emails or using social networking sites are not acceptable methods for reporting any absence. If unable to report personally employees must ask a responsible person to do this on their behalf. They will then be contacted by their line manager or designated person. Any delay may affect entitlement to sick pay.

5.1.3 When reporting absence, the employee should inform their line manager of the following:

- Absence reason
- Likely length of absence
- Details of any work-related issues that may be impacting on or have caused their absence, so that their line manager can consider appropriate support and action where required.

This information must be recorded on the Sickness Reporting Form.

5.1.4 If an employee goes home or is sent home from work because they are unwell before completing 50% of their working day, this will be recorded as a whole day's sickness absence. If sent home after completing 50% of their working day this will be recorded as half day sickness.

It should be noted that absences of this nature may mount up and require careful monitoring as this may be indicative of a staff members health impacting on work or demonstrate a pattern of absence. A discussion between the staff member and their manager is advised to explore further.

5.2 Subsequent sick days

5.2.1 The manager should agree with the employee the frequency and nature of updates, taking into account the nature of the absence and whether it is medically certificated or not. The employee should thereafter update their manager as agreed.

5.2.2 If the absence continues the employee must maintain the agreed regular verbal contact with their manager or designated contact to keep them informed of their progress.

5.3 Certification

5.3.1 Certification for the first seven calendar days of each absence (this includes all non-workdays) is recorded on the Sickness Reporting Form which must be signed by the employee at their return-to-work meeting.

5.3.2 Employees who are absent due to sickness beyond seven calendar days are required to submit Statements of Fitness for Work (Fit Notes) which cover all days of absence beyond the seventh calendar day.

5.3.3 On an individual basis, in response to a sickness pattern already highlighted to the employee by their line manager, the Trust reserves the right to call for medical certificates for absences less than seven calendar

days. If a cost is incurred the Trust will reimburse the employee on the production of a receipt.

5.3.4 Failure to submit a medical certificate or to follow the correct reporting procedures could result in the withdrawal of sick pay. Repeated failure to submit medical certificates or follow the correct reporting procedure is considered a disciplinary matter.

5.4 Statement of Fitness to Work (Fit notes)

5.4.1 Statement of Fitness for Work or Fit Note is a medical certificate which states the reason for the sickness absence and that the employee is either “unfit for work” or “may be fit for work”.

5.4.2 If the Fit Note indicates that the employee “may be fit for work” it will indicate the length of time for the recommended adjustments which are designed to help facilitate the employee’s return to work. The line manager should meet with the employee to discuss how the adjustment may be facilitated. Adjustments could be:

- a phased return
- amended job duties.
- temporary work placement (not necessarily within own department)
- altered hours of work
- workplace adaptations

5.4.3 If a phased return, restricted hours/duties or workplace adaptions are agreed this should not normally exceed four weeks. In cases where the employee’s required adjustments cannot be accommodated the Fit Note should be regarded as if the doctor had advised “not fit for work”.

5.4.4 An employee can return to work at any time they feel able to (including before the end of the Fit Note) without going back to see their doctor. However, employees must confirm that they are fit to undertake their contractual duties. For those who hold a professional qualification, they must confirm that they are fit to practice in line with their governing body. Should an employee return to work prior to the end of their fit note expiring and/or without medical assessment, their line manager must complete a risk assessment prior to the employee’s return to work to establish that returning the employee to the workplace would not pose a serious threat to the health & safety of that employee or to that of their colleagues, visitors or the general public.

Depending on the seriousness of the condition, a line manager may take further advice from Occupational Health on an employee’s ability to return to work. In the event that the manager cannot accommodate the employee’s immediate return to work, the manager should explain the reasons for this decision and provide a plan of action which may include temporary redeployment to another area or role. In such instances, further support from HR and OH can be identified.

5.4.5 Where the absence extends over a longer period the medical certificate should provide continuous certification of absence, with no gaps between. Failure to submit medical certificates may result in loss of pay.

Continuing certificates should be forwarded with three calendar days of expiry of the previous statement.

5.4.6 If an employee is in hospital or receiving medical treatment from any other provider; they should provide their manager with a discharge certificate where able and as soon as possible.

5.4.7 It is an employee's responsibility to ensure that a medical certificate can be verified i.e., that it includes the surgery stamp which shows clearly the name, job title, address and telephone number of the person signing it. Employees should under no circumstances alter or amend the medical certificate. If there is any doubt by the manager of the authenticity of the medical certificate, managers should discuss their concerns with the HR Business Partner.

5.5 Bank Work / Temporary Workforce Services

5.5.1 Following a period of frequent sickness absence a member of staff must not work any additional hours for a period of one week.

5.5.2 Employees whose sickness absence has triggered a review under frequent absence section of this procedure may be restricted from working additional shifts via the Temporary Workforce Service or additional hours for up to three months following the last episode of absence.

5.5.3 Staff who have been on long term sick leave will not be permitted to work additional shifts via Temporary Workforce Services or additional hours for a period of at least two weeks following return to ensure they are fully recovered from their absence. Managers reserve the right to temporarily stop an employee working bank shifts following a period of absence, should they have concerns that this may adversely affect their recovery.

5.5.4 Bank shifts or additional hours will also not be permitted during periods of a phased return or temporary work placement.

5.5.5 It is the responsibility of the line manger to inform Temporary Workforce Services of the decision to place restrictions on bank working.

5.6 False claims of sickness or working while off sick

5.6.1 It is not normally permitted to work while off sick whether in a paid, unpaid, self-employed or voluntary capacity, even if permission has been given on previous occasions or when the employee was not off sick.

5.6.2 An employee who continues to work in a second job and/or wishes to work, while off sick, for therapeutic reasons or to aid recovery must seek authorisation from their line manager in advance on each occasion. The Trust would not expect you to work for another employer and should this happen, it would be unauthorised.

5.6.3 An employee who works while off sick without authorisation from their line manager or who is suspected of falsely claiming to be sick will be referred to the Counter Fraud Service for investigation under the Fraud Act 2006

and could lead to prosecution, a disciplinary sanction (including dismissal) and recovery of sick pay.

5.6.4 If the line manager suspects any breach of policy in connection with the above, they must contact the NHS Local Counter Fraud Specialist for advice before commencing an investigation and contact Human Resources. Contact details on the Counter Fraud Page of the Extranet.

5.7 Return to Work

5.7.1 An informal and where possible face-to-face return to work discussion between the manager and the employee should take place after each episode of absence including long term sickness. This discussion should take place on the day of return by Line Manager or designated person. In exceptional circumstances e.g., for staff based in small community units or due to working patterns, a face-to-face meeting is not possible, it is acceptable for this return-to-work discussion to be conducted over the telephone or Teams but only for those staff who are not on a formal absence review trigger.

5.7.2 The return-to-work meeting forms the basis of absence management and must be recorded by completing the Sickness Reporting Form.

5.7.3 At every return-to-work discussion the manager should:

- welcome the employee back to work.
- take time to listen to how they are feeling on returning to work and take consideration of their general well-being and re-orientation back to the workplace.
- ascertain with the employee they are fit to work.
- establish the precise reason for the absence; If stress is given as the reason an individual Stress Risk Assessment should be completed and reviewed with their Line Manager - Stress resources (esht.nhs.uk). This can be done in advance to support the return-to-work conversations.
- reiterate reporting procedures if these were not followed appropriately and record this in Part three of the Sickness Reporting Form.
- if appropriate, advise the employee if their attendance record is giving cause for concern, discuss any support that can be provided to help the employee to improve their attendance, and inform employee that a First / Second Review Meeting is to be arranged.
- complete part two of the Sickness Reporting Form which should be signed by both parties.
- update the employee on any relevant information, which may have occurred during their absence.

If there is an ongoing underlying health issue that is likely to impact on the employee's ability to work, they should be offered a referral to Occupational Health so that advice can be offered. In all cases staff should be encouraged to access the range of wellbeing resources available to them from both within and outside of the trust Where a staff member has accepted a referral to OH in relation to stress a copy of their individual stress risk assessment should be enclosed alongside their referral.

5.7.4 Thereafter the manager should update Health Roster/ESR and file the Sickness Reporting Form, together with a Fit Note (if appropriate) on the employee's staff file.

5.8 Occupational Health Referrals

5.8.1 When managing sickness absence, line managers are expected to obtain advice on an employee's fitness to attend work.

5.8.2 The purpose of a management referral is to:

- establish the likely duration and prognosis for recovery.
- establish whether an employee has an underlying medical condition.
- gain advice to facilitate a timely return to work – for example, adjustments/phased return

5.8.3 Referrals are made using the Management Referral to Occupational Health Form. When managers refer staff to Occupational Health, they must ensure that the employee is fully aware of the reasons for the referral and outline any adjustments that have already been implemented.

5.8.4 Following the appointment the Occupational Health specialist, recommendations to both the employee and the manager will be outlined within a report.

5.8.5 The line manager will be provided with a written report once the staff member has consented to its release.

5.8.6 If an employee fails to attend appointments or engage with Occupational Health, their line manager will need to make any decisions in the absence of Occupational Health specialist advice. Non-attendance/late cancellation or postponements of Occupational Health appointments will be monitored and reported to the referring line manager as this may demonstrate a breach of the Trust's Disciplinary Procedure.

5.8.7 The Occupational Health clinician may need to consult with the employee's GP or other specialist practitioner. In such cases Occupational Health will request written consent from the employee prior to approaching their GP or specialist practitioner. If the employee declines to give consent any decision regarding management of their health in relation to work will be taken on the basis of the limited information available.

5.9 Management of frequent sickness absence

5.9.1 Trigger points

The trigger points for identifying when action must be taken regarding an employee's sickness absence record are detailed below. It is not the intention that they be used exclusively without reference to other information including: the employee's previous attendance record; change of personal circumstances; the reasons given for absence; length

of the absence; any long-term medical condition and any recent organisational changes.

5.9.2 Informal review triggers:
A return-to-work meeting will be carried out after each episode of absence.

5.9.3 Formal review triggers:
- 2 episodes in 3 month or
- 4 in a rolling 12-month period
- Pattern of absence which significantly impact colleague's role or the service.

5.9.4 If an employee attempts to return to work, but is unsuccessful and it results in further absence, for the purposes of this procedure, this should be linked as one absence if within two days of return.

5.9.5 Where appropriate managers must refer to paragraph 5.29 Disability related sickness or paragraph 5.30 Pregnancy related sickness.

Where an underlying health condition is identified, you must refer to the Long-Term Sickness / Sickness relating to Disability or Underlying Health Condition below for further guidance on how to proceed.

5.10 Formal process for the management of frequent absence

5.10.1 The formal part of the procedure will be initiated when one of the above trigger points has been reached. Managers will notify the employee in writing of a meeting to discuss their sickness absence record. The purpose and tone of the meeting should be positive and provide an opportunity to discuss the facts about the employee's absence; explain the Sickness Management Procedure, identify any support that can be provided; explain the impact the staff member's absence has on their colleagues and the service and ensure the employee is aware that an improvement in their record is required.

5.10.2 The manager should make it clear that they are not questioning whether the reasons for the absences are genuine, unless they have reasonable grounds for doing so.

5.10.3 There are three formal stages in managing frequent absence as outlined below.

5.11 First Review Meeting

5.11.1 Where monitoring an employee's sickness absence record indicates this procedure has been triggered a First Review Meeting will be arranged. This meeting should take place in the presence of the manager and the employee.

The employee should be informed of the meeting in writing with five working days' notice and advised that s/he is entitled to be accompanied by either a colleague who is an employee of the Trust or represented by

a full time or lay Trade Union officer. Managers should obtain a template letter from the HR Solutions Extranet.

A copy of the Sickness Management Procedure is available via the HR Solutions Extranet and a copy of the Employee Responsibilities should be enclosed with the letter.

5.11.2 Should the circumstances of the individual case require it the manager can request to be accompanied by a Human Resources Representative.

5.11.3 At the formal meeting the manager will:

a) present to the employee information relating to their absences, highlighting frequency, duration, cause and pattern.
b) discuss with the employee whether referral to Occupational Health would be beneficial at this point.
c) allow the employee to share their views on the situation and raise any concerns that may be impacting on their health e.g., personal issues, work related issues
d) discuss if any support can be provided to the employee to help them to improve their attendance – signposting and encouraging staff to access the range of wellbeing support available to them
e) explain the impact the absence is having on service delivery and the team
f) explain that if the employees' health prevents them from providing a regular and reliable attendance at work that their continued employment could be at risk, with one potential outcome being dismissal due to capability.

5.11.4 A letter outlining the key points covered in the meeting will be sent to the employee and will state the consequences if the employee does not improve their attendance i.e. that if their absence levels cause concern again within 6 months of their last sickness episode, i.e. two or more further absences the policy will be reapplied at Second Review of the procedure. Any absences in the 6-month monitoring period will be reviewed in consideration of individual circumstances including any absences due to a disability or pregnancy, before arranging a further formal meeting. Managers should obtain a template letter from the Extranet.

5.12 Second Review Meeting

5.12.1 The employee should be given five working days' notice from receipt of letter of the meeting and advised that he/she is entitled to be accompanied by either a colleague who is an employee of the Trust or represented by a full time or lay Trade Union officer. A Human Resources Representative will also be present.

5.12.2 At the meeting the manager/matron will cover the points outlined above for the First Review Meeting. In addition, a referral to Occupational Health will be made if not already made.

5.12.3 A letter outlining the key points covered in the meeting will be sent to the employee and will state the consequences if their absence levels cause concern again within 12 months of their last sickness episode, i.e. four or more further absences the policy will be reapplied at Final Review of the

procedure and that their continued employment is at risk. Managers should obtain a template letter from the HR Solutions Extranet.

5.13 Final Review Meeting

5.13.1 A referral to the Occupational Health Department should be made by the line manager to gain current advice and guidance for the employee. (Please refer to Occupational Health section within this policy for further details.) Information provided by Occupational Health must be taken into consideration prior to determining to progress to a Final Review Meeting in conjunction with advice from the HR Department. Due consideration must be given to any disability or pregnancy related illness. Should the employee decline to attend Occupational Health or not agree for the information from Occupational Health to be shared then a decision to proceed to a Final Review Meeting will be taken based on the information available.

5.13.2 The Final Review Meeting will be chaired by one independent senior manager supported by a professional member of the HR Department. Both the Line Manager and employee attend with all information sent to all parties prior to the meeting being held.

5.13.3 The employee should be given five working days' notice of the meeting and advised that s/he is entitled to be accompanied by either a colleague who is an employee of the Trust or represented by a full time or lay Trade Union officer. The letter should advise the employee that as a result of the meeting s/he may be dismissed with appropriate notice for reasons of capability.

5.13.4 At the meeting consideration will be given to:

- the employee's absence record, reasons for absence and any mitigating factors
- the Occupational Health Report
- whether there is adequate documentary evidence available to demonstrate that the Trust's procedure has been followed
- the needs of the service and impact on work colleagues

5.13.5 The Senior Manager will then decide on the action to be taken, which may be dismissal with the appropriate period of notice on the grounds of the individual's inability to attend work on a regular basis and failure to maintain an acceptable level of attendance.

5.13.6 The employee will be informed of their right to appeal against a decision to terminate their contract.

5.13.7 A letter confirming the decision and outlining the key points covered in the meeting will be sent to the employee.

5.14 Management of Long-Term Sickness / Sickness relating to Disability or Underlying Health Condition

General

5.14.1 The aim of this procedure is to ensure that staff who are absent due to long term sickness (i.e. a period of 28 days or more) or those with an underlying health condition where their underlying health condition absence meets the frequent absence triggers. are dealt with fairly, consistently, and sensitively and are supported in making a return to work if and when they are fit and able to do so.

5.14.2 It is important that managers have referred their staff member to Occupational Health and obtained a report so that decisions can be made based on medical advice. This is to ensure that certain duties will not aggravate or regress the staff members health issue or injury, which had caused their incapacity for work.

5.14.3 The employee should be informed of formal meetings held under this procedure in writing, giving five working days' notice and advised that s/he is entitled to be accompanied by either a colleague who is an employee of the Trust or represented by a full time or lay Trade Union officer

5.15 Occupational Health Advice

5.15.1 In order to provide appropriate advice and support for employees on long term sickness absence managers must refer staff to Occupational Health**.**

5.15.2 Occupational Health will contact the employee to arrange an appointment; managers must ensure that the contact details are correct and include personal email addresses if the member of staff is on long term sick leave and has given their permission.

5.15.3 Occupational Health will provide a medical opinion on the employee's fitness for work and ability to attend any meetings required under this policy. They will advise the manager on whether the employee has an underlying condition affecting their ability to attend work; the likely length of absence, whether the illness or injury will be temporary or permanent, whether any adjustments to their hours or duties would facilitate an earlier return, whether in the light of the needs of the Trust and the demands of the occupation in question, the employee will be capable of regular and efficient service in their current role.

5.15.4 In the event of conflicting medical advice the employee or the Trust can request an independent medical opinion and the Occupational Health Department will obtain a report from the medical practitioner to be agreed by both parties.

5.16 Keep in touch arrangements.

5.16.1 It is essential that regular contact should be maintained. This is a joint responsibility, and the line manager and employee should agree early on the frequency and method of contact which should be maintained through the period of absence. Contact should be on a regular basis and at least

monthly. In exceptional circumstances, and where the employee agrees, this could include home visits. If appropriate the manager may wish to be accompanied by an HR representative or a work colleague.

5.16.2 Managers must provide themselves with up-to-date information and ensure that they are in a position to give employees the following advice:

- What action may need to be taken if the employee is unlikely to be able to return to work on health grounds.

5.16.3 Employees should be advised that even if they have exhausted their sick pay entitlement, they must continue to provide up to date Fit Notes, be available (health permitting) to attend meetings and adhere to Trust terms and conditions and policies and procedures.

5.16.4 Unauthorised Absence procedures are to be applied where an employee either fails to inform their manager of their absence OR ceases to maintain contact having initially reported their absence. Please refer to Disciplinary Procedures for further details.

5.17 Health & Wellbeing Meetings

5.17.1 When an employee has been absent for more than 28 days (or it is known they will be), or meets the frequent absence trigger due to an underlying health condition, the manager should take the following action:

- arrange 4 weekly Health & Wellbeing meetings with the employee to discuss their absence and whether any support can be provided; this meeting should take place between the manager and the employee. Managers should complete Health & Wellbeing Record form available on HR Solutions Extranet.

- Discuss referral to Occupational Health with the employee and complete the managers referral to Occupational Health as required.

5.17.2 The purpose of this meeting will be to:

- establish the prognosis and, if possible, when the employee will be fit to return to work
- review what reasonable adjustments can be made to facilitate a return to work, in accordance with the Equality Act, including carrying out a risk assessment if appropriate
- if appropriate, discuss phased return to work

5.17.3 Health & Wellbeing meetings are to be held for a maximum of 6 months. Where options of permanent redeployment, Ill Health Retirement or mutual agreement to dismiss are recommended or relevant, the employee should be moved to the formal First Ill Health Meeting.

5.17.4 A summary confirming the content and outcome of the meeting will be sent to the employee together with arrangements for the next contact. Managers should use form available on HR Solutions Extranet.

5.17.5 If prior to the next contact the employee is fit to return to work the meeting will be brought forward. Once staff are declared fit to return to work by a medical practitioner, they may return without further liaison with OH.

5.18 First Ill Health Meeting (no later than 6 months from when absence commenced)

5.18.1 If the long term sickness continues, or the frequent absences related to underlying health condition continues, the employee will be invited to meet formally with the manager and with HR present under First Ill Health Meeting stage, with a view to supporting the employee back to work and/or improving attendance levels. These formal meetings will be in addition to the arrangements agreed for keeping in touch. Prior to the formal meeting the manager should obtain updated information from Occupational Health if recent report not available including advice on whether a phased return could be considered. An invitation letter is available on extranet.

5.18.2 This meeting will follow a similar format to the Health & Wellbeing Meeting. The manager should give further consideration to any reasonable adjustments which could be made to the employee's current role which would enable them to return to work and/or improving attendance levels.

5.18.3 Workplace adjustments can be temporary or made on a permanent basis.

Adjustments, where they can reasonably be accommodated, might include:

- adjusting an individual's working hours
- allowing an employee to be absent from work for rehabilitation treatment
- enabling an employee to work in a more accessible area
- making alterations to premises
- providing new or modifying existing equipment
- modifying work furniture
- providing additional training
- modifying the duties of the role

5.18.4 A letter confirming the content and outcome of the meeting will be sent to the employee together with arrangements for the next contact. Managers should use the letter template available on HR Solutions Extranet.

5.19 Rehabilitation - Phased Return to Work Programme

5.19.1 Where a member of staff who has been absent for more than 28 days is fit to return to work but not on full contractual hours or full range of duties the manager should consider their return to work on a phased return basis. This enables staff to work towards fulfilling all their duties and responsibilities within a defined and appropriate time period, where the employee may return on reduced hours, and then gradually increase their working hours back to the full contractual hours. This may include allowing an employee who has been on a prolonged period of sickness absence, to return to work sooner than they may otherwise have been able to.

5.19.2 It is important to note that a phased return to work is not always suitable or possible. Consideration will be given to a range of factors including, but not limited to: the length of and reason for the absence, proposed number of hours to be worked, type of work, support available and service requirements.

An absence of 28 days or more does not necessarily mean that an individual is automatically entitled to a phased return, phased returns should be considered when recommended by a medical professional GP via fit note or Occupational Health.

5.19.3 Where the Occupational Health Department advises that an employee can return to work on their full contractual hours undertaking only limited, restricted duties, the manager will need to assess the feasibility of accommodating any recommendations against the needs of the service.

5.19.4 A phased return to work may be agreed within the following parameters:

a) that it will not be at less than 50% of the employee's contracted hours and may include shorter working shifts or fewer shifts and will be subject to the needs of the service.
b) it will not usually last more than four weeks and during this period the employee will receive full pay
c) one phased return of up to four weeks with full pay will be permitted in any rolling 12 month period, for any subsequent phased returns payment will reflect the reduced hours worked.
d) here, exceptionally, extensions are agreed to the four week period then outstanding annual leave will be used to make up the shortfall in hours to cover the extended period.
e) if OH advises that certain shifts should be restricted (such as nights), this will only be agreed for the period of the phased return to work. If the advice is to restrict these shifts indefinitely and if night working is a requirement of the job, consideration will be given as to whether this is a reasonable adjustment under the terms of the Equality Act 2010 or whether redeployment may need to be considered.
f) the manager should regularly review the employee's progress during the assisted return period.
g) any member of staff undergoing a phased return to work programme will not be permitted to work additional shifts/hours within their own department, or through Temporary Workforce Services or other employment.
h) staff should not participate in any activities which could hinder their recovery.
i) managers should ensure the employee is not required to deal with any backlog of work during the phased return that has been caused by the period of absence and take all reasonable steps to facilitate the employee's re-integration into the workplace.

5.20 Rehabilitation - Temporary Work Placements

5.20.1 If a manager feels unable to support an assisted return to work for an employee for operational reasons, a temporary work placement should be considered by the manager in liaison with the Human Resources and Occupational Health Departments.

5.20.2 The Trust is committed to supporting staff in temporary work placements when they could return to work but are unfit for their substantive role. Initially a temporary role will be sought within their immediate work area. (e.g. non-clinical duties-audit etc.), if this is unavailable then the wider Department / Division will be asked to identify a suitable role.

5.20.3 The employee's existing rate of pay will be protected during the temporary placement and the funding for the role will be provided by the employee's substantive departmental budget. Such roles are designed to be strictly temporary and not usually last for more than three months and are restricted to one occasion in a 12 month period. It should be noted that no right to substantive alternative employment in the temporary role will be earned by undertaking the role on this basis.

5.20.4 In the interests of aiding the employee's recovery to their substantive role s/he will not be permitted to work additional shifts/ hours through the Temporary Workforce Service or other employment during the period of the temporary work placement.

5.21 Redeployment

5.21.1 Permanent redeployment is appropriate where Occupational Health have advised that the employee is no longer able to perform their established role, or when a line manager is not able to accommodate adjustments that would enable the staff member to remain in their substantive role/area.

5.21.2 The employee, supported by their line manager and Human Resources will have a period of 12 weeks, from the date of notification, to secure a suitable alternative post into which they can be redeployed. OH can provide advice and guidance on the suitability of roles for the staff member taking into account their health needs.

5.21.3 The employee will be required to complete a Redeployment Application Form and their details will be passed to Recruitment and they will send an email link to the employee to register for vacancies.

5.21.4 The employee must actively seek a suitable alternative post; providing they fulfil the criteria outlined in the person specification. Once a post has been identified Human Resources can request clearance from the Occupational Health Department prior to commencing any new position to ensure the new role will be medically suitable for the employee and offer any further support.

5.21.5 Where an employee moves to a post on a lower grade or working fewer hours there will be no protection of salary or other conditions. The manager of the redeployed employee will regularly monitor and review their progress to ensure they are coping with the transition into the new

role and where necessary further referral to Occupational Health or Human Resources may be required.

5.21.6 In cases of either Rehabilitation or Redeployment it may be necessary for the manager to allow the individual to take reasonable time off for assessment, treatment, rehabilitation therapies or trial periods of up to four weeks work within another role. In this case the timeframe is paused and picked up at the point at which it was paused; however this would not exceed a total of twelve week. Managers should seek support from HR and Occupational Health in this situation.

5.21.7 If no suitable redeployment opportunities occur within the 12-week period the employee's employment with the Trust will be terminated on the grounds of capability. Contractual notice periods will run in parallel with the 12-week redeployment period. There should be regular communication during this process between the Manager and Employee to review progress to date.

5.22 Ill Health Retirement

5.22.1 Employees who are members of the NHS Pension Scheme may be eligible to consider an application for an Ill Health Retirement Pension. Employees choosing this option will have their contract of employment terminated in line with Final Ill Health Meeting. The Pensions Agency will decide on the level of pension paid based on the medical status of the individual.

5.22.2 Employees whose employment has been terminated for reasons of Ill Health Retirement but do not have the recommendation of the Occupational Health Physician are able to make an application independent of the Trust supported by their GP and/or Specialist Consultant. Further information is available on HR Solutions Extranet within Ending Employment Including Retire and Return Procedure.

5.23 Dismissal on the grounds of capability

5.23.1 Where an employee is no longer able to perform their role, or where Occupational Health are not able to advise when the employee is likely to be fit to return to work, or if the employee has refused suitable alternative employment or none is available, the employee will be advised that a dismissal on the grounds of capability is likely and that a Final Ill Health Meeting to consider the situation and decide on appropriate action will be convened.

5.23.2 The meeting must be held before the employee has had 12 months of continuous sickness absence. A letter confirming the meeting arrangements and the possible outcomes will be sent to the employee, preferably by recorded delivery if it cannot be delivered by hand.

5.23.3 The manager cannot move to a Final Ill Health Meeting unless all the options in the First Ill Health Meeting have been considered, and the employee has been advised in writing that dismissal is a potential outcome of the meeting.

5.24 Final Ill Health Meeting

5.24.1 The employee will be invited in writing to a Final Ill Health Meeting, which will be chaired by an independent senior manager of the relevant Department / Division supported by a professional member of the HR Department.

5.24.2 The manager chairing the meeting will consider all the details of the case including:

- the length of the absence to date and the likely length of the continuing absence
- any medical advice/prognosis on the individual
- whether there is adequate documentary evidence available to demonstrate that the procedure has been followed
- the effect of the continuing absence on the service and impact on work colleagues
- NHS Terms and Conditions of Service relating to sick pay entitlement

5.24.3 If the decision is to terminate employment on the grounds of impaired capability due to ill health a date will be set at which the employee's contract will be terminated, if the employee is unable to return to work in their substantive post or is unable to find a suitable re-deployment opportunity, prior to that date.

5.24.4 The period of notice of termination of employment will be in accordance with the employee's contractual notice period.

5.24.5 During any period of notice the employee will receive full pay less sickness, invalidity or injury benefits receivable from the Department for Work and Pensions. This includes any period of notice during which the employee would normally be receiving half-sick pay, or where entitlement to occupational sick pay has expired at a date prior to notice being served.

5.24.6 The employee will have the right of appeal against a decision to terminate his/her contract.

5.25 Terminal illness

5.25.1 Where an employee is suffering from a terminal illness the Trust would aim, as far as possible, to accommodate the employee's wishes and would try to provide the most financially beneficial arrangements for the employee and/or his/her relatives.

5.25.2 In all cases of terminal illness, employees should be referred to the Pensions Officer as soon as possible to enable calculations and options to be identified.

5.25.3 Options include:

- that the employee continues to work fully or in a reduced capacity;
- that, if the employee is eligible, they could make an application for ill-health retirement or, where life expectancy is 12 months or less, their

incapacity pension could be commuted so that the value of their benefits is paid as a single lump sum

5.26 Medical Suspension

5.26.1 There may be occasions when a manager believes that it would not be appropriate or advisable for an employee to remain on duty. Examples may include:

- A health and/or safety problem
- If a manager doubts an employee's ability to perform the full range of their duties

5.26.2 The manager will normally advise the individual to take sick leave, certified by a Sickness Reporting Form or GP Fit Note as appropriate. If the individual does not agree to this, or if there is the possibility that the GP will not provide a Fit Note, then the manager will suspend the relevant employee on medical grounds on full pay.

The suspension will continue until the individual is fit to return to work, which will be established through Occupational Health often in collaboration with the employees GP, specialist or external specialist services. Occupational Health. Suspension will be confirmed in writing by the line manager.

5.27 Annual leave and sickness

5.27.1 If an employee falls sick during their annual leave, they are required to inform their manager using the normal reporting arrangements on the first day of sickness. The employee will be deemed to be on sick leave from that day and will be reallocated the period of annual leave. The employee will be required to produce either a self-certificate for an absence lasting up to seven days or a medical certificate from the eighth day onwards.

5.27.2 If the employee recovers from their illness during the period that was annual leave, they must notify their manager, and take the rest of the period as annual leave.

5.27.3 This does not apply to designated public holidays, which will be taken as a public holiday, irrespective of whether the employee is ill. Employees are not entitled to any additional time off if sick on a public holiday that they would otherwise have been required to work as part of their basic week. Please note any colleagues required to use a proportion of annual leave to support public holidays will have the element of annual leave reallocated.

5.27.4 If an employee is away from work due to sickness during a period of pre-booked annual leave and they still wish to go on holiday, they should do so only after obtaining the appropriate medical advice. They will be required to inform their manager.

5.27.5 In order to take paid annual leave following a period of sick leave, an employee must be signed as medically fit to return to work. Therefore, they must take annual leave to go on holiday only if their GP has signed

them fit to return to work and they are planning to return to work after their holiday.

5.27.6 Where sickness has prevented an employee from taking statutory annual leave entitlements within a leave year, it may be carried over into the following year, and arrangements made for it to be taken as soon as possible. However, it cannot be carried forward into a further leave year. Such leave may be used to facilitate a phased return to work.

5.27.7 For any sickness on days where annual leave has been requested but declined a medical certificate could be requested where an ongoing pattern is identified.

5.28 Incident reporting

All injuries, however minor, occurring whilst the employee is on duty, must be reported to their manager at the time or at the earliest possible opportunity thereafter and recorded on an incident report form in line with the Incident Reporting and Management Policy. The manager should discuss and consider with the employee whether any support is needed in line with the Supporting Staff involved in Incidents, Complaints or Claims Procedure.

5.29 Disability related sickness

5.29.1 An employee who is protected under the Equality Act and is absent with a disability related illness must follow the normal absence reporting procedure and provide medical certification as would be required for non-disability related illness. Their line manager will carry out a return to work interview after a period of absence and explore whether any support can be provided or to consider any adjustments that could be made to help the employee.

5.29.2 The legal definition of disability is defined at s.6 of the Equality Act as ‘a physical or mental impairment that has a substantial and long term adverse effect on the ability to carry out normal day to day activities’. This definition is wide ranging and covers mobility difficulties e.g., wheelchair users, sight or hearing impairments; learning disabilities; long-term conditions such as depression, diabetes or sickle-cell anaemia and certain illnesses such as cancer. HIV and MS are automatically covered by the Act.

5.29.3 For employees with a disability or a long-term health condition, their sickness absence may have nothing to do with their disability. However, if their sickness absence is related to a disability, the Trust has a duty under the Equality Act 2010 to make reasonable adjustments.

5.29.4 Reasonable adjustments may include: adapted equipment, physical changes to the environment, changes to working hours, location, shift pattern, or time off for treatment or appointments and further to advice from Occupational Health regarding the individuals underlying medical condition. Managers will then move the employee to the Long Term Sickness process within the Sickness Management Procedure.

5.29.5 Any request to change working arrangements (i.e., working hours/times) which may constitute a reasonable adjustment; must be made by

submitting a flexible working request in accordance with the Work Life Balance and Special Leave Policy.

5.29.6 Disability-related absences will be recorded as sickness absence on the Part three of the Sickness Reporting Form any reasonable adjustments will also be recorded and flagged as disability-related (in order that disability and non-disability related absences can be identified separately). All absences will be paid according to the employee's sickness entitlement, which remains unchanged.

5.29.7 In instances where the employee's attendance (whether disability related or not) is unsatisfactory and/or s/he is unable to return to work following long term sickness absence, and where no reasonable adjustments or redeployment are possible, it may be necessary to consider terminating the employee's employment.

5.29.8 The (Dis)Ability and Health passport is for all employees who may have a long-term health condition, mental health condition, neurodiversity, or disability/ learning disability or difficultly, to help them access the support or reasonable adjustments they may need to accommodate them within the workplace.

The aim of the passport is to support employees to manage their health at work and remove obstacles in communicating their condition in the workplace, as they change roles, departments or Trusts throughout their NHS career.

5.30 Pregnancy related sickness

5.30.1 A pregnant employee absent with a pregnancy-related illness must follow the normal absence reporting procedure and provide medical certification as would be required for non-pregnancy related illness. Their line manager will carry out a return to work interview after a period of absence and explore whether any support can be provided or to consider any adjustments that could be made to help the employee.

5.30.2 Non-pregnancy related sickness absence will be recorded separately in the normal way.

Pregnancy related illness will also be recorded and although it will be included when reviewing the employee's sickness absence record, it will not be used within the formal stages of this procedure.

5.30.3 Occupational Health advice may be sought to clarify pregnancy related absence; especially if absences are frequent; and/or where a pregnant employee requests a change of working pattern outside normal working arrangements, during her pregnancy.

5.30.4 If the employee is off work with a pregnancy related illness during the last four weeks before the expected week of childbirth, maternity leave will be deemed to have commenced.

5.30.5 Third party accident-related sickness absence

An employee who is absent as a result of an accident where damages may be received from a third party, will be paid Occupational Sick Pay. It is a requirement of receiving this payment that the employee signs a form of undertaking to include, as special damages, a claim for the full extent of such advance payments in any claim for damages made against a third party and to refund to the Trust the amount of damages received in respect of such advance payments.

5.31 Stress

If an employee informs their manager they are suffering from stress, whether absent from work or not, the manager should arrange to have a conversation with the staff member to ascertain what support may be required particularly within the workplace.

The staff member should be encouraged to complete an individual Stress Risk Assessment, Stress resources (esht.nhs.uk) (as found on the Occupational Health page of the extranet) and then discuss the findings with their manager or appropriate person so that actions can be taken to either eliminate, reduce or escalate, work related stressors.

Please refer to the Trusts Psychological Wellbeing & Safety policy for more details

5.32 Substance misuse

Where sickness absence is known or suspected of being related to drugs, alcohol or other substance misuse, the Substance Misuse Policy should be used in conjunction with this procedure.

5.33 Appeals against dismissal

5.33.1 An employee may appeal against a decision to dismiss under this procedure, and this must be made in writing, stating the grounds of appeal, to the Director of Human Resources, within 10 working days of receipt of written confirmation of the decision.

5.33.2 Grounds for the appeal may be one or more of the following:

- The action of dismissal is too severe in relation to the incapability
- There is an allegation of bias
- Misrepresentation of facts affecting the reason(s) for dismissal
- The procedure was not fairly followed

5.33.3 If redeployment is accepted as an alternative to dismissal, there will be no right of appeal.

5.33.4 Where an employee lodges an appeal a hearing should be arranged normally within five weeks of receipt if possible and in any event without unreasonable delay. Where the hearing date is not fixed by mutual agreement the appellant shall be given at least 10 working days' notice of the date of the hearing. The member of staff may be represented at the appeal by either a colleague who is an employee of the Trust or represented by a full time or lay Trade Union officer.

5.33.5 Appeals against termination of contract will be heard by an equal or more senior manager. The appeal manager will determine whether a full hearing, with all witnesses, is required or whether the appeal need focus only on specific points of contention. The appeal manager will have the discretion to uphold or revoke the decision to terminate the contract.

5.33.6 A professional member of the Human Resources Department will be appointed to serve as Secretary to the Appeal Manager. The role includes ensuring the administrative aspects of the hearing are carried out and to advise the Appeal Manager on relevant employment law and good practice.

5.33.7 Appeal documentation must be submitted to the Secretary to the Appeal Manager at least five working days before the hearing so that both management and staff side cases may be exchanged and circulated to all parties.

5.33.8 If there is any new evidence from either side, which has come to light since the final meeting this will be considered at the appeal hearing, the detail of this with any supporting documentation must be provided with the statement of case, so that it can be sent to all parties in advance.

5.33.9 The Appeal Manager may, at its discretion recall both parties and announce its decision or it may announce that parties will be notified of the decision at a later date. In either event the appellant and their representative will be notified in writing of the decision of the Appeal Manager within five working days, if possible, of the decision being made.

5.33.10 Failure of the appellant to attend the hearing without adequate reason will result in the appeal being deemed to have been withdrawn and the original dismissal decision will stand.

6. Equality and Human Rights Statement

An Equality and Human Rights Impact Assessment has been carried out and is documented in **Appendix A**.

7. Training

Please refer to the Induction and Mandatory training policy and the Training Needs Analysis.

On-line guidance of the policies referred to in this policy can be found via the HR Solutions Extranet Page.

8. Data protection

8.1 When managing employees under the Sickness Management Procedure, the Trust processes personal data collected in accordance with its Data Protection Policy. Data collected from the point at which the Trust commences action under the procedure is held securely and accessed by, and disclosed to, individuals only for the purposes of managing their performance. Inappropriate access or disclosure of employee data constitutes a data breach and should be reported in accordance with the organisation's Data Protection policy immediately. It may also constitute a disciplinary offence, which will be dealt with under the Trust's Disciplinary Procedure.

9. Monitoring Compliance with the Document

Monitoring Table

Element to be Monitored	Lead	Tool for Monitoring	Frequency	Responsible Individual/Group/ Committee for review of results/report	Responsible individual/ group/ committee for acting on recommendations/action plan	Responsible individual/group/ committee for ensuring action plan/lessons learnt are Implemented
Sickness absence data	Workforce Information Team	Health Roster/ESR Reports	Monthly	Divisional Lead	Divisional Lead/HR Business Partners	HR Senior Team
Sickness absence documentation	HR Adviser	Staff Files/ER Tracker	During review process	HR Business Partner	Divisional Lead/HR Business Partner	HR Senior Team
Sick Pay	Payroll Manager	ESR input	As required	Payroll Team Leader	Deputy DOF	DOF
Sickness absence levels	Workforce Information Team	Workforce Reports	Monthly	Trust Board	Director of HR	Director of HR

10. References

NHS Terms and Conditions of Service Handbook
NHS Pensions Agency: www.nhsbsa.nhs.uk/pensions

Appendix A: Equality and Health Inequalities Impact Assessment (EHIA) template

Undertaking EHIA helps us to make sure that our services and polices do not inadvertently benefit some groups more than others, ensuring that we meet everyone's needs, and our legal and professional duties.

This is important because:

- Assessing the potential for services and policies to impact differently on some groups compared with others is a legal requirement.
- People who find it harder to access healthcare services are more likely to present later when their disease may be more progressed, have poorer outcomes from treatment, and need more services than other groups who have better access.

The Equality Act 2010 legally protects people from discrimination in the workplace and in wider society. It is against the law to discriminate against anyone because of:

- age
- gender reassignment
- being married or in a civil partnership
- being pregnant or on maternity leave
- disability
- race including colour, nationality, ethnic or national origin
- religion or belief
- sex
- sexual orientation.

These are called 'protected characteristics'. The Act requires that public sector organisations meet specific equality duties in respect of these protected characteristics. This is known as the public sector equality duty.

Public Sector Equality Duty

Public bodies have to consider all individuals when carrying out their day-to-day work – in shaping policy, in delivering services and in relation to their own employees.

Public bodies must have due regard to the need to:

- eliminate discrimination
- advance equality of opportunity
- foster good relations.

Armed Forces Covenant Duty

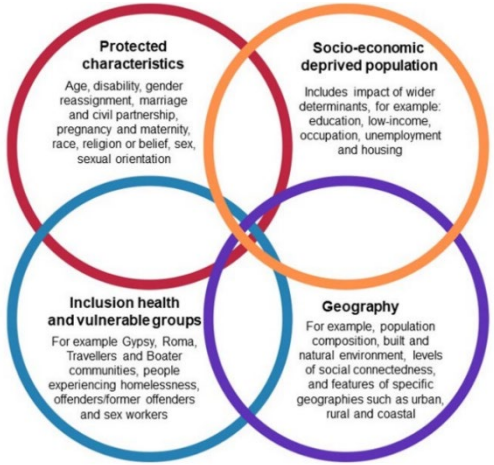
The new Covenant Duty raises awareness of how Service life can impact on the Armed Forces community, and how disadvantages can arise due to Service when members of that community seek to access key local services. The Duty requires organisations to pay due regard to the Covenant principles when exercising functions in healthcare. "Due regard" means that we need to consciously consider the unique obligations and sacrifices made by the Armed Forces; that it is desirable to remove disadvantages faced by the Armed Forces community; and that special provision may be justified in some circumstances.

Health Inequalities Duties- Equity for all
In addition to our legal duties in relation to Protected Characteristics, the Health and Social Care Act and other legislation, NHS Planning Guidance and sector specific recommendations require the NHS to have regard to the need to address health inequalities (or differences in access to or outcomes from healthcare) and take specific action to address them.

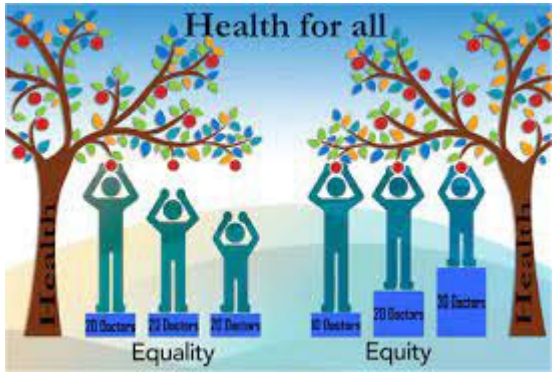
Figure 1 shows the different population groups, factors associated with where we live, or our individual circumstances, which separately, or when combined, influence access to and outcomes from health care.

Getting equal outcomes may require different inputs (or services). In completing an EHIA its important to think about whether a one size fits all approach will generate the same good outcomes for everyone, or whether we might need to make some tweaks or adjustments to enable everyone to benefit equally. The health tree diagram shows that unless we think about the needs of different people, equal services might generate unequal outcomes.

Factors associated with poorer health outcomes (PHE 2021)[1]



The Health Tree[1]



The following principles, drawn from case law, explain what we must do to fulfil our duties under the Equality Act:

- **Knowledge:** everyone working for the Trust must be aware of our equality duties and apply them appropriately in their work.
- **Timeliness:** the duty applies at the time of considering policy options and/or before a final decision is taken – not afterwards.
- **Real Consideration:** the duty must be an integral and rigorous part of your decision-making and influence the process.
- **Sufficient Information:** you must assess what information you have and what is needed to give proper consideration.
- **No delegation:** the Trust is responsible for ensuring that any contracted services which provide services on our behalf can comply with the duty, are required in contracts to comply with it, and do comply in practice. It is a duty that cannot be delegated.
- **Review:** the equality duty is a continuing duty. It applies when a policy/process is developed/agreed, and when it is implemented/reviewed.
- **Proper Record Keeping:** to show that we have fulfilled our duties we must keep records of the process and the impacts identified.

NB: Filling out this EHIA in itself does not meet the requirements of the equality and health inequalities duties. All the requirements above must be fulfilled or the EHIA (and any decision based on it) may be open to challenge. Properly used, an EHIA can be a tool to help us comply with our equality and health

[1] https://www.researchgate.net/figure/Equality-and-equity-of-medical-resources-distribution_fig2_323266914

inequalities duty and as a record that to demonstrate that we have done so. It is advised that you complete the short EHIA training session on MyLearn before completing this EHIA.

SECTION A ADMINISTRATIVE INFORMATION

This form is a central part of how the Trust makes sure and can demonstrate to others that we are meeting our legal duties; and how we can assure ourselves that all patients will get the best outcome for them from our services.

A completed copy of this form must be provided to the decision-makers in relation to your proposal. The decision-makers must consider the results of this assessment when they make their decision about your proposal. **Function/policy/service name and number:**	Sickness Management Procedure		
Main aims and intended outcomes of the function/policy/service and summary of the changes you are making (if existing policy/service):	The Trust recognises that the health and well-being of staff is vital for ensuring that it can provide effective patient care and continually improve the quality of services for patients. The Trust approach to staff health and well-being is centred on prevention, promotion of positive health and, where sickness occurs, enabling staff to return to work safely as soon as is appropriate. The purpose of this policy is to provide clear guidance to managers and staff in managing sickness absence so that they are aware of their obligations and responsibilities in relation to attendance, health and wellbeing		
How will the function/policy/service change be put into practice?	Through promotion on Trust Extranet, training sessions, people panels and coaching of managers		
Who will be affected/benefit from the policy?	This procedure applies to all staff employed by East Sussex Healthcare NHS Trust. For Medical staff, this policy should be applied in conjunction with the Maintaining High Professional Standards Policy		
State type of policy/service	Policy ✓	Service ☐	
	Business Case ☐	Function ☐	Existing
Is an EHIA required? NB :Most policies/functions will require an EA with few exceptions such as routine procedures	Yes ✓		
	No ☐ (If no state reasons)		
Accountable Director: (Job Title)	Deputy Chief Executive and Chief People Officer		
Assessment Carried out by:	Name: HR Business Partner		
Contact Details:	Julie.hales@nhs.net		
Date Completed:	13 February 2024		

SECTION B ANALYSIS AND EVIDENCE

Analysis of the potential impact – Equality and Health Inequalities Duties
For this section you will need to think about all the different groups of people who are more likely to experience poorer access or have poorer outcomes from health and care services. For each group please describe in the first column the potential impact you have identified, in the second column explain how you have arrived at this conclusion and what information you used to identify the potential impact, and in the third column say what you are going to do to prevent it from happening, or which elements of a service or policy specifically address the potential impact. Key things to remember.

- Everyone has protected characteristics but some groups who share one or more protected characteristics may be more likely to have poorer outcomes or access compared with others – and it is this potential that the EHIA process seeks to identify and address.
- The information included here should be proportionate to the type and size of the policy/service/change.
- An update to a policy should demonstrate that you have considered the potential for the policy to impact differently on different groups and taken steps to address that.
- A minor policy update is likely to need to be much less comprehensive than an EHIA for a major service change.
- You will need to know information about who uses or could use your service/policy will apply to (the population). You can use information about current patients or staff, and about the general population the Trust serves.

3. PROTECTED CHARACTERISTICS - Main potential positive or negative impact of the proposal for protected characteristic groups summarised

Please write in the box below a brief summary of the main potential impact (positive or negative) Please state **N/A if your proposal will not impact adversely or positively on the protected characteristic groups listed below, but make sure you include information on how you know there will be no impact.**

The Trust approach to staff health and well-being is centred on prevention, promotion of positive health and, where sickness occurs, enabling staff to return to work safely as soon as is appropriate. This policy takes into account the need for understanding and supporting underlying health conditions which may require absence from work.

Protected characteristic groups	Summary explanation of the *potential* positive or adverse impact of your proposal	How do you know this? (include here a brief explanation of what information you have used to identify potential adverse impact e.g. NICE guidance, local data, evidence reviews, stakeholder or patient feedback	Action that will be taken to address the potential for negative impact.
Age: older people; middle years; early years; children and young people.	Ensuring all appropriate care and support is given to staff experiencing sickness absence	Local data, staff survey and Deep dive analysis	Monitoring of absence data and data relating to case management to ensure any disparity is justified. Access for employees to occupational health and fast tracked appointments.
Disability: physical, sensory and learning impairment; mental health condition; long-term conditions.	Positive – changing LTS absence support, to understanding the need for longer periods of recovery/support. Offering 5 x Health & Wellbeing meetings prior to first formal Stage 1 review being held.	Local data, staff survey and Deep dive analysis; The Workforce Disability Equality Standard, set out by NHS England details the positive association between increased disability equality and workplace experience for disabled individuals	Reasonable adjustments offered at every stage of the process and in respect to adjustments for work
Gender Reassignment and/or people who identify as Transgender	Procedure will allow colleagues to follow a fair, consistent and transparent process	Local data, staff survey and Deep dive analysis; There is strong evidence that where an NHS workforce is representative of all protected characteristics it fosters a sense of belonging – detailed in the NHS People Plan NHS England » Belonging in the NHS	Where appropriate reasonable adjustments can be viewed in line with the Equality Act,
Marriage & Civil Partnership: people married or in a civil partnership.	Procedure will allow colleagues to follow a fair, consistent and transparent process	Local data, staff survey and Deep dive analysis; There is strong evidence that where an NHS workforce is representative of all protected characteristics it fosters a sense of belonging – detailed in the NHS People Plan NHS England » Belonging in the NHS	
Pregnancy and Maternity: before and after childbirth and who are breastfeeding.	Procedure will allow colleagues to follow a fair, consistent and transparent process	Local data, staff survey and Deep dive analysis; There is strong evidence that where an NHS workforce is representative of all protected characteristics it fosters a sense of belonging – detailed in the NHS People Plan NHS England » Belonging in the NHS	Pregnancy sickness related absence is referred to within the policy.

Protected characteristic groups	Summary explanation of the *potential* positive or adverse impact of your proposal	How do you know this? (include here a brief explanation of what information you have used to identify potential adverse impact e.g. NICE guidance, local data, evidence reviews, stakeholder or patient feedback	Action that will be taken to address the potential for negative impact.
Race:	Procedure will allow colleagues to follow a fair, consistent and transparent process	Local data, staff survey and Deep dive analysis; There is strong evidence that where an NHS workforce is representative of all protected characteristics it fosters a sense of belonging – detailed in the NHS People Plan NHS England » Belonging in the NHS	
Religion and belief: people with different religions/faiths or beliefs, or none.	Procedure will allow colleagues to follow a fair, consistent and transparent process	Local data, staff survey and Deep dive analysis; There is strong evidence that where an NHS workforce is representative of all protected characteristics it fosters a sense of belonging – detailed in the NHS People Plan NHS England » Belonging in the NHS	
Sex:	Procedure will allow colleagues to follow a fair, consistent and transparent process	Local data, staff survey and Deep dive analysis; There is strong evidence that where an NHS workforce is representative of all protected characteristics it fosters a sense of belonging – detailed in the NHS People Plan NHS England » Belonging in the NHS	Gender specific illness may fall under the definition of disability under the Equality Act, whereby reasonable adjustments will become applicable, including to the application of formal stages of the policy.
Sexual orientation	This policy has a positive impact on staff no matter what their sexual orientation is	There is strong evidence that where an NHS workforce is representative of all protected characteristics it fosters a sense of belonging – detailed in the NHS People Plan NHS England » Belonging in the NHS	
Veterans/Armed Forces Communities	Procedure will allow colleagues to follow a fair, consistent and transparent process and	Local data, staff survey and Deep dive analysis; There is strong evidence that where an NHS workforce is representative of all protected	

Protected characteristic groups	Summary explanation of the *potential* positive or adverse impact of your proposal	How do you know this? (include here a brief explanation of what information you have used to identify potential adverse impact e.g. NICE guidance, local data, evidence reviews, stakeholder or patient feedback	Action that will be taken to address the potential for negative impact.
	ensures 'due regard' is considered for veterans and the armed forces community	characteristics it fosters a sense of belonging – detailed in the NHS People Plan NHS England » Belonging in the NHS	

4. HEALTH INEQUALITIES -Potential positive or adverse impact for people who experience health inequalities summarised

Please briefly summarise the main potential impact (positive or negative) on people at particular risk of health inequalities (as listed below). **If the policy/procedure is unrelated to patients, this sections does not require completion.**

Please state none if you have assessed that there is not an impact, but please make sure you complete the 'how do you know this' column to demonstrate that you have considered the potential for impact**. If you identify the potential for impact for one or more of these groups please complete the full assessment in Appendix A**

Groups who face health inequalities[2]	Summary explanation of the potential positive or adverse impact of your proposal	How do you know this? (include here a brief explanation of what information you have used to identify potential adverse impact e.g. NICE guidance, local data, evidence reviews, stakeholder or patient feedback	Action that will be taken to address the potential for negative impact.
This includes all groups of people who may have poorer access to or outcomes from healthcare services. It includes: People who have experienced the care system; carers; homeless people; people involved in the			

Groups who face health inequalities[2]	Summary explanation of the potential positive or adverse impact of your proposal	How do you know this? (include here a brief explanation of what information you have used to identify potential adverse impact e.g. NICE guidance, local data, evidence reviews, stakeholder or patient feedback	Action that will be taken to address the potential for negative impact.
criminal justice system; people who experience substance misuse or addiction; people who experience income or other deprivation; people with poor health literacy; people living in rural areas with limited access to services; refugees or asylum seekers; people in or who have been in the armed force; other groups who you identify as potentially having poorer access and outcomes.			

SECTION C ENGAGEMENT

5. Engagement and consultation

a. Talking to patients, families and local communities can be a rich source of information to inform health care services. If you are making substantial changes it's likely that you'll have to undertake specific engagement with patients. For smaller changes and policies your may have undertaken some engagement with patient groups, gained insight from routine sources e.g. patient surveys, PALS or Complaints information or information from Healthwatch, you may also have looked at relevant engagement that others have undertaken in the Trust, or locally
Have any engagement or consultative activities been undertaken that considered how to address equalities issues or reduce health inequalities? Please place an x in the appropriate box below.

Yes	No

b. If yes, please ensure all stakeholders are listed in the consultation table at the beginning of the policy.

SECTION D SUMMARY OF FINDINGS

Reflecting on all of the information included in your review-

6. EQUALITY DUTIES: Is your assessment that your proposal will support compliance with the Public Sector Equality Duty? Please **add an x** to the relevant box below.

	Tackling discrimination	Advancing equality of opportunity	Fostering good relations
The proposal will support?			
The proposal may support?			
Uncertain whether the proposal will support?			

7. HEALTH INEQUALITIES: Is your assessment that your proposal will support reducing health inequalities faced by patients? Please add an x to the relevant box below.

	Reducing inequalities in access to health care	Reducing inequalities in health outcomes
The proposal will support?		
The proposal may support?		
Uncertain if the proposal will support?		

8. Outstanding key issues/questions that may require further consultation, research or additional evidence. Please list your top 3 in order of priority or state N/A

Key issue or question to be answered		Type of consultation, research or other evidence that would address the issue and/or answer the question
1		
2		
3		

9. EHIA sign-off: (this section must be signed)

Person completing the EHIA:	**HR Business Partner**	**Date: 13/2/2024**
Line Manager of person completing:	**Deputy Chief Executive and Chief People Officer**	**Date: 13/2/2024**

Appendix A

Breakdown of Groups who are more likely to experience health inequalities:

Groups who face health inequalities[3]	Summary explanation of the potential positive or adverse impact of your proposal	How do you know this? (include here a brief explanation of what information you have used to identify potential adverse impact e.g. NICE guidance, local data, evidence reviews, stakeholder or patient feedback	Action that will be taken to address the potential for negative impact.
Looked after children and young people			
Carers of patients			
Homeless people. People on the street; staying temporarily with friends /family; in hostels or B&Bs.			
People involved in the criminal justice system: offenders in prison/on probation, ex-offenders.			
People with addictions and/or substance misuse issues			
People or families on a low income			
People with poor literacy or health Literacy: (e.g. poor understanding of health services poor language skills).			
People living in deprived areas			
People living in remote, rural and island locations			

Groups who face health inequalities[3]	Summary explanation of the potential positive or adverse impact of your proposal	How do you know this? (include here a brief explanation of what information you have used to identify potential adverse impact e.g. NICE guidance, local data, evidence reviews, stakeholder or patient feedback	Action that will be taken to address the potential for negative impact.
Refugees, asylum seekers or those experiencing modern slavery			
People who have served in the Armed Forces			
Other groups experiencing health inequalities (please describe)			

Appendix B – EHIA Resources
Sources of Information on the East Sussex population and sources of community or patient insight.

Population Data
State of the County 2021 Focus on East Sussex
East Sussex JSNA
Community Insight
Further Reading on Equality and Health Inequalities
Training

East Sussex Healthcare NHS Trust

Incident Reporting and Management Policy

Document ID Number:	184
Version:	V6.1
Ratified by:	Clinical Documentation & Policy Ratification Group
Date ratified:	11 January 2022
Name of author and title:	Nicky Creasey, Patient Safety Lead [redacted], Trust Risk Lead & Health and Safety
Date originally written:	December 2003
Date current version was completed	October 2023
Name of responsible committee/individual:	Patient Safety and Quality Group
Date Issued:	26 January 2022
Review date:	December 2024
Target audience:	All Staff
CQC Fundamental Standards:	Receiving and Acting on Complaints
Compliance with any other external requirements (e.g. Information Governance)	Information Governance Toolkit Assessment 11-302
Associated Documents:	Risk Management and Quality Delivery Strategy Risk Management Policy and Procedures Health and Safety at Work Policy Fire Safety Policy Claims and Legal Services Policy and Procedure Legal Services Policy (Management of Claims, Inquests & Access to Legal Assistance Learning & Development Policy Duty of Candour (Being Open) Policy Supporting Staff Involved in Incidents, Complaints or Claims Policy for the Investigation of Incidents, Complaints and Claims Morbidity and Mortality Policy

Version Control Table

Version number and issue number	Date	Author	Reason for Change	Description of Changes Made
V1 2003121	Dec 2003	[redacted]		New Policy
V1.1 2004099	Oct 2004			
V1.2 2006244	Aug 2006			
V1.3 2007040	Apr 2007			
V1.4 2008188	Aug 2008			
V1.5 2009075	Apr 2009			
V1.6 2011104	Jun 2011		Ensure Chairman is included in SI notifications.	Amendment to Flow Chart Page 5
V2.0 2012181	July 2012		Revision following organisational restructure Meeting NHSLA requirements	Significant changes to reflect the new organisation.
V2.1 2013205	October 2013		Annual review.	Significant changes
V2.2 2014168	August 2014		Minor Change	Addition of appendix H
V3.0 2015086	February 2015		Update	Significant changes to reflect the new organisation.
V4.0 2017189	October 2016		Update	Significant changes to reflect new processes.
V5.0	October 2018		Update	Additional process updated
V5.1	April 2019		Minor Change	Changes to reflect that we no longer have a category for death from surgical procedure
V5.2	December 2019	Lisa Forward	Amendment following an incident	Section 4.3 – title change and Section 16 – added information on NHS screening Programme incidents
V5.3	March 2020	Nicky Creasey	Amendments following changes in	Amendments 4.5, 4.18, 4.19, ‘amber ‘

			structure and a few processes	flowchart, delete associate director governance p17 & p18, changes to flowchart p19
V5.4	December 2020	[redacted]	Amendment following review by Internal Audit	Addition of Section 5.1.1
V6	December 2021	Lisa Forward	Interim review until new Patient Safety Incident Response Framework is implemented	Title changes Removal of term 'Clinical Unit' Section 4.19 amended Section 8.4 amended
V6.1	October 2023	Lisa Forward	Appendix added	Appendix added for Gynae incident trigger list

Consultation Table

This document has been developed in consultation with the groups and/or individuals in this table:

Name of Individual or group	Title	Date
Patient Safety and Quality Group		Sept 18
[redacted]	Trust risk Lead	December 2021
Nicky Creasey	Patient Safety Lead	December 2021
Gail Gowland	Head of Safeguarding	December 2021
Tina Lloyd	Assistant Director of Nursing	December 2021
Clinical Documentation and Policy ratification Group		January 2022

Table of Contents

1. Introduction

East Sussex Healthcare NHS Trust is committed to continuously improving the outcomes for patients and achieving excellence in patient care. It recognises that it has a statutory and regulatory duty to ensure that systems of control are in place to reduce the impact of any risks that could potentially affect the organisation. As part of its risk management processes, this policy is to ensure that staff know what and how to report incidents which have or could have occurred.

2. Purpose

The purpose of this policy is to ensure:

- There is a systematic and robust mechanism for the reporting and management of all incidents, serious incidents and near misses.
- There is an effective process in place to reduce the likelihood of incidents and near misses reoccurring by facilitating shared learning.
- That improvement in practice takes place as a result of the shared learning following a near miss, incident or serious incident investigation.

2.1. Rationale

East Sussex Healthcare NHS Trust has a statutory and regulatory duty to ensure that systems are in place to reduce the impact of any risks which could affect the organisation. By reporting incidents and near misses the Trust is able to learn from them and put in place controls or mitigating actions to help prevent the incident from reoccurring, or in the event of a near miss, occurring.

2.2. Principles

The Trust promotes that the purpose of reporting an incident is not to apportion blame to an individual or group of people, but to identify problems and to remedy them. Furthermore the Trust acknowledges that without an open culture, the reporting of inappropriate care or the reporting of incidents will not take place and it will be difficult to learn lessons thus preventing similar situations reoccurring. Appropriate incident reporting should be encouraged; incident reporting is considered to be indicative of a positive learning culture.

2.3. Scope

This policy applies to all permanent and temporary staff employed by East Sussex Healthcare NHS Trust as well as staff working under contract for services or under a service level agreement within the Trust.

3. Definitions

(Adverse) Incident

An event or circumstance which resulted in actual or potential unintended or unexpected damage, loss or harm (physical / psychological) to patients, staff, visitors, members of the public or the organisation.

Datix
Integrated risk management system (software) which is used for centrally recording incidents, complaints and claims (amongst other risk based information).
Datixweb
Web based system for reporting and managing (handling) all incidents (linked to the Datix software / database described above).

Duty of Candour
Duty of Candour aims to help patients receive accurate, truthful information from health providers (NHSLA 2017) and is a legal responsibility for all hospital, community and mental health trusts. It is a process by which patients receive an apology and are informed of any mistakes in their care that have resulted in significant harm.

All healthcare professionals have a duty of candour – a professional responsibility to be honest with patients when things go wrong (NMC/GMC 2015). In November 2014 new legislation introduced a statutory duty of candour for all healthcare providers in England. Therefore when harm occurs to a patient that reaches the threshold of the statutory duty of candour staff must follow a process of disclosure (RCS 2015).

Incident Handler
Usually, the manager responsible for the area where the incident occurred or if unknown the reporter's manager. This individual will receive notification from Datix that an incident has been reported and they are responsible for managing the incident via the system, escalating it as a Serious Incident if necessary.

Incident Investigator
Another term used by DatixWeb, Incident Investigators may be nominated by Incident Handlers to investigate the incident and provide an update directly onto the DatixWeb record.

Investigation
Detailed systematic search to uncover facts and determine the truth of the factors (who, what, when, where, why and how) of incidents, claims and complaints.

National Reporting and Learning System (NRLS)
The NRLS receives confidential reports of patient safety incidents from healthcare staff across England and Wales. Clinicians and safety experts analyse these reports to identify common risks to patients and opportunities to improve patient safety.

Near Miss
An event or circumstance which could have, but did not result in unintended or unexpected damage, loss or harm (physical / psychological) to patients, staff, visitors or members of the public.

Never Event
Preventable serious incidents, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers'. NHS England, 2015. NHS England has published a core list of never events – see Appendix B.

Non-Clinical Incident
Unintended or unexpected incident which could have or did lead to harm or an undesired effect which was not as a result of patient intervention or the patient's clinical presentation.

Patient Safety (Clinical) Incident
An event or circumstance that could have resulted, or did result, in unnecessary damage, loss or harm such as physical or mental injury to a patient, staff, visitors or members of the public (NPSA 2010).

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)

The duty to report certain serious workplace injuries, occupational diseases and specified dangerous occurrences (near misses) as detailed within the regulations. These will be monitored by the Health and Safety Steering Group.

Weekly Patient Safety Summit (WPSS)
A weekly meeting to discuss all severity 3, 4 and 5 incidents reported during the previous week and confirm grading, actions and sign off reports.

Serious Incident (SI)
Serious Incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious Incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare, NHS England, 2015. The Trust will work within the Serious Incident Framework, NHS England 2015.

Amber Investigations
All incidents with an actual severity score of 3 (moderate harm), or more require a robust investigation. This ensures the root cause and contributory factors have been identified by the organisation, and that any resulting actions are implemented to prevent a repeat event. This report will be requested following the confirmation of a severity 3 (moderate harm) or more incident at the Weekly Patient Safety Summit (WPSS). This could also be required if the incident is discussed at the WPSS and identified the risk for potential harm should the incident occur again be a score of 12 or above as a minimum.

Root Cause Analysis (RCA)
A recognised process for investigating incidents, claims and complaints which provides a framework for identifying what happened, how it happened and why it happened i.e. the root causes.

Strategic Executive Information System (StEIS)
National database for the recording of serious incidents. The Trust is required to enter new incidents, provide progress reports of investigations and mark when the report is complete. NHS Sussex, NHS England Area Team, Department of Health (DH) and Care Quality Commission (CQC) have access to view all serious incidents reported onto StEIS. NHS Sussex and Area Team are responsible for closing of incidents when all agencies are assured that appropriate investigation and learning has taken place.

4. Accountabilities and Responsibilities

4.1. Chief Executive
Has overall responsibility for ensuring that policies support appropriate reporting and management of incidents and that learning from incidents is identified and shared. Furthermore that there are robust processes in place to enable the organisation to understand the type and number of incidents raised. The Chief Executive nominates operational responsibility for this to executive directors and heads of Divisions/departments.

4.2 Medical Director and Chief Nurse
The Medical Director and the Chief Nurse have delegated responsibility for ensuring and overseeing the implementation of appropriate governance systems. This includes the development and maintenance of risk management, incident reporting and quality processes. They will provide the leadership to ensure the Trust undertakes this function in accordance with best practice, legal and statutory duties and will lead the Trust's approach on achieving compliance with standards relating to quality.

4.3. Head of Governance

The Head of Governance has overall responsibility, on behalf of the Medical Director and Chief Nurse, for ensuring the incident reporting system is robust and the central governance team and functions are effective in supporting the Divisions/Departments to deliver their quality and risk responsibilities. This includes supporting the Divisions to establish robust structures and ensuring there is a Trust wide framework for the review, learning and implementing actions following incidents.

The Head of Governance will ensure the Governance team deliver the requirements within this policy. The central team will ensure there are systems in place and will offer support and advice for the management of incidents/serious incidents, risk, clinical effectiveness, health and safety and patient experience Specific roles from senior team members will be detailed within the relevant policies (e.g. Risk Management Policy and Procedure).

4.4. Chief of Division, Associate Director of Operations, Assistant Directors Nursing, Deputy Director of Nursing, Heads of Nursing, Service Managers, Heads of Department and other Senior Managers

Are responsible for ensuring that:

- All staff in their Division, department or team are aware of this policy including duties to report incidents and near misses, and monitor and manage compliance with this process.
- The Division, department of team reviews incidents, serious incidents and near misses at least monthly
- All reported incidents and near misses are acted upon within the appropriate timescales
- Amber incidents are investigated promptly and robustly within the timescales
- Any risks identified from incidents, serious incidents or near misses are added to the risk register, and that action plans to address issues raised are developed and monitored as appropriate
- Any action plans developed to address issues identified via incidents, serious incidents or near misses, are prepared and acted upon within appropriate timescales
- Trends from incidents, serious incidents and near misses are discussed at Divisional risk / governance meetings, department or team groups and are fed into the Patient Safety and Quality Group.
- Learning from incidents is identified shared locally and escalated to forums where it can be shared more widely across the organisation.
- The Trust Duty of Candour (Being Open) Policy is followed in order that the Trust is able to meet it's legal obligations, should patients experience significant harm (incidents of severity 3 or above on Datix), and that patients or their representatives are involved in the investigation if they wish. The Duty of Candour (Being Open) Policy is available on the Trust Extranet
- Any staff involved in a serious incident are fully supported, in line with the 'Supporting Staff Involved in Incidents, Complaints or Claims' Policy available on the Trust Extranet

4.5. Associate Director of Communications

Is responsible for handling media enquiries related to incidents and for reporting incidents which may attract media attention to NHS Sussex, NHS England Area Team and NHS Improvement.

4.6. Patient Safety Lead

The Trust Patient Safety Lead provides advice and guidance for all patient safety related issues and how they should be reported, investigated and managed. To ensure the serious and moderate (Amber) incidents are manged effectively in terms of identifying, investigating, complying with Duty of Candour and learning from the events. To support members of the Governance team to conduct the investigations.

4.7. Patient Safety Team

The Patient Safety Team is responsible for managing the process for incident investigations with a severity score of 3 (Moderate), or above reported on Datix (with the exception of pressure ulcer incidents). This includes the management of the WPSS log, a database of all (non-pressure ulcer) severity 3, 4 or 5 incidents reported since 01/04/2016. The WPSS log holds information relating to Duty of Candour, the investigation status of all amber and serious incident investigations, details of lead investigators and the individual deadline for each of the reports. It also identifies which reports are overdue and this information is sent to the WPSS members including the Chief Nurse and Medical Director each week. The Team are responsible for ensuring details of SIs and amber investigations are captured on Datix and for escalating issues relating to the investigation of amber or serious incidents.

The Patient Safety Team is also responsible for

- ensuring that all serious incidents are appropriately reported on to StEIS;
- Manage the Trust SI log to ensure it reflects the accurate number and status of all SI's.
- the allocation of new SIs to members of the Governance Team and the correct templates used;
- SIs and amber investigations are ratified by WPSS prior to them being shared outside of the Trust;
- Upload all actions identified from SIs and Amber investigations onto Datix; it remains the responsibility of the Divisions to ensure that actions from investigations have been completed within the agreed timescales;
- Review completed actions to ensure embedded in practice – Closing the Loop reviews;
- Support Divisions with advice and guidance on conducting and completing Amber investigations.

4.8. Risk and Datix Team

The Risk Lead will act as a source of specialist expertise and ensure the Datix system is managed effectively and provide guidance and support to staff to ensure that all incidents are reported and managed in line with Trust policy.
Specific responsibilities include:

- Reviewing incidents which have been reported and ensuring code validity
- Reporting patient safety incident to the National Reporting & Learning System (NRLS), as per the NRLS convention
- Preparing and providing routine and ad hoc incident reports and trend analysis retrieved from the DatixWeb system.
- Ensuring that DatixWeb is updated following Divisional/Directorate meetings/other corporate reviews so that comments/feedback following investigations are recorded and the status of incidents, serious incidents and near misses are noted.

The Trust Risk Lead and the Risk and Datix Teams will develop training programmes for incident reporting and the use of the DatixWeb system to contribute to services and staff development and will ensure maintenance of the system.

4.9. Equality and Diversity Manager
Acts as a source of specialist expertise and advice for reporting, reviewing and managing discrimination incidents and any breaches to human rights.

4.10. Health &Safety Team
Responsible for reviewing and managing staff and patient related incidents to ensure the investigators have managed the incident effectively. To ensure the reporting RIDDOR incidents are completed as per regulations.

4.11. Medical Education
To work alongside the Head of Governance and the Governance Team to ensure the incident reporting system and learning from them is integrated into the Junior Doctor training programme and that Junior Doctors receive the appropriate feedback reports provided for the organisation.

4.12. Managers
Are responsible for ensuring all members of staff within their team or department are aware of this policy and their responsibilities and have been given guidance on the process for reporting incidents. Managers are also responsible for ensuring that temporary or agency staff are given guidance on the need to report incidents and the process for doing so and that any person whom they may delegate to take charge of the Team or Department is familiar with this policy, as part of their induction.
Managers must ensure that action is taken to contain the incident and to minimise harm and are responsible for communication with staff and services users, their carers and families, and the provision of appropriate support.

Managers will ensure all members of staff within their team or department complete any related training within required timescales and report incidents using the Datix system when/if they occur (see section 7 for training).

4.13. All Staff (including Doctors, clinical and non-clinical staff)
Must ensure that:

- They familiarise themselves with this policy and other Trust policies relating to the investigation and management of risks including the Duty of Candour (Being Open) Policy
- They co-operate with East Sussex Healthcare NHS Trust to comply with their statutory duties to bring to the notice of their line manager any workplace health and safety risks, clinical or non-clinical incidents or near misses, by completing an incident form on Datixweb as soon as possible, within 24 hours.
- They fulfil their training requirements within the timeframes indicated

4.14. Quality and Safety Committee
The Quality and Safety Committee ensure, on behalf of the Board, that taking account of best practice, there are effective structures and systems in place that support the continuous improvement of quality services. This includes Patient Safety and assurance the trust has effective reporting and learning systems in place.

4.15. Division/Directorate Integrated Performance Meetings

These meetings provide the opportunity for each Division/Directorate to share quality and performance qualitative and quantitative data and subsequent concerns and successes with the Executive Team. The core aim is to ensure each Division/Directorate is aware of their quality and safety risks, performance and delivery risks and to provide assurance to the Executive Team quality improvement plans are in place and working to address issues.

4.16. Division/Directorate Governance Meetings

The Governance meetings are for each Division/Directorate to share issues, risks and learning from incidents/events with its team members and to establish actions to resolve them. This will provide the background information and discussion to the Integrated Performance Reviews. There are specific sections such as risks, incidents, complaints, mortality, and infection control to ensure the learning is discussed and shared. Each Division has a risk meeting to review the detail of incidents and risks.

4.17. Patient Safety and Quality Group

The Patient Safety and Quality Group will review patient safety incidents and trends and triangulate alongside claims and complaints and other patient experience data. The group will request deep dives and actions where trends and themes are identified. Trust wide analysis reports are reviewed at this meeting.

4.18. Weekly Patient Safety Summit

All incidents or unplanned/unexpected events (with the exception of pressure ulcer incidents) with an initial grading of 3 (moderate), 4 (major) and 5 (catastrophic) reported to the Weekly Patient Safety Summit (WPSS) where a decision is made to confirm grading, declare and conduct a serious incident investigation, undertake an internal “Amber” investigation for moderate harm or downgrade and complete the standard investigation on Datix system. The Duty of Candour process for those incidents is also managed through this meeting. The process for this is outlined in the flow chart on page 18. All deaths occurring from a surgical procedure, if there were any care concerns or potential learning, must be entered onto Datix with a moderate severity or above. If the procedure was undertaken to save life as no alternative option but unsuccessful it will be discussed, recorded and closed, however will link to the Specialty Mortality Review process.

All Serious and Amber Incidents are shared with this group for lessons learnt after the Trust Executive has approved the report to be shared, where appropriate, with the Clinical Commissioning Group and patients/families.

4.19. RCA Review Group

This group is responsible for receiving the draft investigation reports and reviewing them. The Group will seek for clarity where required and ensure the report is in lay terms for patients/families.

4.20. Pressure Ulcer Review Group

Pressure ulcer incidents are managed by the pressure ulcer review group process and are not discussed at the WPSS unless the group has deemed there to be significant failings and harm that caused the pressure ulcer. Where significant harm has occurred as a result of trust failings the incident will need to be escalated to WPSS for a decision on the level of investigation. Please refer to the flowchart for the management of pressure ulcers in **Appendix D** of this policy.

4.21. Trust Health and Safety Steering Group and Clinical Procurement/Medical Devices Group

Both the Trust Health and Safety Steering Group and the Medical Devices Groups receive reports regarding incidents involving staff and medical devices. These reports are discussed and identified trends/themes acted upon.

5. Incident Management (actual or near miss)

5.1. Reporting on the trust incident form

Any member of staff who is involved in or witnesses an incident or near miss must report it by completing a Datix Incident Form (DIF1) online, as soon as possible after the incident / accident has occurred (wherever possible within 24 hours).
Staff should not go off duty until they have reported the incident via Datixweb. Where this is not possible, staff must report the incident to their line manager prior to going off duty.

The Trust uses one incident reporting form for the reporting of all incidents (clinical / non-clinical), accidents or near misses and the link to Datixweb is available via a direct link on the Home page of the Trust Extranet; fast find navigation; A-Z finder and icons on PC desktops and mobile devices.

Where an incident involves a patient, clinical staff must record in the patient's health record details of the incident, the incident reference number, any ill effects noted, including hospital acquired infections. The patient's doctor or the on-call doctor must be informed and should review any patient that may have been harmed and record the results of any examination or investigations. Printed copies of incident forms from Datix **must not** be included with the Patient's Health Record.
The incident form has mandatory fields (marked with an *) to ensure the minimum information is recorded. It is important to complete the free text boxes (Description and Action taken) with concise and factual details only. No names should be used, only titles e.g. patient, staff nurse as the actual names are recorded in the contacts section of the form. This will ensure that the Trust does not breach Information Governance rules by submitting patient or staff identifiable information to the NRLS.

5.1.1 Reporting an incident – Failure of the IT System

Short Term Failure of IT (Datix Functionality)

- A communication by the Datix Manager will be sent out to all Datix Users providing information about the expected time the system will be unavailable which will be followed up when the issue is resolved.
- Where the downtime is known in advance this will also be sent out via Communications

After 24 hours – Longer term failure of all IT Systems/Datixweb Functionality

- If this is due to complete system failure, copies of blank incident forms will be distributed by hand, or will be available from Site offices. The completed form must be sent to the Datix Team via the internal post for addition to the system.
- The Datix Team will collate these and escalate any severity 3, 4 or 5 incidents appropriately to the Patient Safety Team/Division staff for management of the incident until such time as the system is accessible again when all forms will be added to the system by the Datix and Risk Teams.

5.2. Informing patients about harm (Duty of Candour - Being Open)

When an incident has not led to harm or is a near miss logged on datix the patient should where possible be informed. If it has resulted in harm the patient, relative and or carers must be kept informed and supported through the event in line with the Trust's Duty of Candour (Being Open) Policy (Located through the Trust Extranet under document search).

Clear and unambiguous information about an incident or event where a patient has suffered harm must be given to patients / their representative in a timely, truthful and open manner by an appropriate person, usually the senior clinician in charge of their care. They should be provided with a single point of contact for any questions that might arise.

Information given should be based solely on the facts known at the time and therefore it is important that staff explain that new information may emerge as the incident is investigated. Patient, relatives and or carers should be kept up-to-date with the progress of the investigation by the lead clinician or lead investigator and where appropriate, offered a copy of the final report.

5.3. Confirming the severity of the incident

The reporter of the incident provides the initial severity grading of harm caused to the person or people involved and must follow the National Patient Safety Agency Risk Management Matrix (**Appendix B**) to determine the severity. The levels of harm are detailed below:

- **Severity 1 - None (no Harm or near miss) –** Any unexpected or unintended incident which ran to completion but no harm occurred;
- **Severity 2 - Minor (low severity) -** Any unexpected or unintended incident which required extra observation or minor treatment and caused minimal harm, to one or more persons;
- **Severity 3 - Moderate** - Any unexpected or unintended incident which resulted in further treatment, possible surgical intervention, cancelling of treatment, or transfer to another area and which caused short term harm, to one or more persons;
- **Severity 4 - Major** - Any unexpected or unintended incident which caused permanent or long term harm, to one or more persons;
- **Severity 5 - Catastrophic** - Any unexpected or unintended incident which caused the death of one or more persons;

The Datix Team will check the severity when the incident is reported and if graded incorrectly will change or contact the reporter to seek further information.
All patient safety incidents rated as a severity 3, 4 or 5 are included on the Weekly Patient Safety Log and are discussed at the weekly meeting to confirm the severity and determine the level of investigation required. As described in the incident management flowchart and serious and moderate incident flowchart

5.4. Investigating the Incident

5.4.1 Not all investigations require a full Root Cause Analysis (RCA). The level of investigation conducted should be proportionate to the severity of the event. This decision should be taken by the appointed handler or the Weekly Patient Safety Summit. Both Amber and Serious Incident Investigations involve Root Cause Analysis and must be conducted for incidents classified as moderate, major and catastrophic. Below is a simple guide for investigation levels;

- **No Harm (severity 1)** – Local investigation by the Handler (manager of area responsible) usually requiring discussions with staff involved and review of notes / evidence. The actions taken are then recorded on the Datix Risk Management System within the investigation section.
- **Low Harm (severity 2)** – The same principles apply to the no harm investigation process above;
- **Moderate Harm (severity 3)** – A more thorough investigation is required therefore an Amber or Serious Incident investigation will be required with sign off

by the Serious Incident Scrutiny Group. The WPSS will determine the investigation level for these incidents.

- **Major or Catastrophic (severity 4 and 5)** – A minimum of an Amber but most often a Serious Incident Investigation would be required.
- **Potential for significant harm based on risk rating -** Incidents that are determined as severity 1 (no harm or near miss) or severity 2 (low harm) may have the potential to cause significant harm should they occur again therefore the Trust still needs to learn from the event. These incidents will be assessed for risk and if it is felt that they may result in significant harm in future then a decision can be made at WPSS that an Amber investigation is to be completed. This will not require the full Duty of Candour but the normal Amber incident process and sign off will need to be followed. These will be tracked on the WPSS Log.

5.4.2 Investigating and closing Severity 1 and 2 Incidents
Steps to take

1. The DatixWeb Form is used
2. The handler will investigate and is the manager of the area responsible for the incident (or most appropriate manager)
3. Local investigation completed with handler assigning other managers to investigate aspects of event where needed.
4. Completion of investigation section on DatixWeb
5. Investigation Sign off by Band 6 or 7 managers as minimum:
   - Learning identified shared by handler/manager to those required
   - Once complete and signed move to “Finally Approved Section”
   - Complete Closed Date and Final Approval Given Date fields
6. Automated Feedback email to the Reporter will be generated by DatixWeb
7. These incidents will be reported within trends in Trust wide and Divisional Reports

5.4.3 Investigating and closing severity 3,4 or 5 incidents or those with a low actual severity but potential risk rating of 12 or above (potential harm if happened again) – see also flowchart in section 6 of this policy (figure 2).

Steps to take

1. The Datix Form is used to report initial incident and manager informed (immediate actions taken to ensure safe)
2. Recorded on WPSS log for discussion at weekly meeting
3. Incident severity discussed at WPSS with confirmation on harm and investigation level (Amber or serious Incident)
4. Recorded on WPSS Log as Amber, Serious Incident or N/A as downgraded
5. Investigation decision:

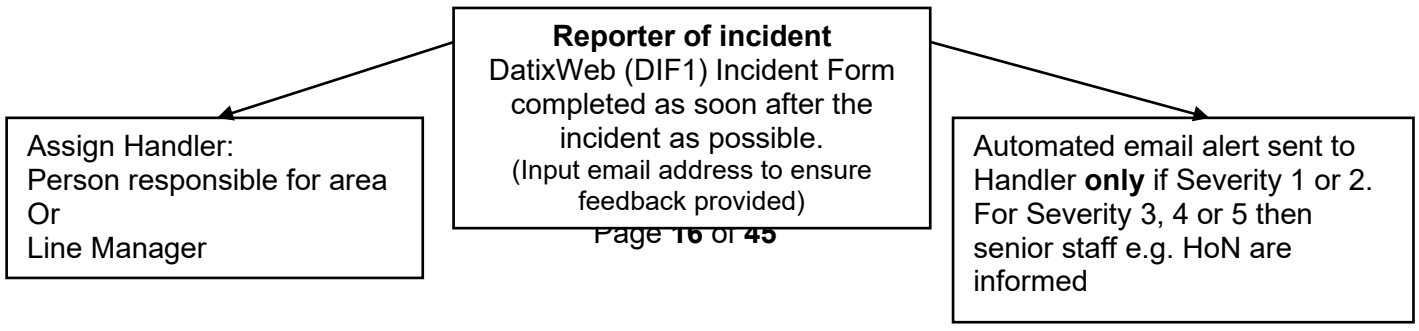
Investigation	Form to use	Investigator
Amber	Amber Incident Form or Internal Review Report Following Harm from a Known Complication During a Procedure (Modified Amber Report)	Division or Department responsible
Serious Incident	Comprehensive RCA Template	Governance Team

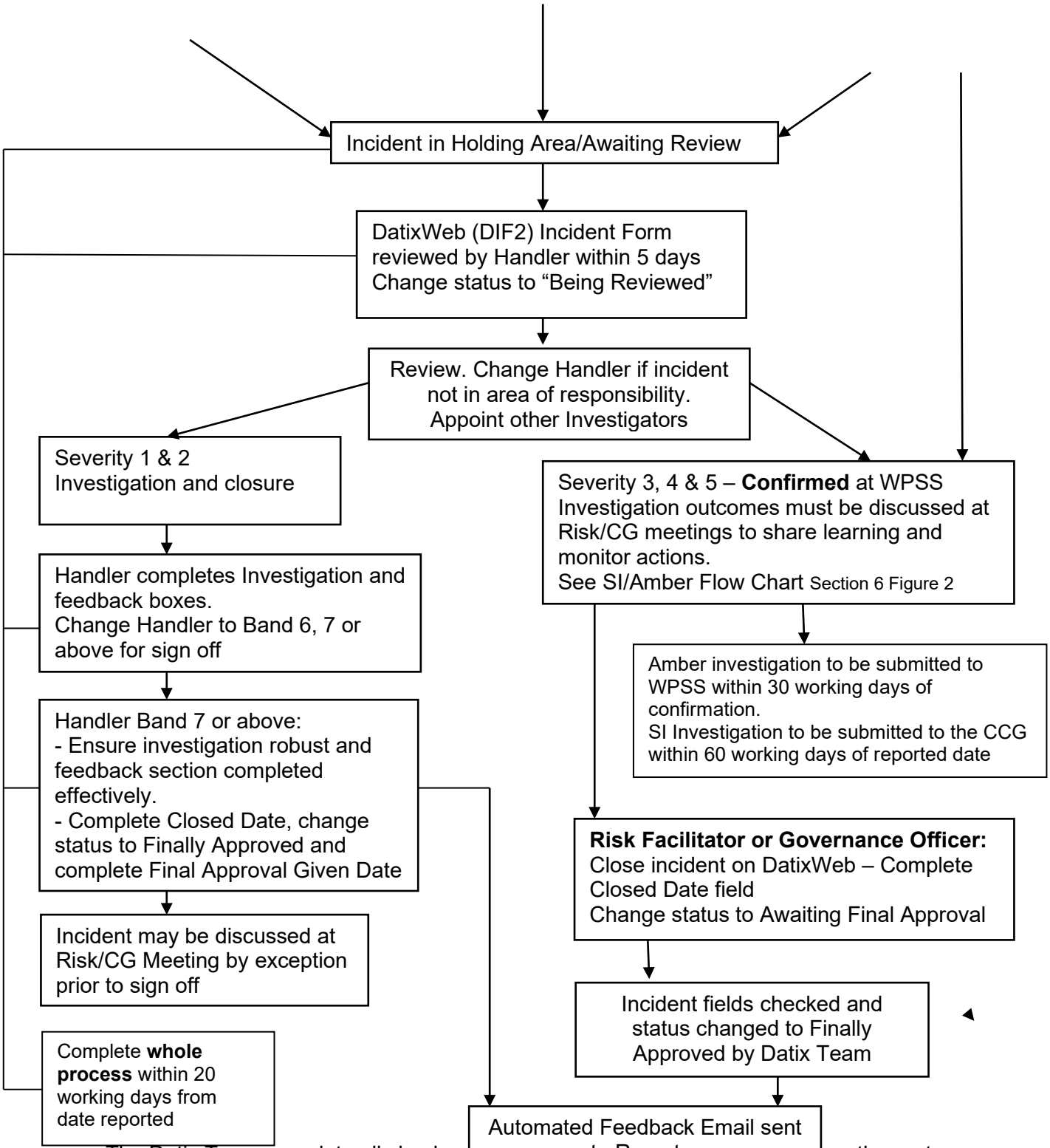
6. Investigation completed and action plan on learning developed by Division
7. Incident report signed off by Division
8. Incident report submitted and for review and approval by WPSS
9. Approved report from WPSS returned for Division to share learning and findings and complete action plan

10. Report and findings uploaded onto Datix and incident closed
11. Serious Incidents are sent to Clinical Commissioning Group for external scrutiny
12. Datix Team complete and close on system
13. These incidents will be reported within trends in Trust wide and Divisional Reports

The flowchart below (figure 1) details the incident process

Figure 1 **Incident Reporting & Investigating Process**





The Datix Team complete all checks o on the system. This includes linking the contacts and confirming severity from the Amber and SI reports. All patient safety incidents that occur within the Trust will be uploaded to the NRLS by the Datix Team within one week of the incident occurring.

5.5 Actions from Incidents

All actions identified from Serious and Amber Incidents will be logged on the Datix system and tracked for compliance through the Divisional Risk and Governance Meetings. The

Patient Safety Team will monitor actions over 6 months old and escalate to the relevant manager responsible. The Head of Governance report on the overdue actions to the Patient Safety and Quality Group and the Quality and Safety Committee (QSC).

Regular checks will be conducted by the Patient Safety Team to ensure the completed actions have been embedded in practice.

Actions identified from severity 1 and 2 incidents (not Amber or SI) will be managed by the manager (Handler) investigating and owning the incident.

Trends and themes will be reported to the respective divisional meetings on a monthly basis with Trust wide reviews completed through the trust wide incident report. Serious and Amber incidents are reported through the Serious and Amber Incident Report completed on a monthly basis.

6. Serious Incidents and Amber Incidents (see also Appendix A)

All incidents reported as severity 3, 4 or 5 could be potential Serious or Amber Incidents therefore are included for discussion at the Weekly Patient Safety Meeting (WPSS). At this meeting all relevant information must be made available in order for an informed decision on the actual severity and subsequent level of investigation. Divisions should ensure that specialty leads have input into the WPSS where appropriate in order to ensure that the information discussed is accurate. The decision for reporting as a Serious Incident, an amber incident or downgrading the severity is documented on Datix and on the WPSS log.

If a Serious Incident is declared then a lead investigator will be identified by the Patient Safety Team. Lead investigators for Amber investigations are identified at the WPSS meeting but will be managers from within the area responsible. For more details on conducting investigations, please refer to the Trust Policy for the Investigation of Incidents, Complaints and Claims.

All serious incidents must be reported on STEIS by the Patient Safety Team within two working days of the incident being identified and confirmed by the Trust.

The Patient Safety Team advise the nominated investigators of the deadlines for the SI or Amber investigations; this includes the date of the Weekly Patient Safety Summit meeting where the SI/amber investigation will be reviewed and the date that the SI is due with the NHS Sussex.

If prior to the WPSS it is clear it is a serious incident or meets the criteria of a Never Event, the senior person on duty in the department or clinical area must be notified immediately who will escalate this to the Senior Divisional Team and Corporate Nursing Team and Medical Director/Chief Nurse. The Patient Safety Team and Head of Governance should also be informed at the earliest opportunity. The on call manager must be informed out of normal working hours. The communications team will be contacted should there be significant media interest.

The Patient Safety Team will monitor the progress of all SI / amber investigations and will escalate any barriers to deadlines being met (please see SI and amber incident flow chart for details). This will be updated on the WPSS log and Datix.

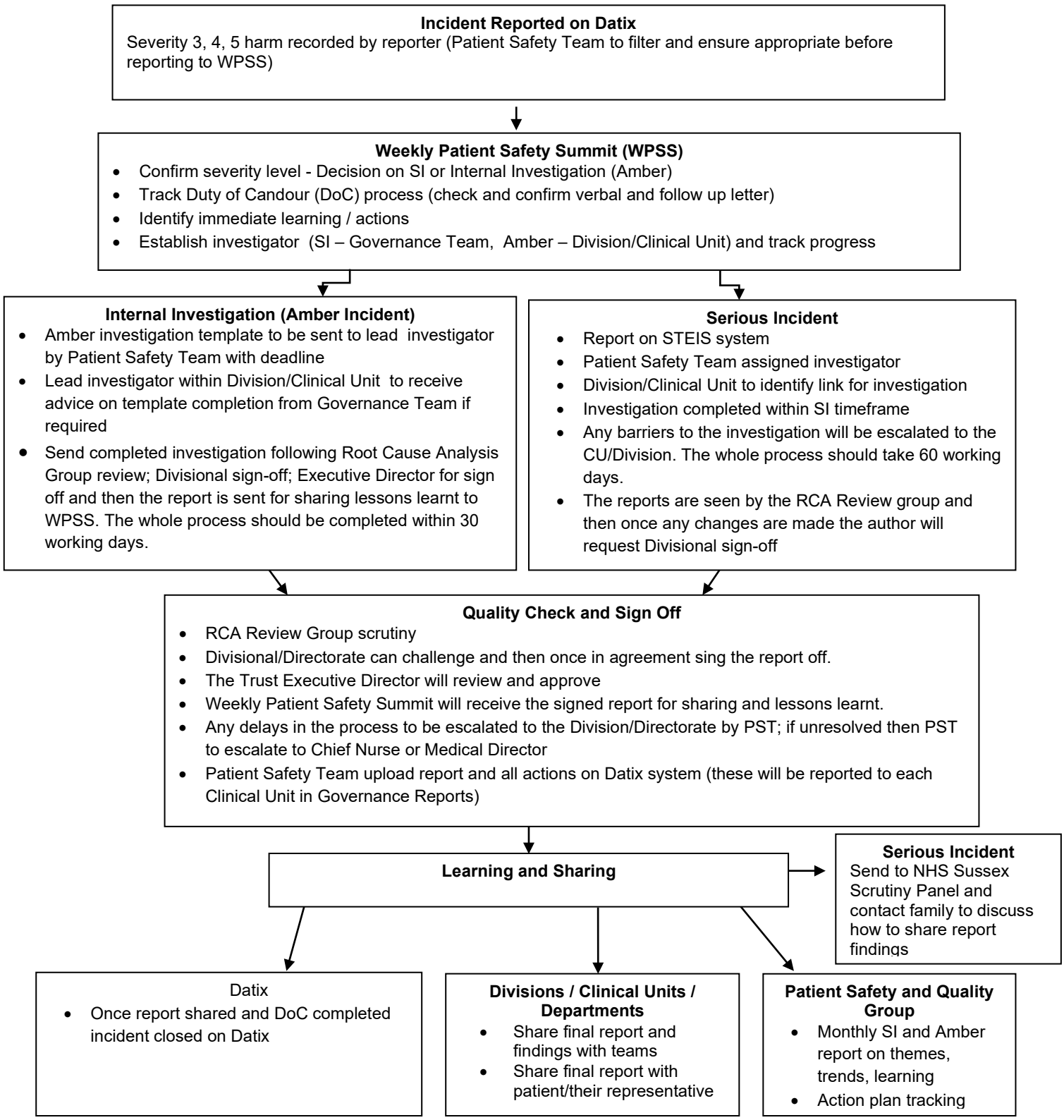
All actions from amber and SI investigations are captured on Datix and are monitored by Divisions / Directorates via their monthly risk meetings.

If the patient involved in the amber or serious incident investigation dies during the investigation period as a result of the harm caused, the investigator must inform the Chief Nurse, the Medical Director and the Head of Governance immediately.

The following flowchart (figure 2) demonstrates the process to follow for all potential severity 3, 4 and 5 incidents:

Figure 2

Serious Incident (SI) and Amber Incident Flowchart (grade 3, 4 and 5 severity)



7. Information Governance Breaches

If the incident relates to an information governance breach, the Trust Information Governance Lead and Data Protection Officer must also be informed immediately of the incident as they will be required to inform external agencies should the breach be deemed serious within 72 hours. Minor breaches must be reported and learning identified. The Medical Director as the Caldicott Guardian must also be informed on serious breaches. If in doubt the Governance Team or the Information Governance Lead and Data Protection Officer will provide advice or signpost to the right information or person.

8. Reporting of Deaths

8.1 Suspicious Deaths

Where a death is suspicious and serious harm caused the Medical Director, Chief Nurse, Consultant, Senior Manager and where out of hours, the Executive Director on call, must be informed and a discussion held. The police must be informed immediately by the person in charge and the scene of the incident not interfered with other than that which is necessary to ensure the safety of staff and other persons and to prevent reoccurrence. The Coroner must be informed of any sudden deaths.

8.2 Unexpected and potentially or confirmed avoidable deaths

All deaths are reviewed through the mortality review process which is monitored through the Clinical Outcomes Group. Where a death has been identified through this review as being unexpected and definitely avoidable it must be reported to the WPSS for a decision on whether a Serious Incident or Amber investigation.
If this is also identified as requiring an inquest the investigation report will be sent to the Coroner once it has been reviewed and ratified by the WPSS. The Legal Team will liaise with the Patient Safety Team for these cases however the clinical Teams responsible for the care must be involved at every stage.

8.3 Deaths during a Surgical Procedure

All deaths involving a surgical procedure must be reported on the Datix system however this is to provide the opportunity for review and discussion at the WPSS to ensure there were no other options in the care of the patient to avoid the death. For example if nothing was done the patient would die therefore it was an attempt by clinical staff to save life. This is not stating harm was caused. The initial review will determine if acting on best interests but unfortunately unsuccessful or there was potential learning or need for a review. If this is the case the level of investigation will be determined.

8.4 Deaths requiring an Inquest

The Coroner may inform the Trust an inquest is required to review a death that has not already been identified as a Serious or Amber incident. In the event of this occurring, the Legal Team will send the information to the Patient Safety Lead who will review the case. If they feel harm may have been caused, this will be sent on to the appropriate Division for review. The Division will be requested to add the incident to Datix (at severity 3 or above) if not already done and the incident will be included on the WPSS log and next meeting for discussion and confirmation on the level of investigation required.

9. Safeguarding Incidents

If an incident involves a suspected safeguarding issue (adults or children) that occurred within the Trust care it must be reported on the Datix system, line manager informed and reported on the safeguarding reporting systems for East Sussex. To ensure that the case is investigated appropriately please follow the relevant safeguarding documentation:

'Safeguarding Adults at Risk' - Alerting Guide for ESHT NHS Trust Staff which complements the Sussex Safeguarding Adults at Risk Policy and Procedures.

Child Protection Policy and Guidelines. Sussex child protection policies and procedures can be found at **http://wwwproceduresonline.com/pansussex/scb/**
Trust policies and procedures can be found on the ESHT intranet site.

Safeguarding concerns identified by trust staff whilst visiting or working in other organisations must be reported on the East Sussex Safeguarding systems as per the Sussex policies. They do not need to be reported on Datix in addition to this as the Trust Safeguarding team can obtain safeguarding reporting information from the shared systems. Concerns or trends on a particular location or organisation must also be discussed with the staff member's line manager

10. Doctors in training – reporting incidents

The processes detailed within this policy apply to all staff therefore Consultants must report and encourage their Junior Doctors to report incidents as they arise. The Divisions have governance arrangements where there are monthly risk meetings discussing the details of incidents and risks and monthly Governance meetings that reviews trends, themes and assurance on closure of the Serious and Amber incidents. There is a Governance Report detailing trends and themes and actions that should be shared with all members of the Division, including Junior Doctors.

Serious Incidents involving doctors in training must be reported to the Trust Director of Medical Education who will monitor these events and report to Health Education Kent, Surrey and Sussex (HEKSS) where required.

11. Pressure Ulcer Incidents

The Pressure Ulcer Review Group ensures there is scrutiny on all reported pressure ulcers. The group will confirm the grading and ensure all actions taken to prevent wherever possible. Learning will be disseminated by this group. Should the group identify as Category 3 or 4 Pressure Ulcer that was caused through severe failings in trust care it will be reported to the WPSS for review and decision on investigation level. See Appendix D for the process flowchart.

12. Harm caused by known complications

Known complications will continue to occur during and following surgical procedures hence the reason for robust consent processes. All complications should be recorded by each specialty on their own database or system but any complication causing moderate or above harm should be reported on the Datix system to ensure discussed at WPSS. WPSS will determine if further review/investigations are required as important to ensure the complication was unavoidable. Duty of candour will only be required should the WPSS or the investigation findings deem the harm could be avoided.

13. Maternity Incidents

Maternity incidents meeting certain criteria require an external investigation by the Healthcare Safety Investigation Branch (HSIB). Should any incident meet this criteria (see Appendix A) the Associate Director of Midwifery or the Patient Safety Lead must contact the HSIB to raise and log the incident. The WPSS may need to be consulted prior to this or informed post notification. If declared as a serious incident it will be logged onto STEIS with

a note to state who is undertaking the investigation. Duty of Candour remains the responsibility of the Trust and the Consultant caring for the patient at the time of the event.

14. Reporting Injuries, Diseases and Dangerous Occurrences Reports (RIDDOR)

Injuries to patients, staff, visitors and members of the public may be subject to the requirements under this legislation. The Health and Safety Team review all incidents causing harm to these groups and where necessary report to the Health and Safety Executive under RIDDOR. These cases are reported to the Health and Safety Committee.

15. Reporting Incidents that Cross Organisational Boundaries

If more than one organisation is involved in a Serious Incident, the organisation which identified the incident is responsible for reporting the incident via StEIS if unclear what organisation was responsible for the care at the time of the event. If it is clear on the responsibility then the organisation responsible must report on StEIS and all other organisations involved support through completing relevant sections of the investigation. The Clinical Commissioning Groups will assist in supporting the investigation across organisations if there is an issue with engagement.

Where possible, incidents which involve the actions of other organisations should be shared and communicated so that incident reporting and investigation procedures can be initiated.

16. Reporting Incidents to External Agencies

Serious incidents must be notified without delay (or within specified timescales) to all relevant bodies via the appropriate routes. Guidance produced by specific bodies should be referred to in order to ensure compliance with their requirements. Commissioners should be notified of serious incidents no later than 2 working days after the incident is identified.

In order that ESHT fulfils national reporting obligations it is essential that external agencies are informed of specific incidents. For a list of external agencies and who is responsible for reporting Datix incidents to them, please see **Appendix C**.

All incidents that arise from a screening programme should be reported via:

- The Trust incident reporting process
- The Public Health England process: Managing Safety Incidents in NHS Screening Programmes. The following link provides further information https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/672737/Managing_safety_incidents_in_National_screening_programmes.pdf

17. Feedback to reporters

It is important that feedback is provided to those reporting incidents. Feedback can be made directly to individuals or via verbal or written communication to teams. It is the manager's responsibility to provide feedback but the individual reporting can also ask what has happened as a result of an incident they reported.

17.1 Feedback to individuals reporting the incident

To receive feedback the reporter must provide their NHS email address when completing the incident form. This is clearly stated and requested.
Within Datix Web there is a section on feedback to reporter which must be completed by the Handler of the incident. The Manager/Handler assigning the incident to "Awaiting Final Approval or Final Approval" is responsible for ensuring the feedback section is completed and provides a robust response to the reporter.

Once the incident is moved to the “Final Approved” section an automated feedback message is sent to the reporter thanking them for reporting and providing the completed feedback text provided by the Handler/Manager.

17.2 Feedback through reports

Monthly Divisional Quality reports are provided that includes trends, themes and analysis of incidents, complaints and patient experience. These provide assurance the incidents are reviewed and analysed and actions taken as a result. The staff within each Division or Team should be provided with the reports by the Divisional leads.
Trust wide quality reports are reviewed by the Patient Safety and Quality Group and QSC. Both these groups receive the Serious and amber Incident informaiton via a Q&S report which details the incidents and trends and wherever possible the actions taken. The monitoring of actions is through the Datix system and the Divisional Risk meetings.

17.3 Feedback through Datix reports

The Datix WEB system allows managers of teams and areas to run their own reports and trends from incidents for discussion within their teams. This can include the actions, graphs and listing reports. Training on how to achieve this is provided by the Datix Team on request.

17.4 Quarterly newsletters

Shared Learning is provided and circulated across the trust quarterly by the Datix Team newsletter “You Said, We Did”.

18. Support for staff following involvement in an incident or serious incident

The trust will endeavour to provide facilities for informal or formal de-briefing of clinical teams following a patient safety incident, and will:

- Provide advice and training on the management of patient safety incidents
- Provide information on the support systems currently available for professionals involved in patient safety incidents
- Provide staff counselling services (via Occupational Health) should these be required

For more information, please refer to the Trust Policy for Supporting Staff Involved in an Incident, Complaint or Claim.

19. Raising Concerns

East Sussex Healthcare NHS Trust promotes an open and honest culture in which staff and all other workers feel able to challenge, without fear of retribution, practices or circumstances where they believe other staff are acting in an unethical, unsafe, inappropriate, unprofessional or illegal way. The Raising Concerns Procedure sets out the process for raising concerns about wrong doing at work, which can then be properly investigated and dealt with whilst ensuring that the interests of staff who raise concerns are protected throughout. Please refer to the Trust Raising Concerns Procedure (available on the Trust Extranet). There is also a Speak up Guardian at the Trust who can be contacted to offer advice. Email contact details are: esh-tr.speakupatESHT@nhs.net

Staff wishing to raise a concern they do not feel can be shared with line manager or any other member of staff must contact the Speak up Guardian separately when reporting the incident through the Datix system.

20. Concerns raised by family / friends of deceased patients

The Bereavement Team monitor the Mortality database and families/friends of deceased patients are contacted by the Bereavement Team to ask if there were any concerns regarding the care provided by ESHT to their deceased family /friend. Any concerns raised are recorded on to the mortality database and details of the patient are forwarded to the esh-tr.weeklypatientsafetysummit@nhs.net with a brief outline of the concern. This will be followed up by the Patient Safety Lead either directly with the family, through Complaints Team and where required reported to WPSS for discussion. The WPSS will review and determine the need and level of investigation.

21. Equality and Human Rights Statement

An equality impact assessment has been carried out in order to establish that this policy does not discriminate or have a detrimental impact upon employees or service users on the grounds of disability, age, race, gender, sexual orientation, religion or belief. None have been identified.

22. Training

All employees joining the Trust receive an Induction Planner to support the Induction of new staff, this including informing the member of staff how to report an incident.
In addition to this there is a Corporate Induction which includes incident reporting and management. The Datix Team provide further training to all managers as they need to manage their incidents through the Datix system.

23. Monitoring Compliance with the Document

Compliance with the procedures in this policy is detailed in the table below:

Element to be Monitored	Lead	Tool for Monitoring	Frequency	Responsible Individual/Group/ Committee for review of results/report	Responsible individual/ group/ committee for acting on recommendations/action plan	Responsible individual/group/ committee for ensuring action plan/lessons learnt are Implemented
1. Incident reporting and management process	Trust Risk Lead	Tracking of incidents through the Governance Team Key Performance Indicators	Monthly	Patient Safety and Quality Group and Health and Safety Steering Group	Patient Safety and Quality Group and Health and Safety Steering Group	Patient Safety and Quality Group and Health and Safety Steering Group
2. Number of incidents reported	Trust Risk Lead and Patient Safety Lead	Numbers reported monthly reported within quality reports. Divisional reports include staff groups reporting such as Junior Doctors	Monthly	Patient Safety and Quality Group and Health and Safety Steering Group	Patient Safety and Quality Group and Health and Safety Steering Group	Patient Safety and Quality Group and Health and Safety Steering Group
3. Serious and Amber incident process and actions	Patient Safety Lead	WPSS log and tracking on open and closed incidents – within SI and Amber Report Open actions reported to Divisions and Closing the Loop reports provided to determine if embedded.	Monthly	Patient Safety and Quality Group and Health and Safety Steering Group	Patient Safety and Quality Group and Health and Safety Steering Group	Patient Safety and Quality Group and Health and Safety Steering Group

24. References

- Health and Safety at Work Act (1974)
- NHSLA Risk Management Standards 2012/13
- Medicines and Healthcare products Regulatory Agency Website http://www.mhra.gov.uk/#page=DynamicListMedicines
- Health and Safety Executive Website
- http://www.hse.gov.uk/
- National Patient Safety Agency, National Framework for Reporting and Learning from Serious Incidents Requiring Investigation (2010)
- http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132355
- NPSA Risk Matrix for Risk Managers
- http://www.npsa.nhs.uk/nrls/improvingpatientsafety/patient-safety-tools-and-guidance/risk-assessment-guides/risk-matrix-for-risk-managers/?locale=en
- Health and Social Care Information Centre Checklist Guidance for Reporting, Managing and Investigating Information Governance Serious Incidents Requiring Investigation (1st June 2013, Version 2.0) must be consulted: https://nww.igt.hscic.gov.uk/resources/IGIncidentsChecklistGuidance.pdf
- Statutory notifications - Guidance for registered providers and managers of NHS organisations: http://www.cqc.org.uk/sites/default/files/media/documents/20120621_100504_v5_00_guidance_on_statutory_notifications_from_nhs_bodies_for_external_publication.pdf
- NHS Commissioning Board Serious Incident Framework (2013)
- Duty of Candour
- Knight M, Kenyon S, Brocklehurst P, Neilson J, Shakespeare J, Kurinczuk JJ (Eds) on behalf of MBRACE-UK. Saving Lives, Improving Mothers' Care-Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquires into maternal Deaths and Morbidity 2009-12. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2014: p45-55
- Never Events List 2015/16 - NHS England (27 March 2015)
- Revised Never Events Policy and Framework - NHS England (27 March 2015)
- Serious Incident Framework – Supporting Learning to Prevent Recurrence - NHS England (27 March 2015)

Appendix A – Serious Incident Guidance Including the 'Never Events' List 2018

Serious incidents in the NHS include:

1) Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:
   - Unexpected or avoidable death of one or more people. This includes suicide/self-inflicted death; and homicide by a person in receipt of mental healthcare within the recent past.
   - Unexpected or avoidable injury to one or more people that has resulted in serious harm;
   - Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent the death of the service user or serious harm
   - Actual or alleged abuse, sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where healthcare did not take appropriate action/intervention to safeguard against such abuse occurring or where abuse occurred during the provision of NHS-funded care
   - This includes abuse that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally-led investigation, where delivery of NHS funded care caused / contributed towards the incident.

2) A Never Event (see below). All Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death.

3) An incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following: data loss and/or information governance related issues, property damage, security breach/concern, incidents in population-wide healthcare activities like screening and immunisation programmes, inappropriate enforcement/care under the Mental Health Act (1983), systematic failure to provide an acceptable standard of safe care, activation of Major Incident Plan.

4) Major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation.

Taken from the Serious Incident Framework, NHS England, March 2013

Never Events

This list of "never events" is for use in the NHS in 2018 (updated February 2021) and are serious incidents considered 'wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers'. NHS England, 2015.

Surgical

1. Wrong site surgery – now excludes removal of wrong tooth (2021)
2. Wrong implant/prosthesis
3. Retained foreign object post-procedure

Medication

4. Mis-selection of a strong potassium containing solution
5. Administration of medication by the wrong route
6. Overdose of Insulin due to abbreviations or incorrect device
7. Overdose of methotrexate for non-cancer treatment
8. Mis-selection of high strength midazolam during conscious sedation

Mental Health

9. Failure to install functional collapsible shower or curtain rails

General

10. Falls from poorly restricted windows
11. Chest or neck entrapment in bedrails
12. Transfusion or transplantation of ABO-incompatible blood components or organs
13. Misplaced naso- or oro-gastric tubes
14. Scalding of patients
15. Unintentional connection of a patient requiring oxygen to an air flowmeter
16. Undetected oesophageal intubation (**Temporarily suspended pending further clarification**)

HCAI Outbreaks

An outbreak is defined as:

- an incident in which two or more people experiencing a similar illness are linked in time or place;
- a greater than expected rate of infection compared with the usual background rate for the place and time where the outbreak has occurred;
- a single case for certain rare diseases such as diphtheria, botulism, rabies, viral haemorrhagic fever or polio; or
- a suspected, anticipated or actual event involving microbial or chemical contamination of food or water.

For Norovirus outbreaks expected within hospital in the UK, particularly in the winter period; Serious incidents will be reported when four or more wards are affected on a hospital site and/or when there is a significant impact on patient services.

Mortality related to HCAIs (MRSA bacteraemia & Clostridium difficile infection for example) recorded on part 1 of death certificates are routinely reported as SIs

Women and Children (Maternity) - Healthcare Safety Investigation Branch (HSIB) Reporting Criteria

Eligible babies include all term babies (at least 37+0 completed weeks of gestation) born following labour who have one of the following outcomes:

- Intrapartum stillbirth: when the baby was thought to be alive at the start of labour but was born with no signs of life.
- Early neonatal death: when the baby died within the first week of life (i.e. days 0–6) of any cause.
- Severe brain injury diagnosed in the first 7 days of life, when the baby:
    - was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) OR
    - was therapeutically cooled (active cooling only) OR
    - had decreased central tone AND was comatose AND had seizures of any kind.

Babies whose outcome was the result of congenital anomalies are excluded from this review.

The definition of labour for Each Baby Counts includes:

- any labour diagnosed by a health professional, including the latent phase of labour at less than 4 cm cervical dilatation
- when the woman called the unit to report any concerns of being in labour, for example (but not limited to) abdominal pains, contractions or suspected ruptured membranes
- induction of labour
- when the baby was thought to be alive following suspected or confirmed pre-labour rupture of membranes.

HSIB also investigate direct or indirect maternal deaths in the perinatal period

Appendix B – NPSA Risk Matrix
Scoring of Risks – Risk Assessment Tool for Evaluation of Likelihood and Impact of Risk

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for <3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organizational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Likelihood scores:

Likelihood Score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Certain**
Frequency How often might it/does it happen	This will probably never happen / recur	Do not expect it to happen / recur but it is possible that it may do so	Might happen or recur occasionally	Will probably happen / recur, but it is not a persisting issue / circumstances	Will undoubtedly happen / recur, possibly frequently

Multiply Severity score by Likelihood score

e.g. Severity (Major) = 4 x Likelihood (Unlikely) = 2 = Total Score of 8 (Amber)

	Likelihood scores				
Severity scores	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	**5**	**10**	**15**	**20**	**25**
4 Major	**4**	**8**	**12**	**16**	**20**
3 Moderate	**3**	**6**	**9**	**12**	**15**
2 Minor	**2**	**4**	**6**	**8**	**10**
1 Negligible	**1**	**2**	**3**	**4**	**5**

(Adapted from the NPSA Model Matrix on NPSA Website. www.npsa.nhs.uk

Appendix C – Reporting Incidents to External Agencies

i. National Reporting and Learning System (NRLS)

All patient safety incidents are uploaded to the NRLS at least monthly. All confirmed Severity 4 (major) and 5 (catastrophic) incidents must be exported from Datix to the NRLS by the Datix Team within two working days. The data is anonymised fully before it is uploaded. The NRLS use this data to provide a national picture of reported incidents from which they produce alerts containing advice and deadlines by which organisations should be compliant and other patient safety information which they circulate nationally using the Central Alert System (CAS) which is also used for cascading alerts from agencies such as the MHRA. Every six months (September and March), a report is produced from the NRLS which benchmarks the Trust's incident reporting activity against other similar organisations. In between these months the Trust can log into the NRLS to access a NRLS Provisional Organisational Data Summary report which includes a report on incidents reviewed by the clinical staff in the patient safety division of the NHS Commissioning Board (incidents which have a severe degree of harm or death).
By reporting incidents to the National Reporting and Learning system the Trust typically meets its requirement to report incidents to the CQC.

ii. Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) to the Health and Safety Executive (HSE)

Organisations have a legal requirement to report certain incidents to the Health and Safety Executive (HSE) under RIDDOR. The process for RIDDOR reporting is clearly set out in the Health and Safety Policy 2018 which is available for viewing on the Trust Extranet. Please refer to Appendix G for the Patient incident related RIDDOR reporting flow chart.
nww.esht.nhs.uk/healthandsafety/riddor/

For more information and the full list of reportable incidents please refer to:
http://www.hse.gov.uk/riddor/

RIDDOR reporting is the responsibility of the Health and Safety Team – please contact them if you believe an incident meets is RIDDOR reportable.

iii. Medicines and Healthcare Products Regulatory Agency (MHRA) incidents

Organisations should report suspected problems with a medicine or medical device to the MHRA using the Yellow Card Scheme as soon as possible if:

- A medicine causes side effects
- Someone's injured by a medical device, either because it's labelling or instructions aren't clear, it's broken or has been misused
- A patient's treatment is interrupted because of a faulty device
- Someone receives the wrong diagnosis because of a medical device
- A medicine doesn't work properly
- A medicine is of a poor quality
- You think a medicine or medical device is fake or counterfeit

Then reports also need to be made via the MHRA website by the person completing the Datixweb incident reporting form.

The Trust Controlled Drug Accountable Officer must be informed of all incidents relating to controlled drugs. This is the Chief Pharmacist who can be contacted on (01323) 438226.

http://www.mhra.gov.uk/#page=DynamicListMedicines

iv. Serious Adverse Blood Reactions and Incidents (SABRE)

The UK Blood Safety and Quality Regulations 2005 and the EU Blood Safety Directive require that serious adverse incidents and serious adverse reactions related to blood and blood components are reported to the MHRA, the UK Competent Authority for blood safety. This information is vital to the work that the Serious Hazards of Transfusion (SHOT) uses to compile its reports. Further details on reporting can be found at:

http://www.mhra.gov.uk/Safetyinformation/Reportingsafetyproblems/Blood/index.htm

v. Defects and Failures

Where incidents relate to a defect or failure involving engineering plants, infrastructure and/or non-medical devices, a defect and failure report should also be submitted by the organisation to the Department of Health via the defect and failure reporting portal http://efm.hscic.gov.uk/. The Trust Medical Devices Safety Officer (MDSO) should also be informed.

For more information please refer to the Trust Central Alert System (CAS) Policy and Procedure for the distribution of Safety Alerts

vi. Care Quality Commission (CQC) – (including IRMER and Serious Incidents)

The Trust is required to report ionisation radiation incidents under the Ionising Radiation (Medical Exposure) Regulations 2000 (IR[ME]R), to the Care Quality Commission where exposures are 'much greater than intended', occurring otherwise than as a result of equipment failure. An online form must be completed on the same day by the Clinical Services Manager for Radiology as well as the incident being reported on Datixweb. The Chief Executive must be advised of such reports being made to the CQC via the Company Secretary. Investigations into these incidents are submitted to the Trust Serious Incident Review Group (SIRG) before being sent to the CQC. The CQC advise the Chief Executive when they have closed the incident.

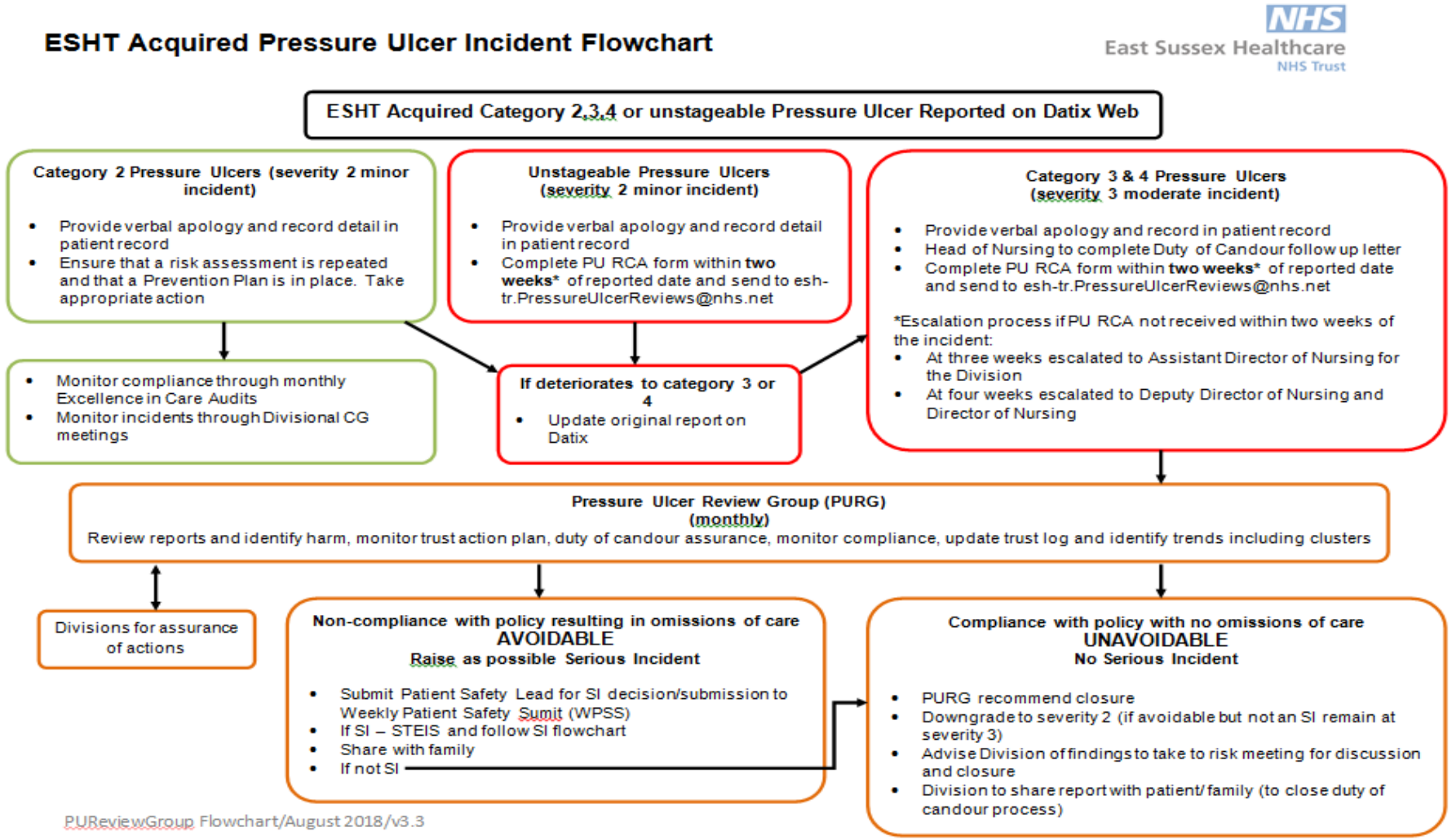
Organisations are required to notify the Care Quality Commission about events such as Serious Incidents which indicate risks to on-going compliance with registration requirements. The CQC will access the NRLS and StEIS as a source of information for the Intelligent Monitoring Report (IMR) – a quarterly report they produce, and as part of their monitoring of compliance with the essential standards. The Trust Company Secretary is responsible for communicating Serious Incidents directly to the local CQC Inspector.

vii. Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK)

The Governance Lead for the Women and Children's Division acts as the MBRRACE-UK Co-coordinator for Trust reporting of stillbirths, perinatal deaths and infant deaths via the MBRRACE-UK online reporting system (**www.mbrrace.ox.ac.uk**).

viii NHS Screening Programmes
Reporting is via:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/672737/Managing_safety_incidents_in_National_screening_programmes.pdf

Appendix D – Pressure Ulcer Management Flowchart



East Sussex Healthcare NHS Trust

Non ESHT Acquired Pressure Ulcer Incident Flowchart

Non ESHT Acquired Pressure Ulcer Reported on Datix Web that Deteriorates Under ESHT Care

Non ESHT acquired PU damage reported on Datix should be reviewed

Non ESHT Acquired Category 2 Pressure Ulcers

- Provide verbal apology and record detail in patient record
- Ensure that a risk assessment is repeated and that a Prevention Plan is in place. Take appropriate action

Category 2 or Deep Tissue Injury damage that occurred prior to admission to hospital or community caseload

If deteriorates to category 3 or 4 within 72 hours of admission

- Update original report on Datix
- PU RCA NOT required as damage occurred outside ESHT care

If deteriorates to category 3 or 4 after 72 hours of admission

- Re-report on Datix as ESHT acquired deterioration of PU damage
- PU RCA IS required

PUReviewGroup Flowchart/August 2018/v3.3

Appendix E Gynae Datix trigger list

Women and Childrens
Gynaecology Datix Trigger list

- Damage to structure (Ureter, bowel, vessel)
- Delayed or missed diagnosis (e.g. Ectopic pregnancy)
- Anaesthetic complications
- VTE
- Failed procedure
- Unplanned ICU admissiom
- Unexpected operative blood loss > 500mls
- Unplanned return to theatre
- Moderate OHSS
- Procedure performed without consent
- Unplanned readmission within 30 days of original operation
- Retained swab or instrument.

Appendix F: EIA Form

Equality Impact Assessment Form

1. Cover Sheet

Please refer to the accompanying guidance document when completing this form.

Strategy, policy or service name	Incident Reporting and Management Policy
Date of completion	December 2021
Name of the person(s) completing this form	Lisa Forward
Brief description of the aims of the Strategy/ Policy/ Service	To describe and provide a framework for all staff within the organisation to enable effective reporting and management of incidents. .
Which Department owns the strategy/ policy/ function	
Version number	V6
Pre Equality analysis considerations	Click here to enter text.
Who will be affected by this work? **E.g. staff, patients, service users, partner organisations etc.**	Staff, patients, service users and partner organisations..
Review date	December 2024
If negative impacts have been identified that you need support mitigating please escalate to the appropriate leader in your directorate and contact the EDHR team for further discussion.	To whom has this been escalated? Name: Click here to enter text. Date: Click here to enter a date.
Have you sent the final copy to the EDHR Team?	Choose an item.

2. EIA Analysis

<table>
<tr><td></td><td>☺ 😐 ☹</td><td>Evidence:</td></tr>
<tr><td>Will the proposal impact the safety of patients', carers' visitors and/or staff?

Safe: Protected from abuse and avoidable harm.</td><td>Choose:
Negative</td><td>Click here to enter text.</td></tr>
<tr><td>Equality Consideration
Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)</td><td>Choose:
Negative</td><td>
<table>
<tr><th>Race</th><th>Gender</th><th>Sexual orientation</th><th>Age</th><th>Disability & carers</th></tr>
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<tr><th>Gender reassignment</th><th>Marriage & Civil Partnership</th><th>Religion and faith</th><th>Maternity & Pregnancy</th><th>Social economic</th></tr>
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<table>
<tr><td>Is the proposal of change effective?

Effective: Peoples care, treatment and support achieves good outcomes, That staff are enabled to work in an inclusive environment. That the changes are made on the best available evidence for all involved with due regards across all 9 protected Characteristics</td><td></td><td>Click here to enter text.</td></tr>
<tr><td>Equality Consideration
Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)</td><td></td><td><table><tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr><tr><td>Gender reassignment</td><td>Marriage & Civil Partnership</td><td>Religion and faith</td><td>Maternity & Pregnancy</td><td>Social economic</td></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr></table></td></tr>
<tr><td>What impact will this have on people receiving a positive experience of care?</td><td>Choose:</td><td>Click here to enter text.</td></tr>
<tr><td>Equality Consideration
Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)</td><td></td><td><table><tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr><tr><td>Gender reassignment</td><td>Marriage & Civil Partnership</td><td>Religion and faith</td><td>Maternity & Pregnancy</td><td>Social economic</td></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr></table></td></tr>
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<table>
<tr><td>Does the proposal impact on the responsiveness to people's needs?</td><td>Choose:
Positive
Neutral
Negative</td><td></td></tr>
<tr><td>Equality Consideration Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)</td><td></td><td>
<table>
<tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr>
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<tr><td>What considerations have been put in place to consider the organisations approach on improving equality and diversity in the workforce and leadership?</td><td>Choose:
Positive
Neutral
Negative</td><td>There is equal access and support for all staff to incident reporting, root cause analysis and duty of candour training. Please see section 6.</td></tr>
<tr><td>Equality Consideration Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)</td><td></td><td>
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<tr><td colspan="3">Access
Could the proposal impact positively or negatively on any of the following:</td></tr>
<tr><td>• Patient Choice</td><td>Choose:
Positive
Neutral
Negative</td><td></td></tr>
<tr><td>• Access</td><td>Choose:
Positive
Neutral
Negative</td><td></td></tr>
</table>

<table>
<tr><td>• Integration</td><td>Choose:
Positive
Neutral
Negative</td><td></td></tr>
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<tr><td>Engagement and Involvement
How have you made sure that the views of stakeholders, including people likely to face exclusion have been influential in the development of the strategy / policy / service:</td><td>Choose:
Positive
Neutral
Negative</td><td></td></tr>
<tr><td>Equality Consideration
Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)</td><td></td><td><table>
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Duty of Equality Use the space below to provide more detail where you have identified how your proposal of change will impact.	Choose: Positive Neutral Negative	There is equal access and support for all staff to incident reporting, root cause analysis and duty of candour training. Please see section 6.
Characteristic	**Rating** ☺ ☹ 😐	**Description**
Race	Choose: Positive Neutral Negative	
Age	Choose: Positive Neutral Negative	
Disability and Carers	Choose: Positive Neutral Negative	
Religion or belief	Choose: Positive Neutral Negative	
Sex	Choose: Positive Neutral Negative	
Sexual orientation	Choose: Positive Neutral Negative	
Gender re-assignment	Choose: Positive Neutral Negative	
Pregnancy and maternity	Choose: Positive Neutral Negative	
Marriage and civil partnership	Choose: Positive Neutral Negative	

Human Rights

Please look at the table below to consider if your proposal of change may potentially conflict with the Human Right Act 1998

Articles		Y/N
A2	Right to life	Y/N
A3	Prohibition of torture, inhuman or degrading treatment	Y/N
A4	Prohibition of slavery and forced labour	Y/N
A5	Right to liberty and security	Y/N
A6 &7	Rights to a fair trial; and no punishment without law	Y/N
A8	Right to respect for private and family life, home and correspondence	Y/N
A9	Freedom of thought, conscience and religion	Y/N
A10	Freedom of expression	Y/N
A11	Freedom of assembly and association	Y/N
A12	Right to marry and found a family	Y/N
Protocols		
P1.A1	Protection of property	Y/N
P1.A2	Right to education	Y/N
P1.A3	Right to free elections	Y/N

East Sussex Healthcare NHS Trust

Psychological Wellbeing and Safety of Staff Policy (Formerly stress and mental wellbeing)

Document ID:	830
Version:	V3.1
Ratified by:	Clinical Documentation and Policy Ratification Group
Date ratified:	13 December 2022
Name of author and title:	Liz Lipsham, People Potential Manager, Engagement and Wellbeing
Date originally written:	April 2012
Date current version was completed:	July 2022
Name of responsible committee/individual:	Health & Safety Steering Group
Date issued:	05 January 2023
Review date:	December 2025
Target audience:	All ESHT employees
Compliance with CQC	Good Governance
Compliance with any other external requirements (e.g. Information Governance)	Health & Safety Executive. (2022). *What are the Management Standards?* Available from What are the Management Standards? - Stress - HSE NHS. (2020) *NHS People Plan*. Available from NHS England » Online version of the People Plan for 2020/2021 NHS. (2022) *NHS People Promise.* Available from NHS England » The Promise NICE. (2022) *Mental Wellbeing at Work*. Available from Mental wellbeing at work (nice.org.uk) World Health Organisation. (2020) *Doing What Matters in Times of Stress. An Illustrated Guide.* Available from: Doing What Matters in Times of Stress (who.int)
Associated Documents:	• ESHT People Strategy • Trust Health and Safety Policy • Dignity & Respect at Work Policy • Violence & Aggression Policy • Resolution Procedure • Freedom to Speak Up; Raising Concerns (whistleblowing) Policy • Attendance Management Policy • Flexible Working Policy • Agile Working Policy

Version Control Table

Version number and issue number	Date	Author	Reason for Change	Description of Changes Made
V1.0 2012151	April 2012	[redacted]	New policy for merge of Trusts	
V1.1 2012201	September 2012	[redacted] & Nicky Creasey	Minor changes. Approved by Chair, Health and Safety Steering Group	Updated 25/04/2013 following meeting with Moira Tenney and Paula Hunt
V1.2 2013120	May 2013	[redacted] & Nicky Creasey	Review and update required – Minor changes request for HSSG chairs action to approve – completed	Additions to monitoring table and text
V1.3 2013127	May 2013	Jennifer Newbury & [redacted]	Additional review following NHSLA requirements for level 2. Minor changes. Chairs action to approve 29th May – completed.	Requirement for annual departmental assessments. Additional audit standard and reporting requirements
V1.4	April 2015	Nicky Creasey following email confirmation from OH – [redacted] Dec 2014 no change to the policy	Review date and monitoring tool	Minimal corrections only
V2	March 2019	Liz Lipsham with Health & Safety representation	Rewrite to include a different approach to undertaking stress risk assessments and combining team and individual stress risk assessment templates	Agreement on recording and reporting of team stress risk assessments and content of policy
V2.1	Oct 2019	Liz Lipsham		Minor amendment to working in Appendix E 3.5 and 4.7
V2.2	June 2022	Liz Lipsham	This needs a full review, extension from May 22 to December 2022	Extended the review date
V3	July 2022	Liz Lipsham	Expiry date reached	Review of content to demonstrate current support available for staff. Change to title
V3.1	March 2023	Liz Lipsham	Update to Appendix C	Appendix C has been changed

Consultation Table

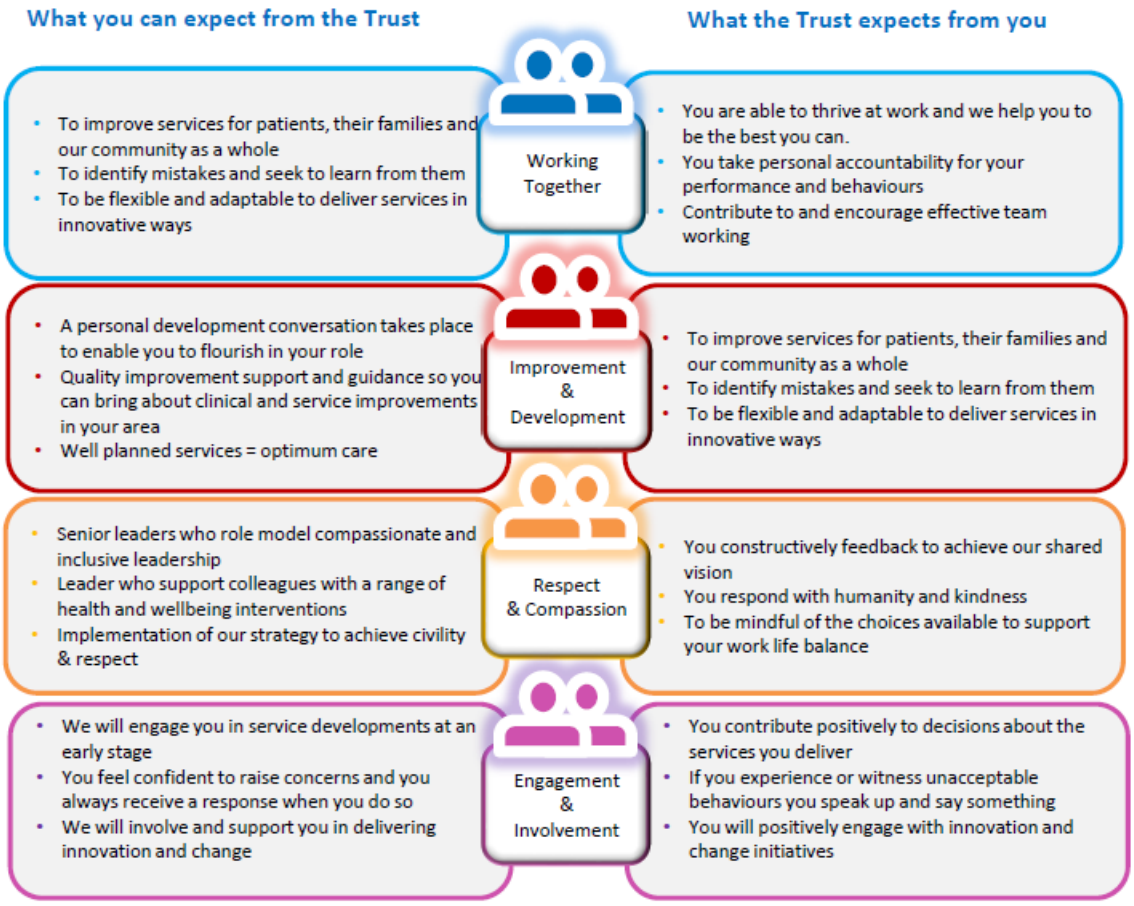
This document has been developed in consultation with the groups and/or individuals in this table:

Name of Individual or group	Title	Date
All members	OD, Staff Engagement & Wellbeing Senior Leads	Virtual agreement August 2022
Steve Aumayer	Chief People Officer	Virtual agreement August 2022
[redacted]	Deputy Director or Culture	Virtual agreement August 2022
Ruth Agg & Dominique Holliman	Freedom to Speak up Guardians	Virtual agreement August 2022
All members	Occupational Health Governance Group	Virtual agreement August 2022
All members	Staff Networks	Virtual agreement August 2022
All members	Health and Safety Steering Group	Aug 2022 Final ratification Nov 2022
All members	Workforce & People Policy Group	Sept 2022
All members	Policy Ratification Group	Dec 2022

This information may be made available in alternative languages and formats, such as large print, upon request. Please contact the document author to discuss

Table of Contents

Summary of our 'Charter': Positive outcomes



1.0 Introduction

1.1 East Sussex Healthcare NHS Trust is committed to protecting the health, safety and wellbeing of all its people by creating a psychologically safe work environment.

1.2 Trust objectives and strategies are aligned in supporting this endeavour as reflected in the People Strategy based on the NHS People Plan.

1.3 The Trust recognises that there may be times when an individual experiences excessive or prolonged pressure at work or who are experiencing psychological distress and/or suffering from mental ill-health/symptoms that are impacting on their ability to work. The Trust is committed to both minimising work-related stress and supporting staff, by ensuring there is access to appropriate services and resources.

1.4 Work pressures, personal issues, or a combination of both can impact on the psychological wellbeing of employees. This policy aims to actively support staff who experience psychological distress as a result of their work whilst also considering the needs of staff suffering from a mental health condition or symptoms, impacting on their ability to work.

2.0 Purpose

2.1 The purpose of this policy is to:

- Set out the Trusts approach and commitment to supporting the psychological wellbeing and safety of staff through a tiered infrastructure, (see appendix B).
- Promote psychological wellbeing and safety in every aspect of the organisation.
- Provide direction and guidance to staff and managers on the identification, prevention and management of work-related stress alongside the promotion of psychological wellbeing for all our People, (refer to section 5).
- Provide mechanisms to identify causes of work-related stress, in line with HSE standards and offer solutions to eliminate, mitigate or escalate these when found, (refer to section 5).
- Provide staff and managers with skills required to create an inclusive and compassionate approach to supporting staff experiencing psychological distress and/or suffering from mental ill-health symptoms that are impacting on their ability to work, (refer to section 5.4, 5.5, 5.6).
- Improve the working experience of all our People so that optimum care can be delivered to our patients and service users.
- It is the responsibility of all staff including temporary workforce and volunteers to promote a culture and climate that is inclusive, where each colleague feel that they are treated according to Trust values.
- It is the responsibility of managers to promote a culture and climate that is positive, inclusive, engaging and a psychologically safe working environment

that inspires each staff member / volunteer to thrive to develop their full potential.

2.2 The anticipated benefits from implementing this Policy include:

- Creation of a positive, inclusive culture and psychological safe working environment
- Collection of accurate intelligence indicating the sources of work-related stress at all levels of the organisation
- To gain a top-level overview of the areas where work-related stress is high or enduring, so that interventions to mitigate this can be considered
- Early identification of stress in individuals and teams and promotion of actions to alleviate or eliminate the causes
- Improved awareness about the possible causes of work-related stress and opportunities to promote positive psychological wellbeing and safety with our People
- Improved awareness and knowledge about psychological and mental distress and ways in which to both prevent and manage staff suffering from this in a compassionate and inclusive way
- Greater awareness of sources of support available to staff and teams
- Collection of accurate intelligence that indicate the sources of positive, inclusive and engaging culture and climate, and psychological safe working environment at all levels of the organisation.
- To gain a top-level overview and insight of the areas with positive, inclusive and engaging culture and climate, and psychological safe working environment at all levels of the organisation.

2.3 Principles

2.3.1 The Health and Safety Executive (HSE) identified six key 'Management Standards' that represent a set of conditions that reflect high levels of health, wellbeing, and organisational performance. These management standards provide a practical framework which comprises a series of 'states to be achieved'. (Refer to Appendix C)

2.3.2 This policy sets out an organisation-wide approach to promoting the psychological wellbeing of all employees. This approach should be reflected and integrated into all policies and practices concerned with managing our People, including those related to employment rights and working conditions.

2.3.3 The Trust has committed to endorsing the use of Team Stress Questionnaires and Individual Stress Risk Assessments for both teams and individuals to promote early identification of sources of work-related stress so that solutions and mitigations can be considered to reduce or eliminate these

2.3.4 The Trust has committed to endorsing the use of the Managers Stress Audit and Action Plan for managers to use as a tool to respond to unacceptable levels of work-related stress reported via the Team Stress Questionnaire. This promotes action around measures that can be implemented to reduce, eliminate or escalate, (where local solutions cannot be achieved), sources of work-related stress and identify interventions that can be applied to support staff who are experiencing unacceptable and prolonged levels of work-related stress.

2.4 Scope

2.4.1 This policy will apply to all staff working for East Sussex Healthcare NHS Trust including temporary workforce staff and volunteers

3.0 Definitions

Evotix (formerly ASSURE)

An online Health and Safety risk assessment platform and audit software used for the undertaking and recording of health and safety documentation including the Team Stress Questionnaire and Managers Stress Audit and Action Plan. (Currently Individual Stress Risk Assessments cannot be completed on the evotix system)

Compassionate Leadership

As defined by West, (2021), involves four components:
Attending – being present with and listening to those you lead,
Understanding – appraising situations through dialogue and reconciling conflicting perspectives
Empathising – feeling the distress and frustrations of those we lead without becoming overwhelmed
Helping – removing obstacles and providing resources to deliver high quality care

Management Standards

Standards indicated by the HSE that fall into 6 categories Demand, Control, Support (management and collegiate), Relationships, Role and Change, with associated goals to be achieved. (Appendix C)

Mental Health

Defined by World Health Organisation, (WHO), ‘as a state of wellbeing, in which the individual realises his, her, [or their], own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community’. ESHT acknowledges Mental health includes our emotional, psychological and social wellbeing.

Stress

For the purposes of the Policy, East Sussex Healthcare NHS Trust adopts the HSE’s definitions of stress:
‘Stress is the adverse reaction people have to excessive pressure or other types of demand placed on them’.

This includes:

Positive Stress - A manageable degree of stress which is short lived and feels like acceptable pressure and can be a motivating factor.

Negative Stress - Excessive stress or distress, which can occur when pressure becomes too excessive, is prolonged or happens too frequently.

Psychological Safety

An absence of fear which requires candour: where individuals can have productive disagreement and free exchange of ideas. Where all staff have the confidence to offer ideas and voice concerns. Where staff believe they can and must be forthcoming at work. It sets the stage for a more honest, more challenging, more collaborative and more effective work environment, (Edmonson, 2019)

Psychological Wellbeing

A core feature of mental health, psychological wellbeing can be defined as including enjoyment, pleasure, meaning, fulfilment, and happiness, as well as resilience (coping, emotional regulation and healthy problem solving)

4.0 Roles and Responsibilities

4.1 Chief Executive

The Chief Executive has overall responsibility for the management of health and safety at work in the organisation, and for the health, safety and welfare of employees and others who may be affected. This includes ensuring the implementation of effective, up to date policy arrangements for the assessment of risk to employees, guaranteeing that sufficient funds and resources are available to carry out the procedures and actions stated within this and related policies and supporting staff in the implementation of this policy.

4.2 Chief People Officer (CPO)

The Chief People Officer is the lead Executive for these policy arrangements within the Trust and is responsible for ensuring the implementation of this policy. In addition, the CPO ensures that the Human Resources Department performs effectively in its role to manage the workforce including their attendance at work, in a way that is in line with the purpose of this policy and the Trust Attendance Management procedure. This includes providing relevant data to monitor and evaluate reasons for absence including stress, which will provide guidance for the effectiveness of this policy and its procedures.

4.3 Human Resources Team will:

- Raise awareness of problems related to staff psychological distress and mental health through collection and analysis of workforce data.
- Communicate and promote relevant training programmes for staff and managers.

- Work with the Occupational Health team and local managers to effectively and compassionately manage absence resulting from stress and mental health issues in line with the Attendance Management Procedure.
- Work with the Occupational Health department and local managers to effectively and compassionately manage and support staff who experience difficulties in completing their substantive duties as a result of stress and mental health problems.
- Work with the Occupational Health department and local managers to effectively and compassionately manage and support staff experiencing psychological distress as a result of work.
- Collect, analyse and track data from staff leaving the Trust via exit interviews and leavers data in order to identify any areas of concern where interventions are required to improve working conditions or practices affecting our People.

4.4 Health and Safety Department will:

- Audit the undertaking of the Managers audit and action plan, (completed annually), through Occupational Health and Safety Management audits on a three-year risk-based cycle.
- Ensure an effective template for the undertaking of the Team Stress Questionnaire and Managers Stress Audit and Action Plan is available for use on the Evotix system.
- Identify potential advancements in the use of the Evotix system to further enhance information relating to work-related stress.
- Provide training for staff in the use of the Team Stress Questionnaire and Managers Stress Audit and Action Plan on the Evotix system.
- Provide expert advice and guidance on any legislative changes related to work-related stress that the Trust needs to be aware of.

4.5 Occupational Health will:

- Provide impartial advice to managers and staff in order to support the management of workplace stressors and contribute to the implementation of these policy arrangements.
- Work with the Human Resources team by offering specialist advice, in respect of employees suffering the effects of stress, on fitness to work and return to work strategies.
- Work with managers and Human Resources team to manage sickness absence as a result of stress or mental health.
- Provide onward referral and signposting for staff to relevant professionals and agencies as indicated. This includes specialist professionals if required e.g. counselling for those who have fled their home countries or counsellors trained in gender transitioning.
- Provide support and guidance to managers on the completion of Team Stress Questionnaires and Individual Stress Risk Assessments.

- Support, advise and guide managers and teams around possible mitigations to address the causes of work-related stress.

4.6 People Potential Manager, (within Engagement & Wellbeing Team), will:

- Regularly review the content and delivery of psychological wellbeing and trauma interventions provided by the Trust, leading on changes and adaptations, in order to meet the emerging needs of staff.
- Regularly review and evaluate the effectiveness of psychological wellbeing and trauma interventions provided by the Trust.
- Work with key stakeholders responsible for the delivery of psychological wellbeing and trauma interventions to ensure appropriate interventions for employees are offered within an acceptable timeframe.
- Work with key stakeholders responsible for the delivery of affiliated support services to ensure appropriate interventions for employees are offered within an acceptable timeframe.
- Work collaboratively with affiliated support services to agree mechanisms for staff user feedback and be the first point of contact for staff raising concerns about services received.
- Consider and act upon anonymised intelligence gathered as a result of both internal and external psychological wellbeing and trauma interventions and support services, that identify trends or themes indicating departmental or organisational issues of concern.

4.7 Wellbeing team will:

- Support and promote positive mental health and psychological wellbeing for staff in the workplace through a range of programmes.
- Ensure training for line managers includes the ability to promote mental health and psychological wellbeing and to be aware of the signs and symptoms of poor mental health and distress.
- Develop and deliver programmes that raise mental health awareness among employees.
- Encourage open conversations about mental health and psychological distress promoting the support available to employees if they are struggling.
- Act upon intelligence provided via workforce data and staff feedback in order to develop and amend wellbeing interventions for staff which may include taking into account culturally and socially different approaches to any interventions.
- Work with Occupational Health to provide interventions that support team and individual self-care and reduce stress.
- Work with Occupational Health to respond to staff need where areas of concern have been identified.

4.8 Divisional Leads will:

- Support and enable leaders within their area to create a psychologically safe culture where the wellbeing of staff is prioritised.
- Be responsible to act upon escalated concerns relating to work-related stress in areas that they manage, identifying and working towards solutions.
- Report through IPRs any areas of concern where work-related stress is prolonged and unacceptably high, providing detail as to the main causes of stress and the actions being taken to mitigate this.
- Consider actions to reduce causes of work-related stress and take responsibility to escalate issues that are beyond their sphere of control.
- Consider and support actions to reduce work-related stress and role model behaviours that are aligned with compassionate and inclusive leadership.

4.9 Divisional Governance Managers/Leads will:

- Ensure departments and teams within their area of responsibility are accurately recorded on Evotix and maintain a top-level overview, via Evotix, of annual Team Stress Questionnaires and Managers Stress Audits and Action Plans undertaken in their area ensuring a minimum 90% compliance.
- Provide a top-level overview to Divisional leads of recurring themes emerging from Team Stress Questionnaires, mitigating actions being implemented by managers and escalating any barriers or challenges in reducing work-related stress.
- Within quarterly Health & Safety report, highlight insights and any areas of concern regarding the management of work-related stress in teams within their area, reporting this back to the Health & Safety Steering Group, (HSSG).

4.10 Service and Line Managers will:

- Create a positive, inclusive and engaging culture and climate and psychologically safe working environment for staff / volunteers.
- Carry out wellbeing conversations as part on-going conversations and one-to-ones with their staff.
- Ensure teams are provided with the time and access to undertake a Team Stress Questionnaire on an annual basis or more frequently if indicated.
- Actively encourage and promote participation from all team members by highlighting the reasons and benefits for this approach.
- Consult and communicate to their teams the findings of the Team Stress Questionnaire and work with their teams to identify and implement changes with a view to mitigating work-related stress.
- Regularly review, update and adapt mitigating actions within the Managers Stress Audit and Action Plan with their teams in response to any work-based changes.
- Be responsible for escalating to their seniors, work-related stressors that are beyond their sphere of control, that are impacting on the psychological wellbeing of their staff.

- Review and repeat the Team Stress Questionnaire if prolonged or high levels of stress are identified.
- Respond to individual staff members who are experiencing stress by discussing the issues causing their stress, supporting them and if appropriate asking them to complete an Individual Stress Risk Assessment and offering the opportunity to complete the (dis)Ability and Health Passport.
- To consider interventions that will alleviate work-related stress as identified through risk assessment.
- To work with individual staff members in addressing work-related stressors identified within their stress risk assessment and consider referral to Occupational Health if stressors cannot be alleviated at a local level.
- To ensure new staff have a comprehensive induction, clearly defined roles and responsibilities with an early opportunity to clarify any issues.
- To promote and role model behaviours aligned with compassionate leadership and that promote psychological wellbeing and safety, actively encouraging staff to speak out if they are feeling stressed or their mental health is compromised.
- To promote use of clear, transparent and respectful communication within the team, particularly where there are organisational or procedural changes to ensure staff feel engaged and considered at every stage.
- To be familiar with and draw upon Trust resources to support individuals and teams during times when levels of stress are increased or anticipated to be so.
- To ensure that jobs are properly designed, with realistic demands and workloads and that expectations and job roles are clear.
- To ensure that staff are trained to undertake the demands of their job and are able to contribute to decisions about how the job is done.
- To ensure that there are regular opportunities to discuss work and obtain feedback on performance during regular one-to-one meetings and/or team meetings.
- To monitor working hours and annual leave to ensure that staff are not overworking and are taking appropriate breaks.
- To ensure that bullying and harassment is not tolerated and agreement around acceptable behaviours is clearly confirmed and communicated with staff and teams.
- To be alert to signs of staff experiencing difficulties and offer additional support to any member of staff who is known to be experiencing stress or mental ill health whether work related or not.

4.11 Employees will:

- Take responsibility for managing their own health and wellbeing, by adopting positive health behaviours.
- Improve their knowledge of stress so they feel able to take ownership of the issue by seeking information and making use of training and support offered by the organisation at an early stage.
- Bring to their managers attention any concern relating to their mental health or psychological wellbeing, this could be through completing the (dis)Ability and Health Passport.
- Actively participate in the Team Stress Questionnaire and contribute to identifying solutions that will resolve or alleviate work-related stressors.
- Contribute to a psychologically safe working environment by demonstrating Trust values and compassionate, inclusive behaviours to all colleagues.
- Access sources of additional support if required, actively engaging with services that will improve their mental health and psychological wellbeing.
- If ability to work is being affected by mental health or psychological distress, to request referral to the Occupational Health Department and engage with any support services being offered to them.

5.0 Procedures and Actions to Follow

In order to provide the appropriate direction and guidance to staff and managers on the identification, prevention and management of work-related stress the following questionnaire, assessment and plan should be adopted:-

5.1 Annual Team Stress Questionnaire

Managers are required to enable their teams to undertake an annual Team Stress Questionnaire which must be recorded in the appropriate section on the Evotix system. (Refer to Appendix D Team Stress Questionnaire Managers Guidance and Appendix E Team Stress Questionnaire Staff Guidance)

5.2 Evaluate Risk, Record Findings and Implement Plan.

See Appendix F for Responsibility Tree for Team Stress

The results from the Team Stress Questionnaire must be shared with all staff and arrangements made for consultation to confirm findings and evaluate the risk. Managers must review the results from the Team Stress Questionnaire and in consultation with their teams, complete a Managers Stress Audit and Action Plan to identify actions that will reduce or eliminate work-related stressors. This must be regularly reviewed and progress recorded.

Consideration can be given to other departmental data and whether there is any correlation with the Team Stress Questionnaire responses i.e. sickness absence, staff turnover, accidents/incidents.

Managers are responsible to lead on the implementation of any actions and to monitor and review these as necessary or where significant changes occur.

Communication and consultation with all members of the team is crucial to the success of this and should be delivered in a proactive, positive and inclusive way. Ensuring that all staff have a chance to engage and contribute to the process of identifying risks and offering suggestions to mitigate these will help to create a culture of psychological wellbeing and safety.

Managers should note that the results of the annual Team Stress Questionnaire will provide indicators as to work-related stress and as such they may want to explore issues in more detail with smaller groups of staff or as part of a wider divisional plan.

5.3 Individual Stress Risk assessments

The Individual Stress Risk Assessment, (Appendix G), should not be completed on the Evotix system. This can be found on the Trust Extranet.

Employees are encouraged to complete this with their line manager so that an open dialogue about work-related stress can be initiated and where ways to alleviate this can be discussed. If for any reason, this is not practicable, the employee can request that the assessment is completed with another line manager, senior colleague or their Human Resources representative.

A copy of an individual's stress risk assessment must be retained in the employee's personnel file. Should an individual wish to receive additional support in relation to work-related stress, they can ask their line manager to refer them to Occupational Health where a copy of their completed individual stress risk assessment should be enclosed. Occupational Health can then assist or signpost the employee as indicated and provide the line manager with guidance as to how best to support their employee.

Individual stress risk assessments should be used in the following instances:

- When an employee is displaying signs of stress or mental distress
- When an employee reports experiencing unacceptable levels of stress
- When an employee is absent from work due to stress. This should be completed during the return to work interview though can be utilised for staff who continue to be absent due to stress to aid their return to work
- If the Team Stress Questionnaire has indicated a cause for concern

Additional Support

5.4 Work-related Trauma

In recent years and accelerated by the COVID pandemic, the psychological impact of work-related trauma on teams and individual staff members has increased. Staff may experience this as a result of a Potentially Traumatic Event, (PTE), or as an accumulation of trauma at any level. It is widely recognised that the quality, content and governance arrangements around the interventions offered to staff following a PTE must be evidence-based and provided by appropriately trained staff. This is to avoid any unnecessary risk or further distress for the staff involved.

With that in mind the Trust has invested in specific evidence-based interventions to assess, support and manage staff who have experienced trauma as a result of work. Full details can be found on the Wellbeing pages of the Trust extranet but the following provides a summary of these interventions.

5.4.1 TRiM

TRiM is a means of supporting staff after a Potentially Traumatic Experience (PTE) or accumulation of experiences and to early identify symptoms of stress. TRiM is not a treatment for stress, however, processing and talking about the event can be beneficial.

Experiences may include: unexpected death of a patient or colleague, injury to staff, violence and aggression, major incidents, 'never events' and other potentially traumatic experiences. TRiM may not be appropriate for personal trauma or other forms of stress such as workload pressure where other support should be sought.

TRiM is delivered by ESHT staff who have been trained as TRiM Practitioners, from all levels within the organisation. They are not counsellors or therapists but they will provide a confidential space to talk about the experience and carry out a simple risk assessment to gauge how much stress may have been taken on board. The staff member may be offered a referral for the most appropriate source of support if necessary.

5.4.2 Defuse

Defusing is the immediate actions managers and shift leaders can take to support their staff following a potentially traumatic event at work. These actions may be deemed as common sense but under stressful conditions can be used as a guide to ensure staff are supported appropriately and that any staff who are significantly impacted are identified quickly.

It involves practical actions such as: checking in with staff and being present if possible immediately after the event, offering them the opportunity to take a break, ensuring they are ok and safe to travel home, enquiring if they have support once they leave work, following up with them the next day. It also prompts managers to follow up on affected staff within the next day or so and referring them to the TRiM team, Occupational Health, Wellbeing team or other supportive services offered by the Trust.

5.4.3 Psychological Wellbeing & GREP, GTEP for teams

Group Resilience Episode Protocol (GREP)
Group Traumatic Episode Protocol (GTEP)

This intervention is delivered by appropriately trained Therapists experienced in Trauma working alongside the Occupational Health and Staff Engagement & Wellbeing teams. It is offered to teams of staff who have recently shared a work-based trauma or accumulative work pressure. This was initially offered to support ESHT staff who worked through the COVID pandemic but is now being used to support staff as we all move forward. This programme has already been successfully rolled out to personnel working within the armed forces, the Police force, humanitarian workers and many others who face traumatic experiences in their work.

The Psychological Wellbeing intervention consists of:

- **Session 1: Debrief (2 hours)** Reflective space to give you the opportunity to pause and consider recent events
- **Session 2: GREP (90 mins)** Focus on resilience
- **Session 3: GTEP 1 (90 mins)** Focus on self-care
- **Session 3 GTEP 2 (90 mins)** Continued focus on self-care. Evaluation & post screening

5.5 Violence & Aggression

Issues related to violence & aggression within the workplace and guidance for staff and managers within such situations is covered in the Trust Violence & Aggression Policy. Please also refer to the dedicated Violence & Aggression pages on the Trust extranet for further details.

5.6 Mental Health First Aid

The Trust has invested in the Mental Health First Aid training and offers a rolling programme to any staff within the organisation. This provides a comprehensive, evidence-based training programme, that raises awareness about mental health issues and symptoms whilst providing advice and guidance on action and support that can be offered to staff suffering from mental distress.

6.0 Training

6.1 Principles of risk assessment and the methodology for undertaking risk assessments are covered in risk assessment training

6.2 Resources, guidance and interventions related to work-related stress and psychological wellbeing & safety can be found on the Wellbeing pages of the Trust extranet.

7.0 Monitoring Compliance with the Document

Monitoring Compliance with Psychological Safety & Wellbeing Policy

Element to be Monitored	Process for monitoring Lead	Tool for Monitoring	Frequency of monitoring	Responsible Individual/Group Committee for review of results/report	Responsible individual /group /committee for acting on recommendations / action plan	Responsible individual/group/ committee for ensuring action plan/lessons learnt are implemented
Annual Team Stress Questionnaire compliance	Ward managers/ Matrons/Team Leaders to facilitate completion of the Team Stress Questionnaire annually or more regularly if indicated.	Evotix	Yearly	Divisional Governance Lead	Divisional Governance Lead	• Ward managers/ Matrons/Team Leaders • Divisional Leads
Managers Stress Audit and Action Plan	Ward managers/ Matrons/Team Leaders to complete Managers Stress Audit and Action Plan in response to the Team Stress Survey	Evotix	Yearly and in response to Team Stress Questionnaire	Divisional Governance Lead	Divisional Governance Lead	• Ward managers/ Matrons/Team Leaders • Divisional Leads
Individual Stress Risk Assessments	Ward managers/ Matrons/Team Leaders		As required	Ward managers/ Matrons/Team Leaders	Ward managers/ Matrons/Team Leaders	• Ward managers/ Matrons/Team Leaders
Effectiveness of Policy:	• Number of departments completing yearly Team Stress Questionnaires along with Managers Stress Audit and Action Plan. • Results of staff survey • Management Referrals to Occupational Health with a reason code of work-related stress	Evotix NHS Staff Survey eOPAS	Yearly Yearly Monthly	HSSG POD Workforce Insights Group	Divisional Leads Divisional Leads Line Manager/OH/ HRBP	Divisional Leads Divisional Leads Line Manager/OH/ HRBP

8.0 Useful references and resources

Edmondson, A, C. (2019) *The Fearless Organisation*. USA: John Wiley and Sons.

Health & Safety Executive. (2022). *What are the Management Standards?* Available from What are the Management Standards? - Stress - HSE

NHS. (2020) *NHS People Plan*. Available from NHS England » Online version of the People Plan for 2020/2021

NHS. (2022) *NHS People Promise.* Available from NHS England » The Promise

National Institute for Health and Care Excellence, (NICE). (2022) *Mental Wellbeing at Work*. Available from Mental wellbeing at work (nice.org.uk)

Scott, K. (2019) *Radical Candor. How to get what you want by saying what you mean.* New York: Pan Books.

West, M. (2021) *Compassionate Leadership: Sustaining Wisdom, Humanity and Presence in Health and Social Care.* UK: The Swirling Leaf Press

World Health Organisation. (2020) *Doing What Matters in Times of Stress. An Illustrated Guide.* Available from: Doing What Matters in Times of Stress (who.int)

World Health Organisation Mental health (who.int)

Health & Safety Executive. A Talking Toolkit: Preventing work-related stress. This guides managers into having problem and solution focussed conversations with teams of staff

Health & Safety Executive. Tackling Stress: workbook for managers; This is a large document at nearly 60 pages. This includes detailed information around solutions and expectations

A Guide to Communication and Stress by stress.org.uk. Useful information for every member of staff in how their communication is affected by stress

Chartered Institute of Personnel and Development, (CIPD). Top tips for having a conversation about stress; guidance to support managers when a team stress assessment has identified individuals who need further support

Appendix A: Equality Impact Assessment Form

East Sussex Healthcare NHS Trust

Equality Impact Assessment Form

1. Cover Sheet

Please refer to the accompanying guidance document when completing this form.

Strategy, policy or service name	Psychological Wellbeing & Safety of Staff Policy
Date of completion	August 2022
Name of the person(s) completing this form	Liz Lipsham
Brief description of the aims of the Strategy/ Policy/ Service	To provide clarity on the Trusts commitment to promote psychological wellbeing and safety in every aspect of the organisation by providing direction and guidance to staff and managers on the identification, prevention and management of work-related stress alongside the promotion of psychological wellbeing for all our People
Which Department owns the strategy/ policy/ function	OD, Staff Engagement & Wellbeing Team.
Version number	V3
Pre-Equality analysis considerations	The Equality Act 2010, Human Rights Act 1998 and Public Sector Equality Duties 2011
Who will be affected by this work? **E.g. staff, patients, service users, partner organisations etc.**	All ESHT employees including temporary workforce staff and volunteers
Review date	3 years unless equality legislation changes
If negative impacts have been identified that you need support mitigating please escalate to the appropriate leader in your directorate and contact the EDHR team for	To whom has this been escalated? Name: Click here to enter text. Date: Click here to enter a date.

further discussion.	
Have you sent the final copy to the EDHR Team?	Yes

2. EIA Analysis

	☺ 😐 ☹	**Evidence:**
Will the proposal impact the safety of patients', carers' visitors and/or staff?	Choose: Positive	This policy sets out the Trusts position on supporting the psychological wellbeing of our staff whilst promoting a culture of psychological safety.
Equality Consideration *Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)*	Choose: Positive	**Race** ☒ · **Gender** ☒ · **Sexual orientation** ☒ · **Age** ☒ · **Disability & carers** ☒ **Gender reassignment** ☒ · **Marriage & Civil Partnership** ☒ · **Religion and faith** ☒ · **Maternity & Pregnancy** ☒ · **Social economic** ☒
Is the proposal of change effective?		Yes: That staff are enabled to work in an inclusive, compassionate and psychologically safe environment.
Equality Consideration *Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)*		**Race** ☒ · **Gender** ☒ · **Sexual orientation** ☒ · **Age** ☒ · **Disability & carers** ☒ **Gender reassignment** ☒ · **Marriage & Civil Partnership** ☒ · **Religion and faith** ☒ · **Maternity & Pregnancy** ☒ · **Social economic** ☒

<table>
<tr><td>What impact will this have on people receiving a positive experience of care?</td><td>Choose:
Positive</td><td>There is a wealth of evidence that demonstrates that the creation of psychologically safe environments within Healthcare lead to better quality care and standards for patients and service users.</td></tr>
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</td></tr>
<tr><td>Does the proposal impact on the responsiveness to people's needs?</td><td>Choose:
Positive</td><td>The purpose of this policy, in creating an inclusive, compassionate and psychologically safe working environment for staff supports the ability for staff to access support when required and/or identify any issues of concern at an early stage.</td></tr>
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<tr><td>What considerations have been put in place to consider the organisations approach on improving equality and diversity in the workforce and leadership?</td><td>Choose:
Positive</td><td>The trust have a number of programmes such as: New managers orientation, bite size training for managers where sessions on improving equality and diversity are delivered to managers

A robust governance structure is in place where reporting on workforce Equality Diversity and Inclusion objectives are reviewed at the People and Organisational Development Committee and Trust Board for assurance</td></tr>
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</td></tr>
<tr><td colspan="3">Access
Could the proposal impact positively or negatively on any of the following:</td></tr>
<tr><td>• Patient Choice</td><td>Choose:

Positive</td><td>Psychologically safe environments are known to provide better care for patients and service users. This in turn may lead patients to engage more positively in ESHT services.</td></tr>
<tr><td>• Access</td><td>Choose:

Positive</td><td>The purpose of the policy is to promote compassion and inclusivity: to support staff who are struggling with mental health or psychological distress in a non-judgemental and proactive way.</td></tr>
<tr><td>• Integration</td><td>Choose:

Positive</td><td>This policy promotes a culture of positivity for ESHT, where all staff feel safe and belong, knowing that they will be supported if they do experience mental ill health of psychological distress.</td></tr>
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<table>
<tr><td>Engagement and Involvement
How have you made sure that the views of stakeholders, including people likely to face exclusion have been influential in the development of the strategy / policy / service:</td><td>Choose:
Positive</td><td>• OD, Staff Engagement & Wellbeing Senior Leads
• Chief People Officer
• Deputy Director or Culture
• Freedom to Speak up Guardians
• Occupational Health Governance Group
• Staff Networks
• Health and Safety Steering Group
• Workforce & People Policy Group
• Policy Ratification Group</td></tr>
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</table></td></tr>
<tr><td>Duty of Equality
Use the space below to provide more detail where you have identified how your proposal of change will impact.</td><td>Choose:
Positive</td><td>The policy states expectations to all staff of the behaviours from them with regards to the culture in our organisation where psychological wellbeing, safety, compassion and inclusion is prioritised.</td></tr>
<tr><td>Characteristic</td><td>Rating
☺ ☹ 😐</td><td>Description</td></tr>
<tr><td>Race</td><td>Choose:
Positive</td><td>This policy has a positive impact for all staff regardless of their race or ethnicity</td></tr>
<tr><td>Age</td><td>Choose:
Positive</td><td>This policy protects staff from all age groups no matter what age they are as outlined in the Equality Act 2010</td></tr>
</table>

Disability and Carers	Choose: Positive	This policy has a positive impact on all staff that have a disability or long-term health condition. It links into the (Dis)Ability & Health Passport to enable adequate adjustment to take place and the Carers Passport to achieve a work life balance
Religion or belief	Choose: Positive	This policy has a positive impact on all staff who wish to observe religious practices and those that don't
Sex	Choose: Positive	This policy has a positive impact on staff no matter what their gender
Sexual orientation	Choose: Positive	This policy has a positive impact on staff no matter what their sexual orientation is.
Gender re-assignment	Choose: Positive	This policy has a positive impact on those that are transitioning from their gender assigned at birth to another gender.
Pregnancy and maternity	Choose: Positive	This policy has a positive impact on pregnancy, maternity and also including paternity rights with, The Employment Rights Act 1996 which sets out rights to health and safety, time off for ante-natal care, maternity leave and unfair dismissal.
Marriage and civil partnership	Choose: Positive	This policy does not have a negative impact on a member of staffs marital or civil partnership status

Human Rights

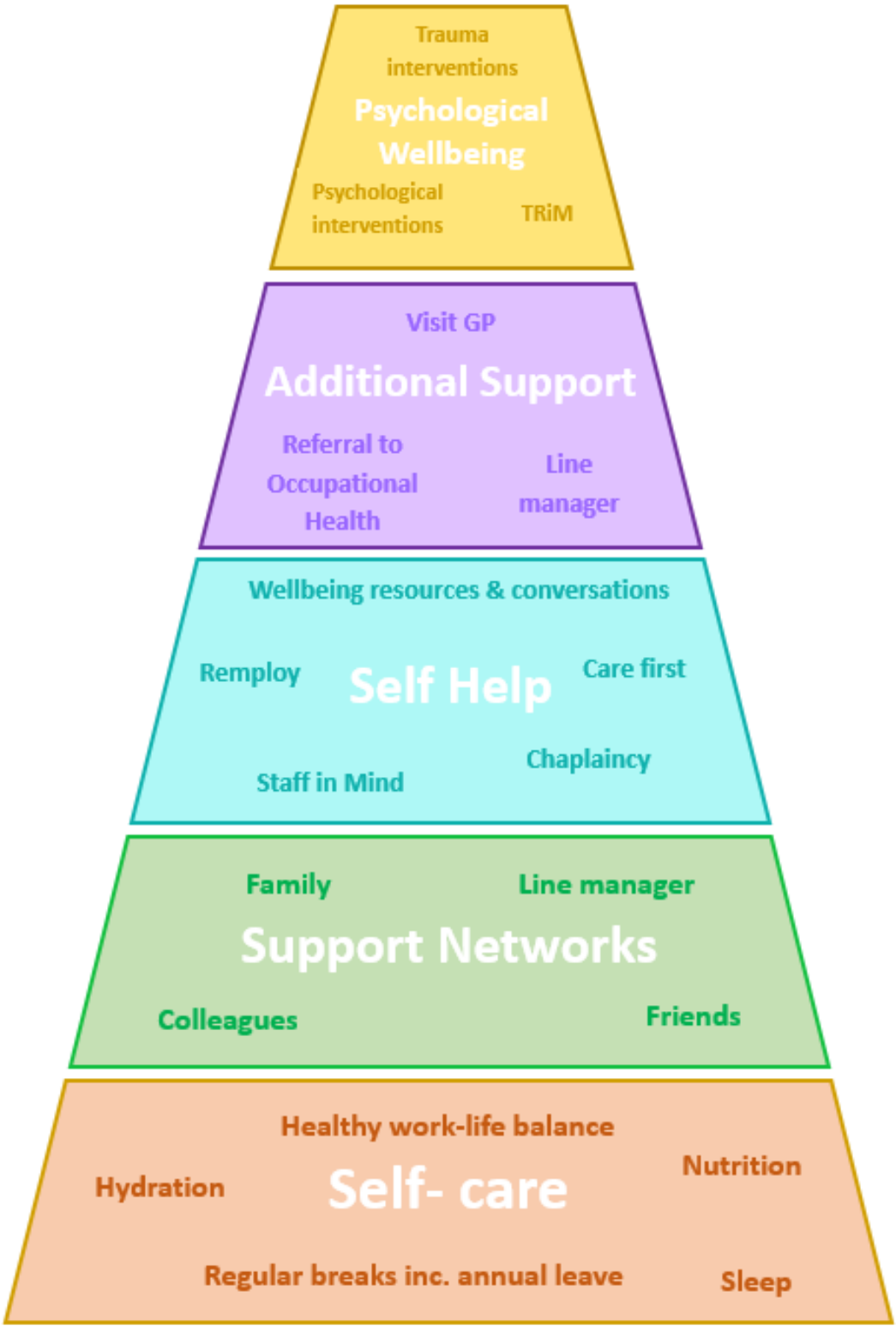
Please look at the table below to consider if your proposal of change may potentially conflict with the Human Right Act 1998

Articles		Y/N
A2	Right to life	**No**
A3	Prohibition of torture, inhuman or degrading treatment	**No**
A4	Prohibition of slavery and forced labour	**No**
A5	Right to liberty and security	**No**
A6 &7	Rights to a fair trial; and no punishment without law	**No**
A8	Right to respect for private and family life, home and correspondence	**No**
A9	Freedom of thought, conscience and religion	**No**
A10	Freedom of expression	**No**
A11	Freedom of assembly and association	**No**
A12	Right to marry and found a family	**No**
Protocols		
P1.A1	Protection of property	**No**
P1.A2	Right to education	**No**
P1.A3	Right to free elections	**No**

Appendix B: Infrastructure of Support

NHS
East Sussex Healthcare
NHS Trust

Pyramid of Staff Support



Appendix C

Team Stress Questionnaire
Managers Stress Audit & Action Plan
Managers Guidance

The Team Stress Questionnaire is an opportunity for you and your team to consider any aspects of work that may be causing stress. It should be completed annually but you have the option to undertake this again for your team at any point during the year if you wish to.

The process consists of two parts:

1. **Team Stress Questionnaire** – completed by all members of your team via the link on the Evotix, Portal (formerly ASSURE). Responses are anonymised so please reassure your team that they can feel confident in giving true and honest answers to the questions. All responses are then collated into a report that provides an overall picture for your team. To increase accessibility, these can be completed by staff using a PC, laptop or alternatively, using the QR code for a smartphone or tablet in the timeframe you have given them.
   https://uk.sheassure.net/esht/portal/portal/index

2. **Managers Stress Survey and Action Plan** – completed by you as the line manager on the Evotix system. This is found under 'Audits' on Evotix.

1. Team Stress Questionnaire

Planning and preparation:

It's important to consider the following points in preparation for your team completing the Team Stress Questionnaire:

- Ensure that you and your team know where to find the Team Stress Questionnaire on the Evotix Portal. Please see the QR code above.
- Consider when would be the best time of year for your team to complete the Team Stress Questionnaire. You may want to avoid doing this at the same time as the NHS staff survey, (October/November), so as not to cause any confusion.
- Once you have decided when you want to do this, give your team a set time to respond and clearly communicate this to **all of your team**. Three weeks is a good time frame for your team to complete the questionnaire but you may need to be mindful of annual leave so you can extend this if preferable for you and the team but do be clear about the timings.
- Inform your team in a positive way about the Team Stress Questionnaire: that it is an opportunity to share their views and have a voice rather than it being a task-based assessment.
- Consider enlisting key team members to encourage and motivate their colleagues to complete the survey. You may want to allocate them time to support their colleagues to do this.

The Results:

The actions you take following the outcome of the Team Stress Questionnaire are as important as completing the questionnaire itself.

Once you have reached the closing date you have set for your staff to complete the Team Stress Questionnaire, the anonymised responses are collated into an overall score for each question. There is also an overall score for each of the 7 stress management standards with a risk factor for each.

What are the results telling you?

You need to look at the results for your team by clicking on the Insights+ link (view) on the side toolbar of the Evotix system after logging in. Please contact Health and Safety if you cannot see this or do not have access esh-tr.healthandsafety@nhs.net

Review guidance and information:
Have a look at the information below for guidance around stress conversations and how to put together an action plan with your team based on the priorities that have emerged from the questionnaires.

The Occupational Health section of the extranet has information and resources for you and your team to access including:

- A Talking Toolkit: Preventing work-related stress. This guides managers into having problem and solution focussed conversations with teams of staff
- HSE, Tackling Stress: workbook for managers; This is a large document at nearly 60 pages but does have detailed information around what we need to try and achieve as well as potential solutions
- A Guide to Communication and Stress by stress.org.uk. Useful information for every member of staff in how their communication is affected by stress
- CIPD, Top tips for having a conversation about stress; guidance to support managers when a team stress assessment has identified individuals who need further support

Discussing solutions and actions:

You will need to consider what actions you can take to mitigate any work-related stressors that have been identified by the team, by **eliminating** or **reducing** these. If this is not possible you should **escalate** concerns to your line manager.

Ensure that you discuss the overall results of the Team Stress Questionnaire with your team and ask for their ideas as they are likely to know of possible solutions to some of the challenges they face during the course of their work.

You can approach this engagement in a number of ways that suit you and your team but managers have found the following approaches helpful:

- Feeding back questionnaire results during a team meeting
- Printing out and displaying on staff notice boards, the Insights+ report that clearly illustrate the main causes of work-related stress reported by the team
- Picking out the top three work-related stressors that have been identified by the team; putting each one onto a poster and asking staff to contribute ideas and solutions by writing on the poster. The talking toolkit from the HSE provides good examples and ideas for this.

2. Managers Stress Audit and Action Plan

Finding the template to use on Evotix

The Managers Stress Audit and Action Plan is found on the Evotix system by clicking on the 'Audit' button and 'New Record'.

The template is divided into 7 sections with a single statement in each. Score each question from 1 – 5 based on what Insights+ is telling you. There are only 5 factors as 0 is not used in the HSE survey
There is an overall score for each of the management standards which you should use when you complete the Managers Stress audit. These range from 1.00 to 5.00, using the number closest to the 'Main Findings' chart on your Evotix Insights report.
You can use some degree of discretion when assigning priorities for the actions: low, medium or high, relevant to the level of risk.

Scoring your Audit on Evotix

Insights Score is closest to	What this potentially means for each of the Standards	What you should score on the audit
1	There is a significant problem around this question and the team clearly have a lot of concerns. Almost all staff have answered negatively. It is longstanding and likely to continue	1
2	The team have raised several issues which have been longstanding and with a common theme. There doesn't seem to be any clear progress or headway on getting where we need to be for this issue.	2
3	Some concerns noted which may be different or a common theme that has been raised by less than half of the team. We need to act on this before it starts to become a problem.	3
4	The team response to this is quite good but we might need to undertake some further work around this standard just to be sure.	4
5	We are in a pretty good place. The question and outcome is fully met or very close and we have very few concerns that stress is caused by this factor.	5

The Insights report will also give you the ability to view the answers to each question within the standard. From this, you will be able to see which specific issue staff are reporting problems with.

Under each section on the Managers audit and action plan you can add a single action or multiple actions. You should only allocate actions for people within your service. The actions need to be proportionate and SMART, (Specific, Measurable, Achievable, Realistic, Timely).

The Main Findings chart indicates the standards that you may need to prioritise and the importance of these standards in terms of risk factors.

Appendix D: Team Stress Questionnaire Managers Guidance

East Sussex Healthcare NHS Trust

Team Stress Questionnaire
Managers Stress Audit & Action Plan
Managers Guidance

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The process consists of two parts:

3. **Team Stress Questionnaire** – completed by all members of your team via the link on the Evotix, Portal (formerly ASSURE). Responses are anonymised so please reassure your team that they can feel confident in giving true and honest answers to the questions. All responses are then collated into a report that provides an overall picture for your team
4. **Managers Stress Survey and Action Plan** – completed by you as the line manager on the Evotix system. This is found under 'Audits' on Evotix.

Planning and preparation:

It's important to consider the following points in preparation for your team completing the Team Stress Questionnaire:

- Ensure that you know where to find the Team Stress Questionnaire on the Evotix Portal
- Consider when would be the best time of year for your team to complete the Team Stress Questionnaire. You may want to avoid doing this at the same time as the NHS staff survey, (October/November), so as not to cause any confusion
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The Results:

The actions you take following the outcome of the Team Stress Questionnaire are as important as completing the questionnaire itself.

Once you have reached the closing date you have set for your staff to complete the Team Stress Questionnaire, the anonymised responses are collated into an overall score for each question. There is also an overall score for each of the 7 stress management standards with a risk factor for each.

What are the results telling you?

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Review guidance and information:

Have a look at the information below for guidance around stress conversations and how to put together an action plan with your team based on the priorities that have emerged from the questionnaires.

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- CIPD, Top tips for having a conversation about stress; guidance to support managers when a team stress assessment has identified individuals who need further support

Discussing solutions and actions:

You will need to consider what actions you can take to mitigate any work-related stressors that have been identified by the team, by **eliminating** or **reducing** these. If this is not possible you should **escalate** concerns to your line manager.

Ensure that you discuss the overall results of the Team Stress Questionnaire with your team and ask for their ideas as they are likely to know of possible solutions to some of the challenges they face during the course of their work.

You can approach this engagement in a number of ways that suit you and your team but managers have found the following approaches helpful:

- Feeding back questionnaire results during a team meeting
- Printing out and displaying on staff notice boards, the Insights+ report that clearly illustrate the main causes of work-related stress reported by the team
- Picking out the top three work-related stressors that have been identified by the team; putting each one onto a poster and asking staff to contribute ideas and solutions by writing on the poster. The talking toolkit from the HSE provides good examples and ideas for this.

Managers Stress Audit and Action Plan

Finding the template to use on Evotix

The Managers Stress Audit and Action Plan is found on the Evotix system by clicking on the 'Audit' button. The template is divided into 7 sections with a single statement in each. Score each question from 1 – 5 based on what Insights+ is telling you. There are only 5 factors as 0 is not used in the HSE survey

There is an overall score for each of the management standards which you should use when you complete the Managers Stress audit. These range from 1.00 to 5.00, using the number closest to the 'Main Findings' chart on your Evotix Insights report. You can use some degree of discretion when assigning priorities for the actions: low, medium or high, relevant to the level of risk.

Insights Score is closest to	**What this potentially means for each of the Standards**	**What you should score on the audit**
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The Insights report will also give you the ability to view the answers to each question within the standard. From this, you will be able to see which specific issue staff are reporting problems with.

Under each section on the Managers audit and action plan you can add a single action or multiple actions. You should only allocate actions for people within your service. The actions need to be proportionate and SMART, (Specific, Measurable, Achievable, Realistic, Timely).

The Main Findings chart indicates the standards that you may need to prioritise and the importance of these standards in terms of risk factors.

Appendix E: Team Stress Questionnaire Staff Guidance

East Sussex Healthcare NHS Trust

Team Stress Questionnaire Staff Guidance

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The process consists of two parts:

1. **Team Stress Questionnaire** – completed by all members of the team via the link on the Evotix Portal. Responses are anonymised but only if completed on the Portal so please be assured in feeling confident to give true and honest answers to the questions. All responses are then collated into a report that provides an overall picture for your team
2. **Managers Stress Audit and Action Plan** – completed by your line manager on the Evotix system. This is found under 'Audits' on Evotix.

Planning:

- Your line manager will advise you as to where to find the Team Stress Questionnaire on the **Evotix portal**
- Please choose your area of work and team from the drop-down menu on the Evotix system. Please do this carefully so that your questionnaire goes to the right area. (Ask your manager for guidance if you are unsure)
- Your line manager will allocate a set time for you to respond
- This is a great opportunity to share your views and have a voice about how work can impact on your wellbeing

Results:

- When the closing date for your Team Stress Questionnaire arrives, your line manager will access a report combining all the responses from everyone within your team
- Your line manager will then discuss the results of the Team Stress Questionnaire with you and your colleagues and ask you for your ideas as to how to eliminate or reduce any work-related stressors. If this is not possible, your line manager will agree with you what aspects may need to be escalated to your senior managers
- We encourage this approach as we know that you are likely to have solutions to some of the challenges you face during the course of your work that may be causing you stress

Please be aware that undertaking this Team Stress Questionnaire may cause you to feel unsettled so do seek out support from colleagues and your line manager or look at the Wellbeing resources on the Extranet for other sources of support.

Appendix F - Responsibility Tree for Team Stress

NHS
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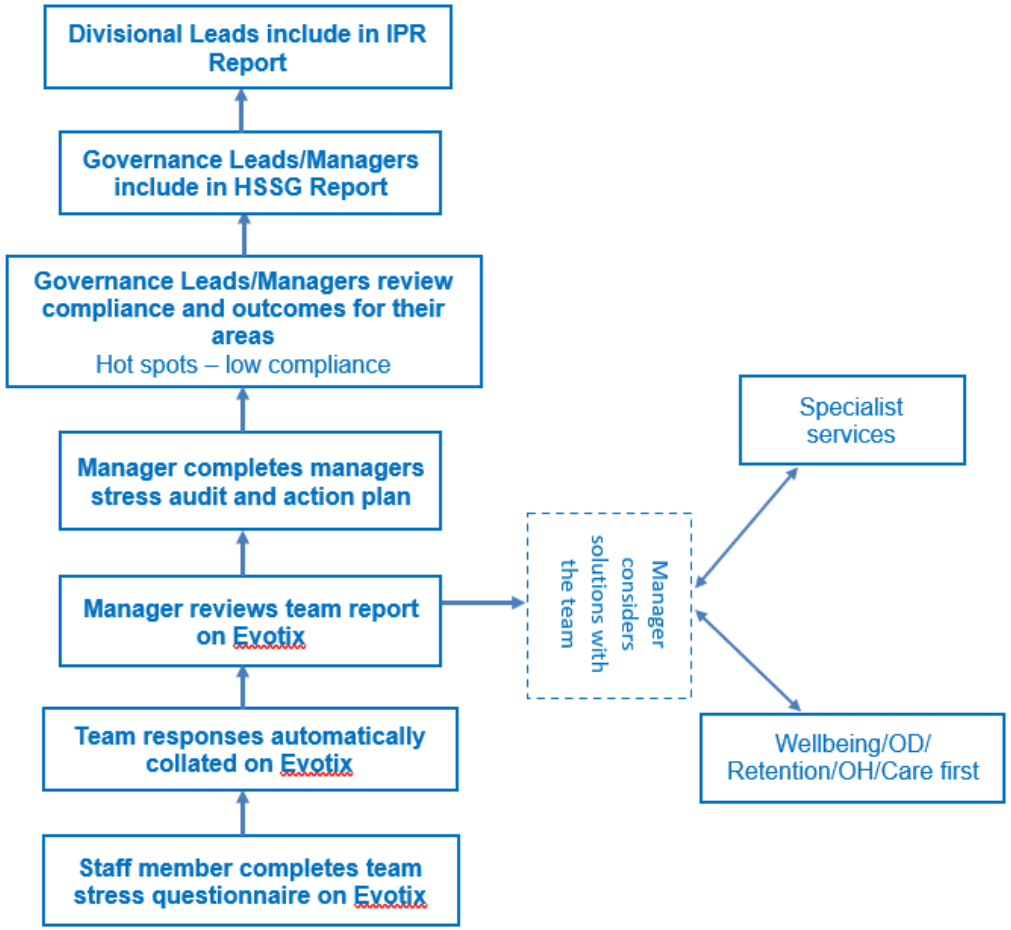
Responsibility Tree for Team Stress



Appendix G Individual Stress Risk Assessment.

East Sussex Healthcare
NHS Trust
Occupational Health
What matters to you, matters to us all

Individual Stress Risk Assessment

Please save a copy of this stress risk assessment on the employee's personnel file.
Individual stress risk assessments should not be recorded on Evotix

Stress Risk Assessment	
Demands: Employees are able to cope with the demands of their jobs	**Answer (Yes/No)**
1.1. The organisation provides employees (including managers) with adequate and achievable workload	
Comments:	
1.2. Job demands are assessed in terms of quantity, complexity and intensity and are matched to people's skills and abilities.	
Comments:	
1.3. Employees have the necessary competencies to be able to carry out the core functions of their job.	
Comments:	
1.4. Employees who are given high demands are able to have a say over the way the work is undertaken (see standard on Control).	
Comments:	
1.5. Employees who are given high demands receive adequate support from their managers and colleagues (see standard on Support).	
Comments:	
1.6. Repetitive and boring jobs are limited, so far as reasonably practicable.	
Comments:	
1.7. Employees are not exposed to poor physical working environment (the organisation has undertaken a risk assessment to ensure that physical hazards are under	

appropriate control).	
Comments:	
1.8. Employees are not exposed to physical violence or verbal abuse.	
Comments:	
1.9. Employees are provided with mechanisms which enable them to raise concerns about health and safety issues (e.g. dangers – real or perceived), working conditions and work patterns and where necessary appropriate action is taken.	
Comments:	
Control: Employees have a say about the way they do their work	**Answer (Yes/No)**
2.1. The organisation provides employees with the opportunity to have a say about the way their work is undertaken.	
Comments:	
2.2. Where possible, the organisation designs work activity so that the pace of work is rarely driven by an external source (e.g. a machine).	
Comments:	
2.3. Where possible, employees are encouraged to use their skills and initiative to complete tasks.	
Comments:	
2.4. Employees are supported, even if things go wrong.	
Comments:	
2.5. Employees are able to exert a degree of control over when breaks can be taken.	
Comments:	
2.6. Employees are able to make suggestions to improve their work environment and these suggestions are given due consideration.	
Comments:	
Support: Employees receive adequate information and support from their Managers and Peers, (you may wish to comment separately for both).	**Answer (Yes/No)**
3.1. The organisation provides employees (including managers) with adequate support at work.	
Comments:	

3.2. There are systems in place to help employees (including managers) provide adequate support with their staff or colleagues.	
Comments:	
3.3. Employees are encouraged to seek support at an early stage if they feel as though they are unable to cope.	
Comments:	
3.4. The organisation has systems to help employees with work-related or home-related issues and employees are aware of these.	
Comments:	
3.5. If there has recently been a traumatic or stressful event in the department the process for supporting staff has been followed: Datix completed, signposted to Wellbeing extranet page for TRiM or additional support, signposted to Violence & Aggression extranet page for guidance, referral to Occupational Health considered.	
Comments:	
Relationships: Employees are not subject to unacceptable behaviour e.g. bullying at work	**Answer (Yes/No)**
4.1. The organisation has in place agreed procedures to effectively prevent, or quickly resolve, conflict at work.	
Comments:	
4.2. These procedures are agreed with employees and their representatives and enable employees to confidentially report any concerns they might have.	
Comments:	
4.3. The organisation has a policy for dealing with unacceptable behaviour at work. This has been agreed with employees and their representatives.	
Comments:	
4.4. The policy for dealing with unacceptable behaviour at work has been widely communicated in the organisation.	
Comments:	
4.5. Consideration is given to the way teams are organised to ensure that they are cohesive, have a sound structure, clear leadership and objective.	

Comments:	
4.6. Employees are encouraged to talk to their line manager, employee representative, and external provider about any behaviour that is causing them concern at work.	
Comments:	
4.7. Individuals in teams are encouraged to be open and honest with each other.	
Comments:	
Role: Employees understand their role and responsibilities	**Answer (Yes/No)**
5.1. The organisation ensures that, so far as possible, the demands it places upon employees (including managers) do not conflict.	
5.2. The organisation provides induction for employees to ensure they understand their role within the organisation.	
Comments:	
5.3. The organisation ensures that employees (including managers) have a clear understanding of their roles and responsibilities in their specific job (this can be achieved through a plan of work).	
Comments:	
5.4. The organisation ensures that employees understand how their job fits into overall aims and objectives of the organisation/department/unit.	
Comments:	
5.5. Systems are in place to enable employees to raise concerns about any uncertainties or conflicts they have in their role.	
Comments:	
5.6. Systems are in place to enable employees to raise concerns about any uncertainties or conflicts they have about their responsibilities.	
Comments:	
Change: Employees are engaged frequently by the organisation when undergoing an organisation change	**Answer (Yes/No)**
6.1. The organisation ensures that employees (including managers) understand the reason for proposed changes.	
Comments:	
6.2. Employees receive adequate communication during the	

change process.	
Comments:	
6.3. The organisation builds adequate employee consultation into its change programme and provides opportunities for employees to comment on the proposals.	
Comments:	
6.4. Employees are made aware of the impact of change on their jobs.	
Comments:	
6.5. Employees are made aware of the timetable for action and the proposed first steps of the changing process.	
Comments:	
6.6. Employees receive support during the change process.	
Comments:	
Conclusion	
Conclusion	
Risk:	
Actions to eliminate, reduce or escalate work-related stressors:	

Appendix H: Psychological Safety