**RDA****SH ESTABLISHMENT CONTROL FORM – VACANCIES**

In order to manage and control recruitment costs and ‘at risk’ processes, this document must be completed in order to seek approval to fill all vacancies.

**Section 1 – Information about the Vacancy to be Filled**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Title of Post: | |  | | | | | | | | | | | |
| Care Group/Directorate : | |  | | | | | | | | | | | |
| Department/Team: | |  | | | | | | | | | | | |
| Base/location | |  | | | | | | | | | | | |
| ESR Position Number | |  | | | | | | | | | | | |
| Is the post holder required to access a care home? | |  | | | | | | | | | | | |
| Hours per Week | |  | | WTE | |  | | | A4C Band | | |  | |
| Permanent |  | Fixed Term | |  | | Fixed Term Duration | | | |  | | | |
| Reason for Fixed Term Post | |  | | | | | | | | | | | |
| Direct  Replacement |  | Revised Post |  | | New Post (existing funding) | | |  | | | New Post (new funding) | |  |
| If replacement, specify the date the post became vacant: | |  | | | | | Name of previous post holder: | | | |  | | |

**Section 2 – Extending Fixed Term Posts or making Fixed Term Posts Permanent**

|  |  |  |  |
| --- | --- | --- | --- |
| Title of Post: |  | | |
| Care Group/Directorate : |  | | |
| Department/Team: |  | | |
| Base/location |  | | |
| Position Number |  | | |
| Date Current Fixed Term Ends |  | Extend Fixed Term For/Until |  |
| Make Post Permanent From |  | | |
| Reason for Extension or Making Permanent |  | | |

**Section 3 – Impact of non-approval**

|  |
| --- |
| *Please explain why the post should be filled, include justification of continuation of post/band/hours* |

|  |  |  |  |
| --- | --- | --- | --- |
| Name of originating manager: |  | Date: |  |
| Signature of originating manager: |  | Contact number: |  |

**Section 4 – Authorisation to be completed by Head of Department**

I confirm and verify that the information above is correct and that the post is a necessary requirement to maintain service delivery.

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Head of Department: |  | Date: |  |
| Signature of Head of Department: |  | Contact number: |  |

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**Section 5 – Authorisation to be completed by Assistant Director (or equivalent)**

|  |  |  |  |
| --- | --- | --- | --- |
| *Please add comments in support of or to add further detail to manager comments.*  Comments | | | |
| Name of Assistant Director (nominee): |  | Date: |  |
| Signature of Assistant Director (nominee): |  | Contact number: |  |

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**Section 6 – Authorisation to be completed by Finance Department**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Will existing department budget cover all costs? | | | Yes/No | | | If no, how will this post be funded? Give details below? | | | | | | | | | | | |
| Cost Code: |  |  | |  |  | |  |  | Subjective Code: |  |  |  |  |  |  |  |

|  |  |
| --- | --- |
| Comments |  |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Finance Manager: |  | Date: |  |
| Signature of Finance Manager: |  | Contact number: |  |

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**Section 7 – Authorisation to be completed by HR Department**

I confirm this post has been agreed as part of the core structure

|  |  |
| --- | --- |
| Comments |  |
|  |

Could this post be considered for ‘at risk’ staff Yes/No

|  |  |  |  |
| --- | --- | --- | --- |
| Name of HR practitioner: |  | Date: |  |
| Signature of HR practitioner: |  | Contact number: |  |