Maidstone and Tunbridge Wells NHS
NHS Trust

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NHS Trust

Ref: FOI/CAD/ID 3196

Please reply to:
FOI Administrator
Trust Management
Service Centre
Maidstone Hospital
Hermitage Lane
Maidstone
Kent
ME16 9QQ
Email: mtw-tr.foiadmin@nhs.net

20 April 2016

Freedom of Information Act 2000

I am writing in response to your request for information made under the Freedom of Information Act 2000 in relation to policy's regarding confidentiality, equal opportunities, codes of practice, health and safety and training

Please may I have the policy's regarding confidentiality, equal opportunities, codes of practice, health and safety and training?

Please see the attached policy's as requested.

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Confidentiality Code of Conduct

Requested/ Required by:	Workforce and the Data Protection Officer
Main author:	Information Governance Lead
Document lead:	Director of Health Informatics **Contact Details:** Ext. 28511
Directorate:	Corporate
Specialty:	Trust Management
Supersedes:	Code of Confidentiality (Version 2.0: March 2013)
Approved by:	Information Governance Committee, 19 November 2014

Ratification by: Not required

Review date: November 2017

Document history

Requirement for document:	• To comply with guidance issued by the Health and Social Care Information Centre • Confidentiality: NHS Code of Practice • The Data Protection Act 1998
Cross references:	• Confidentiality: NHS Code of Practice • The Data Protection Act 1998 • The NHS Care Record Guarantee • The Caldicott 2 Review Report
Associated documents:	

Version Control:		
Issue:	**Description of changes:**	**Date:**
1.0	None - new policy	11 February 2009
2.0	Reviewed – no amendments made.	13 March 2013
3.0	Major rewrite – adoption of exemplar text from the Health and Social Care Information Centre	19 November 2014

Statement for

Confidentiality Code of Conduct

Confidentiality is a legal, contractual and ethical obligation.

The Code applies to everyone involved in providing health services at the Trust even if they are not employed by the Trust, work as a volunteer or are in training.

You are obliged to comply with the NHS Code of Practice and the Trust's Confidentiality Code of Conduct, which supports the NHS Code. Breach of this Code may result in disciplinary action up to and including dismissal. It could result in sanctions for professional misconduct, and could result in legal action against the individual concerned.

You should be aware of your confidentiality obligations under:

- the Common Law Duty of Confidentiality;
- the Data Protection Act 1998 and, where relevant;
- your professional code of ethics.

Everyone involved in healthcare has a duty of confidentiality to the people in their care and this applies to all those involved in providing that care, not just to clinicians.

Confidentiality applies not just to healthcare information. It applies to any form of personal information.

Under normal circumstances, you should not disclose confidential information to anyone who does not have a need-to-know. Usually this means those directly involved in the healthcare of a patient.

A patient has the right to say who can see their personal information and to restrict access.

Individuals have a right to know why their personal information is being collected and what it will be used for. Normally, explicit consent must be obtained for uses other than those originally stated or expected.

You have a right and a duty to raise with the Trust any matters of concern you may have about issues concerned with the delivery of care or services to our patients. This includes any issues or concerns regarding confidentiality.

Your duty of confidentiality remains even after you stop working for the Trust, for whatever reason. This applies even if you move on to another NHS organisation.

Questions and issues regarding the use of personal information, whether healthcare-related or not, should be directed to the Trust's Data Protection Officer.

Questions and issues regarding the sharing of personal or confidential healthcare information should be directed to the Trust's Caldicott Guardian.

1. Introduction

Everyone working for or in the organisation is under a legal duty to keep patients' and employees personal information confidential. Patients who believe their confidence has been breached may make a complaint to the organisation and they could take legal action.

This Code of Conduct applies to all persons involved in the provision of services at the Trust whether they are employees of the Trust, employees of a third party, contractors or voluntary workers, hereafter referred to as 'staff'. It applies whether the individual is directly involved in patient healthcare, such as a clinician, or indirectly involved, such as a hospital finance administrator. For example, the Code applies to all doctors and medical staff, even those in training.

2. Purpose

This Confidentiality Code of Conduct has been produced to ensure all staff members at Maidstone and Tunbridge Wells NHS Trust are aware of their legal duty to maintain confidentiality, to inform staff of the processes in place to protect personal information; and to provide guidance on disclosure obligations.

3. Scope

The code is concerned with protecting personal information, and applies equally to patients' and staff personal information. Personal information is data in any form (paper, electronic, tape, verbal, etc) from which a living individual could be identified; including name, age, address, and personal circumstances, as well as sensitive personal information like race, health, sexuality, etc. Although the Data Protection Act 1998 is only relevant to the personal information of living individuals, this code also covers information about deceased patients. The code applies to all staff including permanent, temporary, and locum members of staff.

4. Recognise your obligations

A duty of confidence arises out of the common law duty of confidence, employment contracts and for registered health professionals, it is part of your professional obligations. Breaches of confidence and inappropriate use of records or computer systems are serious matters which could result in disciplinary proceedings, dismissal and possibly legal prosecution. So, make sure you do not:

- Put personal information at risk of unauthorised access;
- Knowingly misuse any personal information or allow others to do so;
- Access records or information that you have no legitimate reason to look at this includes records and information about you, your family, friends, neighbours and acquaintances.

5. Keep personal information private

Make sure you comply with the following staff guidelines which set out practical things you should do to keep personal information protected:

- Good record keeping (see Record management procedures);
- Appropriate use of computer systems (see Access control procedure);
- Secure use of personal information (see Information handling procedures);
- Reporting information incidents (see Incident management procedure);
- Using mobile computing devices.

6. Disclose with appropriate care

Maidstone and Tunbridge Wells NHS Trust will ensure that patients are adequately informed about the use and disclosure of their personal information in a leaflet. This will tell them why, how and for what purpose personal information is collected, recorded and used by the organisation. You should ensure you are familiar with the patient information material and ensure you seek advice from the Head of Information Governance if patients have questions you are unable to answer.

If you are authorised to disclose personal information you should ensure you do so in accordance with the **Information handling procedures** and you must only:

- Share with those with a legitimate right to see/hear the information;
- Transfer in accordance with the organisation's secure transfer methods;
- Disclose the minimum necessary to provide safe care.

If you are authorised to disclose information that can identify an individual patient for non-healthcare purposes (e.g. research, financial audit) you must only do so if:

- You have the patient's explicit consent;
- The consent is written - to ensure there is no later dispute about whether consent was given.

Under the common law duty of confidence, identifiable personal information may be disclosed without consent in certain circumstances, these are:

- Where there is a legal justification for doing so, e.g. to comply with an Act of Parliament (statute) or court order;
- Where there is a public interest justification - i.e. where the public good that would be achieved by the disclosure outweighs both the obligation of confidentiality to the patient concerned and the broader public interest in the provision of a confidential service.

You must refer all requests for disclosure of personal information without the consent of the patient, including requests from the police, to the organisation's Head of Information Governance.

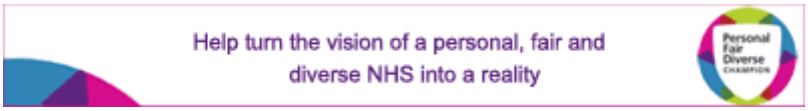
7. Approval

This code has been approved by the undersigned and will be reviewed on a 3 yearly basis.

Name	**Information Governance Committee**
Date approved	**19 November 2014**
Review date	**November 2017**

Equality and diversity policy and procedure (incorporating Single Equality Scheme (SES))

Requested/ Required by:	Workforce Committee
Main author:	HR Business Partner
Other contributors:	Staff Side Representative
Document lead:	HR Business Partner **Contact Details:** 01892 635663
Directorate:	Corporate
Specialty:	Workforce
Supersedes:	Single Equality Scheme (Version 1.0, April 2011)
Approved by:	HR Senior Meeting, 20 August 2013
Ratified by:	Workforce Committee, 9 September 2013
Review date:	September 2018 or sooner if legislation or other circumstances change



Document history

Requirement for document:	We have a responsibility to ensure that we do not discriminate either in the recruitment and retention of staff or in the services we provide. Some of the legislation which supports our work with equalities and diversity includes: • The Disability Discrimination Act 1995 (DDA) • The Race Relations Act 1976 (as amended) • The Sex Discrimination Acts 1975 & 1986 (SDA) • The Gender Recognition Act 2004 • The Carers (Equal Opportunities) Act 2004 • The Equality Act 2006 • The Civil Partnership Act 2004 • The Human Rights Act 1998 (HRA) • The Equal Pay Act 1970 (EPA) • The Employment Equality (Religion & Belief) Regulations 2003 • The Employment Equality (Sexual Orientation) Regulations 2003 • The Employment Equality (Age) Regulations 2006 • The Equality Act (Sexual Orientation) Regulations 2007 • The Racial and Religious Hatred Act 2006 This legislation places specific obligations on public sector organisations, which we cannot ignore. These are mandatory requirements, known as general and specific duties. The aim of the duty is to make equality central to the way public authorities work, and to put it at the heart of policymaking, service delivery and employment practice. The duty has three key aspects: 1. To eliminate unlawful or unfair discrimination or harassment 2. To promote equality of opportunity for all 3. To promote good relations between people from different minority groups. In meeting the duty, MTW has elected to produce a Single Equality Scheme (SES) which encompasses all six areas of legislation.
Cross references:	• Department of Health. (2009). Single Equality Scheme 2009-2012
Associated documents:	• Maidstone and Tunbridge Wells NHS Trust. *Equality and Human Rights Policy* [RWF-OPPPCS-NC-WF11] • Maidstone and Tunbridge Wells NHS Trust. *Equality and Human Rights Procedure* [RWF-OPPPCS-NC-WF49] • Maidstone and Tunbridge Wells NHS Trust. *Equality Impact Assessment Toolkit* [RWF-OWP-APP575]

Version Control:

Issue:	Description of changes:	Date:
1.0	First version of this policy (Single equality scheme [RWF-OPPPCS-NC-WF14])	April 2011
2.0	Reviewed and updated; Single equality scheme incorporated into this policy and procedure	September 2013

Equality and diversity policy

Maidstone & Tunbridge Wells NHS Trust is proud to serve a diverse population and to employ a diverse workforce. It is fully committed to promoting equality of opportunity, access, dignity and respect in the services it provides and in its workforce strategy and employment practices.

We know that discrimination and poor access can have a detrimental impact upon the health of communities and that the needs of those communities and how they experience the NHS differ. Therefore our Single Equality Scheme (SES) (see **Appendix 4**) sets out plans to address any potential for discrimination. It also sets out our action plans (see **Appendix 5**) for equality and diversity in terms of race (ethnicity), disability, age, gender, sexual orientation, religion and belief.

The Single Equality Scheme outlines the Trust's objectives and actions over the next 3 years and includes its duties in respect of the specific strands of equality legislation.

The Single Equality Scheme will provide internal strategic direction, challenge attitudes and assumptions, encourage strategic partnerships, widen ownership and demonstrate commitment, particularly from the Trust's leadership. The scheme has taken on board the contributions of staff and community stakeholders in its development to reflect the priorities and concerns of diverse communities.

By adopting this Single Equality Scheme, the Trust Board has clearly acknowledged its support and commitment for the Scheme and the delivery of the action plans.

Glenn Douglas
Chief Executive Officer

Tony Jones
Chairman

September 2013

Equality and diversity procedure

Contents

Appendix	Title
4	Single Equality Scheme
5	Singe Equality Scheme action plans
6	Equality Impact Assessments Toolkit

1.0 Introduction and scope

Maidstone & Tunbridge Wells NHS Trust is committed to delivering the very highest standards of access and care to patients from a diversity of cultures, different age groups and with a wide range of abilities and needs. We want to lead in the field of equality, diversity and human rights within the local healthcare economy and the community that we serve to become the healthcare provider of choice.

We are equally committed to being the employer of choice for existing employees and those wishing to work for us, enabling every individual working within the Trust to maximise their potential and contribution to the organisation.

The Single Equality Scheme (see **Appendix 4**) underpins the Trust's Equality & Diversity Policy and Procedure and ensures that clear objectives and action plans (see **Appendix 5**) are in place to support our commitment to ensure that we proactively develop a culture which is diverse; where individual differences are valued and respected; and to develop our services and workforce to reflect the communities that we serve.

We will take all reasonable steps to ensure there is no unlawful or unfair discrimination towards patients, communities and staff in relation to the nine characteristics protected by the Equality Act 2010:

- Age
- Disability including physical and mental impairment
- Gender re-assignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race including nationality and ethnicity
- Religion or belief
- Sex
- Sexual orientation

2.0 Definitions

2.1 People who are protected from discrimination on the basis of any of the nine characteristics listed above are described in this document as belonging to one or other "protected group".

3.0 Duties

3.1 **Members of staff** are expected to observe this policy, regardless of their role or employment status, and to behave appropriately towards other staff members and members of the public, in particular they are expected to:

- Support and implement the principles of equity and fairness
- Report any incident or behaviour which contravenes this policy and not indirectly support unfair treatment by ignoring what is happening around you
- Treat all staff, managers, patients, visitors and members of the public with dignity and respect

3.2 **Managers** have a responsibility for ensuring that this policy is fairly and consistently applied by them and they should ensure that:

- They are aware of the contents and importance of observing the principles of equality and diversity
- They eliminate any unfair practices of which they are aware, whether or not a complaint has been made
- Any allegations of discriminatory behaviour or practices are properly investigated, all relevant documentation retained and, disciplinary action taken (where appropriate) in a non-discriminatory manner.
- They are good role models of best practice for their staff.

3.3 **Human Resources staff** are responsible for providing advice and guidance to staff and managers on the application and effective implementation of this policy. They are also responsible for ensuring that the duty to promote is observed and actioned where necessary and the general duties of the equality legislation are observed.

3.4 **Legal liability**
Individual members of staff can be held personally liable for acts of unlawful discrimination.

3.5 The Trust, as an employer, may be liable for any act of unlawful discrimination committed by you during the course of your employment, unless it can be proved that all reasonable and practicable steps had been taken to prevent such an act from occurring. This also extends to a social setting, where staff are together because of their connection to work, for example, a leaving function.

3.6 The Trust has a primary legal and moral responsibility for ensuring that discrimination does not occur.

4.0 Training / competency requirements

4.1 All staff employed by the Trust are required to undertake Equality & Diversity training, this can be completed via e-learning or attending a face to face training session delivered by Human Resources staff. All existing staff are required to undertake this training every 3 years and it also forms part of the Trust Induction programme for new staff.

5.0 Procedure

5.1 It is recognised that in serving diverse communities, the Trust needs to recruit and retain the right people with the right skills to deliver high quality care. This can be best achieved through a workforce that reflects the community that we serve. The Trust's values are centred on developing a personal, fair and diverse culture:

- We always put the patient first
- We respect and value our patients, visitors and staff
- We take every opportunity to improve services
- We aim to deliver high standards of quality and efficiency in everything we do
- We take every opportunity to enhance our reputation

5.2 Our aim is to engender an organisational culture that is good for all people, treating everybody with respect and dignity, promoting fairness, ensuring that our core standards of behaviour are reflected in all of our dealings with those who come into contact with the Trust.

5.3 We are committed to the principles of the Equality and Human Rights Commission (EHRC).

5.4 We believe that staff can achieve their full potential in an environment where all staff, regardless of their role, are valued and treated with dignity and respect. This is embedded in the Trust's values as detailed above. All staff working within the NHS are also expected to abide by the Nolan Committees Standards on Public Life: selflessness, integrity, objectivity, accountability, openness, honesty and leadership.

5.5 Staff diversity will be viewed positively and in recognising that everyone is different, The Trust will value equally the contribution that individuals from different backgrounds can make. We will seek to engage with and support staff more widely through the development of local networks and also engagement and representation at Regional Networks, such as the SEC BME Network.

5.6 We are committed to equal opportunities for all. Our aim is to ensure that no patient, carer or visitor to the Trust, job applicant or member of staff, is discriminated against on the grounds of:

- Gender, sexual orientation or gender reassignment
- Part-time working
- Marital status
- Pregnancy, maternity or paternity
- Race, colour, nationality, national or ethnic origin
- Disability
- Religion or belief
- Age
- Membership/non-membership of a Trade Union

5.7 Selection for employment, training and promotion will be based solely on objective and job related criteria.

5.8 If you have a disability or develop a disability during your time working with the Trust, we will make reasonable adjustments to prevent you from being placed at a substantial disadvantage in all aspects of employment.

5.9 We are keen to resolve concerns raised by staff at an early stage. If you believe that you have been discriminated against, victimised or harassed, by staff or patients, on any of the grounds identified above then you should speak to your line manager in the first instance. The HR Directorate, Occupational Health and your staff or Trade Union representative will also be able to support you and help you to understand the options available to you through the appropriate Trust policies.

5.10 Equality and Diversity is implicit within all of the Trust's employment policies and these are all Equality Impact Assessed and regularly reviewed to ensure there is no element of bias or discrimination. The process for Equality Impact Assessments can be found in **Appendix 6** (Equality Impact Assessments Toolkit).

6.0 Monitoring and audit

6.1 This policy and procedure will be monitored on an on-going basis by the HR Department via:

- Analysis of equality and diversity data captured in relation to both staff and patients
- Feedback from staff, managers and HR staff who have used the policy
- Feedback from Diversity Steering Group(s)
- Monitoring of equality impact assessments

APPENDIX ONE

Process requirements

1.0 Implementation and awareness

- Once approved the document lead or author will submit this policy/procedural document to the Clinical Governance Assistant who will activate it on the Trust approved document management database on the intranet, under 'Trust polices, procedures and leaflets'.
- A monthly publications table is produced by the Clinical Governance Assistant which is published on the Bulletin Board (Trust intranet) under "Trust Publications"; notification of the posting is included on a bi-weekly Bulletin Board round-up email, circulated Trust wide by the Communications team.
- On receipt of the Trust wide Bulletin Board notification all managers should ensure that their staff members are aware of the new publications.
- This policy will be included on the Trust's intranet with other employment policies. It will also be publicised in updates on policies and form an integral component at Staff Induction and orientation.
- All staff briefed by their respective managers on the main aspects of this policy.
- Further promotion via trust communication methods e.g. team brief, trust news and trust e-mail bulletin

2.0 Review

To be reviewed five years after approval/ratification or sooner if monitoring highlights the need and/or changes in legislation.

3.0 Archiving

The Trust intranet retains all superseded files in an archive directory in order to maintain document history.

APPENDIX TWO

CONSULTATION ON: Equality & Diversity Policy and Procedure

Consultation process – Use this form to ensure your consultation has been adequate for the purpose.

Please return comments to: HR Business Partner (DL)

By date: 18th July 2013

Name: *List staff to be included in the consultation. See Section 5.5 of the "Production, Approval and Implementation of Policies and Procedures" policy and procedure for guidance.*	**Date sent**	**Date reply received**	**Modification suggested? Y/N**	**Modification made? Y/N**
The following staff MUST be included in ALL consultations:				
Local Counter Fraud Specialist	27/06/2013			
Clinical Governance Assistant	27/06/2013	03/07/2013	Y	Y
Staff-side Chair (AK)	23/05/2013	29/05/2013	Y	Y
Medical Staff-side Chair (MB)	27/06/2013			
Director of Strategy & Workforce	27/06/2013			
Associate Director of Workforce	23/05/2013			
Head of Employee Services	27/06/2013			
HRBP Team	23/05/2013			
ADO's/Heads of Nursing	27/06/2013			
GM's/Matrons/Heads of Service	27/06/2013			
JCF Members	27/06/2013			
JMNC Members	27/06/2013			
Head of Communications	27/06/2013			
Head of Quality & Governance	27/06/2013			
Director of Nursing	27/06/2013			
The role of those staff being consulted upon as above is to ensure that they have shared the policy for comments with all staff within their sphere of responsibility who would be able to contribute to the development of the policy.				

APPENDIX THREE

Equality Impact Assessment

The duty to undertake Equality Impact Assessments is a legal requirement under the Equality Act and covers nine protected characteristics on the grounds upon which discrimination is unlawful

The completion of the following Stage One - Equality Impact Assessment grid is therefore mandatory and should be undertaken as part of the policy development and approval process. Please consult the Equality and Diversity Policy on the Trust intranet, for details on how to complete the grid and to determine whether a Stage Two assessment is required.

Please note that completion is mandatory for all policy development exercises. A copy of each Equality Impact Assessment must also be placed on the Trust's intranet.

Title of policy, service, function, project or proposal	Equality and Diversity Policy and Procedure
Department	Human Resources
Lead officer for assessment	HR Business Partner (DL)
What is the main purpose of the policy/service/function/project/proposal?	This policy sets out the Trust's commitment to delivering the very highest standards of access and care to patients from a diversity of cultures, different age groups and with a wide range of abilities and needs. It also demonstrates our commitment to recruiting and retaining a diverse workforce and becoming an employer of choice.
List the main activities of the policy or service redesign (e.g. Manual Handling would relate to health and safety of patients; health and safety of staff; compliance with NHS and Government legislation or standards etc).	As above and to ensure that the Trust meets its duties in respect of the specific strands of equality legislation for public sector organisations
Is the policy or service relevant to: - **Promoting Good Relations between different people?** **Eliminating discrimination?** **Promoting Equality of Opportunity?**	 Yes Yes Yes
Which groups of the population do you think may be affected by this policy/proposal etc?	**Is there an adverse impact or potential discrimination (yes/no).** **If yes give details.**
Women and men	No
People of different ages	No
Minority ethnic people	No
People in different religious/faith groups	No
People who do not speak English as a first language	Yes as they may have difficulty reading the policy but an interpreter can be sourced / provided.
People who have a physical disability	Yes, this document can be produced in Braille should this be required for the sight impaired.
People who have a mental disability	Yes as they may have difficulty understanding the policy but assistance can be sourced to aid understanding if necessary.
Women who are pregnant or on maternity leave	No
Single parent families	No
Lesbian, gay, bisexual and transgender people	No

People with different work patterns (part time, full time, job share, short term contractors, employed, unemployed)	No
People in deprived areas and people from different socio-economic groups	No
Asylum seekers and refugees	No
Prisoners and people confined to closed institutions, community offenders	No
Carers	No
Do you have any information that tells you of the current use of this policy/ service?	Yes/No (if yes please detail) Yes impact of Equality & Diversity policy is assessed through our Trust KPI's relating to Equality
Is it broken down by the protected characteristics, i.e. ethnicity, gender, disability etc?	Yes/No (please detail) Yes our Equality KPI's are broken down into the nine protected characteristic groups and monitored for any adverse impact
Does this information reflect the proportions from the 2001 Census? If there is no information available or if this is patchy, specify the arrangements that will make this available.	Yes/No (if no, can you explain why) Trust Equality KPI's will be assessed against Census data annually to determine whether there is any potential discrimination against minority groups
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	The potential discrimination identified above is minimal and justifiable and therefore a Stage 2 assessment is not required.
When will you monitor and review your EqIA?	Alongside this policy/procedure when it is reviewed.
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix Three of this policy/procedure on the Trust Intranet (QPulse).

FURTHER APPENDICES

The following appendices are published as related links to the main policy /procedure on the Trust approved document management database on the intranet (Trust policies, procedures and leaflets):

No.	Title	Unique ID
4	Single Equality Scheme	RWF-OPPPCS-NC-WF14
5	Single Equality Scheme action plans	RWF-OPPM-CORP143
6	Equality Impact Assessment Toolkit	RWF-OWP-APP575

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Confidentiality Code of Conduct

9 Key messages for all staff about their responsibility for the protection of patient and personal information

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1. **Confidentiality is YOUR duty** – Information given in confidence should remain confidential. This is YOUR legal, ethical and professional obligation.

2. **Informed consent** – Make sure patients understand how their confidential information will be used and disclosed, and know of their right to object. Always respect their wishes.

3. **Need to know?** Before sharing patient information, think: Does that person really need to know? Are they who they claim to be? If in doubt; ask and check.

4. **No fishing!** Don't go checking up on friends and relatives or simply out of curiosity. If you don't have a genuine need to know you don't have the right to look.

5. **Who's looking and listening?** Don't leave paperwork where anyone can see; return it, put it away or dispose of it securely. Make sure your conversation remains private.

6. **Keep your passwords secret** – Don't share your computer passwords with anyone. You might give access to confidential data and any wrongdoings will be attributed to YOU.

7. **Use NHSmail** – NHSmail is approved for sending clinical data if both sender and recipient are NHSmail users. If it doesn't end exactly in "@nhs.net" it may not be secure.

8. **Encrypt it** – If confidential data must be held on removable media such as memory sticks it MUST also be encrypted. Ask the ICT team for advice.

9. **Don't be afraid to ask** – If you are not sure about a confidentiality issue then seek advice from the Trust's Data Protection Officer or the Caldicott Guardian.

Please refer to Q-Pulse for access to the full Code of Confidentiality, ratified by the Finance Committee in March 2013.

Maidstone and Tunbridge Wells NHS
NHS Trust

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Core Statutory and Mandatory Training Policy and Procedure

Requested/ Required by:	Workforce Committee
Main author:	Learning and Development Manager
Other contributors:	Staff-side Representative
Document lead:	Learning and Development Manager **Contact details:** 01622 224875
Directorate:	Workforce
Specialty:	Learning and Development
Supersedes:	Core Statutory and Mandatory Training Policy and Procedure (Version 2.0: April 2009) (Version 2.1: December 2009) (Version 2.2: January 2010) (Version 2.3: December 2010) (Version 2.4: October 2011)
Approved by:	Senior HR Meeting, 3rd June 2014
Ratified by:	Workforce Committee, 17th June 2014
Review date:	To be formally reviewed in June 2019 or at times of legislative or significant change

Document history

Requirement for document:	• NHSLA Risk Management Standards • Health & Safety Executive • Care Quality Commission • Clinical Commissioning Groups • Improving Working Lives • The Trust recognises its legal and ethical responsibilities to create and maintain a working environment that will ensure the health, safety and welfare of all persons on Trust Statutory and Mandatory training is an integral component of our high quality service provision and the Trust is committed to ensuring that all staff undertake the training identified as statutory or mandatory
Cross references:	• NHSLA Risk Management Standards • Health & Safety Executive • Care Quality Commission • Boorman, Dr S. (2009). *NHS Health and Well-Being Review – Final Report* • Boorman, Dr S. (2009). *NHS Health and Well-Being Review – Interim Report* • Department of Health (2000) *An Organisation with a Memory. Report of an Expert: Group on Learning from Adverse Events in the NHS* • Elaine Sauvé Associates for the Department of Health. (2005). *An Education and training Framework for Staff providing Healthcare in Prisons* (Available at: www.dh.gov.uk) • Health Professions Council. (2009). *Your duties as an education provider: Standards of education and training* • NHS Employers. (2010). 'Health and safety essential guide' *NHS Employers website pages* • NHS Executive. (1997). *Code of Practice in the Appointment and Employment of HCHS Locum Doctors* • Department of Health. (2004). *Introduction to Today's NHS: NHS Corporate Induction Programme* • NHS Employers. (2008). *Staff Induction Packs* (Available at on request from www.nhsemployers.org) • NHS Employers and Department of Health (2004) *Guidelines for NHS Employers: Induction Programmes for Consultants and GPs Recruited From Abroad* • Department of Health. (2006). *Safer Recruitment – a guide for NHS employers.* London: Department of Health. • *Health and Safety at Work etc., Act 1974*. London: The Stationery Office. • Management of Health and Safety at Work Regulations 1999. • Regulatory Reform (Fire Safety) Order 2005. • Health Professions Council. (2004). *Standards of Education & Training.* London: Health Professions Council. Available at: www.hpc-uk.org
Associated documents:	The Trust's strategies, policies and guidance are held on the QPulse database and can be accessed by all staff through the Trust's intranet site. Paper copies are held in libraries on all sites. • Maidstone and Tunbridge Wells NHS Trust. *Risk Management Policy and Strategy* [RWF-OPPPCS-NC-CG13] • Maidstone and Tunbridge Wells NHS Trust. *Management of Violence and Aggression Policy and Procedure* [RWF-OPPPCS-NC-FH8]

	• Maidstone and Tunbridge Wells NHS Trust. *Control of Contractors Policy and Procedure* [RWF-OPPPCS-NC-EST5] • Maidstone and Tunbridge Wells NHS Trust. *Induction Policy and Procedure* [RWF-OPPPCS-NC-WF19] • Maidstone and Tunbridge Wells NHS Trust. *Moving and Handling of Patients and Loads Policy and Procedure* [RWF-OPPPCS-NC-FH11] • Maidstone and Tunbridge Wells NHS Trust. *Fire Safety Policy and Procedure* [RWF-OPPPCS-NC-CG4] • Maidstone and Tunbridge Wells NHS Trust. *Infection Control Policy and Procedure* [RWF-OPPPCSS-C-PATH15] • Maidstone and Tunbridge Wells NHS Trust. *Recruitment, Selection and Employment Checks Policy and Procedure* [RWF-OPPPCS-NC-WF47] • Maidstone and Tunbridge Wells NHS Trust. *Bullying and Harassment Policy and Procedure* [RWF-OPPPCS-NC-WF24] • Maidstone and Tunbridge Wells NHS Trust. *Health Records Policy and Procedure* [RWF-OPPCS-NC-TM31] • Maidstone and Tunbridge Wells NHS Trust. *Resuscitation Policy / Not For Attempted Cardiopulmonary Resuscitation Policy and Procedure* [RWF-OPPPPS-C-TIO3] • Maidstone and Tunbridge Wells NHS Trust. *Safeguarding Children Policy and Procedure* [RWF-OPPPCS-C-NUR6] • Maidstone and Tunbridge Wells NHS Trust. *Safeguarding Adults: Protection and Support of Vulnerable Adults Policy and Procedure* [RWF-OPPPCS-C-NUR5] • Maidstone and Tunbridge Wells NHS Trust. *Blood Transfusion Policy and Procedure* [RWF-OPPPCSS-C-PATH1] • Maidstone and Tunbridge Wells NHS Trust. *Venous Thromboembolism Prevention Policy and Procedure* [RWF-OPPPCSS-C-CAN4] • Maidstone and Tunbridge Wells NHS Trust. Severe Sepsis, Early Management of [RWF-OPPPPS-C-TIO10] • Maidstone and Tunbridge Wells NHS Trust. *Medical Devices Policy and Procedure* [RWF-OPPPCS-NC-EST2] • Maidstone and Tunbridge Wells NHS Trust. *Medicines Policy and Procedure* [RWF-OPPPCSS-C-PHAR1] • Maidstone and Tunbridge Wells NHS Trust. *Policy and procedure for the control of contractors* [RWF-OPPPCS-NC-EST5] • Maidstone and Tunbridge Wells NHS Trust. *Disciplinary Policy and Procedure* [RWF-OPPPCS-NC-WF10]

Version Control: *Details of approved versions*

Issue:	**Description of changes:**	**Date:**
1.0	Initial document	August 2007
2.0	April 2009 review of procedures	April 2009
2.1	Amendments to Appendix Four	December 2009
2.2	Amendments to Appendix Four	January 2010
2.3	Review of policy and procedures	December 2010
2.4	Appendix 4 amended / Appendix 6 added	October 2011
3.0	Complete re-write due to changes in governance structure, learning management system and appraisal processes	June 2014

Policy statement for

Core Statutory and Mandatory Training Policy and Procedure

Maidstone and Tunbridge Wells recognises that Staff Training is of vital importance in providing an efficient service and safe environment for our patients, staff, and the general public.

Statutory and Mandatory training is an integral component of our high quality service provision and the Trust is committed to ensuring that all staff undertake the training identified as statutory or mandatory. This will include all staff (including bank staff) who have contracts with the Trust. It is the responsibility of individuals and their managers to ensure that they are booked onto training within the identified time scales, some courses are also available by e-learning to enable flexibility of provision and 24 hour access to information. Failure to do so may mean that staff are unable to work until their statutory and mandatory training is up to date.

Trust staff will be released to attend Statutory and Mandatory Training and the granting of permission for other training will be dependent on staff having attended their required Statutory or Mandatory training for the year. All staff including bank staff will be paid their normal rate of pay for attending the programme. For permanent staff working part time hours, managers will be expected to ensure that any excess hours are paid or granted as time-off in lieu.

Statutory and Mandatory training programmes will be agreed and reviewed by Learning and Development and the subject leads and facilitators and ratified by the relevant Committee.

The provision of Statutory and Mandatory training is essential in managing risk and maintaining high standards within the clinical governance framework. The Statutory and Mandatory training outlined in this document is the minimum core requirement for the Trust. Line Managers should identify any other training requirements specific to the role as part of the appraisal process.

The cost of Statutory and Mandatory training is funded in full by the Trust for all employees.

The Trust Board must be assured that this programme of training is being adhered to. This will be achieved through regular Board level reporting via the Workforce Committee and Health and Safety Committee.

Core Statutory and Mandatory Training Procedure

Contents **Page**

7.0 Introduction and scope

These procedures set out the statutory and mandatory training processes for all staff.

8.0 Definitions

Statutory: Statutory Training is information, instruction and training that Employers are required to provide by Statute Law as described in Section 2 of the Health and Safety at Work Act (1974). All staff must participate in this training, a statutory requirement is a MUST DO by Law.

Mandatory: Mandatory Training is that training which is deemed to be most suitable for our organisation to meet its statutory requirements of competency. All staff must participate in this training as identified for their role. A mandatory requirement is a MUST DO for the organisation.

Staff**:** For the purposes of this policy, the word staff will cover all whole-time, part-time, bank staff, students and volunteers. Contracted staff will be monitored under the *MTW Control of Contractors Policy and Procedure*.

9.0 Duties

3.1 Maidstone and Tunbridge Wells NHS Trust

The Trust has a duty to its staff, visitors and patients to ensure that:

- appropriate statutory and mandatory training is provided for all staff, whether employed whole, part-time or on the bank to meet the needs of their role;
- managers are aware of statutory and mandatory training requirements for their staff;
- all staff attend statutory and mandatory training sessions at the required time intervals;
- accurate records are kept of all statutory and mandatory training undertaken;
- procedures are in place to follow up those who fail to attend statutory and mandatory training;
- procedures are in place to follow up staff that are overdue their statutory and mandatory training;

3.2 Director of Strategy and Workforce

The Director of Strategy and Workforce on behalf of the Trust Board has Executive responsibility for ensuring that all staff receive appropriate and timely Statutory and Mandatory training.

3.3 Managers

It is the responsibility of all line managers to ensure that their staff remain up to date with relevant Statutory and Mandatory training and any additional training specific to the needs of the role. Managers must ensure staff are given protected learning time to complete Statutory and Mandatory training. Managers must follow up non-attendance at any Statutory and Mandatory training session by investigating why it occurred and ensure another date is

arranged. As part of the Trust appraisal process, line managers are responsible for supporting individuals to identify their Statutory and Mandatory training needs upon induction and during annual reviews or upon any changes to the working environment or role. They are then responsible for helping to source the appropriate learning activity to meet those needs before any other developmental training is authorised.

3.4 Staff

All staff have a joint responsibility with their line manager to identify their Statutory and Mandatory training requirements and attend within the specified timescales. They are also responsible for keeping their own record of attendance to demonstrate compliance as part of the appraisal process. Staff who fail to attend Statutory and Mandatory training for any reason must report this to their line manager and re-book.

Statutory and Mandatory training is a critical component of everyone's role and failure to comply with minimum standards will be considered a breach of terms and conditions of employment and may be dealt with under the *Trust Disciplinary Policy and Procedure*.

3.5 Learning and Development Department

The Learning and Development Department is responsible for the booking, monitoring and reporting of attendance at Statutory and Mandatory Training.

Learning and Development will work with training providers, facilitators, subject leads and key stakeholders to define, maintain and change statutory and mandatory training provision to ensure that provision is made in the most effective and efficient way. Activities, updates and changes will be reported to the Workforce and/or Health and Safety Committees where ratification is required.

The Learning and Development Department carries out evaluation of the statutory and mandatory training programme. This is on a random basis and the information is shared with course facilitators for training development.

The Learning and Development Department maintain training records on the Learning Management System which is updated on a daily basis.

The Learning and Development Department generate the compliance reports required for information to the Board, Health and Safety Committee and other Committees who oversee Statutory and Mandatory training compliance as required.

3.6 Trust Board, Workforce Committee and Health and Safety Committee

The Trust Board, Workforce Committee and Health and Safety Committee will be responsible for receiving the monthly Statutory and Mandatory training reports and reviewing compliance against this policy and agreeing recommendations for changes required for effective and cost efficient compliance.

3.7 Trust Training Facilitators and Subject leads

Trust training facilitators and subject leads are responsible for ensuring that they provide up to date robust training sessions which are fit for purpose and comply with current law and practice. They are also responsible for ensuring that maintain the appropriate levels of competence to deliver their training sessions. Facilitators will ensure that attendance at training is recorded accurately so that compliance against this policy can be measured and forward records immediately to the Learning and Development Administration team for recording.

Facilitators are also responsible for reporting on compliance against the specific policy their training is designed to support. The Learning and Development Department will provide facilitators with access to compliance reports through the Learning Management System to assist in the production of action plans to address compliance.

10.0 Training / competency requirements

It is the responsibility of a document lead to ensure that any policy or procedure they are preparing for the Trust includes consideration for the provision of training or guidance for managers and staff and that Learning and Development are included in the consultation process. Leads must ensure that sufficient training places/resources can be made available to meet the demand created by the policy or procedure they produce.

11.0 Procedure

5.1 Training needs analysis

Learning and Development produced a core statutory and mandatory training needs analysis to identify the risk management training requirements for all staff documented in the *Training Matrix* (**APPENDIX FOUR**) and the *Statutory and Mandatory Training Matrix for Medical Staff* (**APPENDIX FIVE**). Both documents indicate the training requirement and frequency for each staff group. The *Guide to Statutory and Mandatory Training Provision* (**APPENDIX SIX**) gives information on how staff can access the core training requirements.

The initial training needs analysis for each document was produced by collating legislative training requirements (statutory training) and external assurance frameworks that inform Trust policy documents (mandatory training). Further changes will be proposed on the basis of legislative, Trust, Subject lead and stakeholder recommendations. Proposed changes to the training needs analysis will be submitted to the Health and Safety Committee on the basis of internal and external developments and if ratified will be reissued on a trust-wide basis as necessary.

The matrix identifies core Trust Statutory and Mandatory requirements, however it is not exhaustive and role specific needs will be discussed with the line manager at Local Induction and specific role training and compliance can be viewed online using the Trust's learning management system.

5.2 Delivery of statutory and mandatory training

Training is delivered via a rolling programme of multi-topic training days for clinical and non-clinical staff covering core statutory and mandatory training subjects, e-learning, handbooks and toolbox talks to ensure there is a wide variety of accessible training available and out of hours provision. A prospectus and dates are published on the Learning Management system which can be viewed by all staff.

The Matrix identifies core Trust Statutory and Mandatory requirements, however it is not exhaustive and role specific needs will be discussed with the line manager at local induction.

Managers and staff will agree individuals' mandatory training requirements in accordance with the Core Statutory & Mandatory Training Policy and record and monitor these as part of the annual appraisal process.

Independent contractors will be treated in line with the *Control of Contractors Policy and Procedure* section 8.

5.3 Procedure for attendance

The line manager and employee will agree the date for training and the Learning and Development Administration team will book the employee onto the relevant training programme. The employee attends the training course and the trainer will collect the attendance sheets and forward these to the Learning and Development Department who record that the employee is up to date with their statutory and mandatory training.

The Trainer may also decide for those staff who have not completed the full course whether the level of attendance can be considered sufficient. This may result in staff needing to repeat book a course/session.

Compliance will be monitored in line with Section 5.5 of this policy.

5.4 Non-attendance

The Learning and Development department will notify line managers if their staff fail to attend booked training so that this can be followed up and re-booked. Failure to attend the re-scheduled date should be documented in the individual's personnel file. Staff who fail to undertake training and become non-compliant will be dealt with in line with section 5.6 of this policy.

It is recognised that on occasions domestic and operational requirements can impede attendance at a training session. It is important that if staff are unable to attend a training session or are unable to complete a training course, they or their manager inform the Learning and Development Administration team as soon as possible with a valid reason for non-attendance of the course/session.

If a cancellation occurs on the day the course is due to commence, it will be recorded as a Did Not Attend (DNA) and will be reported to the line manager.

Staff should note that failure to attend without informing their line manager is potentially a disciplinary offence.

5.5 Monitoring arrangements

The Trust Learning Management System is a database which will manage the administrative requirements of training events, qualifications and professional development courses within the Trust. It stores all information related to Trust delivered training courses such as bookings, time and place of delivery, learning objectives and tracks outstanding and completed training. The system will be used to analyse and produce reports such as course completion and outstanding training for all statutory and mandatory training and for Trust Board and other committee assurance.

The database will be administered by the Learning and Development Department and will provide the following functionality:

- Managers and staff will be able to access their training records through the system online enabling them to plan their schedule of training and keep track of what training has been completed.
- Managers will be able to run compliance reports to check which staff require updating;
- Facilitators/subject leads will be able to access compliance reports to assist with their training action plans;

In addition the Learning and Development team will use the system to monitor compliance as follows:

1. Email reminders for compliance update will be sent to staff and managers for action
2. Reminders will be sent for each subject on a monthly basis
3. Reminders will be audited every quarter
4. Managers and staff who have received three reminders and still remain non-compliant will be escalated to the directorate lead for investigation
5. If the directorate lead is unable to attain compliance upon investigation, this will be reported to the Chief Operating Officer and the Directorate HR Business Partner for formal investigation

The Trust aims for 85% compliance, however areas with less than 75% compliance will be asked to provide an action plan to the Health and Safety Committee and/or Workforce Committee to recover their position.

5.6 Non-compliance

In the first instance, line managers must address non-compliance with their staff member and continued non-compliance should initiate disciplinary action. If the continued non-compliance is escalated to the directorate lead for investigation it may be necessary to suspend staff with high risk non-compliance.

In addition as part of the annual appraisal process, staff will be prohibited from receiving the annual pay progression under Agenda for Change if they are not able to demonstrate compliance. Staff will also be denied funding for other training until their mandatory training obligations have been met.

5.7 Course content

Trust training facilitators and subject leads are responsible for ensuring that they provide up to date robust training sessions which are fit for purpose and comply with current law and best practice to maintain the health and safety of staff and patients. Learning and Development will discuss any feedback arising from evaluations and audits with the relevant lead.

5.8 Process for the development of action plans

Action plans will be created by Directorate leads and/or Subject leads/Facilitators and/or Learning and Development dependant on the required outcome as directed by the Workforce and/or Health and Safety Committee. These will be reviewed and monitored on a regular basis for compliance by the Health and Safety and/or Workforce Committee.

5.9 Process for the development of a training prospectus

The Learning and Development team will collate information from facilitators to update course content on the Learning Management System. The system automatically generates flyers and a prospectus for viewing online or for printing. The prospectus is a live document and will update information and dates as the system is updated.

12.0 Monitoring and audit

The Director of Strategy and Workforce as Chairman of the Workforce Committee, supported by the Learning and Development Manager, will be responsible for monitoring the compliance with this Policy / Procedure on behalf of the Trust. Information on Directorate compliance will be provided to the Trust Board on a monthly basis.

What needs monitoring?	Who will lead on this aspect of monitoring?	What tool will be used to monitor/check that everything is working according to this element of the policy?	How often will we need to monitor/ frequency?	To who or what committee will the results be reported (for information and action)?	Who will undertake the action planning for deficiencies and recommendations?	How will changes be implemented and lessons shared?
Element to be monitored	**Lead**	**Tool**	**Frequency**	**Reporting arrangements**	**Action Lead(s)**	**Change in practice and lessons to be shared**
Training Needs Analysis (TNA)	Learning and Development Manager	AT-Learning (AT-L)	Ongoing by Learning and Development, Facilitators/Subject leads and key Stakeholders	Workforce Committee, Health and Safety Committee	Learning and Development, Facilitators/Subject leads and Key Stakeholders	Reports to relevant Committee e.g. changes to Infection Prevention are reported to IPC Committee, Trustwide communications
Training Prospectus	Learning and Development Manager	AT-L	Ongoing live document through AT-L	Workforce Committee	Learning and Development Manager	Through feedback from Staff and Facilitators/Subject leads to Learning and Development Team and Trustwide communications

What needs monitoring?	Who will lead on this aspect of monitoring?	What tool will be used to monitor/check that everything is working according to this element of the policy?	How often will we need to monitor/ frequency?	To who or what committee will the results be reported (for information and action)?	Who will undertake the action planning for deficiencies and recommendations?	How will changes be implemented and lessons shared?
Element to be monitored	**Lead**	**Tool**	**Frequency**	**Reporting arrangements**	**Action Lead(s)**	**Change in practice and lessons to be shared**
Action Plans to deliver training identified in TNA	Learning and Development, Facilitators/ Subject leads and Senior Directorate Managers	AT-L	Monthly reports to Board, bi-monthly reports to Health & Safety Committee	Workforce Committee Health and Safety Committee Standards Committee Other relevant Committees	Learning and Development, Facilitators/Subject leads and Senior Directorate Managers	Ratification and reporting through relevant Committee
Check permanent staff have completed relevant training	Learning and Development	AT-L	Monthly	Workforce Committee Health and Safety Committee Standards Committee Other relevant Committees	Learning and Development, Facilitators/Subject leads and Senior Directorate Managers	Through the Workforce Committee
Follow up on non compliance	Learning and Development,	AT-L	Monthly	Workforce Committee Health and Safety Committee	Learning and Development, Facilitators/Subject leads and Senior Directorate Managers	Through the Workforce Committee and/or Health and Safety Committee
Co-ordination of Training Records	Learning and Development Manager	AT-L	Ongoing	Workforce Committee	Learning and Development Manager	Through Learning and Development

APPENDIX ONE

Process requirements

1.0 Implementation and awareness

This policy and procedure should be implemented with immediate effect.

- This policy will be bought to the attention of all key staff detailed in Appendix Two via the email system of dissemination. It will also be presented to members of the Health & Safety Committee and Standards Committee for comment.
- The policy will be approved by the Senior HR Meeting Committee and ratified by the Workforce Committee.
- Once approved the document lead or author will submit this policy/procedural document to the Clinical Governance Assistant who will activate it on the Trust approved document management database on the intranet, under 'Trust polices, procedures and leaflets'.
- A monthly publications table is produced by the Clinical Governance Assistant which is published on the Bulletin Board (Trust intranet) under "Trust Publications"; notification of the posting is included on a bi-weekly Bulletin Board round-up email, circulated Trust wide by the Communications team.
- On receipt of the Trust wide Bulletin Board notification all managers should ensure that their staff members are aware of the new publications.

2.0 Review

This policy / procedure will be reviewed once every five years with the next review due in June 2019 (subject to any change in legislative requirements).

3.0 Archiving

The Trust intranet (Q-Pulse) retains all superseded files in an archive directory in order to maintain document history.

APPENDIX TWO

CONSULTATION ON: Core Statutory and Mandatory Training Compliance

Consultation process – Use this form to ensure your consultation has been adequate for the purpose.

Please return comments to: Learning and Development Manager

By date: 15th October 2013

Job title: *List staff to be included in the consultation. See Section 5.5 of the "Production, Approval and Implementation of Policies and Procedures" policy and procedure for guidance.*	**Date sent dd/mm/yy**	**Date reply received**	**Modification suggested? Y/N**	**Modification made? Y/N**
The following staff MUST be included in ALL consultations:				
Clinical Governance Assistant	16.09.13	26.09.13	Y	Y
Chief Pharmacist (if pharmacy/prescribing issues are included in the document)				
Please list key staff whose reply is compulsory before approval can be granted:				
Chief Operations Officer	30.09.13			
Director of Nursing	30.09.13			
Risk Manager	30.09.13			
Head of Infection Prevention and Control	30.09.13			
Quality and Patient Safety Manager	30.09.13			
Associate Director of Workforce	30.09.13			
HR Business Partner	30.09.13			
Staff Side Chair	30.09.13			
Please list other staff to be included in the consultation but whose reply is not compulsory:				
Members of the Board	30.09.13	02.10.13	N	
Members of the H&S Committee	30.09.13	04.10.13	Y	Y
Senior Nurse - Practice Development	30.09.13	17.10.13	Y	Y
Matrons	30.09.13			
Clinical Directors	30.09.13	30.09.13	Y	Y
General Managers	30.09.13	01.10.13	N	
The role of those staff being consulted upon as above is to ensure that they have shared the policy for comments with all staff within their sphere of responsibility who would be able to contribute to the development of the policy.				

APPENDIX THREE

Equality Impact Assessment

In line with race, disability and gender equalities legislation, public bodies like MTW are required to assess and consult on how their policies and practices affect different groups, and to monitor any possible negative impact on equality.

The completion of the following Equality Impact Assessment grid is therefore mandatory and should be undertaken as part of the policy development and approval process. Please consult the Equality and Human Rights Policy on the Trust intranet, for details on how to complete the grid.

Please note that completion is mandatory for all policy development exercises. A copy of each Equality Impact Assessment must also be placed on the Trust's intranet.

Title of policy or practice	Core Statutory and Mandatory Training Policy and Procedure
What are the aims of the policy or practice?	To ensure that all staff receive at least the minimum training required according to Risk Management Standards
Identify the data and research used to assist the analysis and assessment	Analysis and assessment will be based on reported training compliance.
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	**Is there an adverse impact or potential discrimination (yes/no). If yes give details.**
Males or Females	No
People of different ages	No
People of different ethnic groups	No
People of different religious beliefs	No
People who do not speak English as a first language	No
People who have a physical disability	No
People who have a mental disability	
Women who are pregnant or on maternity leave	No
Single parent families	No
People with different sexual orientations	No
People with different work patterns (part time, full time, job share, short term contractors, employed, unemployed)	No
People in deprived areas and people from different socio-economic groups	No
Asylum seekers and refugees	No
Prisoners and people confined to closed institutions, community offenders	No
Carers	No
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	
When will you monitor and review your EqIA?	Alongside this policy/procedure when it is reviewed.
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix 3 of this policy/procedure on the Trust approved document management database on the intranet, under 'Trust policies, procedures and leaflets'.

FURTHER APPENDICES

The following appendices are published as related links to the main policy /procedure on the Trust approved document management database on the intranet (Trust policies, procedures and leaflets):

No.	Title	Unique ID
4	Core statutory & mandatory risk management training matrix	RWF-OWP-APP526
5	Medical staff statutory and mandatory training matrix	RWF-OWP-APP528
6	Guide to statutory and mandatory training provision	RWF-OWP-APP712

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Health and Safety Policy and Procedure

Requested/ Required by:	Trust Management Executive
Main author:	Trust Risk and Compliance Manager **Contact details:** ext. 24581
Other contributors:	Trust Health and Safety Advisor
Document lead:	Chief Operating Officer
Directorate:	Quality and Governance
Specialty:	Safety Team
Supersedes:	Health and Safety Policy and Procedure (Version 10.0: March 2014)
Evidence:	Health and Safety at Work Etc. Act 1974
Approved by:	The Health and Safety Committee, 2nd March 2015 [Version 11.0]
Recommended for ratification by:	Trust Ratification Committee, 2nd July 2015
Ratified by:	The Trust Board, 22nd July 2015 [Version 11.0]
Review date:	July 2018

Document history

Requirement for document	• To state the Trust's philosophy and management commitment to health and safety • To set out the structure of the organisation and how health and safety is managed and communicated within it • To identify those with specific health and safety responsibilities and indicate what these responsibilities are. • To meet HSAWA Regulation 2 - General duties of employers. • To meet the NHS staff council "Workplace Health & Safety Standards".
How policy will be communicated	• Issued as a working policy to all levels of management through the Trust intranet. • Shared with staff via Union representatives and managers through the Health and Safety Committee. • Supported by Health and Safety training delivered on corporate induction and annual mandatory clinical and non clinical updates. • Available on intranet to all Trust staff.
How policy will be monitored, audited and reviewed	• Monitored through local risk management structures. • Monitored by the Health and Safety Committee. • Internal self audit using the Synbiotix tool. • Implementation audited by the Safety Team.
Cross references MTW = Maidstone and Tunbridge Wells NHS Trust	The Trust's strategies, policies and guidance are held on the QPulse database and can be accessed by all staff through the Trust's intranet site. Paper copies are held in libraries on all sites. The source and requirements of the Trust's key policies and procedures are described in Appendix Eight. 1. The Health and Safety at Work etc Act 1974. 2. Management of Health and Safety at Work Regulations 1999. 3. NHS staff council "Workplace Health & Safety Standards". 4. The Safety Representatives and Safety Committees Regulations 1977. 5. The Health and Safety (Consultation with Employees) Regulations 1996. 6. MTW Risk Management Policy and Strategy [RWF-OPPPCS-NC-CG13] 7. MTW Security Policy and Procedure [RWF-OPPPCS-NC-FH3] 8. MTW Management of Violence and Aggression Policy and Procedure [RWF-OPPPCS-NC-FH8] 9. MTW Control of Contractors Policy and Procedure [RWF-OPPPCS-NC-EST5] 10. MTW Induction Policy & Procedure [RWF-OPPPCS-NC-WF19] 11. MTW Statutory and Mandatory Training Policy and Procedure [RWF-OPPPCS-NC-WF22] 12. MTW Management of Stress at Work Policy and Procedure [RWF-OPPPCS-NC-WF3] 13. MTW Risk Assessment Policy and Procedure [RWF-OPPPCS-NC-CG6] 14. MTW Incident Management Policy and Procedure [RWF-OPPPCS-NC-CG22] 15. MTW Serious Incidents (SI) Policy and Procedure [RWF-OPPPCS-NC-CG23] 16. MTW Guidance on Risk Register Administration and Review [RWF-OPPPCS-NC-CG14] 17. Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013 18. MTW Central Alerting System Policy and Procedure (CAS) [RWF-OPPPCS-NC-CG24] 19. MTW Moving and Handling of Patients and Loads Policy and Procedure [RWF-OPPPCS-NC-FH11] 20. MTW Fire Safety Policy and Procedure [RWF-OPPPCS-NC-CG4] 21. MTW Management of Substances Hazardous to Health Policy & Procedure [RWF-OPPPCS-NC-CG16]

	22. MTW Infection Control Policy and Procedure [RWF-OPPPCSS-C-PATH15] 23. MTW Hand Hygiene Policy and Procedure [RWF-OPPPCSS-C-PATH13] 24. MTW Policy and Procedure for Ionising Radiation Safety [RWF-OPPPCS-NC-CG18] 25. MTW Policy for the Implementation of the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) [RWF-OPPPCSS-C-RAD1] 26. MTW Registration Policy and Procedure, Clinical and Professional [RWF-OPPPCS-NC-WF56]
Associated documents: MTW = Maidstone and Tunbridge Wells NHS Trust	• MTW Being Open Policy and Procedure [RWF-OPPPCS-NC-CG2] • MTW Bomb and Suspect Package Policy and Procedure [RWF-OPPPCS-NC-EST1] • MTW Bullying and Harassment Policy and Procedure [RWF-OPPPCS-NC-WF24] • MTW Display Screen Equipment Policy and Procedure [RWF-OPPPCS-NC-CG17] • MTW Artificial Optical Radiation Safety Policy and Procedure [RWF-OPPPCS-NC-CG15] • MTW Lone Worker Policy and Procedure [RWF-OPPPCS-NC-FH1] • MTW Management of Concerns and Complaints Policy and Procedure [RWF-OPPPCS-NC-CG31] • MTW Management of Legal Claims Policy and Procedure [RWF-OPPPCS-NC-CG30] • MTW Medical Devices Policy and Procedure [RWF-OPPPCS-NC-EST2] • MTW Medicines Policy and Procedure [RWF-OPPPCSS-C-PHAR1] • MTW Major Incident Plan [RWF-OPPP-CS-NC1] • MTW Smoke Free Policy and Procedure [RWF-OPPCS-NC-TM37] • MTW Approval Policy and Procedure for Research and Development [RWF-OPPPCS-NC-CG35] • MTW Safety of Electrical Appliance Policy, Procedure and Policy (SEAP) [RWF-OPPPCS-NC-EST8] • MTW Research Adverse Event and Safety Reporting Policy and Procedure [RWF-OPPPCS-NC-CG36] • MTW Prevention and Management of Sharps / Splash Injuries Policy and Procedure [RWF-OPPPCS-C-WF5] • MTW Research Misconduct and Fraud Policy and Procedure [RWF-OPPPCS-NC-CG37] • MTW Resuscitation Policy / Not For Attempted Cardiopulmonary Resuscitation Policy and Procedure [RWF-OPPPPS-C-TIO3] • MTW Safeguarding Adults: Protection and Support of Vulnerable Adults Policy and Procedure [RWF-OPPPCS-C-NUR5] • MTW Slip, Trips and Falls Policy and Procedure [RWF-OPPPCS-NC-CG20] • MTW Supporting staff involved in traumatic and stressful incidents, complaints or claims policy and procedure [RWF-OPPPCS-NC-WF59] • MTW Speak Out Safely Policy and Procedure (Whistle Blowing) [RWF-OPPPCS-NC-WF33] • MTW NHS Trust. Environmental Disinfection Policy and Procedure [RWF-OPPPCSS-C-Path11] • MTW NHS Trust. Policy and Procedure for the Management of Water Hygiene [RWF-OPPPCSS-NC-EST9]

	Linked references ▪ *Leading Health and Safety at Work – Leadership actions for Directors and Board members – Institute of Directors and Health and Safety Commission – INDG 417 (2007).*

Version Control:		
Issue:	**Description of changes:**	**Date:**
1.0	Major rewrite	February 2006
2.0	Minor changes	April 2007
3.0	Revised Management and Committee structure	August 2008
4.0	Includes recommendations made by the HSE in October 2008	March 2009
5.0	Annual update with only minor changes	March 2010
6.0	Includes changes for Tunbridge Wells Hospital at Pembury	January 2011
7.0	Annual update with only minor changes	January 2012
8.0	Minor changes made following HSE Inspection and advise	May 2012
9.0	Reviewed - Minor changes made following operational restructure	March 2013
9.1	Included TOR for H&S committee as and appendix	November 2013
10.0	Reviewed - Minor changes made to meet workplace H&S Standards	March 2014
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Policy statement for

The Health and Safety Policy

The Maidstone and Tunbridge Wells NHS Trust (hereafter referred to as the Trust) recognises its responsibilities under the Health and Safety at Work etc. Act 1974 (HSW 1974) and all associated legislation enabled under the Act. The Trust is committed to safeguarding the health & safety of its employees, patients, visitors, volunteers, contractors and others who visit its premises or are affected by its activities. This policy is prepared in accordance with Section 2(3) of HSW 1974. It is the policy of the Trust to seek to provide safe and healthy working conditions and to enlist the active support of all staff in achieving this.

The use of risk assessment to identify, assess and manage all risks arising from the Trust's undertakings is the cornerstone of health and safety management within the Trust. Where unforeseen risks result in adverse incidents these will be investigated and action taken to significantly reduce the likelihood of recurrence.

All managers will ensure that employees under their control have access to and attend all health and safety training relevant to their job. Managers also have a responsibility for formulating and implementing departmental safety rules, ensuring that suitable and sufficient risk assessments are carried out and the findings acted upon and ensuring that their staff complies with them.

All employees are responsible for acquainting themselves with the Trusts' health & safety policies, procedures and rules governing their work activities, and for co-operating with management in complying with them. Also that they attend any health & safety training arranged for them. All employees must report accidents, incidents and unsafe conditions to their manager in the absence of the manager, their Directorate Risk Lead, Site Practitioner or other identified manager for their workplace.

Managers and employees will work together to make their environment as safe as is reasonably practicable both for themselves and others. The Trust expects all managers and staff to be involved in the development and implementation of its health and safety guidelines and procedures through active joint consultation.

The Trust will cooperate and coordinate its activities with that of the Kent and East Sussex Weald Hospital Limited (KESWHL) to ensure an environment that is as safe as is reasonably practicable for the Tunbridge Wells hospital at Pembury.

The Trust will ensure that adequate resources are allocated for health and safety as required; identified from approved Trust policies and fully considered risk assessments.

The policy shall be revised annually to reflect changes in legislation, Department of Health standards and guidance, findings from risk assessments and adverse incident investigations, inspections, audits and advice and guidance from enforcement authorities. These amendments may be supplemented, in appropriate cases, by further statements that relate to the working practices of particular departments or groups of employees. Any changes will be brought to the notice of employees concerned through the Trust's consultative mechanisms.

The Health and Safety Procedure

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The Health and Safety Policy

Section 1 – Introduction and scope

The Maidstone and Tunbridge Wells NHS Trust (hereafter referred to as the Trust) recognises its responsibilities under the Health and Safety at Work etc. Act 1974 (*HSWA* - reference 1) and all associated legislation enabled under the act. The Trust is committed to safeguarding the health and safety of its employees, patients, visitors, volunteers, contractors and others who visit its premises or are affected by its activities.

This policy is prepared in accordance with Section 2(3) of HSWA 1974. It is the policy of the Trust to seek to provide safe and healthy working conditions and to enlist the active support of all staff in achieving this.

It is the duty of all staff to ensure strict compliance with this policy and other policies and procedures emanating from it, failure to do so could lead to disciplinary action.

Section 2 – Duties and responsibilities

Please refer to **Appendix 5 and 6** for the management structure and committee framework. Staff can access the names of local key staff and managers from the Risk page of the Trust's intranet or from this policy **(Appendix 7).** Staff can also access these appendices from the links on page 28.

Further detail on the management of risk including heath and safety is contained within the Trust's *Risk Management Policy and Strategy* (reference six).

2.1. Chief Executive

The Chief Executive has overall accountability for the management of health and safety within the Trust, ensuring that effective policies and procedures are developed and implemented and that the performance of these is monitored and evaluated against statutory obligations and Trust objectives.

2.2. The Chief Operating Officer

The Executive Director with responsibility for the day-to-day organisation and implementation of health and safety within the Trust is the Chief Operating Officer (COO). The Chief Operating Officer will:

- Chair the Health and Safety Committee and report to the Trust Management Executive (TME) on relevant matters.
- Shall ensure that sufficient resources are available so that all staff are provided with appropriate and effective information, instruction, supervision, training and where necessary supervision to enable them to fulfil their health and safety responsibilities within the workplace.
- Shall have responsibility for ensuring the Trust has suitable and sufficient arrangements in place for the management of health and safety. This shall include:
    - The appointment of sufficient competent persons to assist the Trust in complying with legal requirements;
    - Maintaining records of accredited staff - site representatives.

The Chief Operating Officer manages the Estates and Facilities function though the "Director of Estates and Facilities". The Director of Estates and Facilities will:

- Have responsibility for Facilities functions within the Trust including security (reference 7) and the management of violence and aggression on all Trust premises (reference 8).
- Have responsibility for the Estates function within the Trust including compliance with Health and Safety Statutory Instruments with regard to the buildings, traffic routes, environment and infrastructure of the Trust. This also includes responsibility for the management of contractors (reference 9).
- The Director of Estates and Facilities (on behalf of the Director of Finance) is the "Trust Representative" and has responsibility for the co-ordination of the Project Agreement between the Trust and the Kent and East Sussex Weald Hospital Limited (KESWHL) to ensure an environment that is as safe as is reasonably practicable for the Tunbridge Wells Hospital at Pembury.

2.3. Director of Workforce and Communications

- The Director of Workforce and Communications is responsible for the provision of Occupational Health Services which provides health assessment, personal and environmental monitoring and health surveillance where required by statute, risk assessment and organisational need.
- Responsible for the planned delivery of induction training – see reference 10) and ensuring the competence of potential new employees, including the checking of qualifications and registration (see reference 23).
- Responsible for the training needs analysis and the planned delivery of mandatory and statutory update training.
- Ensuring that the content of health and safety information and instruction in respect of staff selection, recruitment and training is sufficient and appropriate in meeting the aims and objectives of this policy. The maintenance of relevant employee records including training received (reference 11).
- Maintaining records of recognised accredited staff representatives from unions and staff side organisations. Encourage the election and development of staff representatives. Ensure staff representatives have sufficient time for their function.
- Responsible for the *Management of stress at work policy and procedure* and the provision of training for managers.
- Ensuring each individual's health and safety responsibilities, both statutory and job specific are contained in their written job description which is reviewed and amended as required. Health and safety objectives, targets and relevant KPI's must be included in an individual's annual appraisal which is reviewed throughout the year.

2.4. Directors / Clinical Directors

All Directors or Clinical Directors are responsible for the overall management of health and safety within their Directorate. They are pivotal in providing health and safety leadership within the Directorate and they need to ensure that all their decisions reflect the health and safety intentions as articulated in the Health and Safety Policy statement.

Directors will ensure that:-

- They have systems in place and resources available that will ensure their staff, from all levels, participate in managing health and safety effectively. This includes identified key personnel in post at all levels of the Directorate. See *Risk Management Policy and Strategy* (reference 6).
- They review Directorate health and safety performance as a minimum on an annual basis.
- The work related risks faced by staff and by people not in Trust employment are suitably assessed (reference 13).
- Effective arrangements are in place for planning, implementing, monitoring and reviewing preventative and protective measures.
- All staff within the Directorate are provided with comprehensible and relevant information on the risks they face and the preventative and protective control measures in place that effectively manage those identified risks.
- All Wards/Departments within their sphere of authority have a suitable number of competent persons to manage health and safety and risk including undertaking risk assessments and adverse incident reporting and investigation.
- All Wards/Departments within their sphere of authority have a suitable number of competent persons to undertake workplace health and safety audits, providing reports to Directorate Meetings, via the Directorate Risk Lead
- All staff within the Directorate operates within the parameters of Trust policies.
- Reports on Directorate Health and safety performance and issues are given to the Health and Safety Committee and the Quality and Safety Committee.

Some of these responsibilities can be devolved to appropriate persons within the Directorate structure but the ultimate responsibility rests with the Director.

2.5. Associate Directors / Deputy Directors / Assistant Directors

Each Director may have:

- Associate Directors / Deputy Directors / Assistant Directors
- Associate Directors of Operations (ADOs)
- Heads of Nursing / Associate Directors of Nursing (ADNs)
- General Managers / Heads of Service

As Senior Managers they are accountable for ensuring that Directorate Risk leads and line managers fulfil their responsibilities under this policy (see below). They should also act as role-models in demonstrating compliance with the letter and spirit of health and safety policy and practice. Staff can identify their Senior Managers from the risk web page and **Appendix 7**.

2.6. Directorate Risk Leads

Each Directorate will have a nominated Directorate Risk Lead. The Risk Lead will have delegated responsibility for health, safety and welfare on behalf of their Senior Leaders (See the *Risk Management Policy and Strategy* - reference 6, and Management Structures **Appendix 5 and 6**).

Directorate Risk Leads will remain accountable to their Directors for ensuring that delegated functions are carried out. This will include:

- The development and implementation of individual policies in line with the Trust's health and safety objectives to ensure compliance within all workplaces under their control.
- Monitoring and reporting on Directorate performance in managing health and safety to Directorate committees.
- Assessing the suitability and sufficiency of their managers and key staff in their health and safety roles (reference 6).
- Ensuring that all staff receive health and safety training appropriate to their responsibilities (reference 10 and 11).
- Ensuring risk assessments are carried out routinely including prior to the introduction of new, or changes in established; procedures, practices, staffing levels, staff competencies, equipment, machinery, substances or the working environment (reference 13).
- Ensuring recommendations for remedial action are undertaken as soon as is practicable.
- Implementing where necessary any recommendations of the Health and Safety Committee and Infection Prevention and Control Committee.
- Attending or ensuring that a suitable and empowered representative from their Directorate attends the Health and Safety Committee.

The Trust employee known as the "Trust Representative" will act as the Risk Lead for the project agreement between the Trust and the Kent and East Sussex Weald Hospital Limited (KESWHL). The "Trust Representative" will coordinate the two organisations health and safety arrangements as a member of the "Programme Liaison Committee" and the Trust "Health and Safety Committee".

2.7. Departmental / Ward Manager

Departmental/ ward managers are responsible for the day-to-day implementation of Trust policy and are empowered to take all reasonable measures to ensure that all workplaces and work practices within their areas of responsibility are safe, healthy and meet legal requirements.

They have overall responsibility for health and safety in all work areas under their control. In fulfilling these responsibilities, they shall:

- Ensure risk assessments are carried out in accordance with current health and safety legislation and within the parameters of the Trust *Risk Assessment Policy and Procedure* (reference 13).
- Design and implement in conjunction with their Risk Assessor safe systems of work for any tasks that pose a significant risk to health and safety.
- Liaise with the relevant staff consultative committee prior to incorporating local written polices and procedures.

- Ensure all staff receive training in the use of appropriate control measures prior to undertaking the task.
- Ensure identified staff attend Occupational Health for health surveillance as required.
- Ensure each individual's health and safety responsibilities, both statutory and job specific are contained in their written job description which is reviewed and amended as required.
- Ensure that all staff are appraised annually and that the appraisal discussion includes a review of compliance with *health and safety policy and practice*. Health and safety objectives, targets and relevant KPI's must be included in an individual's annual appraisal which is reviewed throughout the year.
- Ensure any accredited staff representatives from unions and staff side organisations within the team are allowed sufficient time to develop and carry out their function.
- Ensure that appropriate health and safety signage and equipment within the local work environment is in place, appropriate and within date.
- Ensure all staff are provided with suitable and sufficient information, instruction, supervision and training on health and safety issues relevant to their workplace as identified by risk assessment.
- Ensure all workplaces have sufficient first aid provision including trained staff to provide cover during working hours and that these persons receive training in their statutory responsibilities and that records are maintained
- Ensure all adverse incidents are reported, investigated and action taken to reduce/ eliminate recurrence in accordance with the "Incident Management Policy and Procedure".
- Ensure all equipment, plant and machinery is regularly serviced, maintained and records kept.
- Report defects and faults in buildings, grounds, equipment and machinery.
- Ensure remedial action is carried out effectively and in accordance with Trust guidelines. Out of Hours, the duty Senior Manager on site should be approached and if deemed necessary they will authorise the switchboard to contact the On Call Technical Officer who will implement the appropriate actions relevant to the need.
  - At the Maidstone hospital and other sites report to the Estates Department via the telephone help line (01892-6 34001).
  - At the Tunbridge Wells Hospital building maintenance is undertaken by the KESWHL through "InterserveFM", their sub-contractor. Report to the InterserveFM telephone help line (01892 634001).
- Report defects and faults in electrical / mechanical medical equipment to local EME department telephone number 01622 223151 for all sites.
- Ensure that six monthly, systematic and documented safety inspections of the workplace and work practices take place to ensure safe systems of work are appropriate and that risk assessments are still valid (reference 13).
- Ensure re-assessments are carried out following any significant changes.
- Have a suitable number of competent persons to undertake workplace health and safety audits, providing reports to Directorate Meetings, via the Directorate Risk Lead.
- If they manage teams or individuals who are unable or incapable of using or accessing computers; managers must provide Trust wide communications as

either:
  - Printed versions of the communications as handouts or
  - Posters on notice boards within their work area or
  - Verbal reports within their workgroup meetings.
- Consult and/or meet with staff, their representatives and other relevant parties for the discussion and remedy of local risk issues.
- Where a manager engages the services of non-Trust personnel to undertake business on behalf of the Trust, both on and away from Trust premises, they shall consult with those persons before work begins to ensure that risks to all persons are identified, assessed and controlled (reference 9).
  - Employees of KESWHL and InterserveFM will also be expected to comply with Trust policy, procedures and safe systems of work.

2.8. Competent persons

The Trust employs adequate numbers of competent persons to assist in undertaking the measures necessary to comply with health and safety legislation. These are individuals with specialist skills, knowledge and qualifications that are assessed by external bodies such as the 'Institute for Occupational Safety and Health' (IOSH). They are available to advise managers and employees on all aspects of health, safety and risk.

The competent persons will:

- Promote and provide advice and guidance on health, safety and risk management.
- They will undertake Trust wide risk assessments in key areas of hazard and risk.
- From these they will develop policies and procedures (safe systems of work).
- Monitor performance and provide reports to managers and committees.
- Identify new legislation and guidance and review related policies and procedures.
- Serve on Trust committees and advise on risk issues
- Act as key contact with enforcing officers from regulatory bodies.

Competent persons are not employed to manage local risk within the Trust but to advise and support managers to carry out their duties. Risk remains a line management responsibility. Ignoring the advice of Competent Persons could be interpreted as gross negligence.

2.9. All staff

Maidstone and Tunbridge Wells NHS Trust requires all staff at whatever level within the organisation, and whether working under a permanent temporary, staff bank or agency contracts of employment, to:

- Take care of their own health and safety and that of other employees, patients, visitors and non - employees who may be affected by their acts or omissions.
- Comply with all health and safety regulations and notices issued by an enforcement agency.
- To co-operate with the Trust so far as is necessary to enable compliance with all health and safety regulations and notices issued by an enforcement agency.
- Comply with safe systems of work and recognised procedures as identified by risk assessment.
- Not interfere with, mis-use or intentionally disregard the appropriate use of any

equipment, article or notice provided by the Trust in the interest of health and safety.

- Bring to the attention of their managers any shortcomings they are aware of in respect of health and safety policies, procedures, practice, guidelines, safe systems of work, training and supervision.
- Report any adverse incident of which they are aware to their line manager or person in charge of the workplace at the time of the incident and complete an incident report form in accordance with the *Incident Management Policy and Procedure* (reference 14).
- Participate fully in any training programme identified by their manager.
- Report any health issue that may inhibit the individuals ability to carry out the full range of duties in a safe manner

These requirements also apply to contractors working for and within the Trust. Employees of KESWHL and InterserveFM are also expected comply with Trust policy, procedures and safe systems of work.

Individual employees contravening the above responsibilities could face disciplinary action or prosecution.

All staff receive an annual appraisal which includes discussion of compliance with health and safety policy and practice.

Section 3 - Health and safety arrangements

3.1 Trust committee structure

The Trust has a committee structure which shall formally constitute a strategic committee for the development and implementation of its health and safety policy in accordance with its overall arrangements for managing risk. The structure of the meetings hierarchy is as set in **Appendix 6**. Further detail on the management of Risk including heath and safety is contained within the Trust's *Risk Policy and Strategy* (reference 6).

The management committee structure focuses on line management committees that allow health, safety and risk to be discussed and managed locally or escalated to Directorate committees.

The governance structure focuses on specialist committees that contain expertise on key areas of risk. Directorate representatives sit on these committees giving a link to the management committee structure. Key committees are described below:-

3.1.1 Trust Board

The Trust Board consists of a Non-Executive Chairman (appointed by the Secretary of State for Health) and five other Non-Executive Directors, together with five Executive Directors. The Executives include the Chief Executive, who is supported by the Chief Operating Officer, the Director of Finance, the Medical Director and the Chief Nurse.

Whilst the Executive Directors are responsible for the day to day running of the Trust, the entire Board takes collective responsibility for the policies they agree, the plans they make for the future and the overall achievement against performance targets. It is for the Board to ensure that all relevant statutory instruments are complied with and that appropriate arrangements are in place for resourcing and managing risk.

Each year the Board will receive a Health and Safety Annual Report. This will include:

- Health and safety statistics and performance.
- Suggested KPIs and targets
- A draft strategic plan for health and safety.
- Clear ownership of objectives and KPIs

The Board will discuss and modify the KPIs, targets and strategy. The Board will delegate the monitoring and implementation of the strategy to the lead director and the Health and Safety Committee.

3.1.2 Directorate committees

Directorate management committees are responsible to the Board and the Trust Management Executive for ensuring that the strategic and tactical management of health and safety risk is effective and meets statutory requirements.

3.1.3 Trust Management Executive

The Trust Management Executive is the senior management committee in the Trust.

The Trust Management Executive will:

- Oversee the work of the Health and Safety Committee.
- Receive reports from the Health and Safety Committee.
  - Assist in the management of health and safety risks that cannot be managed at directorate level, including accepting risk on behalf of the Trust.
- Make recommendations to Trust Board, as required.

3.1.4 Quality Committee

The Quality Committee is a Board Sub-committee and will:

- Receive reports and act upon recommendations from the sub-committees that comprise the Trust's specialist risk committees.
- Make recommendations to Trust Board, as required.

3.1.5 Trust Health and Safety Committee

The committee acts as the Trust's health and safety committee as required under the 'Health and Safety at Work etc Act 1974' (reference 1). As such it includes elected safety representatives from Trades Unions and Staff Side Organisations recognised by the Trust and those who are elected by a work group who do not have any trades union membership. It is the key committee for health and safety issues that are not covered by other specialist committees (see **Appendix 6**); for example infection control issues are covered by The Infection Prevention and Control Committee.

The committee makes recommendations to the Chief Executive and/or the Trust Management Executive and/or the Board on any subject which it considers appropriate to the health and safety of the Trust's employees or to persons who may be affected by the activities of the Trust and its employees.

The committee undertakes the following on behalf of the Board:

- Influences the annual health and safety KPIs, targets and strategy.
- Monitors the annual KPIs and targets.
- Implements the annual health and safety strategy.
- Manages and monitors a health and safety action plan.
  - Manages and monitors the implementation of the *Health and Safety Policy and Procedure* other key health and safety documentation (see **references and section 3.3**).
- Provide Reports to the Trust Management Executive
  - Seek assurance from directorates that they are managing their health and safety risks.
  - Audits and monitors directorate risk assessments and risk assessment programmes.
- Monitor the outcomes from workplace audits.
  - Monitors suitable health and safety statistics to detect trends and plan programmes to reduce adverse incidents and harm to staff and patients.

- Manages and monitors the coordination of the health and safety arrangements between the Trust and KESWHL. The “Informed Client” (IC) and “Trust Representative” are both are members of the committee as well as the monthly “programme liaison committee”. The Trust Representative will give assurance to the committee through regular reports (see reference 6).

It is a requirement of the “The Safety Representatives and Safety Committees Regulations 1977” and hence the “Workplace Health and safety Standards that. The Trust posts a notice stating the composition of the committee and the workplaces to be covered by it. This notice must be accessible to all employees. Therefore the Terms of reference of this committee are included as an appendix to this procedure (see **Appendix 10**).

3.2 Communication and consultation

3.2.1 Staff consultation processes

The Trust will consult with staff on health and safety matters either directly through communications department, or through employee representatives and Directorate Risk Leads on the Trust’s Health and Safety Committee. For large issues the Trust shall establish appropriate management and staff consultative structures including the Joint Consultative Forum.

3.2.2 Staff safety representatives

The Trust acknowledges the roles of both Union accredited and locally elected staff safety representatives and shall encourage their active participation in both the organisation and implementation of health and safety within the Trust. All recognised Trades Unions and Professional Organisations who are signed up to the Trust Partnership Agreement have a right to a place on the Health and Safety Committee as do persons who are elected from a work group who are not represented by a Trades Union or Professional Organisation.

The Trust encourages the election and development of staff representatives and ensures that staff representatives have sufficient time for their function.

Representatives will feedback issues discussed at Health and Safety Committee to their members and to the Staff Side Chair for further discussion at the established Joint Consultative Forum.

3.2.3 Direct Communication

As well as communication through the Union Safety Representatives (staff side) the Trust also consults with staff directly on health and safety matters through several communication processes to ensure that all staff receives all the necessary information they require.

These include:

- E-mail to all staff through the Communication Department.
- Cascade of these e-mails through line managers via local management meetings.
- The Chief Executive's update to all staff.
- The Clinical Governance newsletter to all staff.
- Through the Trust's intranet and internet sites.
- Through committee minutes and reports.
- Mandatory update training.
- Internal safety alerts issued by the Quality and Governance Directorate.
- Posters including the statutory health and safety poster.

Staff without immediate access to computers can access computers in libraries. All staff will be given e-mail accounts and managers will ensure some computer access.

Staff unable or incapable of using or accessing computers their managers will provide either:

- Printed versions of the communications as handouts or
- Posters on notice boards within their work area or
- Verbal reports within their workgroup meetings.

3.3 Hazard identification and risk assessment

This process is described in detail in the *Risk Assessment Policy and Procedure* (reference 13).

3.3.1 Local hazard identification and risk assessment

All managers have to undertake an annual review of their risk assessments which includes a review of their "hazard profile checklist". This document lists all the possible hazards their staff could face.

All managers carry out local health and safety inspections during which they may identify further hazards.

Adverse incident reporting and management will also identify unforeseen hazards.

The manager will either:

- Record the way some risks are managed in the profile checklist (if covered by trust wide policy, procedure or risk assessment).
- Complete formal risk assessments for significant hazards.
- Ignore trivial risks or those that are part of everyday life (but record this on the checklist).

The manager will share all the documentation with all relevant staff who will sign to confirm they have read and understood.

3.3.2 Trust-wide hazard identification and risk assessment

The Trust's competent persons will identify hazards within their area of expertise. They undertake Trust-wide risk assessments for these hazards. The results of these assessments will be incorporated into policies and procedures that are implemented Trust-wide. Significant assessments are added to the risk register as closed risks (archived but accessible to staff). Some assessments will be appended to policies and procedures.

The Trust's competent persons view all adverse incidents in their areas of expertise. They sit on Trust committees so are able to identify or indicate hazards around the Trust.

Where policies, procedures or assessments exist they are hyperlinked to the hazard profile checklist and hence shared with local managers.

3.4 Policy and procedure

3.4.1 Policies and procedures

The Trust's "undertakings" are complex and offer many risks hence there are a large number of risk assessments carried out at all levels of the Trust. These result in many 'safe systems of work' ranging from local rules and method statements through to Trust wide policies, procedures and guidance documents.

If all the Trust's health and safety arrangements were detailed within the Health and safety policy it would become a very large and unwieldy document. Hence, this policy is supported by a framework of specific polices and procedures. These each undergo consultation and peer review before approval through specialist committees.

Once approved all policies, procedures and guidance documents are published in an electronic library. This is available to all members of staff through the Intranet. Computers are provided in the Trust libraries. All staff are informed of changes and updates in a monthly posting on the bulletin board, for which a notification is emailed Trust-wide by COMMS, and through local management meetings. Many key safe systems are appendices to these policies and procedures and are also available in the intranet.

Some policies and procedures are specifically required by the Department of Health and its enforcing agencies and bodies. They are mandated under standards which have prescriptive requirements for the documents. Therefore the Trust's health and safety arrangements will be encompassed within these documents. The relevant documents are described in **Appendix 8** and listed below:

3.4.2 Risk Management Strategy

The Trust is required to have a *Risk Management Policy and Strategy* (reference 6) by the Department of Health. The document describes the Trust's arrangements for the management of all forms of risk including health and safety risks. It includes detailed descriptions of:

- Definitions, duties, roles and accountabilities
- Trust risk committee structure
- Local process for the management of risk, including escalation and reporting.
- Introduction to risk assessment and incident investigation.
- Monitoring, auditing and assurance.

There will be a significant overlap between the *Risk Management Policy and Strategy* and the *Health and Safety Policy and Procedure* and both must be read in conjunction. Implementation of the *Risk Management Policy and Strategy* will also ensure the implementation of the *Health and Safety Policy and Procedure* and hence to prevent confusion a single implementation, monitoring and audit plan will be adopted. This is described in detail within the strategy.

3.4.3 ***Risk Assessment Policy and Procedure*** (reference 13)

Describes the Trust's arrangements for the systematic assessment and management of all types of risk.

3.4.4 ***Incident Management Policy and Procedure*** (reference 14)

Serious Incidents (SI) Policy and Procedure (reference 15)

Describes the Trust's arrangements for the investigation of adverse incidents.

3.4.5 ***Guidance on Risk Register Administration and Review*** (reference 16)

Risks identified from local risk assessment and adverse incident investigations are placed on a risk register. This allows risks to be managed effectively or escalated through the local management committee structure to Directorate and Board level and allows risks to be managed (mitigated or accepted) at the correct level, recorded and shared.

3.4.6 Other key linked policies and procedures

This policy is supported by many other specific polices and procedures. Many of the Trust's health and safety arrangements are encompassed within these documents. The relevant documents are listed in the references section.

3.5 Health and safety assistance

The Trust employs competent persons to assist it in complying with the requirements and prohibitions of any relevant statutory provisions, and for the provision of advice, guidance, instruction and training to assist Trust personnel in meeting their obligations. The names of the staff in these roles at present are given in **Appendix 9**. Their objectives and targets are included in their job descriptions and reflected in their annual appraisals.

These staff will also identify Trust wide hazards and carryout Trust wide risk assessments. From these policies and procedures (safe systems of work) are developed and shared with all staff. These include clinical specialists, Trust leads and Trust Officers:

These persons include:

3.5.1 Risk and Compliance Manager

- The competent person for health, safety and risk within the Trust advising management and staff.
- Prepares the draft annual health and safety report and strategy for the Board.
- Manages and coordinates the activities of the health and safety advisers within the Safety Team.
- Acts as key contact with the Health and Safety Executive (HSE) Inspectors.
- Develops risk, health and safety policies and procedures
- Advises managers on investigations and the identification of remedial actions
- Ensures risk, health and safety training for staff meets the needs of the Trust and statutory requirements.

3.5.2 Health and Safety Advisor

- Assists the Risk and Compliance Manager in the carrying out of the functions of the Safety Team.
- Assists in health and safety policy development.
- Ensures that there is in place a programme for the delivery of health and safety training.
- Ensures that an Investigation of those health and safety incidents reportable to an external agency has taken place. (See *Incident Management Policy and Procedure* – reference 14).
- Acts as point of contact with the Health and Safety Executive (HSE) Inspectors
- Ensures that all RIDDOR reportable adverse events (incidents) are reported to the HSE (reference 17).
- Is also a source of competent advice and assistance in the management of health and safety throughout the Trust.
- Is the focal point for health and safety training in the Trust, and the responsible person for the production, delivery and evaluation of the Trust's health and safety training programme. This will include co-ordination of the risk management components of the Trust corporate induction and mandatory training (reference 10 and 11).

3.5.3 Patient Safety Lead

- Leads on patient safety and clinical risk for the Trust.
- Leads on clinical risk policy development.
- Manages and coordinates the activities of the Patient Safety Team.
- Advises managers on investigations and the identification of remedial actions for clinical risk (See *Incident Management Policy and Procedure* – reference 14).
- Ensure that an investigation of clinical incidents reportable to an external agency takes place (reference18).
- Ensures that all serious incidents requiring investigation (known as 'serious incidents' or 'SI') are reported externally and managed appropriately (reference 27).
- Ensures the quality of the incident management reporting system and the investigation of all adverse incidents.

3.5.4 Moving and Handling Co-ordinator

- The Trust's competent person for assessment, advice, training and the development of safe systems of work relating to the moving and handling of people and loads.
- Ensures all staff receives training on all matters relating to manual handling safety.
- Leads on policy development for manual handling operations (reference 19).
- Investigates and advises on adverse incidents involving manual handling operations that are reportable to an external agency.

3.5.5 Fire Safety Officer

- Ensures that the Trust has fire risk assessments for all areas.
- Develops Trust *Fire Safety Policy and Procedure* as well as practical, technical guidance (reference 20).
- Ensures all staff receive training on all matters relating to fire safety.
- Reports on and makes recommendations on all identified deficits which compromise the Trust's ability to comply with fire safety legislation.
- Will investigate and advise on all adverse events (incidents and near misses) where fire is a component part.
- Act as point of contact with the Enforcing Fire Authority and other local government bodies.

3.5.6 Occupational Health Service

- The Occupational Health service shall provide competent advice and clinical practice to all levels of staff with equality of access.
- The service shall contribute to the prevention of ill health and disease associated with work and aim to optimise staff health in the workplace.
- To ensure that any occupation diseases referred are reported under the RIDDOR regulations as required.
- Occupational Health Service will employ competent staff and provide recommendations on health surveillance and control measures associated with the Control of Substances Hazardous to Health Regulations (reference 21).

3.5.7 The Director of Infection Prevention and Control (DIPC)

- The Trust's competent advisor in all matters relating to infection control.
- Leads the Infection Prevention and Control Team.
- Develops infection prevention and control policies and procedures (reference 22 and 23).
- Investigates and advises on all infection prevention and control risks that are reported
- Carry out inspections and audits across Trust sites.
- Deliver infection prevention and control training as identified by risk assessment, training needs analysis and Department of Health guidance.

3.5.8 Radiation Protection Adviser (RPA)

- A suitably qualified person appointed under the Ionising Radiations Regulations 1999, to provide advice and assistance in the safe management and use of radioactive isotopes and radiation generating equipment (reference 24 and 25).
- Supported by Radiation Protection Supervisors on each main hospital site.

3.5.9 Local Security Management Specialist (LSMS)

- A suitably qualified person appointed to offer advice and expertise on all aspects of security including the prevention of violence and abuse.
- Develops policies and procedures on violence and abuse (reference 8).
- Investigates and advises on reported security incidents and risks (reference 7).
- Carry out inspections and audits across Trust sites.
- Delivers conflict resolution training for all staff as identified by risk assessment.

3.5.10 Dangerous Goods Safety Advisor (DGSA)

- A suitably qualified person appointed to provide advice and assistance in the disposal of waste and dangerous goods.
- Carry out inspections and audits across Trust sites.
- The DGSA is accessed through the Waste Manager.

3.5.11 "Trust Representative"

The Tunbridge Wells Hospital is operated under a PFI Project Agreement between the Trust and the Kent and East Sussex Weald Hospital Ltd (KESWHL). Both the "Trust representative" cooperates and coordinates the health and safety arrangements between the two organisations. At present the "Trust representative" is the Director of Estates and Facilities.

This is achieved through weekly interface meetings, a monthly mitigation meeting and a quarterly liaison meeting.

3.5.12 Trust Secretary

Leads on the development of the Board Assurance Framework.

Section 4 - Implementation

This policy will be ratified by the Board. It will also be agreed and accepted by Trade Unions, professional bodies, other staff representative groups and signed by the chair of the Joint Staff Forum.

This policy will be issued as a working policy to all levels of management via the Trust intranet. The policy will be readily accessible to all staff at all times including Bank or Agency staff.

This policy should be read in conjunction with other associated health, safety and risk management policies (see **Appendix 8** and **section 3.3**. This policy will form the basis of health, safety and risk management training provided for all staff at all levels.

The implementation of this policy will be driven by the implementation of the Trust's *Risk Management Policy and Strategy* in that the strategy defines the organisation and arrangements for managing all risk including health and safety. Health and safety key performance indicators (KPI's) are set through the *Risk Management Policy and Strategy*, other Trust policies and by key committees. KPI's will be monitored to measure the Trust's performance. They shall be used as part of the directorate review process to assess compliance and hence improvement in health and safety throughout the organisation.

The Safety Team will ensure that all key staff and managers have access to sufficient information and training to undertake their duties. The Safety Team will be available to advise and support all staff in the management of health and safety.

3.1 Implementation of this policy will be closely linked to that of the Trust *Risk Management Policy and Strategy*. The *Risk Management Policy and Strategy* implementation plan involves the setting of key performance indicators and performance targets. These include risk assessment, key staff, risk registers and incident investigation. It is important that the policy is implemented from the top down to show management commitment and demonstrate an appropriate level of priority and importance. The implementation will be monitored by the Health and Safety Committee.

3.2 The Trust *Health and Safety Policy and Procedure* must be ratified by the Trust Board. Once ratified the lead will submit this policy/procedure document to the Clinical Governance Assistant who will activate it on the Trust intranet (Q-Pulse document database).

3.3 A monthly publications table is produced by the Clinical Governance Assistant which is published on the Trust intranet under "Policies"; notification of the posting is included on the intranet "News Feed" and in the Chief Executive's newsletter.

3.4 On reading of the news feed notification all managers should ensure that their staff members are aware of the new publications.

3.5 All Staff Side members and other members of the Health and Safety Committee were included in the consultation for this policy and will give their approval at a committee meeting. Staff Side representatives will share this policy with their members.

3.6 Implementation will be progressed through a process of continuous improvement. This will continue to ensure that once an acceptable standard is reached, it is maintained and improved. The KPIs and targets used will be set by the relevant committees.

Section 5 - Review and audit

The Safety Team carry out risk management performance audits against KPI's. Each department and directorate will be compared as part of a benchmarking exercise across the Trust. The Trust will be compared with national figures from similar Trusts taken from HSE databases. Performance will be reported to the Health and Safety Committee. This will be part of a process of continuous improvement.

This policy will be reviewed annually and revised periodically to incorporate new or revised statutory requirements and changes in the needs and objectives of the Trust and its services.

This policy will be reviewed annually and any changes presented to the Board for ratification with the annual report.

APPENDIX ONE

Process requirements

1.0 Implementation and awareness

- This policy will be bought to the attention of all key staff detailed in **Appendix 2** via the email system of dissemination. It will also be presented to members of the Health & Safety Committee and the Quality & Safety Committee for comment.
- The policy will be approved and ratified by the Trust Board of Directors.
- Once approved the document lead or author will submit this policy/procedural document to the Clinical Governance Assistant who will activate it on the Trust approved document management database on the intranet, under 'Trust polices, procedures and leaflets'.
- A monthly publications table is produced by the Clinical Governance Assistant which is published on the Trust intranet under "Policies"; notification of the posting is included on the intranet "News Feed" and in the Chief Executive's newsletter.
- On reading of the news feed notification all managers should ensure that their staff members are aware of the new publications.

2.0 Review

The Risk and Compliance Manager will formally review with full consultation, approval and ratification every three years.

3.0 Archiving

The Trust intranet retains all superseded files in an archive directory in order to maintain document history.

APPENDIX TWO

CONSULTATION ON: Trust Health and Safety Policy and Procedure

Please return comments to: Trust Risk and Compliance Risk Manager

By date: 2-3-2015

Name: *List key staff appropriate for the document under consultation. Select from the following:*	Date sent	Date reply received	Modification suggested? Y/N	Modification made? Y/N
Members of the Board	16-2-15			
Chief Operating Officer	16-2-15			
Trust secretary	16-2-15			
Non-Executive Directors	16-2-15			
Directors	16-2-15			
Members of the Trust Management Executive	16-2-15			
Clinical Directors	16-2-15			
Members of the H&S Committee	16-2-15			
Directorate Risk Leads	16-2-15			
Dietician	16-2-15	18-2-15	N	N
Nurse Consultant Infection Prevention	13-2-15	17-2-15	Yes	Yes
Local Counter Fraud Specialist	16-2-15			
Staff Side chair	16-2-15			
Trust Health and Safety Advisor	16-2-15			
Estates Health and Safety Advisor	16-2-15			
Associate Director of Governance, Quality and Patient Safety	16-2-15			
Patient Safety Leads	16-2-15			
Clinical Governance Assistant	16-2-15	17-6-15	Y	Y
The “Trust Representative” (Director of Estates and Facilities)	16-2-15	24-2-15	Y	Y
Trust fire Officer	16-2-15			
Radiation Protection Advisor	16-2-15			
The role of those staff being consulted upon as above is to ensure that they have shared the policy for comments with all staff within their sphere of responsibility who would be able to contribute to the development of the policy.				

APPENDIX THREE

Equality Impact Assessment

In line with race, disability and gender equalities legislation, public bodies like MTW are required to assess and consult on how their policies and practices affect different groups, and to monitor any possible negative impact on equality.

Please note that completion is mandatory for all policy development exercises. A copy of each Equality Impact Assessment must also be placed on the Trust's intranet.

Title of Policy or Practice	Health and Safety Policy and Procedure
What are the aims of the policy or practice?	To ensure H&S of employees and others.
Identify the data and research used to assist the analysis and assessment	To meet H&S at Work etc Act 1974
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	Is there an adverse impact or potential discrimination (yes/no). If yes give details.
Males or Females	No
People of different ages	No
People of different ethnic groups	No
People of different religious beliefs	No
People who do not speak english as a first language	May need to provide H&S information and training pictorially or in different languages.
People who have a physical disability	No
People who have a mental disability	No
Women who are pregnant or on maternity leave	Need to complete risk assessments for pregnant employees
Single parent families	No
People with different sexual orientations	No
People with different work patterns (part time, full time, job share, short term contractors, employed, unemployed)	No
People in deprived areas and people from different socio-economic groups	No
Asylum seekers and refugees	No
Prisoners and people confined to closed institutions, community offenders	No
Carers	No
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	
When will you monitor and review your EqIA?	Annually with this policy
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix three of this policy/procedure on the Trust Intranet (Policies and Guidelines).

FURTHER APPENDICES

The following appendices are published as related links to the main policy /procedure on the Trust Intranet (Policies and Guidelines):

No.	Title	Unique ID
4	Risk categorisation matrix	RWF-OWP-APP51
5	Trust management structure chart	RWF-OWP-APP1
6	Trust governance committee structure chart	RWF-OWP-APP2
7	Directory of local key staff and managers	RWF-OWP-APP678
8	Trust risk documentation	RWF-OWP-APP3
9	Key contacts	RWF-OWP-APP4
10	Terms of reference of the Health and Safety Committee	RWF-OWP-APP725

FOI Applicant Feedback

Maidstone & Tunbridge Wells NHS Trust constantly reviews the services that we provide in order to ensure that we deliver the highest quality possible to our service users. In order to assist with this process we would ask you please to take a couple of minutes to provide us with some feedback with regard to the FOI service that you have been provided.

FOI Request reference Number	
Did you find it easy to make a request for information?	Yes / No
Did you receive an acknowledgement within a reasonable timeframe?	Yes / No
Are you satisfied that your request was dealt within a timely manner?	Yes / No
Did the response content address the requirement of your request?	Yes / No
What if anything do you feel the Trust could do differently to improve the FOI service for the benefit of our service users?	

Please send this completed form to:

Mtw-tr.foiadmin@nhs.net or

G Spinks
Head of Information Governance
Maidstone & Tunbridge Wells NHS Trust
Maidstone Hospital
Hermitage Lane
Maidstone
Kent ME16 9QQ