# Complaints, MP letters and Concerns Policy

<table>
<thead>
<tr>
<th>Policy Folder &amp; Policy Number</th>
<th>Corporate</th>
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<tbody>
<tr>
<td>Version:</td>
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<tr>
<td>Ratified by:</td>
<td>Governing Bodies</td>
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<tr>
<td>Name of originator/author:</td>
<td>Deputy Director of Corporate Services and Governance</td>
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<tr>
<td>Name of responsible committee/individual:</td>
<td>Quality and Safety Committees in common</td>
</tr>
<tr>
<td>Date approved by Committee:</td>
<td>20\textsuperscript{th} July 2019</td>
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<td>Date issued:</td>
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<tr>
<td>Review date:</td>
<td>Three years from date of ratification or earlier if there is any legislation changes</td>
</tr>
<tr>
<td>Date of first issue</td>
<td>April 2013</td>
</tr>
<tr>
<td>Target audience:</td>
<td>All employees, including temporary staff and contractors, Members of the public</td>
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### CONSULTATION SCHEDULE

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<tr>
<th>Name and Title of Individual</th>
<th>Groups Consulted</th>
<th>Date Consulted</th>
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<tbody>
<tr>
<td>Chief Operating Officer</td>
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<tr>
<td>Executive Director of Quality and Safety</td>
<td>Internal</td>
<td>June 2018</td>
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<tr>
<td>Equality and Inclusion Business Partner</td>
<td>MLCSU</td>
<td>June 2018</td>
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### RATIFICATION SCHEDULE

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### VERSION CONTROL

<table>
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<tr>
<td>1</td>
<td>Combination of existing policies from six CCGs</td>
<td>27.08.2018</td>
<td>Alex Palethorpe</td>
</tr>
<tr>
<td>2</td>
<td>Quality Review of combined policy and SOP</td>
<td>24.12.2018</td>
<td>Vicki Graham</td>
</tr>
<tr>
<td>3</td>
<td>Inclusion of comments received from Quality Committee and final alignment across the six Staffordshire CCGs.</td>
<td>02.08.2019</td>
<td>Tracey Revill</td>
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### IMPACT ASSESSMENTS – Available upon request

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<tr>
<th>Impact Assessment</th>
<th>Stage</th>
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1.0 Introduction

1.1 This document sets out the CCGs’ approach to dealing with complaints, MP letters and concerns about the services provided by Cannock Chase Clinical Commissioning Group, East Staffordshire Clinical Commissioning Group, North Staffordshire Clinical Commissioning Group, South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group, Stafford and Surrounds Clinical Commissioning Group and Stoke-on-Trent Clinical Commissioning Group (the CCGs) and the services commissioned. It provides a framework for how the CCG will handle, respond to and learn from complaints and how this will influence future commissioning of services. The CCGs welcome the opportunity to learn from user experience and to improve services in the future.

1.2 The CCGs will meet the legal requirements of the Local Authority Social Services and National Health Service Complaints (England) regulations 2009. The CCG will act in accordance with the NHS Constitution and in line with the Francis Report (2013) and Clywd Hart Review (2013) and will be guided by best practice.

1.3 Midland and Lancashire Commissioning Support Unit (the MLCSU) manage complaints on behalf of the CCGs and also offer a Patient Advice and Liaison Service (PALS). The CCGs are committed to working with the MLCSU to provide the best service for patients, their families and carers.

2.0 Aims

2.1 The CCGs are committed to high quality patient care for all local residents. This includes encouraging a culture that seeks and uses people’s experiences of care to improve commissioned services. The CCGs are accountable to local residents for commissioning decisions and will use the valuable insight from patients and their representatives to improve services.

2.2 The CCGs will take all complaints seriously and make sure they are properly investigated and responded to in an unbiased, non-judgmental, appropriate and timely way. The CCGs aim to deal with all complaints fairly for both the complainant and complained about, including any staff that may be involved. Where complaints can be resolved quickly and informally, the CCGs will aim to support this.

2.3 The CCGs work will be underpinned by the NHS Constitution including the ‘Duty of Candour’ and the ‘Compassion in Practice’ 6Cs:
   • Courage
   • Commitment
   • Competence
   • Care
   • Compassion
   • Communication

2.4 There is also a range of documents and publications that will guide how the CCGs manage complaints and concerns which are set out in Section 4.0 of this document.

3.0 Scope of the Policy

3.1 A complaint may be made by the person who is receiving, or has received NHS treatment or services, which are provided or commissioned by the CCGs, or it may be made by a person acting on behalf of the person affected in any case where that person:

3.1.1 is a child; (an individual who has not attained the age of 18)

In the case of a child, the CCG must be satisfied that there are reasonable grounds for the complaint being made by a representative of the child and furthermore that the representative is making the complaint in the best interests of the child.
3.1.2 *has died;*
In the case of a person who has died, the complainant must be the personal representative of the deceased. The CCGs need to be satisfied that the complainant is the personal representative. Where appropriate, evidence may be requested to substantiate the complainant's claim to have a right to the information.

3.1.3 *has physical or mental incapacity;*
In the case of a person who is unable by reason of physical capacity, or lacks capacity within the meaning of the Mental Capacity Act 2005, to make the complaint themselves, the CCGs need to be satisfied that the complaint is being made in the best interests of the person on whose behalf the complaint is made.

3.1.4 *Has given consent to a third party acting on their behalf;*
In the case of a third party pursuing a complaint on behalf of the person affected the CCG will request the following information:
- Name and address of the person making the complaint;
- Name, date of birth and address of the affected person; and
- Contact details of the affected person so that they can be contacted for confirmation that they consent to the third party acting on their behalf. This will be documented in the complaint file and confirmation will be issued to both the person making the complaint and the person affected.

3.1.5 Has delegated authority to act on their behalf, for example in the form of a registered Power of Attorney which must cover health affairs.

3.1.6 Is an MP, acting on behalf of and by instruction from a constituent.

3.2 A complaint should be made within 12 months of:
- The date of the event that led to the complaint took place
- The date it came to the attention of the complainant

*Except in exceptional circumstances.*

3.3 Where a complaint is received after the time limit the CCG will decide whether to investigate. This will be based on the reason the complaint was not made sooner and whether it can still be fairly investigated.

3.4 Although the CCGs delegate the management of the complaint process to the MLCSU, it remains their duty to make sure that Providers co-operate and the complaint is handled in a timely and user-centred way.

3.5 Some types of complaints fall outside the scope of this policy. They include:
- Complaints about privately funded healthcare;
- If a complaint is also part of an ongoing police investigation or legal action it will be discussed with the relevant police authority or legal advisor and only continue as a complaint if it does not compromise the police or legal action. When other action is concluded there will be a discussion with the complainant about whether to investigate and respond at that stage;
- A matter that has already been investigated under the complaint regulations;
- Matters which are being or have been investigated by the Ombudsman;
- A matter arising out of an alleged failure to comply with a data subject request under the Data Protection Act 2018;
- A matter arising out of an alleged failure to comply with a request for information under the Freedom of Information Act 2000;
- Concerns raised under the Public Interest Disclosure Act 1998 (whistle blowing);
3.5 In these circumstances, the CCGs will contact the complainant and explain the reasons for not dealing with the complaint.

3.6 The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 also apply to GPs, dentists, pharmacists, optometrists and prison healthcare providers. However, these service areas are commissioned by the NHS England sub regional team and so any complaint for these services will be their responsibility and are outside the scope of this policy.

3.7 The Complaint and Concerns Policy is not designed to blame staff, but to investigate complaints to provide a satisfactory outcome for the complainant, to learn any lessons and make improvements. If a complaint identifies information which indicates a need for disciplinary action this will be managed separately under the CCG’s Disciplinary Policy and Procedures.

4.0 Timescales

4.1 Once a complaint or MP letter is received by the CCGs it must be dealt with immediately in order that it can follow the process and allow the MLCSU Patient Services Team to acknowledge the complaint within the statutory three working day timescale (this timescale starts from the day of receipt. It is therefore vital that there are no delays in complaints or MPs letters being sent to the Governance Team.

4.1.1 Response to receipt of complaint within three working days.

4.1.2 Aim to respond to complaint in full within 20 working days, if investigation needs longer, complainant to be notified and kept up to date with the ongoing investigation.

4.1.3 Respond to complaint no later than 40 working days unless there is additional complexity which could cause a delay, notification to the complainant must be adhered to.

4.2 COMPLAINTS:
The statutory timescale for responding to complaints is within six months, NHS England guidance suggests 40 working days maximum as a timescale for responding to a complaint, and therefore the CCGs commit to providing a response within 40 days. Where it is not possible to provide a response within short timescales reasons must be stated and fed back to the MLCSU in order for them to provide timely updates to the complainant. Where a complaint has not been concluded with a response sent within six months then the reasons must be set out and the complainant must be informed.

4.3 MP LETTERS:
The CCGs have made a commitment to their local MPs that their queries will be dealt with within ten working days. In the event that this timescale is not possible the Executive Assistant to the Accountable Officer MUST be informed immediately setting out the reasons that the timescale cannot be met in order that the MP can be advised and an extension requested.

4.4 QUALITY ASSURANCE REVIEWS:
If a review of a draft response is required from the CCG or a response from a provider it should be reviewed within three working days and returned to the Governance Team with comments via use of the quality assurance form (Appendix B).

4.5 PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN (PHSO):
If a complainant is unhappy with a complaint response and local resolution has been exhausted, a complainant has the right to ask the Parliamentary and Health Service Ombudsman (PHSO) to review the complaint. In such cases, the PHSO will make contact with the CCG and review the complaint and investigation.

4.6 Where the CCGs have been asked to provide information or carry out recommendations following a PHSO investigation this must be done without any delays, to meet the timescale set by the PHSO. The PHSO commit to completing their investigations/findings within a time period of three to six months where possible.

5.0 Definition of Terms and Glossary

5.1 A **Complaint** is an expression of dissatisfaction that requires a formal response. It is usually a problem which has not yet been resolved, or which concerns past treatment. It can be made face-to-face or over the telephone (verbal complaints) or by letter and e-mail (written complaints).

5.2 A **MP Letter** is an expression of dissatisfaction that requires a formal response from a member of parliament on behalf of and by instruction from a constituent. It is usually a problem which has not yet been resolved, or which concerns past treatment.

5.3 **Concern** is a problem which can be dealt with more quickly and informally. This is usually by the end of the working day after it is received.

5.4 **Local Resolution** is the investigation and resolution of complaints under the first stage of the NHS complaints procedure. It includes everything done locally, before a complaint is considered by an Ombudsman.

5.5 **A Serious Incident (SI)** is any event where the organisation or individual has, through act or omission, caused significant or permanent harm to patients, reputational damage to organisations or significant disruption of normal services (NHSE (2015)).

5.6 The **Ombudsman** refers to the Parliamentary and Health Service Ombudsman (PHSO) who are the second stage of the NHS complaints procedure. If the CCGs cannot resolve a complaint, the complainant has the option to approach the Ombudsman for a review. The Ombudsman will assess if the CCGs have acted fairly in the complaint investigation and if the response has adequately addressed the complaint.

5.7 Local **Advocacy Services** are available to act on a patient’s behalf throughout the complaint process including dealing with the Ombudsman.

5.8 The **Local Authority Social Services and National Health Service Complaints (England) Regulations 2009** is the legislation which provides the framework for managing complaints in the NHS.

5.9 “**Datix**” is the CCGs’ risk management system which is used for the recording and reporting of incident, complaints, PALS, claims and organisational risks.

6.0 Principles of handling concerns and complaints

6.1 The CCGs will make sure that complaints are considered in accordance with the law and this policy. There are several documents and publications that give helpful guidance in how to deal with complaints and concerns.

6.2 The Parliamentary and Health Service Ombudsman (PHSO) 2009 guidance sets out ‘**Principles of Good Administration, Principles of Good Complaints Handling and Principles for Remedy.**’

6.3 These three sets of principles outline the approach to be taken by public bodies when delivering good administration and customer service, and how to respond when things go wrong.

Draft Complaints and Concerns Policy
6.4 They underpin the Ombudsman's assessment of performance, their vision of good complaint handling and their approach to put things right. The same six themes which apply to each of the three principle documents are:

- Getting it right;
- Being customer focused;
- Being open and accountable;
- Acting fairly and proportionately;
- Putting things right;
- Seeking continuous improvement.

6.5 These documents also provide some specific rights for patients. These include:

- Have their complaint acknowledged and properly investigated;
- Discuss how the complaint will be handled and when they can expect a reply;
- To be kept informed of the progress and promptly told the outcome;
- Have access to further redress through the PHSO, the Information Commissioners Office or legal channels including Judicial Review.

6.6 The PHSO also issued 'My Expectations for Raising Concerns and Complaints' which articulates a user led vision for raising complaints and concerns based around a series of 'I' statements across the life cycle of a complaint. For example, when someone is considering making a complaint they should be able to say 'I felt confident to speak up' and they would know they had a right to complain, they knew how to complain, they could receive support to complain and their future care would be unaffected. A summary of the 'I' statements is below.

<table>
<thead>
<tr>
<th>Stage of Complaint</th>
<th>I Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Considering a complaint</td>
<td>I feel confident to speak up</td>
</tr>
<tr>
<td>Making a complaint</td>
<td>I felt that making my complaint was simple</td>
</tr>
<tr>
<td>Staying informed</td>
<td>I felt listened to and understood</td>
</tr>
<tr>
<td>Receiving outcomes</td>
<td>I felt my complaint made a difference</td>
</tr>
<tr>
<td>Reflecting on the experience</td>
<td>I would feel confident making a complaint in future</td>
</tr>
</tbody>
</table>

6.7 The 'Good Practice Standards for NHS Complaints Handling' was published by the Patients Association in September 2013. The standards can be summarised as:

- Openness and transparency, including well publicised and accessible information that is understood by all parties to the complaint;
- A consistent approach, centred on evidence based and complainant led investigations and responses;
- A logical and rational approach;
- Provide opportunities to give feedback on the complaints service;
- Offer support and guidance throughout the complaint process;
- Provide a level of detail which is proportionate to the complaint;
- Identify the cause of the complaint and take action to prevent recurrence;
- Using lessons learned to make changes and improvements;
- Ensure that ongoing care is not affected by having complained.

6.8 The CCGs’ complaint system will enable patients and the public to readily make their
own views known, without fear of discrimination and will ensure that lessons learned are widely disseminated.

6.9 The CCGs and the MLCSU will promote equality of access to the complaint service and will ensure that people from minority and disadvantaged communities are given full and equal access to the Complaints and Concerns process. The CCGs acknowledge that it may be difficult for some people to express their concerns and the CCGs and MLCSU will encourage people to voice their opinions where appropriate. The PALS service will be an important point of contact, or referral, to facilitate this.

6.10 The handling of complaints will adhere to the principles of the Mental Capacity Act 2005 and the Data Protection Act 1998. Confidential patient information will not be disclosed to a third party unless the patient has given their consent. The CCGs and MLCSU will assume a person has capacity to make their own decisions, and support them to do so. If it is assessed that a person cannot give consent they will seek evidence that the person complaining on the patient’s behalf has the authority to do so.

7.0 Roles and Responsibilities

7.1 CCGs and MLCSU will undertake a number of roles in relation to the management, resolution and investigation of complaints, these roles are:

- The thorough investigation of complaints received by the CCGs or MLCSU;
- To co-operate fully with other NHS and Social Care bodies to co-ordinate complaint investigations;
- To monitor whether commissioned providers adhere to the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009;
- To request and use information about complaints which is provided by healthcare providers commissioned by the CCGs, when monitoring the quality of services commissioned;
- To use information gained through complaints investigation, to inform the commissioning process, to ensure that the services commissioned meet the expectation and needs of the local population.

7.2 The complaints process is managed by the MLCSU Complaints and PALS Service. They will make sure the system works effectively and efficiently and that deadlines are met. The team is responsible for ensuring investigations are completed, drafting a response to the complainant and keeping a log of lessons learned. The MLCSU will produce a quarterly report for the Quality and Safety Committees in common.

7.3 The MLCSU will be accessible to the public and to all staff for advice and support. Cover arrangements must be in place for periods of absence from work. The MLCSU will also provide a PALS service to act as an accessible guide and information point about health services, as well as working to resolve informal concerns about commissioning decisions and commissioned services.

7.4 All staff must be aware of the correct procedure to follow should anyone wish to raise a concern or make a complaint. If a complainant wishes to make a formal complaint but is unable or unwilling to put it in writing, the person who takes the call should take down the details of the complaint using the Verbal Complaints Form at appendix 1. The completed form should then be sent to the generic Complaints inbox; sas.centralgovernance@nhs.net. In addition staff must provide information reasonably required of them by the MLCSU during complaint investigations.

7.5 The CCGs’ Governing Bodies will take a lead role in ensuring that the complaints are handled effectively, and that services are improved as a result of the lessons learned. The Quality and Safety Committees in common will feed information into the Governing Body and will receive a quarterly complaints report including trends, themes and
improvement actions. The Governing Bodies will receive a copy of the Annual Complaints Report which will be distributed in accordance with Regulation 18 of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

7.6 The Accountable Officer of the CCG is ultimately responsible for ensuring there is an effective process for the management, investigation and resolution of complaints and for ensuring that the CCGs and MLCSU comply with the regulations. The Accountable Officer will sign all complaints responses sent by the CCGs, except where this would lead to a significant delay. On such occasions, a suitable deputy will sign the letter.

7.7 The Quality and Safety Committees in common is responsible for monitoring the CCGs’ complaints process. They will identify any areas of concern with the process, investigation and outcome of complaints responded to by the CCG or commissioned providers. The Quality and Safety Committees in common will raise identified concerns with the appropriate Quality Improvement Manager to ensure that action is taken. The Committee will receive reports on:
- the numbers of complaints received and their outcomes;
- themes and trends;
- actions taken as a result of complaints investigation including lessons learned;
- the time taken to respond to complaints by the CCGs and main commissioned providers Ombudsman investigations and action plans.

7.8 The CCGs’ Internal Complaint Lead is the Governance Manager; the CCGs’ MP Lead is the Executive Assistant to the Chief Officer. They are responsible for managing the complaint and ensuring that all requested information is received back in a timely manner.

7.9 The Midlands and Lancashire Commissioning Support Unit’s (MLCSU), Patient Services Team are commissioned to handle complaints, enquiries and MP letters and liaise with complainants and members of the public on behalf of the CCGs. The Team also handles any Parliamentary and Health Service Ombudsman cases that are lodged against the CCGs.

7.10 Each Directorate will be asked to provide the Governance Team with the names of the relevant officers responsible for services and who should provide draft responses in the event of a complaint against any of the services.

7.11 The Quality Team will undertake a quality assurance review of complaint responses involving commissioned services which will include a clinical overview of clinical complaints where necessary.

7.12 Complex complaints will be forwarded to the relevant CCG medical director.

8.0 The Complaints procedure (Local resolution)
8.1 Each phase of the complaint and the associated actions are in the table below:

<table>
<thead>
<tr>
<th>Complaint Phase</th>
<th>Action</th>
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</thead>
</table>
| Assessment      | • Complaint is assessed as being within the scope of our service and acknowledged;  
                  • Advocacy services offered;  
                  • Consider early and informal resolution- look at whether it can be resolved by the end of the next working day; |
<table>
<thead>
<tr>
<th>Complaint Phase</th>
<th>Action</th>
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</thead>
</table>
| Summary of complaint | • Personal contact to agree a summary of the complaint and desired outcomes  
• Explanation of process and timescales  
• Consent sought |
| Investigation | • Complaint sent for investigation with agreed timescale and desired outcome  
• Investigation response of adequate quality received and accepted |
| Complaint Response | • Co-ordinated response to complaint drafted for sign off  
• Response agreed by senior management and sent out to complainant |
| Lessons Learned | • Further actions identified to resolve the individual complaint  
• Wider service improvements identified and implemented |

8.2 If necessary, independent clinical reviews will be carried out. The MLCSU team will ensure that all of the points raised by the complainant are covered in the complaint response. Where a complaint involves more than one NHS or social care organisation, the MLCSU team will agree how the complaint will be managed and include all relevant information in a single coordinated response.

8.3 Serious complaints should be notified to the CCGs’ Accountable Officer without delay.

8.4 Sometimes agreed deadlines cannot be met. Where this is a delay, the MLCSU will contact the complainant, explain to them the reasons for the delay and discuss an extension in timescale. The MLCSU will escalate cases of excessive delay to the CCGs.

8.5 The MLCSU will request an investigation response in simple, easy to understand language which provides an honest, clear and constructive response to all the issues raised together with lessons learned and service improvements log. Once the team receives this information the team will produce a draft response letter. The CCGs will review the draft response to confirm they are satisfied with the way the complaint has been investigated and any action taken. The response will cover how the complaint has been handled, the conclusions reached on the basis of facts and evidence and an explanation of any actions the CCGs intend to take as a consequence.

8.6 The outcome of the complaint should be made clear to the complainant - i.e. upheld, partially upheld or not upheld.

8.7 All written responses will invite the complainant to contact the MLCSU if they remain unhappy with their response. The MLCSU will make a further attempt to address any outstanding concerns. The response letter will always advise of the right to approach the Parliamentary and Health Service Ombudsman (PHSO). Where appropriate, the CCGs will offer to meet with complainants where this could achieve local resolution. This could include using a mediation service.

8.8 If the complainant remains dissatisfied with the response received they have the right to ask the PHSO to review their complaint. They are independent of the NHS and will advise the complainant in writing of the outcome of their application.

8.9 All complaint files will be retained for a minimum of ten years. Archived files will be stored separately and securely for each CCG. To preserve confidentiality any paper complaint files will be held in a locked cabinet at the MLCSU. Data held electronically on the Datix database will be password protected and access restricted.
8.10 **Consent**
The handling of complaints must operate to the principles of the Mental Capacity Act (2005) the Data Protection Act (2018) and the requirements of the General Data Protection Regulation. Confidential patient information should never be disclosed to a third party unless the patient has given their consent to do so. The CCGs and MLCSU will assume a person has capacity to make their own decisions, and support them to do so.

If it is assessed that a person cannot give consent to investigate a complaint themselves they will seek evidence that the person complaining on the patient’s behalf has the authority to pursue the complaint.

9.0 **Patient Advice and Liaison Service (PALS)**

9.1 PALS offer important support for both staff and patients in promptly resolving concerns and enquiries. PALS staff will make initial contact with an enquirer within one working day enquiry and to give a final response as quickly as possible. Where a concern will not be resolved by the end of the next working day, this can still be handled through PALS but the enquirer will be informed that they may make their concerns a formal complaint at any time.

9.2 Wherever possible, PALS will aim to answer enquiries directly. However, in some cases this will involve referral to a person or service more appropriate for resolving the enquiry promptly and comprehensively. Appropriate consent will be needed. Enquirers will be given the option to return to if their enquiry if they are not satisfied with the response they receive.

9.3 PALS will respond to both general enquiries and those about an individual. Enquiries may be made personally or on behalf of someone, but PALS will not discuss issues about an individual without their consent.

9.4 PALS is a confidential service and will not disclose personal information without appropriate consent of the person involved, unless it relates to an actual or potential criminal offence, adult or child protection.

9.5 If an enquirer states that they intend to harm themselves PALS may speak to service staff either already or potentially involved in that person’s care. If the enquiry relates to a specific incident PALS may need to discuss this with relevant staff, but will only contact those people who need to be involved.

10.0 **Multi-Agency complaints**

10.1 Where a complaint involves more than one NHS Provider, or one or more other public bodies, there should be full co-operation in seeking to resolve the concerns through each body’s local procedures.

10.2 A single co-ordinated approach is required and a single response should be sent to the complainant.

10.3 Where a complaint is received which is solely concerned with another body, the MLCSU will, with the consent of the complainant, ensure that it is passed on without delay.

11.0 **Negligence claims**

11.1 The complaints procedure should not stop where the complainant is taking legal advice. However, where legal action is started by the complainant then the MLCSU and/or CCGs will seek legal advice to consider whether handling the complaint could adversely impact the legal action. The MLCSU and/or CCGs will follow the legal advice.
12.0 Coroner’s cases
12.1 Where a death has been referred to the Coroner’s office this does not mean complaint investigations need to be suspended. Investigations will continue and a copy of the final response will be sent to the Coroner for information.

13.0 NHS Resolution
13.1 If the MLCSU identifies a complaint which meets NHS Resolution’s referral criteria, this will be raised with the CCGs, who will then report the complaint to the NHS Resolution.

14.0 Habitual, unreasonably persistent or vexatious complainants
14.1 There are times when nothing further can reasonably be done to help a complainant. As a last resort and after all reasonable measures have been taken to try and resolve the complaints under this policy, the following should be considered.

14.2 Complaints made by persistent complainants should be reviewed by the MLCSU to establish whether the same issues are being raised again. Complaints about matters unrelated to previous complaints should be approached objectively and without any assumption that they are bound to be frivolous, vexatious or unjustified.

14.3 If a complainant is abusive or threatening, the MLCSU may require the complainant to communicate in a specified way that still allows the complaint to be investigated. For example, this could be in writing and not by telephone, or solely with one or more designated members of staff, or with a limit on the number of contacts each week. It is not reasonable to refuse to accept or respond to communications about a complaint until it is clear that all practical possibilities of resolution have been exhausted.

14.4 Complainants regarded as unreasonably persistent or vexatious should be follow the procedure below:
- The CCGs will review the complaint and make a decision as to whether or not it is appropriate for the CCGs to investigate the complaint further;
- If the investigation is to continue, the MLCSU will handle the complaint in line with this policy and may restrict communication with the complainant;
- If the CCGs decide that the complaint will not be investigated, the complainant will be advised of their right to approach the PHSO.

15.0 Serious Incidents (Sis) and complaints
15.1 The procedure for investigating SIs is separate from the complaints procedure and is managed in accordance with the CCGs Serious Incidents Policy. If during the course of investigating an SI, a complaint is also received, the incident procedure will normally take precedence. If a complaint investigation reveals the need to take action under the SI procedure, again the incident procedure will normally take precedence.

15.2 In these circumstances the complainant will be notified of the SI investigation and will be kept updated on the progress by the MLCSU. The issues raised in a complaint will not always be identical to those investigated under the SI procedure and a separate and full response to the complaint will be required.

16.0 Safeguarding of vulnerable adults and children and complaints
16.1 All staff will follow the Adult Safeguarding Policy and Safeguarding Children Policy. If at any point in the complaint investigation process a member of the CCGs or MLCSU staff suspect that a vulnerable person is being abused or is at risk of abuse, they should follow these procedures and report concerns to a Line Manager and the respective Safeguarding Lead. For more information
17.0 Risk assessing the complaint

17.1 By correctly assessing the seriousness of a complaint about a service, the right course of action can be taken. The complaint will be risk assessed at the point at which it is entered onto the DATIX system, which is the electronic data base for all Complaints. The system will calculate the level of risk by looking at the seriousness of the complaint and the likelihood of recurrence. The risk assessment of a complaint will be undertaken again when investigation reports are received and clinical review has been undertaken.

17.2 Step One: deciding how serious the issue is:

<table>
<thead>
<tr>
<th>Seriousness</th>
<th>Seriousness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negligible</td>
<td>Unsatisfactory service or experience not directly related to care. No impact or risk to provision of care.</td>
</tr>
<tr>
<td>Minor</td>
<td>Unsatisfactory service or experience related to care, usually a single resolvable issue. Minimal impact and relative minimal risk to the provision of care or the service. No real risk of litigation.</td>
</tr>
<tr>
<td>Medium</td>
<td>Service or experience below reasonable expectations in several ways, but not causing lasting problems. Has potential to impact on service provision. Some potential for litigation.</td>
</tr>
<tr>
<td>High</td>
<td>Significant issues regarding standards, quality of care and safeguarding of or denial of rights. Complaints with clear quality assurance or risk management issues that may cause lasting problems for the organisation, and so require investigation. Possibility of litigation and adverse local publicity.</td>
</tr>
<tr>
<td>Extreme</td>
<td>Serious issues that may cause long-term damage, such as grossly substandard care, professional misconduct or death. Will require immediate and in-depth investigation. May involve serious safety issues. A high probability of litigation and strong possibility of adverse national publicity.</td>
</tr>
</tbody>
</table>

17.3 Step Two: deciding how likely the issue is to recur:

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rare</td>
<td>Isolated or ‘one off’ – slight or vague connection to service provision</td>
</tr>
<tr>
<td>Unlikely</td>
<td>Rare – unusual but may have happened before</td>
</tr>
<tr>
<td>Possible</td>
<td>Happens from time to time – not frequently or regularly</td>
</tr>
<tr>
<td>Likely</td>
<td>Will probably occur several times a year</td>
</tr>
<tr>
<td>Almost certain</td>
<td>Recurring and frequent, predictable.</td>
</tr>
</tbody>
</table>

17.4 Step Three: Categorise the risk

<table>
<thead>
<tr>
<th>Seriousness</th>
<th>Likelihood of recurrence</th>
</tr>
</thead>
</table>

Draft Complaints and Concerns Policy
<table>
<thead>
<tr>
<th>Rare</th>
<th>Unlikely</th>
<th>Possible</th>
<th>Likely</th>
<th>Almost certain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negligible</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Minor</td>
<td>Moderate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medium</td>
<td>Moderate</td>
<td></td>
<td>High</td>
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</tr>
<tr>
<td>High</td>
<td></td>
<td></td>
<td></td>
<td>Extreme</td>
</tr>
<tr>
<td>Extreme</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

18.0 Measuring complainant satisfaction with the complaints and PALS service

18.1 A process is in place to understand the experience and satisfaction of people using the complaints and PALs service. This will establish if the process of managing their complaint or concern was positive or not and to suggest areas that they think could be improved.

19.0 References and further reading


19.2 Principles of Good Administration, Principles of Good Complaint Handling and Principles for Remedy;


19.5 Results of the Peer Review Panels; Patients Association & Mid Staffordshire NHS Foundation Trust, Various [https://www.patients-association.org.uk/complaints-management](https://www.patients-association.org.uk/complaints-management)


19.18 NHS Litigation Authority. (2014 Guidance on Duty of Candor for Organisations Registered with the CQC
# Draft Complaints and Concerns Policy

**Directorate**: Corporate  
**Purpose**: Guidance  
**Document Purpose**: Procedures  
**Document Name**: Standard Operating Procedure For The Management Of MP and Complaint Letters  
**Author**: Governance Manager  
**Publication Date**: 01 December 2018  
**Review Date**: 30 November 2020 or as legislation changes dictate  
**Target Audience**: All staff employed by:  
- Cannock Chase CCG  
- East Staffordshire CCG  
- North Staffordshire CCG  
- South East Staffordshire and Seisdon Peninsula CCG  
- Stafford and Surrounds CCG  
- Stoke-on-Trent CCG  
**Description**: Standard Operating Procedure For The Management Of MP Letters and Complaints  
**Superseded Document**: N/A  
**Action Required**: To Note  
**Approved by**:  
- Executive Management Team on –  
- Information Governance Group on -  
**Contact Details and further information**: CCG Governance Team  

## Document Status

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As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the internet.
1.0 INTRODUCTION

1.1 This procedure applies to Cannock Chase CCG, East Staffordshire CCG, North Staffordshire CCG, South East Staffordshire & Seisdon Peninsula CCG, Stafford and Surrounds CCG and Stoke-on-Trent CCG, (‘the CCG’, or ‘CCGs’).

1.2 Ensuring good handling of complaints is one way in which the CCGs can improve quality for local patients. Monitoring trends and patterns in complaints will also help the CCGs monitor providers’ performance.

1.3 This document sets out the process for handling complaints received in the CCGs’ offices whether written or verbal. It is intended to assist those members of staff who are involved in providing responses / investigations into complaints and providing guidelines for timescales in which complaints should be responded to. It also sets out the Midlands and Lancashire Commissioning Support Unit’s (MLCSU) role in the handling of MP letters and complaints on behalf of the CCGs.

2.0 Who Can make a complaint

2.1 A complaint may be made by the person who is affected by the action, or it may be made by a person acting on behalf of the person affected in any case where that person as detailed in the main policy.

3.0 Key Roles

3.1 The CCGs’ Internal Complaint Lead is the Governance Manager, the CCGs’ MP Lead is the Executive Assistant to the Chief Officer. They are responsible for managing the complaint and ensuring that all requested information is received back in a timely manner.

3.2 The Midlands and Lancashire Commissioning Support Unit’s (MLCSU), Patient Services Team are commissioned to handle complaints, enquiries and MP letters and liaise with complainants and members of the public on behalf of the CCGs. The Team also handles any Parliamentary and Health Service Ombudsman cases that are lodged against the CCGs.

3.3 The Quality Team will undertake a quality assurance overview of complaint responses involving commissioned services which will include a clinical overview of clinical complaints, where necessary.

3.4 If a complaint is complex, it will be escalated to the relevant CCG Medical Director for review.

4.0 Complaints not investigated by the CCGs

4.1 The CCGs are not responsible for investigating complaints made against primary care services (GPs, dentists, opticians or pharmacists) as these fall under the remit of NHS England. Any complaints of this nature received by the CCGs should be logged as normal and sent to the Governance Team via the Central Governance Inbox.

4.2 The Governance Team and/or the MLCSU Patient Services Team will notify the complainant that they should contact NHS England and provide them with the appropriate contact details.
5.0 PROCEDURE

5.1 **Written Complaint received at the CCGs’ offices:**
   - Complaint letter is received in the post; the letter should be opened and logged on the CCGs’ post log. It should then be scanned and sent to the CCGs’ Central Governance Inbox; **SASCCG.CentralGovernance@nhs.net** regardless of who the complaint is addressed to.

5.2 The Governance Manager or Governance Officer will then log the complaint on the CCGs’ complaint log and then send this to the MLCSU’s Patient Services Team.

5.3 The MLCSU will then acknowledge the complaint to the complainant (within 3 working days of receipt of the complaint by the CCG). The MLCSU will contact the complainant to discuss the complaint and agree the points for investigation. If consent is required the MLCSU Team will send out a consent form (if this is not already enclosed with the initial complaint).

5.4 If consent is required, the timescale to respond to the complaint does not start until signed consent is received to allow the investigation to take place.

5.5 The MLCSU will then advise the Governance Team that the signed consent has been received and requests that the complaint investigation starts. The CCG investigating officer will be asked to provide a timeline for them to complete any investigations and to provide a response. If the timescale agreed cannot be met the investigating officer needs to alert the Governance Team as soon as possible.

5.6 If a complaint is received by any member of staff at the CCGs, then they should send it immediately to the Central Governance Inbox (as above) for logging. **Under no circumstances should they commence an investigation until they have been asked to do so** as consent may be required before the CCGs are able to do any investigations.

5.7 **Verbal Complaint made to the CCGs:**

5.7.1 If a member of staff receives a telephone call from someone wishing to make a complaint in the first instance they should attempt to re-direct the complainant to the MLCSU Patient Services Team;

   - Email: **MLCSU.PatientServices@nhs.net**
   - Freephone: **0800 030 4563** - There is also a 24 hour answer phone service

   **Freepost address**
   
   Freepost Plus
   RTAA-XTHA-LGGC
   Patient Services
   **MLCSU Springfield’s Health and Wellbeing Centre**
   Lovett Court
   Rugeley
   WS15 2FH

5.7.2 If the complainant is insistent and refuses to approach the Patient Services Team and still wishes to log the complaint directly with the CCG then staff are asked to complete the form at Appendix A of this procedure document. The completed form should then be scanned in and emailed to the Central Governance Inbox. Staff should not give any personal advice or opinion to the complainant in connection with the complaint.

5.8 **Complaints sent directly to the MLCSU Patient Services Team**

5.8.1 Where a complaint has been sent directly to the Patient Services Team they will log the complaint. If the complaint is related to Continuing Healthcare (CHC) the Patient Services Team will ask the CHC Team to provide the response. If it relates to any other
service commissioned by the CCGs they will send the complaint to the Central Governance Inbox for onward transmission to the relevant team/ officer for investigation.

5.8.2 If the complaint is in relation to treatment at an external provider e.g. a Trust, or GP Out of Hours Service, the Patient Services Team will liaise directly with the provider in order to get their response. Once the response is received from the provider the CCG will be asked to quality assure the response.

5.8.3 In this instance the CCG needs to check to see if the provider has addressed the following, based on the information available:
• Provided an answer to all of the queries raised in the complaint.
• Followed the appropriate pathways as per the CCGs commissioned service.
• Fulfilled the contract in place with the CCG (e.g. timescales for patients to be seen).
• Conducted a thorough investigation into the complaint.
• Offered appropriate apologies.
• Provided details of lessons learned.

5.8.4 When the draft response has been reviewed and is found to be satisfactory the Patient Services Team will then draft the CCGs’ closing response and send for the Accountable Officer’s sign off to the Central Governance Inbox.

5.8.5 If the response is found to be unsatisfactory it needs to be returned with an explanation as to what is required from the provider via use of the quality assurance form (appendix 2) to make the response satisfactory – this will be fed back to the provider with a request for further investigation and a new response.

5.8.6 There may be times when the reviewer has queries on the provider’s investigation findings that need to be addressed outside of the complaints process, via the regular quality review meetings. Ensure that points that do not directly relate to the complaint being reviewed do not hold up the complaint process and are flagged through the appropriate channels.

5.9 **MP Letters:**

5.9.1 MP letters should be dealt with in the same way as any complaint received, i.e. logged on the post log, scanned and sent to the Central Governance Inbox. They will then be actioned in the same way as complaints are dealt with – taking note of the shorter timescale to formally respond to MPs.

5.9.2 Again, anyone receiving direct contact from an MP should also log this with the Executive Assistant to Accountable Officer who will then action appropriately and in line with the process.

5.10 **All Complaints:**

5.10.1 Once a draft response has been produced for sign off, the CCGs’ Governance Team will ask the relevant Director or their nominated deputy to approve the response for sign off, if approved it will then be sent to the Accountable Officer for his approval and sign off.

5.11 **Complex Complaints**

5.11.1 If a complaint is complex, it will be escalated to the relevant CCG Medical Director for review.
Appendix 1 – Verbal Complaint Form

CCGs’ LOGGING OF ISSUES AND COMPLAINTS

Name of Caller

Contact Number

On behalf of (if applicable)

D.O.B. of patient

Address of patient (incl Post code)

Patients GP

Has verbal consent been given

Has written consent been given

Issues and relevant dates

Expected Outcomes

Call handler

Date and time of call taken

When completed please email to: SASCCG.CentralGovernance@nhs.net
## Appendix 2 – Quality Assurance Checklist

### CSU/CCG Complaint Quality Assurance Form

**Section 1 – to be completed by CSU**

<table>
<thead>
<tr>
<th>Complaint Reference:</th>
<th>46979/W</th>
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<tbody>
<tr>
<td>Date agreed with complainant for response:</td>
<td></td>
</tr>
<tr>
<td>Any extension details:</td>
<td></td>
</tr>
<tr>
<td>Date complaint received:</td>
<td></td>
</tr>
<tr>
<td>Providers:</td>
<td></td>
</tr>
<tr>
<td>Date complaint response received by CSU: (please use multiple lines for additional providers)</td>
<td></td>
</tr>
<tr>
<td>Date sent to the CCG Central Governance Inbox Team:</td>
<td></td>
</tr>
<tr>
<td>Date due back to the CSU complaints Team:</td>
<td></td>
</tr>
<tr>
<td>Version Number of complaint response:</td>
<td>Version:</td>
</tr>
<tr>
<td>Any additions from previous versions:</td>
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</tbody>
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**Part A - F to be completed by the CCG Quality Team**

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<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Are questions answered in the response?</td>
<td>☐ Yes ☐ No (if no, complete section D)</td>
</tr>
<tr>
<td>B</td>
<td>What questions / areas are not answered?</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Actions for the CSU complaints team:</td>
<td>There is no acknowledgement to learning as a result of this complaint. There are many agencies involved which appears to be the cause of the issues raised by the complainant. It appears that there was a lack of capacity in the local authority which meant that MPFT were requested to provide the care. The lack of capacity in MPFT (Home First) led to AMG to be requested to provide the care. There is no real explanation as to if there have been gaps in this patient’s care or whether communication and expectations were not managed effectively and if so is there a need for an apology to the complainant in relation to the care delivered. If the pathway has been hindered due to pressures in the system and therefore the usual care provided would not have been passed to other agencies reference this in the response with an apology.</td>
</tr>
<tr>
<td>D</td>
<td>Quality Actions i.e. escalation to provider CQRM:</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Completed by:</td>
<td>Date:</td>
</tr>
<tr>
<td>F</td>
<td>Recommended for executive sign off?</td>
<td>Yes – however please see highlighted notes above prior to the letter being issued.</td>
</tr>
</tbody>
</table>

---

**FOR MLCSU ONLY**

---

---
HEALTH AND SAFETY POLICY
and Associated Procedures

<table>
<thead>
<tr>
<th>Policy Folder &amp; Policy Number</th>
<th>Corp pan Staffs</th>
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<tr>
<td>Version:</td>
<td>v.3.0</td>
</tr>
<tr>
<td>Ratified by:</td>
<td>Governing Body</td>
</tr>
<tr>
<td>Date ratified:</td>
<td></td>
</tr>
<tr>
<td>Name of originator/author:</td>
<td>Health and Safety Officer, Midlands and Lancashire Commissioning Support Unit</td>
</tr>
<tr>
<td>Name of responsible committee/individual:</td>
<td>CEEE Committee</td>
</tr>
<tr>
<td>Date approved by Committee/individual</td>
<td>January 2019</td>
</tr>
<tr>
<td>Date issued:</td>
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</tr>
<tr>
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<td>April 2013</td>
</tr>
<tr>
<td>Target audience:</td>
<td>All CCG Staff</td>
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## HISTORY OF CHANGES

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<td></td>
<td>• Flowchart for Health and Safety Responsibilities</td>
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<tr>
<td></td>
<td>• Office Safety Procedure</td>
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<tr>
<td></td>
<td>• Display Screen Equipment Procedure</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Lone Working Procedure</td>
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</tr>
<tr>
<td></td>
<td>• Fire Safety Procedure</td>
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<td>2.1</td>
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</tr>
<tr>
<td>3</td>
<td>Updated by CSU to reflect best Practice</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Includes six CCGs in Staffordshire</td>
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</tr>
</tbody>
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GENERAL STATEMENT OF HEALTH AND SAFETY POLICY

At NHS Cannock Chase Clinical Commissioning Group (CCG), NHS East Staffordshire Clinical Commissioning Group (CCG), NHS North Staffordshire Clinical Commissioning Group (CCG), NHS South East Staffordshire and Seisdon Peninsula Clinical (CCG), Stafford and Surrounds Clinical Commissioning Group (CCG) and NHS Stoke-on-Trent Clinical Commissioning Group, the Accountable Officer and the Governing Bodies are committed to achieving high standards of health and safety management.

The Governing Bodies expect all staff, visitors, contractors and other employers who work at the CCGs to share this commitment by complying with the CCGs’ policies and procedures, and to understand that they too have legal and moral obligations to themselves and to one another.

The CCGs intend to ensure the health and safety of all persons who may be affected by activities are maintained by ensuring that, in so far as is reasonably practicable:

- A safe working environment is provided, along with adequate welfare arrangements and facilities;
- Identifying hazards and conducting formal risk assessments when appropriate in order to minimise the risk for all activities undertaken by the CCGs;
- All systems of work are safe and without unnecessary risks to health and safety;
- Providing, managing and maintaining plant and equipment so that it is, so far as reasonably practicable, safe and that risks to health are controlled;
- Ensuring that control measures and emergency procedures are: in place; effective; properly used; monitored and maintained;
- Provide suitable and sufficient information, instruction, training and supervision at all levels necessary to ensure that staff are competent to undertake their work activities;
- Consulting with and involving our staff in matters relating to their own health and safety;
- Keeping up to date with best practice in relation to health and safety and complying with all relevant legislation and authoritative guidance.
- Contractors undertaking work on behalf of the CCGs, are competent to do so;

The CCGs will continually review and develop our safety management systems, with the overarching aim of conducting our activities in a manner which does not negatively affect the health and safety of any staff, contractors, visitors or members of the public.

I and the other members of the Governing Bodies are committed to this Policy and to the implementation and maintenance of the highest standards of health, safety and welfare within the CCGs. We expect every member of the CCGs to share this commitment and to work together to achieve it.

Signature of Accountable Officer

Printed Name: Date:
1.0 Introduction
NHS Cannock Chase Clinical Commissioning Group, NHS East Staffordshire Clinical Commissioning Group, NHS North Staffordshire Clinical Commissioning Group, NHS South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group, NHS Stafford and Surrounds Clinical Commissioning Group and NHS Stoke-on-Trent Clinical Commissioning Group, are fully committed to protecting the health, safety and welfare of its entire staff. For the purpose of this policy, the CCGs will be referred to as ‘the six CCGs’. The Governing Bodies of the six CCGs will provide the leadership to ensure that exemplary health and safety practices are firmly embedded throughout the organisation to provide a secure and healthy environment in which to work.

The six CCGs appoint the Accountable Officer to co-ordinate matters of Health and Safety management. The Accountable Officer has delegated-day-to-day responsibility to the Director of Corporate Services, Governance and Communications. This role does not detract from the responsibilities of the Governing Bodies and other Executives for specific areas of Health and Safety management. The organisation has clear lines of accountability and responsibility in place in compliance with the Health & Safety at Work at 1974 and associated Regulations made under the Act.

Corporate Manslaughter and Corporate Homicide Act 2007
The Corporate Manslaughter and Corporate Homicide Act came into force on 6th April 2008. It was introduced so that companies, including large organisations can be held liable where serious failures in management systems result in a fatality. The Act does not create new duties – they are already owed in the civil law of negligence and the new offence is based on these.

Although the Corporate Manslaughter Act should not make any difference for the six CCGs like these, who are effectively managing risk, the introduction of this Act has seen a rise in the number of cases filed for prosecution. This means that the implications of the Act need to be recognised as part of good health and safety management practices. The police will certainly be carrying out more investigations under the Act and if they feel there are gross management failings they will consider prosecution, involving the HSE as appropriate.

A particular area that may be tested in the courts will be occupational road risk and this could impact on otherwise low-risk organisations that have people who drive for work.

2.0 Scope
This policy applies to all employees of the six CCGs, including bank, locum and agency and subcontracted staff. Managers at all levels are expected to take an active lead to ensure that health and safety, including systems of internal control are of the highest standard and are integral to the operation of the six CCGs. Managers will also seek expert advice and guidance from the organisations competent persons, should it be required.

The six CCGs will ensure that adequate resources and provision are provided to meet legal health and safety standards and provide sufficient information, instruction and training to enable staff to carry out their work safely.

This policy clearly outlines Health & Safety responsibilities within this organisation. This will also include outlining the arrangements in place for monitoring its Health & Safety documentation and control measures.

3.0 Roles and Responsibilities
Health & Safety Legislation requires an organisation to identify key accountabilities and responsibilities for managing Health & Safety risk.
3.1 The Accountable Officer
The Accountable Officer has overall accountability and responsibility for all matters involving health, safety, welfare and fire appertaining to the organisation and has responsibility for:

- Ensuring that adequate resources are available to implement the Health and Safety Policy and any control measures that may be required;
- Ensuring that health and safety performance is regularly reviewed at Governing Body Level. This will be achieved via a quarterly report from the Communications, Engagement, Employment and Equality Committee, where Health and Safety is discussed;
- Gaining assurance from the Governing Bodies & Competent Person that the Health & Safety Policy is implemented effectively, via written annual reports
- Ensuring that this policy is reviewed at least every two years unless due to a legislative change, or lessons learnt changing practice and policy or change in personnel or structure, whichever is the sooner.

3.2 The CCGs Governing Bodies & Governance Lead
The CCGs’ Governing Bodies are responsible for ensuring the organisation has internal systems in place for controlling Health and Safety Management. These systems should ensure that the requirements of Health & Safety legislation are met. The Governance Lead will work with the Governing Bodies to gain assurance of this through the Communications, Engagement, Employment and Equality Committee. This can then be fed back to the Accountable Officer. The Governance Lead delegates some of these responsibilities to members of the senior management team. The Governing Bodies ensure that Key Performance Indicators are set and monitored at the monthly Health and Safety Sub Committee.

3.3 Governance Managers
The Governance Manager has been nominated on behalf of the Governing Bodies with the overall co–ordination and monitoring of the implementation of this policy in the organisation. As part of this role, the Governance Manager should receive the correct level of Health and Safety Training in order to give them an overview of the measures that should be in place. Responsibilities include ensuring:

- The organisations Health and Safety Policy reflects current priorities and is monitored, reviewed and revised as necessary;
- This is an effective organisation, with clearly defined responsibilities, and arrangements for implementing the policy;
- The organisations Governing Body Members and Managers are provided with competent health, safety and welfare advice to assist with the provision of protective and preventive measures and the implementation of health and safety legislation;
- There is a safety forum and/or other arrangements for consulting with trade union or employees’ safety representatives
- Using Training Needs Analysis to identify whether any further training is needed to effectively manage health and safety requirements. Ensuring the right people have the correct level of competency
- Significant health and safety issues which cannot be resolved are escalated to the Governance Lead.

3.4 Competent Person
The role of the competent person is currently provided by Midlands and Lancashire Commissioning Support Unit (MLCSU). They are responsible for providing the organisation with health safety and welfare advice and guidance in order to assist in complying with Health & Safety legislation. Their role includes:

- Act as the organisations competent person for Health & Safety and Fire safety in order to comply with statutory requirements.
• Carry out quarterly audits for each main premises the organisation occupies in order to assess compliance and provide a written assessment and action plan to the Governance Leads.

• Liaise with landlords to gain assurance from them around the buildings Health & Safety requirements and compliance checks.

• Attendance at the Communications, Engagement, Employment and Equality Committee on a quarterly basis.

• Investigate H&S related incidents and produce reports and witness statements.

• To assist the organisation with an enforcement agency, visit or the outcomes of such a visit.

• Provide Health & Safety and Fire training to the organisation as required.

Current Contact Details for the MLCSU are

Sarah Hunter – Health, Safety, Fire & Security Officer (offering the day to day Health & Safety support, covering CCGs within the midlands area)
Sarahhunter2@nhs.net or tel: 07919 303749

Mark Jump – Health & Safety Manager (SH line manager & overall Health & Safety Manager for the MLCSU)
mark.jump@nhs.net or tel: 07771 996217.

Andy Collins – Resilience and Estates Lead (Overall lead for the MLCSU Health & Safety Team)
andy.collins1@nhs.net or tel: 07823 537353

3.5 Executive and Senior Team

Executives and senior managers will support the Governance Manager and carry direct responsibility for the implementation of Health and Safety related policies within their areas of control. They will do all that is reasonably practicable to establish and maintain high standards of health, safety and welfare in their areas of control.

3.6 Line managers

Line managers are responsible for ensuring their staff receives all necessary Health and Safety training, instruction and information and that such activities are properly recorded and records maintained, and must:

• Organise the department, section or workplace so that operations or work carried out is to a satisfactory standard of safety, resulting in minimal risk to people, equipment and materials.

• Plan and maintain good house-keeping.

• Co-operate with safety advisors as necessary.

• Review operating and work instructions and specific related hazards to staff transferred into the department and/or new staff.

• Ensure all accidents are reported to the relevant person so that they may be recorded.

• Ensure all staff are aware of Health and Safety procedures.

• Encourage the good behaviours required by staff by setting a good example with respect to Health and Safety.

3.7 Staff duties and responsibilities

All staff whilst at work have a legal duty to take reasonable care for the Health and Safety of themselves and others who may be affected by their acts or omissions. Staff must also co-operate fully with the arrangements made by management to meet its legal responsibilities for Health and Safety as in Section 7 of the Health & Safety at Work Act 1974.
Staff have a responsibility for bringing to the immediate attention of their Manager any failings that could be detrimental to themselves and others, including visitors.

Specific responsibilities of staff are to:
- Comply with local fire procedures.
- Comply with local first aid procedures.
- Not to bring personal mains electrical equipment into work.
- Report to the six CCGs, any obstructions to any walkways, entrances and exit areas and avoid creating such obstacles.
- Report any building and/or equipment defects and/or shortfalls in cleanliness to the local competent person.
- Set a good personal example with respect to Health and Safety.

4.0 Health and Safety Representatives & Consultation

The six CCGs should have in place arrangements to consult with staff on matters of health and safety as per the Health and Safety (Consultation with Employees) Regulations 1996. Where Health & Safety representatives are in place, whether they are Trade Union or non-Trade Union appointments, full co-operation should be given to the requirements of their role in the workplace. This is overseen by the Communications, Engagement, Employment and Equality Committee. This should include allowing them sufficient paid time to undertake this duty.

A Safety representative should be kept informed of the hazards relating to the organisation. They should also be consulted on new and updated policies, or any changes to processes that may affect staffs safety. They should have the ability to attend relevant safety meetings, in the capacity of safety representative.

Any member of staff may make representation to Safety Representatives or Staff Representatives on any matter relating to their Health, Safety or Welfare.

5.0 General Arrangements for Health and Safety

The six CCGs are mainly office based and the day to day operations are relatively low risk. There is still a need to have policies and procedures in place in order to comply with the various specific statutory obligations or particular hazards, applicable to its work activities.

On each main site the six CCGs’ staff work from, there should be relevant Health & Safety information displayed, this should include as a minimum, the Health & Safety law poster, a copy of the Health & Safety Policy’s general statement and information on the fire and first aid arrangements.

5.1 Risk Assessments

The Management of Health and Safety at Work Regulations 1999 outline the general duties placed on employers with regards to managing risks. In order to meet with the regulatory requirements, the three CCGs will ensure:
- Any significant or foreseeable risks are identified
- Risk assessments are carried out for those risks in order to evaluate and then identify adequate control measures;
- Risk assessments are recorded in writing, on the appropriate form, in accordance with the organisations Risk Management Policy;
- Arrangements are made for putting into practice the preventative and protective measures that follow from the risk assessment;
- Risk assessments are regularly monitored and reviewed to ensure they remain ‘live’ documents. Where they are monitored will depend on the level of risk. Lower risk can be monitored locally, within a team. For corporate risk assessments and ones scoring red
or amber, these will be on the risk register and monitored through the Communications, Engagement, Employment and Equality Committee;

- The outcomes of risk assessments will be readily available and communicated to staff. Staff will receive instructions and/or training associated with the level of risk identified and the control measures taken to prevent or control risks;

Safety training will be provided in safe systems of work and relevant training will be given to employees when:
- They commence employment with the six CCGs.
- They change job role or are given increased responsibility.
- There are changes in work methods/practice, equipment, legislation or guidance.

Full co-operation will be given where work areas are shared with other organisations to ensure the exchange of necessary health and safety information. Joint consultation will be actively encouraged on all health and safety risk management issues.

5.2 Occupational Health
5.2.1 Alcohol / Drugs
The use and misuse of alcohol or drugs can have a detrimental effect on work performance. The use and misuse of alcohol or drugs can impair the capacity to make effective decisions, which may have a knock on effect on patient services and the individual’s capacity to work safely. For these reasons the consumption or misuse of drugs or alcohol in the working environment, or while on call, is prohibited.

5.2.2 Dedicated Policy
The CCGs have a dedicated Policy with the aim of the promotion of the general health of the CCGs’ employees, to avoid unnecessary sickness absence, to ensure effective work performance and to provide a working environment which ensures, as far as possible, the health and safety of all patients, visitors and staff. Please see the Full Health and Wellbeing policy for details.

5.2.3 Smoking
Smoking - Second hand smoke is both a public and workplace hazard. The CCGs seek to guarantee the right of all to breathe air free of tobacco smoke and to comply with smoke – free legislation. Adequate signage will be displayed to inform employees and visitors of the smoke – free status of the CCGs.

For the purpose of this policy, E-cigarettes are to be considered as ‘smoking’ and the same rules should apply to these as with traditional smoking. Staff with E-Cigarettes should not use the chargers in CCG premises or vehicles due to the risk of fire or explosion (Estates & Facilities Safety Alert – EFA 2014 002).

For advice on stopping smoking please consult your GP or refer to the following website; https://www.nhs.uk/livewell/smoking

5.2.3 Working Time Regulations
Managers must ensure that they and their staff are aware of the limits on working time and entitlements provided for in the Working Time Regulations 1998 (as amended). HR can advise further and the link below gives HSE guidance on the issue.

http://www.hse.gov.uk/contact/faqs/workingtimedirective.htm

5.3 Building maintenance
All main bases for this organisation should have planned preventative maintenance for all key building services such as air-conditioning, heating, hot and cold-water supplies, lighting, cleaning, fire equipment and alarm systems, lifts and lifting equipment, security systems,
sanitary facilities and general decoration. Responsibility for arranging these will lie with the landlord which in most cases for this organisation is the local Council.

Service Level Agreements will be put in place for such maintenance and appropriate records will be kept of all maintenance, breakdowns and repairs.

Essential information for use in the event of emergency breakdowns should be available to all designated responsible persons at each site.

The competent person will act on behalf of the three CCGs to gain assurance that these measures are put in place by the landlord.

5.4 Incident and Accident Reporting
In the event of an accident, staff will ensure that a detailed entry of the event is logged onto Datix via the Governance Manager who will subsequently determine, in conjunction with the Competent Person, if notification is required under The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR 95). Records must be kept of the actions taken to ensure and maintain first aid provision. Records of accidents must be kept for a minimum of three years.

Where a serious accident has occurred it may be necessary to carry out a further risk assessment of the task being undertaken at the time, to ascertain if additional precautions, an alteration of the method of work or additional control measures are necessary. This must be written down and the conclusions clearly defined and acted upon. Any incidents that are RIDDOR reportable must be investigated, and any relevant risk assessments reviewed to reflect any changes if applicable.

5.5 Driving Vehicles
All employees who drive vehicles as part of their duties are expected to be in possession of a full, valid and current driving licence for the category of vehicle they are driving.

The six CCGs expect drivers to observe the Highway Code and all road traffic laws, and to drive with due consideration and courtesy to other drivers at all times. Managers should ensure that their staff are allowed adequate time for travel, ensuring opportunity to take breaks, especially if travelling long distances.

All drivers should be adequately fit and healthy, and should bring to the organisations attention any reason why they may not to fit to drive.

Drivers must not be under the influence of drugs or alcohol whilst driving.

All vehicles, including employees own vehicles, should be kept in a roadworthy condition at all times and have a current, valid MOT certificate (where applicable). All drivers should be adequately insured including ‘business use’. The CCGs should check the individuals MOT, business insurance and Driving License at Local Induction and on expiration of these documents. Staff should provide copies of replacement documents for inspection by their Line Manager prior to claiming travel expenses.

5.6 Mobile Telephones
The use of hand held mobile phone whilst driving is prohibited. It is the advice and strong recommendation of the six CCGs that mobile phones, even when legally used, should not be used when driving wherever possible and preference should be given to only using mobile phones when stationary. If a mobile phone must be used when driving it should only ever be through hands-free methods.

Consideration must be given to proper rest breaks and staff should not be contacted involuntarily outside normal working hours, mobile phone users are therefore entitled to switch off their phones during rest breaks, whilst driving and when they are not working.
Mobile phones must not be used in any situation where their use is locally prohibited or where they may cause risk including outside the car whilst on petrol station forecourts, due to the risk of sparking a fuel ignition or in hospitals where their use may affect medical equipment.

5.7 Training

In order to secure the health and safety of all employees, the six CCGs provide health and safety training to new employees, which will be incorporated into general induction training.

Induction training will commence on the first day of employment so that employees are familiar with basic procedures once they are at their place of work. Where this is not possible, induction training will take place as soon as possible after the employee has started work. The person responsible for this will always be the Line Manager.

The health and safety component of induction training will contain the following:

- **CCGs' health and safety policy** — the contents of the policy statement will be covered in detail, including the responsibilities set out in the policy, this will enable the employee to become acquainted with the organizational arrangements.

- **Accident reporting procedures/first aid** — this will cover the action to be taken when an accident has occurred, the person to be informed and where to acquire first aid treatment (this section will also cover the six CCGs procedure as to the investigation of accidents: the reporting procedure will be explained so that the employee is aware as to what will happen when an accident occurs).

- **Fire procedures and precautions** — this section covers action to be taken in a fire situation and will include:
  - the location of the fire exit;
  - the assembly point;
  - the responsible person the employee must report to;
  - further instructions on the action to be taken in the event of discovering a fire;
  - what to do with machinery or processes left prior to evacuating an area.

- **Safety rules** — this section will cover CCGs and local safety rules.

- **Safety procedures** — items for discussion in this section could include:
  - use of display screen equipment;
  - safe manual handling of loads.

Once the induction training has been completed, a record of the training will be kept. The name of the employee, the date and subjects covered should be included.

A training needs analysis will be completed, following the Organisation Development Policy, to establish if additional training is required for staff with specific roles or those that may have elements of their work that carry additional risks due to their role.

On-going Health and Safety training is a statutory requirement of legislation and therefore mandatory for all staff of the six CCGs. Provision will be made to ensure staff receives adequate information, instruction and training with respect to Health and Safety where appropriate. Training can be delivered either face to face, or online.

5.8 Third party contractors

Any buildings works is likely to be commissioned through the landlord. However, if the six CCGs do seek work from third party contractors (not management contractors) they are required to submit a copy of their safety documentation such as, The Health and Safety Policy, liability insurance and risk assessments/method statements along with their tender, in order for the organisation to ensure the contract includes appropriate measures of Health and Safety.
Third party contractors will be supplied with a copy of the CCGs’ Health and Safety policy and will be expected to abide by the policy unless a variation has been explicitly agreed.

All contractors that attend a CCG site will be provided with information on local Health and Safety arrangements and will be issued with permits for work where applicable.

6.0 References
- The Health and Safety at Work etc. Act 1974.
- The Reporting of Incidents, Diseases and Dangerous Occurrences Regulations 1995.
- The Control of Substances Hazardous to Health Regulations 2004.
- The Regulatory Reform (Fire Safety) Order 2005.
- The Health and Safety (Miscellaneous Amendments) Regulations 2002.
- The Safety Representatives and Safety Committees Regulations 1977 (as amended).
- The Health and Safety (Consultation with Employees) Regulations 1996 (as amended).
- The Corporate Manslaughter and Corporate Homicide Act 2007
- Management of Health & Safety at Work HSG65
- The Provision and Use of Work Equipment Regulations 1992 (PUWER)
APPENDIX 1 - Organisational Flowchart Showing Health & Safety Lines of Communication

Accountable Officer

Governing Body & Governance Lead

Executives & Senior Managers

Governance Manager

Competent Person

Line Managers
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1.0 Introduction
The NHS Cannock Chase Clinical Commissioning Group (CCG), NHS East Staffordshire Clinical Commissioning Group (CCG), NHS North Staffordshire Clinical Commissioning Group, NHS South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group (CCG) and NHS Stafford, Surrounds Clinical Commissioning Group (CCG) and NHS Stoke-on-Trent Clinical Commissioning Group (CCG) wishes to ensure that all office environments within their operations are both managed and used in a manner that is conducive to the safety of all the CCGs’ employees and other parties who may have cause to work in the offices, for whatever reason. For the purposes of this procedure, they will be referred to as ‘the six CCGs’. Responsibilities for the Health & Safety in office environments are identified in the organisations Health and Safety Policy.

The six CCGs recognises their statutory responsibilities as described within the Health & Safety at Work etc. Act 1974 and the Management of Health & Safety at Work Regulations 1999 and other relevant legislation and guidance. They will do all that they can to ensure staff and others are not exposed to unacceptable risk. More specific detail is contained in the Workplace (Health, Safety and Welfare) Regulations 1992, which specify standards for the general office environment, including issues such as temperature, seating, space and lighting levels. Other legislations applicable to offices are the, First Aid at Work Regulations, Manual Handling Operations Regulations, Display Screen Equipment Regulations, Electricity at Work Regulations, The Provision and Use of Work Equipment Regulations and The Regulatory Reform (Fire Safety) Order.

All H&S legislation is part of statute law, and breaches of the laws and regulations are criminal offences under the umbrella of the Health and Safety at Work etc. Act 1974. Penalties for breaches of H&S legislation can be severe.

2.0 Purpose
This procedure applies to all employees of the six CCGs, including partner agencies, visitors, contactors, agency and subcontracted staff. Its aim is to provide information on the key areas of Health & Safety that apply to an office environment. Managers at all levels are expected to ensure that these measures are applied in their work areas and strive to create a positive Health & Safety culture. All employees are expected to have due regard for their own health and safety and that of their colleagues and other persons. If safe systems of work have been introduced, employees are expected to follow them, and any other relevant instructions.

3.0 General Housekeeping
Poor housekeeping is a common cause of accidents especially slips, trips and falls and fires in the workplace. In order to ensure that satisfactory standards of housekeeping are achieved the following arrangements should be adhered to by all employees:
- Check that the workplace is free from hazards at the beginning of each day;
- Clear up any spillages or spills etc. immediately as per local procedures;
- Report to the building manager or landlord any loose carpet or any damaged floor coverings;
- Do not allow objects to protrude into walkways;
- Ensure that waste materials are properly stored and are removed on a regular basis;
- Ensure that special arrangements are made for the removal of unusual or extra-large items;
- Ensure that your work area is kept tidy at all times;
- Trailing leads will be avoided wherever possible or otherwise ramped or protected to avoid potential tripping hazards;
- The bottom drawers of filing cabinets should be filled first and, in the absence of safety devices to prevent it toppling, only one drawer at a time should be opened to avoid the risk of toppling;
- Chairs - routinely inspect chairs for condition, do not use chairs for climbing – a stepping stool or step ladder only should be used.

### 4.0 Electrical Risks

Electrical accidents can have very serious consequences. To help prevent them, remember these three basic rules:

- Always check electrical equipment visually before use, look out for any scorch marks or damage to casings or wires.
- Report faulty or damaged equipment; do not attempt to use it;
- Do not try to repair faulty equipment; leave it to a competent person;

#### 4.1 Fixed Wiring Systems

The integrity and safety of the electrical installation from supply into the building to the electrical socket outlet is the responsibility of the Landlord which in most cases for this organisation is the local council. Fixed wiring is subject to routine examination and testing by a NICEIC (National Inspection Council for Electrical Installation Contracting) accredited company at a minimum of every five years. Work on fixed systems must only be done by persons who are competent to do this.

#### 4.2 Portable Appliances

The responsibility for the safety of equipment from the electrical socket to the equipment is the responsibility of this organisation.

This means that the CCGs will purchase electrical appliances and equipment from reputable suppliers, manufactured to an appropriate standard and where possible they must be CE marked. The equipment should be used correctly and the equipment should be periodically subject to a Portable Appliance Test. The six CCGs will, ensure that all portable appliance equipment is tested in accordance with current guidelines. Long or coiled extension leads are to be avoided wherever possible. If their use is unavoidable, ensure that the connector is manufactured to BS EN 60309. No unauthorised electrical equipment is permitted without authorisation.

Any defects should be reported immediately and the equipment is to be taken out of use straight way.

**Note:** Plug in Block Adaptors are prohibited in all CCG occupied premises.

### 5.0 Lighting

Offices require sufficient light to enable work to be undertaken without risks to the occupants. There are standards contained in Health & Safety Executive publications that offer guidance to the lighting levels in office environments. The provision of adequate light can be by natural or artificial means. Where possible natural light should be utilised, but because the quality of light in this country is variable, and often poor during the autumn and winter months, there is a great reliance on artificial means. Any artificial lighting should be fully diffused where DSE equipment is in use. The quality of light is important and a mixture of good natural light and artificial systems is the best method of providing the correct lighting level. There are ways of measuring lighting levels so if staff have any concerns, they can raise this with Managers or the competent person.
6.0 Ventilation/Air Quality
Ventilation refers to the rate of exchange of air in a specified area of a building. This can either be through natural means, such as opening windows or mechanical. If staff have any concerns around ventilation in their work area they can raise this with their Manager or the competent person.

7.0 Temperature
Thermal comfort is subjective but describes an individual's satisfaction with their temperature environment. There are a number of factors that can affect thermal comfort including air movement, humidity, type and amount of clothing worn, and the type of work being undertaken.

The temperature in workrooms should normally be at least 16 degrees Celsius unless much of the work involves high levels of physical effort in which case the temperature should be at least 13 degrees Celsius. This is according to guidance from the Health & Safety Executive, although the Regulation itself does not specify an upper or lower temperature. If staff feel there is an issue with the temperature in their office they can raise this with their Manager or the competent person.

8.0 Adequate Space to Work
Offices will have enough free space to allow people to get to and from workstations and to move within the room, with ease. The number of people who may work in any particular room at any one time will depend not only on the size of the room, but on the space taken up by furniture, fittings, equipment, and on the layout of the room.

Health & Safety Guidance states that in an office environment, each desk space should have a minimum of 11m³. This can be measured by multiplying the width x length x height of the room and then dividing by 11. This should then give you the recommended number of desks that should be in the room. The figure of 11 cubic metres per person is a minimum and may be insufficient if, for example, much of the room is taken up by furniture etc.

The floor space per person indicated above will not always give sufficient unoccupied space, as required by the Regulations. Rooms may need to be larger, or to have fewer people working in them, depending on such factors as the contents and layout of the room and the nature of the work. Where space is limited careful planning of the workplace is particularly important.

9.0 First Aid Arrangements
The organisation ensures that there are adequate first aid provisions for employees who may become ill or are injured at work. A suitable person must be appointed to take responsibility for first aid provision and maintenance of the first aid box under the Health and Safety (First Aid) Regulations 1981 (as amended).

The six CCGs consider the nature of activities at the workplace when determining the number and types of first aiders to appoint. As a minimum, a low-risk workplace such as a small office should have a first-aid box and a person appointed to take charge of first-aid arrangements, such as calling the emergency services if necessary.

Employees are informed of arrangements, which have been made for first aid, including the location of equipment, facilities and appointed personnel.

Further information and guidance on First Aid requirements can be found at Appendix A
10.0  Manual Handling
Poor lifting and carrying techniques can contribute to manual handling related injuries to staff. Good technique is vital and there is training available via the Skills for Health online training website or face to face training can be provided by the Competent Person. If the object to be lifted is large, awkward or heavy then an assessment should be undertaken. The first part of any assessment will consider whether the object needs to be lifted at all. Engineering methods e.g. lifting appliances, or trolleys etc., are considered next, if this is not possible a method for manual lifting with the assistance of other staff can be used.

Some tips on efficient lifting:
- Is it necessary to lift the load? If not – don’t!
- Assess the lift and decide if help is needed.
- Obtain a firm grip on the load (use gloves if necessary).
- Bend at the knees not from the waist.
- Keep your head up as you bend – this will help to keep a straight back.
- Use your legs not your back to thrust upwards (the leg muscles were designed for power and strength).
- Keep the load near to your body.
- Do not twist your spine when lifting or carrying loads.

Assessments are reviewed when conditions change.

Further advice and guidance on Manual Handling Operations can be sought through the Competent Person.

11.0  Welfare Facilities
Welfare facilities include the provision of adequate toilet and washing facilities. The six CCGs ensure that there are adequate toilets and that they are clean, well maintained and have adequate ventilation. Hot and cold water, soap and hand drying facilities are also in place. The provision of suitable drinking water is also a statutory requirement and is available (this does not have to be water coolers and can be tap water)

Part of the requirements under welfare facilities is having facilities to prepare food & drink. There should be kitchen facilities in place where staff can make hot drinks.

Further advice and guidance on Welfare Facilities can be sought through the Competent Person

12.0  CCG Workplace Inspections
The six CCGs will undertake a quarterly Health, Safety, Fire & Security audit. This will be carried out by the Competent Person, with support from Governance Manager where required. A report will be prepared and submitted to the Governance Lead for action.

13.0  Control of Substances Hazardous to Health (COSHH)
The six CCGs are based in a low risk office environment with very few hazardous substances present.

Where necessary, risk assessments are undertaken to ensure staff do not become harmed in any way from exposure to hazardous substances in the workplace. Where elimination of that substance is not possible, a substitute is found to lower the risk and if a substitute cannot be found, then other control measures are put into place.

Any potentially hazardous substances identified are suitably stored and labelled correctly. Appropriate information is readily available relating to the natural characteristics of a particular substance, and suitable control measures and contingency plans are put in place to ensure appropriate action is taken in the event of an accident or injury.
Full training and information is given to all staff that are required to handle such substances.

Protective personal equipment is provided where appropriate, and a full review of substances is carried out at regular intervals.

Further advice and guidance on using COSHH can be sourced from the Competent Person.

14.0 Office Lone Working

It is often necessary for employees of the organisation to have to work on their own. In the vast majority of cases, this poses no problem. The CCGs are committed to the safety of all employees as far as is reasonable practicable and will ensure that measures are in place to manage staff who may be lone working and to minimise any foreseeable resultant risks to those staff.

Lone Working can involve employees in premises where:
- the person is in the building on their own;
- the person works separately from others in the same building; or
- the person works outside normal hours

Lone working is specifically **not** permitted within the six CCGs for employees under the age of 18 or expectant mothers in the later stages of pregnancy.

From time to time there may be a need for staff to be within a building on their own. The following in particular should be taken into account:
- Regular checks should be arranged by other staff to ensure the well-being of the lone worker;
- The room layout should be designed to ensure that wherever possible and practical there is an adequate physical barrier between personnel and any potential attacker;
- The room layout should have clear and accessible escape routes from the area;
- Where personnel are alone in a building they should where possible lock all entry doors, although they should ensure that they still have a means of escape in the event of a fire.

Line Managers of lone workers have a duty to:
- Undertake a suitable and sufficient risk assessment of the hazards to which the lone worker may be exposed;
- Put control measures in place to reduce the risk, and;
- Monitor the effectiveness of the control measures applied.

Employees have a duty to:
- Follow all procedures and arrangements made for lone workers, and;
- Report all incidents or near misses relating to lone working.

Please see Appendix 4, Lone Work Procedures.

15.0 Young Persons

Under the Management of Health and Safety at Work Regulations, the six CCGs should carry out risk assessments specific to the employment of young persons, before they start work. This will apply to all young people including long-term employees, temporary staff, those on government-funded schemes and those on work experience programmes. The extent of the risk will determine whether the work of young people should be restricted. In the case of young people under the minimum school leaving age, their parents (or those having the parental responsibility) will be informed of the key findings of the risk assessment and the control measures taken.
Young persons may be exposed to additional risks at work due to their lack of knowledge, experience and possible immaturity. The following procedures should be implemented by line managers to ensure their safety.
- Additional training, instruction and supervision should be provided until the young person has demonstrated a satisfactory degree of competence;
- Both the young person and the Line manager should pay careful attention to any restrictions placed on the type of work, which may be undertaken.

16.0 New and Expectant Mothers
The six CCGs accept their responsibilities as set out within the Management of Health and Safety at Work Regulations to protect new, expectant and breastfeeding mothers.

Line managers are responsible for completing a New and Expectant Mothers risk assessment to ensure that the employee and the unborn child are not exposed to any significant risk.

The organisation will provide suitable facilities for nursing mothers to rest, express milk and store milk within a dedicated fridge. This facility must be situated conveniently in relation to sanitary facilities.

Further information and guidance can be obtained from the HR department.

17.1 Contractors and Visitors
Visitors must report to reception and be escorted to their destination. They should be made aware of any local safety procedures and, in the event of fire evacuation, escorted out of the premises to the assembly points.

If contractors or visitors are seen acting unsafely this should be reported to the building manager or landlord so that the matter may be raised with the individual or company concerned.
Appendix A

First Aid Requirements Guidance
The aim of first aid is to reduce the effects of injury or illness suffered at work caused either by the work itself or by some other factor outside the organisation's control. First aid provision must be 'adequate and appropriate in the circumstances'. This means that sufficient first aid personnel and facilities should be available to:

- Give immediate assistance to casualties with common injuries or illness and injuries likely to arise from specific hazards at work;
- Provide first aid and offer assistance to a member of the public, resident, guest or service user who is on the organisation's premises, including those visiting or attending any CCG events; and;
- Summon an ambulance or other professional help.

The extent of the first aid provision required depends on the circumstances in each workplace.

As with risk assessments, first aid assessments shall be reviewed on a regular basis, that is, every year and whenever there is a material change either to the amount and type of work carried out or to the number of staff members employed on the site.

In assessing needs, the following need to be taken into account:

- Workplace hazards and risks;
- The number of staff members employed on the site;
- The accident record of the site;
- The nature and distribution of the workforce;
- The remoteness of the site from emergency medical services;
- The needs of travelling, remote and lone workers;
- Annual leave and other absences of First Aiders and, if applicable, appointed persons.

**Suggested numbers of first-aid personnel to be available at all times people are at work**

<table>
<thead>
<tr>
<th>Degree of Hazard</th>
<th>How many employees</th>
<th>What First Aid personnel are recommended</th>
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</thead>
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<tr>
<td>Low Hazard e.g. offices</td>
<td>Less than 25</td>
<td>At least one appointed person</td>
</tr>
<tr>
<td></td>
<td>25 - 50</td>
<td>At least one first aider trained in Emergency First Aid at Work (EFAW)</td>
</tr>
<tr>
<td></td>
<td>More than 50</td>
<td>At least one first aider trained in First Aid at Work (FAW) for every 100 employed (or part thereof)</td>
</tr>
</tbody>
</table>

**Appointed Person**

When an employer's first-aid needs assessment indicates that a first-aider is unnecessary, the minimum requirement is to appoint a person to take charge of first-aid arrangements. The roles of this appointed person include looking after the first-aid equipment and facilities and calling the emergency services when required. They can also provide emergency cover, within their role and competence, where a first-aider is absent due to unforeseen circumstances (annual leave does not count).

**Emergency First Aid at Work (EFAW)**

Provides basic lifesaving first aid including:

- Understanding of Health and safety (first aid) regulations;
- Managing an incident;
- The priorities of first aid;
• Treatment of an unconscious casualty;
• Resuscitation;
• Shock;
• Choking;
• Seizures;
• Bleeding;
• Common workplace injuries.

First Aid at Work (FAW)
Provides comprehensive set of practical skills for first aid situations including:
• Accidents and illness;
• Treatment of an unconscious casualty;
• Heart attacks;
• Resuscitation;
• Shock;
• Choking;
• Bleeding;
• Burns and scalds;
• Poisoning;
• Fractures;
• Seizures;
• Asthma;
• Severe allergic reaction;
• Eye injuries;
• Low blood sugar;
• Fainting.

Qualified physicians and nurses can act as fully qualified First Aiders without having to attend specific training courses. To be counted as part of the organisations complement of first aiders a doctor or nurse must:
• be in clinical practice;
• maintain competency in resuscitation techniques;
• be willing to attend incidents on request;
• be included on lists of first aiders;

First Aid equipment
There is no mandatory list of items that should be included in a first aid kit (only a suggested contents card as a minimum). As a guide, where no special risk arises in the workplace, a minimum stock of first aid items would normally be:
• A leaflet giving general guidance on first aid (for example, HSE’s leaflet No 6, Basic Advice on First Aid at Work);
• 20 individually wrapped sterile adhesive dressings (assorted sizes), appropriate to the type of work;
• two sterile eye pads;
• four individually wrapped triangular bandages (preferably sterile);
• six safety pins;
• six medium sized individually wrapped sterile unmedicated wound dressings – approximately 12 cm x 12 cm;
• two large sterile individually wrapped unmedicated wound dressings – approximately 18 cm x 18cm;
• one pair of disposable gloves.

This is a suggested contents list only; equivalent but different items will be considered acceptable.

Additional materials and equipment may be necessary, for example scissors (blunt nose type), disposable aprons, and individually wrapped moist wipes. These may be kept in the first aid kit container, if there is room, but they may be stored separately as long as they are available for use if required.

The nominated first aider must check the first aid box on a regular basis to ensure that it is still fully stocked and the items have not expired.
APPENDIX 3 - Display Screen Equipment Procedure

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APPENDICES:

Appendix A – Health and Safety Guidance for working with Display Screen Equipment and laptop computers
1.0 Introduction

1.1 The main risks that may arise from working with Display Screen Equipment (DSE) are musculoskeletal disorders such as back pain or upper limb disorders (sometimes known as repetitive strain injury or RSI), visual fatigue, and mental stress. While the risks to individual users are often low, they can still be significant if good practice is not followed. DSE workers are also so numerous that the amount of ill health associated with work such is significant and tackling it is important.

1.2 The Health and Safety (Display Screen Equipment) Regulations 1992 requires an analysis of workstations for the purpose of assessing risks. In particular, the risks of musculoskeletal discomfort, visual disturbance and mental stress should be assessed. Any risks highlighted must be rectified as far as is reasonably practicable at the earliest opportunity.

1.3 Many employees use Display Screen Equipment (DSE) as part of their work. In order to comply with current Health and Safety law, Cannock Chase Clinical Commissioning Group (CCG), NHS South East Staffordshire and Seisdon Peninsula CCG and Stafford and Surrounds CCG have compiled a procedure to ensure that staff are not subjected to unacceptable levels of risk to their health or safety when using DSE.

2.0 Purpose

2.1 Employees who use DSE may be at risk of developing adverse health effects if their workstation is not set up correctly, and if they are unaware of how adverse health effects are caused. The Health and Safety (Display Screen Equipment) Regulations 1992 place duties on employers to ensure that risks to health and safety from DSE use are controlled and that employee are aware of the potential risks to their health and safety from DSE use, together with the actions they can take to reduce these risks.

2.2 All employees have the right not to be harmed by their work activities. This extends to the use of DSE. The CCGs will therefore take action to prevent adverse health risks to any employee using the DSE as part of their work, and to inform and train them as appropriate.

3.0 Scope

3.1 This procedure applies to all employees of the six CCGs who use DSE as part of their work, and employees of partner agencies whose employees use the CCGs’ DSE.

4.0 Definitions

4.1 Under the Health and Safety (Display Screen Equipment) Regulations 1992

4.2 Display Screen Equipment – DSE; DSE means any alphanumeric or graphic display screen, regardless of the display process involved.

4.3 User; A ‘User’ is an employee who habitually uses display screen equipment as a significant part of normal work.

4.3.1 An employee will generally be classified as a ‘User’ if:
- He/she depends on the use of display screen equipment to do their job as alternative means are not readily available for achieving the same results;
- He/she has no discretion as to whether they use display screen equipment;
- He/she needs significant training and/or particular skills in the use of display screen equipment to do the job;
• He/she more or less uses display screen equipment daily for continuous spells of an hour or more at a time. (Continuous spells should include short breaks of 5 to 10 minutes away from the screen every hour);
• The fast transfer of information between the ‘User’ and the screen is an important requirement of the job;
• The performance requirements of the system demand high levels of attention and concentration by the ‘User’, for example where the consequences of error may be critical.

4.4 Workstation means; an assembly comprising:
• display screen equipment (whether provided with software determining the interface between the equipment and its operator or user, a keyboard or any other input device);
• any optional accessories to the display screen equipment;
• any disk drive, telephone, printer, document holder, work chair, work desk; work surface or other peripheral items to the display screen equipment, and
• the immediate work environment around the display screen equipment.

4.5 Lap Top Computers; for the purposes of this policy, laptop computers fall within the scope of this policy where they are used for more than 2 hours at a time.

4.5.1 Online DSE Training: This training is to be completed by any worker who uses DSE as part of their work. Any issues that are raised will be followed up with a paper form and advice will be given by a member of MLCSU’s Health and Safety team.

5.0 Responsibilities
5.1 The responsibility for securing the health and safety of employees rests with the six CCGs’ Governing Bodies who are responsible for ensuring compliance with legal standards and for monitoring progress on implementation of this procedure. Employees have an obligation to comply with policies and procedures put in place for their health and safety.

5.2 Line Managers’ will, in consultation with employees be responsible for:
• Implementing this procedure throughout their areas of control;
• Identifying all CCG employees and employees of Partner Organisations who use the DSE;
• Ensuring that DSE Assessments are carried out for each member of staff and are to include the display screen equipment, furniture and the working environment;
• Where health and safety issues have been highlighted in the DSE Assessment, managers are to ensure that appropriate remedial action is taken to reduce any identified risks;
• Liaising with Occupational Health and Human resources where there are specific issues making this necessary e.g. pre-existing relevant medical conditions, return to work;
• Maintaining records of all DSE self-assessments and risk assessments;
• Managers are to encourage the early reporting by User(s) of any symptoms which may be related to display screen work, e.g. with posture or vision;
• In circumstances where an injury/ill health associated with DSE use is identified, managers’ are to ensure that an incident report/accident report is completed;
• Written Display Screen Equipment Assessments will be reviewed annually in conjunction with the User(s), or earlier if circumstances change, as above;
• Planning the activities of the User(s) so that short/frequent breaks are taken to prevent intensive periods of on-screen activity. 5-10 minute breaks are advised for each hour of display screen equipment work.
5.3 **Employees’ Responsibilities**

5.3.1 As an identified User, individual employees must co-operate with management to reduce the risk of injury from the use of DSE, and:

- Co-operation with the completion of the workstation DSE assessment and all measures/training given to promote safe working practice;
- Using equipment in the intended manner, ensuring they are comfortable as possible at their workstation;
- Adopting the advice of their line manager to plan work ensuring changes in activity within the working day to prevent intensive periods of on-screen activity;
- Using any corrective glasses prescribed specifically for working with DSE;
- Employees must inform their line manager immediately if they experience any problems or ill health which could affect their capability to work with DSE;

5.3.2 All Staff are responsible for keeping themselves informed and up to date about changes to the procedural documents, particularly Policy changes. This information will be provided via e-mail, intranet, staff meetings and professional forums.

6.0 **Workstation Assessment**

6.1 Line managers are responsible for ensuring a suitable and sufficient assessment is carried out by all their staff of the workstations they use, taking into account all aspects of the working environment. The first stage of the risk assessment requires any employee who uses DSE as part of their work, to complete the DSE online training. This should be completed at induction for new employees. All employees should review their training annually, or when there are significant changes to their workstation.

6.2 Workstation DSE Assessments should be repeated/reviewed where there is:

- a change in the display screen worker population;
- a change in the individual’s capabilities;
- a major change to the software used;
- a major change to the display screen equipment or furniture, including remedial work;
- a change in workstation location;
- a substantial increase in the amount of time required to be spent using display screen equipment;
- modification to the lighting;
- if requested by the user;

6.3 The findings should be recorded in written form or in some other retrievable manner. All necessary steps will be taken to remedy any risks highlighted as a result of the risk assessment. Further assistance and guidance on workstation assessments can be requested from the Commissioning Support Unit’s Health and Safety Advisor.

6.4 A workstation DSE assessment should also be undertaken for all DSE users using laptops and for homeworkers.

6.5.1 Guidance on the minimum requirements for workstations can be found at Appendix A.

7.0 **Breaks**

7.1 The key purpose of a break from working with DSE is to prevent the onset of fatigue. To achieve this, the CCGs will endeavour to incorporate changes of activity into the working day. There is no prescribed frequency or duration of breaks from DSE work. Where possible, users will be given discretion to decide the timing and extent of off-screen tasks. Any employee who believes that their DSE workload does not permit adequate breaks should bring this to the attention of their line manager. The work
break in the context of DSE means a break in the DSE work routine; for example, sorting paperwork, going to a printer, etc.

7.2 Users of DSE are encouraged, and will be expected, to take opportunities for breaks in their work routine.

7.3 General guidance on breaks
- Breaks should be taken before the onset of fatigue when performance is at a maximum and before productivity suffers. The timing of the break is more important than its length.
- Breaks or changes of activity should be included in working time. They should reduce the workload at the screen; that is, having been introduced they should not result in a higher pace or intensity of work to compensate for the time taken for the break.
- Short, frequent breaks of routine are more satisfactory than occasional, longer breaks; for example, a five–ten minute break after 50–60 minutes continuous screen and/or keyboard work is likely to be more beneficial than a 15 minute break every two hours.
- If possible, work routine and rest breaks should be taken away from the screen/workstation.
- It appears, from research evidence, that informal breaks, that is time spent not viewing the screen (for example, on other tasks), are more effective in relieving visual fatigue than formal rest breaks.
- Wherever practicable, users should be allowed some discretion as to how they carry out tasks; individual control over the nature and pace of work allows optimal distribution of effort over the working day.

8.0 Eye and Eyesight Tests
8.1 Employees expected to use DSE as the main element of their day to day work should be encouraged to have an eye and eyesight test. This can be undertaken by an Optometrist. The cost of this test will be refunded to the user by their employing CCG, up to a maximum of £25, and up to a maximum of £60 for glasses or contact lenses that may be required, upon presentation of official receipts. Claims need to be submitted within four weeks of the test having taken place and reimbursement will be via the CCGs’ expenses system.

8.2 Employees are encouraged to ensure future testing should they, with the support of their managers, determine that this is appropriate. (This will normally be over a two year period).

8.3 The CCGs will contribute towards the costs involved where the change of lenses or new glasses are required to correct vision defects at the viewing distances or distances used specifically for DSE work concerned. The Optometrist will be requested to provide written confirmation of this fact and for the breakdown of the associated costs.

8.4 The CCGs are only obliged to pay for basic frames and lenses. They will pay up to £60 in total, as this is considered to cover the cost of basic frames and lenses. The DSE user may if they wish contribute to the cost to purchase a more costly appliance.

8.5 Contact lenses are considered by the Association of Optometrists as being ‘very suitable’ for DSE users. However, contact lenses correct specific vision problems so wearers may need single lens glasses in addition to or instead of contact lenses to operate their display screens.”
9.0 Information and Training
9.1 The CCGs will provide information and training for all employees that use DSE. This shall include statutory requirements, the employee’s role in the recognition of hazard and risks, the need to take regular breaks, employees’ contribution to assessments, set up of the workstation, their ergonomic use of DSE to facilitate good posture and personal comfort, and their obligation to report any health concerns to their manager.

9.2 Further information, including guidance leaflets, and advice on the scope of training can be obtained from the HSE website: [http://www.hse.gov.uk/msd/dse/](http://www.hse.gov.uk/msd/dse/)

10.0 Dealing with Health and Safety Issues
10.1 Where an issue is raised by an employee on the use of DSE, the Line Manager will investigate the circumstances, take any necessary corrective action and inform the employee of the action taken.

10.2 Employees will be advised to inform their Line Manager where a problem arises in the use of DSE. In the case of adverse health conditions the Line Manager would normally refer the employee to the Occupational Health Department.

11.0 Use of Laptops
11.1 As in many organisations, the use of laptops is increasing, with employees working in variety of locations, including at home, few of which may have been designed and planned for display screen work. If a laptop is used for long periods of time it will be classed as an item of DSE. If a laptop is used for prolonged periods, an attempt should be made to find a sensible compromise that retains the benefits of mobile working but removes the risk of causing harm to staff.

11.2 For prolonged use of a laptop in a fixed location, such as, an office where the user is constantly present and using the laptop, the provision of ‘docking stations’ or laptop risers should be considered because these enable full size, good quality display screens and full size keyboards and mouse to be used.

11.3 Such an arrangement allows the laptop to be used as a portable in the normal way; but, when in the office, the laptop user has access to a full size keyboard and screen, using only the laptop’s processor and disc drive, and effectively turning the laptop into a fixed workstation. This will offer the user the flexibility inherent in using a laptop but remove problems that can occur such as back, shoulder, neck and wrist pains. Also see Guidance Document on the use of Laptops Appendix A.

12.0 IPads, Tablet etc.
12.1 The use of these types of equipment is becoming increasingly prevalent; these appliances are designed for work of a short duration and should not be used in preference to a desk top computer set up.

13.0 Additional Monitors / Screens
13.1 It is becoming more common place these days for a standard desk top computer to have attached to it a primary and a secondary monitor. If this is the case in your DSE set up then the secondary monitor should be set in line with the primary one to enable ease of viewing and the same considerations i.e. re glare and flicker etc. applied.

14.0 Radiation and Pregnancy
14.1 Employees using DSE are not at risk from radiation. Thus, there is no reason for an expectant mother to avoid working with such equipment.
14.2 It is recognised that, where an employee has a genuine concern, this can contribute to stress and ill health. The policy is therefore that any expectant mother may request a temporary transfer or a reduction in the volume of DSE work that she undertakes, such requests will be given full consideration and an assessment carried out, and where possible and viable, changes will be made.

15.1 References
Health and Safety at Work, etc. Act 1974
The Management of Health and Safety at Work Regulations 1999
Display Screen Equipment Regulations 1992 (as amended 2002)
Workplace Health, Safety and Welfare Regulations 1992
Provision and Use of Workplace Equipment Regulations 1998
Appendix A

Health and Safety Guidance for working with Display Screen Equipment
Display Screen Equipment (DSE) can cause difficulties in several areas:

These include:

Musculoskeletal injury: damage to upper limbs, back, shoulders etc., resulting from poor equipment, poor posture, incorrect work routines;

Visual fatigue: although there is no accepted evidence of VDU usage actually causing damage to eyesight, it can make small visual problems more noticeable and prolonged usage can cause tired or dry eyes, headaches etc. Poor lighting conditions, including siting issues, can also affect eyesight and cause visual fatigue;

Mental overload: the demanding nature of VDU work, or a lack of discretion caused by work with VDUs can place excessive pressure on workers;

Some of these risks can be managed effectively with ease by the user by applying the following advice to their workstation set up below:

Display Screen
• The display screen should preferably be in front of the user;
• The characters on the screen shall be well-defined and clearly formed, of adequate size and with adequate spacing between the characters and lines;
• The image on the screen should be stable, with no flickering or other forms of instability;
• The brightness and the contrast between the characters and the background shall be easily adjustable, and also be easily adjustable to ambient conditions;
• The screen must swivel and tilt easily and freely to suit the needs of the person;
• It shall be possible to use a separate base for the screen or an adjustable table;
• The screen shall be free of reflective glare and reflections liable to cause discomfort;

Keyboard
• The keyboard shall be in front of the user, tilt able and separate from the screen to allow a comfortable working position, avoiding fatigue in the arms or hands;
• The space in front of the keyboard shall be sufficient to provide support for the hands and arms;
• The keyboard shall have a matt surface to avoid reflective glare;
• The arrangement of the keyboard and the characteristics of the keys shall be such as to facilitate the comfortable use of the keyboard;
• The symbols on the keys shall be adequately contrasted and legible from the working position;
Using a Mouse
- The mouse should be positioned within easy reach, with the forearm supported on the desk;
- It should be used with the wrist straight, and without gripping the mouse too tightly;
- A mouse mat of soft foam material should be used and, if needed, with an integral wrist rest;
- The mouse and roller ball should be regularly cleaned;
- The sensitivity of the mouse should be adjusted to reduce the amount of movement required;

Work Chair
- The work chair shall comprise five castors, be in good repair, be stable and allow easy freedom of movement and a comfortable position;
- The seat shall be adjustable in height;
- The seat back shall be adjustable in both height and tilt;
- Armrests (if required) for reading, writing and general desk work;
- A footrest shall be made available to any person where a need is demonstrated;
- Adjust the contoured backrest to fit and support the small of your back and the lumbar spine area;
- Adjust the height so that your legs are comfortable and your forearms are horizontal when your fingers are on the keyboard;
- Adjust the tilt forward up to 15° for reading and writing, and backwards up to 5° for terminal and keyboard work;
- Move close to desk (remove arm rests if necessary).
Work Desk or Work Surface
- The work desk or work surface shall have a sufficiently large, low reflective surface and allow a flexible arrangement of the screen, keyboard, mouse, documents and related equipment;
- Any document holder shall be stable and adjustable and shall be positioned so as to minimise the need for uncomfortable head and eye movements;
- There shall be adequate space to arrange a comfortable position;

Space Requirements
- The workstation shall be dimensioned and designed so as to provide sufficient space for persons to change position and vary movements;

Lighting
- Any room lighting or task lighting provided shall ensure satisfactory lighting conditions and an appropriate contrast between the screen and the background environment, taking into account the type of work and the vision requirements of the person;
- Possible disturbing glare and reflections on the screen or other equipment shall be prevented by co-ordinating workplace and workstation layout with the positioning and technical characteristics of the artificial light sources;
- Reflection and Glare;
- Workstations shall be so designed that sources of light, such as windows and other openings, transparent or translucent walls, and brightly coloured fixtures or walls cause no direct glare and no distracting reflections on the screen;
- Windows shall be fitted with a suitable system of adjustable covering to attenuate the daylight that falls on the workstation;
- Anti-glare screens may be appropriate as a last resort;

Noise
- Noise emitted by workstation equipment shall be taken into account at the design stage to ensure that attention is not distracted and speech is not disturbed.

Heat
- Workstation equipment shall not produce excessive heat which could cause discomfort.

Temperature /Humidity
- An adequate level of temperature & humidity shall be established and maintained (between 16°C ~ 30°C).

Software
In designing, selecting, commissioning and modifying software, and in designing tasks using display screen equipment, the following principles shall be taken into account:
- software must be suitable for the task;
- software must be easy to use and, where appropriate, adaptable to the level of knowledge or experience of the person, with no quantitative or qualitative checking facility used without the knowledge of the person;
- systems must provide feedback on the performance of the software;
- systems must display information in a format and at a pace appropriate to the person’s ability, and;
- the principles of software ergonomics must be applied, in particular to data processing.

Use of a Telephone
- Position your phone on the opposite side of your desk to the mouse;
- Regularly clean the phone mouthpiece and keys;
- Avoid holding the phone between your ear and neck as this can lead to “phone-neck” a very painful condition;
- Use a phone headset if data is routinely entered whilst using the phone.
Appendix C

Other Good practice with Computers

- Take regular breaks away from the computer;
- Use movement to reduce fatigue (stand up and walk around);
- If you are having difficulties with your vision over the computer screen distance speak to your line manager regarding an eye test;
- Persistent aches, pains, tingling or numbness are early warning signs and should be reported to your line managers.

Office Exercises

- Exercise will move joints and stretch muscles and nerves;
- Movement stimulates the circulation and lubricates the joints;
- Will help to relieve muscle and nerve tightness;
- Just one to two stretches every 20 minutes to relieve fatigue;
- Aim to keep yourself generally fit, active and hydrate

LAPTOP COMPUTERS: HEALTH AND SAFETY GUIDELINES

The three CCG’S fully recognise their duties under the Health and Safety (Display Screen Equipment) Regulations (As Amended). We have produced these guidelines, which apply to all users of laptop computers.

Due to the compact design of laptop computers and the smaller size of the screen and keyboard, users may experience discomfort if certain precautions are not taken for usage. The CCG policy for usage recommends the following to be considered by users and adopted as working practice. Note that in this context a laptop computer is defined as a portable computer having a screen size, as specified by the manufacturer, of not less than 350mm (14 inches).

- Leave enough working room in front of the laptop to rest your wrists and forearms whilst carrying out work;
• Ensure that you adopt an upright sitting position and do not crouch over the laptop computer;
• Use a mouse which is separate to the laptop wherever possible;
• Always adjust the angle of the computer screen in order to reduce or eliminate reflections;
• If any discomfort is experienced when using a laptop, stop work and report to your manager;
• Whilst working at the office, use a desktop computer or laptop docking station when available;
• Ensure that whilst using the laptop that it is at the correct height in order to prevent discomfort from having to look up or down at the screen;
• Take regular breaks away from the laptop;
• Ensure that the laptop is on a solid, flat surface;
• Never overload the laptop carrying case with additional folders, etc., to prevent injury through awkward lifting and stress on the shoulders, neck and spine;
• Distribute the load in your laptop carrying case as evenly as possible;
• When carrying your laptop in public area be aware of your own personal security and the environment you are in;
• Do not use the laptop in your car whilst stationary: the limited space and sitting position could lead to discomfort;
APPENDIX 4 - Lone Working Guidelines

1.0 Introduction

Many of the CCGs’ employees may find themselves as a Lone Worker at times i.e: people whose work activity involves a significant part of their working time in situations where there is no regular, close involvement with other personnel or supervision. This could involve people being:

• in a building on their own;
• working separately from others in the same building;
• working outside normal hours e.g. staff who through flexible working arrangements start work earlier or finish work later than what is generally regarded as normal office working hours (8.30am – 5pm);
• visiting clients and carers in their own homes;
• travelling between sites to attend meetings

Lone workers therefore could be members of any staff group: clinical staff, administrative staff, ancillary staff or managers.

In the vast majority of cases, lone working poses no problem but the CCGs recognise the importance of all employees being afforded as safe a working environment as is reasonably practicable and will ensure that measures are in place to manage staff who may be lone working and to minimise any foreseeable resultant risks to those staff.

Line Managers of lone workers have a duty to:

• Undertake a suitable and sufficient risk assessment of the hazards to which the lone worker may be exposed (see section 3 below);
• Put control measures in place to reduce the risk, and;
• Monitor the effectiveness of the control measures applied.

Employees have a duty to:

• Follow all procedures and arrangements made for lone workers; and
• Report all incidents or near misses relating to lone working.

Generally there are no specific prohibitions on staff working alone. However, some health and safety legislation stipulates that a minimum of two people must be involved in certain work activities and particular safe systems of work must be followed. In other legislation a minimum level of supervision is required and limits the extent to which personnel may work on their own, for instance, young persons under the age of 18.

Lone working is specifically not permitted within the CCGs for employees under the age of 18 or expectant mothers in the later stages of pregnancy.

2.0 General principles around lone working

The first consideration should be whether lone working is necessary. Although it may well be in some cases and for limited periods every effort should be made to reduce it. This will include staff sharing offices and travelling together if possible. When flexible working is being considered staff safety should be part of the decision making process.

The following general principles should be followed to reduce the risk to lone workers:

• Staff should have a means of communicating to base;
• Staff at a central location should know where staff are likely to be;
• Staffs details (e.g. car, home address) should be accessible within a reasonable timeframe, where practicable;
• Staff should report to a central place or person when they start and finish work;
• Staff should report concerns about safety to their line manager, and report incidents when appropriate;
• Where a re-occurring situation is identified a management plan should be formulated, actioned and reviewed when necessary, e.g. via case conference;
• Staff should inform other teams or agencies of risks;
• Information about individual risks should be readily available to all team members and should be obvious;
• Crime should be reported to the police;
• All equipment used in the course of employment should be in good condition and be suitable for the task. Staff should be aware of the procedures to obtain replacements as necessary, ensuring that equipment is exchanged as soon as possible if it does not function correctly;
• If a staff member has to work alone in a room regular checks should be arranged by other staff to ensure the well-being of the lone worker; the room layout should have clear and accessible escape routes and be designed to ensure that wherever possible and practical there is an adequate physical barrier between personnel and any potential intruder;
• If a staff member has to work alone in a building they should, where possible, lock all entry doors, although they should ensure that they still have a means of escape in the event of a fire.

3.0 Assessing and Reducing the Risk to Lone Working

Although low, lone working does present some risks. The table below details some risks, factors for consideration and possible controls that should be used as part of the risk assessment. It is important to remember however that each situation will require its own assessment and response.

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<tr>
<th>Potential risk</th>
<th>Factors to consider</th>
<th>Possible controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vehicle risks; for example breaking down,</td>
<td>Remoteness of working area.</td>
<td>Provision of mobile telephones</td>
</tr>
<tr>
<td>road traffic accidents</td>
<td>Knowledge of where staff are expected to be</td>
<td>Use of office diaries, making sure diaries are kept up to date and colleagues know</td>
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<tr>
<td></td>
<td>at any time.</td>
<td>where you are meant to be, location boards, calling in to offices regularly.</td>
</tr>
<tr>
<td></td>
<td>Remoteness of car parking.</td>
<td>Whenever possible walk with another colleague to the car park, especially during</td>
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<td></td>
<td></td>
<td>the dark mornings/night. When this is not possible being extra-vigilant during the</td>
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<tr>
<td></td>
<td></td>
<td>dark winter months and letting colleagues or a family member know when you are</td>
</tr>
<tr>
<td></td>
<td></td>
<td>leaving the office.</td>
</tr>
<tr>
<td>Potential risk</td>
<td>Factors to consider</td>
<td>Possible controls</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Verbal abuse (including over the telephone) / physical abuse</td>
<td>Nature of work and likely distress / anger of callers or people being visited (e.g. people refused funding or awaiting assessment)</td>
<td>Information regarding situation prior to visiting or taking or receiving calls.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provision of mobile telephones.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Use of office diaries, making sure diaries are kept up to date and colleagues know where you are meant to be, location boards, calling in to offices regularly.</td>
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<tr>
<td></td>
<td></td>
<td>Training on recognition and de-escalation of conflict.</td>
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<tr>
<td></td>
<td></td>
<td>Sharing/documenting information regarding abusive behaviour.</td>
</tr>
<tr>
<td>Working alone in vulnerable places e.g. offices.</td>
<td>The layout and security procedures of the individual area.</td>
<td>Regular checks by colleagues, altering layouts as appropriate.</td>
</tr>
<tr>
<td>Working alone in circumstances that are out of the Shropshire CCG’s control e.g. people’s homes / other organisations’ premises.</td>
<td>Remoteness of location.</td>
<td>Awareness of risks, ensuring that all staff are informed of potential risk in individual circumstances.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sharing documenting known information regarding particular areas.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provision of mobile telephones.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Use of office diaries, location boards, calling in to offices regularly.</td>
</tr>
<tr>
<td>Lack of immediate managerial or professional support.</td>
<td>Type of work undertaken.</td>
<td>Informal and formal support systems.</td>
</tr>
<tr>
<td></td>
<td>Experience of staff.</td>
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# APPENDIX 5 - Fire Safety Procedures

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**Appendices:**
- Appendix A: Fire Safety and Fire Prevention measures in CCG Premises
- Appendix B: Personal Emergency Evacuation Plan (PEEP)
1.0 Introduction
It is the policy of NHS Cannock Chase Clinical Commissioning Group (CCG), NHS East Staffordshire Clinical Commissioning Group (CCG), NHS North Staffordshire Clinical Commissioning Group (CCG), NHS South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group (CCG), Stafford and Surrounds Clinical Commissioning Group (CCG) and NHS Stoke-on-Trent Clinical Commissioning Group (CCG) to seek to ensure as far as is reasonably practical, that all steps are taken by the six CCGs to minimise the effects of fire.

The six CCGs acknowledge their responsibility for the safety of people within the CCG if fire occurs, for the prevention of fire and the requirement to have a written statement of general policy under the statutory requirements of:
• The Health and Safety at Work etc. Act 1974;
• The Management of Health and Safety at Work Regulations 1999;
• Regulatory Reform (Fire Safety) Order 2005 (RRFSO).

The fire safety procedure, together with any subsequent revisions, will be brought to the notice of all the six CCGs' employees.

2.0 Statement of Policy
The six CCGs take every step necessary to ensure all employees are aware of potential fire risks and hazards. The Regulatory Reform (Fire Safety) Order 2005 requires the CCGs to observe specific requirements in order to reduce the risk of a fire occurring by:
• Providing a safe working environment and paying attention to fire prevention and evacuation procedures;
• Ensuring that systems are in place and regularly scrutinised to ensure their adequacy, i.e. emergency fire evacuation drill, inspection of the means of escape and maintenance of fire warning systems and firefighting equipment;
• Carry out a Fire Risk Assessment of the workplace (including all employees and all other people who may be affected by fire in the workplace) and to make adequate provisions for any less able – bodied persons on site;
• Identify the significant findings of the risk assessment and the details of anyone who might be especially at risk;
• Provide appropriate information, suitable instruction and training in basic fire prevention measures and evaluation procedures, together with mandatory annual updating for all people of the CCGs.

The fire safety procedure is available to all employees in order to help them become aware of potential fire risks and hazards. The fire safety procedure also informs employees of what to do in the outbreak of a fire and how best to ensure the safety of employees, and others.

3.0 Responsibility for Fire Safety
As with wider health and safety, overall responsibility rests with the Governing Bodies of the six CCGs.

3.1 Accountable Officer
Responsibility for Fire Safety rests with the Accountable Officer who has nominated the Director of Corporate Services, Governance and Communications as the person with managerial responsibility.

The Accountable Officer is responsible for:
• Reviewing the implementation of the Fire Safety Procedure.
• Demonstrating commitment to the promotion of fire safety within the CCGs.
• Ensuring sufficient resources are allocated to implement the Fire Safety Procedure.
• Ensuring that mandatory training for all employees is provided and that adequate resources are available to meet those training needs.
4.1 Health and Safety Representative
The Health and Safety Representative is responsible for the implementation of the Fire Safety Procedure, and for the following:

- Ensuring compliance with the general requirements for good fire safety within all departments and areas of the CCGs as detailed.
- Confirming that they are being conducted and then maintaining records of inspections and tests conducted on fire safety and fire safety equipment (e.g. alarm systems, emergency lighting, fire door closures).
- The provision of suitable fire exit routes with appropriate signage and maintained and tested emergency lighting.
- Ensuring employees receive fire safety training appropriate to the level of risk and duties they may be required to perform.
- Ensuring competent persons (Fire Wardens) are appointed in all areas.
- Maintain appropriate fire evacuation plans.
- Arranging fire drills and advising on any remedial action.
- Ensure Personal Emergency Evacuation Plans are completed accordingly.

4.2 Individual Employee Responsibilities

- To know and follow the fire evacuation plan if a fire breaks out.
- To report all suspected or discovered fires.
- To know the fire hazards in their environments.
- To practice and promote fire prevention in their working area.
- To attend fire training annually.
- To report any concerns around evacuation and fire safety.

5.0 Fire Risk Assessment
The six CCGs will ensure that fire risk assessments (FRAs) are conducted on all properties occupied by it for the purposes of its business.

Risk assessments will be reviewed bi-annually or sooner if a process changes or temporary works are due and the significant findings are to be recorded.

6.0 Fire Safety Training
It is the responsibility of line managers to ensure that all employees (including temporary and agency staff) are given appropriate information about, and instruction in, the fire precautions and evacuation procedures to be taken or observed in the premises. Information and instruction will be given during induction at the start of the person’s employment and whenever there is a change in the fire risk.

The need for further training will be determined by the Director of Corporate Services, Governance and Communications, but all staff must attend a minimum of one training/briefing session per year. The MLCSU Health and Safety Team are able to support with this.

The Director of Corporate Services, Governance and Communications must ensure a record is kept of all fire safety training undertaken. Records should include the type of training, local information and instructions provided, date and names as necessary. These may be kept electronically.

7.1 Fire Wardens
The Health and safety Representative is responsible for appointing sufficient Fire Wardens to oversee evacuations for their respective areas at all times of the day. They will require specific training around their role, the MLCSU Health and Safety Team are able to support with this.
7.2 Roles and Responsibilities:
- To act as a focal point for fire safety issues within their areas of responsibilities.
- To assist in the fire safety regime within their areas of responsibilities.
- To assist in the fire response in their areas.
- To liaise with other fire wardens and appointed building Fire Officer.
- To ensure that all staff and visitors within their areas are accounted for during an incident.

8.0 Fire Drills
A fire drill is intended to ensure, by means of training and rehearsal, that in the event of fire:
- The people who may be in danger act in a calm and orderly manner. Where necessary those designated carry out their allocated duties to ensure the safety of all concerned;
- The means of escape are used in accordance with a pre-determined and practised plan;
- If evacuation of the building becomes necessary, staff should be aware of what to do.

Fire drills will be held at least once a year. Where there are alternative means of escape the drill should be based on the assumption that one or more of the escape routes cannot be used because of a fire. During these drills a member of staff who is told of the supposed fire should operate the fire alarm and, thereafter, the fire routine should be rehearsed as circumstances allow.

Normally advance warning should NOT be given of the fire drill. However, you can individually warn anyone who may need to know in advance. Every opportunity should be taken to learn lessons from the drill and to reinforce employees training where gaps are identified. It is good practice to appoint a small number of people to observe the drills and highlight areas of concern. It is important that all managers are aware of the procedures, as employees will naturally look towards them in an emergency.

9.0 Fire Detection and Warning Systems, Emergency Lighting and Fire Fighting Equipment
The six CCGs, through liaison with the Landlord and NHS Property services, will ensure that there is a suitable and sufficient Fire Detection and Warning system, emergency lighting and Fire Fighting Equipment installed within the CCGs’ areas of responsibilities. Where the CCGs are occupying space in Council owned buildings, the responsibility will lie with the Council to install and maintain these. The CCGs will also ensure that all equipment and systems are tested and maintained in accordance with the relevant legislation and standards. Further guidance can be found at Appendix A (Fire Safety and Prevention measures in CCG premises).

10.0 Means of Escape
All corridors and stairways that form part of designated escape routes are to be kept clear and hazard free at times. In addition all final exit doors are to be kept clear at all times and regular checks are required to ensure that these doors open freely without any obstructions. Further guidance on means of escape can be found at Appendix A (Fire Safety and Prevention measures in CCG premises).

11.0 Fire Prevention
The CCGs place great emphasis on Fire Prevention in order to minimise the risk of a fire occurring. In order to achieve this all employees and visitors are to ensure:
- All waste material must be kept in suitable containers before it is removed from the premises;
- All combustible material must not be stored against electrical equipment or heaters;
- All excess combustible material must be stored in a dedicated storage area that is fire resistant;
- No unauthorised electrical equipment is to be used within the CCGs’ premises;
• Electric plug sockets are not to be overloaded and only authorised extension cables are to be used. The use of 3 way adaptors is prohibited.

The CCGs will also ensure, by liaising with the landlord and NHS property services that all Mechanical and Electrical equipment within the CCG’s area of responsibility is maintained, serviced and tested in accordance with relevant legislation, guidance and standards including:
• Fixed Wire Testing and Portable Appliance Testing;
• Heating Systems
• Lifts

Further guidance on Fire Prevention can be found at Appendix A (Fire Safety and Prevention measures in CCG premises).

12.0 Smoking
Smoking is prohibited within the CCGs premises for all staff and visitors for further information please section 5.2.3 of the Health and Safety Policy.

13.0 Help for People with Special Needs
When planning evacuation procedures and assessing the adequacy of fire precautions, consideration must be given to the requirements of people with special needs. Some common forms of disability that you may need to take account of include:
• Mobility impairment, which can limit speed of evacuation.
• Hearing impairment, which can limit the response to an alarm.
• Visual impairment, which can limit the ability to escape
• Learning difficulties, which can affect the response to an alarm.

Where people with special needs (employees and visitors) work in or use the premises, their needs should, so far as is practicable, be discussed with them. These will often be modest and may require only changes or modifications to existing procedures. However, in some cases, more individual arrangements involving the development of ‘personal emergency evacuation plans’ (PEEPs) may need to be considered (See Appendix B).

14.0 References
• The Health and Safety at Work etc. Act 1974;
• The Management of Health and Safety at Work Regulations 1999;
• Regulatory Reform (Fire Safety) Order 2005 (RRFSO);
• HM Government Fire Safety Risk Assessment – Offices and Shops - (ISBN 978185112815 – 0);
• Health Technical Memorandum 05-01: Managing healthcare fire safety (Second edition) dated April 2013;
• Disability and the Equality Act 2010;
• The Building Regulations 2010 Approved Document M – Access to and Use of buildings;
• The Health and Safety (Safety Signs and Signals) Regulations 1996;
• The Smoke – free (Exemptions and Vehicles) Regulations 2007;
• IEE’s Wiring Regulations 17th Edition wiring regulations (BS 7671);
• BS 5588 Fire precautions in the design and construction of buildings;
• BS EN 2 Classification of fires;
• BS EN3 Pt. 7 2004 Characteristics, performance requirements and test methods;
• BS 5306 Pt. 3 2009 Fire extinguishing installations and equipment on premises;
• BS 5306 Pt. 8 2007 Selection and positioning of portable fire extinguishers;
• BS 6643 Pt. 1 2008 Recharging fire extinguishers;
• BS 6643 Pt. 2 2008 Specifications for powder refills;
• BS EN 50172 (BS 5266-8): Emergency Lighting;
• BS 5891-1: Fire detection and alarm systems for buildings;
• BS 5499: Safety Signs Including Fire Safety Signs;
• BS 5839 – 1; Fire detection and alarm systems for buildings
Appendix A

Fire Safety and Fire Prevention measures in the CCG’s Premises

1. Housekeeping
Good housekeeping will lower the chances of a fire starting, so the accumulation of combustible materials in premises should be monitored carefully. Good housekeeping is essential to reduce the chances of escape routes and fire doors being blocked or obstructed.

Keep waste material in suitable containers before it is removed from the premises. If bins, particularly wheeled bins are used outside, secure them in a compound to prevent them being moved to a position next to the building and set on fire. Skips if used should be a minimum of 6m away from any part of the premises.

2. Storage
Many materials found within your premises will be combustible. If there are inadequate or poorly managed storage areas then the risk of fire is likely to be increased. The more combustible material you store the greater the risk of fuel to a fire.

Combustible materials are not just those generally regarded as being highly combustible, such as polystyrene, but all materials that will readily catch fire. Careful consideration of the type of material, the quantities kept and the storage arrangements, the risks can be significantly reduced.

In offices the retention of large quantities of paper records, especially if not filed away in proprietary cabinets, can increase the fire hazard. Care is to be taken to ensure that there is not a build-up of paper records and files. Records archiving should be undertaken in a secure area linked to the fire alarm system.

All employees are to be made aware of the hazards and risks of improper storage of combustible materials. Do not pile combustible material against electrical equipment or heaters, even if they are turned off in the summer and do not allow smoking in or around areas where combustible materials are stored externally.

Store excess combustible materials and stock in a dedicated storage area, storeroom or cupboard that is fire resistant. Do not store excess stock in escape routes or areas where staff or visitors would normally have access.

Under no circumstances are electrical and gas service cupboards and rooms to be used as storage areas for combustible materials.

3. Voids
Voids (including roof voids) must not be used for the storage of combustible materials. Such voids should be sealed off or kept entirely open to allow for easy access for inspection and removal of combustible material.

4. Combustible Waste and Packaging
Delivery of some goods results in large quantities of combustible waste and packaging. The sighting use and removal of these materials needs to be carefully managed to ensure that they cannot come into contact with potential ignition sources and to not cause obstructions.

5. Equipment and Machinery
Lack of preventive maintenance on equipment and machinery increases the likelihood of failure resulting in overheating or sparking and hence an increased risk of fire starting. All machinery, apparatus and office equipment should be properly maintained by a competent person. Appropriate signs and instructions on safe use may be necessary.
6. Heating
Individual heating appliances require particular care if they are to be used safely, particularly those which are kept for emergency during power cut or as a supplementary during severe weather. The greatest risks arise from lack of maintenance and misuse.

Convector or fan heaters should be preferred to radiant heaters because they present a lower risk of fire and injury. The following rules should be observed:
- All heaters must be kept clear of combustible materials and in a position where they do not cause an obstruction. Their use must be continuously risk assessed.
- The use of portable fuel burning heaters, including bottled gas (LPG) are not to be used in the office environment.

Gas heating appliances should only be used in accordance with manufacturer’s instructions and will be serviced annually by a competent appointed contractor.

7. Hot Work
The three CCG’s require that where any hot works are to be carried out within their areas of responsibility, then a permit to work is to be in place. The permit to work is to be controlled by either the building manager or NHS Property services. Hot work is defined as burning, welding, brazing, soldering, grinding or cutting work producing sparks, during activities such as plumbing and flat roof work. Such works are usually carried out by contractors.

8. Electrical systems
8.1 Fixed Wiring
Fixed wiring systems are installed and maintained in accordance with the IEE’s Wiring Regulations 17th Edition wiring regulations (BS 7671). Fixed wiring will be subject to routine examination and testing by a NICEIC (National Inspection Council for Electrical Installation Contracting) accredited company at a minimum of every five years.
Work on fixed systems must only be done by persons who are competent to do this.

8.2 Portable Appliances
Portable appliances will be subject to routine inspection and testing in accordance with the guidance set out by the CCG’s Office Safety Procedure.

Where a permanent supply is required all reasonable steps will be made to modify the mains circuit to provide a permanent outlet and avoid long-term use of portable extension leads or multi-socket adaptors.

The Designated Person will ensure that arrangements are made for the above tests to take place.

Where employees provide their own electrical equipment such as mobile phones these will be included in the portable appliance testing. All new portable items introduced into sites must be reported to the Designated Person for inclusion in the appropriate register of appliances.

9. Arson
Recent fire statistics in the UK indicate that over 2100 serious deliberately set fires occur every week resulting in injuries and fatalities. All premises can be targeted deliberately or just because they offer easy access. Be aware of other deliberately set fires in the locality, which can indicate an increased risk to your premises. Be suspicious of and record any small ‘accidental’ fires on the premises and investigate them fully.
10.0 Display Materials and Decorations
Displays are often located in corridors, entrance foyers etc. and generally comprise of materials such as paper, cardboard and plastic which provide a means for rapid spread of fire. To reduce the risk of fire spread the CCG’s will try and:
- Avoid the use of displays in corridors and foyers;
- Minimise the size and number of display areas to discreet, separate areas;
- Keep displays away from light fittings and heaters;
- Keep displays away from ceiling voids which may lack fire barriers; and
- Ensure that there are no ignition sources in the vicinity.

Information should be confined to appropriately located display boards in areas away from escape routes. Display boards may be used on escape routes as long as they are no bigger than 1m² or have been enclosed in a sealed display case.

11. Fire Precautions and Maintenance
The Nominated Person is responsible for ensuring their site maintains records of the routine fire safety checks and fire risk assessments in the fire safety log book. This log is required to be accessible at all times for inspection or checks by the local enforcing authorities.

12. Fire Detection and Alarm Equipment
The provision of adequate means of detecting a fire and raising the alarm are of vital importance in offices. Early detection permits time for orderly evacuation and allows time for fire to be tackled at an earlier stage, therefore reducing the risk to life and the damage caused.

Buildings will have a means for warning persons within the building of a fire. This is done by a combination of automatic smoke and heat detectors and manual break-glass call points.

12.1 Testing and Maintenance
The Designated Person will ensure competent persons have been appointed to conduct all aspects of the testing and maintenance as follows:

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Responsibility</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily check of Fire Panel – power supply in place and no fault lights showing.</td>
<td>Building nominated competent person</td>
<td>Any faults should be logged in Fire Safety Log Book and reported to the approved specialist fire alarm engineer for action.</td>
</tr>
<tr>
<td>Weekly check – manual call point activated (using a different call point for each successive test). Manual call points may be numbered to ensure they are sequentially tested</td>
<td>Building nominated competent person</td>
<td>The result must be recorded in the Fire Safety Log Book and if failures are detected, these must be reported immediately.</td>
</tr>
<tr>
<td>Six – monthly servicing and preventive maintenance of fire alarm</td>
<td>Approved specialist fire alarm engineer</td>
<td>The result must be recorded in the Fire Safety Log Book and if failures are detected, these must be remedied immediately.</td>
</tr>
</tbody>
</table>

Further guidance on testing and maintenance of the fire warning systems can be found in BS 5839 Part 1.

13. Fire Fighting Equipment
In offices the emphasis must be towards the safety of staff and visitors rather than fighting the fire; extinguishers should primarily be used to protect life and facilitate safe escape.
They should only be used, by trained staff, if they can be used safely and without risk of trapping the user.

Fire extinguishers should normally be located in conspicuous positions on escape routes, preferably next to exit doors, and should not become a trip hazard. Wherever possible, firefighting equipment should be grouped to form fire points. These must be clearly visible and conspicuously indicated so that fire points can be readily identified.

The CCG’s will ensure a competent servicing contractor is appointed to undertake the annual fire extinguisher servicing and maintenance and the records for this are to be held on site in the fire safety log book.

The Nominated Person is to nominate a competent person to have a monitoring role to ensure that the annual servicing of firefighting equipment is taking place as required and to report any defective units identified during the monthly inspections to the contractor for repair or replacement. All defects are to be recorded in the fire safety log book with action taken to rectify defect.

13.1 Colour Coding of Extinguishers
BS EN 3 1997 is the current standard for portable fire extinguishers. All new extinguisher bodies must be red, and subject to national regulations, an area up to five per cent of the body may be colour coded to assist identification of the extinguishing material it contains.

Graphic symbols are to be used on the extinguisher body to assist identification of the type of fire it can be used on.

Guidance on the selection and installation of fire extinguishers is given in BS 5306-8 and should be inspected and maintained in accordance with BS 5306 - 3.

13.2 Testing and Maintenance
The following checks are required to be carried out by a nominated person on all fire-fighting equipment. All records of checks are to be recorded in the Fire Safety Log Book and any faults / damage reported to the firefighting equipment contractor for remedial action.
Weekly
• All fire extinguishers are in their correct place.
• All fire extinguishers are clearly visible.
• No visible damage i.e. safety pins have not been tampered with.

Monthly
• The pressure in ‘stored pressure’ fire extinguishers is correct.

Annual
• Service by a nominated competent contractor and replacement of safety pins (colour coded.)

In addition discharge testing must be done by the competent contractor at least every 5 years.

For more information on extinguisher testing please refer to BS EN3 and BS 5306 – 3 Annex A&B.

13.3 Fire Blankets
Fire blankets should comply with the ‘light duty standard’ as defined in BS 6575 and are useful for small discrete fires such as those in kitchens, and for putting out fires on people’s clothing in these areas.

14. Means of Escape
Means of escape enable a person to move away from a fire via structural parts of a building (corridors / staircases) to reach a place of safety. The extent of a means of escape is dependent on the assessed fire risk, size of the premises and profile of occupants.

It is essential that escape routes and the means provided to ensure they are used safely, are managed and maintained to ensure they remain usable and available at all times when the premises are occupied. Corridors and stairways that form part of escape routes should be kept clear and hazard free at all times. Items that may be a source of fuel or pose an ignition risk should never be located on any corridor or stairway that will be used as an escape route.

14.1 Testing and Maintenance
The following checks are required to be conducted, recorded and remedial action taken accordingly:

Weekly Checks
• Check all emergency fastening devices to fire exits (push bars and pads).
• Check all internal / external routes are clear and safe.
• Check to ensure all electronic release mechanisms on escape doors work correctly. Ensure they ‘fail safe’ in the open position. This can be done at the same time the fire alarm is tested on a weekly basis and a record must be made in the fire safety log book to confirm doors closed as intended.

Monthly Checks
• Check fire door seals and self-closing – devices are in good condition.
• Check all internal self – closing fire doors work correctly.

15. Emergency Lighting
Escape lighting is that part of the emergency lighting which is provided to ensure the escape routes are illuminated at all material times. (Emergency lighting is that provided for use when the power supply to the normal lighting fails).
The escape lighting should cover the corridors, stairways, large day rooms (those indicated for more than nine service users and which have a floor space exceeding 25m²), other large rooms and any external routes to a place of safety.

Escape lighting should be installed in accordance with the current version of BS 5266: Part 1.

15.1 Testing and Maintenance
BS EN 50172:2004/ BS 5266-8:2004 Emergency escape lighting systems, specifies the minimum provision and testing of emergency lighting for different premises and also additional information on servicing can be found in BS 5266 – Part 1 – 2005 Emergency lighting. The following tests are required and must be recorded in the fire log book:

Monthly
- Short functional test in accordance with BS EN 50172:2004/ BS 5266-8:2004. The period of simulated failure should be sufficient for the purpose of this test whilst minimising damage to the system components e.g. lamps. During this period, all luminaires and signs shall be checked to ensure that they are present, clean and functioning correctly. The result must be recorded in the Fire Safety Log Book and if failures are detected, these must be remedied as soon as possible.

Annually
- A test for the full rated duration of the emergency lights (e.g. 3 hours) must be carried out by a nominated competent contractor. The emergency lights must still be working at the end of this test. The result must be recorded in the Fire Safety Log Book and if failures are detected, these must be remedied as soon as possible.

16. Internal Smoke/Fire Doors
Where practicable it is good practice for all doors in the escape route to open in the direction of escape. This is particularly important for doors in high-risk areas, where the doors are at the base of stairs or where more than 50 persons are expected to evacuate.

All such doors must be able to be opened from the direction of travel without the use of a key or pass card (where security systems are in place, provision must be made for linking to the fire alarms to override locks when alarms are activated).

Smoke/Fire doors must be self-closing, fitted with intumescent strips and cold smoke seals and conform to BS 478 pt. 22 (fire resistance standard for fire door sets). Fire resistant doors fitted to cupboards and service risers that open onto escape routes must be kept locked, be fitted with intumescing strips and cold smoke seals.

17. External Final Exit Doors
These are doors designed to be part of the means of escape for use to reach an external place of safety. They must meet the following criteria:
- Open in the direction of travel
- Be free from obstruction or trip hazard. Where steps or slopes are in place these must be minimised and if necessary highlighted.
- Doors that are also used for normal access and egress must be capable of being opened / unlocked or released by a single turn handle or device like a thumb turn
- Doors that are used only for emergency evacuation must be capable of being opened with a single action device such as a push bar or pad.

18. Fire Notices and Signs
Signs must be used, where necessary, to help people identify escape routes and fire-fighting equipment. For a sign to comply with the Health and Safety (Safety Signs and
Signals) Regulations 1996 and BS 5499-4 and BS 5499-5 it must be in pictogram form. The pictogram can be supplemented by text if it is considered necessary to make the sign more easily understood, but you must not have a safety sign that uses only text.

The CCG’s will ensure that there are sufficient appropriate fire notices and signs within their premises. The purpose of fire notices is to give concise instructions of the actions to be taken on discovering a fire and hearing the alarm.

The purpose of fire signs is to direct people towards fire exits, or to provide specific information or warning about particular equipment, doors, rooms or procedures. They should be recognisable, readable and informative, as they convey essential information to regular and infrequent users of the premises and the fire and rescue service.
Appendix B  
Personal Emergency Evacuation Plan (PEEP) 

**To be completed by the Line Manager.** *(If the individual works in more than one building, then it may be necessary to prepare a separate PEEP for each building).* 

### PERSONAL EMERGENCY EVACUATION PLAN

<table>
<thead>
<tr>
<th>Name</th>
<th>Department</th>
<th>Building</th>
<th>Room Number and Floor</th>
<th>Contact Number</th>
</tr>
</thead>
</table>

#### AWARENESS OF PROCEDURE

(Insert Name) is informed of a fire evacuation by: *(please tick relevant box)*

- Existing alarm system; 
- Visual alarm system; 
- Pager device; 
- Other (please specify);  

#### DESIGNATED ASSISTANCE

The following has been designated to give assistance to get out of the building safely in the event of an emergency:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Contact details:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Name:</th>
<th>Contact details:</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

#### METHODS OF ASSISTANCE

#### EQUIPMENT PROVIDED

#### PERSONALISED EVACUATION PROCEDURE *(A step by step account beginning with the first alarm)*

1

2

3

4

#### MONITOR and REVIEW

Signed Manager  
Date

Signed Individual  
Date
Personal Emergency Evacuation Plan (Example)

*To be completed by the Line Manager.* (If the individual works in more than one building, then it may be necessary to prepare a separate PEEP for each building).

<table>
<thead>
<tr>
<th>PERSONAL EMERGENCY EVACUATION PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>Department</td>
</tr>
<tr>
<td>Building</td>
</tr>
<tr>
<td>Room Number and Floor</td>
</tr>
<tr>
<td>Contact Number</td>
</tr>
</tbody>
</table>

**Awareness of Procedure**

<NAME> is informed of a fire evacuation by: (please tick relevant box)

- Existing alarm system;
- Visual alarm system;
- Pager device;
- Other (please specify);

**Designated Assistance**

The following has been designated to give <NAME> assistance to get out of the building safely in the event of an emergency

- Name:
  - Contact details:
- Name:
  - Contact details:

**Methods of Assistance**

**Equipment Provided**

**Personalised Evacuation Procedure** (A step by step account beginning with the first alarm)

1
2
3
4

**Monitor and Review**

Signed Manager Date
Signed Individual Date
### Personal Emergency Evacuation Plan (PEEP) MATRIX

<table>
<thead>
<tr>
<th>Options</th>
<th>Types of Escape</th>
<th>Mobility Impaired People (a)</th>
<th>Sensory Impaired People</th>
<th>Cognitive Disabilities (f)</th>
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<tbody>
<tr>
<td></td>
<td>Electric Wheelchair (b,c)</td>
<td>Wheelchair user(b)</td>
<td>Mobility impaired person</td>
<td>Asthma/breathing problems</td>
</tr>
<tr>
<td>1</td>
<td>Meet assistances at refuge</td>
<td>√</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Meet assistance at the workstation</td>
<td>√</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Where suitable fire evacuation lifts exists these may be used</td>
<td>√</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Make own way downstairs slowly</td>
<td>√</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Move downstairs on bottom after main flow</td>
<td>√</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Use evacuation chair or similar</td>
<td>√</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Travel down in own chair with support</td>
<td>√</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Can get downstairs using handrails</td>
<td>√</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Needs assistance to walk downstairs 1 person (Buddy system).</td>
<td>√</td>
<td>√</td>
<td></td>
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<tr>
<td>10</td>
<td>Needs assistance to walk downstairs 2 person (Buddy system).</td>
<td>√</td>
<td>√</td>
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<tr>
<td>11</td>
<td>Horizontal evacuation</td>
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<tr>
<td>12</td>
<td>Cannot transfer readily</td>
<td>√</td>
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<tr>
<td>13</td>
<td>Needs colour contrast on stairways</td>
<td>√</td>
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</tr>
<tr>
<td>14</td>
<td>Needs step edge markings</td>
<td>√</td>
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<td></td>
</tr>
<tr>
<td>15</td>
<td>Needs showing escapes routes</td>
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<td></td>
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<tr>
<td>Options</td>
<td>Mobility Impaired People (a)</td>
<td>Sensory Impaired People</td>
<td>Cognitive Disabilities (f)</td>
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<tr>
<td>------------------------------------------------------------------------</td>
<td>------------------------------</td>
<td>------------------------</td>
<td>---------------------------</td>
<td></td>
</tr>
<tr>
<td>16 Needs assistance for person and dog</td>
<td></td>
<td>√</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 Needs door opening (Buddy system)</td>
<td></td>
<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>18 Needs orientation information</td>
<td></td>
<td>√</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>19 Needs tactile map of building</td>
<td></td>
<td>√</td>
<td></td>
<td></td>
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<tr>
<td>20 Large print information</td>
<td></td>
<td>√</td>
<td>√</td>
<td></td>
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<tr>
<td>21 Needs taped information</td>
<td></td>
<td>√</td>
<td></td>
<td></td>
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<tr>
<td>22 Needs information in Braille</td>
<td></td>
<td>√</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23 Buddy system</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>24 Provision of alternative alarm</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>25 Provision of flashing beacons</td>
<td></td>
<td>√</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26 Additional checks by fire wardens</td>
<td></td>
<td>√</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>27 Identification of escape route by reception / security</td>
<td>√</td>
<td>√</td>
<td>√</td>
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</tbody>
</table>

**Notes on disabilities**

a. There is a vast range of people who fit into this category. Issues relating to this group of people may also be relevant for people who have heart disease, asthma or heart conditions.

b. This group of people is considered most at risk in terms of escape. However, in some instances, a person who frequently uses a wheelchair may be able to walk slightly and therefore be able to assist with their own escape or even facilitate independent escape. It is essential that the disabled person is asked the relevant questions tactfully and in a way that produces the best escape plan.

c. Electrically powered wheel chair users may have less mobility than people who use manual chairs. It is wise to allow the escape of all other groups of disabled people in the building to ensure that is sufficient staff to assist this group.

d. People who are visually impaired are helped to escape by the provision of good signage and other orientation clues. It should be noted that most visually impaired people have some sight and that they will be able to use this during the escape in order to make their own way out of the building. The provision of a high powered torch may be useful. If the “Buddy System” is used it is recommended that the vision impaired person grasps their “Buddy’s” elbow as this will enable the person being assisted to walk half a step behind and thereby gain information about doors and steps.

e. Hearing impaired and deaf people need to know that there is an escape in progress.

f. People with cognitive disabilities often problems comprehending what is happening in escape conditions, or may not have the perceptions of risk as non-disabled people. Provision of good orientation facilities and measures within the building is essential. There may be reluctance by some to take an unknown route from the building. Some people with cognitive disabilities may fall into the group of unknown disabilities, such as dyslexia, dyspraxia and autism. These people may not be aware of the problem. The PEEP system should be used to give them the opportunity to understand the possible need for choice and direction change during an escape.
DEFINITIONS

Protected escape route
A protected escape route may consist of a corridor or stair enclosure which, once entered, will lead directly to a place of safety via an emergency exit.

The escape route is separated from the rest of a building by fire-resisting construction, providing a minimum fire resistance of 60 minutes. Access to the escape routes is by ‘Fire Doors’ which provide a minimum fire resistance of 30 minutes. These doors are fitted with self-closing devices capable of closing the doors from all angles of swing.

Once inside a protected escape route, you are deemed to be in a place of safety.

In order to maintain a satisfactory standard:

- No combustible material should be stored or sighted within protected stair enclosure. (Open notice boards, paper/cardboard stored below stairs etc.)
- Stairways and corridors to be kept free from obstruction. (No siting of equipment within these areas)
- A programme of inspection to ensure that all fire doors function properly and that any defects are immediately identified and repaired.

Refuges
A refuge is an area normally sited within an enclosure such as a protected lobby, protected corridor or protected stairway, which provides a temporary safe area for people who will not be able to use stairways without assistance.

The refuge normally needs to be big enough to allow wheelchair use and to allow the user to manoeuvre into the wheelchair space without undue difficulty.

A means of communication must be provided so that the person requiring assistance can make contact with those people who have been designated to provide assistance. This could be by fixed telephone at the refuge point, mobile phone, or two way radio link.

It is essential that the location of any wheelchair spaces within a corridor or stair enclosure does not adversely affect the means of escape for other people by narrowing the escape route width.

In circumstances where the refuge area identified for a wheelchair user may restrict the free passage of others trying to evacuate the building, the area may still be suitable for use as a refuge providing that the wheelchair is manoeuvred into position after other persons have left that part of the building.

Evacuation chairs (EVAC chairs)
Evacuation chairs are specially designed chairs for the evacuation of a person down a stair enclosure in a controlled and safe manner.

Whilst they are primarily for the use of wheelchair users, they can also be of assistance to those with impaired mobility, chronic/asthmatic conditions etc.

They must only be operated by person(s) trained in their use.
Buddy System
The 'Buddy System' is a procedure whereby a friend, colleague or staff member is allocated the responsibility of ensuring that the person, who may require assistance, is alerted of the need to evacuate a building and may assist that person in the evacuation.

Normally the person allocated this responsibility will be employed within the vicinity or work area of the person requiring assistance. In order to maintain the continuity of the evacuation procedures, persons should be nominated to deputise for those allocated the responsibility in their absence.
# Risk Stratification Policy

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<td>Governing Bodies meeting in common</td>
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<td>Date ratified:</td>
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<tr>
<td>Name of originator/author:</td>
<td>M&amp;L CSU IG Team</td>
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<tr>
<td>Name of responsible committee/individual:</td>
<td>Audit Committee</td>
</tr>
<tr>
<td>Date approved by Committee:</td>
<td></td>
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<tr>
<td>Date issued:</td>
<td>xx.xx.2019</td>
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<tr>
<td>Review date:</td>
<td>Three years</td>
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<tr>
<td>Date of first issue</td>
<td>2013</td>
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<td>Target audience:</td>
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## CONSULTATION SCHEDULE

<table>
<thead>
<tr>
<th>Name and Title of Individual</th>
<th>Groups consulted</th>
<th>Date consulted</th>
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<tr>
<td>MLCSU IG Lead</td>
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## APPROVALS AND RATIFICATION SCHEDULE

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<thead>
<tr>
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## VERSION CONTROL

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<th>Date</th>
<th>Author/amended by</th>
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<tr>
<td>1.0</td>
<td>Policy aligned across all six CCGs</td>
<td>20 June 2019</td>
<td>Tracey Revill</td>
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## IMPACT ASSESSMENTS – AVAILABLE UPON REQUEST

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<td>1</td>
<td>25 July 2019</td>
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</tbody>
</table>
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1.0 Introduction

1.1 Purpose of Policy
This policy provides the organisation with the actions agreed necessary to ensure that Risk Stratification is undertaken in line with current legislation.

The required actions are set out in the document ‘CAG 7-04(a)/2013 compliance for CCGs published by NHS England: http://www.england.nhs.uk/ourwork/tsd/ig/risk-stratification/ and are included in summary by this policy and responses set out in Appendix 1.

1.2 Risk Stratification
Risk stratification tools have had a profound impact on the delivery of health services across the developed world. These tools use relationships in historic population data to estimate the use of health care services for each member of a population. Risk stratification tools can be useful both for population planning purposes (known as “risk stratification for commissioning”) and for identifying which patients should be offered targeted, preventive support (known as “risk stratification for case finding”).

1.3 NHS England’s position statement
NHS England encourages CCGs and GP practices to use risk stratification tools as part of their local strategies for supporting patients with long-term conditions and to help prevent avoidable unplanned admissions.

As part of the 2013/14 GP contract, NHS England introduced a new directed enhanced service (DES) that promotes the use of risk stratification tools for identifying and managing patients who are chronically ill or who are at high risk of emergency hospital admission. GP practices choosing to take up this DES may elect to work collectively through their CCG to commission risk stratification tools. In this case, the risk stratification tool would be used to help identify patients at high risk of unplanned hospital admission (risk stratification for case finding).

NHS England has asked CCGs to take the lead in agreeing the details of the risk stratification DES with their participating GP practices so that the arrangements support the CCGs’ wider strategy for patients with long-term conditions.

CCGs may themselves commission risk stratification services to support commissioning decisions more generally (risk stratification for commissioning). In this case, knowledge of the risk profile of a population can be useful for:

- commissioning wider preventive services and for promoting quality improvement across member practices.
- In both cases, CCGs need the support and agreement of their member GP practices if risk stratification is to be conducted most effectively.

2.0 Policy Statement

2.1 The organisation will implement the requirements of the Risk Stratification Assurance Statement through actions set out below.

2.1.1 Information Sharing Agreements will be drawn up and agreed between partners involved in the Risk Stratification Process. This will include the CCG, GP practices, other providers and the CSU or/and the Risk Stratification Supplier.

2.1.2 A Privacy Impact Assessment will be completed by the CCGs as per the Information Commissioners Office’s (ICO) guidance. This may be undertaken jointly by all partner organisations involved in the risk stratification process.
2.1.3 Ethical Review

Risk stratification is comparable to screening because it uses a population’s data to identify individuals that are at sufficiently high risk of a Triple Fail event (such as an unplanned hospital admission) to justify offering a preventive intervention (such as the support of a community matron).

However, any screening test has the potential to cause more harm than good; for example, by exposing patients to false positive and false negative results and for these reasons, strict ethical guidelines are required to safeguard against the inappropriate use of risk stratification. In 1968, The World Health Organisation published ten prerequisites that should be met by any ethical screening program known as the Wilson and Jungner criteria; they have recently been adapted for risk stratification purposes:

i)  The Triple Fail event should be an important health problem.

ii) There should be an intervention that can mitigate the risk of the Triple Fail event.

iii) There should be resources and systems available for timely risk stratification and preventive interventions.

iv) There should sufficient time for intervention between stratification and the occurrence of the Triple Fail event.

v) There should be a sufficiently accurate predictive risk model for the Triple Fail event.

vi) The predictive risk model and impactibility model should be acceptable to the population.

vii) The natural history of the Triple Fail event (i.e., the practices and processes that typically lead to the event) should be adequately understood by the organisation offering the preventive intervention.

viii) There should be an accepted policy about who should be offered the preventive intervention.

ix) The cost of risk stratification should be “economically balanced” (i.e., it should not be excessive in relation to the cost of the programme as a whole).

x) Risk stratification should be a continuous process, not just a "once and for all" occurrence.

Source: Lewis et al., 2013, based on Wilson & Jungner, 196816

2.1.4 Following completion of the ethical review the CCGs have selected a suitable risk stratification tool based on the following factors:

• the adverse outcome to be predicted;
• the accuracy of the predictions;
• the cost of the model and its software and;
• the availability of the data on which it is run.

IG considerations

The CCGs will use the Combined Predictive Model, originally developed by the King’s Fund, tool for risk stratification.

2.1.5 The GP’s will use automated decision-taking and human review with automated decision-taking, the outputs of the tool are used directly to determine which patients should be offered a preventive intervention.
With human review, an appropriate clinician, with responsibility for the care of the individual patient, reviews which patients are to be offered preventive services. The decision is based both on the risk stratification outputs and any other information known to them.

2.1.6 The CCGs will develop preventative interventions that will be offered to high-risk patients. GP’s will refer patients to preventative services only with their consent.

The use of risk scores will underpin our approach to designing and managing commissioned services for unscheduled and emergency care over the next five years including a joint approach across health and social care and a targeted approach to admission avoidance and a critical part of what the Cross Economy Transformation Team have set out to achieve.

There are a number of clinical uses of the risk stratification data which will form part of current and future planning on admissions avoidance for the CCGs:

- To identify people with highly complex, multiple morbidity and/or frailty who might benefit from MDT support as part of case management and care planning
- To identify and target specific service needs of patient groups
- To identify suitable patients for the caseload of specialist nursing or medical services such as community geriatricians, community matrons or mental health practitioners, or for end of life advance care planning and/or reduce unnecessary unplanned admissions

2.1.7 The risk stratification process will be carried out in the following manner:

a) Data is received in a “de-identified data for limited access” form (i.e NHS number as the patient identifier) or is pseudonymised on landing; AND

b) Processing is within a “closed box” with strict role based access control; AND

c) Re-identification is solely for the purpose of direct care and is available only to those with a direct clinical care relationship with the patient.

d) Any publication of data other than in accordance with c. above must be anonymised in line with the ISB Anonymisation for publication standard.

2.1.8 The organisation responsible (CSU/risk stratification supplier) for undertaking the risk stratification processing will ensure that a detailed process is written to outline:

- The secure mechanism for receipt and processing of data within the risk stratification tool
- Data retention periods and data destruction
- Audit trails in place and confidentiality audits enabled
- The minimum data set(s) necessary to be collected and processed
- Training for staff handling data for purpose of risk stratification
- Process for reporting breaches identified

A high level procedure based on the detailed process for risk stratification will be included in the Information Sharing Agreement for risk stratification.

2.1.9 A Communications Plan will be developed to ensure that fair processing is in place for all patients and service users to inform them that their data may be used for risk stratification purposes. The fair processing notice will provide:
- an explanation of risk stratification,
- clarity about who the data controller and data processors are,
- a description of what type of data will be used for risk stratification,
- detail the rights individuals can exercise in relation to this i.e. the right to access their personal data and to object to its use for this purpose and how to exercise this right.

2.1.10 A process will be agreed to ensure patient objections can be handled and processed by the GP and CSU/risk stratification supplier.

3.0 Scope

3.1 Officers Within the Scope of this Document

3.1.1 This policy will apply to all GP practices within the membership of Cannock Chase, East Staffordshire, North Staffordshire, South East Staffordshire and Seisdon Peninsula, Stafford and Surrounds and Stoke-on-Trent Clinical Commissioning Groups (see appendix)

The following members of staff will have access to the identifiable data to support the clinical management of the patient by the practice staff:
- Data Quality Facilitators (Cannock Chase, East Staffordshire, North Staffordshire, South East Staffordshire and Seisdon Peninsula, Stafford and Surrounds and Stoke-on-Trent CCGs)
- Clinical Commissioning Group Facilitators (Cannock Chase, East Staffordshire, North Staffordshire, South East Staffordshire and Seisdon Peninsula, Stafford and Surrounds and Stoke-on-Trent CCGs)
- Locality Development Managers (Cannock Chase, East Staffordshire, North Staffordshire, South East Staffordshire and Seisdon Peninsula, Stafford and Surrounds and Stoke-on-Trent CCGs) DSCRO as the data processor

4.0 Roles & Responsibilities

4.1 GP Practices

4.1.1 The risk stratification tool will be made available to all practices to support them in identifying patients at high risk of
- hospital admission,
  - developing a long term condition e.g. diabetes, cardiovascular disease

4.2 Data Services for Commissioners Regional Offices (DSCRO)

4.2.1 The process is ‘black box’ (closed system) and will be done by the DSCRO, they are part of the MLCSU (but this team is ‘seconded’ to the Health and Social Care Information Centre (HSCIC), who are the legal processors of all patient identifiable data.

4.3 DQFs

4.3.1 To support the implementation of the tool.
To support practices to use the tool.
To support practices to manipulate the data generated into a usable manner.

4.4 CCG Facilitators and Locality Development Managers

4.4.1 To support practices to track patients on the budget manager and practice profiler tools and monitors the pathway of care.
5.0 Distribution & Implementation

5.1 Distribution Plan

5.1.1 This document will be made available to all Officers via the SharePoint and Share Net sites.

5.1.2 A global notice will be sent to all Officers notifying them of the release of this document.

5.1.3 A copy of the document will be emailed to each practice and a hard copy of the document will be sent to each member practice of the Cannock Chase, East Staffordshire, North Staffordshire, South East Staffordshire and Seisdon Peninsula, Stafford and Surrounds and Stoke-on-Trent Clinical Commissioning Groups.

5.2 Training Plan

5.2.1 A training needs analysis will be undertaken with Officers affected by this document.

5.2.2 Based on the findings of that analysis appropriate training will be provided to Officers as necessary.

5.2.3 Guidance will be provided on the SharePoint and Sharenet sites.

6.0 Monitoring

6.1 Compliance

6.1.1 Compliance with the policies and procedures laid down in this document will be monitored via the primary care team, together with independent reviews by both Internal and External Audit on a periodic basis.

6.1.2 The Director of Primary Care, in conjunction with the Head of Commissioning with responsibility for Primary Care, is responsible for the monitoring, revision and updating of this document.

6.2 Equality Impact Assessment

6.2.1 This document forms part of Cannock Chase, East Staffordshire, North Staffordshire, South East Staffordshire and Seisdon Peninsula, Stafford and Surrounds and Stoke-on-Trent CCGs’ commitment to create a positive culture of respect for all staff and service users. The intention is to identify, remove or minimise discriminatory practice in relation to the protected characteristics (race, disability, gender, sexual orientation, age, religious or other belief, marriage and civil partnership, gender reassignment and pregnancy and maternity), as well as to promote positive practice and value the diversity of all individuals and communities.

6.2.2 As part of its development this document and its impact on equality has been analysed and no detriment identified.

7.0 Associated Documentation

7.1 Reference any NHS England or other documentation that may be linked or related in some way (e.g. forms or detailed operational procedures)

NHS England Risk Stratification Assurance Statement detailing CAG 7-04(a)/2013 compliance for CCGs.

8.0 References

8.1 Reference any external CCG, NHS England or Midlands & Lancashire CSU documentation that may be linked or related in some way (e.g. acts of parliament) NHS England Risk Stratification Assurance Statement.
Appendix 1  Risk Stratification Assurance Statement – Checklist, CCGs response

Information Governance and Risk Stratification: Advice and Options for CCGs and GPs includes a checklist that organisations conducting risk stratification for case finding are advised to follow. The following summarises the approach of the CCGs to meeting these requirements, answers in bold type;

1.0 Develop and implement a risk stratification policy.

2.0 Conduct an ethical review to safeguard against unintended consequences, such as the inadvertent worsening of health care inequalities.

A draft Risk Stratification Policy & Ethical Review process is set out in this document

The algorithm used by the Risk Stratification provider has been developed and extensively tested by the King’s Fund; the model targets those most at risk of emergency hospital admission and who are likely to benefit from interventions in community settings, particularly those with Long Term Conditions.


3.0 Develop one or more preventive interventions that will be offered to high-risk patients.

The use of risk scores will underpin our approach to designing and managing commissioned services for unscheduled and emergency care over the next five years including a joint approach across health and social care and a targeted approach to admission avoidance and a critical part of what the Cross Economy Transformation Team have set out to achieve.

4.0 Select a suitable predictive model.

The algorithm used is the Combined Predictive Model (CPM) developed by the King’s Fund as a successor to the PARR and PARR+ models. The algorithm was developed into a tool by the former Blackpool PCT and has proved to be of great benefit to Blackpool clinicians.

The model uses secondary care activity data and GP system data relating to long-term conditions and disease registers to predict the likelihood of emergency hospital admission within the next 12 months; patients are ranked and grouped into categories based on anticipated intervention level (case management, disease management, supported self-care, prevention & wellness promotion).

5.0 Where the data are to be processed in identifiable form (i.e., confidential patient information) ensure there is a legal basis to obtain and process the data for these purposes (the only legal basis to process identifiable data “in the clear” for risk stratification purposes is consent). The legal basis is currently provided by s251 approval, but longer term arrangements to utilise pseudonymised data and re-identify only by those with a legitimate relationship with and individual should be developed or alternative legal basis sought such as consent.

Data processing is undertaken by the Risk Stratification provider, NHS Midlands & Lancashire CSU using pseudonymised data only; decryption to clear NHS number is only available to clinicians.

6.0 Agree a defined data set to be used for risk stratification that is adequate, relevant, but not excessive – including the extent of historical data needed to run the model (e.g. two or three years’ worth of data).
When fully implemented for a CCG the CPM utilises the following datasets:

- Long-term conditions; patients diagnosed with a defined long-term condition at any time
- Events – all clinical data entries expect those containing ‘sensitive’ codes (3 years data)
- Secondary care attendances & admissions (3 years data)
- Out of hours service contacts (3 years data)
- Community contacts (3 years data)
- Community Matron caseloads (snapshot)
- Practice registered population (snapshot)

The minimum required for a basic implementation of the model (with less predictive power) is secondary care activity data and practice register data.

Details of the data set to be used are included in the Information Sharing Agreement for Risk Stratification and the CSU Risk Stratification Processing Document.

7.0 For predictive models that use GP data, consider how the GP data will be obtained (e.g., using the GP Extraction Service [GPES] or directly from the GP system supplier).

GP data is to be extracted by a combination of MIQUEST queries, EMIS Searches and Reports and EMIS-IQ. Data extracts are undertaken by the Primary Care Data Quality team and permission from the practice is always sought prior to any extract being taken.

GP data extracts containing identifiable data are sent directly to the DSCR0 secure data warehouse where they are pseudonymised before being released to the CSU for processing in the Risk Stratification tool.

8.0 Determine whether to use automated decision-taking or human review. With automated decision-taking, the outputs of the tool are used directly to determine which patients should be offered a preventive intervention. With human review, an appropriate clinician, with responsibility for the care of the individual patient, reviews which patients are to be offered preventive services. Their decision is based both on the risk stratification outputs and any other information known to them.

The GP’s will use automated decision-taking and human review. With automated decision-taking, the outputs of the tool are used directly to determine which patients should be offered a preventive intervention. With human review, an appropriate clinician, with responsibility for the care of the individual patient, reviews which patients are to be offered preventive services.

9.0 Ensure that any data service providers being used for risk stratification have appropriate information governance controls in place. These controls include but are not limited to:

a) Checks to verify the accuracy of the data and to ensure they are up to date.

b) Processes to ensure that the data are not retained longer than necessary by the organisation conducting the risk stratification analysis (i.e. there should be a rolling programme of anonymisation or destruction as the data exceed the defined time period required for the risk stratification tool).

1 Details of exclusions are contained in the CSU ‘Risk Stratification Processing Document’
2 Data Service for Commissioners Regional Office; part of the Health and Social Care Information Centre and legally allowed to receive & process identifiable patient data
c) Checks that the data are not processed outside the European Economic Area unless there are equivalent legal, technical, and organisational measures in place to protect the data appropriately.

Full details of the CSU’s processing for Risk Stratification, including details of retention, access controls, etc. are contained in the CSU ‘Risk Stratification Processing Document’. Additional details and controls are contained in the Information Sharing Agreement for Risk Stratification.

Both the CSU and the DSCRO have achieved their respective IG toolkit requirements.

10.0 Establish appropriate contractual arrangements with any data service providers that:

a) Ensure there are appropriate organisational and technical measures in place to protect the data;

b) Prevent the unauthorised re-identification, onward disclosure, or further unauthorised or unlawful use of the data; and

c) Include mechanisms to manage the contract and audit how the data are being used.

d) Include a local process for managing patient objections. Patients may object to the disclosure or use of their personal confidential information, and/or they may object to automated decision-taking.

Each participating GP practice will have an agreement with the CSU Primary Care Data Quality Team to allow access to their systems for Risk Stratification extracts, but only with prior approval from a practice representative.

Each participating practice will also be a co-signatory to the Data Sharing Agreement between practices, CCG and CSU as Data Service Provider.

Full details of the CSU processing, security controls, retention policy, technical measures and management of patient objections are contained in the CSU ‘Risk Stratification Processing Document’.

Additional controls are included as part of the Information Sharing Agreement for Risk Stratification.

11.0 Develop a communications plan, including communication materials for patients (these materials may be incorporated into wider fair processing information).

12.0 Inform patients that their identifiable or weakly pseudonymised data may be used for risk stratification purposes.

GP Practices already provide information for patients regarding use of their data. Work will be undertaken in conjunction with the LMC regarding advice to Practices on communication materials and content.

• posters and leaflets available within the surgery;

• actively providing information at the time of registration and other points of written communication;

• dissemination via local patient groups; and

• Inclusion of the information on the practice website.

Information for patients is provided at the point of care (primary & secondary care) Under these proposals risk stratification will be undertaken using pseudonymised data.
13.0 Ensure that only those clinicians who are directly involved in a patient's care can see a patient's identifiable risk score.

All data processing within the CSU is conducted on pseudonymised data, no CSU or CCG staff has access to clear patient data except for those involved in the development of the tool and reports (and all these are seconded to HSCIC to allow them legal access to clear data).

The reports are delivered to end users through the CSU’s Aristotle BI portal; all users are required to register and have their request approved by a nominated practice authoriser (usually a line manager for CSU/CCG staff and a GP or practice manager for practice or community staff). At the point of registration a practice or community user can also request access to clear data on the basis of having a clinical relationship with the patients, and the practice authoriser must explicitly approve this before access is given.

All de-encryption of pseudonymised data is done automatically within the Risk Stratification reports and no users have access to the encryption keys.

14.0 Where a tool provides other clinical information (such as information derived from secondary care data), the GP must ensure that these types of data are relevant and that they have the consent of the patient to view this additional information.

The Combined Predictive Model reports allow for the inclusion of additional information about a patient's activity history with secondary care or community providers, plus details of Community Matron caseloads where applicable. Such data is only presented for the patients that are the direct clinical responsibility of the GP practice concerned.

15.0 Refer patients to preventive services only with their consent.

The use of risk scores will underpin our approach to designing and managing commissioned services for unscheduled and emergency care over the next five years including a joint approach across health and social care and a targeted approach to admission avoidance and a critical part of what the Cross Economy Transformation Team have set out to achieve.

16.0 Conduct Risk Stratification using one of the options outlined in Annex 1 (Page 17) of the original ‘Information Governance and Risk Stratification: Advice and Options for CCGs and GPs’ document released by NHS England in 2013

The CSU as Risk Stratification provider is using Option B (pseudonymisation at landing).

17.0 Using pseudonymous data, evaluate and refine the risk stratification model used and the preventive interventions offered according to its predictions

The CPM algorithm was developed and extensively tested by the King’s Fund. Whilst being implemented in the former Blackpool PCT the project team included clinical input from GPs, Matrons and other clinical staff, as well as Public Health and statistical specialists.

The former Northwest SHA commissioned a piece of work to re-validate the CPM and improve its predictive accuracy.

A project has just been commissioned by the North West DSCRO to compare the predictive accuracy of various Risk Stratification algorithms & tools, including the CPM model used locally.
Appendix 2   Definitions

Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this document shall have the same meaning as set out in the National Health Service Act 2006 and the Health & Social Care Act 2012 or in any secondary legislation made under the National Health Service Act 2006 and the Health & Social Care Act 2012 and the following defined terms shall have the specific meanings given to them below:

Clinical Commissioning Group/CCG means a body established in accordance with section 11 of the NHS Act 2006

Employee means a person paid via the payroll of Staffordshire & Lancashire CSU.

HSCA 2012 means Health & Social Care Act 2012

Security Management Policy

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<td>Andy Collins, CSU</td>
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1.0 Introduction

Cannock Chase, East Staffordshire, North Staffordshire, South East Staffordshire and Seisdon Peninsula, Stafford and Surrounds and Stoke-on-Trent Clinical Commissioning Groups (CCGs) recognise and will ensure that all reasonably practicable measures are taken to deliver a proper secure environment for all who work and visit CCGs' premises and/or other places of work.

This document has been written in line with NHS Protect’s ‘Standards for Commissioners’, setting out key responsibilities for Clinical Commissioning Groups, for its staff and for those services it commissions under the NHS Standards Business Contract, Service Condition 24.

It defines the main functions and responsibilities of those involved in implementing this policy. This document will be available to all employees and providers via the CCGs’ websites. It should be read carefully and its guiding principles adhered to.

2.0 Purpose

The purpose of this strategy and policy is to detail the CCGs' aims and responsibility for the effective management of security in relation to staff, patients, visitors and property. The CCGs are committed to the provision of safeguards against crime and the loss or damage to its property and/or equipment.

The CCGs will develop a culture which recognises the importance of security;

- Provide and maintain a working environment that is safe and free from the danger of crime for all people who may be affected by its activities including employees, patients and visitors.
- Prevent loss of/or damage to CCGs' assets or property as a result of crime, malicious acts, loss, damage or trespass.
- Maintain good order of premises under the CCGs' control.
- Report all criminal activity to the CCGs' management and ensure a robust response.
- Provide support to staff involved in a security incident and supply up to date information for all parties, especially after an incident.
- Work in partnership with local agencies e.g. police and local authority to ensure a safe and secure environment within all CCGs' locations.
- Support all staff who have been a victim of assault (both physical and verbal), through the course of their work, supporting civil prosecution where the Crown Prosecution Service (CPS) will not pursue this.
- Build the internal and external profile of the CCGs as organisations that take security seriously, from prevention of crime through to prosecution of those committing crime against it.

3.0 Strategy

The CCGs’ anti-crime strategy sets out its aims to continuously improve its anti-crime provision to safeguard the CCGs for the future. In order to ensure this continuous improvement, there are four strategic aims:

- To provide leadership for all CCG crime work by applying an approach that is strategic, co-ordinated, intelligence-led and evidence based.
• To **work in partnership** with other NHS commissioners and providers, as well as key stakeholders, such as the Police, the Crown Prosecution Service and local authorities.

• To **establish a safe and secure environment** that has systems and policies in place to: protect NHS staff from violence, harassment and abuse; safeguard NHS property and assets from theft, misappropriation or criminal damage.

• To lead, within a clear professional and ethical framework, **investigations** into losses due to criminality and criminal behaviour towards the CCGs’ staff.

These aims will be met by working in accordance with the following three key principles, which underpin all anti-crime work in the NHS.

3.1 *Inform and Involve*

• The CCGs communicate with other bodies, including providers, regulators and advisory bodies regarding security issues, including violence, theft and criminal damage.

• The CCGs carry out risk assessments to identify risks within the organisation relating to the security of its staff, property, premises and assets.

• The CCGs will develop proportionate and effective policies to mitigate identified risks.

• The CCGs will evidence communication between relevant departments within its organisation, on security matters.

3.2 *Prevent and Deter*

• The CCGs risk assess job roles and undertake training needs analysis for all employees, contractors and volunteers whose work brings them into contact with NHS patients and members of the public. Conflict Resolution Training can be provided, and will be monitored, reviewed and evaluated.

• The CCGs assess risks to lone workers, including the risk of violence. The CCGs will take necessary steps to avoid or control the risks and these measures are regularly and soundly monitored, reviewed and evaluated for their effectiveness.

• The CCGs distribute national and regional NHS England alerts to primary care contractors, relevant staff and third parties, taking action to raise awareness of security risks and incidents. This process will be, monitored, reviewed and be evaluated.

3.3 *Hold to Account*

• The CCGs have arrangements in place to ensure that security related incidents are investigated in a timely and proportionate manner and these arrangements are monitored, reviewed and evaluated.

• The CCGs are committed to applying all appropriate sanctions against those responsible for security related incidents.

4.0 **Scope**

4.1 This Policy applies to all directorates, services and departments of these CCGs including contracted or embedded staff and in all aspects of its activities.
4.2 This Policy covers the security of staff, contractors, visitors and property within. It focuses on improving and sustaining physical and personal security.

4.3 The CCGs’ Security Policy is based on the framework recommended as best practise by NHS Protect, its aim was to:

_To protect the NHS so that it can better protect the public’s health._

5.0 **Definitions**

_NHS Protect_  
Was the strategic body of the NHS to guide all NHS organisations to tackle security related issues and provide direction on these matters. The organisation ceased to exist in 2017 but CCGs are encouraged to continue to work to the standards they created until it becomes clearer what future arrangements will be regarding accountability and direction for security.

_Physical Assault_  
The intentional application of force to the person, without lawful justification, resulting in physical injury or personal discomfort.

_Non-Physical Assault_  
The use of inappropriate words or behaviour causing distress and/or constituting harassment.

6.0 **Roles and Responsibilities**

6.1 **Clinical Commissioning Groups**  
The CCGs’ Senior Executive team acknowledges its responsibilities for security management as employers and commissioners by following NHS Protects ‘Standards for Commissioners’. This set of standards will be followed by the CCGs and a self-assessment will assess compliance.

6.2 **Clinical Chief Officer**  
The Accountable Officer has appointed the Director of Corporate Services, Governance and Communications as the Security Management Director (SMD), having the responsibility for raising the profile of security management work within the organisation and Governing Body level, gaining their support and backing for important security management strategies and initiatives.

6.3 **Security Management Director (SMD)**  
Takes overall responsibility for all aspects of operational security matters, ensuring the following are considered:
- Appropriate policies are developed.
- Arrangements and appropriate levels of provision are in place for security management to take place effectively. This should be reviewed annually;
- Serious incidents and criminal acts are reported internally and investigated.
- Working with the police and/or Local Security Management Specialist (LSMS) in seeking prosecution of perpetrators of criminal acts, violent behaviour and verbal abuse.
- Providing feedback to staff involved in the more serious incidents.
- Ensure security management objectives are discussed and reviewed at a strategic level within the organisation.
• Ensure strategic management and support of security management work within the organisation, and leads on seeking assurance from providers regarding their compliance with security management requirements through contract monitoring processes. (NHS Standards Contract, service condition 24).
• Ensures assurance is actively sought from providers and measures are in place to ensure this takes place regularly.

6.4 **Directors**
It is the responsibility of all Directors to:
• Disseminate the Security Management Policy within the area of their responsibility.
• Ensure the co-ordination of security issues with other employers who share the worksite with the CCG.
• Ensure the implementation of the Security Management Policy within the area of their responsibility by providing support and advice to their managers.

6.5 **Local Security Management Specialist (LSMS)**
The nominated Local Security Management Specialists (LSMS) will provide professional skills and expertise to tackle security management issues on behalf of the CCGs.

The overall objective of the LSMS will be to work on behalf of the CCGs to deliver an environment that is safe and secure for all staff to the highest standards.

The LSMS will:
• Prepare a written work plan, and prepare annual reports on progress against the plan.
• Complete Commissioners Self Review tool, in conjunction with the CCGs, and submit to NHS Protect annually.
• Provide advice and support to the CCGs on all security matters.
• Ensure the CCGs are meeting the standards laid out in NHS Protect’s ‘Standards for Commissioner’. (As recommended by NH England.)
• Be responsible for advising on the security of all the locations within the CCGs, carry out inspections, write reports and advise the CCGs on all matters of security.
• Provide advice to managers at all levels on security matters/measures and deal with the management of violent and aggressive behaviour.
• Provide assistance to managers implementing risk reduction measures and post-incident management.
• Report the results of Security Surveys/Risk Assessments undertaken to the appropriate Manager and SMD.
• Assist local managers in carrying out investigations into security related incidents, liaising as required with the Police, , Legal Protection Unit and assisting in evidence gathering for submission to Court as part of the prosecution process.
• Deliver awareness sessions to staff on this Policy and to create a Pro-security Culture within the CCGs.
• To foster links with local agencies and bodies, such as the Police, Crime Disorder Partnerships and other security professionals in Neighbouring organisations.
• Provide advice, guidance and assistance to managers undertaking security risk assessments.
6.6 Managers
It is the individual manager’s responsibility to ensure that safe and secure environments are maintained, that all incidents are reported in full and that appropriate action is taken when and where necessary. Security is the responsibility of all managers who must ensure that preventative measures for the safety of staff and property are in place. They should ensure that the right policies, procedures and systems are in place in their local areas and that such policies are kept under constant review.

Line managers and department heads should also;
- Ensure that arrangements are made to secure the Department/Directorate out of working hours, together with the safe custody of keys.
- Ensure the setting of any security alarm or device to protect the property out of hours.
- Seek advice from the LSMS to ensure that the highest standard of security is maintained within their Department/Directorate.
- Ensure all staff employed by the CCGs, staff from other organisations working in NHS Midlands & Lancashire CSU (MLCSU), contractors and official visitors wear an ID badge at all times.
- Ensure that all staff are made aware of this Security Policy and fully understand its content and their responsibilities.
- Assess the impact on security of new projects and changes.
- To carry out security risk assessments and ensure that appropriate measures are in place.
- Ensure all staff receives appropriate security training by means of a training needs analysis and risk assessment for their role.

6.7 CCG Employees
- The CCGs’ employees are expected to co-operate with management to achieve the aims, objectives and principles of the Security Management Policy. Great emphasis is placed on the importance of co-operation of all staff playing their part in observing security and combating crime.

- The CCGs’ employees have a number of duties and responsibilities regarding security, these include.
  - Staff should ensure they keep property and assets of the CCGs secure at all times. Loss of equipment supplied by the CCGs may be investigated by LSMS and not replaced. Staff may have to fund replacement equipment, through their own department budget, should they lose or damage through negligence, any property or assets of the CCGs.
  - Staff should be aware of their responsibilities in protecting at all times, the assets/property of contractors, visitors and the CCGs. Where specific security procedures exist, staff must abide by them at all times. Where staff know or suspect a breach in security, they must report it immediately on an Incident Form or to their manager, or LSMS.
  - Staff should be aware of their responsibilities in protecting at all times, the assets/property of contractors, visitors and the CCGs. Where specific security procedures exist, staff must abide by them at all times. Where staff know or suspect a breach in security, they must report it immediately on an Incident Form or to their manager, or LSMS.
  - All staff are reminded that it is a criminal offence to remove property belonging to the CCGs without written authority. Failure to seek appropriate authority from their line manager could result in disciplinary action or criminal proceedings being taken against them.
  - Staff are responsible at all times, for the protection and safe keeping of their private property. The LSMS will, if requested, advise staff on the security of their property. Any loss of private property must be reported without delay. If private property has been stolen, then it is the owner’s responsibility, not the
CCGs’ responsibility, to contact the police. Theft will be seen as from the person not the CCGs by the Police.

- The CCGs will not accept liability for the loss of, or damage to private property including motor vehicles or other modes of transport. Motor vehicles brought onto the CCGs’ car parking facilities are entirely at the owner’s risk.

- All staff, visitors and contractors working on behalf of the CCGs or its representative, must wear an approved security identification badge and/or pass at all times, and challenge colleagues or strangers for not wearing them.

- Should a member of staff be vulnerable for any reason, or have a disability that could impact upon their security needs, they should bring this to the attention of their line manager who will make the necessary arrangements for drawing up a Personal Security Plan if required.

- Report all security related incidents, including violence and aggression, theft or loss through the CCGs incident reporting procedures, ensuring that line managers are fully aware of the circumstances.

- Be aware of security issues at all times and not allow anyone to tailgate them through controlled access doors. All staff must use their fobs to gain access through all doors at all times.

6.8 Staff from Other Organisations
Staff from other organisations e.g. Midlands and Lancashire CSU, should be made aware and read the details of the CCGs’ Security Management Policy. Where required, the CCGs will ensure adequate liaison is established between other bodies to ensure consistency of procedures and guidelines.

The CCGs’ staff visiting or working at other organisations should familiarise themselves with security arrangements for that location and if necessary, risk assess any perceived risks outlined in this policy.

7.0 Risk Management
Cannock Chase, East Staffordshire, North Staffordshire, South East Staffordshire and Seiden Peninsula, Stafford and Surrounds and Stoke-on-Trent Clinical Commissioning Groups’ risk management policy should be followed and can be found on the CCGs' websites. Follow link:


The CCGs have identified the following potential security related risks for its organisation:

- Physical Assault against staff.
- Non-Physical Assault against staff.
- Harassment of staff by another.
- Theft of the CCGs’ property.
- Theft of personal belongings.
- Criminal damage.
- Unauthorised intruders.

A risk assessment will be completed following the CCGs’ Risk Management Policy to analyse the impact and likelihood of those potential risks, and escalate any that meet the threshold for a corporate risk register. Risk assessments have been included in this policy in appendix one.

7.1 Managing Physical Security

The following steps should be taken annually to ensure the management of physical security is maximised at all times:

- A site wide risk assessment of all physical security in place at all buildings under the control of the CCGs in accordance with the CCGs’ Risk Management Strategy.
- An assessment must take place to improve or increase security after an incident or new vulnerabilities realised by the CCGs and Security Management Director.

7.2 Visitors/Contractors

- Contractors and other personnel, who visit the CCGs, are to be issued with a visitor’s identification badge that must be displayed at all times when personnel are on the premises.
- This will be signed for in the register held at the appropriate reception area. The member of staff who is responsible for the visitor/contractor will then arrange for them to be escorted to the relevant department.
- On leaving, the visitor’s badge should be reclaimed. All relevant times should be recorded in the register held within the department.

7.3 Staff Identification

The CCGs' Security Management Policy requires that all staff wear identification badges at all times. Photographic identification badges for staff will be produced by the Stafford Borough Council. All requests for ID Badges should be made to the Corporate Services team who will then request the badge from the Council, the pass will be issued via the Corporate Services team.

7.4 CCTV

The installation of CCTV at sites identified as benefiting from the facility is for the primary purpose of deterring criminal activity against the CCGs, its staff or visitors. An annual review of CCTV needs or requirements will take place following an incident or identified vulnerabilities were it is deemed necessary to strengthen the security of the CCGs and its staff.

- Where crime is committed any relevant data captured by CCTV will be used as evidence to support criminal or civil prosecution of the perpetrator/s. This may include the use of third parties data e.g. Landlords CCTV.
- Access to images will be governed in accordance with ICO guidelines (in accordance with the Data Protection Act, Section 29) and Subject Access Requests.
7.5 Access Control and Fobs
The CCGs’ staff will be issued with a fob/ID pass for access to the buildings and areas they are employed to work within.

- Fobs/passes will only be issued to employed staff (including those working as embedded or at the discretion of the Security Management Director) or visitors who have business at the CCGs and have signed for their use. Visitor fobs/passes must be returned at the end of each day.

- Data in relation to the activity of fobs/passes will be recorded by the access control computer and this data may be used in the prevention or detection of crime, in accordance with the Data Protection Act, Section 29 and Subject Access Requests. It must not be misused for any reason.

- It may also be used for a fire register should the need arise during a drill or fire situation. All staff are therefore required to present their fobs on entry and exit of the main building regardless of the position of the main doors.

8.0 Loss of CCG Equipment/Assets
The CCGs will provide staff with equipment e.g. iPads and laptops, for staff members to conduct their work. Staff must take care of equipment and ensure it is secure at all times. Staff must take care when off site and travelling to another meeting or venue, with the CCGs’ equipment/assets.

Staff who are deemed to have acted carelessly with the CCGs’ equipment/assets may be subject to disciplinary proceedings.

Should a department want to replace this item then replacement would be at the discretion of the Security Management Director and may have to be funded out of that department’s budget.

9.0 Reporting and Review of Security Incidents and Lessons Learnt
- The CCGs should follow its own incident reporting procedures to report security related incidents.

- The LSMS should review all security incidents; including security related Serious Incidents and report to the Security Management Director on steps required following LSMS findings.

- Lessons learnt from security management related incidents will be reported to the Audit Committee for review and implementation.

10.0 Security Management Awareness
- The LSMS will attend staff training sessions to raise awareness of Security Management within the CCGs.

- Additional training will be based on training needs analysis e.g. Conflict Resolution training.

11.0 Monitor and Review of Policy
The outcome of the successful implementation of the Security Management Policy will be reviewed at the Audit Committee. The Committee will review the security related incidents, security related risk assessments and statistical analysis of security reports given to the group.
This policy will be reviewed annually by the Audit Committee at its first meeting in the financial year and in accordance with the following as and when required:-
- Following legislative changes.
- Publication of good practice guidance.
- Case law.
- Significant incidents reported.
- New vulnerabilities identified.
- Changes to organisational infrastructure.

12.0 References & Bibliography

NHS Protects Standards for Commissioners 2016/17

Concordat between Health and Safety Executive & CFSMS

CCTV Code of Practice

13.0 Related Policies
The following documents should be consulted alongside this policy:
- Health and Safety Policy, including the following procedures:
  - Office Safety Procedure
  - Display Screen Equipment Procedure (DSE)
  - Lone Working
- Fire Safety
- Incident Reporting Procedure
- Risk Management Strategy
- DH Serious Incident Framework 2015