The Tavistock and Portman
NHS Foundation Trust

Board of Directors Part One

Agenda and papers of a meeting to be held in public

Tuesday 25 September 2018

1.30pm–4.00pm
Lecture Theatre, 5th Floor Tavistock Centre,

120 Belsize Lane, London, NW3 5BA

NHS
The Tavistock and Portman
NHS Foundation Trust

AGENDA

BOARD OF DIRECTORS – PART ONE
MEETING HELD IN PUBLIC
TUESDAY, 25 SEPTEMBER 2018, 1330 – 1630
LECTURE THEATRE. THE TAVISTOCK CENTRE, 120 BELSIZE LANE LONDON, NW3 5BA

		Presenter	Timing	Paper No
1 Patient Experience Stories and Service Reports				
1.1	Patient Story	Family – CYAF Complex Needs	1.30pm	Verbal
1.2	Service Line Report – CYAF Complex Needs	Associate Clinical Director – CYAF Complex Needs	2.00pm	1
1.3	Service Line Report Psychoanalytic Applied Portfolio	Portfolio Manager	2.10pm	2
2 Administrative Matters				
2.1	Chair's opening remarks and apologies	Chair	2.30pm	Verbal
2.2	Board members' declarations of interests	Chair		Verbal
2.3	Minutes of the meeting held on 24 July 2018	Chair		3
2.4	Action log and matters arising	Chair		Verbal
3 Operational Items				
3.1	Chair and Non-Executives' Reports	Chair and Non-Executive Directors	2.40pm	Verbal
3.2	Chief Executive Report	Chief Executive	2.50pm	4
3.3	Finance and Performance Report	Deputy Chief Executive / Director of Finance	3.05pm	5
4 Items for decision or approval				
4.1	Procurement Strategy	Deputy Chief Executive / Director of Finance	3.15pm	6
4.2	Procurement Policy	Deputy Chief Executive / Director of Finance	3.20pm	7
4.3	Health and Safety Policy	Deputy Chief Executive / Director of Finance	3.25pm	8
4.4	Fire Safety Policy	Deputy Chief Executive / Director of Finance	3.30pm	9
4.5	Water Safety Policy	Deputy Chief Executive / Director of Finance	3.35pm	10

		Presenter	Timing	Paper No
4.6	New Constituencies	Director of HR & Corporate Governance	3.40pm	11
5 Items for discussion				
5.1	Guardian of Safe Working Hours	Medical Director & Guardian of Safe Working	3.45pm	12
6 Board Committee Reports				
6.1	Clinical, Quality, Safety and Governance Committee	Medical Director	3.55pm	13
6.2	Equality, Diversity and Inclusion Committee	Deputy Chair	4.15pm	14
7 Any other business				
8 Date of Next Meeting				
	27 November 2018 – 1400 – 1700 – The Lecture Theatre, Tavistock Centre, Belsize Lane, London, NW3 5BA			

The Tavistock and Portman NHS Foundation Trust

Report to	Date
Board of Directors	25 September 2018

Complex Needs Service Line Report

Executive Summary

The purpose of this report is provide assurance to the board about the quality and safety of the Complex Needs Service Line and to update the board of the current developments and challenges.

Recommendation to the Board

The board is asked to approve this report

Trust strategic objectives supported by this paper

Objective 1 – People
Support our workforce to deliver the Trust's Mission in line with our values.
Objective 2 - Services
Maintain and develop our clinical, educational and training and consultancy services, adapting as appropriate to the changing environment.
Objective 3 – Growth and Development
Develop and implement a strategy for growth, identifying and working with partners within and outside the NHS, which delivers a sustainable financial future for the Trust and extends the reach of its distinctive approach to mental health.
Objective 4 – Finance and Governance
Meet regulatory requirements critical to the on-going well-being and independence of the Trust.

Please see Complex Needs Service Line Strategy in Appendix One for further details.

Author	Responsible Executive Director
Associate Clinical Director	Director of Children, Young Adults and Family Services

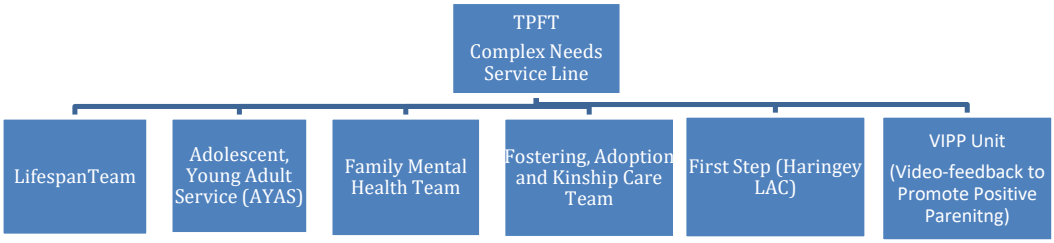
COMPLEX NEEDS SERVICE LINE REPORT
Children, Young Adults and Families (CYAF) Directorate

1. OVERVIEW OF THE SERVICE

1.1 This service line consists of a range of complex needs clinical services in CYAF, including the Lifespan Team, the Adolescent and Young Adults (AYA) Service, the Family Mental Health Team, the Fostering, Adoption and Kinship Care team, the First Step Team, and the VIPP (Video-feedback to Promote Positive Parenting) Unit. It does not include services that fall under the Camden contract, FDAC, or the Westminster Family Contact Contract.

1.2 The work of the service line is complex and involves negotiation with a large number of commissioners, including health, local authority and public health commissioning. An ongoing issue for the service line is that commissioners frequently change, meaning that relationship management is difficult.

1.3 The last service line report on Complex Needs was presented in September 2016. Since that time, a service line restructure took place, with the current service line structure as follows:



1.4 The new structure incorporates a leadership team of the 5 team managers who meet on a monthly basis to address a range of service wide issues. In addition, there is a single point of access within the complex needs service line with multi-disciplinary representation at the relevant intake discussion meetings, which supports cross-team capacity building and joint-working, where appropriate.

1.5 This service line does the majority of work on our main contracts in CAMHS (excluding Camden) such as Haringey, Barnet, Islington, Enfield as well as other

smaller contracts, and as such the service has over 14 commissioners potentially interested in its work. The services are mostly based in the main Tavistock Centre, although outreach services are present in Haringey at Bounds Green Health Centre.

1.6 The Lifespan Team

The Lifespan Team is a multidisciplinary CAMHS, managed by Nina Wessels. The team works with children, adults and families where there is a neurodevelopmental concern, such as autism, learning disability or brain injury. Our Lifespan team works with people of all ages who experience psychological difficulties as a result of having an autism spectrum condition and / or a learning disability. The team provide specialist assessment and treatment for people of all ages with autistic spectrum conditions (ASD) and learning disabilities, who experience psychological difficulties linked to their condition.
The team's referral and DNA statistics, covering the period 01.04.17 – 31.03.18:

Referrals Accepted	137
First Appointments (total)	182
Subsequent Appointments (total)	3778
Attended Appointment (total)	3102
DNA's (first)	29
DNA's (subsequent)	252
DNA Rate (total)	8.3%

Evaluation of Service Questionnaire (ESQ) data for the Lifespan team for 2017-18 is shown in Appendix 1. Emergent themes from the qualitative feedback included:

- Service users expressed a feeling of safety within the therapeutic relationship.
- It was noted that service users experience waiting rooms as busy and noisy. Staff feedback identified internal communication being an issue with patients using varied waiting rooms. This feedback influenced the PPI Quality Improvement strategy to improve facilities.
- Service users expressed some frustrations regarding waiting times for appointments.
- Service users requested more written information about therapy.

1.7 The Family Mental Health Team

The Family Mental Health Team is a multidisciplinary team that takes referrals from across all our contracts, and works with generic CAMHS cases as well as more specialist work with parents with mental health difficulties. The team is managed by Sarah Wynick.

The team's referral and DNA statistics, covering the period 01.04.17 – 31.03.18:

Referrals Accepted	147
First Appointments (total)	176
Subsequent Appointments (total)	3745
Attended appointments (total)	3082
DNA's (first)	18
DNA's (subsequent)	275
DNA Rate (total)	8.7%

ESQ data from the Family Mental Health team for 2017-18 is shown in Appendix 1.
Emergent themes from the qualitative feedback from service users included:

- Families complimented the practical liaison between different members of the multi-disciplinary team.
- Clinicians were complimented on being 'open minded and accepting'.
- Patients requested strategies to use between sessions.
- Waiting room issues were noted, such as the age range of patients being an issue for older patients in the busy CYAF waiting room.

1.8 The Adolescent and Young Adult Service

This service consists of two clinical teams led by Justine McCarthy Woods. The service specialises in analytically informed work with adolescents, young adults and their families. The service takes referrals from a wide range of areas, and has established a self-referral pathway for some services, including the YPCS (Young People's Consultation Service), for Camden and Barnet. The service offers individual therapy, family therapy and group therapy, along with parent work. The AYA service is particularly concerned about the increased levels of complexity and risk with the adolescents and young adults referred and how best to manage this from an outpatient psychotherapy service perspective. AYAS has become more established as a psychoanalytic psychotherapies service and, after an initial dip in the accepted referrals, they are now seeing the rate of referral increase to previous levels. Commissioners think well of the service, its flexibility

with age range, and quality. The service is currently working on objectives around growth and increased presence and the profile of the service has been raised in relation to national developments within student mental health and the re-launching of the AYAS Parent Consultation Service (PCS), along with the provision of a parent group for the first time in the history of the service.

Data for all AYA teams	
Referrals Accepted	313
First Appointments (total)	394
Subsequent Appointments (total)	5964
Attended Appointments (total)	4632
DNA's (first)	22
DNA's (subsequent)	527
DNA Rate (total)	10.8%

ESQ data from AYA for 2017-18 is shown in Appendix 1. Emergent themes from the qualitative feedback from service users included:

- An appreciation of thoughtful treatment and therapeutic relationships.
- Information before first appointment was requested. It was noted by staff that this is sent out as standard practice, and is also available in the waiting area, and is therefore an interesting area to consider within treatment.
- The accessibility of the administrative staff and their communication around appointments was complimented.
- Patients asked for practical actions and strategies for use between appointments.

1.9 The Fostering, Adoption and Kinship Care Team

The Fostering, Adoption and Kinship Care Team is a specialist multi-disciplinary team that provides consultation, assessment and treatment for children, young people and their families who are currently looked-after in foster or kinship care, or who are living in adoptive or special guardianship families. The team provide a full range of brief and longer-term interventions, beginning with consultation to the network and a multi-dimensional assessment.

Most of the referrals to the team are through local CAMHS because of our particular specialism in this area, although referrals can also be made on a named patient agreement (NPA) basis or via social care led applications to the Adoption Support

Fund. The team offers consultation and training to colleagues who are working in this field, and to statutory and voluntary agencies.

Referrals Accepted	73
First Appointments (total)	79
Subsequent Appointments (total)	2692
Attended Appointments (total)	2329
DNA's (first)	5
DNA's (subsequent)	97
DNA Rate (total)	4.2%

ESQ data from the Fostering, Adoption and Kinship Care Team for 2017-18 is shown in Appendix 1.

1.10 **The First Step Team**

First Step is a dedicated CAMHS for Haringey looked after children (LAC), which includes screening for mental health all children and young people placed in care and then at yearly intervals as well as CAMHS interventions to children who would otherwise not been eligible owing to the lack of stability of their placements. The team is co-located with the LAC nursing team to promote partnership working and is managed by Wendy Lobatto.

Referrals Accepted	154
First Appointments (total)	75
Subsequent Appointments (total)	467
Attended Appointments (total)	457
DNA's (first)	8
DNA's (subsequent)	35
DNA Rate (total)	8.6%

1.11 The VIPP Unit

Video-feedback Intervention to promote Positive Parenting and Sensitive Discipline (VIPP-SD) is a highly innovative evidence based preventative intervention, aimed at reducing the risk of placement breakdown amongst families that are grappling with highly complex relationships. It aims to develop and increase parental sensitivity to their children, improve discipline strategies, and reduce behavioral problems in children aged 0-6.

VIPP is not currently available to as a standard offer within our existing contracts, but can be commissioned on a NPA basis, or via social care led applications to the Adoption Support Fund (ASF). The VIPP Unit is focused on developing the sustainable growth of VIPP across the UK to increase accessibility of the evidence-based intervention, and recently launched the national VIPP Community of Practice in collaboration with Leiden University. We are currently working with the Business Development Team to develop a Trust Strategy for growth across VIPP pipelines.

The VIPP Community of Practice Launch June 2018

2. KEY INTERACTIONS WITH OTHER PARTS OF THE TRUST

2.1 There are many trainees from all disciplines within the Complex Needs Service Line, and many staff hold joint posts between the clinical and training directorates.

3. KEY SERVICE STRENGTHS AND SERVICE DEVELOPMENT OPPORTUNITIES

3.1 Each team has co-produced the objectives for the service line strategy which clearly outline the service development opportunities (see Appendix One for full details). All teams within the service line collaboratively developed their team strategies, aligned to the Trust objectives and service line objectives.

3.2 We have been further embedding the THRIVE Framework across all teams within the service line. A particular area of work relates to promoting genuine shared decision making in care planning and the use of i-THRIVE Grids to support this, alongside developing closer working relationships across the system to promote holistic and local services to support CYP and family resilience.

3.3 It is now standard practice across the directorate to co-design care plans with CYP and their families, and to share them with relevant agencies within the network, where appropriate. We are working to understand the service user experience of their involvement in care planning across the service line, and have identified this as a quality priority to improve patient and carer experience of care planning.

3.4 Within the service line we have engaged with NHS England's new workforce initiatives to develop capacity in the children's workforce. Even though we are not the local Haringey provider trust, the commissioner was very clear that T&PFT were the preferred provider for the CWP posts due to our engagement with CYP-IAPT and whole system transformation through i-THRIVE, alongside our success in workforce recruitment due to being a sought after employer. We therefore recruited 3 CYP-IAPT Children's Wellbeing Practitioners to work with Haringey children and young people in educational settings who would not ordinarily access CAMHS, and the Haringey commissioner is motivated to support our engagement with this for the next cohort as she is hopeful that Haringey will be a trailblazer site when the new investment is released aligned to the recent Green Paper.

3.5 There are NICE champions in each team across the service line to ensure up to date best practise and evidence based guidance is disseminated across teams in a timely way. The NICE champions ensure that NICE guidelines are regularly discussed in team meetings. In addition, we are developing the capacity of the teams to deliver evidence-based group interventions to increase team capacity and patient choice.

3.6 Across the service line we are working to embed continuous quality improvement cycles into day to day practice to improve service quality, and all teams are undertaking QI projects. An example of this can be found in the Lifespan Team where a QI project is currently underway to effectively manage the increased levels of complex referrals for over 18's to the team.

3.7 In collaboration with the Quality Team, we are working to improve the routine use of outcome monitoring tools to embed the meaningful use of outcome measures across the service line, and to support clinical feedback and review processes. We are working with the Head of Informatics to develop a method of presenting outcome data in a form that can be easily shared with patients and carers to provide timely feedback on their progress.

3.8 Service users fed back via the ESQ that they would benefit from written information about the work of the clinical teams to improve the patient journey. Teams are working collaboratively with service users to develop team level leaflets and electronic resources to facilitate a greater understanding of the work of the clinical teams.

3.9 The experience of transition from CAMHS to adult mental health services is a specific focus for NHS England. We are drawing on the learning from our colleagues within the Camden Service Line in the development of the "Minding the Gap" system-wide transitions meetings to improve the experience of transition for young people in other CCG areas, such as Haringey.

3.10 There were a total of five complaints received in 2017/18. Two were upheld, two were partially upheld, and one was not upheld. The main theme within the

complaints related to communication. The teams developed action plans as a result of the learning from the complaints.

3.11 Data on incidents are reported separately to the Board. However, in summary, there were three incidents across the service line in 2017/18. All incidents were followed up with actions disseminated for learning. In addition, all team managers are invited to attend the ongoing T&PFT workshops to disseminate learning from incidents.

4. AREAS OF RISK AND / OR CONCERN AND RELATED ACTION PLANS

4.1 An issue regarding appointments being added to the system too late for data submissions has been identified. The contract team are moving forward on a new way of reporting this to team managers through new internal monitoring reports. Teams are being trained on how to use the workbooks to see where there are trends. The internal auditors picked up this issue with the quality team and all teams have engaged in the ongoing work since this was identified as a Quality Priority. The issue of appointments being added late has been addressed with team managers and information on best practice is being cascaded to teams. In addition, team managers are collaborating with the quality team in relation to the quality priority action plan.

4.2 There are a number of Estates issues with the outreach premises at Bounds Green in Haringey which includes a current investigation by Whittington Health into the occupancy of rooms and the cost to the Trust, ongoing issues regarding the toilets often being out of order, and old furniture requiring removal. However, we would ideally like to increase the multi-disciplinary offer from the Bounds Green premises to increase the accessibility of our services to Haringey residents. There have been staff changes within T&PFT Estates which have meant the issues at the Bounds Green premises have not yet been fully resolved. It would be helpful if the Board could support the contractual arrangements being clarified as teams would benefit from having increased space to support a greater level of community working for the Haringey children, young people and families we serve.

4.3 The Family Mental Health Team has recently experienced usually high staff turnover due to the retirement of senior and very experienced team members. Whilst the vacancies have been filled quickly, the impact on team stability presents a reputational risk to T&PFT if there are delays to the commencement of employment due to efficiency savings as this will impact on the teams' capacity to manage ongoing cases and new referrals.

4.4 Due to an extended vacancy in the Haringey commissioner post external to our organization, we are yet to receive confirmation of funding for the First Step team and the Lifespan Autism Spectrum Conditions Assessment clinic beyond this financial year which presents a financial risk to the T&PFT. The new Haringey commissioner is due to commence in role at the end of July 2018, when the re-contracting of existing services will be prioritised.

4.5 The development of the Lifespan ASC assessment clinics have resulted in significant improvements in the quality of ASC assessments, and efficiencies in terms of throughput and patient experience. Staff have also reported increased satisfaction and feeling more on top of workloads. However, there continue to be long wait-times for assessment due to the large number of referrals received, the high levels of comorbid mental health issues and the complexity of cases, which presents a reputational risk. The new Haringey commissioner is due to commence in role at the end of July 2018, when the re-contracting of existing services will be prioritised with the goal of securing a longer-term contract to provide ASC assessments for Haringey children.

4.6 The Adolescent and Young Adult Service raised concerns that as a result of the recent CYAF Admin restructure, their capacity to provide a safe clinical service to patients was compromised. As a result of this concern being raised, T&PFT Medical Director is leading a formal review of risk in the service. The final report is being drafted, but early indications are that risk is no greater in this service than in other teams. However, administrative processes need to be improved as they currently contain risk. The admin manager is working with the service administrators to ensure these changes are systematised.

5. APPENDICES:
APPENDIX ONE: Complex Needs Service Line Strategy

Objective 1 – People	*Support our workforce to deliver the Trust's Mission in line with our values*
Key Success Criteria	**Timing / Milestones**
1. Develop greater collaborative working with team managers to improve operational effectiveness (e.g., referral pathways) and relationships across teams within the service line, and with external partner agencies, to enhance THRIVE-like system-wide collaborative practice and opportunities for shared learning and decision making.	1. Re-structure Complex Needs service line team manager and Intake meetings to develop sustainable internal and external feedback systems. Timescale: March 2018.
2. Improve operational consistency and communication across teams within the service line.	2. Identify an admin resource to help co-ordinate and minute service line team manager meetings. Timescale April 2018.
3. Develop sustainable opportunities to increase workforce resources within clinical teams. To include developing the skill mix within the Trust aligned with the Five Year Forward View.	3. i) Increase team capacity to support clinical supervision of trainee practitioners within teams. Timescale: October 2018. ii) Recruit 3 Children's Wellbeing Practitioner's (CWP's), and a CWP Service Development Lead, to deliver a low intensity mental health provision within two Haringey educational settings. Timescale: April 2018.
4. Review training gaps within the service line and invest in staff training, where clinically appropriate, to build capacity within teams to deliver evidence based assessments and interventions.	4. In collaboration with team managers, identify training gaps (e.g., NVR, VIPP, VIG, DIT, group based interventions) to identify priority areas for investment. Timescale: May 2018.
5. Develop the evidence-based group work offer across the service line to increase clinical capacity and service-user choice.	5. Review group work proposals across teams and develop strategies to promote recruitment within and across teams, as appropriate. Timescale: July 2018.
6. Review Autism Spectrum Conditions Assessments carried out across teams to ensure NICE adherence and appropriate funding and resource allocation.	6. Develop collaborative plan for the completion of ASC assessments across teams, in collaboration with team managers and Contracts, to ensure equitable access and wait times. Timescale: May 2018
7. Develop a greater awareness of the needs of BAME and Refugee Groups across the workforce.	7. Review team processes for ethnicity data collection and working with diversity. Timescale: September 2018

Objective 2 - Services	*Maintain and develop our clinical, educational and training and consultancy services, adapting as appropriate to the changing environment*
Key Success Criteria	**Timing / Milestones**
1. Improve range of multidisciplinary resources and services in outreach settings to increase accessibility for service users.	1. Review resource allocation in outreach settings and develop plan to increase multi-disciplinary capacity in collaboration with Estates. Timescale: July 2018.
2. Develop greater partnership working with partner agencies across sectors in the different localities to develop closer working relationships and improve team performance.	2. Identify the range of holistic support options available within local communities, and develop closer working relationships with key providers. Timescale: September 2018 and ongoing.
3. Embed shared decision making in routine clinical practice through embedding the use of i-THRIVE Grids to ensure equitable access to a range of evidence-based interventions.	3. Deliver i-THRIVE Grid training to clinical teams and explore possibility of developing an e-learning resource to ensure sustainability over time. Timescale: October 2018.
4. Use data to improve patient flow and enable teams to respond to changing demands in a timely way.	4. Review systems for monitoring staff workloads to facilitate timely problem solving across teams to effectively manage patient flow and waiting times. Timescale: September 2018.
5. Participate in research opportunities to develop the evidence base for specific populations.	5. Continue to support team level engagement with research opportunities, e.g., VIPP-FC. Timescale: ongoing to March 2019.

Objective 3 – Growth and Development	*Develop and implement a strategy for growth, identifying and working with partners within and outside the NHS, which delivers a sustainable financial future for the Trust and extends the reach of its distinctive approach to mental health*
Key Success Criteria	**Timing / Milestones**
1. Review the range of assessments and interventions provided across the service line to ensure an appropriate range of NICE recommended, evidence informed interventions are available.	1. Develop the capacity of the teams to deliver evidence based group interventions to increase team capacity and patient choice. Timescales: Ongoing.
2. Ensure opportunities for innovation are maximised to provide potential opportunities for growth. e.g., group work for targeted populations, NVR, specialist neurodevelopmental assessments for LAC children and young people.	2. Review piloted interventions to explore potential for growth and investment in clinical services, alongside collaborative training opportunities with DET. Timescale: October 2018 onwards.
3. In collaboration with service users, develop service user and referrer information resources to promote the work of the clinical teams, improve the patient journey, and encourage growth.	3. A) Develop team level leaflets and electronic resources across the service line to increase awareness and referral rates. Timescale: September 2018 B) In collaboration with the Commercial Team, develop resources to promote growth through the Adoption Support Fund. Timescale: June 2018.
4. Develop greater partnership working with partner agencies across sectors in the different localities to promote opportunities for growth.	4. Identify and engage with local opportunities for growth. Timescale: ongoing.
5. Develop CPD training opportunities for external practitioners within clinical teams to generate income within teams.	5. i) In collaboration with DET, develop standard formula to cost CPD training opportunities within teams. Timescale: September 2018. ii) Develop promotional resources to market clinical CPD opportunities in collaboration with the Commercial Team. Timescale: October 2018.

Objective 4 – Finance and Governance	*Meet regulatory requirements critical to the on-going well-being and independence of the Trust*
Key Success Criteria	**Timing / Milestones**
1. Embed continuous quality improvement cycles into day to day practice within the service line to improve service quality.	1. i) Improve data collection for indirect patient contacts and activities across the service line. Timescale: July 2018. ii) Develop QI project to reduce DNA rates across the service line. Timescale: March 2019. iii) Review impact of team information on website/leaflets (FMHT) on service user engagement. Timescale: December 2018. iv) Develop QI project in AYAS to improve clinician and service user understanding and communication re: confidentiality. Timescale: December 2018. v) Develop QI project in Lifespan to effectively manage increased levels of complex referrals for over 18's. Timescale: September 2018.
2. Develop sustainable feedback systems to maximise opportunities for service user involvement and feedback to improve service provision.	2. i) Recruit honorary research assistant/assistant psychologist in FAKT, to explore themes from the current experience of service questionnaires (ESQ) with service users. Timescale: May 2018- January 2019. ii) Review ESQ in collaboration with the Quality Team to ensure it is appropriate for cross-team contexts to enhance the meaningful collection of feedback. Timescale: July 2018 iii) FMHT project to review service user experience of CaR Clinics. Timescale: September 2018. iv) Embed a culture of service user participation within all teams. Timescale: March 2019.
3. Improve the service user experience of transitions from CAMHS to adult mental health services.	3. Collaborate with local action plans to implement the national Transitions CQUIN. Timescale: ongoing to April 2019.

APPENDIX TWO: ESQ data

ESQ Responses by True % (team by team level) for the period 1st April 2017 to 31st March 2018

Response	Lifespan (%True)	Adolescent Young Adult (%True)	Fostering & Adoption (%True)	Family Service (%True)	First Step (%True)	VIPP (%True)
Listened to	93%	95%	89%	93%	100%	100%
Easy to talk	87%	75%	85%	84%	100%	100%
Treated well	93%	96%	96%	93%	100%	100%
Views and worries	92%	95%	91%	92%	100%	100%
Know how to help	88%	76%	78%	76%	100%	100%
Given enough explanation	65%	76%	75%	73%	83%	100%
Working together	86%	89%	85%	88%	88%	100%
Comfortable facilities	82%	93%	93%	83%	100%	100%
Convenient appointments	80%	86%	78%	73%	90%	100%
Convenient location	64%	78%	91%	79%	67%	100%
Recommend to friend	92%	91%	82%	84%	90%	100%
Options	94%	85%	88%	89%	88%	100%
Involved	100%	89%	94%	88%	100%	100%
Quickly Seen	63%	79%	79%	83%	100%	100%
Good help	96%	93%	89%	90%	90%	100%

Report to	Date
Board of Directors	25 September 2018

Service Line Report: Psychoanalytic Clinical Portfolio

Executive Summary

The education & training programmes within the Psychoanalytic Clinical Portfolio are continuing to make a strong contribution to the Trust's financial and strategic objectives. An outline of the likely position from the current new student recruitment cycle is provided.

Considerable work across the portfolio has been done to implement the Race Equality strategy, and this is described in the report.

An indication of international opportunities is set out in the report. Some of the potential buoyancy in the international market is counterbalanced with significant concerns about the impact of possible significant changes to the funding arrangements for Child & Adolescent Psychotherapy training in the UK, which the Board is asked to note and discuss.

Recommendation to the Board

The board is asked to note and discuss this service line report.

Trust strategic objectives supported by this paper

7c: Extend existing and develop new services to respond to changing demand / new opportunities, including, where appropriate, the use of technology / 9: Develop the Trust's position in national and transnational education including the launch of a Digital Academy 14: Continue to meet regulatory standards with QAA / 16: Meet our Control Total for 2018/2019

Author	Responsible Executive Director
Portfolio Manager	Director of Education & Training / Dean of Postgraduate Studies

SERVICE LINE REPORT – PSYCHOANALTIC CLINICAL PORTFOLIO, DIRECTORATE OF EDUCATION AND TRAINING (DET)

1. OVERVIEW OF THE SERVICE

1.1 The Psychoanalytic Clinical Portfolio delivers ten long psychotherapy training courses which are accredited by a professional body and /or lead to an academic award. Four of the courses are also delivered in our National centres in Leeds and Manchester. The portfolio also delivers a range of CPD courses. The staffing consists of one portfolio manager, eight course leads, one link tutor, and eighteen other members of staff with small amounts of dedicated time for education and training. Two recently recruited Associate Clinical Trainers/Lecturers are joining the portfolio shortly. This is a positive development which will consolidate staffing resources, reduce reliance on the use of a large number of visiting lecturers, seminar leaders and clinical supervisors, and help with succession planning. This new staffing resource will also facilitate the development of new CPD courses and more flexible programme delivery.

1.2 Considerable work has been done to optimize use of staff time allocated to adult psychotherapy trainings over the last year. An audit was carried out in June 2017 which demonstrated a number of staff were working fluidly between the clinical and DET service lines with insufficient time being used for training functions. A management plan has been implemented to re-align use of staff resources according to service line funding source. This has been key in identifying the portfolio's contribution to 3.3% savings this year and has required close liaison with Clinical Service management. Significant progress has been made in ensuring staff are now working proportionately to paid DET hours and work on this issue is on-going. There is a strong wish to achieve a balance between enhancing the management of DET sessions in line with DET strategic requirements, and allowing staff to creatively engage with appropriate teaching developments.

1.3 The Portfolio has developed an Equalities Action Plan in line with the Trust objective of implementing the Race Equality strategy. The Doctoral Programme in Psychoanalytic Child and Adolescent Psychotherapy has included a diversity workshop which is being evaluated. In addition, both the adult psychodynamic and psychoanalytic psychotherapy trainings are conducting curriculum reviews of course content with the aim of ensuring up to date literature on issues of diversity is included in all programmes. All course teams are also discussing how to improve an experience of inclusivity in all aspects of training. This has been informed by

workshops run by Stonewall exploring LGBT issues in our education and training, and also liaison with the relevant professional bodies, specifically the British Psychoanalytic Council (BPC) and The Association of Child Psychotherapists (ACP), around issues of diversity.

1.4 The MA programme in Foundations of Psychodynamic Psychotherapy underwent a successful re-validation from the University of Essex in summer 2017. This was an achievement given the challenging context of a change of Course Lead and multiple changes in Course Administrator when preparation for the re-validation event was being done.

1.5 Both Course Leads for the MA programme in Foundations of Psychodynamic Psychotherapy and The Inter-Cultural Psychodynamic Psychotherapy have developed placement handbooks for their respective trainings in the last year. These handbooks helpfully lay out roles and responsibilities of student, training school and clinical placement and ensure matters of risk and governance are clear and accountable. This is an example of how our Academic Governance and Quality Assurance procedures are more embedded now in our non-validated programmes, which ultimately benefits the student experience.

1.6 Our student survey outcome for the last academic year has given positive feedback about the quality of teaching across programmes within the portfolio and has been described as life changing by a number of our students. The student experience of the early phase of implementing our new student information system has had some negative feedback, especially in relation to navigating enrolment and re-enrolment processes last year. Considerable work has been undertaken to rectify these initial problems and rigorous testing in advance of the next academic year suggests this will now be unproblematic.

1.7 The British Psychoanalytic Council (BPC) is conducting an accreditation visit in the autumn 2018 in relation to The Interdisciplinary Training in Adult Psychotherapy (M1). Plans to prepare for this visit are underway in close collaboration with the Associate Dean for Academic Governance & Quality Assurance (AGQA) and the AGQA Team. Many of the recommendations made at the last accreditation visit 5 years ago have been implemented, and it is expected that the next site visit by the BPC will be a positive one. The re-accreditation visit also provides an opportunity to review all aspects of the M1 programme to ensure it is relevant to the modern NHS. The balance between cost-effectiveness without compromising high quality training experience will be a key aspect of reviewing the programme in readiness for the re-accreditation process.

2. KEY INTER-ACTIONS WITH OTHER PARTS OF THE TRUST

2.1 There continues to be a close working relationship between the Directorate of Education and Training and the Clinical Services within the Trust. There is a shared acknowledgement that there is a mutually beneficial and interdependent link between the two service lines which is to be fostered. The Clinical Services offer valued clinical placements to many of our students who are training in either adult or child psychotherapy. The Directorate of Education and Training is providing students who are contributing to the clinical work of the Trust. Moreover, many staff work in both service lines. This year for the first time, joint appraisals were conducted for staff by Portfolio Manager together with Head of Complex Needs Service. This collaborative approach is also well established in the Child and Family Department and was welcomed by staff in the Adult Department.

3. NEW STUDENT RECRUITMENT

Course code	2016/ 2017	2017/2018 enrolled	2018/2019 accepted offers	2018/2019 pipeline remaining	18/19 total
M80	20	18	21	0	20
M80 NSCAP	6	5	7	1	8
M1	11	7	5	5	10
D59I	21	16	13	5	18
D59C	5	didn't run	10	0	10
D59L	not running	9	not running	0	0
D58	30	31	24	5	29
BD58	12	9	9	1	10
D58L	6	10	3	2	5
D58M	7	0	0	Not running	0
M14	4	2	2	1	3
TOTAL	122	107	94	20	113

3.1 The recruitment status described above captures data in September when final applications were being processed. The indications are that the majority of programmes within the portfolio will meet recruitment targets and some will exceed targets.

3.2 The Foundations of Psychodynamic Psychotherapy (D58 and BD58) is recovering from an unsettled period of staffing and student dissatisfaction, and it is particularly noteworthy that there hasn't been a significant drop in successful applications. A new Course Lead has been appointed who has been in post for over a year and the course

is becoming more robust under her leadership and is likely to resume even stronger recruitment in forthcoming years.

3.3 The Foundation of Psychodynamic Psychotherapy in Manchester (D58M) will not be running this year due to insufficient student applications. Some work is planned to explore a different approach to marketing this course, to consider shared teaching resources with Leeds and to look into the viability of this programme.

3.4 The Psychodynamic Psychotherapy with Couples Course (D59C) has doubled its recruitment target this year. This is especially pleasing as it did not recruit sufficiently to run last year and has the context of a strong competitor with a similar offering. It may be that having a more focal place in recruitment Open Events accounts in part for the surge of interest.

4. KEY SERVICE STRENGTHS AND SERVICE DEVELOPMENT OPPORTUNITIES

4.1 Both Child Psychotherapy training and Adult Psychotherapy training are leaders in the field and have a strong national and international reputation. Child Psychotherapy as a profession began at the Tavistock in the 1940s and has flourished since then, with the Trust training more than half the Child & Adolescent Psychotherapists working across the UK.

4.2 The positive reputation of the Tavistock abroad also means that a number of overseas students are interested in adult psychotherapy training at the Trust. Visa restrictions present a particular challenge in that programmes of study have to be completed in a timely way. This can be problematic for some students, particularly those with English as a second language who need time to improve English language skills and adapt to the UK culture.

4.3 Further work is planned to capitalize on international market opportunities. For example, an introductory course in adult psychotherapy approaches is currently being explored which could potentially offer a 'taster' opportunity for overseas students in tandem with their enrolment in an English language school. This would also provide an additional step towards readiness for a lengthier programme of study. This opportunity is being explored with the International Working Group chaired by the Director of Education & Training.

4.4 The development of different modalities of delivery of clinical training programmes, for example digitally/blended programmes is

also underway to enhance the accessibility and appeal of these courses while ensuring the core ethos of our training approach remains intact.

4.5 The Child Psychotherapy discipline at the Tavistock has a long tradition of being invited abroad for short periods to teach psychoanalytic approaches to working with children and young people. International connections include Italy, Greece, Ireland, Turkey, Russia, Mexico, South Africa, Taiwan, China for example. A week long CPD course, themed around the subject of trauma, has been commissioned by a group of Russians colleagues as a result of this established connection. This is being delivered in September 2018. These opportunities are being assessed in line with the developing international strategy in DET.

5. AREAS OF RISK AND / OR CONCERN AND RELATED ACTION PLANS

5.1 Heath Education England (HEE) currently offers full financial support to Child Psychotherapy training, including payment of course fees, payment of analytic fees and salary support over a 4 year period while trainees are on clinical placements. Plans for funding of Child Psychotherapy training are currently subject to review by HEE and the outcome of this is as yet unclear. However the possibility of no change to the current funding arrangements is unlikely. It is probable some change will be implemented in 2019/2020 or 2020/21 at the latest, which will impact on current funding arrangements in a way that is as yet unknown.

5.2 This is likely to have consequences for the numbers of people training with knock-on impact for our clinical services. This review has arisen in the context of HEE being subject of a comprehensive spending review in 2015 which resulted in the removal of funding of non-medical clinical trainings and ushered in the end of training bursaries for nursing, midwifery and Allied Health Professionals. Following on from this, funding for both child & adolescent psychotherapy and clinical psychology training is now under consideration. The time-line for outcome of HEE decision-making is unknown in relation to this issue. A complicating factor is the significant organizational change and associated multiple role changes within HEE over the last year.

5.3 There has been close contact with the Professional Body, The Association of Child Psychotherapists (ACP) who are lobbying on this issue. Paul Jenkins and Brian Rock have also convened meetings within the Trust to consider how best to influence decision-making by HEE.

5.4 An analysis of outcome measures is being undertaken demonstrating the effectiveness of a child psychotherapy with complex clinical cases

with high degree of co-morbidity. Work led by the Head of the Child Psychotherapy discipline in the Trust is ongoing to increase the media presence of Child Psychotherapists in recent months which has been successful.

5.5 Arguments are being made that reduction of numbers training as Child Psychotherapists will have implications for a number of NHS Trusts across the UK in terms of delivering specialist clinical services. For example clinical services within the Tavistock in both child and family and young adult services would lose a number of trainees on 4 year placements who do considerable clinical work for the Trust. Moreover there is concern that reduced funding will adversely affect the diversity of trainees recruited to train as Child & Adolescent Psychotherapists which has been slowly growing in recent years.

5.6 Arguments are also being made that Child Psychotherapy is a small specialist profession and without the structures attendant with central commissioning of training, it may struggle to survive. At present the Child Psychotherapy training delivers highly competent clinicians who are all fully employed on qualification and continue to have high retention rates in terms of working in the NHS.

6. AREAS OF RISK AND / OR CONCERN AND RELATED ACTION PLANS

6.1 The portfolio is diverse, challenging and enjoyable to manage. There is often much to grapple with in terms of fitting complex clinical training programmes into rigid university structures and systems. Visa restrictions cannot flex around unforeseen obstacles in clinical training and this present further complication for our overseas students. Alongside these challenges, the opportunity to develop the further reach of our training through digital learning presents exciting possibilities. The overall success of the portfolio is testament to the relevance of psychoanalytic thinking in the training of clinicians working with high levels of disturbance. The creativity, dedication and commitment of all Course Leads within the portfolio, assisted by Course Administrators and a range of professional support staff, ensures the continuing success of the portfolio.

Anne Hurley
Portfolio Manager (Psychoanalytic Clinical Programmes)

Board of Directors Meeting Minutes (Part One)
Tuesday 24 July 2018, 1.30 – 4.55pm

Present:			
Prof Paul Burstow Trust Chair	Prof Dinesh Bhugra Deputy Chair	Mr David Holt NED, SID, Audit Chair	Ms Helen Farrow NED
Ms Jane Gizbert NED	Dr Debbie Colson NED	Dr Sally Hodges Director of CYAF	Mr Paul Jenkins Chief Executive
Ms Louise Lyon Director of Q&PE	Mr Terry Noys Deputy CEO and FD	Mr Brian Rock Director of E&T/ Dean	Dr Julian Stern Director of AFS
Dr Rekha Elaswarapu, Associate NED	Dr Chris Caldwell Nursing Director		
Attendees:			
Craig de Sousa, Director of HR & Corporate Governance (minutes)	Marion Shipman, Associate Director – Quality and Governance (Items 3.3 and 6.2)	Claire Kent, Public and Patient Involvement Service Lead (Item 5.3)	Amanda Hawke, Complaints Manager (Item 6.6)
Isabelle Bratt, Complaints Liaison Officer (Item 6.7)	George Wilkinson, Governor		
Apologies:			
No apologies were received			

Actions

AP	Item	Action to be taken	Resp	By
1	2.3.1	Minor amendments to be made to the minutes of the previous meeting.	CdS	Immed
2	6.4.2	Discuss with the Named Professional for Child Safeguarding the context of issues around pressure and bullying.	SH	Aug 18

1. Patient Experience Stories and Service Reports

1.1 Annual Safeguarding Training Update

1.1.1 Dr Senior delivered the Trust Board annual safeguarding training update, particularly focusing on the work being undertaken to establish the Child House.

1.1.2 The Board of Directors noted the training session.

1.2 Race Diversity Champion Update

1.2.1 Ms Henderson presented a report on her work during the last four months since her appointment as the Champion. She particularly noted that:

- She was glad that the Trust has formally recognised the issue of race inequality and set a strategy.
- She is highly enthusiastic about the role.

- The Black, Asian and Minority Ethnic (BAME) network had now been established and the group is working with the Associate Director of Equality, Diversity and Inclusion from Barts Health NHS Trust to share best practice.

- The Board and Executive support for the agenda has been invaluable.

- That the Trust's Human Resources Directorate would be training 10 BAME staff to act as interview panel members.

1.2.2 Responding to Mr Holt, Ms Henderson explained that the support she needed to be successful in this role is that the Board and Executive maintain the profile of the issues.

1.2.3 Dr Elaswarapu asked whether the issues of racism within the organisation are a perception or a reality. Reflecting on this, Ms Henderson explained that the Trust's statistics were strong evidence a number of issues, a prominent one being the lack of diversity at the highest levels of the organisation. She also noted that the Trust had launched a new approach and procedure for managing bullying and harassment.

1.2.4 Professor Burstow noted that this continues to be an important focus for the Board and profiled as a strategic objective, he particularly emphasised that the organisation's focus should be more on changing culture rather than solely focus on process.

1.2.5 The Board of Directors thanked Ms Henderson and noted the report.

2. Administrative Matters

2.1 Chair's Opening Remarks and Apologies

2.1.1 Professor Burstow welcomed all of those in attendance.

2.1.2 Apologies were noted, and are provided above.

2.2 Board Members' Declarations of Interests

2.2.1 There were no declarations of interest for the items noted on the agenda.

2.3 Minutes of the Meeting Held on 24 July 2018

2.3.1 The minutes of the previous meeting were agreed as a true and accurate record, subject to minor amendments [AP1].

2.4 Action Log and Matters Arising

2.4.1 The action log was noted.

- AP1 was completed.

- AP2 was added to the Board Seminar forward plan.

- AP3 was not completed, due to the wider system work not reaching a conclusion.

- AP4 was added to the Board Seminar forward plan.

- AP5 was not completed and will be picked up at a future meeting.

- AP6 was completed.

2.4.2 There were no matters arising, not covered by the agenda.

3. Operational Items

3.1 Chair and Non-Executives' Reports

3.1.1 Professor Burstow noted that he, Mr Jenkins and Dr Stern had attended a meeting with the Team Around the Practice. He particularly emphasised how staff had felt following the Clinical Commissioning Group's approach to the re-contracting of the service.

3.1.2 Ms Gizbert noted that she had attended the Gloucester House Steering Committee and highlighted the excellent work that the service is doing. It was noted that the service is working to develop a pay policy to align with the teacher's terms and conditions of service.

3.1.3 Professor Bhugra noted that he had undertaken four service visits which included the Looked After Children Service, Trauma Unit, Fitz John's Unit and the Refugee Team. He commented on the composition of the teams and that whilst each of the services have high head counts, the full time equivalent make up is quite low.

3.1.4 Ms Farrow noted that she had previously visited the Refugee Team and noted the exceptional contribution that trainees make to the service.

3.1.5 The Board of Directors noted the verbal reports.

3.2 Chief Executive's Report

3.2.1 Mr Jenkins presented his report, particularly emphasising that:

- The Trust hosted a delegation of 25 Chinese mental health leaders which had been well received, he thanked Mr Rock, Ms Tanner and Directorate of Education and Training Staff involved in coordinating the event.

- Felicitas Rost had been interviewed regarding the NICE depression guideline and that the Trust was contributing to continued lobbying for the document to be amended.

- This Board meeting would be Dr Senior's last and that he had made an outstanding contribution to the organisation.

3.2.2 Professor Burstow echoed Mr Jenkins final point and thanked Dr Senior for his commitment to the Trust.

3.2.3 The Board of Directors noted the report.

3.3 Quality Dashboard

3.3.1 Ms Shipman tabled additional information at the Board and presented the quality dashboard, she emphasised the following:

- That there has been no serious incidents in quarter one.
- That there has been strides made with the MHDS data.
- Good progress was being made against the quality priorities.

3.3.2 Responding to Professor Burstow, Ms Shipman explained that the Trust's service user equality data compliance was low but having undertaken an analysis from month one of this financial year there is improved recording of the data. She particularly noted that digital initiatives like future planned self-service check in may improve this data recording.

3.3.3 Reflecting on a comment from Ms Farrow, Ms Shipman explained that service user non-attendance rates have improved and that this could be attributed to the introduction of text message reminders for appointments.

3.3.4 Responding to a question from Dr Colson, Mr Rock explained that the data presented on page ten of the dashboard related to short course provision.

3.3.5 Mr de Sousa noted that the statement regarding sickness absence data was not reflective of the current circumstances, it was noted that the Trust has a manual recording system for absence but data returns are high.

3.3.6 The Board of Directors noted the quality dashboard.

3.4 Finance and Performance Report

3.4.1 Mr Noys presented the finance and performance report, particularly noting that staff costs, year to date, are higher than planned budget. He noted that agency expenditure was higher than planned and that work is being undertaken to bring utilisation down to ensure that the Trust remains within its agency ceiling set by NHS Improvement.

3.4.2 The Board of Directors noted the finance and performance report.

4. Items for Decision or Approval

4.1 Responsible Officer Report

4.1.1 Dr Senior presented the report assuring the Board that the Trust remained complaint with the General Medical Council requirements to ensure that all medically qualified doctors are revalidated.

4.1.2 Dr Senior noted that as he was due to step down from the medical director role and that the Trust Board would need to formally ratify Dr Dinesh Sinha's appointment as the successor responsible officer.

4.1.3 Responding to a question from Professor Burstow, Dr Senior advised that the Trust provides revalidation services to a small number of doctors who were previously employed by or had a close working relationship with the organisation. He particularly noted that a service charge is applied for providing this service.

4.1.4 The Board of Directors noted the report and approved the decision to appoint Dr Dinesh Sinha as the successor responsible officer.

4.2 Consideration of the Strategic Future of the Tavistock Centre & Terms of Reference

4.2.1 Mr Noys presented a revised set of terms of reference for the Relocation Programme Board. He particularly noted that the group's name would change reflecting the group's purpose in a more accurate way.

4.2.2 The Board of Directors approved the terms of reference.

5. Items for Discussion

5.1 Workforce Race Equality Standard & Strategy Update

5.1.1 Mr de Sousa presented the workforce race equality standard and strategy update particularly noting that:

- The Equality, Diversity and Inclusion Committee received the update the week prior and no further amendments were proposed to the report content.
- The Trust's non-clinical workforce had become more diverse in the last twelve months.
- The likelihood of BAME candidates being appointed following shortlisting is showing improvement, but noting that this is for non-clinical roles.
- Having taken feedback from the BAME network and learning from other Trusts, that the approach to using HR business partners on selection panels for Band 8a and above roles should change.
- That the key actions set in the race equality strategy have either been or are being delivered to the timescales set out.

5.1.2 Responding to Mr Noys, Mr de Sousa agreed that further consideration ought to be given to interview panel diversity. However, he noted that due to the current issues affecting BAME staff that using the approach described in the paper is a start point.

5.1.3 Mr Rock noted that there emergence of new academic theories was helpful, Mr de Sousa agreed to work with Director of Education and Training about the learning gained from the cultural intelligence workshops held for staff and its transferability to the wider education programmes.

5.2 Gender Identity Wait Times Update Report

5.2.1 Dr Hodges presented the report particularly emphasising the following:

- That both of the gender services receive a high level of referrals.
- The services both receive a significant level of public interest.
- That there is pressure on the Gender Identity Development Service (GIDS) resulting from inappropriate referrals.
- The GIDS has recently been restructured in a more formalised geographic team structure to improve spans of control.

5.2.2 Responding to a concern from Professor Burstow, Dr Hodges explained that there was an exponential rise in activity for the Charing Cross Gender Identity Clinic (GIC) following the Trust acquiring the service. She noted that this had been attributed to the previous host organisation prioritising new appointments and as a consequential impact that the service is now working to manage this.

5.2.3 Reflecting on a further question from Professor Burstow, Dr Hodges advised that to meet the 18 week commissioner performance target the GIDS service would need 90FTE additional staff, expanding that to achieve this in 18 months would need an additional 200FTE staff. She also noted, that to achieve the same for the GIC service that this would require an increase of 70FTE staff.

5.2.4 Responding to Ms Farrow, Dr Hodges noted that work was being undertaken to support local services improve referrals and some of the pressure is a result of reduced resources in local Child and Adolescent Mental Health Services (CAMHS) across the country.

5.2.5 Mr Jenkins noted that the gender wait lists are an increasing risk and as such have been profiled on the Board Assurance Framework (BAF) with appropriate mitigating actions.

5.2.6 The Board of Directors noted the report.

5.3 Public and Patient Involvement Review

5.3.1 Ms Kent presented the paper highlighting that the document built on previous strategies developed for the function.

5.3.2 Ms Gizbert commented that the document was impressive and really highlighted the extensive work that the team is leading on.

5.3.3 Responding to Ms Farrow, Ms Kent explained that there is good levels of non-executive director involvement in their work, mainly through quality stakeholder events.

5.3.4 Reflecting on a question from Dr Elaswarapu, Ms Kent explained that the organisation is heavily rooted in co-design and has embedded service user involvement in many ways, one being through one of the courses provided by the Trust.

5.3.5 Ms Kent also noted that undertaking involvement activities outside of the Tavistock Centre had helped with raising awareness.

5.3.6 The Board of Directors noted the Patient and Public Involvement Strategy Review.

6. Items for Information

6.1 Board Assurance Framework

6.1.1 Mr Jenkins presented the BAF reporting that the Trust's executive had undertaken a resetting of the document to reflect the current strategic objectives. He particularly emphasised that that there were two risks categorised as red.

6.1.2 Responding to Mr Holt, Mr Jenkins explained that adding timescales for an anticipated score reduction is challenged as many of the risks relate to factors which are outside of the Trust's control.

6.1.3 The Board of Directors noted the BAF.

6.2 Operational Risk Register

6.2.1 Ms Shipman presented the operational risk register and particularly highlighted that a new risk had been added which related to the adult safeguarding mandatory training compliance.

6.2.2 Responding to a concern from Professor Burstow, Dr Senior explained that the low levels of compliance with adult safeguarding training was the result of implementing a new training standard and this taking time to deliver to all eligible staff. Mr de Sousa noted that the level of compliance had increased in quarter one.

6.2.3 The Board of Directors noted the operational risk register.

6.3 Serious Incident Report

6.3.1 Dr Senior presented the Serious Incident Report noting that there was a typographical error on item four of the report and noted that this was a repetition of item two. He highlighted the following:

- That there had been a service user suicide within the refugee service. Dr Hodges noted that the root cause analysis had shown that there were no obvious failings in the individual's care with the Trust.

- A service user, being seen by the Charing Cross Gender Identity Clinic, had died by suicide. Dr Hodges noted that the death was unrelated to the individual's gender issues.

6.3.2 The Board of Directors noted the Serious Incident Report.

6.4 Annual Safeguarding Report

6.4.1 Dr Senior presented the report particularly noting:

- The Trust continues to meet its statutory obligations.

- That there had been an increased focus by the Government on safeguarding issues.

- That the Trust's safeguarding metrics continue to give a good indication of concerns being raised within the Trust.

- The Adult Safeguarding Lead had been appointed and has commenced in to post.

- The successor Named Doctor for Child Safeguarding had been appointed and would commence when Dr Senior steps down from the position.

6.4.2 Responding to a concern from Professor Burstow about work pressure and bullying, Dr Hodges explained that this needed greater contextualisation and that she would discuss with the Named Professional for Child Safeguarding about the detail [AP2].

6.4.3 Dr Colson noted that paragraph 6.2.2 of the report indicated that there was an exasperation from the Named Professional regarding supervision. Dr Senior noted that the tone of the report reflects the post holder's approach to ensuring that safeguarding supervision is prioritised.

6.4.4 The Board of Directors noted the report.

6.5 Quarterly Guardian of Safe Working Report

6.5.1 Dr Senior presented the report noting that a number of actions had been taken forward to reduce the pressure on the Child and Adolescent Junior Doctor Trainee On-call Rota.

6.5.2 The Board of Directors noted the report.

6.6 Annual Clinical Service Complaints Report

6.6.1 Mrs Hawke presented the annual complaints report and particularly highlighted that:

- That the acquisition of the Charing Cross Gender Identity Clinic had resulted in a significant increase in complaints.

- There was a reduction in complaints during Quarter 3 of 2017/18, but this increased in Quarter 4.

- When Charing Cross Gender Identity Clinic's complaints were excluded from the analysis that the Board should note that there has not been an increase in complaints for other services.

6.6.2 Dr Hodges noted that there had been complaints regarding appropriate use of pronouns and that a recent training programme had delivered to staff in both gender services.

6.6.3 Responding to Dr Colson, Mr Jenkins noted that future service line reports should include excerpts or themes of complaints.

6.6.4 The Board of Directors noted the report.

6.7 Annual Education Complaints Report

6.7.1 Ms Bratt presented the report and highlighted that:

- There had been eight formal student complaints during the financial year.
- There were four informal complaints.
- One complaint was escalated.
- There had been no complaints passed to the Office of Independent Adjudication.
- The themes of student complaints related to communications, this included timeliness and accuracy.

6.7.2 The Board of Directors noted the report.

7. Board Committee Reports

7.1 Executive Appointments and Remuneration Committee

7.1.1 The Board of Directors noted that the committee had met on 04 July 2018

7.2 Clinical Quality, Safety and Governance Committee

7.2.1 Dr Senior presented the committee's annual report highlighting that:

- The committee's focus had included providing oversight to the completion of the Information Governance Toolkit and the Trust's preparedness and implementation of the General Data Protection Requirement.
- There had been an effectiveness review of the committee against its terms of reference and noted that going forward there needs to be an increase of prospectively seeking assurance rather than receiving reports looking back.
- Non-Executive Director attendance at the committee had improved.

7.2.2 Professor Burstow noted that Dr Colson will become the Non-Executive Deputy Chair of the committee.

7.2.3 The Board of Directors noted the report.

7.3 Training and Education Committee

7.3.1 Dr Colson presented the report and noted that:

- A joint working group was being established with the University of Essex.

- That a joint meeting with Professor Burstow, Mr Jenkins and Mr Rock had taken place with the Vice Chancellor at the University.

7.3.2 Dr Caldwell noted that the National Workforce Skills Development Unit was undertaking a national programme of working around career mapping and issues stemming from psychology graduates.

7.3.3 The Board of Directors noted the report.

8. Any Other Business

8.1 There were no further matters raised.

The Tavistock and Portman NHS Foundation Trust

Report to	Date
Board of Directors	25 September 2018

Chief Executive's Report

Executive Summary

This report provides a summary of key issues affecting the Trust.

Recommendation to the Board

The Board of Directors is asked to note this report.

Trust strategic objectives supported by this paper

All

Author	Responsible Executive Director
Chief Executive	Chief Executive

Chief Executive's Report

1. CQC Well Led Inspection

1.1 We are preparing for our Well Led Inspection from CQC on 18-19th September.

1.2 Earlier in the month CQC visited a number of our services. This included:

- Charing Cross Gender Identity Clinic
- North and South Camden CAMHS
- Whole Family Service
- CAISS (Camden Adolescent Intensive Support Service)

1.3 We have had some initial feedback on those visits.

2. Children and Young People's Green paper – Trailblazers

2.1 Along with other areas Camden has been invited to submit a proposal to be a trailblazer site for the implementation of the Children and Young People's Green Paper. We are working with colleagues in the CCG and Local Authority to prepare a proposal.

3. Trust-wide scheduling project

3.1 Following the approval of the Trust-wide Scheduling business case, the Trust has procured and implemented the Scientia Enterprise timetabling platform, the market leader within the higher education sector for timetabling. The function of this system has then been tailored to meet both the education & training timetabling and the clinical scheduling needs of the Trust.

3.2 Over the same period the project team undertook a sizeable workstream of engagement workshops with clinical, education & training and corporate staff to identify and document the practices of the Trust with regard to planning of activity, space allocation and space utilisation.

3.3 The system went live of 3rd September and is now bedding in, with the iterative release of the central management of room allocation from the Scheduling Team to the Trust staff over the first three weeks of September. This is supported by a team of eight floor walkers and a separate Scheduling Helpdesk. While there are inevitably some issues to be addressed over the go live period, particularly where appointments were not entered onto CareNotes before the end of August deadline, we have now reached a point where the floorwalkers are able to address issues promptly and the horizon for which we have validated known bookings has been extended to the end of November.

3.4 The system has gone live using a reactive "booking" model rather than the proactive "scheduling" model which will be required to deliver the benefits set out in the business case. We therefore now move into a second phase of the project where we will utilise the new technology to migrate clinical services from booking to scheduling and begin rescheduling of activities with a view to driving up space utilisation rates.

3.5 We are continuing to keep a close senior management overview on the project to ensure any "teething" difficulties can be picked up and addressed.

4. Student recruitment

4.1 We are approaching the conclusion of recruitment for 18/19 Academic Year. It looks as if student numbers will be the same as or marginally ahead of last year's enrolment of 576 students. This represents a significant amount of work across the recruitment team and faculty. A steady state position was factored into our financial assumptions for the 18/19 Financial Year.

4.2 There has also been a focus on targeting an increase in the number of international students.

4.3 A programme of events for new students has been organised for Welcome Week in the week commencing 24th September.

Paul Jenkins
Chief Executive
17th September 2018

The Tavistock and Portman NHS Foundation Trust

Report to	Date
Board of Directors	September 2018

Finance and Performance Report – July 2018

Executive Summary

The Finance and Performance Report for July 2018 is attached.
This shows the net surplus of the Trust to be a positive variance against Budget of £215k due to a positive variance on costs.

Recommendation to the Board

The Board is asked to note the report

Trust strategic objectives supported by this paper

Finance and Governance

Author	Responsible Executive Director
Terry Noys, Deputy CEO and Director of Finance	Terry Noys, Deputy CEO and Director of Finance

The Tavistock and Portman NHS
NHS Foundation Trust

MONTHLY FINANCE AND PERFORMANCE REPORT

Period 4 **Jul-18**

Section

FINANCE AND PERFORMANCE REPORT **SUMMARY I&E** **Section 1**

Period 4
31 July 2018

	2017/18 Actual **Month** £'000	2018/19 Actual **Month** £'000	2018/19 Budget **Month** £'000	Variance Actual v Budget £'000	2017/18 Actual **YTD** £'000	2018/19 Actual **YTD** £'000	2018/19 Budget **YTD** £'000	Variance Actual v Budget £'000	**Variance Actual v Budget %**
Income	3,927	4,411	4,567	(155)	15,946	**17,227**	17,276	(49)	**(0)%**
Staff costs	(2,878)	(3,178)	(3,296)	119	(11,812)	**(12,368)**	(12,573)	205	**2%**
Non-staff costs	(825)	(848)	(948)	102	(3,324)	**(3,625)**	(3,709)	84	**(2)%**
Operational costs	(3,702)	(4,026)	(4,244)	221	(15,136)	**(15,993)**	(16,282)	289	**2%**
EBITDA	224	385	323	**65**	810	**1,234**	994	**240**	**0**
- Margin	6%	**9%**	7%		5%	**7%**	6%		
Interest receivable	0	2	1	1	2	**6**	2	**0**	**0%**
Interest payable	0	(2)	(2)	0	0	**(9)**	(9)	**0**	
Depreciation / amortisation	(67)	(99)	(99)	0	(261)	**(397)**	(397)	**0**	**0%**
Public Dividend Capital	(45)	(54)	(54)	(0)	(179)	**(217)**	(217)	**0**	**0%**
Restructuring costs		(25)	0	(25)	0	**(25)**	0	**(25)**	
Net surplus	113	206	168	42	372	**592**	373	**215**	**58%**
- Margin	3%	5%	4%		2%	**3%**	2%		

COMMENTARY

The Trust surplus is £592k, which is £215k above budget.
Revenue is £49k below budget due mainly to shortfalls in CYAF (new business targets) and AFS (Camden TAP), offset by DET HEFCE revenue not budgeted
Pay costs are £205k below budget, with underspends in CYAF and AFS partially offset by Corporate overspends in Estates
Non pay costs are £84k below budget, underspend in CYAF of £159k, partly masking overspends in Corporate £73k
The £73k Corporate non-pay overspend is largely split between Informatics - £31k (SITS support) and Estates maintenance £19k

FINANCE AND PERFORMANCE REPORT **BALANCE SHEET** **Section 2**

Period 4

31 July 2018

	May £'000	June £'000	July £'000	Aug £'000	Sept £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000
Intangible assets	194	185	190								
Land and buildings	18,866	18,934	19,124								
IT equipment	2,812	2,863	2,921								
Other	0	0	0								
Property, Plant & Equipment	21,678	21,797	22,045	0	0	0	0	0	0	0	0
Total non-current assets	21,872	21,982	22,234	0	0	0	0	0	0	0	0
Trade and other receivables	3,272	3,673	2,426								
Accrued Income and prepayments	4,851	5,349	3,936								
Cash / equivalents	4,960	3,654	8,006								
Total current assets	13,083	12,676	14,368	0	0	0	0	0	0	0	0
Trade and other payables	(1,566)	(1,817)	(1,065)								
Accruals	(3,012)	(3,152)	(3,497)								
Deferred income	(5,312)	(4,440)	(5,586)								
Provisions	(77)	(231)	(231)								
Total current liabilities	(9,967)	(9,640)	(10,378)	0	0	0	0	0	0	0	0
Total assets less current liabilities	24,989	25,018	26,225	0	0	0	0	0	0	0	0
Non-current provisions	(226)	(73)	(73)								
Long term loans	(1,000)	(1,000)	(2,000)								
Total assets employed	23,763	23,946	24,152	0	0	0	0	0	0	0	0
Public dividend capital	3,474	3,474	3,474								
Revaluation reserve	12,238	12,238	12,238								
I&E reserve	8,050	7,848	8,440								
Total taxpayers equity	23,763	23,946	24,152	0	0	0	0	0	0	0	0
Cash Analysis											
Non-ITFF balance	3,960	2,654	6,006	0	0	0	0	0	0	0	0
ITFF balance	1,000	1,000	2,000	0	0	0	0	0	0	0	0
Total cash	4,960	3,654	8,006	0	0	0	0	0	0	0	0

MONTHLY FINANCE AND PERFORMANCE REPORT **FUNDS FLOW** **Section 3**

Period 4

31 July 2018

	May Act £'000	June Act £'000	July Act £'000	Aug Act £'000	Sept Act £'000	Oct Act £'000	Nov Act £'000	Dec Act £'000	Jan Act £'000	Feb Act £'000	Mar Act £'000	YTD Act £'000
Net Surplus	214	172	206									592
Depreciation / amortisation	199	99	99									397
PDC dividend paid	108	54	54									217
Restructuring costs	0		25									25
(Increase) / Decrease in receivables	730	(899)	2,660									2,491
Increase / (Decrease) in liabilities	302	(481)	738									559
Increase / (Decrease) in provisions	75	1	0									76
Interest paid	(1)	2	0									1
Net operating cash flow	1,626	(1,052)	3,783	0	0	0	0	0	0	0	0	4,357
Interest received	1	3	2									6
Interest paid	(4)	(3)	(2)									(9)
PDC dividend paid	(108)	(54)	(54)									(217)
Restructuring costs			(25)									(25)
Cash flow available for investment	1,515	(1,105)	(79)	0	0	0	0	0	0	0	0	(244)
Purchase of intangible assets	(10)		(5)									(16)
Purchase of property, plant & equipment	(368)	(200)	(347)									(914)
Net cash flow before financing	1,137	(1,305)	3,352	0	0	0	0	0	0	0	0	3,183
Drawdown of debt facilities	0	0	1,000	0	0	0	0	0	0	0	0	1,000
Repayment of debt facilities	0	0	0	0	0	0	0	0	0	0	0	0
Net increase / (decrease) in cash	**1,137**	**(1,305)**	**4,352**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**4,183**
Opening Cash	3,823	4,960	3,654	0	0	0	0	0	0	0	0	0
Closing cash	**4,960**	**3,654**	**8,006**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**4,183**

The Tavistock and Portman NHS Foundation Trust

Report to	Date
Board of Directors	September 2018

Procurement

Executive Summary

A Procurement Strategy and Procurement Policy follow this cover note. Currently, the Trust does not have either of these documents in place. Procurement within the Trust is extremely immature. The Strategy and Policy are aimed at progressing the Trust's journey to a more mature state.

Recommendation to the Board

The Board is asked to approve the Strategy and the Policy

Trust strategic objectives supported by this paper

Finance and Governance

Author	Responsible Executive Director
Verity White, Procurement Consultant	Terry Noys, Deputy CEO and Director of Finance

Procurement Strategy

2018 – 2021

Version:	1.0
Bodies consulted:	EMT
Approved by:	Board of Directors
Date Approved:	
Lead Manager:	Assistant Director, Finance
Lead Director:	Director of Finance
Date issued:	
Review date:	September 2020
Intranet:	Yes
Extranet	Yes

1. INTRODUCTION

1.1. This strategy is designed to ensure the purchase of goods, works and services required for the Trust is handled in a transparent, timely and cost-effective manner with due regard to purchasing best practice.

1.2. For the avoidance of doubt, this strategy applies to all goods and services acquired by the Trust, both for clinical and for non-clinical purposes.

1.3. Procurement is one of the key functions responsible for ensuring all goods, works and services that are procured by the Trust:

- Represent best value and appropriate quality,
- Are market tested to ensure best value,
- Are protected by a legally enforceable contract,
- Have been purchased in compliance with the Trusts SFIs and Public Sector Regulations, and are
- Procured from the most sustainable resources.

1.4. The underlying purpose of this strategy is to positively influence procurement throughout the Trust, supporting it to deliver high quality healthcare and education to patients and students through a philosophy of best value and best practice. It has been developed to address the total supply chain and:

- Provide a strategic vision and priority for initiatives for the next 3 years
- Is flexible to meet the changing needs of the wider NHS
- Satisfies legislative compliance and Public Sector policy including current EU regulations and the Public Contracts Regulations 2015
- Will actively contribute to Non-Pay Efficiency Savings targets set for the Trust
- Will actively seek to reduce the Trust's burden on the environment through various means such as locally sourced goods, procuring only energy efficient appliances and working with suppliers to reduce packaging.

2. BACKGROUND

National Agenda & Priorities

2.1. The Department of Health (DH) has launched a suite of strategies, guides and resources in recent years, notably:

- E- Procurement Strategy - (NHS e-Procurement Strategy, 2014)
- NHS Procurement Standards - (NHS Procurement Standards, 2013)
- NHS Procurement Dashboard - (NHS Procurement Dashboard, 2013)
- NHS Procurement Transparency - (Procurement Transparency, 2014).

2.2. These are underpinned by a supporting Centre for Procurement Excellence (CPE) within the DH. The CPE is focusing on supporting Trusts with the following priorities:

- Board level recognition and sponsorship of Procurement
- Executive authority and influence
- Organisational alignment
- Category management and sourcing strategies
- Supplier Relationship Management
- Risk management
- Operational Process Management
- Performance management
- Data, information and knowledge
- People strategy
- Excellence in governance, planning, programme and change management.

2.3. This strategy aims to address the areas identified as priorities by the CPE.

2.4. The strategic objectives and actions herein have been designed to align with the DH guidance and fall within 4 main themes:

- Leadership
- People
- Partnership
- Process.

3. THE OBJECTIVES OF THIS PROCUREMENT STRATEGY

3.1. The following principles underpin the strategy and will be applied to all purchasing activity conducted on behalf of the Trust.

3.2. **Patient Care** – Products and services will be purchased which will be supportive of patient care within available resources consistent with the Trusts governance, health and safety and other policies.

3.3. **Best Value** – Procurement activity will be conducted to ensure that best value is attained, taking account of not just purchase price but whole life acquisition and process costs.

3.4. **Reduction in the use of Waivers** – Goods, works and services will be market tested quickly and efficiently to ensure value for money is obtained. Users will be encouraged to approach Procurement for all purchases over the Trusts Tender / Quote financial limits.

3.5. **Procurement Savings** – Purchasing will contribute savings towards the Trust's efficiency saving targets. Targets are set in areas of high spend annually.

3.6. **Collaborative Purchasing** – Where appropriate / feasible, the Trust will work collaboratively with other health bodies in order to maximise its purchasing power and to optimise its operating costs. This will include the use of National Frameworks, purchasing consortia and other joint sourcing initiatives. Usage data for high spend items will be shared with NHS Improvement to compare and contrast with that of other Trusts to ensure price consistency nationally.

3.7. **Selection of Products/Services** – In selecting goods and services to be used, the Trust will generally adopt generic specifications, promote standardisation and rationalisation and ensure that product/service users are appropriately engaged on the procurement process.

3.8. **Environmental Consideration** – In the selection of goods and services the Trust will take into consideration the environmental and carbon impacts associated with the product, and wherever possible aim to reduce the impact to a minimum.

3.9. **Suppliers** – the Trust will work in partnership with its suppliers, seeking to develop long-term mutually beneficial relationships, promoting innovation and technical advancement wherever appropriate and will be seen to reduce the number of suppliers where possible. The Trust will seek to work closely with SMEs to ensure they are able to participate in the Trusts procurement processes.

3.10. **Usage and Disposal of Products** – The Trust will promote the efficient use of products recognising that overall expenditure is significantly influenced by the effective management of demand as much as the purchase price paid.

3.11. **Promotion of the reduction of waste** associated with the use and disposal of products. Purchasing and disposal of waste will be in line with WEE regulations.

3.12. **Purchasing Cards** – are used to process low value and specialised overseas orders to reduce both process cost and time.

3.13. **NHS Standards in Procurement** –The Trust will seek to work towards a minimum Level 1 accreditation within the next 3 years.

3.14. The other major component of this strategy is the continued modernisation of the 'purchase to pay' cycle and increased economies of scale through the collaboration with partners with the local area.

4. SUSTAINABLE AND ENVIRONMENTAL PURCHASING

4.1. The Trust will ensure that all goods and services purchased take into account Central Government and Department of Health commitments to Sustainable Policies, including reduction in the Trust's carbon footprint.

4.2. Whilst complying with EU rules and domestic policy governing public procurement, the Trust will ensure that it will:

- Integrate environmental considerations in purchasing procedures in accordance with Government and EU guidelines.
- Specify and exercise a preference for environmentally preferable products that offer value for money
- Take account of whole-life costs in the evaluation of tenders, wherever practical

- Reduce the environmental impact of purchasing and supply activities by reducing paper flow through the procurement process
- Work in partnership with other government purchasing organisations and service providers especially, where possible, those operating in the local community
- Ensure our purchasing and supply activities contribute positively to the Trust's overarching environmental policy.
- Explore ways of measuring the environmental and carbon impacts associated with procurement to enable the Trust to further reduce its carbon footprint.

4.3. In respect of the efficient use of materials, our aim is to minimise the consumption of finite natural resources and to minimise the quantity of waste being sent to landfill sites.

4.4. These objectives to be pursued while avoiding adverse impact on cost, quality or other requirements in this strategy.

5. E-PROCUREMENT

5.1. The Trust has an integrated finance system for the production of Purchase Orders (SBS.) Users must raise purchase orders on this system before ordering any goods, works or service and can then approve invoices electronically through this system. The system will be constantly monitored to ensure it can be used to it full capacity.

5.2. The potential future benefits through better use of the system will be:

- Establishment of Catalogues of approved products as a mechanism for standardisation and consolidation.
- Improved reporting and visibility of Budgets with improved 'drill down' facilities for all budget holders.

5.3. A recent improvement in this area has been the implementation of an eTendering software package which sends out and receipt pre-qualification questionnaires and tenders electronically, giving better visibility to suppliers and a clear audit trail for the Trust.

5.4. This system also ensures transparency for the Trust as all tender projects will be available on Contracts Finder. Contracts Finder is part of the GOV.UK website. This ensures compliance with the transparency and partnership aspects of EU legislation, by advertising all Public Sector requirements over 25k. This encourages smaller businesses to participate and broadens the market for all products/services.

6. ROLES, RESPONSIBILITIES, RESOURCES

6.1. The Chief Executive has overall responsibility for the maintenance and implementation of the strategy.

6.2. The Director of Finance is the Board Level lead responsible for the implementation of the strategy.

6.3. It is recognised that the dedicated resources available to the Trust in this area are very limited. This will, inevitably, limit the speed and scope by which the Trust will be able to pursue the strategy.

7. MONITORING ARRANGEMENTS

7.1. Departments will be monitored on their adherence to the procurement strategy and related documents. A review of departmental practices will be undertaken at least once a year by Finance / Procurement.

Equality Impact Assessment

Completed by	**Verity White**
Position	**Procurement Consultant**
Date	**28 August 2018**

The following questions determine whether analysis is needed	Yes	No
Is it likely to affect people with particular protected characteristics differently?		X
Is it a major strategy, significantly affecting how Trust services are delivered?		X
Will the strategy have a significant effect on how partner organisations operate in terms of equality?		X
Does the strategy relate to functions that have been identified through engagement as being important to people with particular protected characteristics?		X
Does the strategy relate to an area with known inequalities?		X
Does the strategy relate to any equality objectives that have been set by the Trust?		X
Other?		

If the answer to *all* of these questions was no, then the assessment is complete.

If the answer to *any* of the questions was yes, then undertake the following analysis:

	~~Yes~~	~~No~~	~~Comment~~
~~Do policy outcomes and service take-up differ between people with different protected characteristics?~~			
~~What are the key findings of any engagement you have undertaken?~~			
~~If there is a greater effect on one group, is that consistent with the policy aims?~~			
~~If the policy has negative effects on people sharing particular characteristics, what steps can be taken to mitigate these effects?~~			
~~Will the policy deliver practical benefits for certain groups?~~			
~~Does the policy miss opportunities to advance equality of opportunity and foster good relations?~~			
~~Do other policies need to change to enable this policy to be effective?~~			
~~Additional comments~~			

If one or more answers are yes, then the policy may unlawful under the Equality Act 2010 –seek advice from Human Resources (for staff related policies) or the Trust's Equalities Lead (for all other policies).

The Tavistock and Portman
NHS Foundation Trust

Procurement Policy

Version:	1.0
Bodies consulted:	EMT
Approved by:	Board of Directors
Date Approved:	
Lead Manager:	Assistant Director, Finance
Responsible Director:	Director of Finance
Date issued:	
Review date:	September 2020
Intranet	Yes
Extranet	Yes

Contents

Procurement Policy

1 Introduction

1.1. Procurement is the process of acquiring goods, works and services, covering both acquisitions from third parties, other NHS Trusts and any in-house suppliers providing a commercial service.

1.2. The process spans the whole life cycle from identification of needs, management of the process and through to its expiry and disposal.

1.3. The management of procurement is important to the efficiency and effectiveness of the Trust's services. Patient care and student experience depends on the guaranteed availability of quality equipment, premises, materials and services. Accountability for the expenditure of taxpayer's money requires that sound economic decisions are taken in relation to procurement.

1.4. The Tavistock and Portman NHS Foundation Trust ("Trust") recognises that the provision of quality patient care and student experience is supported by using cost effective procurement processes which deliver value for money. This can be achieved by developing supplier and customer relationships that consider whole life cost and by ensuring appropriate competition.

1.5. Procurement performance at the Trust is reported monthly to the Director of Finance. It recognises and endorses the key recommendations of the Best Practice Guidelines published and updated by the Department of Health and NHS Improvement, including the NHS Procurement and Commercial Standards.

1.6. This policy sets out the principles that ensure the Trust provides an effective procurement process, good stewardship and value for money.

1.7. The role of the Procurement Department can be defined as follows:

- To lead and operate a best practice supply management service, that adds value to the provision of healthcare for patients and to the educational experience of students by delivering value for money.
- To deliver procurement services that are efficient, innovative, cost effective and continually developing for the overall benefit of the Trust, its patients and its students.

1.8. This policy should be read in conjunction with the Trust's Standing Financial Instructions.

2 Purpose

2.1 There are four main objectives for procurement within the Trust:

- To provide end users with what they need, when they need it and at the best value for money.
- To protect the Trust and minimise risk through means of appropriate managerial and contractual arrangements.
- To provide the tax payer with value for money through expenditure on procurement.
- To support the Trust's core objective of providing excellent health care and education and training.

2.2 The department's activities are also influenced by:

- EU and UK Law
- Public Sector and Department of Health Policy and Guidance
- Other Trust Policy and Procedures

3 Scope

3.1 The European Union (EU) Procurement Directives, and the Public Contracts Regulations 2015 as amended ("Regulations") that implement them in the UK, set out the law on public procurement. Their purpose is to open up the public procurement market and to ensure the free movement of goods and services within the EU.

3.2 The rules apply to purchases by public bodies which are above set monetary thresholds. They cover all EU Member States and, because of international agreements, their benefits extend to a number of other countries worldwide. Where the Regulations apply, contracts must be advertised in the Official Journal of the EU (OJEU) and there are other detailed rules that must be followed. The purchase of all goods and services are subject to the EU regulations, regardless of whether they are capital or revenue funded. The Regulations also specify thresholds over which the full OJEU must be applied.

3.3 Details of current EU contract thresholds can be found on the intranet.

3.4 It should be noted that the UK sterling thresholds are revised every two years, in line with fluctuations in exchange rates, with the next due in January 2019.

3.5 More details can be found here: https://www.gov.uk/government/publications/procurement-guide-for-commissioners-of-nhs-funded-services

3.6 The Trust has a legal requirement to adhere to these regulations.

4 Duties and responsibilities

4.1 Specific roles and responsibilities are noted below.

Director of Finance

4.2 The Director of Finance has overall responsibility for ensuring good procurement practice throughout the Trust.

Procurement Function

4.3 It is the responsibility of the Procurement function to develop procedures to cover all the Trust's non-pay expenditure that encompass the requirements of Standing Financial Instructions, Standing Orders, EU Procurement Directives and all specific NHS/DoH Policies.

Trust Managers

4.4 Trust Managers have a key role in ensuring good procurement practice and therefore are expected to be conversant with Standing Financial Instructions and Standing Orders.

Other Staff

4.5 All staff involved in procurement must comply with Standing Financial Instructions, Standing Orders, EU Procurement Directives, and follow relevant Trust procedures.

4.6 There is a general duty on all public sector procurers to apply the key principles of public procurement. These require the delivery of value for money (VFM), appropriate quality and service to meet business needs, and appropriate governance (i.e., adherence to HM Treasury rules concerning the use of public money in procurement).

4.7 It is the responsibility of all managers and staff involved with procurement to understand the above and strive for best value.

Ordering Probity

4.8 The placing of a purchase order with suppliers prior to receipt of goods and invoice is good business practice. Standing Financial Instructions state that **an official purchase order must be placed in advance of receipt of any goods.**

4.9 A purchase order is a legally binding contract between the buyer and seller. It is important for both parties to understand which terms and conditions of contract they are working on. The Trust asks that all orders are placed using one of the following contracts:

- Framework contract conditions
- Standard NHS Terms and Conditions
- JCT/NEC standard contract (works only).

4.10 On rare occasions the Trust may need to sign into supplier Terms. If this is the case they will need to be agreed by the Director of Finance before signature.

Trust Procedures and Standing Financial Instructions

4.11 The Trust operates a No PO No Pay procedure. This means for all procurements an order must be raised in advance via SBS without exception

4.12 Invoices for items/services without a valid purchase order number may be returned to suppliers or become the personal liability of the person who placed the order.

5 Procedures

5.1 The Trust shall endeavour that all procurement activity is conducted in line with the professional and ethical guidance provided by the Chartered Institute of Purchasing and Supply. Regardless, Public Procurement Regulations will also be adhered to, as will Trust Standing Orders and Standing Financial Instructions.

Acquiring Goods And Services

5.2 In order to ensure best value for money it is essential that competitive quotations or tenders are obtained. This is the case whether an Item is to go onto the Trust catalogue or not. In determining the number of quotes or tenders to obtain consideration should be given to the likely volume of the goods or services to be required in the year ahead and subsequent years.

5.3 The following are the quotation and tender requirements based on total life time costs (i.e. goods + x years maintenance) or total value over contract period, excluding VAT:

Value	Route To Market	Procurement Lead
Over OJEU limit	OJEU required	Procurement
£60,000 – to OJEU limit	Formal Tender	Procurement
£10,000 – 60,000	At least three written quotes	Department / Procurement
> £9,999	Up to three written quotes	Department
< £500	P-Card	Department

NB. As the OJEU limit varies from timed to time, any contract with a value of £150k (for goods and services) should be considered as needing to be compliant with OJEU.

5.4 If a framework (see below) can be used for a contract, then this is always the preferred route to market, and negates the need for some of the tendering processes.

Framework Agreements

5.5 Prior to undertaking any competition, a review of goods or services available through National and Regional Contracts / Framework Agreements should be performed. A Framework Agreement is a centrally pre-tendered list of suppliers who are available for the Trust to contract with - without the need to follow a more strenuous tendering procedure (e.g. OJEU.) The Framework itself is not a contract but the 'call off' from the Framework is a contract. Frameworks can be used for services, supplies and works.

NHS Supply Chain

5.6 Where appropriate, evaluation of the range of items held on the NHS Supply Chain catalogue should also be undertaken. Benchmarking price, quality and service of proposed purchases with other trusts can also prove valuable and is supported by the Procurement Department.

5.7 Through using the Procurement Department's contacts in other trusts, there may be an opportunity for both formal and informal collaboration. For some products and services, combining demand can improve the commercial outcome and ensure better value for the Trust.

Tendering

5.8 Once it is established that specific goods or services cannot be sourced through the above mentioned routes, the Trust should seek to obtain best value for money through competition.

5.9 This procedure is conducted in line with the Procurement Strategy, the Trust Procurement Policy and the Trust Standing Financial Instructions/Standing Orders. The Procurement Department will be happy to lead tendering exercises and, in line with the DoH eProcurement Strategy, utilise online tendering portals.

5.10 Each tender must have a clear specification or scope and a strong scoring system agreed prior to the issue of documentation. The most economically advantageous tender (MEAT) will be awarded the contract, provided that the total amount falls within the agreed budget. This scoring mechanism will be the basis for all debriefs to unsuccessful bidders. Guidance will be given by the Procurement Department in constructing the evaluation criteria, examples of which can be found in the Appendix to this Policy.

5.11 All purchases/contracts which exceed the relevant European financial thresholds (except those where appropriate National Contracts are in place), will be advertised in the Official Journal of the European Union (OJEU), through the Procurement Department.

5.12 Failure to comply with Trust rules could result in disciplinary action.

5.13 Failure to comply with EU procurement could result in:

- The High Court setting aside a contract
- High Court claims for damages from companies denied the ability to participate in competitive tenders

5.14 Infringement proceedings in the European Court of Justice
For purchases which fall below the OJEU threshold, potential alternative sources can be found through placing an electronic notice through the Procurement department on to the Government Opportunities website.

6 Benchmarking

6.1 The Trust will share information and best practice with other parts of the Health Service and Public Sector to measure the cost and effectiveness of its procurement processes.

6.2 Benchmarking is an important part of the procurement process and the transparency and sharing of pricing information is supported in the NHS Terms and Conditions of Supply. There is an online portal which has been set up for NHS procurement staff to share innovation and pricing details.

7 Collaboration

7.1 The Trust will work with other NHS or Public Sector partners where appropriate to investigate the use of joint or consortium contracts when cost or service benefits can be identified.

8 Retention Of Documents

8.1 All documentation will be kept either electronically or on file in accordance with the NHS recommendations in HSC1999/053. Documents will be retained electronically via the Trust's IT infrastructure in the Procurement Drive.

9 Training Requirements

9.1 All staff involved with any procurement processes must be fully conversant with this policy, and all related policies and procedures.

9.2 All staff with any budgetary responsibility must be trained on procurement procedures in the Trust at induction.

9.3 All staff who requisition orders on behalf of the Trust are also recommended to do the online training.

10 Process for monitoring compliance with this Procedure

10.1 The Director of Finance is ultimately responsible for monitoring compliance with this Policy.

10.2 A Trust Procurement Risk Register will be held centrally and updated regularly.

11 References

NHS Procurement and Commercial Standards
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/539626/Standards_of_Procurement.pdf

NHS eProcurement Strategy
https://www.gov.uk/government/publications/nhs-e-procurement-strategy

12 Associated documents[1]

Procurement Strategy
Trust Standing Orders
Trust Standing Financial Instructions
Trust Scheme of Delegation

[1] For the current version of Trust procedures, please refer to the intranet.

Appendix A : Equality Impact Assessment

Completed by	**Verity White**
Position	**Procurement Consultant**
Date	**July 2018**

The following questions determine whether analysis is needed	**Yes**	**No**
Is it likely to affect people with particular protected characteristics differently?		X
Is it a major policy, significantly affecting how Trust services are delivered?		X
Will the policy have a significant effect on how partner organisations operate in terms of equality?		X
Does the policy relate to functions that have been identified through engagement as being important to people with particular protected characteristics?		X
Does the policy relate to an area with known inequalities?		X
Does the policy relate to any equality objectives that have been set by the Trust?		X
Other?		X

If the answer to *all* of these questions was no, then the assessment is complete.

If the answer to *any* of the questions was yes, then undertake the following analysis:

	~~Yes~~	~~No~~	~~Comment~~
~~Do policy outcomes and service take-up differ between people with different protected characteristics?~~			
~~What are the key findings of any engagement you have undertaken?~~			
~~If there is a greater effect on one group, is that consistent with the policy aims?~~			
~~If the policy has negative effects on people sharing particular characteristics, what steps can be taken to mitigate these effects?~~			
~~Will the policy deliver practical benefits for certain groups?~~			
~~Does the policy miss opportunities to advance equality of opportunity and foster good relations?~~			
~~Do other policies need to change to enable this policy to be effective?~~			

If one or more answers are yes, then the policy may unlawful under the Equality Act 2010 –seek advice from Human Resources.

The Tavistock and Portman NHS Foundation Trust

Report to	Date
Board of Directors	September 2018

Health & Safety

Executive Summary

A revised and updated Health and Safety Policy together with new policies on Fire and Water Safety follow this cover note.
These documents represent part of the ongoing effort by the Trust to ensure up to date compliance with health and safety related matters.
The policies have been prepared with external input / over sight from the Trust's relevant professional advisers

Recommendation to the Board

The Board is asked to approve the Health & Safety Policy, the Fire Safety Policy and the Water Safety Policy

Trust strategic objectives supported by this paper

Finance and Governance

Author	Responsible Executive Director
Terry Noys, Deputy CEO and Director of Finance	Terry Noys, Deputy CEO and Director of Finance

The Tavistock and Portman
NHS Foundation Trust

HEALTH & SAFETY POLICY

Version:	3.0
Bodies consulted:	EMT, Health & Safety Manager, Estates staff
Approved by:	Board of Directors
Date Approved:	
Lead Manager:	Director of Estates, Facilities & Capital Projects
Lead Director:	Deputy Chief Executive
Date issued:	
Review date:	September 2019
Intranet:	Yes
Extranet:	Yes

Contents

1. INTRODUCTION, PURPOSE AND SCOPE

1. The Health & Safety at Work Act etc. 1974 ("Act") places an absolute duty on employers to safeguard the health, safety and welfare of all employees and anyone who may be affected by their undertakings. The Tavistock and Portman NHS Foundation Trust (the "Trust") recognises and accepts its responsibilities under the Act and all other regulations that fall under the Act.

2. In addition, the Trust recognises and accepts the health & safety standards in the Safety Domain of 'Standards for Better Health' set by the Health Commission and the risk management standards set by the National Health Service Litigation Authority.

3. It is the policy of the Trust to ensure, so far as is reasonably practicable, the health, safety and welfare of all its employees, visitors, contractors and members of the public and all persons who may be affected by the Trust's activities.

4. In compliance with the Act, the Trust will undertake all practical measures to ensure:

    - A physically and mentally safe and healthy working environment
    - Safe systems and methods of work and a safe means of access and egress
    - Suitable and sufficient training, information, instruction and supervision
    - Completion and regular revision of risk assessments
    - Regular consultation with employees
    - Active participation and support of all employees
    - Suitable welfare facilities and arrangements
    - Continuous improvement in health & safety standards and annual revision of the policy.

5. This Policy applies to all staff and students employed by the Trust. The Duties and Responsibilities section covers the specific health & safety responsibilities of all staff within the Trust.

6. The Trust is committed to developing a positive health & safety culture amongst its employees and the Procedures section outlines the practical measures in place to develop and maintain an effective health & safety management system as outlined in Health & Safety Executive ("HSE") publication HSG65.

7. This policy will be reviewed annually and signed by the Chief Executive of the Trust.

Name:	…….. Paul Jenkins
Position:	Chief Executive
Date:	

2. DUTIES AND RESPONSIBILITIES

8. This section outlines the health & safety responsibilities that have been assigned to specific employees.

The Chief Executive

9. The **Chief Executive** is ultimately responsible for maintaining and achieving the outcomes of the Health & Safety Policy. Day to day responsibilities will be delegated to the **Director of Estates, Facilities & Capital Projects**.

10. The **Chief Executive** will:

- Sign the Health & Safety Policy, on completion of the annual review
- Advise the Board of Directors on resources and actions required to meet statutory requirements and the requirements set by the Department of Health ("DH") Standards
- Ensure that health & safety and risk management responsibilities form an integral part of the Trust personnel job profiles
- Ensure that staff receive risk management and health & safety training appropriate to their grade/position
- Ensure all employees of the Trust are aware of the Board of Directors expectations for carrying out their health & safety responsibilities.

The Board of Directors

11. The Board of Directors has overall responsibility for the health, safety and welfare of all employees and anyone that may be affected by the Trust's undertakings.

12. The Board of Directors recognise their responsibility (collective and individual) to provide leadership in relation to the provision of health & safety management for staff, patients, students and visitors and will:

- Ensure appropriate resources are allocated to maintain health & safety within the Trust. This will include, but will not be limited to:
  - ❖ Appropriate financial resources
  - ❖ Access to external advice on health & safety issues
  - ❖ Appropriate Occupational Health provision
  - ❖ Access to external advice on fire safety and manual handling
- Adopt best practice in health & safety management, in line with standards set by external bodies such as:
  - ❖ National Health Service Litigation Authority, Risk Management Standards ("NHSLA")
  - ❖ Care Quality Commission
  - ❖ Health & safety Executive, Regulations, Approved Codes of Practice and Guidance
- Regularly review the Trust's performance against health & safety standards
- Agree the level of training required for all staff within the Trust to ensure that staff are competent to carry out the health & safety duties assigned to them
- Ensure that appropriate resources are available to facilitate training
- Ensure thorough discussion and consideration of risks on the Trust Risk Register
- Prioritise and sanction identified risk reduction actions to reduce risks to an acceptable level

- Review risks and make a corporate decision on those risks which the Board of Directors is prepared to accept based on the principles of absolute requirements, practicable to achieve and reasonably practicable
- Incorporate risk reduction action plans into relevant Trust business plans.

Director of Estates & Capital Projects

13. The **Director of Estates, Facilities & Capital Projects** has delegated responsibility for the day to day implementation of the Health & Safety Policy and will:

- Ensure the Health & Safety Policy is reviewed on an annual basis, and arrange for the Chief Executive to sign the updated policy document
- Arrange for the **Chief Executive** to sign an annual certificate of compliance to certify that all relevant health & safety legislation is complied with or that a plan is in place to ensure compliance by a specified date
- Ensure that the advice of clinical and non-clinical specialists will be sought, as necessary, to ensure that the Trust fulfils its statutory responsibilities under the Act and all other relevant legislation or regulations. This will include access to a 'Competent Person' as defined by the Management of Health & safety at Work Regulations 1999
- Provide assurance, via the Clinical Quality Safety and Governance Committee ("CQSGC"), to the Board of Directors that health & safety is well managed
- Oversee the implementation of this Policy and ensure that any risks associated with the Policy are treated in accordance with the Trust's Risk Management Strategy
- Have delegated authority to alter circumstances (in the Trust's control) which are considered to present a serious health & safety hazard
- Access the Trust's legal advisors for health & safety advice or in the event of a health & safety related claim
- Ensure that adequate training resources, reviews, procedures and records are identified
- Maintain the Trust's Estates Risk Register
- Inform the Chief Executive of significant risks in relation to health & safety.

Head of Estates & Facilities Management

14. The **Head of Estates & Facilities Management** is the direct line manager for the Estates & Facilities Management ("FM") team and will:

- Ensure suitable arrangements are in place for statutory and planned maintenance as required by the Act, associated regulations, approved Codes of Practice, British Standards and Health Technical Memoranda ("HTM") and Health Building Notes ("HBN")
- Ensure statutory and planned maintenance is undertaken at the required times
- Ensure full records of statutory and planned maintenance are held on file to allow the Trust to demonstrate a compliant position at all premises
- Maintain a database of accredited contractors which should include (for each contractor) copies of the following documents as a minimum:
  - ❖ Current Health & Safety Policy
  - ❖ Current Employers, Product & Public Liability insurance certificates
  - ❖ Generic risk assessments for regularly undertaken planned and reactive maintenance works

- Ensure contractors are provided with up to date Asbestos Registers at each of the Trust premises
- Where a Permit to Work is required by the Control and Management of Contractors Procedure, ensure these documents are completed with the contractors prior to works commencing
- Be responsible for all contractors whilst they are working on Trust premises.

Health & Safety Manager

15. The **Health & Safety Manager** has responsibilities across the Trust for both clinical and non-clinical areas. With regards to the relevant clinical elements of their portfolio (including infection control), the Health & Safety Manager reports to the Medical Director.
16. The Health & Safety Manager is the Trust's nominated 'Competent Person' and will:

- Promote a positive safety culture to continually improve safe working practices
- Provide a central resource of information and advice in regard to health & safety issues, and where appropriate arrange access to external experts
- Undertake and record a formal induction with all new Trust employees, including the identification of any training requirements
- Arrange for the delivery of identified training requirements and maintain up to date training record
- Complete, and regularly review, Personal Emergency Evacuation Plans where it has been identified as a requirement at induction
- With the FM team, arrange and co-ordinate fire evacuation drills on an annual basis at each of the Trust premises, completing a report following evacuation outlining the evacuation time and any lessons learned
- Undertake and record regular health & safety site risk assessments of all service areas, to ensure that safe conditions are maintained
- Monitor incident and accident reports to identify trends and work with managers to eliminate hazards
- Where necessary, complete and submit the appropriate documents required by RIDDOR
- Issue reports to the Health & Safety Working Group and the Director of Estates, Facilities & Capital Projects as required
- Chair the Health & Safety Working Group and monitor the effectiveness of the Working Group by ensuring that it meets its agreed objectives
- Work with managers to develop and review robust and effective risk assessments for all areas
- Provide support and assistance to managers to effectively carry out their health & safety duties
- Work on the development of effective systems to comply with legislation and NHS standards and guidance.

Health & Safety Working Group

17. The Health & Safety Working Group, chaired by the **Health & Safety Manager**, is responsible for monitoring the effectiveness of the following

- The Trust's system of reporting, analysis and investigation and response to lessons learned of all workplace hazards and incidents

- The Trust's system of training in health & safety regulation, law, procedures and policies
- The Trust's procedures for ensuring that suitable and sufficient risk assessments are carried out for work undertaken by Trust staff.

18. The Health & Safety Working Group will report any clinical issues it has identified to the CCSGC.

Executive Management Team

19. The Trust's Executive Management Team has responsibility for co-ordinating compliance with the Health & Safety Policy within their local service department and will:

    - Promote a positive safety culture within their service department and lead by example
    - Ensure that all staff, trainees and students are made aware of the risks within their working environment, their practice and their personal and professional responsibilities
    - Ensure that all members of staff, trainees and students under their direct control receive adequate information, instruction, training and supervision to ensure that all work activities are conducted in a safe manner
    - Initiate the required actions to ensure that health & safety risks arising from work activity or within the workplace are fully investigated and, if within their level of authority, dealt with. If the matter is outside their level of authority, the matter must be passed to the **Health & Safety Manager** or **Director of Estates, Facilities & Capital Projects**
    - Ensure that no member of staff, trainee or student under their direct supervision is instructed to carry out any action, or operate any machinery or equipment for which they have not been adequately trained
    - Ensure that any defect in plant, equipment, work area or work procedure that is reported to them is investigated and, if within their level of authority, dealt with. If it is outside their level of authority, they must ensure that it is escalated to the **Director of Estates, Facilities & Capital Projects.**

All Staff, Trainees and Students

20. Staff, trainees and students are required to:

    - Comply with Trust policies, procedures and regulations designed to protect the health, safety and welfare of all Trust staff and visitors
    - Be aware of emergency procedures including the evacuation and fire precaution procedures
    - Neither intentionally nor recklessly interfere with nor misuse any equipment, provided for health & safety reasons
    - Co-operate with managers in preventing accidents or health risks to themselves, other employees and members of the public or visitors
    - Report any work conditions that they consider unsafe or unhealthy at once to a manager

3. PROCEDURES

21. This section outlines the Trust's arrangements to comply with the requirements of the Act and all associated regulations.

Accident & Incident Reporting (including RIDDOR)

22. All accidents, incidents and near misses will be recorded and managed in accordance with the Trust's Incident Reporting Policy and Serious Incident Policy.

23. The **Health & Safety Manager** will monitor accidents and incidents, and report trends to the Health & Safety Working Group.
24. The procedure for reporting accidents and incidents will be included at Trust induction and annual mandatory training sessions.

25. Where the incident is reportable under the terms of RIDDOR 2013, the Health & Safety Manager will complete a RIDDOR form on the HSE website. Serious accidents must be reported to the HSE immediately and followed up with a written report.

Air Conditioning Equipment

26. All air conditioning equipment will be serviced and leak tested, in accordance with the requirements of the Fluorinated Greenhouse Gas (F Gas) regulations.

27. A register of air conditioning equipment installed at each site will be maintained by the **Head of Estates & Facilities Management** and will include a record of the type and charge of refrigerant within each unit.

28. An Air Conditioning Inspection report will be held by the FM Team for all systems that fall within these requirements.

Asbestos

29. In accordance with the requirements of the Control of Asbestos Regulations 2012, an Asbestos Management Survey will be undertaken by a competent contractor on all properties constructed prior to 2000. This survey will be undertaken every three years.

30. An up to date Asbestos Register will be held centrally and made available for contractors to review before undertaking works. Contractors will be required to sign to say that they have reviewed and understood the Asbestos Register.

31. An Asbestos Refurbishment and Demolition Survey will be completed by a competent contractor prior to any intrusive works being undertaken. Any identified asbestos will be safely removed by a licensed contractor.

32. Full processes and procedures are outlined in the Trust's Asbestos Management Procedure.

Contractors

33. The **Head of Estates & Facilities Management** is responsible for all contractors carrying out planned and reactive maintenance work on the Trust's premises. Contractors are responsible for risk assessing their own works and ensuring appropriate controls are identified and put in place.

34. Contractors are required to provide a copy of their current health & safety policy and insurance documentation prior to commencing work on any premises. Contractors are also required to provide copies of generic risk assessments for regularly undertaken planned and reactive maintenance works prior to commencing work on any premises.

35. Contractors shall be provided with sufficient information, including access to the Asbestos Register, to enable them to conduct their activities without risks arising from the Trust's activities.

36. If the work to be undertaken by a contractor is not covered by the generic risk assessment, they shall be required to provide a bespoke risk assessment and method statement of exactly how the work is to be undertaken which shall include the necessary risk prevention measures and emergency procedures.

37. If an employee of the Trust considers that a contractor's actions or working methods are dangerous, they shall report the matter to the Head of Estates & Facilities Management immediately.
38. The full requirements for contractors are outlined in the Control and Management of Contractors' Procedure.

Control of Hazardous to Health ("COSHH") Regulations

39. The Trust does not routinely use hazardous substances in the course of service delivery. The **Head of Estates & Facilities Management** is responsible for ensuring that all cleaning fluids used by Trust cleaning staff are 'non-hazardous' as defined under COSHH.

40. If a hazardous substance does need to be used, the **Head of Estates & Facilities Management** will obtain copies of the relevant Material Safety Data Sheet and complete a COSHH risk assessment, with the assistance of the Health & Safety Manager if required.

41. On completion of the COSHH risk assessment, the **Head of Estates & Facilities Management** is responsible for communicating the agreed safe system of work and identified control measures to the relevant staff.

42. All contractors are responsible for complying with COSHH regulations under their contract with the Trust and are required to provide evidence of this if requested.

Electrical Installations

43. The IET Wiring Regulations 18th Edition and the British Standard 7671-2018 Code of Practice, recommend that fixed electrical installations in medical and health premises be inspected on a five-yearly cycle.

44. This will include the completion of an Electrical Installation Condition Report (EICR) which will identify any remedial works required to the electrical system. All C1 and C2 remedial repairs must be completed to obtain a 'Satisfactory' EICR.

45. The test and inspection of the fixed wiring installation will be completed by qualified and competent electricians, who are accredited members of NICEIC (National Inspection Council for the Electrical Contracting Industry).

46. The EICR for each for each of the Trust's premises is held by the FM Team.

Fire Risk Evacuation and other Emergency Arrangements

47. The process and procedures for fire safety, including evacuation and emergency arrangements are outlined in the Fire Safety Policy and Fire Safety Procedure.

48. The Trust will ensure that a competent, independent Authorising Engineer (Fire) is appointed. This will be a specialist fire consultant, with sufficient knowledge and expertise including fire safety engineering practice, who is available to advise the board and personnel on fire safety.

49. Emergency contact and key holder details are maintained by the **Head of Estates & Facilities Management** and updated following any changes.

50. Personal Emergency Evacuation Forms (PEEP'S) are completed for staff and patients, to assist in the evacuation of a person with a disability and are maintained by the **Health & Safety Manager** and updated following any changes.

51. Fire drills are arranged by the **Health & Safety Manager** (with assistance from Estates and Facilities) and will be undertaken at least annually and a record kept in the Fire Log Book.

Fire Prevention, Testing of the Fire Alarm System

52. Fire alarm call points at each of the Trust's premises will be tested weekly in rotation by the FM Team and a record kept in the Fire Log book.

53. Any defects on the system will be reported immediately to the alarm contractor/electrical engineer.

54. A fire alarm maintenance contract is in place and the fire alarm system at each premises is serviced on a quarterly basis. Service reports are held by the FM Team.

Fire Prevention, Inspection of Fire Fighting Equipment

55. A maintenance contract is in place and the fire fighting equipment at each of the Trust's premises is serviced on an annual basis. The FM Team complete and record weekly checks to ensure that all fire fighting equipment is available for use and operational and for any evidence of tampering.

56. Defective equipment or extinguishers that need recharging are reported to the FM Team.

Emergency Lighting Systems

57. Emergency lighting is installed at each of the Trust's premises. These systems will be subject to a short duration test on a monthly basis, undertaken and recorded by the FM Team.

58. In addition, a maintenance contract is in place for a full duration test on an annual basis. Records of these tests are held by the FM Team.

Means of Escape

59. The FM Team completes and record daily checks for any obstructions on exit routes and ensures all final exit doors are operational and available for use.

Fire Training & Procedures

60. The Trust's Induction programme will include a fire safety briefing, including evacuation routes from normal work bases and assembly points in the event of an evacuation, for all new starters, and will be part of mandatory training for all staff, as part of the programme on biennial INSET days.

61. Nominated fire wardens receive additional training as wardens and on the use of fire extinguishers.

First Aid and Medication

62. The Trust will endeavour to comply with the requirements of the Health & Safety (First Aid) Regulations 1981. The **Health & Safety Manager** is responsible for ensuring compliance.

63. Compliance is met through a combination of trained first aiders, fully stocked First Aid Boxes and access to medical staff and facilities.

64. The Trust will arrange for sufficient personnel at each premises to be trained as First Aiders and certificated by attending a HSE approved course in first aid. **The Health & Safety Manager** will keep copies of the training certificates in a register.

65. Suitable and sufficient notices are posted in all departments and in the lift lobby of each floor, indicating the name, location and telephone number of the nearest First Aider.

66. First aid boxes will be located within each department. First Aiders in each department are responsible for checking that the contents of their box are sufficient. Replenishment stock can be ordered from the Health & Safety Manager.

67. The medical room at the Tavistock Centre is used as an area of quiet and rest. Other premises have specific rooms that are made available for this use.

Gas Installations

68. In line with the Gas Safety (in use) Regulations 1998, gas heating boilers and water heaters have to be serviced, tested and maintained annually.

69. Servicing and maintenance of Gas installations will only be undertaken by GasSafe registered competent persons.

70. A maintenance contract is in place for all premises and gas installations are serviced on an annual basis and the GasSafe reports are held by the FM Team.

71. Gas catering equipment will be inspected annually by a competent contractor and is regulated by the Gas Safety (installations and Use) Regulation 1998. Gas Safety reports for catering equipment are held by the FM Team

72. Catering extraction systems are also regulated by The Gas Safety (Installation and Use) Regulation 1998. All kitchen extraction systems will be inspected and tested by a competent engineer and will include where appropriate, CO2 and CO emission testing.

73. The inspection will include the cleaning of the filters, fans, ductwork and canopies in accordance with HVCA Ventilation Hygiene Guide to Good Practice. The inspection reports for all catering extraction systems are held by the FM Team.

Insurance Inspections (Thorough Examinations)

74. Certain items of equipment will be subject to regular inspection, known as Thorough Examinations, by a competent person. These will include:

    - Passenger & goods lifts
    - Hoists & patient lifting equipment.

75. The required inspections for each premises are included within the Trust's insurance policy. It is the responsibility of the **Head of Estates & Facilities Management** to ensure that these inspections are undertaken at the required frequency and that any remedial requirements are arranged.

76. Thorough examination reports are held by the FM Team.

Legionella

77. In accordance with the requirements of the Health & Safety Act, the Control of Hazardous to Health (COSHH) Regulations 2012 and the Approved Code of Practice L8: The control of legionella bacteria in water systems, the Trust will undertake a Legionella Risk Assessment at each of the Trust premises.

78. The risk assessment will be undertaken by a competent contractor and will be reviewed on a bi-annual basis or if significant changes are made to water installations.

79. A competent contractor is appointed to undertake the control and monitoring scheme as recommended in the risk assessment. This is likely to include, but not be limited to:

    - Weekly flushing of little used outlets
    - Monthly temperature checks of sentinel outlets on hot and cold water systems
    - Quarterly clean and descale of shower heads
    - Annual inspection of hot and cold water heaters and tanks.

80. Where Trust employees are required to undertake controls themselves, appropriate training will be provided.

81. The **Head of Estates and Facilities Management** is responsible for ensuring that Legionella Risk Assessments are completed and regularly reviewed and that the appropriate control and monitoring arrangements are in place at each of the Trust premises.

82. Full processes and procedures are outlined in the Trust's Water Safety Policy.

Lone Working

83. Staff are encouraged not to work alone within Trust premises. Work involving potentially significant risks (for example work at height) should not be undertaken whilst working alone.

84. The Trust's Personal Safety of Lone Workers' Procedure sets detailed steps to be followed by staff in the event that they are required to work alone.

85. All staff who work in the community and on home visits must adhere to the Procedure, training for staff on personal safety can be arranged with the Health & Safety Manager.

86. Lone workers should report any incidents or situations where they may have felt uncomfortable.

Lifting and Manual Handling

87. As per the requirements of the Manual Handling Operations Regulations 1992, significant manual handling activities will be risk assessed by the **Health & Safety Manager.** This process will aim to eliminate manual handling and lifting wherever possible e.g. by relocating storage and arranging for trolleys and other carrying devises to be available as required.

88. All staff will be made aware of manual handling processes as part of their induction with the Trust. Departmental managers will ensure that staff required to lift in the course of their work receive theoretical and practical training, in manual handling on induction and a refresher every three years, if required.

89. This is a specific requirement for staff working in central services (stores, cleaning, IT, AV, Library and maintenance services). Training is to be arranged by the **Health & Safety Manager**.

90. Employees are responsible for following good lifting techniques and not lifting anything beyond their strength. Any manual-handling hazard injuries or near misses must be reported promptly, in accordance with the Trust's incident reporting procedures.

91. Staff do not receive formal training in the lifting of people (e.g. patients). In the event of an accident or health event that results in a person being on the floor then, in normal circumstances, they should be made comfortable and the ambulance service summoned for assistance.

Office Safety and Display Screen Equipment

92. The **Health & Safety Manager** is responsible for ensuring that managers are trained to undertake work place assessments and any member of staff who is concerned about office safety, including work place arrangements, should contact the **Health & Safety Manager** directly for advice.

93. All new starters should have a workplace assessment by their manager. Managers and staff are responsible for the standards of office safety as described in this section below.

94. PC workstations will be the subject of a recorded workstation assessment in accordance with the Workplace (Health Safety and Welfare) Regulations 1992.

95. Electrical cables and telephone wires must be situated so as not to cause a trip hazard.

96. Electrical sockets must not be overloaded. Fused multi-sockets are available from the FM Team.

97. Offices must be kept reasonably tidy. In particular, gangways and means of escape must be kept free from obstructions.

98. Any faulty electrical equipment must be reported and taken out of use until repaired.

99. Spilled liquids must be cleaned up immediately. If any liquid is spilled on to electrical equipment it must be disconnected at the mains supply immediately and checked by an electrician before being re connected. Spillages on to computer equipment must be reported to the IT department.

100. Personal electrical equipment (such as kettles, fans, fridges, toasters) may not be brought onto Trust premises.

Personal Protective Equipment ("PPE")

101. The Trust will identify the requirements for PPE via the risk assessment process. Employees will be provided with the identified items of PPE at their local induction and can request additional or replacement items from the **Health & Safety Manager.**

102. The Trust supplies uniform and gloves for cleaning staff. Gloves are also available in first aid boxes for staff use as required.

103. All contractors are required to have the appropriate PPE whilst on working on Trust premises, as outlined in their own risk assessments.

Risk Assessment

104. It is the Trust's policy that formal written risk assessments are undertaken prior to commencement of any work which is potentially harmful to physical or mental health. The risk assessments will be completed by the Manager of the relevant department, with input and assistance from the **Health & Safety Manager**.

105. Once completed, the findings of the risk assessment must be communicated to all persons who may be affected by the work to which the risk assessment relates.

106. Risk assessments must be reviewed at least annually or as required due to a change in the risk severity or a change in the working procedures. Any changes made must be brought to the attention of all personnel who may be affected by the change.

107. Pregnancy risk assessments will be undertaken by the pregnant employee's line manager, with support from the **Health & Safety Manager**. This risk assessment will be updated throughout the pregnancy and the Trust will ensure that, as far as practicable, arrangements will be made to reduce to a minimum, health risks to the employee and her unborn child.

108. Risk assessments for employees with disabilities will be undertaken by the employee's line manager, with support from the **Health & Safety Manager**. This risk assessment will seek to minimise the risk of harm to the individual and will seek to adapt facilities and work arrangements as far as practicable in line with the requirements of the member of staff. These assessments will be reviewed and updated if the individuals' circumstance change.

109. Risk assessments that demonstrate significant on-going risks and/or new risks that are not adequately controlled should be added to the Trust's risk register.

Stress at Work

110. The Board of Directors is committed to protecting the health, safety and welfare of the Trust's employees. The Trust values all of its employees and the contribution each of them makes to its overall success and strives to create and maintain a working environment that encourages communication, support and mutual respect.

111. The Trust is committed to improving and safeguarding the health, safety and welfare of its employees and in that regard, recognises the importance of identifying and reducing workplace stressors.

112. The Trust is committed to preventing stress at work and to help and support staff, at all levels, to manage stress both in themselves and in those they manage.

113. To help employees manage stress, the Trust use the following as preventative measures:

- Access to confidential counselling service
- Regular meetings and appraisal reviews
- Consideration of workload management for staff
- The opportunity to meet with line managers to discuss work issues

114. The following supportive measures can be utilised when employees are absence from work:

- Access to Occupational Health Services
- Access to confidential counselling service
- Regular review and support meetings as part of the Sickness Absence Policy, including the Return To Work Procedure.

Work Equipment

115. Work Equipment is broadly defined as any equipment used by an employee at work. The Trust has a duty to ensure that arrangements are in place to comply with the Provision and Use of Work Equipment regulations (PUWER) 1998 which states that all work equipment should be safe and suitable for the intended use.

116. All work equipment provided by the Trust for use by its employees shall be maintained in an efficient state, in efficient working order and in good repair. The Trust shall provide suitable storage facilities for all work equipment and appropriate signage to highlight significant hazards to employees and visitors.

117. When deciding what equipment to purchase, the Trust shall ensure that the equipment is fit for purpose and where applicable conforms to relevant British or EU standards.

118. Regular inspection and testing of work equipment is conducted by appropriate contractors according to recommended timescales. Records of all inspections are held by the FM Team.

119. The **Health & Safety Manager** is responsible for ensuring that staff receive the relevant information, instruction and training and for any reasonable adjustments for any work equipment that they will be required to use.

Working at Height

120. Working at height can present a significant risk to both those undertaking the work and those that may be affected by it. Where such activities cannot be avoided, the **Health & Safety Manager** will undertake a risk assessment to ensure risk levels are reduced to an acceptable level and suitable control measures are in place. The safe system of work established by the risk assessment will be communicated to all relevant staff.

121. When working at height (including accessing storage or putting up displays) appropriate stepladders or kick stools are to be used. Employees must not climb onto chairs or tables.

122. Any contractor who intends to work at height must ensure that the activity is suitably risk assessed prior to commencing work on Trust premises. Contractors must supply their own access equipment (including ladders and stepladders) and must not use Trust equipment.

123. The **Head of Estates & Facilities Management**, with the assistance of the **Health & Safety Manager**, shall ensure:

- All work at height is properly planned and organised
- All those involved in work at height are trained and competent to do so
- The risks from working at height are assessed and appropriate equipment selected
- Any risks from fragile surfaces are suitably assessed and controlled
- Training for new starters and regular refresher training for existing staff.

4. TRAINING

127. As per the requirements of Section 2 of the Act, the Trust is committed to providing information, instruction and training to all employees to ensure they can perform their roles safely. Additional training is provided to employees who have designated responsibilities such as Fire Wardens and First Aiders.

128. A training needs analysis has been conducted and it has been determined that the following training is mandatory for each staff group listed below:

Topic	Details of content	Staff Group
Basic risk management	To include Health & safety awareness, slips trips and falls awareness and the need to undertake specific risk assessments in risky situations (e.g. pregnancy, for staff with an impairment, in unusual/changed working conditions etc.)	All staff once at induction
Basic manual handling	To include theory of good lifting and back care, Ergonomics etc.	All staff once at induction
Practical manual handling	To include theory and practical manual handling	Staff in Central Services and the Library who are required to lift as part of their role (to be delivered by expert trainer) on appointment and then three yearly (if required)
Fire awareness	To include protecting self and others in event of a fire and introduction to use of extinguishers	All staff Basic introduction to fire escapes and local fire marshal as part of local induction Update on fire safety 2 yearly as part of INSET
Conflict resolution	To include de-escalation training to be delivered by subject expert	Front of house staff (once) and optional for other staff (refresher on request)
Chemicals (COSHH)	Whilst it is Trust policy to avoid use of chemicals that come under COSHH regulations, should it be required in exceptional circumstances that these are use then the Head of Estates and Facilities Management will ensure relevant staff receive specific training in the use and storage of these substances.	Specific staff as required
Risk Assessment Training	To include principles and practice of risk assessment (training to support Trust's risk assessment procedure)	Directorate Managers and others required to carry out risk assessments , as required, once (refresher training available one to one ad hoc)
First Aid training	Initial training and then 3 year refresher, but external subject expert	All registered first aider, training arranged by Health & safety Manager
Fire warden training	Initial training and then 3 year refresher, but external subject expert	All fire wardens, training arranged by Health & safety Manager

5. PROCESS FOR MONITORING COMPLIANCE WITH THIS POLICY

129. The **Health & Safety Manager** will provide a quarterly report to the Corporate Governance & Risk Workstream of the CQSG Committee. This report will cover:

- Incident numbers, investigation and lessons learned, including all Health & safety incidents
- RIDDOR reportable incidents
- Any other issues relating to health & safety including issues arising from risk assessments (including security, slip, trips and falls, manual handling, violence and aggression and lone worker care).

130. This report will be presented to the Health & Safety Working Group who will feedback relevant information to staff in their own departments and raise local health & safety matters for discussion and resolution.

131. The **Director of Estates, Facilities & Capital Projects** will consider whether a Trust wide response is required to any health & safety matter and will add the item to the Trust Risk Register. The Working Group may invite relevant staff to come and discuss health & safety incidents and the action taken to the Working Group meeting. This will assist the Working Group to monitor the effectiveness of the Trust approach to health & safety.

132. The **Director of Estates, Facilities & Capital Projects** will provide a report (at least quarterly) to the Estates Compliance Workstream of the CQSG Committee.

133. The **Health & Safety Manager** will monitor compliance with mandatory training and report non-compliance to the Director of Estates & Capital Projects.

6 ASSOCIATED DOCUMENTATION

134. The following documentation should be read in conjunction with this Health & Safety Policy:

- Asbestos Management Procedure
- Business Continuity Plan
- Conducting a Risk Assessment Procedure
- Control and Management of Contractors Procedure
- Fire Log Book
- Fire Safety Policy
- Fire Safety Procedure
- Incident Reporting Procedures.
- Legionella Management Procedure
- Lone Working Procedure
- Major Incident Plan
- Risk Management Strategy and Policy
- Risk Register
- Serious Incident Policy
- Staff Safety & Security Procedure
- Staff Training & Development Procedure

7 DEFINITIONS

136. The Trust has adopted the following as standard definitions in relation to health & safety and risk management:

Term	Definition
Hazard	Anything that has the potential to cause harm to an individual or the Trust.
Risk	The chance that exposure to a hazard will cause harm to an individual or the Trust.
Risk Score	Calculation incorporating the multiplication of the: **Likelihood** of exposure to an identified hazard and the, **Consequence** of that exposure to an individual or the Trust using a numerical 5x5 scoring matrix.
Risk Assessment	Careful examination, by 'competent person', of what could/has caused harm or loss to an individual or the Trust in order: To evaluate whether sufficient control measures are/were in place and if not, To enable additional control measures to be identified and, For an Action Plan to be drafted and implemented to minimise the risk of that harm or loss occurring/reoccurring.
Reasonably Practicable	The measure of a risk *versus* the effort, time and cost required by the Trust to avert that risk. Where there is a gross disproportion between them i.e. the risk being insignificant in relation to the control measures identified then the Trust is considered to have discharged its 'duties' under health & safety legislation. The greater the risk then the greater the resources required to balance the equation.
Competent Person	A person or persons appointed by the Trust having such training, experience or knowledge of the work activities to enable them to carry out risk assessments that are both suitable and sufficient.
Safety Representative	A person appointed by a recognised Trades Union as a 'Safety Representative' ref: the Safety Representatives and Safety Committee Regulations 1977 or elected by their peers as a 'Representative of Employee Safety' ref: the Health & safety (Consultation with Employees) Regulations 1996. NB The Trust recognises the differences between the two sets of Regulations in particular the sourcing of training and appointment process but does not differentiate between their roles and responsibilities.

EQUALITY IMPACT ASSESSMENT

Completed by	**Lisa Tucker**
Position	**Health & safety Manager**
Date	**27 August 2018**

The following questions determine whether analysis is needed	Yes	No
Is it likely to affect people with particular protected characteristics differently?		X
Is it a major policy, significantly affecting how Trust services are delivered?		X
Will the policy have a significant effect on how partner organisations operate in terms of equality?		X
Does the policy relate to functions that have been identified through engagement as being important to people with particular protected characteristics?		X
Does the policy relate to an area with known inequalities?		X
Does the policy relate to any equality objectives that have been set by the Trust?		X
Other?		X

If the answer to *all* of these questions was no, then the assessment is complete.
If the answer to *any* of the questions was yes, then undertake the following analysis:

	~~Yes~~	~~No~~	~~Comment~~
~~Do policy outcomes and service take-up differ between people with different protected characteristics?~~			
~~What are the key findings of any engagement you have undertaken?~~			
~~If there is a greater effect on one group, is that consistent with the policy aims?~~			
~~If the policy has negative effects on people sharing particular characteristics, what steps can be taken to mitigate these effects?~~			
~~Will the policy deliver practical benefits for certain groups?~~			
~~Does the policy miss opportunities to advance equality of opportunity and foster good relations?~~			
~~Do other policies need to change to enable this policy to be effective?~~			
~~Additional comments~~			

If one or more answers are yes, then the policy may unlawful under the Equality Act 2010 –seek advice from Human Resources (for staff related policies) or the Trust's Equalities Lead (for all other policies).

The Tavistock and Portman
NHS Foundation Trust

FIRE SAFETY POLICY

Version:	1.0
Bodies consulted:	EMT, Estates staff, Health & Safety Manager
Approved by:	Board of Directors
Date Approved:	
Lead Manager:	Director of Estates, Facilities & Capital Projects
Lead Director:	Deputy Chief Executive
Date issued:	
Review date:	September 2019
Intranet:	Yes
Extranet:	Yes

CONTENTS

1. Introduction

1.1. The Tavistock and Portman NHS Foundation Trust (the Trust) is committed to maintaining the highest standards of fire safety in order to minimise the risk of fire and potential personal injury or loss of life through the effects of fire, smoke and associated fire hazards.

1.2. The Trust recognises that it has a statutory duty under the Regulatory Reform (Fire Safety) Order (RRO) 2005, to ensure adequate levels of fire safety for employees, patients, students, contractors, visitors and members of the public that visit Trust premises (together “Users”).

1.3. The Trust also recognises the need for co-operation, and a collaborative approach to fire safety and the need to work with employees, safety representatives and statutory authorities to define robust procedures which ensure the fire safety of Users.

1.4. The consequences of fire in healthcare and other premises can be especially serious because of the dangers and difficulties associated with the emergency evacuation of patients, some of whom may require assistance.

2. Purpose

2.1. The Trust is committed to providing and maintaining an adequate level of fire safety for all people who may be affected by its activities. Implementation of the policy will achieve the objectives listed below.

2.2. Ensure the Trust complies with the relevant legislation, and wherever possible promote best practise in relation to fire, through the provision of a robust Fire Safety Management System.

2.3. Identify the hazards, assess the fire risks and where possible remove, control or prevent re-occurrence of risks.

2.4. Make available appropriate resources to implement this policy effectively.

2.5. Ensure that Users are adequately informed of the identified risks and where appropriate receive instruction, training and supervision.

2.6. Ensure that there are effective plans including designated staff to deal with any fire incident as it occurs. There should be detailed evacuation plans which are practised regularly.

2.7. Ensure that there is effective communication and consultation of fire safety issues through effective risk assessment.

2.8. Ensure that all fire equipment is maintained and fit-for-purpose as appropriate.

2.9. Ensure the sufficiency in number and competence of internal or external resources to be able to adequately advise the Trust on core requirements and best practise across premises where the Trust has fire safety responsibility.

2.10. Ensure that regular monitoring and review of compliance with this policy is undertaken with the objective of providing continual improvement

2.11. Create an annual report detailing fire safety performance.

3. Scope

3.1. The Trust will ensure, as far as is reasonably practical, that Users are not exposed to the risks posed by fire.

3.2. The Trust will comply with:

- Health and Safety at Work etc Act 1974
- Management of Health and Safety at Work Regulations 1999
- Regulatory Reform (Fire Safety) Order 2005.

3.3. The requirements will be met by following the guidance provided in:

- HTM 05-01 Managing healthcare fire safety. Firecode
- HTM 05-02 Guidance to support functional provisions in health care premises
- HTM 05-03 Operational Provisions Parts A-K Firecode
- HSG168 Fire safety in Construction (2nd Edition)
- Building Regulations Approved Document B.

3.4. The Trust will ensure compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

3.5. The Trust will ensure that all relevant staff or contractors involved in the design, installation and maintenance of fire related issues will be competent to carry out the tasks. All necessary resources will be made available to ensure the correct design, construction, supply and use of equipment and maintenance is carried out.

3.6. This policy applies to all buildings where the Trust has responsibility for fire safety. This may include the whole of a building or parts of premises where the Trust is a tenant or acts as the landlord.

3.7. Where the Trust is a tenant or acts as the landlord of premises, this policy will apply to the areas for which fire safety responsibility imposes requirements on the Trust, and the Trust will ensure such areas of responsibility and any joint requirements are clearly established.

4. Definitions of terms used

4.1. **Fire risk assessment** is the process of identifying fire hazards and evaluating the risk to people, property, assets and the environment arising from them, taking into account the adequacy of existing fire precautions and deciding whether the fire risk is acceptable without any rectifications and/or what additional or revised control measures are required.

4.2. **Fire safety management system** is a robust system of procedures and protocols used to ensure that an organisation can fulfil all tasks required to achieve the safety objectives set out in the fire safety policy.

4.3. **HTM** – Health Technical Memoranda which give comprehensive advice and guidance in the design, installation and operation of specialised building and engineering technology used in the delivery of healthcare. HTM 05-01, 05-02 and 05-03 are collectively known as NHS Firecode.

5. Duties and Responsibilities

Board of Directors

5.1. The Board of Directors has the responsibility for demonstrating commitment to all matters relating to fire safety.

Chief Executive

5.2. The Chief Executive will, on behalf of the Board of Directors ensure that the Regulatory Reform (Fire Safety) Order 2005 is complied with and where appropriate the NHS Firecode guidance is implemented in all premises owned, occupied or under the control of the Trust.

Director of Estates, Facilities Management & Capital Projects (Designated Senior Operational Fire Safety Manager)

5.3. The Chief Executive discharges the day to day operational responsibility for fire safety through the Director of Estates, Facilities Management & Capital Projects ("Estates Director").

5.4. The duties of the Estates Director are to ensure:

- The physical fire safety measures within the Trust are implemented, adequately maintained, replaced and improved in accordance with statutory legislation and Firecode
- Co-operation between other responsible persons where Trust premises are shared or where the Trust occupies shared premises
- Through senior management and line management structures that full staff participation in fire training and fire evacuation drills is maintained
- That an annual audit of fire safety and fire safety management is undertaken and the outcomes communicated to the Board of Directors
- That fire risk reports outlining issues identified are produced and made available as required.

5.5. The Estates Director manages the strategic development and implementation of corporate fire safety risks and will also act as the Designated Senior Operational Fire Safety Manager. This includes developing and implementing the Fire Safety Management System, the implementation of a robust and regular fire risk assessment process and the provision of the Trust's Approved Codes of Practice (ACOPs). In addition, they will act as a focus for all fire safety matters. They are tasked with developing and managing the Fire Safety Management System and will be responsible for:

- Day to day implementation of the fire safety policy
- Reporting of non-compliance with legislation, policies and procedures
- Establishing and maintaining the Trust Fire Safety Committee
- Appointing and liaising with the Authorising Engineer (Fire)
- The development, implementation, monitoring and review of the organisation's Fire Safety Management System
- Ensuring that fire risk assessments are undertaken, recorded and suitable action plans developed
- Ensuring that requirements related to fire procedures for less-able staff, patients and visitors are in place
- The development and delivery of an effective fire training programme
- Monitoring the inspection and maintenance of fire safety systems
- Ensuring that suitable fire safety audits are undertaken, recorded and the outcomes suitably reported
- Ensuring an appropriate level of management is always available by the establishment of Fire Response Teams
- Ensuring all new works and projects are fully compliant with statutory requirements and the Firecode and that a fire compliance report is compiled for all works in accordance with the Trust's ACOPs
- Establishing and maintaining an integrated approach to fire safety where areas of responsibility overlap, particularly for new works and where there is divided shared responsibility for fire safety

Head of Estates & Facilities Management (Designated Authorised Person Fire)

5.6. The Head of Estates & Facilities Management will be accountable to the Designated Senior Operational Fire Safety Manager for matters of fire safety. They will be responsible for:

- Determining and implementing the additional internal and/or external resourcing required to fully discharge their duties
- Advising on the mandatory training objectives for staff, which is appropriate to the personnel, the areas in which they work and the activities involved in their work. They will also monitor the delivery of such training
- Train and monitor Emergency Response Team members to ensure they are competent to carry out their tasks
- Liaision with other Trust personnel responsible for continuity and emergency planning issues and assistance in the formulation of an overall Trust Emergency Plan
- Maintaining an up to date register of Fire Wardens

- Carry out fire risk assessments in accordance with HTM 05 and the Regulatory Reform (Fire Safety) Order 2005 where the Trust has fire safety responsibility throughout the Trust, covering all wards, departments, plant rooms and circulation spaces, etc. All findings will be reported via an electronic reporting system. All identified hazards will be reported to the respective department manager, with engineering issues also raised with the Estates Director
- Ensuring fire evacuation procedures are prepared for each workplace where the Trust has responsibility for fire safety and that the detail is communicated to all relevant personnel
- Liaising with the Estates Director or their nominated works officer on schemes undertaken directly under their control to ensure that overall Trust objectives are accommodated in the design and execution of works, and if necessary, seeking advice from the Authorising Engineer (Fire)
- Preparing a monthly and annual report for the Estates Director that summarises progress and all other matters arising in respect of fire safety management within the Trust.

Authorising Engineer (Fire)

5.7. The Trust will ensure that a competent, independent Authorising Engineer (Fire) is appointed. This will be a specialist fire consultant, with sufficient knowledge and expertise including fire safety engineering practice, who is available to advise the Board and personnel on fire safety. They will:

- Advise on the interpretation and application of fire safety legislation and guidance including Firecode, providing specific guidance on the measures required for compliance with legislation and Firecode specific to the peculiarities of the Trust's premises and advise on the content of the Trust's Fire Safety Policy and Fire Safety Management System.
- Monitor the effectiveness and execution of the Fire Safety Management System and undertake an annual audit.
- Undertake such other duties as required by the Trust for compliance with NHS Firecode.

Fire Incident Manager/Accountable Emergency Officer

5.8. The most senior person in charge of an area at the time of a fire incident occurring will assume the role of Fire Incident Manager. They are required to:

- Take control of the incident
- Direct the local response
- Ensure that the fire alarm has been activated
- Initiate the local emergency action plan
- Liaise with the Fire Response Team.

Fire Response Teams

5.9. The Estates Director, as Designated Senior Operational Fire Safety Manager, should ensure that Fire Response Teams are established on all Trust sites – these will be based on the nature of the site.

5.10. A senior manager will be nominated as the Fire Response Team Leader to ensure initial control of an emergency. They are required to:

- Respond in the event of a confirmed incident.
- Liaise with the Fire Incident Manager and the attending fire and rescue services.
- Direct the Fire Response Team
- Instigate the Trust's major incident plan if required

Competent Persons

5.11. Installers and maintainers of fire safety equipment will be appointed by the Trust and must be able to demonstrate the relevant competence for the work they are to carry out. This may include staff members with specific responsibility for systems or equipment

5.12. Documented within the Fire Safety Management System are the necessary controls for fire safety when working for the Trust.

Management Teams

5.13. All line managers are responsible for ensuring that the Trust's Fire Safety Policy is implemented within their area. They are responsible for:

- Monitoring fire safety within their respective workplaces and ensuring that contraventions of fire safety precautions do not take place
- Ensuring local risk assessments are undertaken and maintained up to date
- Reporting any defects in the fire precautions and equipment in their areas and ensuring that appropriate remedial action is taken
- Ensuring that local fire emergency plans are developed and brought to the attention of staff
- Ensuring that local fire emergency action plans are devised in response to any changes including temporary works
- They are responsible for liaising with the Head of Estates & Facilities Management to ensure sufficient numbers of Fire Wardens are identified and trained as necessitated by the nature of activities involved
- Ensure that all staff attend the relevant training

Fire Wardens

5.14. The Trust will ensure that Fire Wardens and Deputy Fire Wardens are appointed for each area of the Trust's premises (who will have designated areas of responsibility). Fire wardens will attend fire training as required and to undertake refresher training every three years.

5.15. Exact duties of Fire Wardens will be detailed in the Fire Safety Management System for the particular building or area where the Trust has responsibility for fire safety. However, in general Fire Wardens will:

- Act as a focal point of fire safety issues for local staff
- Organise and assist in the fire safety regime within local areas
- Raise issues regarding local fire safety with their line management
- Support line managers in their fire safety issues
- Carry out regular audits / checks of the local area.

All other employees

5.16. All staff employed by the Trust and those who are self-employed or employed by others occupying Trust premises are legally responsible for their own safety and other persons who may be affected by their actions.

5.17. All staff are responsible for ensuring any duties allocated to them by their employer, which may ultimately be the Trust, are performed or complied with.

5.18. Employees will inform the Trust through line management of any work situation, shortcoming or failure which might reasonably constitute a serious risk to fire, health and safety.

5.19. Employees are responsible for respecting at all times the need for vigilance in the maintenance of fire safety systems and all other equipment and materials, to ensure that hazards are not created ad that risks are reduced.

Employees working in other locations

5.20. Where members of staff are working in premises which are owned and/or managed by parties other than the Trust, the Trust will ensure that the other party understands and accepts the respective responsibilities of the Trust, the employees of the Trust and the other party in respect of fire safety.

5.21. Specific discrete responsibilities however, are defined as follows:

a) The Trust will agree with third parties who is the responsible person or Duty Holder for fire safety and thus who is responsible for assessing and managing fire risk, including the scope and detail of any areas where responsibility is shared.

b) For any work related activities undertaken outside the premises owned / managed by other parties, the Trust will ultimately be accountable for ensuring those activities are carried out safely through application of safe systems of work and/or professional standards, and that effective fire safety risk management will be exercised

c) Where another party is responsible for managing the work, on a day to day basis, the Trust and other party are responsible for independently monitoring fire safety provisions. The other party will be responsible for taking management action to correct any shortfalls in the first instance, referring to the Trust if such shortfalls are not adequately addresses within the time specified

d) Where such management actions fails to result in improvements to fire safety within a reasonable time period, the other party must inform the Trust so that the Trust can take whatever action is appropriate as the employer of the staff to ensure safe systems of work are practised and maintained

6. Procedures

6.1. The key to ensuring a high standard of fire safety is by the introduction of a robust Fire Safety Management System, which should include an up to date fire safety policy.

6.2. Specific management roles and responsibilities should be allocated to staff that have the relevant competencies.

6.3. All areas that are the responsibility of the Trust will have up to date fire risk assessments and recorded in the Fire Safety Management System. Any identified actions will be rectified within reasonable timescales.

6.4. There will be a fully compliant fire alarm and detection system which will be maintained as required.

6.5. Staff will be aware of fire safety and emergency procedures by way of a high standard of training, delivered by both face to face and e-learning, as appropriate and identified in a fire training analysis.

6.6. There will be adequate numbers of well-trained fire wardens, as appropriate and identified in a fire training analysis, to assist with developing fire procedures, monitoring fire safety generally and with evacuation in the event of an incident.

6.7. Emergency plans, including evacuation, will be developed and reviewed, in particular, following a fire risk assessment and after an incident or practise.

6.8. Proactive measures will be undertaken to prevent unwanted fire alarm incidents, through training, proper maintenance and use of equipment and system, and by the implementation of “seek and search” procedures if necessary and where appropriate to do so.

6.9. Records will be kept of all maintenance activities and regular audits will be undertaken.

7. Training

7.1. The Chief Executive will ensure appropriate occupational health provision is in place for all Trust personnel. This includes provision of mandatory and supplementary fire safety training for all staff.

7.2. All new permanent members of staff and volunteers must attend a Trust induction, which includes mandatory provision on fire safety. They must also be made aware of the fire procedures that apply within their own department before they begin normal working duties with records being kept of this local induction. They must also receive corporate “refresher” training on fire safety on a regular basis.

7.3. Competency based training is essential in maintaining a safer and healthy workforce and in delivering high quality services. Where specialist skills are required outside the normal scope of fire training provided, the local managers must arrange for such training to ensure that their staff have the skills and knowledge to be able to undertake any task that is required of them.

8. Monitoring

8.1. The contents of this policy will be reviewed on an annual basis to ensure that it remains compliant and relevant. Any legislative changes will be made as soon as practically possible.

8.2. Trust compliance to this policy will be carried out by regular audit. This may be by way of internal or external audits. All identified deficiencies will be tracked until completion and results of these audits will be discussed at the various committee meetings.

8.3. Local monitoring of the fire safety procedures and fire risk assessments will be undertaken and a report produced monthly by the Head of Estates & Facilities Management for the Director of Estates, Facilities Management and Capital Projects.

8.4. An annual audit will be undertaken by the Authorising Engineer (Fire) and presented for discussion at the relevant committees including the Board of Directors.

9. References

- Health and Safety at Work etc Act 1974
- Control of Substances Hazardous to Health Regulations 2002
- Management of Health and Safety at Work Regulations 1999
- Regulatory Reform (Fire Safety) Order 2005
- Dangerous Substances and Explosive Atmospheres Regulations 2002
- Equality Act 2010
- Workplace (Health, Safety and Welfare) Regulations 1992
- HTM 05.01 Managing healthcare fire safety
- HTM 05-02 Guidance to support functional provisions in health care premises. Firecode
- HTM 05-03 Operational Provisions Parts A-M
- Building Regulations Approved Document B
- HSG 168 Fire safety in Construction (2nd Edition)

10. Associated Documentation

- Health and Safety Policy

Equality Impact Assessment

Completed by	**Alessandro Ruggeri**
Position	**Head of Estates and Facilities Management**
Date	**29 August 2018**

The following questions determine whether analysis is needed	Yes	No
Is it likely to affect people with particular protected characteristics differently?		X
Is it a major policy, significantly affecting how Trust services are delivered?		X
Will the policy have a significant effect on how partner organisations operate in terms of equality?		X
Does the policy relate to functions that have been identified through engagement as being important to people with particular protected characteristics?		X
Does the policy relate to an area with known inequalities?		X
Does the policy relate to any equality objectives that have been set by the Trust?		X
Other?		X

If the answer to *all* of these questions was no, then the assessment is complete.

If the answer to *any* of the questions was yes, then undertake the following analysis:

	~~Yes~~	~~No~~	~~Comment~~
~~Do policy outcomes and service take-up differ between people with different protected characteristics?~~			
~~What are the key findings of any engagement you have undertaken?~~			
~~If there is a greater effect on one group, is that consistent with the policy aims?~~			
~~If the policy has negative effects on people sharing particular characteristics, what steps can be taken to mitigate these effects?~~			
~~Will the policy deliver practical benefits for certain groups?~~			
~~Does the policy miss opportunities to advance equality of opportunity and foster good relations?~~			
~~Do other policies need to change to enable this policy to be effective?~~			
~~Additional comments~~			

If one or more answers are yes, then the policy may unlawful under the Equality Act 2010 –seek advice from Human Resources (for staff related policies) or the Trust's Equalities Lead (for all other policies).

The Tavistock and Portman
NHS Foundation Trust

WATER SAFETY POLICY

Version:	1.0
Bodies consulted:	EMT, Estates staff
Approved by:	Board of Directors
Date Approved:	
Lead Manager:	Director of Estates, Facilities & Capital Projects
Lead Director:	Deputy Chief Executive
Date issued:	
Review date:	September 2019
Intranet:	Yes
Extranet:	Yes

CONTENTS

1. Introduction

1.1. The Tavistock and Portman NHS Foundation Trust (the "Trust") is committed to maintaining the highest standards of water safety in order to minimise the risk of causing a water related infection to a patient, student, visitor or member of staff.

1.2. The Trust recognises that it has a statutory duty under the Health and Safety at Work Act etc. 1974 ("Act") and the Health & Safety Executive (HSE) ACOP L8 to adequately manage the water services under its control.

1.3. The Trust also recognises the need for co-operation and a collaborative approach to water safety and the need to work with employees and the statutory authorities to define robust procedures that ensures the water safety of staff and users.

2. Purpose

2.1. The Trust is committed to providing and maintaining an adequate level of water safety for all people who may be affected by its activities.

2.2. Implementation of the policy will ensure:

- The Trust complies with relevant legislation and wherever possible promote best practise in relation to water safety.
- Hazards are identified, assess the water risks and where possible remove, control or prevent re-occurrence of risks.
- Availability of appropriate (internal and external) resources to implement this policy effectively.
- Employees, students, patients, contractors and visitors (together "Users") are adequately informed of the identified risks and where appropriate receive instruction, training and supervision.
- Effective communication and consultation of water safety issues through effective risk assessment.
- A suitable maintenance and monitoring Scheme of Control is implemented, maintained and kept up to date.
- Regular monitoring and review of compliance with this policy is undertaken with the objective of providing continual improvement.

3. Scope

3.1. The Trust will ensure, as far as is reasonably practical, that no Users are exposed to the potential risks posed by water.

3.2. The Trust will comply with:

- Health and Safety at Work etc Act 1974 ("Act")
- Management of Health and Safety at Work Regulations 1999
- Health & Safety Commission Approved Code of Practice & Guidance - The Control of Legionella bacteria in water systems (L8) 4th Edition 2013
- Control of Substances Hazardous to Health Regulations (COSHH) 2002

3.3. The requirements will be met by following the guidance provided in:

- The Public Health (Infectious Diseases) Regulations 1988
- The Water Supply (Water fittings) Regulations 1999
- The Water Supply (Water Quality) Regulations 2000
- HTM 04-01: Safe Water in Healthcare Premises - Parts A, B & C 2016

3.4. The Trust will ensure that all relevant staff or contractors involved in the design, installation and maintenance of water related services and issues will be competent to carry out the tasks. All necessary resources will be made available to ensure the correct design, construction, supply and use of equipment and maintenance is carried out.

3.5. This policy applies to all buildings where the Trust has responsibility for water safety and where patients, students, visitors, employees, contractors and members of the public attend. This may include the whole of a building or parts of premises where the Trust is a tenant or acts as the landlord.

3.6. Where the Trust is a tenant or acts as the landlord of premises, this policy will apply to the areas for which water safety responsibility imposes requirements on the Trust, and the Trust will ensure such areas of responsibility and any joint requirements are clearly established.

4. Definitions

4.1. **Legionella risk assessment** is the process of identifying Legionella related hazards and evaluating the risk to patients, students, visitors and staff, taking into account the adequacy of the control measures in place and implementing further controls if necessary.

4.2. **Legionella Management Scheme of Control** is the maintenance and monitoring programme in place to help control the risk of Legionella and other waterborne infections, from the water services.

4.3. Health Technical Memoranda which give comprehensive advice and guidance in the design, installation and operation of water services in healthcare properties. HTM04-01 is the HTM relevant to the Trust.

5. Duties and Responsibilities

Board of Directors

5.1. The Board of Directors has the responsibility for demonstrating commitment to all matters relating to water safety.

Chief Executive

5.2. The Chief Executive will, on behalf of the Board of Directors, ensure that the relevant legislation and codes of practice (as per 2.2 and 2.3 above) are complied with, along with the implementation of this policy, in all premises for which the Trust has the responsibility for water safety.

Director of Estates, Facilities and Capital Projects

5.3. The Chief Executive discharges the day to day operational responsibility for water safety through the Director of Estates, Facilities and Capital Projects ("Estates Director"). The Estates Director is the designated Senior Operational Water Safety Manager and is responsible for ensuring that:

- This policy is being implemented, on a day to day basis, by the Head of Estates & Facilities Management (Designated Authorised Person Water)
- The Head of Estates & Facilities Management has the necessary resource to fully implement this policy
- An Annual Audit is undertaken and any actions implemented
- The Board receives appropriate reporting on all water hygiene related issues.

Director of Estates, Facilities Management & Capital Projects (Designated Senior Operational Water Safety Manager)

5.4. The Estates Director manages the strategic development and implementation of corporate water safety risks and will also act as the Designated Senior Operational Water Safety Manager.

5.5. They are tasked with developing and managing the Water Safety Management System and will be responsible for:

- Ensuring this policy is properly implemented
- Ensure the Head of Estates & Facilities Management has the necessary resource to fully implement this policy
- Ensuring all new works and projects are fully compliant with statutory and guidance requirements
- Reporting any significant matters on water hygiene to the Board
- Attend the Water Safety Group Meetings

Head of Estates & Facilities Management
(Designated Authorised Person Water)

5.6. The Head of Estates & Facilities Management will be accountable to the Designated Senior Operational Water Safety Manager for matters of water safety. They will be responsible for:

- Day to day implementation of the water safety policy
- Determining and implementing any internal and/or external resourcing required to fully discharge their duties
- Advising on the mandatory training objectives for staff, which is appropriate to the personnel, the areas in which they work and the activities involved in their work. They will also monitor the delivery of such training
- Ensuring Legionella Risk Assessments are undertaken in line with this policy and that remedial actions are planned and completed in line with the assessments action plans
- Liaise closely with the Trust's Authorising Engineer (Water)
- Liaising with the Estates Director or their nominated works officer on schemes undertaken directly under their control to ensure that overall Trust objectives are accommodated in the design and execution of works, and if necessary, seeking advice from the Authorising Engineer (Water)
- Preparing reports for the Estates Director on matters arising in respect of water safety management within the Trust
- Chair the Water Safety Group Meetings

Authorising Engineer (Water)

5.7. The Trust will ensure that a competent, independent Authorising Engineer (Water) is appointed. This will be a specialist water consultant, with sufficient experience, knowledge and expertise. They will:

- Advise on the interpretation and application of water safety legislation and guidance.
- Complete an annual compliance status audit.
- Attend two Trust Water Safety Group Meetings per year
- Provide phone and email support as required

Water Hygiene Contractor

5.8. The Water Hygience Contractor will:

- Complete the Trust's Water Management Scheme of Control
- Provide water services site log books and update after each service and monitoring visit
- Liaise closely with the Trust Designated Authorised Person Water and report any issues or out of range findings in line with the scheme of control requirements

Estates & Facilities Management Staff ("E&F")

5.9. Under the instruction from the Trust Designated Authorised Person Water E&F staff will flush the highlighted infrequently used outlets to the agreed Trust regime and document the flushing on the Trust forms.

All other employees

5.10. All staff employed by the Trust and those who are self-employed or employed by others occupying Trust premises are legally responsible for their own safety and other persons who may be affected by their actions.

5.11. All staff are responsible for ensuring any duties allocated to them by their employer are performed or complied with.

6. Procedures

6.1. Key to ensuring a high standard of water hygiene safety is the introduction of a robust monitoring Scheme of Control along with a current water safety policy.

6.2. Specific management roles and responsibilities should be allocated to staff that have the relevant competencies.

6.3. Specifications for water safety in upgraded, refurbished and new-builds must follow the Trust's Procedures. The Designated Senior Operational Water Safety Manager will need to be aware of all work that may impact on water safety including maintenance activities.

6.4. Records will be kept of all maintenance and monitoring activities and regular audits will be undertaken. The results of these audits will be discussed at the Trust's Water Safety Group.

7. Training

7.1. The Chief Executive will ensure there is adequate resource available for a robust training programme with a three yearly refresher frequency.

7.2. The designated Senior Operational Water Safety Manager and Designated Authorised Person Water will complete and pass an accrediated Responsible Persons course on water hygiene.

7.3. All other staff members involved in water hygiene management will have appropriate Water Hygiene General Awareness training.

8. Monitoring and review

8.1. The contents of this policy will be reviewed on an annual basis to ensure that it remains compliant and relevant. Any changes necessary as a result of new legislation will be made as soon as practically possible.

8.2. Trust compliance with this policy will be carried out by regular audit. This may be by way of internal or external audits. All identified deficiencies will be tracked until completion and results of these audits will be discussed at the various committee meetings.

8.3. An annual audit will be undertaken by the Authorising Engineer (Water) delivered to the Designated Authorised Person (Water) and the Water Safety Group.

9. References

- Health & Safety Executive Approved Code of Practice 2013 - The Control of Legionella bacteria in water systems (L8)
- Health & Safety Executive Guidance (HSG 274 Parts 2 and 3)
- HTM 04-01: Safe Water in Healthcare Premises - Parts A, B & C 2016
- Health and Safety at Work etc., Act 1974
- Management of Health and Safety at Work Regulations 1999
- Control of Substances Hazardous to Health Regulations 2002, Regulation 6 (COSHH)
- The Public Health (Infectious Diseases) Regulations 1988
- The Water Supply (Water fittings) Regulations 1999
- The Water Supply (Water Quality) Regulations 2000
- Requirements for building services used in Healthcare Premises (2011)

10. Associated Documentation

- Health and Safety Policy

Equality Impact Assessment

Completed by	**Alessandro Ruggeri**
Position	**Head of Estates and Facilities Management**
Date	**29 August 2018**

The following questions determine whether analysis is needed	Yes	No
Is it likely to affect people with particular protected characteristics differently?		X
Is it a major policy, significantly affecting how Trust services are delivered?		X
Will the policy have a significant effect on how partner organisations operate in terms of equality?		X
Does the policy relate to functions that have been identified through engagement as being important to people with particular protected characteristics?		X
Does the policy relate to an area with known inequalities?		X
Does the policy relate to any equality objectives that have been set by the Trust?		X
Other?		X

If the answer to *all* of these questions was no, then the assessment is complete.

If the answer to *any* of the questions was yes, then undertake the following analysis:

	~~Yes~~	~~No~~	~~Comment~~
~~Do policy outcomes and service take-up differ between people with different protected characteristics?~~			
~~What are the key findings of any engagement you have undertaken?~~			
~~If there is a greater effect on one group, is that consistent with the policy aims?~~			
~~If the policy has negative effects on people sharing particular characteristics, what steps can be taken to mitigate these effects?~~			
~~Will the policy deliver practical benefits for certain groups?~~			
~~Does the policy miss opportunities to advance equality of opportunity and foster good relations?~~			
~~Do other policies need to change to enable this policy to be effective?~~			
~~Additional comments~~			

If one or more answers are yes, then the policy may unlawful under the Equality Act 2010 –seek advice from Human Resources (for staff related policies) or the Trust's Equalities Lead (for all other policies).

The Tavistock and Portman NHS Foundation Trust

Report to	Date
Board of Directors	25 September 2018

Service User (Patient & Carer) and Student Constituencies

Executive Summary

At the September Council of Governors meeting it was agreed that two new constituencies should be established within the Trust's constitution.

This paper presents the final agreed terms for ratification by the Board of Directors.

Recommendation to the Board of Directors

The Board of Directors is asked to approve this recommendation.

Trust strategic objectives supported by this paper

Finance and Governance

Author	Responsible Executive Director
Director of Human Resources & Corporate Governance	Director of Human Resources & Corporate Governance

Service User and Student Constituencies

1. Introduction

1.1 At the September 2018 Council of Governors meeting a draft set of insertions to the Trust's constitution were presented.

1.2 The following paper presents to the Board proposed insertions to the constitution.

2. Paragraph Inserts

2.1 The following segments have been developed using the most recent model constitution and examples from other foundation trust constitutions that have similar constituencies.

2.2 Where paragraph numbering is used, this will be incorporated in to the main constitution's numbering order.

New Constituency Descriptions and Eligibility / Exclusion Requirements
1. Service User Constituency 1.1 Members of the Service User Constituency shall be individuals who: 1.1.1 Are service users or service user carers; 1.1.2 are not eligible to become a Member of the Staff Constituency and are not Members of any other Membership Constituency and are not otherwise disqualified for membership; 1.1.3 have made an application to the Trust to become a Member and whose name has been entered on the Register of Members in accordance with paragraph [para]; and 1.1.4 are not less than 14 years of age at the time of their application to become a Member. 1.2 A Service User is an individual whose name is recorded as a service user on the Trust's clinical administration system or other record maintained by the Trust for the purposes of identifying service users of the Trust and who has attended the Trust as a service user within the period of five years immediate prior to that person applying to become a Member. A person ceases to be a Service User when five years have elapsed since his last attendance at the Trust as a service user. 1.3 A Service User Carer is an individual who:

1.3.1 Is not less than 14 years of age at the date of applying to become a member; and

1.3.2 Provides care on a regular basis for a Service User; and

1.3.3 Does not (as set out in Paragraph 3(6) of Schedule 7 to the 2006 Act) provide that care:

1.3.3.1 By virtue of a contract of employment or other contract with any person; or

1.3.3.2 As a volunteer for a voluntary organisation; and

1.3.4 Has either been:

1.3.4.1 Nominated by that Service User as his Service User Carer for the purposes of this paragraph and has been accepted by the Trust as that Service User's Carer for that purpose; or

1.3.4.2 has been accepted by the Trust as a Service User Carer for the purposes of this paragraph where the Service User is under 14 years of age or lacks the legal or mental capacity to nominate that individual as his Service User Carer and the Trust has to the extent that it is reasonably practicable to do so consulted with that Patient as to his wishes and has then agreed to treat that individual as the Service User Carer for the purposes of this paragraph provided the individual has agreed in writing to act in that capacity and he is otherwise qualified in accordance with this paragraph 8.3.4.

1.3.5 An individual shall not be eligible to apply to become a Member as a Service User Carer or to continue as a Member as a Service User Carer if:

1.3.5.1 The Service User has withdrawn his nomination of that individual under 8.3.5.1 as his Service User Carer; or

1.3.5.2 The Service User on whose behalf he is a Service User Carer is ineligible or disqualified from membership under paragraph [XX]; or

1.3.5.3 When paragraph 8.3.4.2 applies the Service User becomes capable of discharging the functions of a Member and attains the age of 14 years of age.

2. Student Constituency

2.1 Members of the Student Constituency shall be individuals who

2.1.1 Are a Student on a Trust education programme that lasts three years or longer;

2.1.2 are not eligible to become a Member of the Staff Constituency and are not Members of any other Membership Constituency and are not otherwise disqualified for membership;

2.1.3 are not less than 14 years of age at the time of their application to become a Member.

2.2 A Student is an individual whose name is recorded as a student on the Trust's student information system or other record maintained by the Trust for the purposes of identifying students of the Trust and who has been registered as student within the last [time period].

2.3 An individual shall not be eligible to apply to become a Member as a Student or to continue as a Member as a Student:

2.3.1 The Student is a Member of some other Membership Constituency or Class of Membership Constituency under this Constitution; or

2.3.2 Three years following the Students completion of an education programme; or

2.3.3 The Student is ineligible or disqualified from membership under paragraph 13.

2.4 An individual who satisfies the criteria for membership of the Service User Constituency, or of a class within that Constituency, may not while membership of that Constituency or class continues, be a Member of any other Constituency or class.

2.5 An individual who satisfies the criteria for membership of the Student Constituency, or of a class within that Constituency, may not while membership of that Constituency or class continues, be a Member of any other Constituency or class.

3. Conclusions of Recommendations

3.1 The Board of Directors are asked to:

3.1.1 Agree the formation of the service user constituency, by vote; and

3.1.2 Agree the formation of the student constituency, by vote.

Craig de Sousa
Director of HR & Corporate Governance

Report to	Date
Board of Directors Meeting	25 September 2018

Annual report on Safe Working hours: Doctor and Dentists in Training

Executive Summary

This report is the second annual report to the Board regarding the systems in the new Junior Doctor contract for monitoring safe working practices.

The Human Resources Department have been using the contract for all new trainee doctors since February 2017. The implementation of the contract in its complete form has been slow; contracts for Core Trainees and Medical / Forensic Psychotherapy are correctly implemented but aspect of the Child and Adolescent Higher Trainees contract related to the non-resident on call rota are yet to completed. This appears to be due to HR personnel changes and a lack of preparedness related to monitoring of the old contract.

Regarding this rota there have also been a number of challenges relating to the number of trainees available to provide out of hours cover resulting in rota gaps. These have now been successfully addressed, achieved through a collaborative approach from HR, senior members of the Psychiatry Discipline, proactive Trainee input, the GOSWH and LNC.

The Board is asked to note the importance of ensuring that the correct systems are in place to implement employment contract successfully and to be mindful of this in relation to any future changes to doctor's employment contracts.

The Board of Directors is asked to confirm whether this paper is accepted as adequate assurance, and where not, whether the Board of Directors is satisfied with the action plans that have been put in place.

Recommendation to the Board of Directors

The Board of Directors is asked to note and discuss this report

Trust strategic objectives supported by this paper

- Quality
- Patient / User Safety
- Patient Experience and Quality

Author	Responsible Executive Director
Guardian of Safe Working Hours	Medical Director

Annual report on Safe Working hours: Doctor and Dentists in Training

1. Introduction

1.1 The role of the GOSWH is to champion safe working hours and monitor compliance with the terms and conditions within the new contract. The GOSWH role is also to ensure the confidence of the junior doctors and that their concerns are addressed.

1.2 The Guardian's report, as required by the Junior Doctor's contract is intended to provide the Board with an evidence based report on the working hours and practices of Junior Doctors within the Trust, confirming safe working practices and highlighting areas of concern.

1.3 This is the second annual report and covers Q1 – Q4 in 2017 – 2018.

1.4 All trainees but one who is about to move on to a consultant post are now on the new contract.

2. High Level Data

2.1

2.1.1 Number of doctors / dentists in training (total): 13

2.1.2 Number of doctors / dentists in training on 2016 TCS (total): 12

2.1.3 Amount of time available in job plan for guardian to do the role: 0.5 PAs per week

2.1.4 Admin support provided to the guardian: For JDF

3. Exception reports (with regard to working hours)

3.1 Exception reports are reports made by trainees to their supervisors and the GOSWH to inform them of times when the trainee has:

- Worked excessive hours (outside of their individualised work schedule)
- Worked through rest breaks
- Missed an educational opportunity due to clinical workload

3.2 Exception reports by quarter:
All but 2 of the exception reports (in Q3) are made by Child and Adolescent Psychiatry Trainees in relation to working patterns overnight.

2017 /18	Q1	Q2	Q3	Q4	Outcome of report: Time off in lieu	Outcome of report: Fines
Total exception reports	**1**	**3**	**5**	**11**	**20**	**0**

3.3 Exception reports are made through computer software called Doctors Rostering System (DRS). DRS has been in use in the trust since October 2017.

3.4 At present trainees working out of hours are reliant on aspects of the contract that stipulate safe working such as not having enough rest during a shift. Where this is impacted an exception report is made.

3.5 An aspect of the contract that has not yet been implemented is around exception reporting out of hours when a trainee has worked more hours than stipulated in the out of hours work schedule.

3.6 Overall clinical and educational supervisors have responded quickly and helpfully to exception reports and enabled trainees to take time off in lieu.

4. Work schedule reviews

4.1 The contract states that generic work schedules should be provided to trainees prior to them starting in post. The work schedules are then personalized between the clinical supervisor and the trainee. The most usual generic work schedule for a full time trainee would be an agreed combination of educational activities and supervised clinical work between 9 – 5pm from Monday to Friday. The provision of work schedules to trainees by HR prior to starting in post does occur but not consistently.

4.2 To date the Child and Adolescent Psychiatry trainees do not have a generic work schedule for the out of hours work they undertake. This is because the number of hours worked out of hours was not known as the old contract have not been monitored for some time. In response to this a diary card exercise was undertaken in May 2018. HR are now working with the results of the diary card exercise to provide data around hours worked out of hours both during the week and at the weekend. This is a significant delay and has impacted on the contract being correctly implemented.

4.3 Once a work schedule is available for the out of hours component of the child and adolescent psychiatry trainee's work exception reports will be made when the hours worked deviate from it. This is likely to result in more exception reporting.

5. Locum bookings – Child and Adolescent Psychiatry Non Resident on call Rota

	Q1	Q2	Q3	Q4
No. of locums requested	**16**	**20**	**27**	**45**
No. of locums provided	**16**	**20**	**26**	**43**
By Whom	**ST's and Staff Grades**	**ST's and Staff Grades**	**ST's and Staff Grades**	**ST's. Staff Grades Consultant Psychiatrists**

5.1 Management of the out of hours Rota has been formalised in recent months due to concerns around viability and payment of work undertaken by the acute trusts. A service

level agreement has been drawn up alongside formalised systems to manage Rota gaps and external locum agency bookings as required.

5.2 There are ongoing gaps in the NROC Rota due to vacancies on the Child and Adolescent Higher training scheme and circumstances of trainees being on maternity leave or unable to provide out of hours cover due to reasonable adjustments. Over the past year numbers have dropped to as low as 1 in 6 for a 1 in 9/10 Rota however they now improving.

6. Vacancies

6.1 Due to the timing of recruitment to training schemes there are often vacancies in the Child and Adolescent Higher training scheme. This is not an issue on the other schemes in the Trust as they have no "on call duties" and the Adolescent service consistently has two core trainees or LTFT equivalents provided from the North London Central Core Psychiatry Training Scheme.

7. Fines

No fines have been levied to date.

8. Junior Doctor Forum

8.1 The role of the JDF is to scrutinize the work of the GOSWH, to provide a forum to review and discuss the contract implementation and decision making around how fines accrued will be spent.

8.2 The first Junior Doctor Forum is held on a quarterly basis It is well attended by the following required members; GOSWH, DME, HR representative and Junior Doctor Representatives from both higher training schemes, Junior doctor rep for the Core trainees. The BMA Industrial relations officer is usually present and more recently the training program director of the Child and Adolescent Higher training scheme has attended which has helped bring different aspects of the training (such as recruitment) and needs of the trainees together.

9. Issues arising & actions taken to resolve issues

9.1.1 The main issue at present is with the NROC rota and HR clarifying the outcome of the diary exercise. Once this has been agreed the contract will be fully implemented and trainees will be paid prospectively for out of hours work undertaken. This aspect is now being actively managed by HR but is yet to be resolved.

9.1.2 Trainees are not yet consistently provided with job plans, work schedules and rotas prior to commencing in post. HR are aware of this and I will be monitoring this once the previous issue has been resolved.

10. Summary

10.1 The contract has now been used by the trust for over a year. In an ideal world all the aspects of the contract; employing the guardian, the junior doctor forums, the job plans and work schedules, hours worked on call, computer reporting system, prospective pay should have all been in place prior to implementation. Over the year major aspects of the contract have been implemented and areas have not yet been are being addressed with the aim for them to implemented imminently.

10.2 During the year, challenges in relation to the NROC rota have presented in relation to numbers available to provide cover and subsequent gaps. This difficulty has presented

intermittently over the years whilst trainees were on the old contract and had been managed primarily within the trainee group. This was not necessarily a satisfactory or long term solution. When the rota gap issues presented in mid 2017 the impact of the imposition of the contract and junior doctors feeling distressed and the new structures of the Guardian, exception reporting and the junior doctor forum resulted in the impact of the gaps being more openly discussed by trainees in the JDF and quantified using exception reporting. This allowed the scale of the problem to be easily understood. The Trust has worked to find long term solution to the issue of gaps in the NROC rota which has had a positive impact on the experience of the child and adolescent psychiatry trainees in terms of wellbeing.

11. Questions for consideration - None at present.

The report is being submitted to the Board for approval and to inform them of the progress on the implentation of the new junior doctor contract by the Trust.

Sheva Habel
Consultant Child and Adolescent Psychiatrist
Guardian of Safe Working Hour

Report to	Board of Directors
Report from	Clinical Quality, Safety and Governance Committee (CQSGC) for Q1 2018/19

Key items to note

The CQSG Committee met on 5th September 2018 to consider the Q1 reports from the following work streams:

- **Information Governance**
- **Patient Safety & Clinical Risk**
- **Clinical Quality and Patient Experience**
- **Corporate Governance and Risk**

All work streams actions are on track and where issues have been identified there are clear robust action plans in place to address them.

Information Governance Update:

- The new data security and cyber security toolkit platform has been launched with greater focus on technicalities rather than procedures and a number of the standards are no longer mandatory, but which are now embedded in day to day practice. This work stream report format will be reviewed and updated in line with the latest cyber security requirements for Q2.

There were no specific IG risks identified in Q1 and the work stream was rated green.

Patient Safety & Clinical Risk Update:

- Unfortunately, there were two patient deaths in Q1, and these have been appropriately investigated and externally reported. The number of complaints for Q1 was 44, 37 from CYAF and 7 from AFS, which is a decrease from previous quarters and additional staff have been recruited to ensure complaints are responded to in the correct time frame as per the complaints procedures.
- In Q1 there were 91 children safeguarding alerts; 32 Section 17 referrals, 42 Section 47 referrals and 17 SEN referrals. Documenting this specific safeguarding supervision remains as issue but work is in hand to increase this across the clinical services and a positive increase is expected in Q2. It has also been identified that there is a gap in the provision of adult safeguarding training for level 2/3 and this has now been addressed by increasing the time the adult safeguarding lead has and a new training programme is being delivered to relevant staff.
- It was agreed the CQSGC would focus on the learning from events

There were no specific patient safety risks identified in Q1 and the work stream was rated amber.

Clinical Quality and Patient Experience Update:
The Clinical Quality Strategy is on track for Q1 and making good progress in the following areas:

- There has been a huge increase in the number of physical health forms being completed by clinicians and this is expected to increase further going forward.
- It has been acknowledged that there is a strain on the system between GIDS and GIC in relation to the transfer of patients from children services to adult, and also the lengthy waiting times for this patient group, and the service have introduced a new PALS officer to aid the service in managing this difficult treatment transition and extended waiting times.
- Data collection remains an item that needs addressing and although there has been a positive increase in the data collection of equalities information, and we have achieved the 85% target in many areas, work continues with teams to increase this across the board.
- Our clinical audit and quality improvement work continues alongside the introduction of the Quality Portal, but has been hampered by the lack of a clinical audit officer, who has now been recruited and is due to begin on 2nd October 2018.

There were no specific quality/patient related risks identified in Q1 and the work stream was rated amber.

Corporate Governance and Risk Update:

- There was an issue with estates compliance in Q1 which is now monitored by the Premises Assurance Model (PAM), in relation to fire evacuations and training which have now been addressed with a fire evacuation and training programme put in place.
- From this year nurses are now required to undertake mandatory BLS training every 3 years and this will be booked as soon as the scheduling project releases rooms.
- Local business continuity plans (BCPs) are now in place for most teams and work is underway to ensure all the remaining teams have a local BCP in place as soon as possible.

There were no specific corporate governance related risks identified in Q1 and the work stream was rated amber.

This report is for information only and there were no exceptional risks to report to the Board.

Actions required of the Board of Directors

For noting and discussion.

Report from	Dinesh Sinha, Medical Director
Report author	Irene Henderson
Date of next meeting	11am – 1pm, Wednesday, 7th November 2018

Report to	Board of Directors
Report from	Equality, Diversity and Inclusions Committee – 13 September 2018

Key items to note

The EDI committee met in September conducting its normal business obtaining assurance and updates from the sub-groups. The committee particularly noted the following.

Diversity champions
That the director of quality and patient experience has identified revenue funding to increase the race diversity champion's sessional time commitment from half a day to a full day.

That at the November meeting the committee will be considering a role description for an LGBTI champion.

Disability work
A comprehensive report was received from the LifeSpan team outlining a survey and assessment the service has undertaken across the trust assessing access levels for service users with autistic spectrum conditions.

The committee noted that in April 2019 a new NHS England standard will be introduced called the Workforce Disability Standard (WDES) which will adopt similar reporting requirements to the Workforce Race Equality Standard (WRES).

LGBTQI+
A number of training sessions for clinical staff around appropriate pronoun use has been delivered. The director of quality and patient experience noted that further training on conversations about sexuality in clinical settings will be rolled out in the coming months.

Equality, diversity and inclusion policy
A draft policy was considered by the committee. It was agreed that further engagement ought to happen across the Trust and a final version presented to the November Board for approval.

Actions required of the Board of Directors

The Board of Directors is asked to note this paper.

Report from	Professor Dinesh Bhugra
Report author	Craig de Sousa, Director of HR & Corporate Governance
Date of next meeting	15 November 2018

The Tavistock and Portman
NHS Foundation Trust

AGENDA

BOARD OF DIRECTORS – PART ONE
MEETING HELD IN PUBLIC
TUESDAY, 25 SEPTEMBER 2018, 1330 – 1630
LECTURE THEATRE. THE TAVISTOCK CENTRE, 120 BELSIZE LANE LONDON, NW3 5BA

		Presenter	Timing	Paper No
1 Patient Experience Stories and Service Reports				
1.1	Patient Story	Family – CYAF Complex Needs	1.30pm	Verbal
1.2	Service Line Report – CYAF Complex Needs	Associate Clinical Director – CYAF Complex Needs	2.00pm	1
1.3	Service Line Report Psychoanalytic Applied Portfolio	Portfolio Manager	2.10pm	2
2 Administrative Matters				
2.1	Chair's opening remarks and apologies	Chair	2.30pm	Verbal
2.2	Board members' declarations of interests	Chair		Verbal
2.3	Minutes of the meeting held on 24 July 2018	Chair		3
2.4	Action log and matters arising	Chair		Verbal
3 Operational Items				
3.1	Chair and Non-Executives' Reports	Chair and Non-Executive Directors	2.40pm	Verbal
3.2	Chief Executive Report	Chief Executive	2.50pm	4
3.3	Finance and Performance Report	Deputy Chief Executive / Director of Finance	3.05pm	5
4 Items for decision or approval				
4.1	Procurement Strategy	Deputy Chief Executive / Director of Finance	3.15pm	6
4.2	Procurement Policy	Deputy Chief Executive / Director of Finance	3.20pm	7
4.3	Health and Safety Policy	Deputy Chief Executive / Director of Finance	3.25pm	8
4.4	Fire Safety Policy	Deputy Chief Executive / Director of Finance	3.30pm	9
4.5	Water Safety Policy	Deputy Chief Executive / Director of Finance	3.35pm	10

		Presenter	Timing	Paper No
4.6	New Constituencies	Director of HR & Corporate Governance	3.40pm	11
5 Items for discussion				
5.1	Guardian of Safe Working Hours	Medical Director & Guardian of Safe Working	3.45pm	12
6 Board Committee Reports				
6.1	Clinical, Quality, Safety and Governance Committee	Medical Director	3.55pm	13
6.2	Equality, Diversity and Inclusion Committee	Deputy Chair	4.15pm	14
7 Any other business				
8 Date of Next Meeting				
	27 November 2018 – 1400 – 1700 – The Lecture Theatre, Tavistock Centre, Belsize Lane, London, NW3 5BA			