The Tavistock and Portman NHS
NHS Foundation Trust

Board of Directors Part One

Agenda and papers
of a meeting to be held in public

2.00pm–4.30pm
Tuesday 22nd May 2018

Lecture Theatre, 5th Floor
Tavistock Centre,
120 Belsize Lane,
London, NW3 5BA

BOARD OF DIRECTORS (PART 1)

Meeting in public
Tuesday 22nd May 2018, 2.00 – 4.30pm
Lecture Theatre, Tavistock Centre, 120 Belsize Lane, London NW3 5BA

AGENDA

PRELIMINARIES				
1.	**Chair's Opening Remarks** Prof Paul Burstow, Trust Chair		Verbal	-
2.	**Apologies for absence and declarations of interest** Prof Paul Burstow, Trust Chair	To note	Verbal	-
3.	**Minutes of the previous meeting** Prof Paul Burstow, Trust Chair	To approve	Enc.	p.1
3a.	**Outstanding Actions** Prof Paul Burstow, Trust Chair	To note	Verbal	-
4.	**Matters arising** Prof Paul Burstow, Trust Chair	To note	Verbal	-
REPORTS				
5.	**Service Line Report – Adult Forensic Service – Complex Needs** Dr Andrew Williams, Consultant Psychiatrist, Associate Clinical Director	To note	Late	-
6.	**Service Line Report – Camden CAMHS** Dr Andy Weiner, Consultant C&A Psychiatrist, Associate Clinical Director	To note	Verbal	-
7.	**Trust Chair's and Non-Executive Directors' Reports** Prof Paul Burstow, Trust Chair	To note	Verbal	-
8.	**Chief Executive's Report Framework** Mr Paul Jenkins, Chief Executive	To discuss	Enc.	p.10
9.	**Board Assurance Framework Report** Mr Terry Noys, Deputy CEO and Finance Director	To approve	Enc.	p.14
10.	**Finance & Performance Report** Mr Terry Noys, Deputy CEO and Finance Director	To note	Enc.	p.45
11.	**Annual Report and Accounts** **a. Annual Report** **b. Annual Accounts** **c. Quality Accounts** **d. External Audit Report** **e. Letters of Representation** Mr Craig de Sousa, Director of HR & Corporate Governance Mr Terry Noys, Deputy CEO and Finance Director Ms Marion Shipman, Associate Director Quality	To approve	To be circulated separately	-

12.	**Annual Self Certifications** Mr Craig de Sousa, Director of HR & Corporate Governance	To approve	Enc.	p.51
13.	**Quality** **a. Quality Performance Dashboard** Ms Louise Lyon, Director of Quality and Patient Experience and Ms Marion Shipman, Associate Director of Quality and Governance **b. CQSG Report and Committee Minutes Q4** Ms Louise Lyon, Director of Quality and Patient Experience **c. Update on the Quality Improvement Programme** Ms Louise Lyon, Director of Quality and Patient Experience	To note To discuss To Note	Enc. Enc. Enc.	p.56 p.75 p.87
14.	**Waiting Times Report** Ms Louise Lyon, Director of Quality and Patient Experience	To note	Enc.	p.95
15.	**Clinical Directorates' Quality Impact Assessments** Ms Louise Lyon, Director of Quality and Patient Experience	To note	Enc.	p.108
16.	**Training and Education Report** Mr Brian Rock, Director of Education and Training / Dean of Post Graduate Studies	To note	Verbal	-
17.	**Organisational Development and People Strategy Report** Mr Craig de Sousa, Director of HR & Corporate Governance	To note	Enc.	p.117
18.	**Gifts, Hospitality and Conflicts Policy** Mr Craig de Sousa, Director of HR & Corporate Governance	To approve	Enc.	p.129
19.	**Audit Committee Terms of Reference** Mr Terry Noys, Deputy CEO and Finance Director	To approve	Enc.	p.164
CLOSE				
20.	**Notice of Future Meetings:** • 12th June 2018, **Leadership Group Conference** 2.00 – 5.00pm, Lecture Theatre • 26th June 2018, **Board Seminar**, 2.00 – 5.00pm, Lecture Theatre • 24th July 2018, **Board of Directors' Meeting** 2.00 – 5.00pm, Lecture Theatre			

Board of Directors Meeting Minutes (Part One)
Tuesday 27th March 2018, 2.00 – 4.30pm

Present:			
Prof Paul Burstow Trust Chair	Prof Dinesh Bhugra NED	Dr Chris Caldwell Nursing Director	Ms Helen Farrow NED
Ms Jane Gizbert NED	Dr Sally Hodges Director of CYAF	Mr David Holt NED, SID, Audit Chair	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 Rob Senior Medical Director
Dr Julian Stern Director of AFS			
Attendees:			
Ms Terri Burns Trust Company Secretary	Mr George Wilkinson Governor	Mr Derek Draper Governor	Sarah Mountain HR Business Partner (item 11)
Apologies:			
Dr Debbie Colson NED			

Actions

AP	Item	Action to be taken	Resp	By
1	3	Minor amendments to be made to minutes of the previous meeting	TB	Immed.
2	5	Equalities Committee to review learning opportunities from difficult conversations with students re race and culture	DB	May 18
3	5	Task & Finish Group to provide workforce data to Education & Training Committee	TN	May 18
4	8	Mr Jenkins to amend his report to reflect Trust commitment to spirit of Modern Slavery Act	PJ	May 18
5	11	Equality & Diversity Committee to seek further assurance re actions to address gender disparity in clinical excellence awards	DB	May 18
6	14	Draw together the quality priorities of the Trust in a simplified format	LL	May 18

1. Chair's Opening Remarks

1.1 Prof Burstow welcomed everyone to the meeting.

2. Apologies for Absence and declarations of interest

2.1 Apologies were noted as above.

2.2 No further declarations of interest were made.

3. Minutes of the Previous Meeting

3.1 AP The minutes of the previous meeting were agreed as a true and accurate record, subject to minor amendments.

3a. Outstanding Actions

3.2 The action log was noted.

3.3 Outstanding action 1 would be covered under part two of the meeting.

3.4 Outstanding action 2 would be complete in July 2018.

3.5 Outstanding action 3 was noted as complete.

4. Matters Arising

4.1 No matters arising were reported.

5. Service Line Report – Education & Training - Systemic

5.1 Prof Burstow noted that there had been a presentation by Ms Ayo and a student during the Board of Director's lunch. He queried whether there was a way in which staff could be encouraged to take up more training opportunities. Research into pricing strategies of other providers should also be considered.

5.2 Mr Rock thanked Ms Ayo for an excellent report. The structure of the service had bene based around existing portfolios. They had been mindful of ensuring margins were acceptable and the Trust remained competitive. There had been a trade-off between attracting larger groups and the level of staff needed. Mr Rock noted that there were often requests for lower fees, however discounts already existed for staff. The Trust had also taken a decision not to enter into a price war with competitors.

5.3 AP Prof Burstow requested that the Equalities Committee review the learning opportunities from difficult conversations which had taken place in relation to race and culture. He also noted that succession and workforce planning would be an ideal discussion topic for the AP Education & Training Committee. Mr Jenkins agreed that the task and finish group would provide the relevant data for this.

5.4 The Board noted the report.

6. Service Line Report – Gender Identity Development Service (GIDS)

6.1 Prof Burstow noted that the GIDS Service Line Report had been discussed at the April Board Seminar. Discussions with NHS England around service specification were ongoing.

6.2 The Board noted the report.

7. Trust Chair's & NED's Report

7.1 Ms Farrow reported that she had visited the GIC service and met with some of the clinicians. They had discussed the future of the service and had confidence in the model. They had raised some concerns over NHS England funding gaps. There were also some concerns over the waiting list length with a group of high risk patients. Taking staff away from clinical work for training, while necessary, also had a knock on effect on productivity.

7.2 Prof Burstow reported that he had had a number of meetings and discussions with the mental health in schools Green Paper team. The material supplied by the Trust had been well received. Prof Burstow reported that he had attended the STP advisory board, the last of which had focussed on immediate operational challenges. However there were no defined metrics on health inequalities. He had also had a discussion with Ms Angela Greatley in relation to the Well Led framework, which had been very helpful.

8. Chief Executive's Report

8.1 Mr Jenkins reported that the feedback from the staff survey had been received at the April Board Seminar. It had now been published and showed a great deal to be proud of. There were marked improvements in scores, particularly in relation to bullying and harassment. However, there were some concerns from BAME staff regarding inequality of opportunity.
AP An action plan would be brought to the Board in May.

8.2 Mr Jenkins reported that Dr Senior would be stepping down as Medical Director in the summer, however he would not be leaving the Trust. A recruitment process was underway, with interviews planned for May.

8.3 The Trust had successfully bid to run a Child House, for victims of sexual abuse or exploitation. It would be a partnership with UCLH and provided via the NSPCC.

8.4 A systematic approach to service visits was being implemented. A calendar of visit opportunities would be circulated to Board members.

8.5 Mr Jenkins stated that the Trust had been actively involved with discussion around NICE guidelines on depression. A broader approach was being encouraged. Ms Gizbert noted that NICE were aware of the concerns expressed and would be holding a stakeholder meeting on 27th April. There would be an opportunity to discuss the methodology used. Prof Burstow noted that there had not been any refresh of input from people with lived experience in developing the new guidelines.

8.6 Mr Holt queried the lack of statement on the Modern Slavery Act. Although the Trust did not meet the private income requirements to make a statement of compliance, he felt that the Trust's commitment to the spirit of the Act should be reflected somehow. Mr Jenkins stated that the statement of compliance was a formal mechanism of words, which the Trust had not carried out the compliance work to make and was not required. However, it would be appropriate to amend the report to reflect the Trust's position. Mr Noys noted that evidence of supply chain work would be required to make a formal statement, which the Trust did not
AP have the resources to compile. Mr Jenkins agreed to amend his report to reflect the Trust commitment to the spirit of the Modern Slavery Act. The Audit Committee would review this on an ongoing basis moving forwards.

8.7 The Board noted the report.

9. Finance & Performance Report

9.1 Mr Noys reported that the year to date net surplus was £1.027m against an income of £46m. Income was in line with the Budget, however the surplus was £143k adverse to the Budget due to restructuring costs and depreciation. The surplus was £77k higher than the Control Total for the year, which was still expected to be met.

9.2 Non-staff costs were adverse to the Budget in all directorates, which were compensated by a positive variance in staff costs. In Education & Training there was over expenditure on visiting lecturers. In CYAF there was additional expenditure in GIDS. There was over Budget expenditure in Research, compensated for by additional income. IM&T overspend reflected an increase in cost of Microsoft licences.

9.3 Mr Noys noted that he was hoping to address the low usage of the electronic purchase order system in 2018/19.

9.4 Mr Noys also reported that cash flow balance had increased by £1.117m to February. However £1m of this represented the drawdown of the ITFF loan. During year to date, the Trust generated operating cash flow of £3m, being net surplus plus depreciation plus the change in working capital. £0.4m was used to pay PDC and £2.5m used to fund capital expenditure, leaving a £0.1m increase in cash.

9.5 The Board noted the report.

10. a. Annual Strategic Plan

10.1 Mr Noys reported that the discussion at the January Board meeting had now been incorporated. Ms Gizbert noted that there was no action timetable corresponding to staff wellbeing and the External Affairs Strategy. It would be helpful for accountability purposes to see some milestones. Prof Burstow noted that deep dives throughout the year would also be useful to review opportunities and investment potential.

10.2 Mr Jenkins noted that the plan had been widely circulated with teams and would be cascaded through to individual objective setting.

10.3 The Board approved the Plan.

b. Operational Plan

10.4 Mr Noys reported that the Plan had been submitted to NHS Improvement. The only change to note was the inclusion of figures not previously available. Ms Gizbert queried whether the timeline for having electronic risk management in place was realistic. Mr Noys confirmed that it would be live for Gloucester House after Easter.

10.5 Mr Jenkins noted that the feedback from NHS Improvement had been quite generic. More detail on how financial targets would be met had been requested. Some new income was still to be secured so could not yet be confirmed.

10.6 Ms Gizbert asked what work was taking place with NHS England in relation to the media burden on GIDS. Dr Senior noted that NHS England were aware of the pressures faced and were supporting the Trust to address concerns. Dr Hodges also noted, that as the only provider, NHS England were keen to work closely with the Trust.

10.7 Ms Farrow asked how the new pay award would be managed. Mr Noys stated that 1% would be carried by the Trust, as previously agreed. There was no confirmed decision for the remainder, however it would be funded centrally by the government.

10.8 The Board approved the Plan.

c. Capex and Cash Flow

10.9 Mr Noys reported that the Budget net surplus was £1.034m, therefore an underlying net surplus of £331k. Staff costs were understated due to a miscalculation of expected depreciation, which had been reported to the Board previously. The Trust contract with NHS England for specialised services had been agreed, with an increase in income.

10.10 For 2018/19 the Trust was budgeting positive cash balances throughout. If the £4m ITFF facility was taken out of the cash flow, then the balances would not be as healthy. While not critical, cash levels were lower than the Trust had previously enjoyed. This was due to outgoings, in particular capital expenditure. The capital budget had therefore been restricted. Mr Noys noted that further pressures were likely to come from apprenticeships and the digital academy, as well as estates and facilities expenditure.

10.11 Prof Burstow asked how the Trust compared with other local providers. Mr Noys was unable to give a comparison, although Mr Holt noted that many acute trusts had large legacy loans in place and had to borrow in order to fund day to day expenditure.

10.12 Mr Noys requested permission from the Board to draw down the second tranche of the ITFF loan facility, although this would not be utilised without further Board approval. Mr Holt queried what the impact of the cross funding was, given the £3m draw down against relocation had not been expected to be spent on the relocation project. Mr Noys noted that £2m was not expected to be spent until September, so there would be a much clearer picture of next steps in terms of relocation by that point. There would have been £2.5m spent and the ITFF loan would fund that. The remaining £1.5m would only be spent if the Board gave further approval.

10.13 The Board approved the request to draw down the second tranche of the ITFF loan facility.

11. Gender Pay Gap Analysis Report

11.1 Ms Mountain reported that the Trust was required to publish against six reporting requirements. There was a small gender pay gap within the Trust. There were some differences in clinical excellence awards, with 57% or male consultant and 47% of female consultants being awarded them. These figures related to a small number of individuals, with the disparity coming from the amounts awarded. Dr Senior noted that it was more difficult to accumulate the various levels of clinical excellence awards when working part time, which many of the Trust's female consultants did. The HR team were looking at how to address this historical difference.

11.2 Ms Gizbert asked how the Trust's pay gap compared to other trusts. Ms Mountain stated that the Trust had a significantly smaller gap than many of those who had so far reported.

11.3 AP Prof Burstow noted that the Board required assurance and actions to address the disparity in the clinical excellence awards and requested that the Equality & Diversity Committee discuss the issue further.

11.4 The Board noted the report.

12. Operational Risk Register

12.1 Mr Noys presented the report.

12.2 Mr Holt reported that the Audit Committee had noted the need for teams to better understand what operational risks should look like and the level they should be at. He suggested training sessions and having experienced staff in team meetings to help guide discussions on risk. Mr Jenkins stated that appropriate policies and procedures were in place and consultation with staff was taking place to identify where barriers to reporting may be. The Trust was doing the right things generally, however there was always room to improve.

12.3 The Board noted the report.

13. Board Assurance Framework including Risk Appetite

13.1 Mr Noys reported that the report now included a section on risk appetite as requested by the Board previously. Appendices 1 and 2 would be further modified to provide greater context. Financial consequences would also be updated as well. Mr Noys drew the Board's attention to the increase in the risk assessment associated with relocation and the addition of risk 16 relating to data.

13.2 Ms Farrow asked what the thinking behind the change to risk in relation to management capacity was. Mr Jenkins stated that it reflected a better definition of the risk against the agenda of business development growth and investment made. However this was still an area that required Board oversight.

13.3 Mr Holt noted that the report looked much better in relation to risk appetite. However greater detail was needed on expected timescales for meeting target scores. This would allow the Board to better hold risk owners to account. Mr Holt also informed the Board that he had requested that compliance with GDPR be reported to the May Audit Committee, to allow time for any updates needed prior to the May Board meeting. The deadline for reporting was 25th May.

13.4 Prof Burstow asked about the delay in third party assessment against risk 14. Ms Lyon stated that the data quality had changed the scope of the assessment, however it would still be carried out very soon. It had been discussed at the Executive Management Team meeting and capability to fulfil contract was being reviewed. Mr Jenkins noted that the project related to assurance of consistency of process rather than production of data itself.

13.5 Ms Caldwell noted that there was a historical inaccuracy against risk five, which was previously rated as 12 and had reduced to 10.

13.6 The Board approved the risk appetite statement - The Trust recognises that its long term sustainability depends on the delivery of its strategic objectives and its relationships with its patients, the public and strategic partners. As such, the Trust will not accept risks that could materially impact on patient or staff safety. It will also not accept any risks that could jeopardise its regulatory compliance or have a significant impact upon its reputation. However, the Trust has a greater appetite to accept risks in relation to its pursuance of innovation and the challenging of current working practices in order to realise positive benefits.

13.7 The Board approved the levels of risk appetite against each main strategic aim.

13.8 The Board approved the annual process of risk appetite review and approval by the Board.

14. Quality

a. Mortality Review & Serious Incidents Report

14.1 Dr Senior reported that the Trust was required to produce a mortality review. He noted that Southern Health had been given a substantial fine the previous day. The Trust had very few deaths and always investigated using root cause analysis. It was rare to find that the Trust could have prevented a death. There were no deaths to report to the Board on this occasion.

14.2 Dr Senior noted that the Trust would be paying particular attention to gender identity services, due to the inherent complexity of them. Dr Stern noted that a learning from deaths exercise had been held previously and was very helpful. This would be a recurring event. Efforts were ongoing to coordinate between mental health trusts in order to improve suicide prevention.

14.3 The Board noted the report.

b. Draft Annual Governance Report

14.4 Mr Jenkins reported that the Annual Governance Statement followed the usual proscribed format and would be included in the Annual Report. Mr Holt noted that the Trust would improve its process over time, in order for the Board to see the key messages included in the report. Ms Lyon noted that it was helpful for the Board to see the Governance Statement in relation to the Well Led review.

14.5 Ms Farrow noted that reference should be made to Charing Cross to give a full picture, even though the Trust had not been responsible for the service at the time of its inspection. Dr Hodges also noted that Gloucester House had been inspected by Ofsted.

14.6 Mr Holt stated that the Trust should review what other trusts had stated in relation to GDPR, and make a measured statement. The Head of Internal Audit Opinion should also be monitored closely.

14.7 Prof Burstow requested that Board members make comments via email or directly to executive leads.

14.8 The Board noted the report.

c. Quality Accounts Update

14.9 Ms Lyon reported that the Trust was as prepare as possible. The data would not be fully ready until year end. Data validation forms had been sent and were due to be returned on 5th April. An audit of local indicators would be taking place in April.

14.10 The Board noted the report.

d. Quality Priorities for 2018/19

14.11 Ms Lyon reported that the priorities had been considered previously by the Board. An extensive consultation process had been carried out. There had been input from patients, quality stakeholder groups, directorates and commissioners. The Clinical Quality Strategy had been reviewed and the top five priorities garnered from that process. They were being brought together with the quality improvement programme. The quality improvement methodology would be used, now that more staff had bene trained to use it. The physical indicators focused on sleep. Waiting times were being led by adult complex needs. The team's involvement in care planning had some very good practice, with consideration being given to how it could be rolled out across the Trust. Other priorities were areas of concern for the CQC and commissioners.

14.12 Dr Hodges reported that high risk patients were being flagged by the CYAF team, so suggested that they be involved in that priority area. Dr Stern noted that the adult teams were fully on board with the process.

14.13 Mr Holt Noted that it would be helpful to have all of the quality priorities of the Trust amalgamated, to enable the Board to see where they sat in relation to other things. A
AP hierarchy would help to give a sense of cohesion. Ms Lyon agreed to try to draw together the quality priorities of the Trust in a simplified format.

14.14 The Board approved the report.

15. Training and Education Report

15.1 Mr Rock reported that the team were beginning to think about student recruitment. There had been a 20% increase in applications from the same time last year. The first task and finish group had taken place to consider how to address the financial challenges faced. A 3.3% budget reduction was required to close the gap. The timeline would be tight. Mr Jenkins noted that he had held meetings with portfolio managers, whose input would be vital. Wider group meetings would be held in April.

15.2 International developments were progressing. There would be a senior leadership delegation visit from China in June. Collaborative partners would be involved. The international plan would be taken to the May Education and Training Committee.

15.3 The graduation ceremony had been held and was an enjoyable event. Honorary doctorate recipients were well chosen and spoke enthusiastically on the day.

15.4 The Board noted the report.

16. Research and Development Strategy Update

16.1 Dr Senior reported that Dr Colson had agreed to chair the research committee. It had been a busy period, with a great deal of politics in the research sector. A great deal of child and adolescent mental health research was being undertaken. The finances were extremely complex, with lots of different sources and caveats attached. Two research psychologists from the Trust had been successful in gaining research doctorates elsewhere. Dr Senior noted that the Trust did well in relation to research, considering the scale of the Trust. A wide range of topics were covered.

16.2 Research capability funding was being capped at £4m for all organisations. This would be a significant issue for larger trusts who had greater reliance on large NHS Improvement grants for their research.

16.3 The Board noted the report.

17. Gifts, Hospitality and Conflicts Policy

17.1 The Gifts, Hospitality and Conflicts Policy would be considered at the next meeting of the Board of Directors.

18. Notice of future meetings

20.1 The next meeting of the Board of Directors was noted as 22nd May 2018, 2.00-5.00pm, Lecture Theatre, 120 Belsize Lane.

19. Any Other Business

21.1 No other business was raised.

The Tavistock and Portman NHS
NHS Foundation Trust

Board of Directors: May 2018– Part 1

Item : 8

Title : Chief Executive's Report

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

For : Discussion

From : Chief Executive

Chief Executive's Report

1. Medical Director

1.1 Following a rigorous recruitment process, which involved a stakeholder panel and a final selection interview, we have selected Dr Dinesh Sinha who will be starting with us around the middle of August.

1.2 Dinesh will be joining us from East London NHS Foundation Trust (ELFT) where he is currently their Associate Medical Director for Adult Psychiatry. He has extensive clinical and leadership experience having been a Consultant Psychiatrist in Psychotherapy and Head of Service in his most recent appointment. In addition to this, he has also held seats on various Clinical Commissioning Groups' (CCG) Governing Bodies and is currently the Independent Clinical Member at Ashford CCG.

1.3 On the lead up to his start date Dinesh will be attending some of our key meetings and will be visible within the organisation.

2. Student Mental Health

2.1 On May 10th Universities UK published the output of a Task and Finish Group on student mental health which I have chaired. The report "Minding our Futures" set out the challenges relating to student mental health and ways in which NHS and University services could work more seamlessly together. The report attracted a significant level of media attention and some interest from NHS England.

2.2 The next stages of the work will involve the development of a number of "exemplar areas" where Universities and NHS services have committed to coming together to develop new approaches to integrating University and NHS provision for students. I am hopeful that North London will be able to be one of these areas.

3. Patient and Public Involvement Strategy

3.1 The Patient and Public Involvement (PPI) team are engaged in developing a revised strategy under the leadership of the newly - appointed PPI Team manager, Claire Kent. A draft strategy was presented to the Management Team in May 2018. The strategy is an update to the last PPI review of 2014 and has been produced by the team based on their learning and experience. They have considered

and included the Trust's patients' feedback and views and refer to National Service User Involvement Standards (4PI).

3.2 Guiding principles informing the strategy include the recognition that patient involvement is a relational activity. Flyers and posters advertising involvement opportunities have limited effectiveness, whereas a recommendation from a clinician, who has explored and considered their patient's potential interest in involvement, is most effective in sustaining interest and engagement in the work. The purpose of developing the strategy at this juncture is to reflect on the substantial involvement work already undertaken in the Trust, to share a vision of embedded involvement and to emphasise the need for this to be recognised and owned by all. The strategy aims to clarify the part the PPI team can play in supporting our moving towards more empowered patient participation in our clinical and education and training services. Next steps in taking the strategy forward include setting out the way in which PPI will support the achievement of Trust objectives and play a central role in our developing quality improvement programme.

4. CQC

4.1 CQC have confirmed that the Trust's Well Led Inspection will take place between 17-19th September.

4.2 In preparation for this, we submitted on 10th May a response to CQC's data request.

4.3 On 14th May CQC are commencing a series of focus group meetings with Trust staff. Later in the summer they will also visit a number of services, to be confirmed at a later stage.

4.4 They will also be interviewing patients carers and families in groups or over the phone and they will be inviting patients to comment on our services through using comment boxes which will be placed in waiting rooms across the Trust.

5. QAA and Institutional Reviews

5.1 At the beginning of May we received our annual monitoring visit from the HEE regulator, QAA. We expect to receive the feedback from the visit in June.

5.2 We have also been subject to Institutional Reviews from our University Partners at the Universities of Essex and East London. These have

generally gone well but with some recommendations for improvement including in relation to improving data quality.

6. NICE Guidelines on Depression

6.1 As we have previously flagged up to the Board we, along with other stakeholders, have raised a number of concerns with the draft guidelines on depression developed by NICE. As a result of engagement with them on this, NICE have agreed to open second consultation on the guidelines with responses due by 12th June.

7. Forensic CAMHS and Practice Supervisors

7.1 We have now had the formal confirmation of contract awards for:

- Forensic CAMHS service for North East and North Central London
- National Practice Supervisor programme

8. GDPR

8.1 25th May sees the implementation of the General Data Protection Regulation ("GDPR"). A paper, assessing our state of readiness, is one the agenda. In general, we are well placed for the introduction of the new regulations but there are a number of residual risks we are continuing to manage.

Paul Jenkins
Chief Executive
15th May 2018

The Tavistock and Portman NHS
NHS Foundation Trust

Board of Directors: May 2018

Item : 9

Title : Board Assurance Framework

Summary :

The Assurance Framework identifies key risks to achieving the Trust's strategic objectives as set out in the Current Annual Strategic Plan.

Risk 12 'Failure to comply with regulatory requirements' has increased from 4 to 9 from the previous quarter owing to some concerns identified on Estates compliance An action plan is being prepared for the Board.

Risk 8, 'Unable to agree or fund relocation/ redevelopment plans' and Risk 15, 'Longer term risk to the sustainability of the Trust' remain our top two risks at 16 and 15 respectively.

The BAF is brought to the Board in May as part of the quarterly reporting timings, having been updated and reviewed again by the Executive Management Team on 15th May 2018. Risks 8 and 15 were discussed in detail and actions reviewed.

The risks link to Trust's 2018/19 strategic objectives and have been reassessed to ensure that they are the correct risks.

Amendments to individual risks are highlighted in red.

For : Approval

From : Deputy Chief Executive & Finance Director;
Associate Director of Quality and Governance

BOARD ASSURANCFRAMEWORK

1. INTRODUCTION

1.1. The Board Assurance Framework ("BAF") seeks to identify the key risks that could prevent the Trust from achieving its strategic objectives.

1.2. The following Framework and approach are in line with the Risk Management Policy and Strategy, and Risk Management Procedure. The approach is outlined below.

1.3 The BAF Heatmap presents all BAF risks on a single page as an overview of the current position. The direction of travel for each risk from last assessment is also included.

1.4 Ongoing work is continuing, reviewing individual risks against agreed risk appetites.

1.5 The new electronic risk management system is not due to be 'live' until July. It is likely that a new look BAF will not be implemented until the autumn.

2. APPROACH TO RISK SCORING

2.1. Significant risks are identified by the Executive Management Team after discussion with each other, with their direct reports and with the Board. In identifying significant risks, various factors are taken into account including, amongst other factors, both the local and general environments for health and social care; the Trust's current and future operational performance; the current and future availability of resources.

2.2. Each significant risk is then given a score for the:

2.2.1. **initial risk:** the risk level assessed at the time of initial identification.

2.2.2. **current risk:** the risk at a point in time, taking in account completed actions / mitigating factors.

2.2.3. **target risk:** this is the level of risk which the Board is expected / willing to accept after all necessary planned measures have been applied.

2.3. Scoring is based on the Trust's Risk Management Policy, as follows:

1 – 4	Green
5 – 8	Yellow
9 – 12	Amber
15 – 25	Red

2.4. The risks have been numbered for easier referencing (although the number does not imply a higher or lower level of inherent or residual risk).

2.5. Assurances are defined as (+) or (-) as per internal audit recommendations and controls map against at least one source of assurance (evidence).

2.6. Directors have reviewed and updated their sections of the BAF including updating the **current risk** scores for each risk and updating the overarching strategic objective(s) affected by the risk.

2.7. The BAF has been reviewed by the Executive Management Team.

3. RISK SUMMARY

3.1. Risk 12, 'Failure to comply with regulatory requirements' has increased from 4 to 9 from the previous quarter owing to some concerns identified on Estates compliance An action plan is being prepared for the Board.

3.2. Risk 8, 'Unable to agree or fund relocation/ redevelopment plans' and Risk 15, 'Longer term risk to the sustainability of the Trust' remain our top two risks at 16 and 15 respectively.

3.3. All other risks levels have remained unchanged from the previous quarter.

4. RISK APPETITE

4.1 Risk Appetite Statement:

'The Trust recognises that its long term sustainability depends on the delivery of its strategic objectives and its relationships with its patients, the public and strategic partners. As such, the Trust will not accept risks that could materially impact on patient or staff safety. It will also not accept any risks that could jeopardise its regulatory compliance or have a significant impact upon its reputation. However, the Trust has a greater appetite to accept risks in relation to its pursuance of innovation and the challenging of current working practices in order to realise positive benefits.'
Agreed Board, March 2018

Overarching risk appetite descriptions

Appetite level	Described as:
Negligible (1)	Avoidance of risk and uncertainty
Low (2)	Preference for ultra-safe delivery options that have a low degree of inherent risk and limited reward potential
Moderate (3)	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
High (4)	Willing to consider all potential delivery options and choose while also providing an acceptable level of rewards (and VfM)
Significant (5)	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk). Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.

Risk Appetite assessment against Strategic Aims

Strategic Aims/ Risk Category	Safety	Financial	Reputation	Compliance/ Regulation	Delivery
People	L	M	M	L	H
Services: Clinical	L	M	H	L	M
Services: Education	L	M	M	L	M
Growth and Development	M	S	H	L	H
Finance and Governance	M	M	M	M	H

See Appendix 1 for detailed descriptions

5. CONCLUSION

5.1. The Board is invited to approve this update to the Board Assurance Framework; and to comment whether, with the action plans as set out, the risks are tolerated.

CURRENT BAF HEAT MAP

Likelihood							
	Almost certain to occur	5					
	Likely to occur	4				R8	
	Could occur	3				R1, R6, R9, R10, R13, R14, R16	R15
	Unlikely to occur	2			R12	R7, R11 R3	R5
	Very unlikely to occur	1					
Risk Matrix			1 Negligible	2 Minor	3 Moderate	4 Severe	5 Extreme
			Consequence				

MARCH 2018 BAF HEAT MAP

Likelihood							
	Almost certain to occur	5					
	Likely to occur	4				R8	
	Could occur	3				R1, R6, R9, R10, R13, R14, R16	R15
	Unlikely to occur	2				R7, R11 R3	R5
	Very unlikely to occur	1				R12	
Risk Matrix			1 Negligible	2 Minor	3 Moderate	4 Severe	5 Extreme
			Consequence				

See next page for risk numbers and headings.

Risk headings, reference numbers.

Arrows denote direction of travel of risk level from last assessment

Risk 1	Clinical quality or governance failures
Risk 3	Education and training quality failures

Risk 5	Delivery of National Training contract	
Risk 6	Loss of workforce engagement and morale	
Risk 7	Failure to recruit or retain skilled workforce	
Risk 8	Unable to agree or fund relocation/ redevelopment plans	
Risk 9	Loss of access to critical systems (IT)	
Risk 10	Insufficient management capacity impacts on the delivery of the Trust's strategic plan	
Risk 11	Damage to the Trust's reputation or drop in public profile of the Trust	
Risk 12	Failure to comply with regulatory requirements	
Risk 13	Failure to deliver savings and growth contribution	
Risk 14	Failure to provide good quality data impacting on Trust work	
Risk 15	Longer term risk to the sustainability of the Trust	
Risk 16	Compliance with evolving information governance and data security regulation and best practice	

The Tavistock and Portman NHS
NHS Foundation Trust

Board Assurance Framework 2017/18 – Summary

				Current Risk Score					
	Risk	Owner	Strategic Aims	July 17	Nov 17	Mar 18	May 18	Target Risk L = likelihood C= consequence Risk = L x C	Current v Target Risk Score
10	Insufficient management capacity impacts on the delivery of the Trust's strategic plan	Paul Jenkins	People Growth & Development	Red 16	Red 16	Amber 12	Amber 12	**Amber 2x4**	**Adverse**
15	Longer term risk to the sustainability of the Trust	Paul Jenkins	Growth & Development	Red 15	Red 15	Red 15	Red 15	**Amber 2x5**	**Adverse**
13	Failure to deliver savings and growth contribution	Terry Noys	Finance & Governance	Amber 12	Amber 12	Amber 12	Amber 12	**Yellow 2x4**	**Adverse**
1	Clinical quality or governance failures in context of elevated risk of serious incidents	Rob Senior	Services	Amber 12	Amber 12	Amber 12	Amber 12	**Yellow 2x4**	**Adverse**
6	Loss of workforce engagement / morale / commitment	Craig De Sousa	People	Amber 12	Amber 12	Amber 12	Amber 12	**Yellow 2x4**	**Adverse**
16	Compliance with evolving information governance and data security regulation and best practice	David Wyndham Lewis	Services			Amber 12	Amber 12	**Yellow 2x4**	**Adverse**
8	Unable to agree or fund relocation / redevelopment plans	Terry Noys	Finance & Governance	Amber 12	Amber 12	Red 16	Red 16	**Yellow 2x4**	**Adverse**

The Tavistock and Portman NHS
NHS Foundation Trust

	Risk	Owner	Strategic Aims	Current Risk Score July 17	Nov 17	Mar 18	May 18	Target Risk L = likelihood C= consequence Risk = L x C	Current v Target Risk Score
9	IT applications and hardware do not sufficiently support Trust objectives. Loss of access to critical systems	David Wyndham Lewis	Services	Amber 12	Amber 12	Amber 12	Amber 12	**Yellow 2x4**	**Adverse**
14	Failure to provide good quality data impacting on Trust work	David Wyndham Lewis	Services		Amber 12	Amber 12	Amber 12	**Green 1x3**	**Adverse**
5	Delivery of National Training contract	Brian Rock	Growth and Development	Red 15	Amber 10	Amber 10	Amber 10	**Amber 2x5**	**Meets**
3	Education and Training quality failures	Brian Rock	Growth and Development	Amber 9	Amber 9	Amber 9	Yellow 8	**Green 1x4**	**Adverse**
7	Failure to recruit or retain skilled workforce	Craig De Sousa	People	Yellow 8	Yellow 8	Yellow 8	Yellow 8	**Green 1x4**	**Adverse**
11	Damage to the Trust's reputation or drop in public profile of the Trust	Paul Jenkins	Services Growth and Development	Yellow 8	Yellow 8	Yellow 8	Yellow 8	**Yellow 2x4**	**Meets**
12	Regulatory failure	Paul Jenkins	Finance and Governance	Green 4	Green 4	Green 4	Amber 9	**Green 1x4**	**Adverse**

Strategic Aims 2018: People; Services, Growth and Development; Finance and Governance

RISK 1): Clinical quality or governance failures – including the risk of serious incidents	
Risk Owner: Medical Director	Date last reviewed: May 2018
Strategic Aim(s) affected by this risk: Services	INITIAL risk rating (at identification): Likelihood 2 x Consequence 4 **8** **CURRENT risk rating (after mitigation):** Likelihood 3 x Consequence 4 **12**
Rationale for current score: The consequence of a serious clinical incident attributable to a failure to comply with appropriate standards of quality or safety is high and the likelihood of incidents has risen because of increased risk in some services and populations. There are well-embedded systems in place to provide governance and early warning of system failures. Evidence of learning from incidents has improved. New GIC contract to be taken up April 2017 with unknown risk level.	
Controls/Influences *(what are we currently doing about this risk?)*: Director of Quality and Patient Experience leads Quality work-stream reporting to CQSG Committee. Continuing development of staff training programmes. Associate Medical Director leads Patient Safety and Risk work-stream. CQC report discussed at MT, CQSGC and Board. Full action plan approved and being implemented. CareNotes now more fully embedded in clinical practice. Individual action plans arising from the investigation of incidents GIC clinical governance meetings set up	Assurances received *(independent reports on processes; when; conclusions)*: CQC inspection report published in May: Good rating overall and in 4/5 domains (+) Quality Reports and Accounts externally audited: Risks attributable to reduced capacity of other providers including Social Care and Voluntary Sector are difficult to mitigate. Investigations including SCR and coroner's inquest have not identified failures by Trust practitioners. Clinical Governance Leads appointed CYAF and AFS (+) CQC inspection report updated February 2017 rated 'good' all KLOes (+) GIC clinical governance meeting ToR agreed (+)
Gaps in controls/influences: Some aspects of poor data quality have potential to impact on clinical quality and safety Acquisition of GIC service associated with some new risks	Action plans in response to gaps identified: *(with lead and target date)* Review risk in light of new GIC contract. See action plan in relation to Risk 14

RISK 3): Education and Training quality failures This includes failure to deliver a quality learning experience to students that is fundamental to our position in the sector.	
Risk Owner: Director of Education and Training / Dean	Date last reviewed: May 2018
Strategic Aim(s) affected by this risk: Growth and Development	INITIAL risk rating (at identification): Likelihood 2 x Consequence 4 **8** **CURRENT risk rating (after mitigation):** Likelihood 2 x Consequence 4 **8**
Rationale for current score: The Trust is a leading quality provider of education and training. Any actual or perceived loss of quality in delivery through the expansion of numbers, courses, sites of delivery and teaching formats would potentially have a serious impact. Course content and approach in delivery of programmes remains of a high quality. Restructuring of professional support services is embedding well evidenced by DET staff survey results. However, further work is required to develop and embed standard operating procedures in line with MyTaP implementation; the latter has put strain on operational teams. University partner regulation changes are making an impact and will require time to become more routine.	
Controls/Influences *(what are we currently doing about this risk?)*: Robust Academic Governance and Quality Assurance arrangements in place, supported and monitored by university partners including Curriculum Quality Group / Partnership Management Board. Further development of T&P academy linked to organisation's people strategy and CPD fellowship opportunities for all staff with Higher Education Academy. Portfolio management engagement. Establishment of Standard Operating Procedures to create clarity of roles and responsibilities to support students across DET functions and course teams. Strategic plan for assessment of national centres (alternative & Associate). Development of complaints procedure in line with membership of OIA and internal quality system for tracking complaints and action plans. Implementation of new student information management system.	Assurances received *(independent reports on processes; when; conclusions)*: QAA monitoring report was extremely positive about progress on action plan arising from review in April 2016. Report published July 2017 (+) Annual student survey engagement high with in line with previous high levels of satisfaction (May 2018) (+) Full analysis of current AY survey results complete including discussion at portfolio level. Action plan being drafted (May 2018) (-) First cohort planned for T&P academy delivery (Sept 2018) (+) National Centres baseline requirements agreed at TEPMB and are being reviewed by Training Executive (April 2018) (+) HEA Fellowship recognition and award for staff (Feb 2018) (+) Institutional reviews by both University partners completed with re-validation for next five years (April 2018) (+)

Action plan being drawn up addressing results from annual student survey (AY16/17)	
Gaps in controls/influences: University partner requirements are placing greater demands on course teams and students. Additional capability and capacity required to deliver reporting requirements for Office for Students (OfS) for 17/18 HESA reporting.	Action plans in response to gaps identified: *(with lead and target date)* Ongoing embedding of professional support services with clearer processes across roles (Beverley Nicholson - ongoing – Sept 2018) DET governance review being implemented to include stronger link between Training Executive and Operational Managers Group and engagement of Portfolio Managers (Isabelle Bratt - April 2018) Annual student survey action plan (Elisa Reyes Simpson – Sept 2018) Work underway with Informatics and relevant operational teams to develop HESA reporting capability with input from University Partner and specialist consultant (DWL/John Martin – Sept 2018)

RISK 5): Delivery of National Training Contract

Significant changes to HEE funding & focus with active review of our National Training Contract is now approaching its second year of implementation. Continuing to deliver and develop our existing portfolio alongside the programmes undertaken by the National Workforce Skills Development Unit will present both challenges and opportunities.

Risk Owner: Director of Education and Training / Director of Nursing	Date last reviewed: May 2018
Strategic Aim(s) affected by this risk: Growth and Development	INITIAL risk rating (at identification): Likelihood 3 x Consequence 5 **15** **CURRENT risk rating (after mitigation):** Likelihood 2 x Consequence 5 **10**

Rationale for current score:

Our National Training Contract has been significantly reshaped through a lengthy and extensive process of discussion and negotiation with HEE. The National Workforce Skills Development Unit is now fully established and operational over five programme of work. The Trust has continued to achieve positive engagement and support from local office, relevant national team and responsible DEQ.

Controls/Influences *(what are we currently doing about this risk?)*:	Assurances received *(independent reports on processes; when; conclusions)*:
Active portfolio review and alignment of portfolio provision with HEE priorities and broader policy drivers. Well established internal governance arrangements including oversight by Education & Training Committee chaired by Chair. Active engagement of key HEE personnel in the development of new activity and on reporting and contract monitoring. Formal establishment of the NWSDU with agreement of key lines of accountability in the Trust involving Director of Nursing and DET Director. Development of the Workforce Development Collaborative with engagement of regional HEE offices Focus on identifying new income streams via BDG in mitigation of overall contract reduction.	Significantly improved quality of reporting in collaboration with HEE contract lead (+) Ongoing engagement with key HEE colleagues in an active process including presentation to key stakeholders at HEE (+) Positive response by HEE to programme briefs (+) Successful completion of one programme and development of other programmes progressed and progressing (+) Full complement of permanent staff now in post (CC May 2018) (+)

Collaboration with HEE continues and engagement with new leadership team is underway with positive early signs	
Gaps in controls/influences: Continued pressure in the system and uncertainty.	Action plans in response to gaps identified: *(with lead and target date)* Identification of HEE sponsors for all programmes (IT 5/2018) 2018/19 project list agreed. Final approval of delivery plans expected by end of May (CC May 2018)

RISK 6): Loss of workforce engagement and morale	
Risk Owner: Director of HR & Corporate Governance	Date last reviewed: May 2018
Strategic Aim(s) affected by this risk: People	INITIAL risk rating (at identification): Likelihood 2 x Consequence 4 **8** **CURRENT risk rating (after mitigation):** Likelihood 3 x Consequence 4 **12**
Rationale for current score: Staff survey consistently shows strong commitment to the Trust and its work. Evidence form a number of sources indicates growing pressure on staff as resources reduced and workload increases.	
Controls/Influences *(what are we currently doing about this risk?)*: Organisational Development and People Strategy agreed by Board in April 2017 with important focus on staff engagement and wellbeing. Continuing programmes of consultation and communication with staff including monthly CE Question Time. New intranet launched to support improved staff communications. Reducing the burden project launched to reduce burden of data collection. Support development of team managers and aspiring leaders as a key level for staff support/engagement.	Assurances received *(independent reports on processes; when; conclusions)*: 2017 NHS Staff survey demonstrates overall engagement has increased but includes clear evidence of continuing pressure on staff (+) Organisational Development and People Strategy (+)
Gaps in controls/influences: Level of external pressure to generate financial savings. Uncertainty of current external environment.	Action plans in response to gaps identified: *(with lead and target date)* People Strategy being implemented with specific recommendations on staff wellbeing and engagement and the development of middle managers. (CdS 03/2020) Further development of intranet to support staff communications. (LT) Follow through of Reducing the Burden project to reduce the burden of data collection. (LL 9/2018)

RISK 7): Failure to recruit or retain skilled workforce	
Risk Owner: Director of HR & Corporate Governance	Date last reviewed: May 2018
Strategic Aim(s) affected by this risk: People	INITIAL risk rating (at identification): Likelihood 3 x Consequence 4 12 **CURRENT risk rating (after mitigation):** Likelihood 2 x Consequence 4 **8**
Rationale for current score: Skills and experience levels remain high within the organisation, however, there are signs of growing pressure. Results from the annual Staff Survey and from the Friends and Family Test remain generally good.	
Controls/Influences *(what are we currently doing about this risk?)*: Employee engagement and employee satisfaction is assessed annually through national survey and four times a year through the Staff Friends and Family Test. The findings of these surveys and any arising concerns are discussed and addressed with the management team and our trade union colleagues. For example, the helpline for staff to raise concerns helpline has been introduced. We have also implemented a localised action planning process. The Trust Board approved a new organisational development and people strategy which has four overarching aims. The strategic priorities are to recruit and attract talent in to the organisation; ensure we retain and develop our existing staff; we protect the health and wellbeing of our workforce; and to value and respect our diverse group of staff. The Trust has developed a much more strategic approach to learning and development commissioning. Through the annual appraisal process a comprehensive development programme has been developed and approved by the Staff Training Committee. In addition to this the Trust also continues to make provision for flexible, multi-professional, continuous professional development funding. The process for succession planning within Directorates is encouraged and a framework will be delivered as part of the people strategy to support a consistent approach. Organisational values: Our Trust values have been developed.	Assurances received *(independent reports on processes; when; conclusions)*: Organisational Development and People Strategy (+) Quarterly assurance reports to the Board and / or appropriate Board committees (+) (-) NHS Staff Survey Results (+) Results of the quarterly friends and family tests and staff survey results – via the dashboard (+) (-) Trust developed action plan to respond to recent staff survey findings (+) (-) Staff development and leadership programmes (+) Behavioural framework for recruitment and appraisal process (+)

Job Descriptions: Managers and trade union colleagues are engaged by HR to assess the future skills requirements in job descriptions that cater to the current and future Trust needs. Behavioural framework including Trust values in place for recruitment and appraisal processes	
Gaps in controls/influences: Increasing levels of sickness absence and reported workplace stress Delivery of People Strategy Delivery Plan Local implementation of staff survey action plan	Action plans in response to gaps identified: *(with lead and target date)* The people strategy delivery plan details a number of actions required to maintain staff engagements and to protect the health and wellbeing of our staff. Implementation of the OD and People Strategy (CdS 3/2020) Directorate succession planning framework will be delivered as part of the people strategy (CdS 3/2020) Staff survey 2017 results published in March 2018. Associate clinical directors, associate deans and heads of corporate functions tasked to produce localised action plans responding to the key finding areas (SM / KM – May 2018) Flexible, multi-professional, CPD funding refreshed annually (KB 3/2018)

RISK 8): Unable to agree or fund relocation / redevelopment plans	
Risk Owner: Deputy Chief Executive	Date last reviewed: May 2018
Strategic Aim(s) affected by this risk: People Finance and Governance	INITIAL risk rating (at identification): Likelihood 3 x Consequence 4 **12** **CURRENT risk rating (after mitigation):** Likelihood 4 x Consequence 4 **16**
Rationale for current score: Currently in exclusive negotiations with vendor regarding new site. Funding agreed in principal (in 2016), however, underlying viability a challenge and significant further work required in order to secure drawdown. Financial parameters of Relocation have changed (declined) since Outline Business Case. Property markets continue to be volatile and negative.	
Controls/Influences *(what are we currently doing about this risk?)*: • Ongoing updated review of costs and potential proceeds • Exclusive negotiations with vendor towards Heads of Terms	Assurances received *(independent reports on processes; when; conclusions)*: • Updated review of costs by Currie and Brown (Oct 17) (+) (-) • Updated valuation of potential proceeds from sale of assets by Montagu Evans (Feb 18) (+) (-) • Ongoing conversations with senior management of vendor (further meeting in May 2018) (+) • Detailed M&E survey of Tavistock Centre (+) (-) • Updated MOU with vendor signed in April 2018 (+)
Gaps in controls/influences: • Future movements in property values (for both sale and purchase) • Changes in future build costs	Action plans in response to gaps identified: *(with lead and target date)* • Extensive financial modelling / appraisal of key options for July 2018. (TN) • Consideration of alternative funding models (TN) • Ongoing updated review of costs and potential proceeds (TN) • Aiming for Heads of Terms by September 2018 (TN)

RISK 9): IT applications and hardware do not sufficiently support Trust objectives. Loss of access to critical systems (IT)	
Risk Owner: Director Technology and Transformation	Date last reviewed: May 2018
Strategic Aim(s) affected by this risk: Services	INITIAL risk rating (at identification): Likelihood 3 x Consequence 4 **12** **CURRENT risk rating (after mitigation):** Likelihood 3 x Consequence 4 **12**
Rationale for current score: IMT Strategy (January 2016) implementation has continued with now one significant project remaining related to this risk- the replacement of our network hardware. Recent incidents across the NHS and within the Trust, such as the fire adjacent to Gloucester House, have further highlighted the need for improved business continuity planning across the Trust even following the introduction for more resilient infrastructure. Two cyber security audits undertaken in the last period have highlighted gaps in our cyber security, both technology and process. A reconciliation exercise has shown that the former category will be remedied though the remaining work of the Network Hardware Refresh.	
Controls/Influences *(what are we currently doing about this risk?)*: These issues will be addressed in the main through the Network Replacement Project. Hardware is now on site at the Trust and the configuration has been signed off following detailed workshops. Implementation will continue through April and May 2018. The project is being planned so as to minimise downtime and it is believed currently that the project can complete with no downtime in working hours. Improvements to electrical provision and security and physical environment for network cabinets has been started with levels 1, 2, 3, 4 and 5 complete. The remaining works require a significant planned downtime for the Trust network to allow for migration to resilient power sources. This has therefore been deliberately delayed until the Network Replacement Project so as to avoid duplication of this downtime.	Assurances received *(independent reports on processes; when; conclusions)*: Penetration testing against the network in 2016/17 yielded broadly positive results with all output issues from the report now addressed. (+) The Trust's avoidance of any impact from the WannaCry ransomware has highlighted the good standard of our processes related to cyber security, although with no room for complacency given the speed with which this threat evolves. (+)

Gaps in controls/influences:	Action plans in response to gaps identified: *(with lead and target date)*
Final implementation of the replacement network along with its improved technical protections, and proactive automated cyber security controls. Recent cyber security audits have highlighted gaps in process over and above the technical controls. These will need to be addressed alongside the Network Hardware Refresh. As a result the Trust would not currently achieve the Cyber Essentials Plus accreditation.	Network replacement to be completed. Action plans for security processes are being implemented alongside this. (DWL – June 2018) Email system replacement is underway with Phase 1 and 2 now complete. Phase 3 (secure send of patient data without NHSMail) due in Q4. (Delayed – awaiting an exception report for additional funding - DWL June 2018) Repeat of Cyber audits and achievement of Cyber Essentials Plus accreditation (Q3 2018).

RISK 10): Insufficient management capacity impacts on the ability to deliver the Trust's strategic plan	
Risk Owner: Chief Executive	Date last reviewed: May 2018
Strategic Aim(s) affected by this risk: People Growth and Development	INITIAL risk rating (at identification): Likelihood 3 x Consequence 4 **12** **CURRENT risk rating (after mitigation):** Likelihood 3 x Consequence 4 **12**
Rationale for current score: As a small and diverse Trust management resources are spread thinly. Need to support growth alongside savings agenda. Considerable growth in external pressure from STP and regulators.	
Controls/Influences *(what are we currently doing about this risk?)*: Use strategic plan to focus priorities and manage trade-offs. Business Development capacity strengthened to address core priorities in both DET and clinical directorates. Use strategic opportunities for additional investment, in particular focused on new income development. Look at alternative options for funding developments through capitalisation, social finance and partnerships.	Assurances received *(independent reports on processes; when; conclusions)*: Review of strategic plan through SCC and Board (+) New strategic plan agreed (3/18) (+)
Gaps in controls/influences Uncertainty of external environment and impact on internal capacity. Pressure to deliver Trust Control Total reduces capacity for additional investment.	Action plans in response to gaps identified: *(with lead and target date)* Identify further opportunities for additional investment to support income generation including looking at novel financing models e.g social finance (ongoing).

RISK 11): Damage to the Trust's reputation or drop in public profile of the Trust	
Risk Owner: Chief Executive	Date last reviewed: May 2018
Strategic Aim(s) affected by this risk: Services Growth and Development	INITIAL risk rating (at identification): Likelihood 2 x Consequence 4 8 **CURRENT risk rating (after mitigation):** Likelihood 2 x Consequence 4 8
Rationale for current score: Generally positive reputation in wider mental health world. Trust playing an active role in the STP.	
Controls/Influences *(what are we currently doing about this risk?)*: Commissioned reputation audit External Affairs Strategy and External Affairs Committee established Setting up a governance structure to oversee this activity Working on the development of another documentary for national television on FDAC amongst other projects.	Assurances received *(independent reports on processes; when; conclusions)*: Media monitoring (+) Communications team staffing levels (+/-) Review of implementation of External Affairs Strategy through External Affairs Committee (+)
Gaps in controls/influences: Change in external environment	Action plans in response to gaps identified: *(with lead and target date)* Implement strategic plan objective on External Affairs (Ongoing) LT

RISK 12): Failure to comply with regulatory requirements	
Risk Owner: Chief Executive	Date last reviewed: May 2018
Strategic Aim(s) affected by this risk: Finance and Governance	INITIAL risk rating (at identification): Likelihood 1 x Consequence 5 5 **CURRENT risk rating (after mitigation):** Likelihood 3 x Consequence 3 9
Rationale for current score: Strong current performance but needs to be kept under review. Positive rating for CQC and QAA in the last year. Currently in top rating for NHS Improvement. Preparing for CQC Well Led Inspection in September 2018. Some concerns identified on Estates compliance and action plan prepared for the Board.	
Controls/Influences *(what are we currently doing about this risk?)*: Range of governance processes in place. CQC Good rating. Further Inspection scheduled for over the summer. QAA Fully meet UK requirement and positive follow up visit May 2017. Trust in receipt of rating of 1 for NHS Improvement Single Oversight Framework	Assurances received *(independent reports on processes; when; conclusions)*: CQC rating (+) QAA rating (+) Anticipating clean audit May 2018 (+) NHS Improvement Single oversight framework (+)
Gaps in controls/influences: Ongoing pressure for efficiency savings impact on management capacity. Estates compliance concerns following assessment	Action plans in response to gaps identified: *(with lead and target date)* CQC action plan agreed and being implemented. (LL) QAA action plan developed and being implemented (BR 3/2018) Implementation of Clinical Quality Strategy - ongoing (LL) Preparation for further CQC Inspection (September 2018) LL Action plan to address concerns on Estates compliance prepared for Board (DWL 5/2018)

RISK 13): Failure to deliver savings and growth contribution	
Risk Owner: Deputy Chief Executive	Date last reviewed: May 2018
Strategic Aim(s) affected by this risk: Finance and Governance	INITIAL risk rating (at identification): Likelihood 4 x Consequence 4 **16** **CURRENT risk rating (after mitigation):** Likelihood 3 x Consequence 4 **12**
Rationale for current score: The Control Target for 20171/8 was achieved. For 2018/19, the Trust requires to make savings / growth contribution equal to £1.9m.	
Controls/Influences *(what are we currently doing about this risk?)*: • Active and regular Executive Management Team consideration of the issues (including monthly management accounts) • Growth targets and action plans reviewed regularly by Business Development Group, Strategic and Commercial Committee, Education and Training Committee and Trust Board	Assurances received *(independent reports on processes; when; conclusions)*: • 2018/19 Operating / Financial Plans submitted to NHSI (+) • Departmental budgets – including required savings and growth targets agreed (+)
Gaps in controls/influences: • £720k of contribution (around £3.6m of new income) to be achieved (heavy dependence on success of TLIF) • DET Struggling to identify £250k of required savings • Additional, non-budgeted cost pressures emerging	Action plans in response to gaps identified: *(with lead and target date)* • On-going development of clinical new business opportunities (RS / SH / JS) • Education and Training 'Start and Finish Group' (10/2018 BR /TN) • Attempt to capitalise Apprenticeship / Digital Academy opportunities (BR / TN) – September 2018

RISK 14): Failure to provide good quality data impacting on Trust work	
Risk Owner: Director Technology and Transformation	Date last reviewed: March 2018
Strategic Aim(s) affected by this risk: Services	INITIAL risk rating (at identification): Likelihood 3 x Consequence 4 12 **CURRENT risk rating (after mitigation):** Likelihood 3 x Consequence 4 12
Rationale for current score: Challenges in achieving local indicators in 2016/17 Apparent inconsistency between data provided to local teams and third parties Reported high level of manual process required to validate this data before use Reported high level of burden in operation of the clinical and education systems by Trust staff	
Controls/Influences *(what are we currently doing about this risk?)*: The governance and management structures are already in place to address these issues in the form of DARC and CDQRG and procedures. Projects	Assurances received *(independent reports on processes; when; conclusions)*: Terms of reference for DARC, CDQRG (+) Clinical Data Quality Procedure (+) Progress made via Quality Improvement work and business as usual work between Data Quality and Informatics teams (+)
Gaps in controls/influences: An action plan is required to handle immediate "backlog" and achieve a stable working position on which the existing structures can then iteratively build. A project brief and commissioning of third party support for work to consider the scope of improvements to be made has completed. This will closely interact with a number of other projects proposed as part of the upcoming Transformation Strategy, such as Trustwide Scheduling. Commencement of work has been delayed to Q1 2018/19.	Action plans in response to gaps identified: *(with lead and target date)* Third party assessment of consistency of clinical process and records commissioned but delayed. Work ongoing to refine the scope to ensure the first phase is achievable. (DWL Q1 2018/19) Inclusions of data quality improvements within proposed upcoming projects, such as Check In and Flow, within the Transformation programme (DWL Q1 2018/19)

RISK 15): Longer term risk to the sustainability of the Trust	
Risk Owner: Chief Executive	Date last reviewed: May 2018
Strategic Aim(s) affected by this risk: Growth and Development	INITIAL risk rating (at identification): Likelihood 3 x Consequence 5 **15** **CURRENT risk rating (after mitigation):** Likelihood 3 x Consequence 5 **15**
Rationale for current score: Trust faces gap of £3.6m over the next 3 years to be filled by savings or contribution from new income. Requirement for step change in income generation with ability to enter new markets.	
Controls/Influences *(what are we currently doing about this risk?)*: • Established new organisational focus on income generation through BDC and SCC. • Developing strategies for development of new markets. • Revisit strategic plan during the autumn • Develop response to the development of Integrated Care Systems in London	Assurances received *(independent reports on processes; when; conclusions)*: • BDC/SCC review of current and future pipelines (+) • Revised strategic plan (+)
Gaps in controls/influences: • Ability to create sufficient capacity to address future growth agenda • Wider system developments beyond the Trust's control	Action plans in response to gaps identified: *(with lead and target date)* • Implement strategic plan objectives for new growth in both DET and clinical Directorates including both existing business streams and new areas e.g work placed mental health and transnational education. (ongoing) • Complete work through Task and Finish group to identify and implement more sustainable models of delivery for education and training (TN/BR) (Sept 18)

RISK 16): Compliance with evolving information governance and data security regulation and best practice	
Risk Owner: Director Technology and Transformation	Date last reviewed: May 2018
Strategic Aim(s) affected by this risk: Services	INITIAL risk rating (at identification): Likelihood 3 x Consequence 4 12 **CURRENT risk rating (after mitigation):** Likelihood 3 x Consequence 4 12

Rationale for current score:

The Trust has already undertaken significant work in the last twelve months to prepare for the implementation of the General Data Protection Regulation, which comes into full force in May 2018. The assessment of readiness and oversight of the programme of works to ensure compliance is undertaken by the IG Workstream, which reports to CQSG. Given the Trust, in achieving full compliance across all Trust services, will face an evolving set of guidance and best practice over the period following the implementation of GDPR the Trust will take a risk prioritised approach to addressing further changes required to practice after Mar 2018 and should expect to continually monitor and improve its performance in relation to information governance and security.

GDPR consolidates legislation and guidance related to both information governance and data & cyber security. While the Trust has performed well in the face of previous cyber-attacks, such as WannaCry, cyber security audits undertaken in Q4 2017/18 have highlighted gaps in both our technical controls and processes across the organisation. Some assurance has been achieved that the gaps in technical controls will be imminently addressed as part of the Network Hardware Refresh project, following a reconciliation of the gaps against the new technology platform to be completed in Q1 2018/19.

GDPR strengthens the role of the regulator within the UK, the Information Commissioners Office. The financial penalties for non-compliance become far more substantial than under existing legislation. The Trust also notes the significant increase in the level of cyber-threat that exists as well as the speed at which the threat evolves, giving the Trust very little time to react to changing external conditions. Finally the Trust notes the reputation damage that may result from a breach and, more importantly, the substantial direct impact that breaches can have on patients, students and staff.

Controls/Influences *(what are we currently doing about this risk?)*:	Assurances received *(independent reports on processes; when; conclusions)*:
GDPR readiness – extensive action plan being tracked through the IG Workstream.	Penetration testing against the network in 2016/17 yielded broadly positive results with all output issues from the report now addressed. (+)

Cyber security – audits undertaken with full outputs and action plans pending. Network Hardware Refresh – replacement of the legacy network will provide technical controls to many of the risks already highlighted. Staff Training – staff will be required to undertake Data Security training in addition to existing Information Governance training as part of 2018/19 mandatory training.	The Trust's avoidance of any impact from the WannaCry ransomware has highlighted the good standard of our reactive processes related to cyber security, although with no room for complacency given the speed with which this threat evolves. (+) Cyber audits have highlighted further gaps in technical controls and organisation wide processes (-) (+)
Gaps in controls/influences: Final implementation of the replacement network along with its improved technical protections, and proactive automated cyber security controls. GDPR action plan is extensive with a substantial time commitment from clinical, education and corporate service lines to deliver and embed changes in actual practice. A detailed timeline for actions and risk-assessed, expected gaps in compliance with GDPR post May 2018 is required. No on-going accreditation of the Trust processes currently in place.	Action plans in response to gaps identified: *(with lead and target date)* Network replacement to be completed. Action plans for security processes are being implemented alongside this. (June 2018) Email system replacement is underway with Phase 1 and 2 now complete. Phase 3 (secure send of patient data without NHSMail) due in Q4. (Delayed – awaiting an exception report for additional funding - June 2018) Repeat of Cyber audits and achievement of Cyber Essentials Plus accreditation (Q3 2018). GDPR readiness report, showing risk assessed gaps that will exist post May 2018 (May 2018)

Appendix 1: Risk Appetite Level
Wording adapted from the Good Governance Institute 'Risk Appetite for NHS Organisations' matrix **www.good-governance.org.uk**

Risk Category / APPETITE LEVEL	Safety	Financial	Reputation	Compliance/ Regulation	Delivery
1 None/ Negligible	No tolerance for any decisions which could impact on patient safety.	Avoid financial loss as a key objective. Only willing to accept the low cost option as VfM is the primary concern.	No tolerance for any decisions that could lead to scrutiny of, or attention to, the organisation. External interest in the organisation viewed with concern.	Play safe, avoid anything which could be challenged, even unsuccessfully.	Defensive approach to objectives – aim to maintain or protect, rather than create or innovate. Priority for tight management controls and oversight with limited devolved authority. General avoidance of systems / technology developments.
2 Low	Only prepared to accept the possibility of very limited impact on patient safety – low level of harm.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure or attention.	Want to be very sure we would win with any challenge. Similar situations elsewhere have not breached compliances.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.
3 Moderate	Prepared to accept the possibility of some impact on patient safety, up to moderate harm, as a short term position only.	Prepared to accept possibility of some limited financial loss. VfM still primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be failure. Mitigations in place for any undue interest.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protect current operations.

4 High	Decisions will have the potential to impact on patient safety which may result in major injury.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Appetite to take decisions with potential to expose the organisation to additional scrutiny / interest. Prospective management of organisation's reputation.	Challenge would be problematic but we are likely to win it and gain will outweigh the adverse consequences.	Innovation supported. Responsibility for non-critical decisions may be devolved. Systems / technology developments used routinely to enable operational delivery.
5 Significant	Decisions will have the potential to impact on patient safety which may result in very serious injury.	Invest for the best possible return and accept possibility of financial loss (with controls in place). Resources allocated without firm guarantee of return.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation. Track record of confidence that the organisation will take difficult decisions for the right reasons with benefits outweighing risks.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup. Consistently pushing back on regulatory burden. Front foot approach informs better regulation.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. New technologies viewed as a key enabler of operational delivery and invested in. High levels of devolved authority.

Appendix 2: Risk consequence categories and scores
Wording is taken from the Trust incident and risk management procedures

Risk Category Score	Safety	Financial Costs below are after all mitigation is in place.	Reputation	Compliance/ Regulation	Delivery
1 None/ Negligible	Insignificant Injury (no intervention)	Minor loss <£10,000 (net surplus impact 2.5%) Negligible	Low level public awareness / concern	Trivial, very short-term single non-compliance	Negligible impact / unnoticed by service users Negligible environmental/estate impact. Negligible service interruption.
2 Low	Minor injury (local first aid treatment with full recovery)	Financial loss £10,000 up to £20,000 (net surplus impact 5%)	Short term local media coverage Local low key external interest	Small, single, short-term non-compliance	Small impact / small inconvenience Minor environmental/estate impact with minor service interruption; Complaint possible; Impact on quality; Loss of teaching time up to 30 minutes
3 Moderate	Moderate injury (professional intervention required up to 3 months to recover) Reportable under RIDDOR (staff)	Moderate loss £20,001 up to £40,000 (net surplus impact 10%) Moderate risk of low value claim	Longer-term local media coverage Local media, stakeholders express concern;	Sustained single or short-term non-compliance	Medium level impact / moderate inconvenience Moderate environmental/estate impact. Moderate service interruption for more than one week; Complaint probable; Impact on quality. Loss of teaching time up to half day
4 High	Major injury (hospital stay / long term illness or injury	Major loss £40,001 up to £60,000 (net surplus impact 15%)	Short-term national media coverage significant impact on reputation, significant	Multiple sustained non-compliances Significant impact on quality including	Major impact / serious inconvenience Major environmental/estate impact leading to loss of

	- up to one year) Reportable under RIDDOR (staff)	Moderate risk of high value claim	medial interest more than one week, significant concerns raised by stake holders	risk of failing to meet CQC standards. Action by HSE anticipated	service/ service interruption of more than one month; Complaint expected/ received;
5 Significant	Fatal injury	Substantial loss >£60,000 Risk of very high value claim	Longer-term national media coverage National press 3+ days, risk of questions in the House of Commons. Certain risk to reputation.	Multiple. Long-term, significant non-compliances Quality- External controls exerted. Threat of Judicial Review.	Substantial/ complete service failure Buildings /property condemned leading to major loss of service Close down of service

The Tavistock and Portman NHS
NHS Foundation Trust

Board of Directors : May 2018

Item: 10

Title: Finance And Performance Report for the period ended March 2018

Summary: The Board are asked to note the contents of the report

For : Noting / Discussion

From : Terry Noys, Director of Finance
30 April 2018

The Tavistock and Portman NHS
NHS Foundation Trust

MONTHLY FINANCE AND PERFORMANCE REPORT

Period 12 **Mar-18**

Section

FINANCE AND PERFORMANCE REPORT **SUMMARY I&E** **Section 1** Page 2

Period 12
31 March 2018

	2016/17 Actual **Month** £'000	2017/18 Actual **Month** £'000	2017/18 Budget **Month** £'000	Variance Actual v Budget £'000	2016/17 Actual **YTD** £'000	2017/18 Actual **YTD** £'000	2017/18 Budget **YTD** £'000	Variance Actual v Budget £'000	**Variance Actual v Budget %**
Income	5,059	6,989	4,319	2,671	49,913	**53,009**	50,328	2,681	**5%**
Staff costs	(2,695)	(3,385)	(3,361)	(24)	(32,600)	**(36,435)**	(37,529)	1,094	**3%**
Non-staff costs	(1,762)	(1,458)	(1,064)	(394)	(14,122)	**(12,032)**	(10,496)	(1,536)	**15%**
Operational costs	(4,456)	(4,843)	(4,425)	(418)	(46,722)	**(48,467)**	(48,025)	(442)	**(1)%**
EBITDA	602	2,146	(106)	**2,253**	3,191	**4,542**	2,303	**2,239**	**0**
- Margin	12%	**31%**	-2%		6%	**9%**	5%		
Interest receivable	1	1	1	1	10	**9**	8	**0**	**0%**
Interest payable	0	0	0	0	0	**0**	0	**0**	
Depreciation / amortisation	(149)	(245)	(65)	(180)	(834)	**(956)**	(781)	**(175)**	**22%**
Impairment						**(90)**		**(90)**	
Public Dividend Capital	(118)	(63)	(48)	(15)	(571)	**(595)**	(580)	**(15)**	**3%**
Restructuring costs	(196)	(77)	0	(77)	(337)	**(122)**	0	**(122)**	
Net surplus	140	1,761	(219)	1,981	1,460	**2,788**	950	**1,837**	**193%**
- Margin	3%	25%	(5)%		3%	**5%**	2%		

COMMENTARY

The Trust has a net surplus for the year of £2,788k, after allowing for £2,098k of STF funding.
Excluding STF monies thre Trust net surplus was £690k.
The Trust exceeded its Control Total (excluding STF monies) by £240k

Income is £1,083k ahead of budget, with shortfalls in DET and AFS offset by higher revenue in CYAF and Corporate (notably STF monies)
Staff costs are £1,094k below Budget (in part because of lower Child Psychotherapy trainees).

Non-pay costs are £1,534k worse than budget , due in part to higher non-staff costs in DET (VLs) and CYAF, the latter reflecting increased activity due to additional revenue

An impairment charge of £90k was incurred, stemming from the year-end revaluation of Trust property assets

FINANCE AND PERFORMANCE REPORT **BALANCE SHEET** **Section 9** Page 3

Period 12

31 March 2018

	Prior Year End £'000	April £'000	May £'000	June £'000	July £'000	Aug £'000	Sept £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000
Intangible assets	191	188	199	194	216	211	205	204	208	217	223	227	185
Land and buildings	18,381	18,432	18,673	18,720	18,507	18,558	18,562	18,578	18,672	18,712	18,777	18,870	18,742
IT equipment	1,329	1,345	1,311	1,354	1,553	1,598	1,697	1,770	1,910	2,535	2,628	2,667	2,766
Other	0	0	0	0	0	0	0	0	0	0	0	0	0
Property, Plant & Equipment	19,709	19,777	19,984	20,074	20,060	20,156	20,258	20,348	20,582	21,247	21,404	21,537	21,509
Total non-current assets	19,900	19,964	20,183	20,268	20,276	20,366	20,464	20,552	20,790	21,465	21,627	21,764	21,693
Trade and other receivables	5,518	3,740	2,979	3,760	3,210	2,795	3,296	2,824	2,192	2,940	7,825	5,369	5,504
Accrued Income and prepayments	2,098	3,614	4,701	3,763	3,230	3,298	4,030	3,657	5,121	4,972	3,813	3,116	3,310
Cash / equivalents	2,152	5,279	3,224	2,480	4,747	3,635	2,477	4,707	3,045	2,032	2,310	3,267	3,823
Total current assets	9,768	12,634	10,905	10,003	11,187	9,728	9,804	11,187	10,357	9,944	13,947	11,752	12,638
Trade and other payables	(2,272)	(2,456)	(2,374)	(1,997)	(2,082)	(2,122)	(1,991)	(2,404)	(2,376)	(2,907)	(3,194)	(2,494)	(2,735)
Accruals	(3,289)	(3,221)	(2,921)	(2,687)	(2,290)	(2,482)	(3,105)	(2,448)	(2,160)	(2,357)	(2,239)	(2,728)	(3,100)
Deferred income	(3,010)	(5,684)	(4,583)	(4,273)	(5,665)	(3,987)	(3,538)	(5,263)	(5,011)	(4,295)	(7,303)	(5,356)	(3,616)
Provisions	(254)	(254)	(254)	(210)	(210)	(210)	(210)	(73)	(73)	(73)	(73)	(73)	(264)
Total current liabilities	(8,824)	(11,616)	(10,132)	(9,167)	(10,247)	(8,802)	(8,845)	(10,188)	(9,620)	(9,631)	(12,808)	(10,651)	(9,715)
Total assets less current liabilities	20,844	20,982	20,955	21,103	21,216	21,293	21,422	21,550	21,528	21,777	22,766	22,865	24,616
Non-current provisions	(82)	(84)	(81)	(82)	(82)	(81)	(81)	(79)	(79)	(79)	(77)	(77)	(65)
Long term loans											(1,000)	(1,000)	(1,000)
Total assets employed	20,761	20,898	20,875	21,021	21,133	21,212	21,342	21,471	21,449	21,698	21,689	21,788	23,551
Public dividend capital	3,474	3,474	3,474	3,474	3,474	3,474	3,474	3,474	3,474	3,474	3,474	3,474	3,474
Revaluation reserve	12,263	12,263	12,263	12,263	12,263	12,263	12,263	12,263	12,263	12,263	12,263	12,263	12,262
I&E reserve	5,024	5,161	5,138	5,284	5,397	5,475	5,605	5,735	5,712	5,962	5,952	6,051	7,813
Total taxpayers equity	20,761	20,898	20,875	21,021	21,133	21,212	21,342	21,471	21,449	21,698	21,689	21,788	23,549

MONTHLY FINANCE AND PERFORMANCE REPORT **FUNDS FLOW** **Section 10** Page 4
Period 12
31 March 2018

	April Act £'000	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	137	(25)	146	45	78	131	197	(22)	249	(10)	99	1,763	2,788
Depreciation / amortisation	75	54	65	67	67	67	70	65	(2)	0	149	245	923
PDC dividend paid	45	45	45	45	49	61	50	48	0	0	48	48	484
Restructuring costs							(72)	0	0	31	0	0	(40)
(Increase) / Decrease in receivables	261	(326)	158	1,083	347	(1,233)	846	(833)	(484)	(3,759)	3,152	(179)	(966)
Increase / (Decrease) in liabilities	2,792	(1,484)	(965)	1,148	(1,445)	43	1,343	(568)	12	3,177	(2,225)	(936)	891
Increase / (Decrease) in provisions	2	(3)	2	0	(2)	0	2	0	0	2	0	12	14
Interest paid	(0)	(1)	(1)	(0)	(1)	(1)	(0)	(0)	(2)	(1)	(1)	(1)	(9)
Net operating cash flow	3,311	(1,740)	(551)	2,387	(906)	(930)	2,436	(1,310)	(343)	(560)	1,223	953	3,971
Interest received	0	1	1	0	1	1	0	0	2	1	1	1	9
Interest paid	0	0	0	0	0	0	0	0	0	0	0	0	0
PDC dividend paid	(45)	(45)	(45)	(45)	(49)	(61)	(50)	(48)	0	(0)	19	(226)	(595)
Cash flow available for investment	3,267	(44)	(44)	(44)	(49)	(61)	(49)	(48)	2	1	20	(225)	(586)
Purchase of intangible assets	3	(11)	5	(22)	5	5	1	(4)	(9)	(6)	(3)	42	6
Purchase of property, plant & equipment	(142)	(262)	(154)	(53)	(162)	(170)	(159)	(300)	(663)	(157)	(282)	(217)	(2,721)
Net cash flow before financing	3,127	(2,057)	(745)	2,268	(1,111)	(1,156)	2,229	(1,662)	(1,013)	(722)	958	554	671
Drawdown of debt facilities	0	0	0	0	0	0	0	0	0	1,000	0	0	1,000
Repayment of debt facilities	0	0	0	0	0	0	0	0	0	0	0	0	0
Net increase / (decrease) in cash	**3,127**	**(2,057)**	**(745)**	**2,268**	**(1,111)**	**(1,156)**	**2,229**	**(1,662)**	**(1,013)**	**278**	**958**	**554**	**1,671**
Opening Cash	2,152	5,279	3,224	2,480	4,747	3,635	2,477	4,707	3,045	2,032	2,310	3,267	2,152
Closing cash	**5,278**	**3,223**	**2,479**	**4,747**	**3,635**	**2,479**	**4,706**	**3,045**	**2,032**	**2,310**	**3,267**	**3,821**	**3,821**
	5,279	3,224	2,480	4,747	3,635	2,477	4,707	3,045	2,032	2,310	3,267	3,823	0
	1	1	0	0	(1)	(2)	0	(0)	0	(0)	0	2	

FINANCE AND PERFORMANCE REPORT

Period 12
31 March 2018

	16/17 B/FWD AUC	17/18 Full Year Spend £'000	17/18 Balance Sheet £'000	17/18 Full Year Bud £'000	Page 1 Variance Bud vs Fcst £'000	
Property Plant and Equipment						
Main reception (Tavistock Clinic)		0	0	30	30	Completed
Ground Floor toilets (Tavistock Clinic)		0	0	45	45	Completed
Lighting (Tavistock Clinic)		0	0	36	36	Completed
Third Floor reconfiguration (Tavistock Clinic)		6	6	400	394	Completed
Proximity access (Gloucester House)		0	0	48	48	Completed
Asbestos Removal		1	1		(1)	Completed
Lecture Theatre		17	17		(17)	Completed
Oasis Building		0	0		0	Completed
General Refurbishment		0	0		0	Completed
Portman external staircases		0	0		0	Completed
Relocation Project	111	666	777			Asset under contruction (AUC)
	111	690	1,579	1,839	1,149	
Information Technology						
IT replacement programme		611	611		(611)	Completed
Intranet and Website project		58	58		(58)	Completed
DET Works - Phase 1		7	7		(7)	Completed
Trustwide Scheduling		167	167		(167)	Asset under contruction (AUC)
Network Replacement		478	478		0	Asset under contruction (AUC)
Remote Sites Infrastructure		0	0		0	Completed
Service Management Toolkit		0	0		0	Completed
Original budget envelope		0		850	850	
		1,388	1,388	850	(538)	
SITS						
SITS (phase 1)	658	641	1,299	442	(199)	Completed
	658	641	1,299	442	(199)	
Other		0		99	99	
Total	769	2,720	4,267	3,230	510	
					0	

Board of Directors : May 2018

Item : 12

Title : Annual Self Certification

Summary:

NHS foundation trusts are required to self-certify whether or not they have: (1) complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), (2) the required resources available if providing commissioner requested services (CRS); and (3) complied with governance requirements.

The following item provides the completed return for board authorisation.

For : Approval

From : Craig de Sousa, Director Human Resources and Corporate Governance

This template may be used by NHS foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS provider licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Condition FT4

Tavistock and Portman NHS Foundation Trust

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "FT4 declaration"

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

1	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Board adopts good corporate governance standards as set out in the Code of Governance and Foundation Trust Network Compendium of best practice.	Please complete Risks and Mitigating actions
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	The Board is kept appraised of NHSI Guidance on corporate governance and the Trust Secretary ensures that the Board has full regard to such guidance.	Please complete Risks and Mitigating actions
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	The Trust has a clear corporate governance structure in place, with effective lines of reporting and decision making. Each committee has a terms of reference, which is reviewed periodically to ensure they are fit for purpose and being applied appropriately. Effectiveness of the Board and it's committees is reviewed annually against stated objectives and compliance with constitutional documents.	Please complete Risks and Mitigating actions
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	The Board regularly reviews its committee structures and reporting lines and sets out the powers reserved to the Board and the scheme of delegation in a published document. The clinical leadership and managerial reporting lines and accountabilities are clearly set out through the corporate and operational structures. Quarterly Performance Reporting; Positive financial performance, declarations and Annual Accounts; External Audit Annual Governance Report and Internal Audit reviews and Head of Internal Audit Opinion. Quality Account; Performance Framework; Board Committee scrutiny; Board and Committee forward plans etc.	Please complete Risks and Mitigating actions
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	Board evaluation/review days, appraisals and development plans; Board Committee Scrutiny; Performance Reports; Quality Account; Service User Experience at Board meetings; Board member service visits; Clinical Governance systems, Quality Committees/Groups.	Please complete Risks and Mitigating actions
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	Board Evaluation, appraisals and development plans; Workforce strategies; Nursing establishment/safer staffing reports to the Board; Organisational Learning and Development plans etc.	Please complete Risks and Mitigating actions

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature **Signature**

Name **Name**

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A

Please Respond

Worksheet "Training of governors"

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

2 Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed	OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name		**Name**	
Capacity	[job title here]	**Capacity**	[job title here]
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A

The Tavistock and Portman NHS
NHS Foundation Trust

Board of Directors: May 2018

Item : 13a

Title : Q4 Dashboards and Quarterly Quality Commentary

Purpose:

Key points to note are:

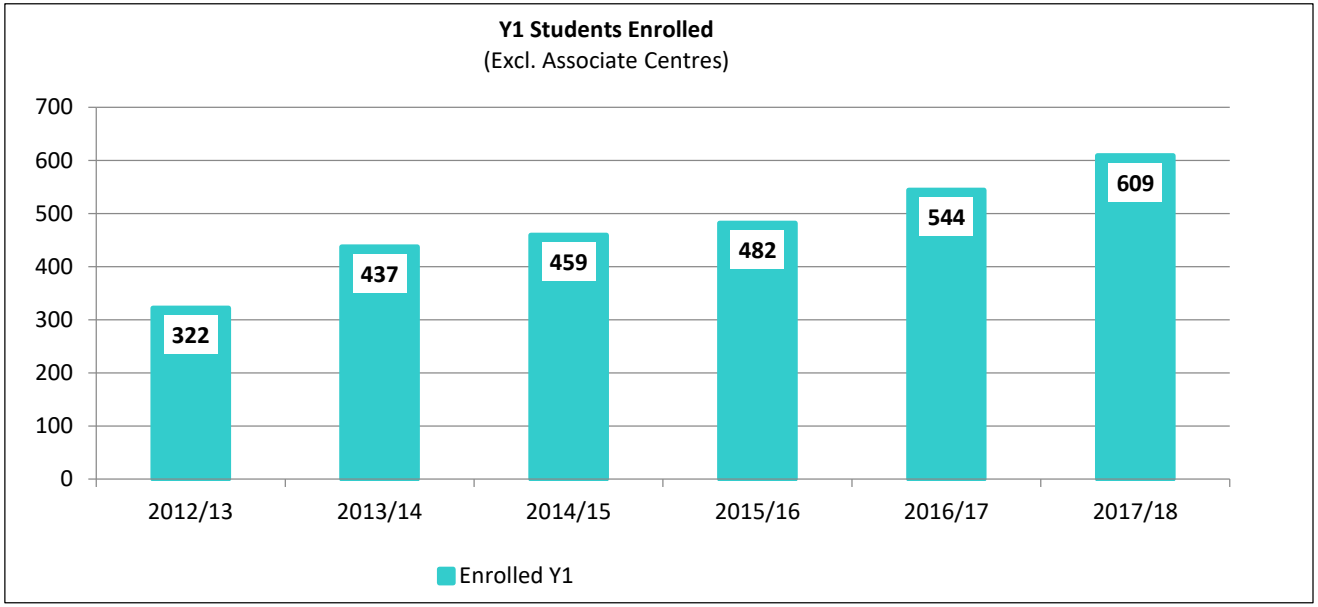
- The Board level dashboard has from Q1 2017/18 been managed by the Quality Team with information in the Quality Commentary providing specific service level responses.
- We continue to perform well in almost all areas.
- There is an increase in patients seen compared to the previous year. This is for the most part due to our taking on the adult Gender Identity Clinic from April 2017. If the trajectory continues this would be over double the numbers seen in 2016/17.
- Gender Services waiting time data has been presented separately owing to the length of the waiting list. Further detail is available in the *Waiting Time Analysis By Team Board Report*
- HR - Sickness data has dropped to 1.3% compared to 1.6% in the previous quarter however, this is not robust data.
- Quality – Safety: Child safeguarding alerts remain elevated, which reflects the introduction of the new system for reporting. It is likely that there is under reporting for Adult safeguarding alerts.
- There were zero serious incidents reported externally in Q4.
- Effectiveness: the Trust-wide DNA rate has decreased from 10.3% in Q3 to 9.2%. This is above the 10% target. Actions taken by services to address issues are included in the Quarter 2 Quality Report Commentary.
- New CYAF outcome monitoring data as agreed with commissioners is now presented.
- DET CPD metrics have been updated.
- Single Oversight Framework: Whilst retaining our overall segmentation rating 1, three data quality indicators continue to have a red rating. An action plan is in place to address these.

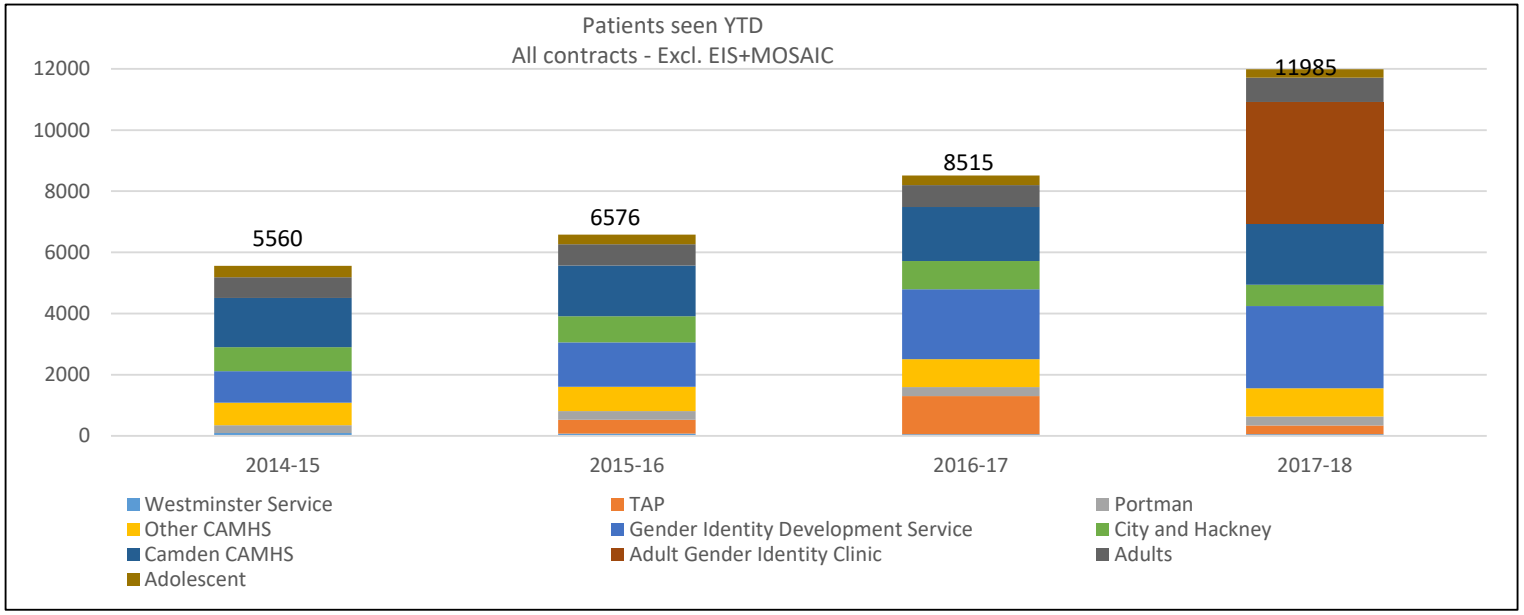
The Dashboards were reviewed at the CQPE Working Group on 19th April 2018.

For : Discussion

From : Marion Shipman, Associate Director Quality and Governance;
Sukhjit Sidhu, Assistant Psychologist and Data Officer, Kerri Johnson-Walker, Data Quality Manager

Q4 2017/18 Trust Reach





Quality - Well Led

Q1 17/18

MORALE

Staff sickness

1.3%	4.0%
Trust	Benchmark (16/17) - all NHS Trusts

Source: TPNHSFT HR

Staff motivation at work

Trust 2014/15 Score	3.91
Trust 2015/16 Score	3.99
Trust 2016/17 Score	3.87
Trust 2017/18 Score	3.94
MH Trust 2016/17 Average	3.91

Source: NHS Staff Survey

Staff recommend Trust as place to work

71%	71%
Q3	Q4

National Average 16/17	61%

Source: TPNHSFT HR

Disclosure and Barring Service Compliance

% of staff with a compliant DBS Check	97%

Source: TPNHSFT HR

TRAINING

Staff appraised

100%	95%
2017/18	Q4

Source: TPNHSFT HR

Staff opinion on quality of appraisals

Trust 2015/16 Score	3.05
Trust 2016/17 Score	3.05
Trust 2017/18 Score	3.31
MH Trust 2017/18 Average	3.22

Source: NHS Staff Survey

Mandatory training: % staff

94%	95%
Q3	Q4

Source: TPNHSFT HR

Staff opinion of training

Trust 2015/16 Score	3.97
Trust 2016/17 Score	4.01
Trust 2017/18 Score	4.18
MH Trust 2017/18 Average	4.06

Source: NHS Staff Survey

MANAGEMENT

Support from immediate managers

Trust 2014/15 Score	4.01
Trust 2015/16 Score	3.95
Trust 2016/17 Score	3.85
Trust 2017/18/Score	4.05
MH Trust 2016/17 Average	3.95

Source: NHS Staff Survey

% staff reporting good comms between senior mgmt and staff

Trust 2014/15 Score	43%
Trust 2015/16 Score	46%
Trust 2016/17 Score	45%
Trust 2017/18 Score	54%
MH Trust 2016/17 Average	36%

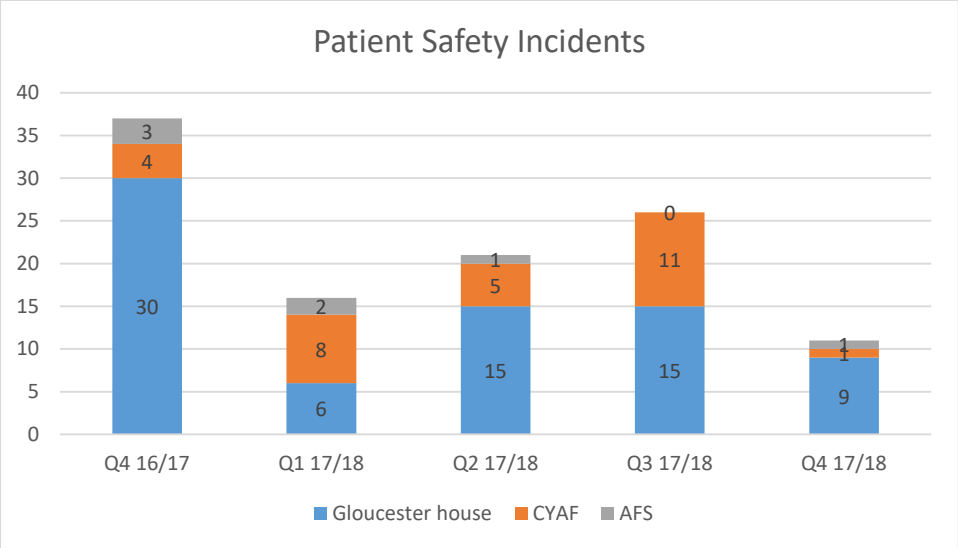
Source: NHS Staff Survey

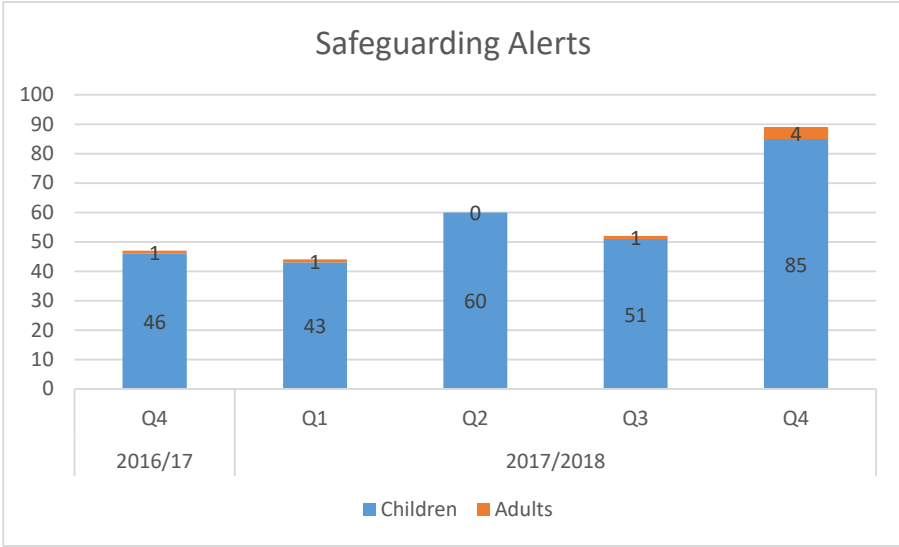
Recognition and value of staff by managers and the organisation

Trust 2015/16 Score	3.92
Trust 2016/17 Score	3.61
MH Trust 2016/17 Average	3.56

Source: NHS Staff Survey

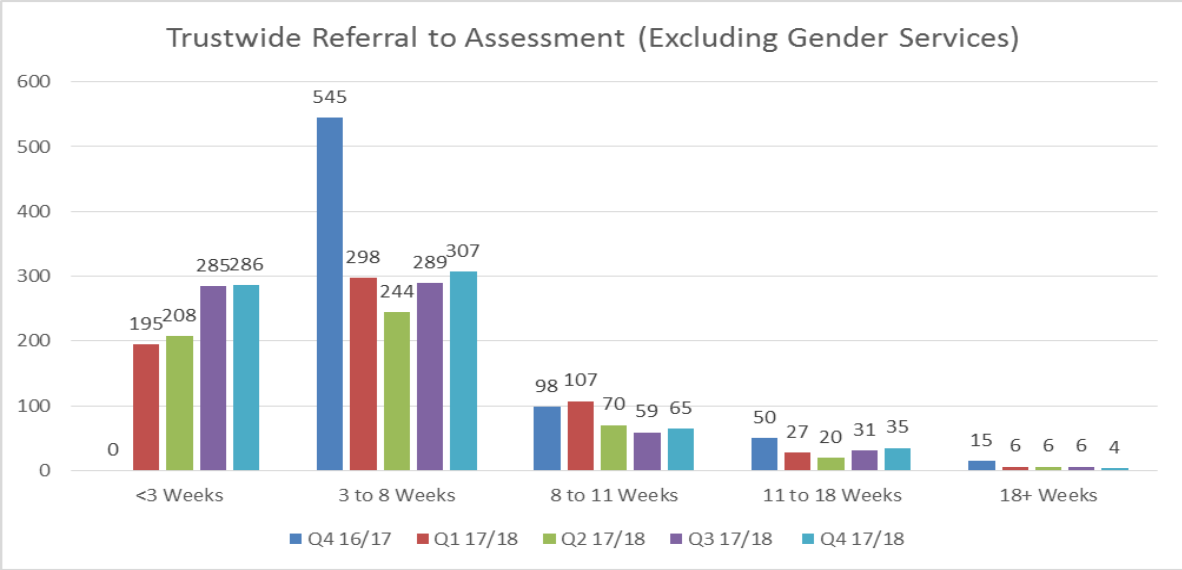
Q4 2017/18: Quality Safety

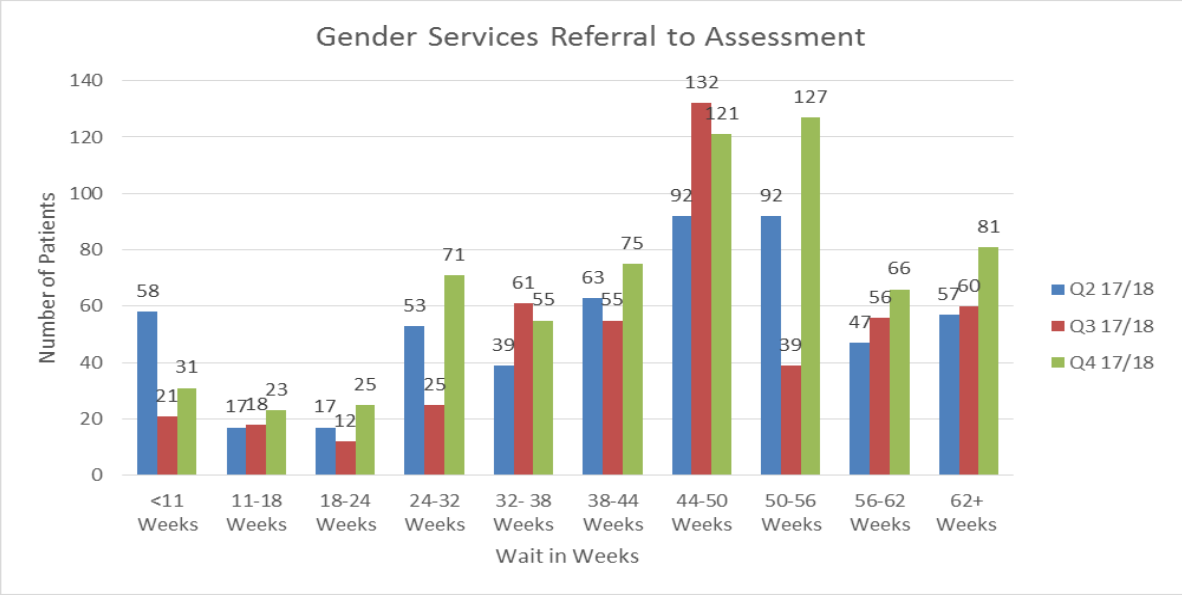




Q4 Serious Incidents reported
One – adult safeguarding incident. However, following investigation it is to be requested to be de-escalated as it is not a serious incident.

Q4 2017/18: Quality Responsive





	First attendances in Q4 16/17 - 708
	First attendances in Q1 17/18 - 633
	First attendances in Q2 17/18 - 548
	First attendances in Q3 17/18 - 670
	First attendances in Q4 17/18 - 697

Adult teams: **Adult Complex Needs** Service has seen 79.5% of their patients with in their 11 week waiting time target, exceeding their target by 10.5% compared to only 4% in quarter 3.

CYAF Teams: **Camden CAMHS** has performed consistently well throughout 2017/18, considering the high volume of patients in the service. **The FAS (Westminster service)** have fluctuated this financial year, due to the patient population. **Other CAMHS**, have a higher breach percentage than the trust target of 10%.

Gender Service Teams: Both the **Gender Identity Clinic** (Over 18) and **Gender Identity Service** (under 18) of these teams continue to breach their 18 wait week targets. Previous plans to bring this in line have now been made obsolete as more referrals than predicted have been made to the gender services in the 2017/18 financial year. The services are working closely with commissioners to manage this and their expectations.

Q4 2017/18: Quality Responsive

	2016/17	2017/18			
	Q4	Q1	Q2	Q3	Q4
Quality Responsive (Q4 from ESQ) Views and worries were taken seriously	94%	100%	98%	99%	99%
Quality Responsive (Q13 from the ESQ) Involved in important decisions about my care	86%	97%	97%	99%	98%

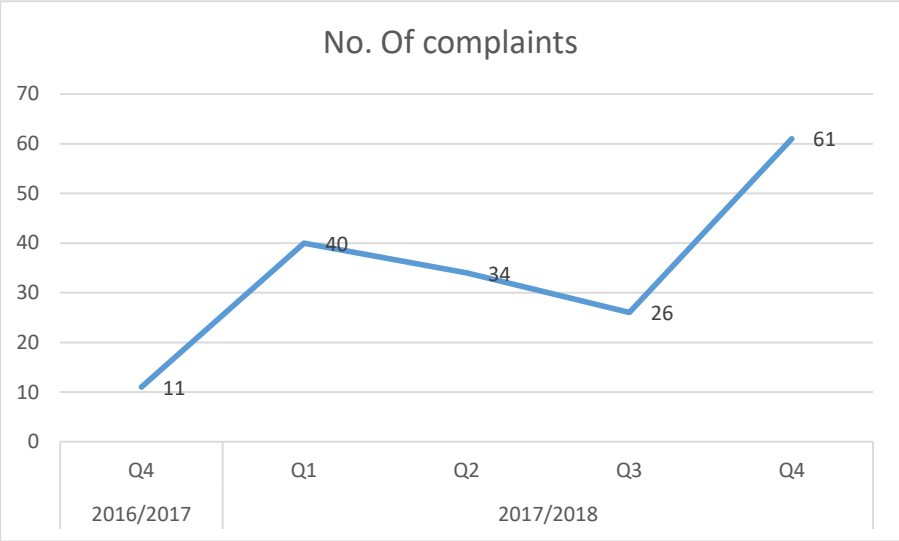
Total PALS 01/04/2017- 31/03/2018

Month	Total PALs	Year
April	67	2017
May	104	2017
June	261	2017
July	106	2017
August	85	2017
September	55	2017
October	92	2017
November	67	2017
December	47	2017
January	71	2018
February	48	2018
March	40	2018

The top PALS enquiries for 2017/18 are:

- Access to treatment
- Communications
- Appointments
- Education / Training

GIC remains the service receiving most enquiries, followed by GIDs and Complex Needs.



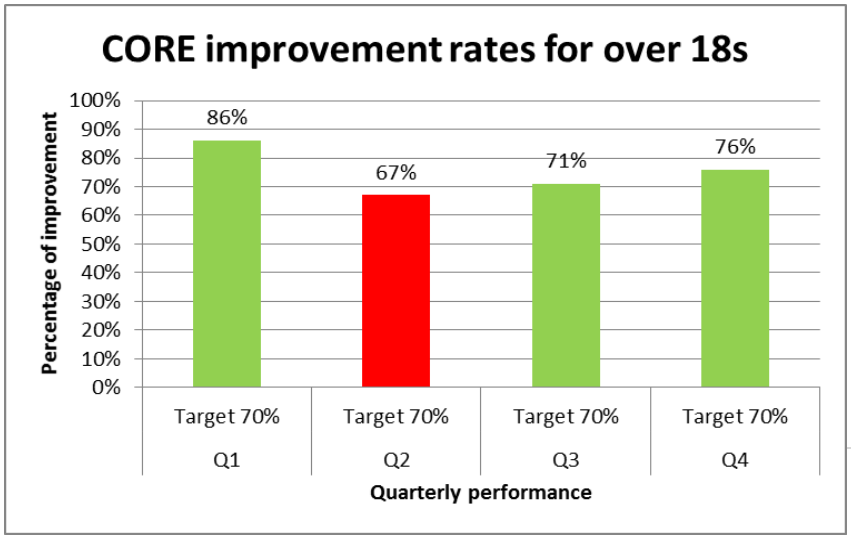
Directorate:	No of complaints :
CYAF	58 (45 GIC)
AFS	2
Corporate	1

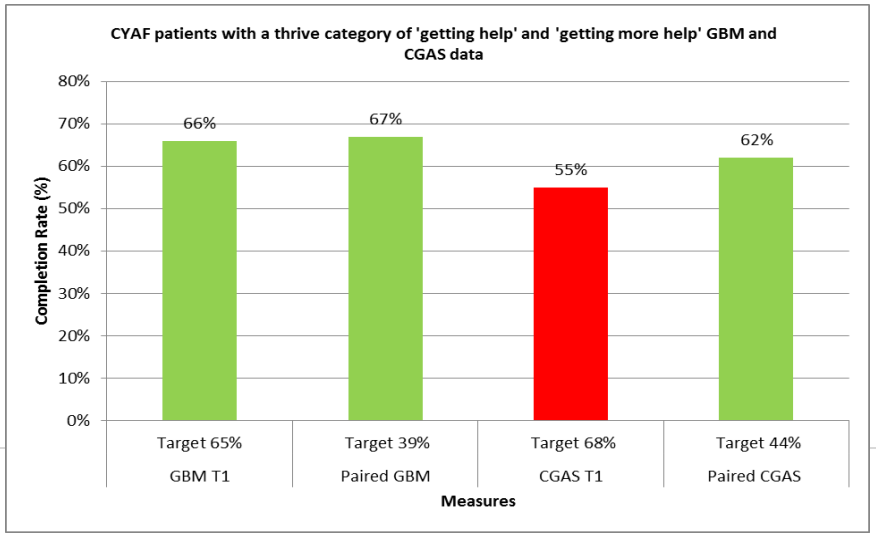
The increase in complaints has been within the GIC service. Main issues remain unchanged – appointments and communications. 238 number outstanding over 25 working days. Additional support is to be provided in GIC for next quarter to help respond to outstanding complaints. It is proposed that the response time set by the Trust from receipt of complaint is extended from 20 to 40 working days. This is not a national requirement and may help manage expectations. Number of complaints Not Upheld is 13, 8 were upheld, 5 were partially upheld and 35 complaints remain open.

Q4 2017/18: Quality Effective

	2016-17				2017-18			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
DNA rates (%)	9.1%	10.0%	8.6%	7.4%	10.6%	11.4%	10.3%	9.2%
Patient Satisfaction (Q6 from ESQ) "The information I received about the Trust before I first attended was helpful." Target =75%	81%	81%	80%	80%	94%	90%	96%	95%
Patient Satisfaction (Q15 from ESQ) "Overall, the help I have received here is good" Target=100%	94%	93%	93%	93%	99%	99%	100%	100%
Patient Satisfaction (Q11 from ESQ) "If a friend or family member needed this sort of help, I would suggest to them to come here " Target=80%	91%	91%	91%	91%	98%	97%	97%	99%

Central SMS reminders started in quarter 4 for both Adolescent and Young Adult service (AYAS) and GIC. This will be rolled out across the Trust in 2018/19.





Patient Reported Measures:

CORE: Clinical Outcomes in Routine Evaluation

GBM: Goal Based Measure

CGAS: Children's Global Assessment Scale

Q4 2017/18: Directorate of Education and Training (DET) (Academic Year)

Directorate of Education and Training (DET)

The next annual Student Survey will be the local survey, with integrated National Survey questions. This is scheduled for May 2018.

Student Experience and Outcomes

Satisfaction: "Overall, I am satisfied with the quality of the course"			Change from previous year
	Benchmark	Tavistock	
2013	88.3%	92.8%	
2014	87.0%	93.0%	↑
2015	83.0%	94.0%	↑
2016	86.0%	90.0%	↓
2017	84.0%	81.0%	↓

Personal Development /Prepared: "I feel better prepared for my future career"			Change from previous year
	Benchmark	Tavistock	
2013	72.4%	82.3%	
2014	77.9%	86.2%	↑
2015	81.0%	91.0%	↑
2016	82.0%	89.0%	↓
2017	78.0%	86.0%	↓

Effectiveness "I have been able to apply my learning on the course to my job"			Change from previous year
	Benchmark	Tavistock	
2013	80.3%	87.1%	
2014	77.0%	81.3%	↓
2015	78.0%	87.0%	↑
2016	80.0%	96.0%	↑
2017	81.0%	87.0%	↓

Benchmark UK data: www.hefce.ac.uk/lt/nss/results (Summary England) [2017]

Notes for 2017:

Overall on a par with Benchmark statistics for England

University Partner ratings:-
University of Essex 88%
University of East London 84%
University of Middlesex 80%

Student experience
Changes have occurred during 2017 across the Course Administration function, including implementation of new student record system / MyTAP. Towards the end of the year, changes in the structure of the course administration team have been implemented with an aim to improve the student experience going forward.

***The personal development questions became optional in the 2017 National Student Survey.**

University Partner ratings:-
There is no comparison data split by University, other than the overall satisfaction rating.

Overall higher score than Benchmark statistics for England but lower than the previous year's score for the Trust

University Partner ratings:-
There is no comparison data split by University, other than the overall satisfaction rating.

Benchmark Question
From NSS 2017 results: "My course has provided me with opportunities to apply what I have learnt"

Q4 2017/18: Directorate of Education and Training (DET)

Short course activity as at 31/3/18							
	Year	**13-14 FY Actual**	**14-15 FY Actual**	**15/16 FY Actual**	**16/17 FY Actual**	**17/18 FY Plan to date***	**Comments**
Course numbers	**CPD/E-learning**	45	58	70	94	93	plus 5 postponed to summer 2018; 8 cancelled due to low recruitment
	Bespoke work	14	18	10	38	45	
	Conferences	18	18	16	4	6	3 HCUK, 3 internal, 1 postponed to June 2018 (due to snow), 1 cancelled
	Perinatal	n/a	n/a	n/a	2	5	
	Visitors Programme					23	
Students	**Student Nos**	2079	2738	2063	2279	2271	
Income	**Income**	501,917	556,261	493,090	£692,710	£852,810	
	Income growth on previous year	35%	16%	-11%	40%	23%	
	Contribution	160,769	158,104	123,616	£197,122	£522,708	17-18 contribution based on income-direct costs (16-17 included indirect costs therefore reduced contribution
Staffing	**Staff number**	3	3	2	3.5	3.6	
* Forecast figures - some income to still come in. Excludes unconfirmed pipeline activity and income							

Q4 2017/18: Single Oversight Framework

Segmentation under the Single Oversight Framework: **1** (the best of the four possible ratings, no identified support needs)

There are five themes under the Single Oversight Framework that NHS Improvement considers when assigning organisations to Trusts. Of these Finance and Use of Resources is covered in the monthly board papers. This information is supplied by the informatics team and also includes some of the MHSDS data. Our current status for the other four themes as assessed by NHS Improvement is:

Quality of Care: Green

Strategic change: Green

Leadership and Improvement Capability: Green

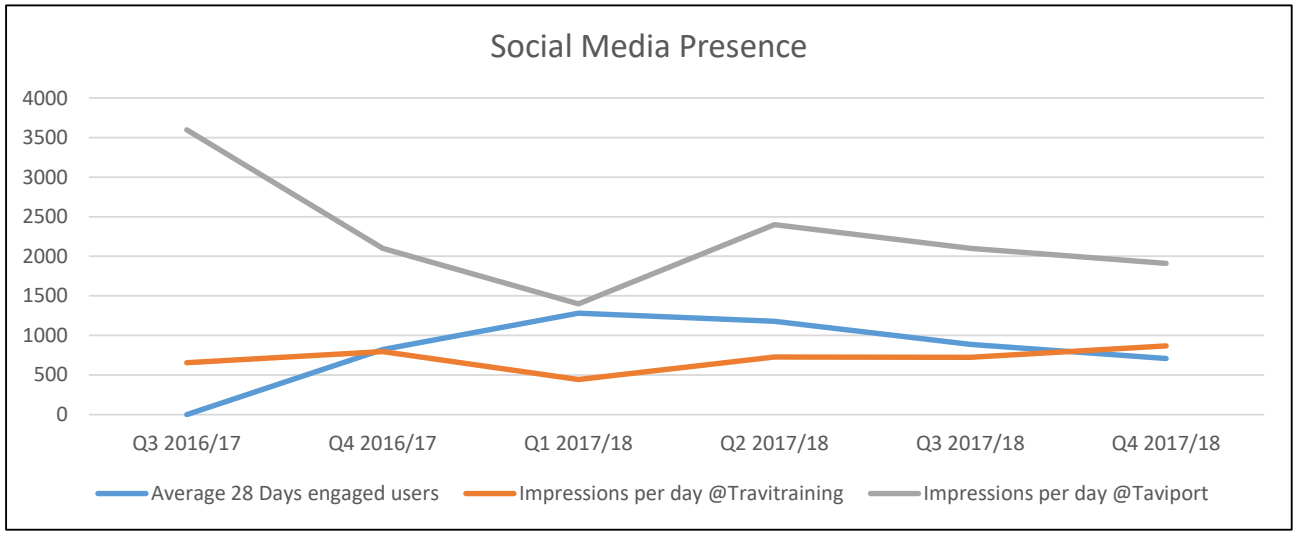
Operational Performance: Amber

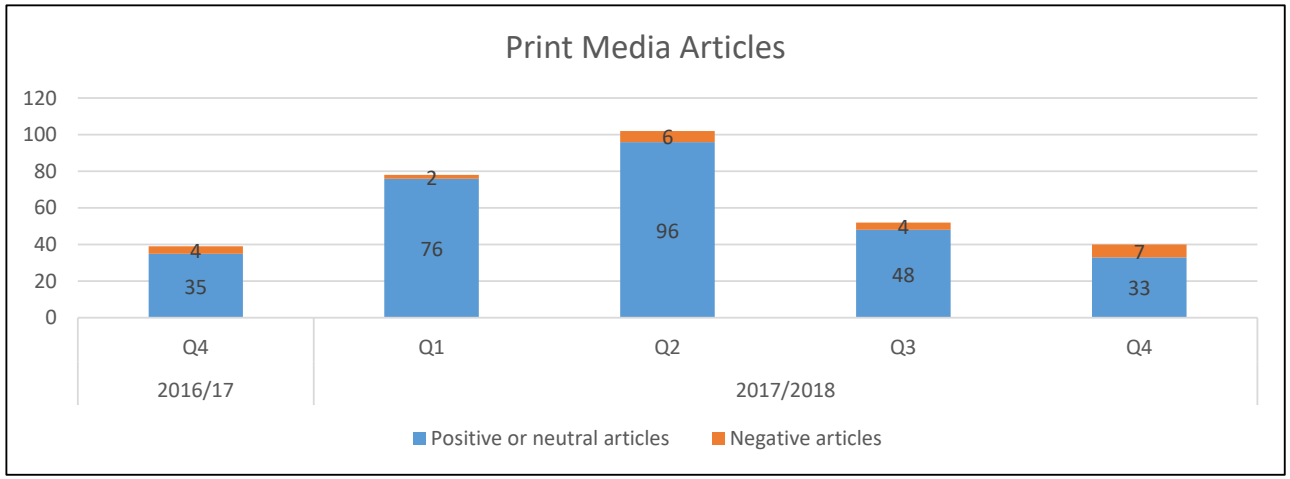
	Target (%)	Month 1 (%)	Month 7 (%)	Month 11 (%)	Current / Future Target
Valid NHS number	95%	96.2%	99.1 %	98.65%	Current
Valid Postcode	95%	99.8%	99.8%	99.75%	Current
Valid Date of Birth	95%	100%	100%	100%	Current
Valid Organisation code of Commissioner	95%	99.5%	99.5%	99.12%	Current
Valid Organisation code GP Practice	95%	99.1%	99.2%	98.12%	Current
Valid Gender	95%	99.8%	99.8%	99.79%	Current
Ethnicity	85%	83%	79.6%	77.27%	Current
Employment Status (for adults)	85%	26.3%	36.9%	46.62%	Current
Accommodation status (for adults)	85%	26.1%	36.6%	46.16%	Current
ICD10 coding	85%	NA	NA	NA	N/A

*The trust is working towards a 99% target

*Cohort Includes any patient that has been referred to us without being discharged. Data is collected through referral information and patient and clinician completed forms.

Q4 2017/18: Media





Quarterly Quality Report Q4 2017/18

1. Introduction

1.1 This report refers directly to the Quarterly Quality Report submitted to commissioners which includes KPIs, CQUINs, quality priorities and other performance related indicators. This report does not directly refer to all of the data collected in the above dashboard.

1.2 As requested by the Board of Directors the following paper provides a summary and narrative for quarter 4 quality metrics currently within the Quality Report. This report specifically covers those metrics where we are not meeting targets or where the trajectory suggests a worsening position. Service level updates and actions are provided by the Service Leads. Some significant improvements are also highlighted. Please note the data in this report is for Trust wide, with the exception of CQUINS that apply to London Contracting or NHSE contracts only.

1.3 The following metrics are summarised below:

- 1.3.1 Waiting times
- 1.3.2 Did not attend (DNAs)
- 1.3.3 MHSDS data
- 1.3.4 Outcome Data
- 1.3.5 Quality Priorities
- 1.3.6 CQUINS

2. Summary Metrics

2.1 Waiting Times

Data is validated by services and is as accurate as possible. Standard operating procedures (SOPs) /validation and reliability of the data have improved due to the introduction of new checklists and validation processes within the Quality Team and services. The percentages below show the proportion of people seen within the waiting time target.

Service	Q2 Performance	Q3 Performance	Q4 Performance	Trajectory (+/-)
Adult Complex Needs	90%	86%	79.5%	**Decreasing**
City and Hackney PCPCS	98%	95%	99%	**Improved**
Portman	96%	100%	100%	**Stayed the same**
Camden CAMHS	94%	97%	94%	**Decreasing (Not a cause for concern)**
Other CAMHS (Excluding first step)	75%	75%	77%	**Improved**
Adolescent	76%	89%	76%	**Decreasing**
GIDS	25%	14%	16%	**Improved**
GIC	6%	4%	5%	**Improved**
Westminster	70%	100%	83%	**Decreasing**

2.1.1 Adult teams: **Adult Complex Needs** Service has seen 79.5% of their patients with in their 11 week waiting time target, exceeding their target by 10.5% compared to only 4% in quarter 3. However, they saw a lot more people off of their waiting list, something that has reduced in this quarter and the past quarter too**. City and Hackney** have reduced their breaches a significant amount, whilst managing to see a significant amount of patients in quarter 4 as in quarter 3. **Portman** have not seen any of their patients breach their 11 week waiting time target this quarter.

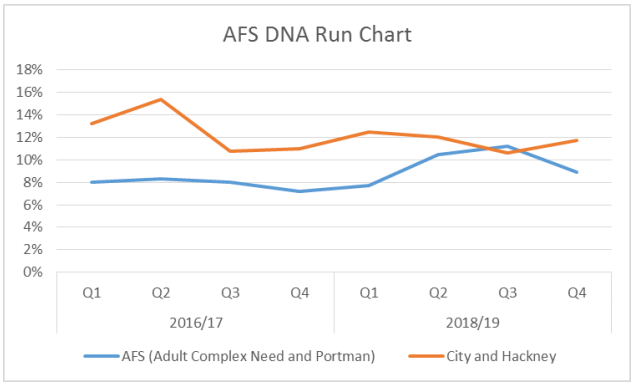
2.1.2 CYAF Teams: **Camden CAMHS** has performed consistently well throughout 2017/18, considering the high volume of patients in the service. **The FAS (Westminster service)** have fluctuated this financial year, this is due to the patient population. **Other CAMHS**, have a higher breach percentage than the trust target of 10%. Although the breach percentage has slightly declined from 25% to 23% in the past quarter. The waiting list has declined from 77 in Q2 to 55 in Q3 and has remained low in quarter 4.

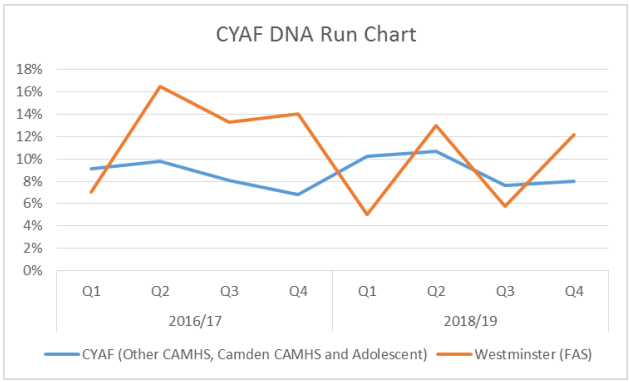
2.1.3 Gender Service Teams: Both the **Gender Identity Clinic** (Over 18) and **Gender Identity Service** (under 18) of these teams continue to breach their 18 wait week targets. Previous plans to bring this in line have now been made obsolete as more referrals than predicted have been made to the gender services in the 2017/18 financial year. The services are working closely with commissioners to manage this and their expectations.

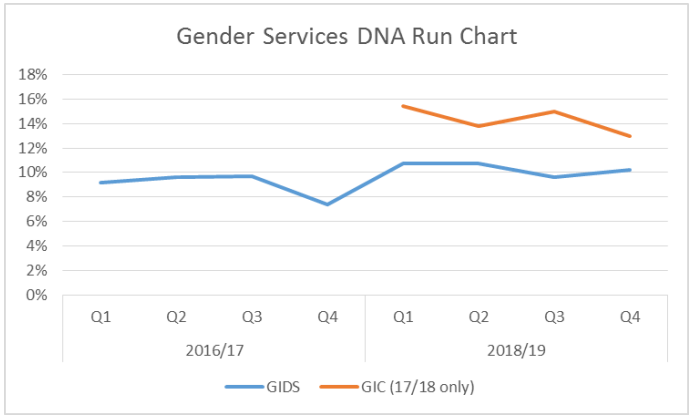
2.2 **Did Not Attend (DNA)**

DNA rates are an average figure and expected to be no larger than 10% (9.2% achieved for Q4). The definition used for DNA figures is **Numerator:** Total DNA / **Denominator:** Total Appointments (Total Attended + Total DNA appointments). CYAF, Adult Complex Needs and Portman services all stayed under the 10% trust wide target. However, GIC, GIDS, Camden TAP, Westminster (FAS) and City and Hackney all breached the 10% DNA target but all have plans in place to address these issues.

Service	Q2 Performance	Q3 Performance	Q4 Performance	Trajectory (+/-)
Adult Complex Needs and Portman	10.5%	11.2%	**8.9%**	**Improved**
City and Hackney PCPCS	12%	10.6%	**11.7%**	**Decreasing**
Camden CAMHS, Other CAMHS and Adolescent	10.7%	7.6 %	**8%**	**Decreasing but still with in target**
GIDS	10.7%	9.6%	**10.2%**	**Decreasing**
GIC	13.8%	15%	**13%**	**Decreasing**
Westminster	13%	5.8%	**12.2%**	**Decreasing**







2.3 **MHSDS Data**

In order to improve on MHSDS (Mental Health Service Data Set, Single oversight Framework Section) completion the Trust reports internally on a monthly basis to see where demographics of patients are not collected. This is shared with services. MHSDS is submitted externally twice for each month, the analysis presented is for November, December and January. The reason for this is that it is the refreshed data is sent nationally 3 months after collection. For many of the categories, including gender, date of birth, referral information, GP information, contract information, marital status and current postcode, targets were met. However areas of concern were completion of accommodation status (56%) and employment status (56%), even though these are up from 25% on quarter at the beginning of the financial year. This quarter it has been identified that our internal systems for accommodation and employment do not match that of the MHSDS submission (displayed in the dashboard as the 'Single Oversight Framework'). The internal reporting includes any patient over the age of 18 that has an accommodation or employment status completed, however the MHSDS submissions only include it as complete if it has been filled out in the past year. The Quality Team will work with informatics to change the internal reporting to ensure all obsolete accommodation and employment statuses are updated on an annual basis. – This will be apparent in the next financial year reporting.

2.4 **Outcome Data**

New targets for OM data have been agreed with the commissioners for the CYAF data with increasing targets up until 2020/21. The new CYAF targets are visible in the trust wide dashboard and focus on data for any patient with a thrive category of 'getting help' or 'getting more help'.

2.4.1 The collection of GBM or CGAS Time 1, for any patient with a thrive category of 'getting help' or 'getting more help'. CGAS Time 1 currently at 55%, this is under target by 13%. GBM Time 1 collection at 66%, achieving target for 2017/18.

2.4.2 The collection of GBM or CGAS Time 2 or End of Treatment, for any patient with a thrive category of 'getting help' or 'getting more help' and who has been discharged or has been open for longer than 6 months. GBM Time 2 currently at 67%, exceeding target of 39%. And CGAS Time 2 at 62%, achieving target for 2017/18 target.

2.4.3 CORE targets have remained unchanged, 76% of patients with a paired CORE showing improvement, this is 6% above target.

2.5 Quality Priorities

2.5.1 Quality Priority 1: Improve the Physical Health of Patients Receiving Treatment.

- The living well programme has been continued to be developed with the addition of sleep as a topic. A consultation was held with senior clinicians to get their views on implementing a targeted intervention to improve sleep within those aged 15+ across the Trust who met certain criteria. Overall, the proposition of this intervention was well received, with clinicians being keen for this intervention to be offered to their patient group. A pilot patient has completed the session on a 1:1 basis, however, it is hoped that from this point onwards, the sleep intervention will be run bi-annually for a 5 week period for those aged 15-17 and 18+.
- A re-recruitment of physical health champions is currently underway, and it is hoped that individuals across the Trust will sign up to this opportunity.
- A continuation of meetings across the Trust with separate teams have been held to try and promote the benefits of improving your physical health alongside your mental health. The online training programme for Very Brief Advice continues to be accessible for all staff via the Trust's intranet.
- Individual support for patients this quarter has been increased with a particular focus on sleep. The Trust's first behavioural sleep intervention session was launched as a pilot. Work has also continued on ensuring that the physical health service remains accessible to all, through promoting the physical health service in general to clinicians across the Trust. This has been done through attending meetings, sending information emails and placing text within the Trust's e-bulletin

2.5.2 Quality Priority 2: Improve the Identification and Management of High Risk Patients

- We have provided training to ensure that clinical staff are fully aware of how to clinically manage clinical risk assessment and self-harm and suicide. We have provided several training sessions and workshops over the year 2017/18 to enable as many clinicians as possible to attend. We have not yet reached the required 80% of staff trained, but the training continues and has now been made mandatory, including the option to complete via e-learning, with a view to achieving the 80% training compliance by Q4 2018/19.
- All relevant policies have been updated and disseminated including the Learning from Deaths policy which is available with all other policies on our intranet and website.

- Clinical Audit Officer carried out an audit in September 2017 looking at data from Q2 to ensure that the risk of suicide and self-harm are being properly identified, recorded and monitored by clinicians in order to ensure the best possible care for the Trust patients. This will be re-audited this year to ensure there has been an increase in the completion of risk management forms on the Electronic Patient Record.
- This year's focus has mainly been on the prevention of suicide and management of self-harm and we have used the relevant sections in the Safer Services toolkit in relation to ligature point audits.

2.5.3 **Quality Priority 3: Embed meaningful use of outcome monitoring in services.**

- Quality improvement (QI) leads have been recruited within the department and administration staff have completed QI training. QI leads and staff are currently working together to look at current outcome data. Patients will be involved in QI in 2018/19 to enable contribution in outcome measures
- As part of Reducing the Burden project outcome measures are being rationalised and the CareNotes assist system are being made simpler to navigate. Work is currently taking place on the programme of implementation. All measures received by the Quality Team are entered onto the patient information system within 1 week receipt.
- A dashboard scoping exercise is currently taking place to allow a more convenient way for patients to complete OM forms, e.g. Online to increase return takes.
- CYAF: 56% of CYAF patients had a Time 1 Goal Based Measure (GBM) on record and of these patients 77% (62/81) indicated an improvement on two or more goals.
- 76% of patients who had a Time1 and Time 2 CORE showed improvement.

2.5.4 **Quality Priority 4: Improve the use of equalities information to ensure clinical services are responsive to the needs of patients, carers and families.**

- Quality Quality Stakeholder group membership was extended to community groups. The group is now chaired by a revolving patient representative.
- Collection of data is under review by the Quality Stakeholder Group and the Equalities Committee in order to increase quantity and quality for the particular demographic in Camden and other boroughs served by the Tavistock and Portman NHS Foundation Trust
- This has not yet been fully achieved. Detailed data is provided to service lines but further work required to identify gaps and plans to address them. The Patient and Public Involvement team have addressed community groups to make links with over 18/19

2.6 **CQUINs**

Only those due to commissioners this quarter are included below.

2.6.1 **The Living Well CQUIN**

The Living Well Programme has been delivered across the Trust, and has included material on smoking, alcohol, good body weight (healthy nutrition) and stress management. Feedback has been collected of those who have had any intervention from the physical health practitioner. The Trust has been improving the completion

of the Physical health form, and has managed to achieve the target of 80%, with 80% of all new patients having completed the form. The number, dates and content of programme have been evidenced as part of CQPE reporting.

Q4 Trust Assessment = fully met

2.6.2 **Safe and Timely Discharge CQUIN**

This requires an audit to be conducted quarterly. The Portman have made significant progress in this CQUIN, in Q4 16/17 they had only met the second part of this CQUIN (completing mandatory fields in GP discharge letters) by 17%, however, have exceeded the target of 80% in Q2 and continued to meet it until Q4 where 87% was achieved, Portman have also met the first part of the target (for discharge letters to be sent within 2 week of discharge) with 100%. Audit report to be presented at CQRG.

Q4 Trust Assessment = fully met

2.6.3 **Transitions out of Children and Young People's Mental Health Services CQUIN**

The end of year report was provided to commissioners on the 30th April 2018. It is anticipated that we will meet the Q4 requirements. There is a detailed action plan and joint working with Whittington Health Trust (sending provider) and Camden and Islington NHS Trust (Receiving Provider).

Q4 Trust Assessment = fully met

2.6.4 **GIDS Telemedicine CQUIN**

Three appointments were held using the technology, on 23 March, 27 March and 28 March, following a period of delay due to firewall issues.

Three clinicians delivered these sessions. A clinician survey and a client survey were developed on Survey monkey. All participants were sent the link. Two of the three clients and all three clinicians completed the surveys. Initial feedback has overall been quite positive, even with some initial technical problems – one of the videolinks ended up being an audiolink due to problems with the video.

Interestingly, clinicians rated the video link as 'same as a face-to-face appointment' on a number of items, with a scale of 'significantly worse than a face-to-face appointment' and 'significantly better than a face-to-face appointment'. The guidance about the use of videolink appointment is very clear that these appointments should only be offered to low-risk patients who have already been assessed, and are in the follow-up phase.

These videolink appointments took place between a client and a clinician where rapport and understanding had already been developed. As mentioned, there was one appointment in which the video didn't work, which took place as an audiolink instead. The clinician said that the client seemed more open than usual, and that the client had expressed that there was something about being in their own space that facilitated that openness. The clinician reported feeling able to manage the risk in the same way they would for a face-to-face appointment.

Two of the three clients also completed the survey and again were positive about the experience. One wrote it was "quick and easy to access" and another was pleased "not having to travel". Clients were asked to rate their experience on a number of items scaled between 1 and 5 (1 being strongly disagree and 5 being strongly agree). On many points they scored the experience very positively, as a 5 out of 5.

There were two items where the scoring was slightly lower: 'I would rather have a videolink than travel to the clinic' and 'it was no different to communicating in person'. One of those two fed back to their clinician that they felt happy having a videolink appointment at this point in their care pathway, they would not have wanted one when they were in assessment.

This feedback reinforces the feedback from clinicians: that videolink appointments may be appropriate for post-assessment, follow-up appointments, but won't typically be suitable for assessment appointments. The next project group meeting, which will take place with the suppliers of the technology and key Tavistock & Portman stakeholders, is scheduled for 20 April. This will be an opportunity for clinicians to provide their feedback about their experiences and for the group to decide whether it is appropriate or not to progress with a phased roll-out of the technology across the service. If this is agreed, it will be an opportunity to request tweaks and resolve some of the minor issues raised with the technology (e.g. audio issues were raised in one videolink). (Keyur Joshi, Service Manager GIDS)

Q4 Trust Assessment = fully met

2.6.5 **GIDS / GIC Transfer arrangements across the Gender Identity Pathway CQUINs (2)**

A survey was sent out to the patients who had graduated from GIDS and had at least 1 appointment at the GIC since April 2017. We sent 18 surveys and received 2 responses. The outcomes of these were fair to positive and the results are attached. These patients would not have benefitted from the changes that we have implemented to improve the transfer for those who are moving from GIDS to Charing Cross GIC.

The GIDS and GIC have regular discussions around transfer of care. A monthly meeting has been set up to ensure communications are ongoing and number of patients likely to transfer are discussed as part of these meetings.

We also have mechanisms in place to routinely identify those who had graduated from GIDS and had at least 1 appointment at the GIC in order to continue to survey patients on the experiences of transfer.

Q4 Trust Assessment = fully met for both CQUINs

2.6.6 **GIC 7 point implementation plan CQUIN.**

The GIC have made efforts to reduce time from referral to treatment, there has been 2 new posts introduced for Referral Screening for a smoother screening process.

The population that has experienced the benefit of a shorter wait time from referral to treatment has been the GIDS patients who are guaranteed to be seen:

3-6 months from their referral date to the Charing Cross GIC or 3-6 months from the 18th birthday, whichever is more appropriate. If a patient has been on the GIDS waiting list and will not be seen by GIDS before their 18th birthday, the patient is contacted and if they would like to transfer to adult services at the Charing Cross GIC, then the Charing Cross GIC will ensure their original GIDS referral date is honoured. Both of these measures ensures that a patient only waits once for access to the Tavistock & Portman services.

Due to waiting times for GIDS, the Charing Cross GIC has been reducing their age of referral acceptance throughout the year. We have stair-stepped down from 17 years and 9 months to 17 years and 0 months over the last 12 months.

Transition clinics have also been reinstated. These are clinics where the Lead Clinician at the GIC spends one day a month at the GID Service. He sees patients who are transferring to adult services with their GIDS therapist to ensure a smooth transition. This counts as a 1IA appointment for the patient as well which we hope is more containing for some of our more complicated transferring cases.

The GIC service are actively involving patients in the development of services e.g. patient feedback on a proposal to change the way follow-up appointments are made with patients; 350 patients who are on the GIC waiting list were invited to a session about the service held 21 September with 114 attending. The next workshop will be held in March 2018.

A weekly Multi-Disciplinary Meeting has been introduced and ongoing since the autumn 2017. This is 3 more per month than were originally occurring. One meeting a month in a longer meeting and incorporates a CPD session that rotates between clinical staff in the clinic as well as some external speakers thus ensuring a well-rounded CPD structure that is ongoing. In addition, all clinicians are encouraged to attend BAGIS every year.

We are structuring a training day with the clinicians to learn about working with Autistic patients as 10% of our patient base is Autistic. There will also be a session with the administration to discuss communicating with this part of the patient population.

We have built in quarterly clinical away days where the clinicians have a large amount of time to discuss concerns and come up with solutions. These are fed back to the Service Manager who can help action changes or be part of the solutions for the clinic. The most recent one of these was the 31 Match 2018 and topics included:
Working towards an appropriate gap between appointments which has been agreed should be around 4 months.

Q4 Trust Assessment = fully met

The Tavistock and Portman NHS
NHS Foundation Trust

Board of Directors: May 2018

Item : 13b

Title : Clinical, Quality, Safety and Governance Committee Minutes Q4 Board Report

Summary:

The Terms of Reference of the Committee need updating.

The introduction of the General Data Protection Regulations on 25th May 2018 require substantial changes to the IG work-stream requirements.

A NED deputy chair needs to be identified. Reviewing the ToR provides an opportunity for the Board to review the leadership and function of the Committee in the context of the Medical Director stepping down.

The excellent progress in achieving level 2 on the IG toolkit was noted. The IG work-stream was rated green for Q4. Other work-streams were all rated amber with notable progress in some areas but some significant challenges including resourcing the management of the increased number of complaints, some mandatory training compliance, waiting times in some services and recording of safeguarding supervision.

For : Consideration

From : Medical Director

A Clinical Quality Safety and Governance Committee (CQSGC) MINUTES FROM A MEETING HELD AT 11:00, TUESDAY 9th May 2018, BOARDROOM

Members	Present?
Rob Senior, Medical Director (& CQSGC Chair) (RS)	Y
Paul Jenkins, Chief Executive (PJ)	N
Paul Burstow, Trust Chair – Non-Executive Ex-officio (PB)	N
George Wilkinson, Public Governor (GW)	Y
Anthony Levy, Public Governor (AL)	Y
Jane Gizbert, Non-Executive Director (JG)	Y
Dinesh Bhugra, Non-Executive Director (DB)	N
Debbie Colson, Non-Executive Director	Y
Terry Noys, Deputy Chief Executive and Finance Director & SIRO (TN)	Y
Sally Hodges, Director of CYAF (in part) (SH)	Y
David Wyndham Lewis, Director of IMT (DWL)	Y
Caroline McKenna, Associate Medical Director (CMK)	Y
Louise Lyon, Director of Quality and Patient Experience (LL)	Y
Julian Stern, Director of Adult and Forensic Services (JS)	N
Marion Shipman, Associate Director Quality and Governance (MS)	Y
Elisa Reyes Simpson, Associate Dean for Academic Governance and Quality Assurance (ERS)	Y
Craig da Souza, Director of HR (in attendance) (CdS)	Y
Irene Henderson, Clinical Governance & Quality Manager & CQSGC Secretary (IH)	Y

SUMMARY OF ACTION POINTS

AP	Item	Action	By	Deadline
From February Meeting	(6.1)	CMK to produce a list of all GIC processes in relation to patient safety.	**CMK**	September Meeting
3		CdS agreed to provide the minuting format of the NHS best practice model of Board level assurance meetings to RS & IH.	**CdS**	30/05/18
4		CdS agreed to produce a proposal to confirm sanction arrangements for non-compliance with mandatory clinical training and bring to the EMT.	**CdS**	June 2018

5		DWL agreed to provide the list of 44 staff who remain non-compliant in IG training to clinical directors and the Medical Director immediately	**DWL**	15/5/18
	5.1	DWL agreed to take information asset and information ownership to the newly formed Task and Finish group.	**DWL**	Sept Meeting
	5.2	DWL agreed to redraft the IG work stream report and IG section of the CQSGC TOR and provide a draft revision for the next meeting to review.	**DWL**	Sept Meeting
	5.3	CdS will attend the next CQSGC to provide a reformatted draft of the CQSGC TOR in line with best practice.	**CdS**	Sept Meeting
	7	LL agreed to circulate the specialist report to the committee.	**LL**	15/5/18
	7	IH to circulate clinical quality strategy to committee.	**IH**	15/5/18
	7	CMK agreed to circulate the clinical audit report to the committee.	**CMK**	15/5/18

Item			Action
1		**Chair's opening remarks** RS welcomed everyone to the meeting and confirmed that this committee will be considering Q4 data. RS also noted this is the last CQSG committee that he will chair in role as Medical Director.	
2		**Apologies for Absence** Apologies were received Dinesh Bhugra, Paul Jenkins, Paul Burstow and Julian Stern.	
3		**Notes from last meeting** The notes from the last meeting were accepted as accurate with two minor amendments: Page 13: item 7.8 should read 85% target Page 44: Subject Access to Records (SARs) resourced at 0.4 WTE instead of reported 0.6 There was some brief discussion around the way the committee agenda and meeting is minuted and it was agreed the notes should remain very comprehensive to provide a true reflection of the committee discussion and agreements, but follow the latest	

		guidance for board level meetings. CdS suggested the committee adopt the NHS best practice model of Board level assurance meetings for all future CQSG committees and this was agreed and it was decided to discuss this further when looking at the TOR. **CdS agreed to provide the format of the NHS best practice model of Board level assurance meetings to RS & IH.** DC asked if all uncompleted actions were carried forward and RS confirmed that they remain on the action list until completed.	**CdS**
4		**Matters Arising** **UPDATE ON ACTIONS** All actions were noted as completed except the one in relation to producing a list of all GIC processes in relation to tracking patients after treatment as it requires further work. This will remain as an action and CMK will update at the next committee meeting. SH commented on the completed action in relation to the GIC waiting lists and wanted the committee to be aware that although a massive amount of work has been undertaken to reduce the waiting list, this is not possible with the current resourcing levels coupled with a record increase in referrals. She also noted the low rate of GIDS collection of ethnicity data and confirmed work undertaken has made the data much better now. There was a brief discussion around the sanctions for non-attendance at CPR training and RS confirmed that for the doctors, it was not a requirement of professional registration, fitness to practice or good standing with the College. CdS commented he had consulted the national skills framework competency guidance which recommends undertaking refresher risk assessment for all medical staff including nurses and clinicians. **CdS agreed to produce a proposal to confirm sanction arrangements for non-compliance with mandatory clinical training and bring to the EMT.** **ANNUAL REVIEW OF TERMS OF REFERENCE (TOR)** RS invited committee comments on the current TOR. AL highlighted that 2.1 states a NED should be the Deputy committee chair and that he was unaware that the Board had decided on this and RS agreed this needed to be confirmed. RS noted that the introduction of the new data regulations within GDPR on 25th May would impact on the IG work stream reporting items and he suggested hearing the IG GDPR Update report prior to reviewing the TOR, which was agreed (*see page 6*).	**CdS**
		REPORTS FROM WORK STREAM LEADS	

5		**Information Governance** *David Wyndham-Lewis, Director of Information Technology & Transformation (on behalf of Terry Noys, Director of Finance and Trust SIRO)* DWL introduced his report noting the following: • the Trust passed the IG toolkit last year for the first time in three years by focusing on achieving level 2 in all areas, achieving 90% overall compared to 84% in previous years. • ensuring IG training compliance across the Trust has been difficult but is currently at 95% which was achieved by buying in training from Guys & St Thomas. Staff feedback showed the face to face training was better received by staff who felt they learned something whereas the online training was perceived to be more of tick box exercise with limited learning achieved. DWL explained that previously staff lists had covered substantial whole time equivalent (WTE) staff but that now the Trust was ensuring that all relevant staff receive the training including visiting lecturers, bank staff, locums etc, which has increased the cohort considerably. • DWL confirmed that this is the first year that sanctions for non-compliance with IG training have been introduced and at the end of the year there were 75 individuals identified as non-compliant. These individuals had their access to electronic systems such as Carenotes blocked and needed to contact IT to request their access be reinstated for 24 hours to enable them to complete the training. To date there remain 44 no-compliant individuals with their access to Carenotes blocked. RS said it was very concerning if staff remained working clinically but without access to Carenotes and that it would be helpful if the clinical directors were made aware of who the clinicians are. **DWL agreed to provide the list of 44 staff who remain non-compliant in IG training to clinical directors and the Medical Director immediately** so this can be looked into. DC congratulated DWL and all on providing the push to achieve this record completion rate. The committee accepted the green rating for this work stream for Q4.	**DWL**
	5.1	**Information Governance update on General Data Protection Regulation (GDPR) from the Information Commission Office (ICO):**	

		DWL gave a brief outline of some of the implications and work to date in readiness of the introduction of GDPR on 25th May 2018: - There are 12 steps to complete and although most of the focus is on the clinical side, we must ensure we include the student and staff requirements. - We now have a data protection officer in post to ensure we update and standardise our templates to reflect GDPR including impact assessments. - DWL confirmed the trust wide items are complete and rated green with policies and procedures being updated to reflect GDPR but departmental items remain rated red until the new GDPR requirements are implementation which includes the new rules around consent. All relevant forms both electronic and in paper format. - It was agreed at the EMT on 8th May to form a Task and Finish group with representation from CYAF, AFS and DET to initially prioritise updating existing forms, and then focusing on the new regulation in relation to information, which is currently between 60-70% complete. - There was brief discussion around the management of information assets and information asset owners and DWL confirmed there was work to do to ensure all areas are compliant. DWL also confirmed that all new items, systems and processes will be DPIA compliant from initial implementation. - DWL assured the committee that overall the Trust is in a good place in relation to GDPR implementation and there are no significant risks after 25th May with the Trust being able to demonstrate our compliance. This has been greatly helped by a lot of good work done with the IG toolkit and Caldicott work. - DC questioned the figure of 25% in relation to data sharing agreements and asked who we share our data with. DWL confirmed that the requirement only requires us to have a list of those we share information with, but DWL stated that he has ensured that the Trust has a data sharing agreement with data sharers. DWL also confirmed there was more work to do to increase compliance with all our assets, which will involve audits and increased communications with staff to increase understanding in relation to information assets. TN suggested this might be best communicated by the EMT directly cascading down to clinical service managers. **DWL agreed to take information asset and information ownership to the newly formed Task and Finish group**. - There was discussion around how data is stored and retained in line with GDPR, including research documentation in paper format, which is often retained by the researcher, for which consent has not been granted for this data to be kept indefinitely. It was acknowledged that this was very challenging but essential to get on top of.	**DWL**

		- ERS noted that this has mostly focused on clinical work and asked what had been done in relation to DET sponsorships and agreements for how we are currently working with student research data. DWL noted that clinical work can sometimes be exempt from GDPR to enable us to process data if we deem it to be essential in providing good quality care, but this differs when it comes to data for research including emails and SMS messaging. DWL confirmed this would be one of the main focuses of the Task and Finish group with consent being the legal basis for processing data. It was also noted that for retrospective identifiable research, consent should be sought where possible for the data retention. DC asked who was responsible for ensuring compliance when students undertake research not commissioned by the Trust. RS confirmed that sponsorship and ethical approval for such research sometimes sits with the HEI involved. SH left the meeting for a previous engagement.	
	5.2	AL asked if we are yet aware of the unknowns and areas where you can't gain consent for, for example in relation to a European citizen receiving care in the UK. DWL confirmed that GDPR case law has yet to be established in relation to exemptions for care and once this happens it will provide a steer for all trusts. DWL also confirmed that currently the UK ICO is the regulatory authority foreign citizens would currently fall under. **GDPR Ramifications:** - DWL noted the combination of GDPR and NHS interest in cyber security eg, the new IG toolkit which focusses on security and governance will follow and change our approach in providing and reporting assurance on 200 items annually informing our approach to data security. - DWL also confirmed all the new arrangements will impact on the Trust responsible individuals, how the IG work stream reports and will require updates to the TOR of the committee to ensure the reporting lines to the CQSGC are still able to provide robust assurance. **DWL agreed to redraft the IG work stream report and IG section of the CQSGC TOR and provide a draft revision for the next meeting to review.**	**DWL**
	5.3	**ANNUAL REVIEW OF CQSGC TOR**	

		AL had raised the point that the TOR noted a NED should be deputy chair of the CQSGC. RS confirmed he had raised this with PJ and this has been referred back to PB in role. RS also suggested that as he will be stepping down it might be helpful if the NED could be identified so they could chair the next committee in September. There was further discussion around how the committee is currently run and TN suggested the usual practice was that Board committees should be chaired by a NED. DC said she felt it was helpful to have someone like the Medical Director chair the committee as a clinical person in the Trust with the ability to ensure discussion from the group is disseminated well internally. DC also noted that the TOR were very detailed and asked how we are assured that each work stream has included all the individual items listed in the TOR. RS confirmed that it was the duty of the work stream leads to ensure their reports covered all areas listed in the TOR with clear action plans with timescales. DC said it would be helpful to reduce the level of detail in the TOR. After further discussion it was also agreed that the TOR should be modelled on the latest guidance for NHS Trusts and it was agreed **CdS will provide a reformatted draft of the CQSGC TOR in line with best practice for the next CQSGC.**	**CdS**
6		**Patient Safety and Clinical Risk (Sign Up to Safety Plan)** *Caroline McKenna, Patient Safety and Clinical Risk Lead* CMK introduced her report noting the following: • There were no patient deaths in Q4. • There were 3 serious clinical incidents with one of them rated as a 9, and one of them due for de-escalation next week following an internal investigation. AL asked who decided the incident should be deescalated and what the process for de-escalation is. RS confirmed de-escalation is not in our power, but that we would request de-escalation on the external reporting system STEIS with all relevant commissioners notified. • There was an increase in complaints in Q4, with the complaints context increasing in number and complexity impacting on the work of the complaints officer and there is a plan in place to provide short term assistance with complaints, which are mostly from the GIC service with the themes; waiting times, treatment and access to clinicians. LL asked if a named NED is involved in the complaints process and MS confirmed that PJ sees all complaints and there is a named NED who receives a quarterly account of complaints received in addition to the annual report which comes to the Board. • The Trust reports very low numbers of adult referrals which has been noted by the CQC as possible under reporting, alongside the lack of an adult safeguarding lead. CMK	

confirmed this has now been addressed with the new safeguarding lead beginning in post of 8th May 2018.
- CMK suggested this will remain an amber rating at the end of the year because there are still areas for improvement in relation to our sign up to safety campaign.

DC questioned why there had been such an increase in the number of children alerts for Section 17 (S17), Section 47 (S47), Children in Need (CIN) and those on Child Protection Plans (CPP).

CMK explained that there had been a massive push in Q1 by the patient safety officer chasing individual clinicians and teams by email to ensure all alerts had been appropriately recorded on Carenotes which produced the 100% figure. In future quarters clinicians were not chased and the reporting figures for safeguarding children alerts dropped showing this process has not been fully incorporated into clinical practice. CMK confirmed that it is expected that there would be some fluctuations throughout the year in reported alerts and that some of the services we deal with within Camden have an increased children's population with very complex issues, which is not a reflection on our performance. RS noted also that there is often an increase at the beginning of the school year, but this does not represent an overall increased risk to children. RS also referenced the project "Reducing the Burden" and noted it was difficult to marry the need for increased clinical documenting on Carenotes while trying to reduce the workload of clinicians in relation to data collection and recording. DWL confirmed this situation is similar in other trusts and there are plans to try to improve the flow and accuracy of child protection information between local authorities and health providers by having CPP information fed directly into Carenotes, as is currently the practice with acute services.

LL asked if we could evidence that specific safeguarding supervision was happening and RS confirmed we still needed to embed safeguarding supervision, because this trust provides safeguarding supervision at case level, whereas most other organisations provide safeguarding supervision in group format, not at case level. RS noted ours was a difficult plan to implement but a good plan in relation to ensuring patient safety. It was noted that although safeguarding supervision was being provided there were still gaps in how this is evidenced on Carenotes.

TN asked for clarity around the clinical risk training and CMK confirmed there is a target of 80% compliance on a 3 year cycle and that we are in discussion with the commissioners for the completion of a full risk assessment by September on data compliance. CMK also confirmed that this training continues to be provided face to face during INSET and inductions and also via e-learning. MS

		confirmed the target is high, and that it was set by this Trust, so perhaps a target revision is required. ERS stated that having previously been in role as the adult safeguarding lead, the training requires blended learning rather than just than e-learning to ensure we are achieving the most effective training. DWL asked what the plan was regarding recording this information and CdS confirmed there is now a part time staff training officer who is managing attendance compliance for safeguarding training including adult safeguarding and WRAP Prevent training. The committee accepted the amber rating for this work stream for Q4	
7		**Clinical Quality and Patient Experience** *Louise Lyon, Director of Quality and Patient Experience* LL introduced her paper with an overall rating of amber, explaining it was a mixed bag of achievements and noting the following: • LL reiterated SH previous comments in relation to the record number of GIC referrals and the limited resources to reduce the waiting times and also accepted that much work had been done including looking at telemedicine to try to increase efficiency in service delivery and also that both services, GIC and GIDS have done all they can with their current resources and have continued to provide an effective and quality service. • it is also noted that despite the problem extended waiting lists patients have provided positive feedback on their treatment which is also a testament to how well clinicians are managing patients while on an extensive waiting list. • the increase in referrals to the adult complex needs service has extended their waiting lists from assessment to treatment and staff are trying to manage these waiting times carefully and safely with their existing resources. • on reviewing there remain gaps in our data quality collection. Outcome monitoring measures such as the adult CORE, Experience of Service Questionnaire (ESQ) and the Goal Based Measure (GBM) provide good results, but the completion rates were still small in number. The need for more electronic data collection systems has been established in order to have a significant impact on our data collection and reporting. • DWL confirmed that the Portman will have transitioned to Carenotes by June 2018. • the CQUIN data collection has done well with the flu vaccination increased by double since last year with a total of 50.6% of staff being vaccinated.	

		• the staff survey still showed staff dissatisfaction despite the many health and wellbeing initiatives introduced, it seems this has not yet had a positive effect on staff. • although there has been no PALS report for Q4, going forward it will now be recorded on the new quality portal that has been introduced. • Reporting for both NICE guidance and clinical audit will be easier going forward as they will both be held on the new quality portal. • the GIC CQC action plan has been completed. • the Trust wide action plan has been completed and remains monitored. • a more details summary re the clinical quality strategy has been produced and although currently on track, it is recognised that a long term cultural change is required and it needs to be implemented slowly to ensure engagement and adoption. JG asked if there was more detailed information available and LL confirmed a detailed waiting times report went to the Board including the specialist services report and the GIC CQC action plan. **LL agreed to forward the specialist report to the committee.** RS suggested that it would be helpful to recirculate the current clinical quality strategy. **IH to forward clinical quality strategy to committee.** TN asked if the clinical audit report was available and **CMK agreed to circulate the clinical audit report to the committee**. The committee accepted the amber rating for this work stream for Q4.	**LL** **IH** **CMK**
8		**Corporate Governance and Risk** *Marion Shipman, Associate Director of Quality and Governance* MS introduced her report with an overall rating of amber. MS noted the following and inviting any questions: • There had been some progress in health and safety estates compliance with introduction of timely fire testing and action plans being developed for more capital work, gaps remain including fire marshals and engineering but details plans are imminent. • it was difficult to gain compliance with unsuitable accommodation for services such as Westminster, who assess families off site. DWL confirmed we are aware of these gaps and pointed out that the council redevelopment of the building was not in our control and services had been advised it was not suitable accommodation, but also	

		confirmed there is now a plan in place to address these issues. • CAS alerts in relation to estates and facilities have been signed off. • emergency planning – of the 58 services assessed as requiring a business continuity plan (BCP) a significant number have been completed but 37 remain outstanding. DWL asked what the quality of the BCPs were and MS said she thinks the new shortened BCPs provide a good quality plan and said the Trust is completing BCPs for all our clinical services at team level, which is not what other organisations are doing. TN asked for the specific number of outstanding BCPs and **MS agreed to confirm the numbers of services who have not completed a BCP** after the meeting, to be included in the minutes once received. The committee accepted the amber rating for this work stream for Q4.	MS
9		**Any Other Business** There was no other business and RS closed the meeting thanking all for their attendance. JG also added a thank you from the committee to RS as chair for all his work and management of the committee.	
10		**Notice of future meetings:** 11am – 1pm, Wednesday 5th September 2018 11am – 1pm, Wednesday 7th November 2018 11am – 1pm, Wednesday 6th February 2019 11am – 1pm, Wednesday 8th May 2019	

The Tavistock and Portman NHS
NHS Foundation Trust

Board of Directors : May 2018

Item :13c

Title Clinical Quality Improvement Programme: Implementation Update

Summary:

This report gives an overview of work undertaken by the Quality Improvement Group to implement an integrated Trust wide quality improvement programme. The programme has been monitored through reports to the Clinical Quality and Patient Experience Work stream of the Clinical Quality Safety and Governance Committee. The report sets out the work undertaken to engage and train staff and future plans.

This report has been reviewed by the following Committees: Management Committee May 15th 2018

This report focuses on the following areas:
(delete where not applicable)

- Quality
- Patient / User Experience
- Patient / User Safety
- Equality
- Finance

For : Noting

From : Director of Quality and Patient Experience

Clinical Quality Improvement Programme

Implementation update - May 2018

1.0 Introduction

1.1 The Clinical Quality Strategy was approved by the Trust Board in January 2017. This was an extension to the strategy approved the previous year and focused on the implementation of a trust-wide quality improvement (QI) programme, building on work already in hand and tailored to our psychodynamic, psychoanalytical, systemic, contextually sensitive approaches.

A QI programme requires a coordinated approach of the following domains for success:

- 1.1.1 having a long term vision and commitment;
- 1.1.2 leadership at every level, patient, carer and family centred and empowering staff;
- 1.1.3 developing capability of staff;
- 1.1.4 developing a system so that improvement becomes part of what we do from planning, to performance review and daily work;
- 1.1.5 support from IT Estates, HR and Finance.

1.2 Recent research indicates that QI works most effectively when it forms part of a coherent, organisation-wide approach as opposed to discrete time limited projects. (Dixon-Woods and Martin, 2016). Our learning from comparable organisations is that to achieve this, it is important to start work with those most interested and build up from a modest scale towards wider engagement.

2.0 Defining Quality Improvement

2.1 There is no single definition of quality improvement but the Health Foundation suggests the definition should reflect a combination of ‘change’ (improvement) and a ‘method’ (an approach with appropriate tools), while paying attention to the context, in order to achieve better outcomes. We already take action to improve our services with varying outcomes but a QI approach provides the opportunity for broader cultural change, ultimately empowering staff and patients with the tools to make the changes that matter to them.

3.0 Our implementation approach

3.1 The Quality Improvement Group defined the aim of the programme as:

To develop an approach to improving quality which listens to patients about their experience so we can work together to provide better services

3.2 Our journey towards developing our approach began with two events for clinical team managers, one of which opened with two interviews with patients - one live and one filmed. Our second event focused on stepping into our patients' shoes and looking at the patient journey through our services. Both events engaged staff in thinking creatively about how services might be improved in small steps taking the patients voice as our lead.

3.3 Patient and public involvement is fundamental to the success of improving quality; our Patient and Public Involvement (PPI) team is currently reviewing and extending our patient and public involvement strategy. Quality improvement is central to the strategy and in order to ensure our work is integrated, the newly appointed PPI team manager is joining the Quality Improvement Group. The PPI team works with clinical and educational teams to provide expertise and support for increasing participation of patients, families and community groups in our services. In the longer term, we aspire to include patients and carers in QI training so that they can work alongside staff in developing QI projects for patient benefit.

4.0 Having a long term vision and commitment

4.1 The Quality Improvement Group has met regularly and has a stable and active membership drawn from across the Trust, as set out in the 2017 strategy. It has agreed Terms of Reference and an overall action plan which is regularly reviewed. The most effective ways of including patient, family and care representatives are yet to be decided as we wish to ensure that the group is structured such as to empower the voice of patients in taking forward quality improvement. As mentioned above this work will go forward in consultation with the PPI team

4.2 In July 2017, the Quality Group held a half day workshop with an external expert consultant to establish our action plan for implementation, including clarifying the aim of the programme. This has clarified the way forward and provided a framework in which key decisions could be made.

4.3 The Quality Improvement Group decided to adopt the Institute for Health Care Improvement model as a basic model with which to take

forward the programme. This decision was based on the knowledge and experience of members of the Quality Improvement Group and an appraisal of the benefits or various models. It is a model used by several neighbouring trusts and in the longer term this would allow for sharing of skills. The group decided that we would introduce other approaches as required such as Experience Based Co design. We plan to develop the capacity to deliver our own training in house but in the first instance we will use external consultants.

4.4 Whilst it is agreed that teams need to focus on issues which are meaningful to their patients and their staff, the Quality Improvement Group is also mindful of the need to ensure that resources are used to support the trust's strategic objectives and to demonstrate meaningful progress against those objectives.

4.5 Three areas identified from the Clinical Quality Strategy presented to the Board in January 2016 were priority areas for QI focus.

4.5.1 Waiting times, shared decision making and effectiveness.

4.5.2 Projects under these broad headings were encouraged in the first instance.

4.6 Over the course of developing our quality priorities for 2018-9 we further reviewed our clinical quality strategy alongside the annual trust strategic objectives and put forward five areas on which to focus. Where possible, we have identified teams to focus on each of these areas using quality improvement methodology to take the work forward.

5.0 Developing leadership

5.1 Funds were made available through Health Education England to support staff retention. A sum of 45.5k was specifically allocated to support staff training and development in quality improvement. The funds were used in 2017 -18 to fund 5 fixed term-part time posts (to end of March 2018) and the delivery of training in house. The posts comprised**:**

5.1.1 Project Manager (.3 WTE) to support the delivery of the Reducing the Burden project, embedding the quality improvement programme trust wide and working on identifying external funding to take the work forward in 2018-9

5.1.2 Three Band 7 Quality Improvement Leads (.2 WTE), 2 in CYAF and 1 in AFS. The leads were trained in QI and worked actively with clinical teams, patients and other relevant stakeholders to implement pilot projects in identified teams.

5.1.3 One administrator (.1WTE) to support the programme. Unfortunately we did not successfully recruit to this role.

5.2 Liz Searle and Andrew Williams, Clinical Governance leads in CYAF and AFS respectively, are now formally confirmed as directorate QI Leads providing overall leadership and support for QI in each of their directorates.

6.0 Developing capability of staff

6.1 We commissioned QI training from Haelo. They are an organisation which has developed within the NHS for the NHS who provide training in the Institute for Health Improvement (IHI) approach to improving quality. They already work with Barnet Enfield and Haringey Mental Health Trust and are respected in the field. We commissioned three one-day basic trainings for up to 25 participants in each cohort between December 2017 and March 2018. In addition we commissioned a three-day more intensive training for up to 15 participants. All the Quality Improvement Leads were be expected to attend this training and were provided with follow-up coaching and supervision from Haelo.

6.2 The approach to date has been to offer the training to staff who show an interest in developing their quality improvement skills. Going forward in 2018 we will be linking training to the commitment by individuals to undertake a quality improvement project, and look at how to increase the quality improvement skills of staff at various levels using a ‘dosing model’ to ensure adequate expertise across the organisation.

6.3 Those staff who completed the intermediate improvement training course meet to share quality improvement work and will be key to supporting this implementation across the organisation.

7.0 Improvement as part of our daily work

7.1 South Camden CAMHS and the Camden Adolescent Intensive Support Service team were identified as pilot teams in CYAF for the development of QI projects and adult complex needs provided pilot teams in AFS. Pauline Williams, QI development lead, has been working with CAISS, Amy Shearer, QI development lead, with South Camden CAMHS and Ellie Cavalli, QI development lead, with adult complex needs. Each has taken up regular coaching with Haelo to make best use of their QI training through implementing a project

7.2 We have been working at increasing staff engagement through ‘community of practice’ meetings, celebrating success for quality projects. A celebration of quality in our clinical services event is planned for 9th July 2018.

7.3 We are working with clinical teams to find ways of releasing staff time to enable them to undertake meaningful quality improvement projects

without having a negative impact on activity levels. In the longer run the QI work should lead to greater effectiveness and efficiency (and increased staff morale) but this will not necessarily be achieved at a pace to match time allocated to QI work.

8.0 Next steps for 2018-19

8.1 Further funding has been secured through HEE to support the roll out of training across the Trust. Funding was also agreed within the Quality and Patient Experience budget for team level QI leads to continue with one session each in role.

8.2 Our QI Project Manager drew up a comprehensive report on most effective ways of embedding QI and associated training options. The Quality Improvement Group is in the process of agreeing a way forward which is likely to include:

8.2.1 familiarisation (1 hour digital minimum) for all staff

8.2.2 a half day introductory training

8.2.3 a 'toolkit training' for those who are supported by their teams and agree to implement QI projects in their teams with training and support.

8.2.4 We will also develop a small, more highly skilled group who can, in due course, take on training and coaching.

8.3 We already have around five staff engaged in higher level external trainings such Generation Q or the UCLP fellowship programme. Our key tasks over the next period include:

- completing pilot formal QI projects and communicating widely about outcome and experience;
- ensuring Board and senior staff awareness and support;
- presenting our data using QI methods so that at every level there is a better understanding of change and variation;
- engaging patients, carers and families;
- engaging clinical team managers.

As our work progresses, we will further define our overall aim (improving services for patient benefit) and the ways in which it allies with Trust strategy, current quality improvement initiatives whether using QI methodology or not, and how this relates to the use of performance and governance information.

Reference

Dixon-Woods, M and Martin, GP (2016) 'Does quality improvement improve quality? 'Future Hospital Journal, vol. 3, no3, pp.191-4 (online) available at http://futurehospital.rcpjournal.org/content/3/3.toc

Action Plan update

Task	Lead	Date	Progress at April 2018
Develop plan for implementation of quality improvement strategy including assessment of readiness in key domains	Director of Quality and Patient Experience with Quality Group	April 2017	Initial implementation plan developed in July 2017. This is now under review as we prepare for the next stage and will be set out in May 2018
Reduce burden of reporting to make way for quality development work	Director of Quality and Patient Experience, supported by the Associate Medical Director, the Associate Director of Governance and Quality, the Commercial Director (dashboard development) and the Director of IMT.	Proposals by end of March 2017	March 2018, agreement reached on key decisions to remove or combine items to streamline clinical and admin tasks
Set date and time for monthly community of practice.	Quality Group	February 2017	Termly meetings agreed and set up
Follow up on small scale projects in each team; work with CG leads to support team managers; encourage each team to develop one QI project.	Quality group	In hand	Projects agreed in target teams. Quality improvement projects are going on in many teams but not always identified as such. April 2018 survey to gather up all projects
Cross Trust record of projects -.	Clinical Audit Officer	June 2017	System in place assisted by implementation of Quality Portal
Identification of quality improvement projects for students arriving in the Autumn to take on.	Team managers	July 2017	Deferred to September 2018
Develop in-house training for staff and trainees.	Quality Group	June 2017	First round of training delivered Dec 2017 to March 2018.Planning in hand for next steps

Invite external speakers	Associate Medical Director and Associate Director of Governance and Quality.	On going	Remains on going

Louise Lyon, Director of Quality and Patient Experience May 2018

The Tavistock and Portman NHS
NHS Foundation Trust

Board of Directors: May 2018

Item : 14

Title : Waiting Time Analysis by Team

Purpose:
The purpose of this report is to provide analysis and narrative commentary for waiting times by Team. The waiting time definition is from receipt of referral to first appointment. Data is presented on a quarterly basis in order to show whether the waiting time trajectory is improving or worsening. Actions taken to address identified issues are included.

This report has been reviewed by the following Committees:
- Clinical Quality and Patient Experience Group Meeting

This report focuses on the following areas:
- Quality
- Patient / User Experience
- Patient / User Safety
- Risk
- Productivity

For : Discussion

From : Louise Lyon, Director of Clinical Quality and Patient Experience

Waiting Times Analysis by Service

1. Introduction

1.1 As requested by the Board of Directors the following paper provides an analysis and narrative for waiting times by Team on a quarterly basis in order to show whether the waiting time trajectory is improving or worsening. Actions being taken to address identified issues are included. Data is provided for the period 1st October 2017 to the 31st December 2017.

1.2 The following services and the relevant referral to first appointment waiting time targets have been included:

- 1.2.1 Adults = 11 weeks
- 1.2.2 City and Hackney = 18 weeks
- 1.2.3 Portman Clinic = 11 weeks
- 1.2.4 Camden CAMHS = 8 weeks
- 1.2.5 Other CAMHS = 8 weeks, 11 weeks for over 18s
- 1.2.6 Adolescent = 8 weeks, 11 weeks for over 18s
- 1.2.7 GIDS = 18 weeks
- 1.2.8 GIC = 18 weeks
- 1.2.9 Westminster = 6 weeks

1.3 This report shows the time to first attended appointment from referral received. Referral to treatment (Second appointment) has been removed from this report this quarter as requested at October's board meeting.

1.4 Service Leads and Team Administrators have provided commentary on where these are not well met and what action plans are in place to improve waiting times and meet the target.

1.5 Please note First Step have been excluded from the analysis.

Summary

1.6 Adult teams: Adult Complex Needs Service has seen 79.5% of their patients with in their 11 week waiting time target, exceeding their target by 10.5% compared to only 4% in quarter 3. However, they saw a lot more people off of their waiting list, something that has reduced in this quarter and the past quarter too. City and Hackney have reduced their breaches a significant amount, whilst managing to see a significant amount of patients in quarter 4 as in quarter 3. Portman have not seen any of their patients breach their 11 week waiting time target this quarter.

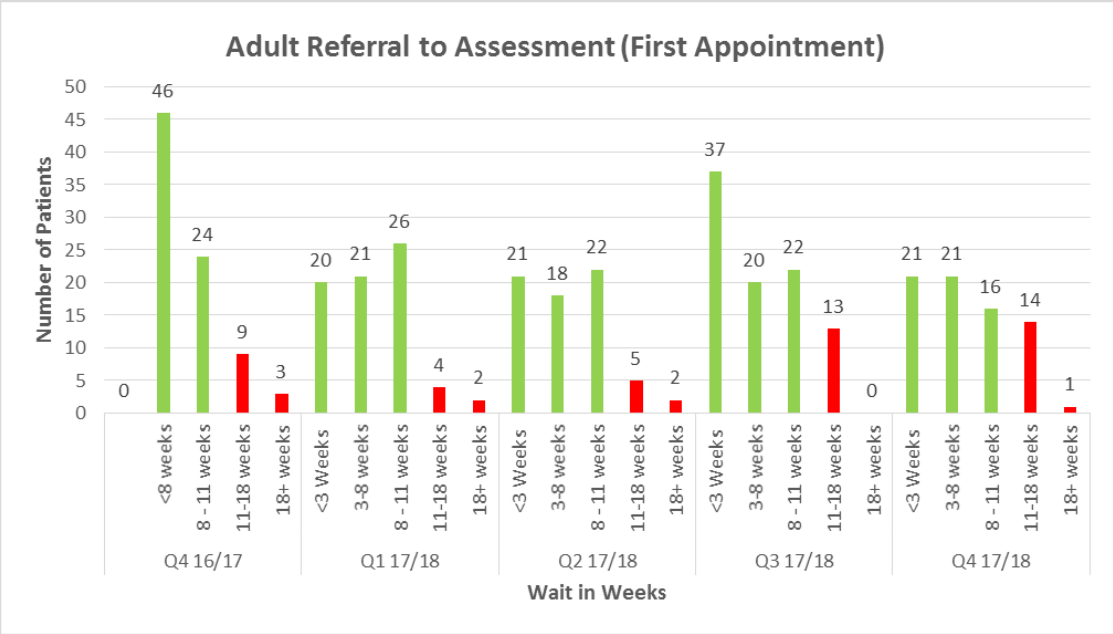
1.7 Other CAMHS, higher breach percentages than the trust target of 10%. Although the breach percentage has slightly declined from 25% to 23%. Having said this waiting list has declined from 77 in Q2 to 55 in Q3 and has remained low in quarter 4.

1.8 GIDS (Gender Identity Service, under 18) and GIC (Gender Identity Clinics, over 18s) have been presented with a wider range of wait time (In weeks) the reason for this is to show improvements when they are made, it is predicted both services will take some time to meet their target waiting time of 18 weeks.

1.9 Camden CAMHS has performed consistently well throughout 2017/18, considering the high volume of patients in the service. The FAS (Westminster service) have fluctuated this financial year, this is due to the patient population.

2. Detailed analysis and commentary

2.1 Adult Complex Needs (All Teams included in analysis)



Number of new patients seen in quarter 4 is 73, a decrease from preceding quarters, although similar to quarter 4 of financial year 16/17. 20.5% of patients breached the 11 week waiting times target, which is an increase on the previous quarter (14%). 8 of the 15 (53%) breaches are owed to the Trauma Unit

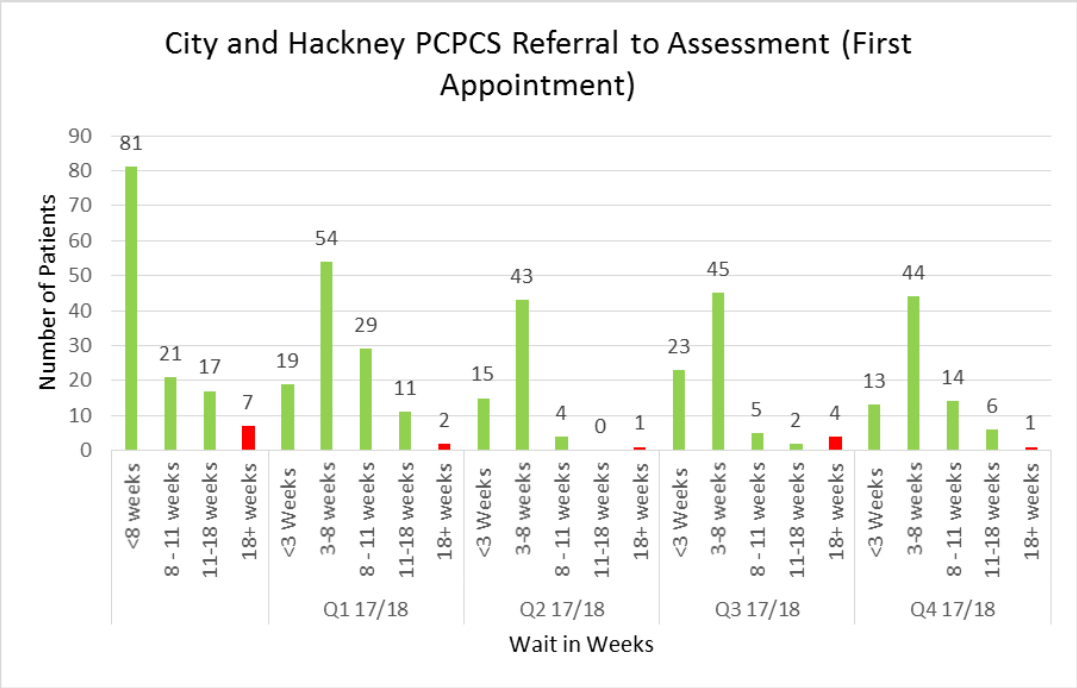
Total open referrals waiting at the end of quarter: 32 (less than half of the previous quarter)

As the data reveals, just over half of the breaches occurred within the Trauma unit. It has been recognised, especially during the last quarter, that the Trauma unit has been under increased strain. The number of referrals exceeds the clinical capacity of the unit, and this has been flagged up as a serious issue. We are currently in the process of reconfiguring the department, not least in relation to deployment of personnel time across the various units, and it is recognised that the Trauma unit requires an increase in resources. Due to staff departures, it has not been possible to do this as yet, but we hope to do so imminently in order to reduce the number of patients who are not being assessed within the 11 week timeframe.

There are other reasons for breaches within other clinical units. Mostly, they are due to the fact that some clinicians offer to see patients who have cancelled or DNA's appointments in a way that means that they are seen after the 11 week window. A review of department protocol is required here, so that there is uniformity between clinical staff in terms of how to manage patients who respond to the offer of an initial appointments by not attending or cancelling appointments.

(Andrew Williams, Head of Adult Complex Needs)

2.2 City and Hackney Service (PCPCS)



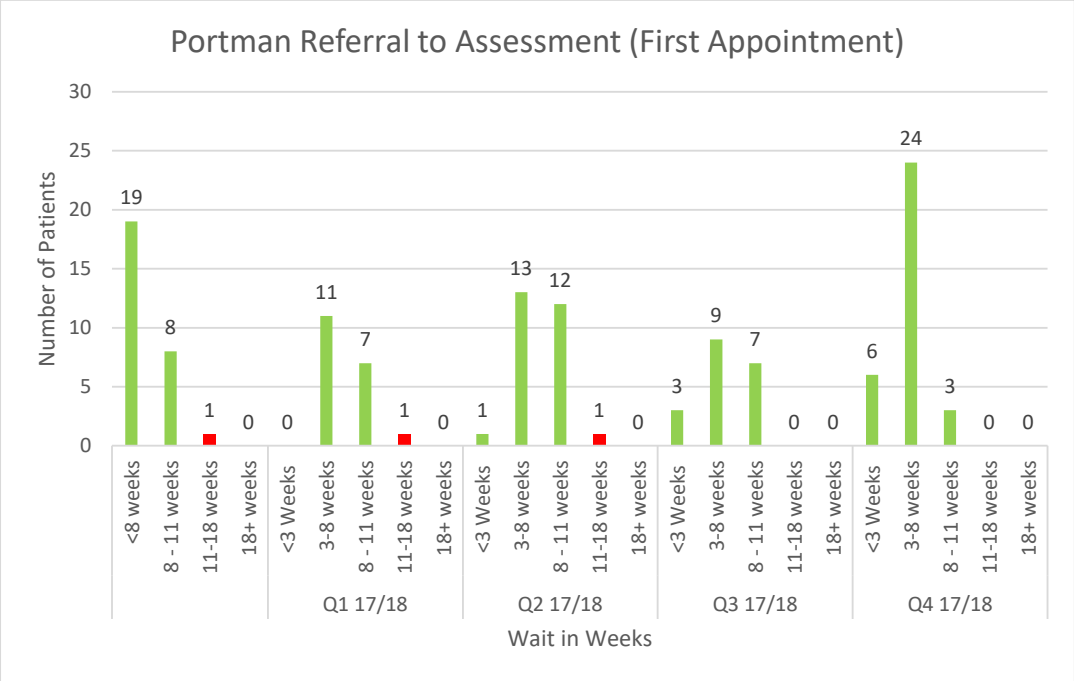
The waiting time target for City and Hackney is 18 weeks with 99% meeting this target in quarter 4. In the quarter 4 City and Hackney saw 78 patients from the waiting list, almost identical to quarter 3.

Total open referrals waiting at the end of quarter: 58 (7 more than last quarter)

Overall we are pleased with the results given our increasingly complex and troubled population. We note that the impact of social inequality and socio-economic situation of many of our patients remains highly relevant to their healthcare use and symptomatic presentation with high demand for legal input, housing, safeguarding, disability allowances etc. Some of these 'external' factors impact attendance patters and in fact people's ability to focus on their psychological life when basic human needs are either threatened or unmet. PCPCS and TAP tend to receive referrals from GPs that have either gone through other services or because the GP is at their wits end and feels stuck, so perhaps it is not surprising that some of our statistical trends speak to the impact of these challenges. In short, it is a very different cohort of people to those who wish to access a psychological therapies service in a proactive or self-motivated way.

(Tim Kent, Service Manager at City and Hackney PCPCS)

2.3 Portman Clinic



The waiting time target for Portman is 11 weeks with 100% meeting this target in quarter 4, only 2 breaches in the financial year. Portman have seen an increase in patients in quarter 4, 33 patients compared to 19 patient's quarter 3.

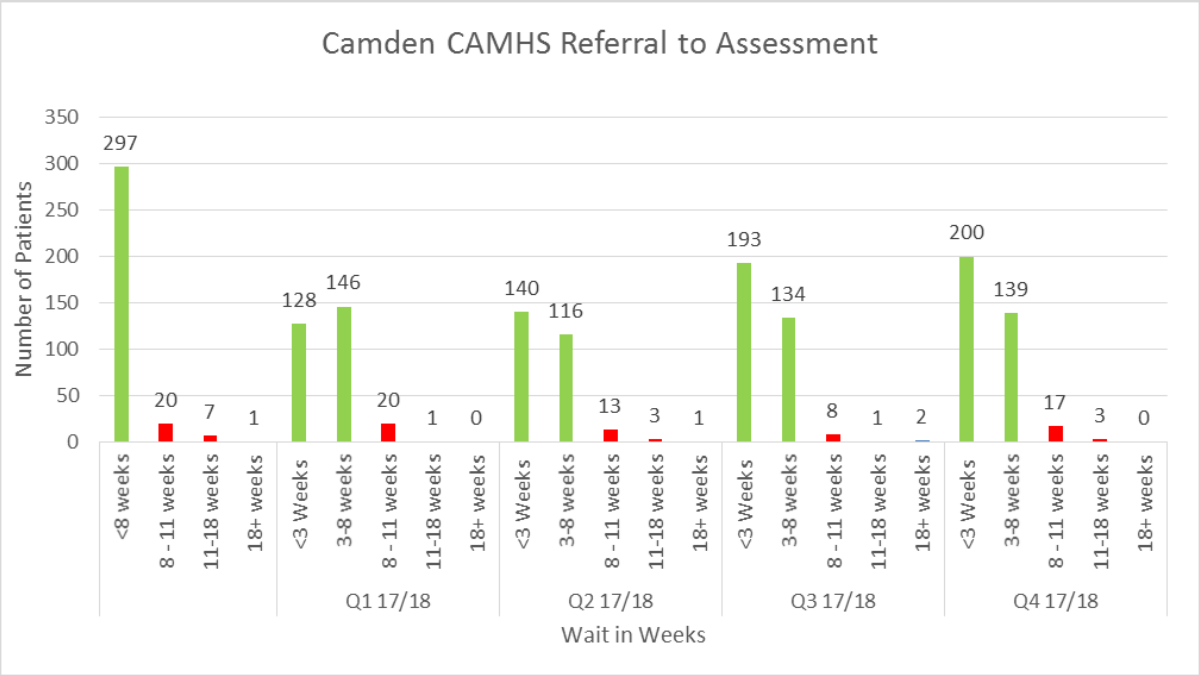
Total open referrals waiting at the end of quarter: 5

We are pleased to again achieve 100% compliance with seeing all patients for assessment within the 11 week target following referral. We continue to have a lot of contact with referrers on the telephone to facilitate the referral process, and are flexible in our approach with patients in offering them days and times that are most convenient for them.

We are also pleased that our referral rate has increased following the last quarter, when the lower rate of referrals may have in part reflected referrers being away over the Christmas period.

(Jessica Yakeley, Director of the Portman Clinic)

2.4 CYAF (Camden CAMHS – All Teams Selected)



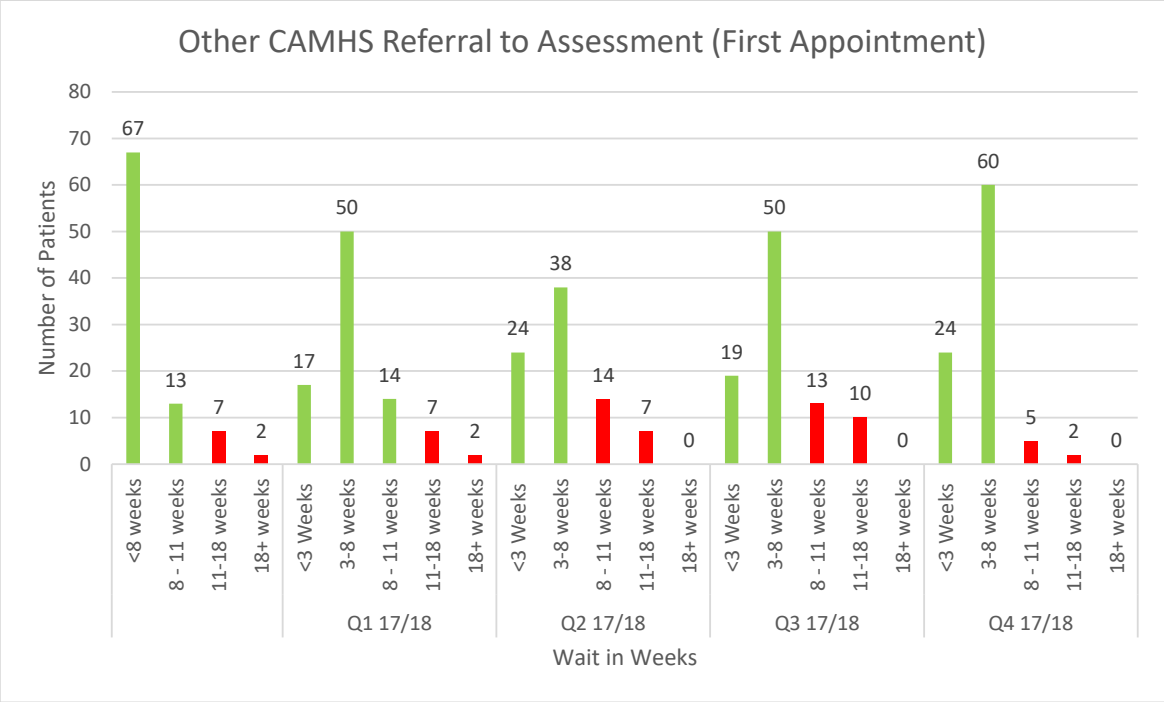
The waiting time target for Camden is 8 weeks with 94% meeting this target in quarter 4; this has slightly decreased from 97% in the previous quarter however Camden CAMHS have seen 21 more people off the waiting list than in quarter 3. A very pleasing result.

Total open referrals waiting at the end of quarter: 109 (4 less people than quarter 3)

'We know from Benchmarking data that Camden's responsiveness is significantly above other areas and these results are still in keeping with this trend. We were pleased to have recently been shortlisted for an HSJ value award based on the evidence of increased access and responsiveness in Camden.'

(Sally Hodges, Director of CYAF)

2.5 CYAF (Other CAMHS – First Step excluded from analysis)



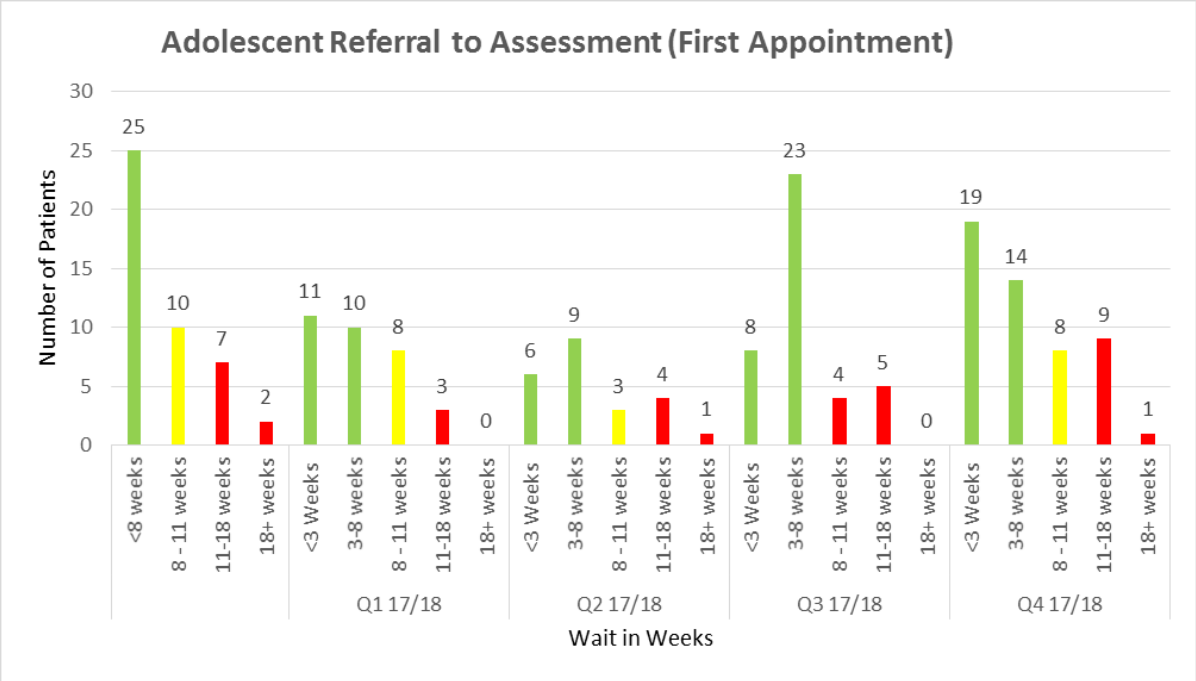
The waiting time target for Other CAMHS is 8 weeks with 77% meeting this target in quarter 4, and improvement on the 2 preceding quarters (75%). Other CAMHS teams saw 91 people off their waiting list.

Total open referrals waiting at the end of quarter: 57

'The teams have all continued to work hard to ensure that waiting times are not breached and we are pleased to see that we continue improve in this area. However there continue to be instances of breeches outside of our control, for example where we cannot contact families despite trying or we do not have the information we need to proceed, which impact on meeting the targets.'

(Rachel James, Associate Clinical Director)

2.6 Adolescent Service



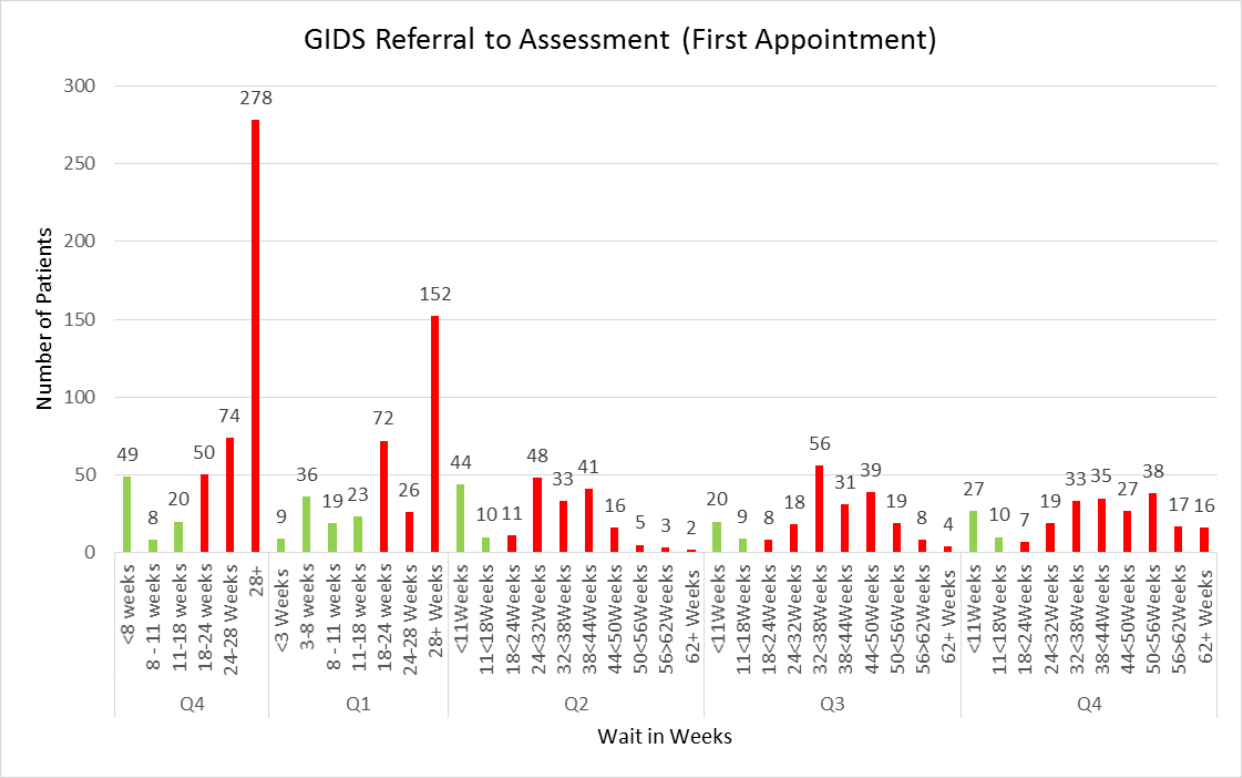
The waiting time target for the Adolescent service is 8 weeks for those under 18 years of age and 11 weeks for those over 18. With this taken into consideration 76% of patients were seen within the target waiting times. This is a 12% decrease on quarter 3. The adolescent service has seen 51 people off the waiting list in quarter 4, 11 more people that the preceding quarter.

Total open referrals waiting at the end of quarter: 35 (identical to Q3)

'As a Service we endeavour to keep waiting times as short as possible for patients. However, because of the need to match patient with the appropriate clinician, especially for more complex cases, there were some delays for seeing patients for their assessment appointments, which contributed to the breaches in the waiting times for the AYAS this Quarter.'

(Justine McCarthy-Woods, AYA Service Lead)

2.7 Gender Identity Development Service



**Please note the difference in reporting the Wait in weeks has been agreed with the Service Manager, Frances Endres. It will show more clearly when improvements are happening with in the service*

The number of new patients seen in quarter 4 is 229. This is a slight increase of those seen in quarter 3 (213). 16% of patients were seen with in the 18 week target time for GIDS, again a slight increase on quarter 3 (14%). Total open referrals waiting at the end of quarter = 1652. This is 234 more than quarter 3 – something that has been increasing throughout the past quarters.

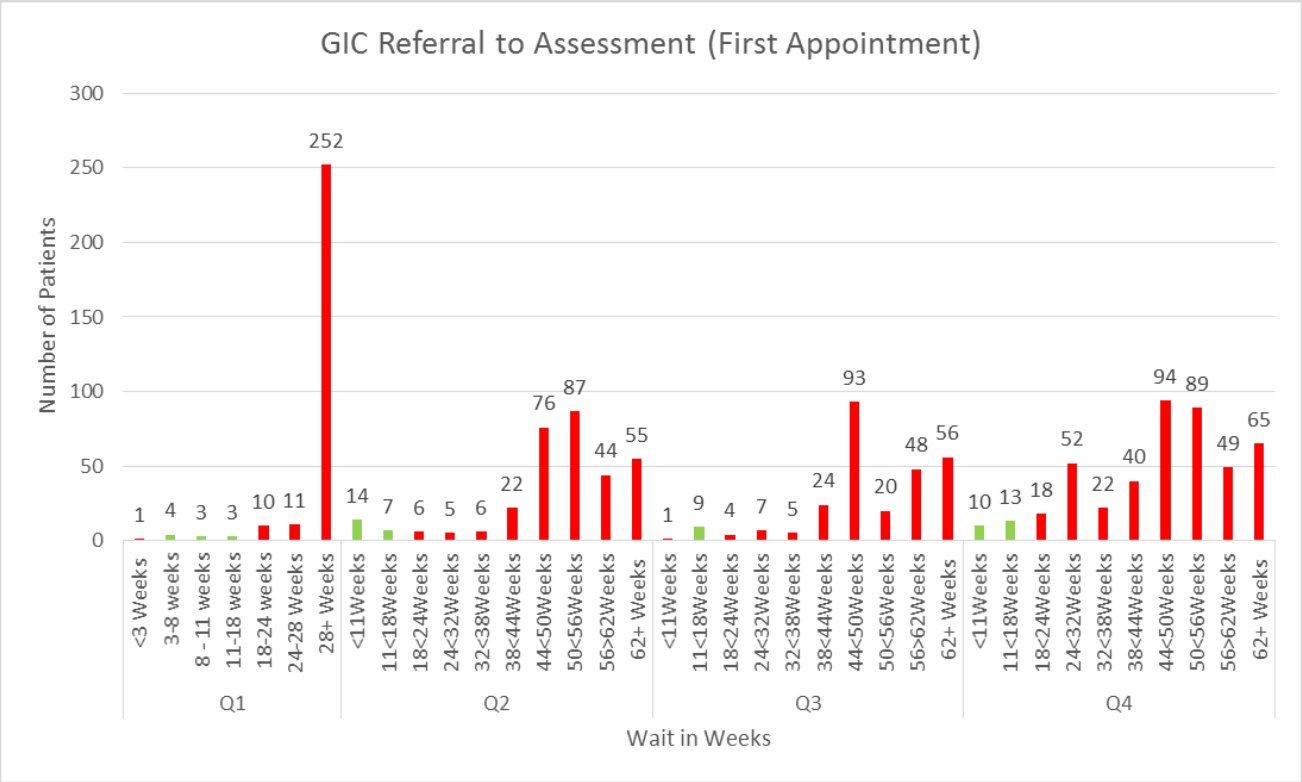
The 2016/17 contract allowed for up to 125 referrals per month. In reality we had an average of 175 referrals a month. This meant that there were 600 referrals over and above the contract at year end. The 2017/18 contract was based on 135 referrals per month. This did not meet the number per month we actually received in 2016/17. 2017/18 the service received approximately 2500 referrals – this is 880 referrals above what is contracted.

We are working closely with our commissioners to manage this and their expectations and they have been told we are looking at, at least, another year before we can reach the 18 week target, if not longer. They are aware this is due to the increase in referrals again and the restraints on staff training. The number of first appointments offered has not increased because a number of clinical staff have left, or are leaving the service. This means that existing cases need to be re-allocated, reducing the capacity for taking on newer referrals. We have received an increase in budget for 2018/19 and will be employing more staff across London and Leeds, but as training is required on the job, it takes a number of months before new staff are fully up and running. We have assumed that no new staff will be in post before month 6 2018/19 as it takes a while to get through the recruitment cycle.

There are also a number of projects underway which have been developed to improve access to the service and will potentially have a positive impact on the waiting list. Projects include more outreach clinics, assessment clinics, and group first appointments for carefully selected young people and telemedicine. In addition we are working closely with Charing Cross Adult GIC to improve transfer from the GIDS to the adult GIC. Timely transfer of young people to adult services would reduce staff caseloads, which in turn creates space for new referrals to be picked up.

(Keyur Joshi, GIDS Service Manager)

2.8 Gender Identity Clinic (GIC)



**Please note the difference in reporting the Wait in weeks, this has been agreed with the Service Manager, Frances Endres. It will show more clearly when improvements are happening within the service*

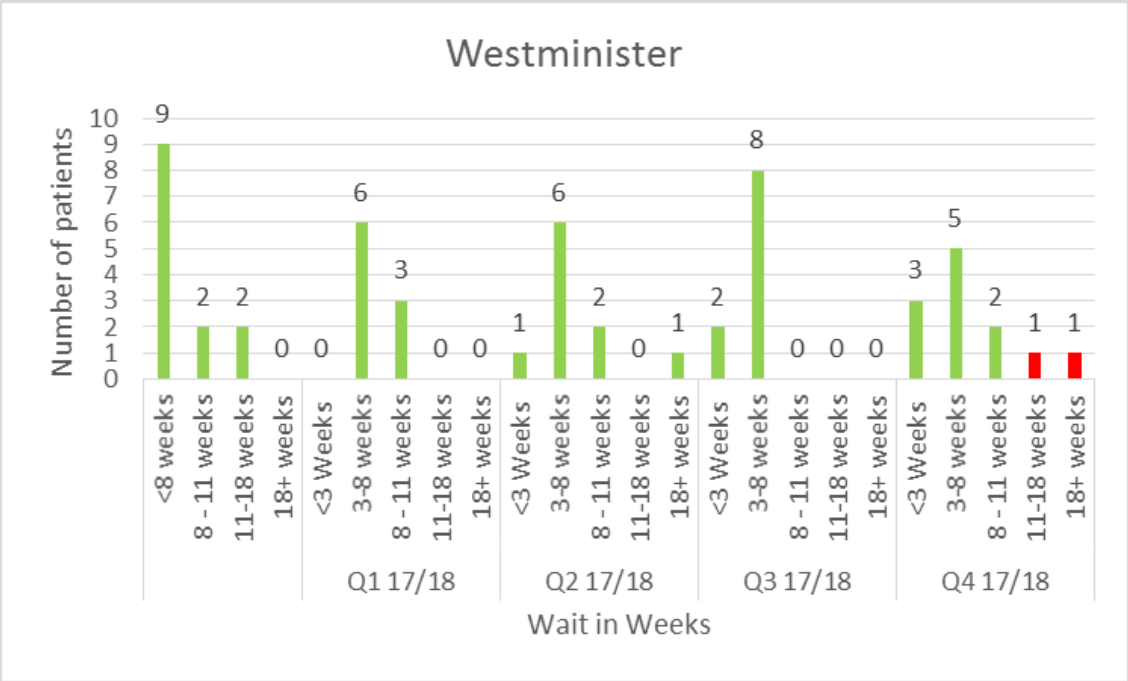
The waiting time target GIC is 18 weeks with 5% meeting this target in quarter 4. This is a new service with a huge number of referrals.

GIC saw 452 patients off their waiting list in quarter 4, 185 more than last quarter.

Please note anyone with a 42 week wait or under is likely to have had cancelled their original appointment and their waiting time would have been restarted from this date.

Total Waiting at the end of Quarter: Awaiting Frances Endres to come back from leave.

2.9 Westminster Service (Family Assessment Service - FAS)



The waiting time target for FAS is 8 weeks, 83% meeting this target in quarter 4, a decrease from quarter 3 (100%).

Number waiting at the end of the quarter: 9 (identical to last quarter)

Our waits in quarter 4 were mainly due to external issues resulting in delays to our start dates. Aside from the normal wait of receipt of LOI's from local authority, referral received for a pre-birth assessment due to the expected arrival of the baby within two weeks of the referral we consulted with local authority and it was agreed that we wait until after the birth so that a complete parenting assessment could be undertaken. Other waits were due to relevant documentation not being sent through from local authority police statements, external assessment report and one case was transferring teams within local authority so delayed as we had to wait for the new social worker who would be holding the case to be in situ before we could hold the relevant pre assessment meeting. One 'wait' due to no capacity owing to annual leave.

(Julie Rogers, Office Manager at Westminster)

Kerri Johnson-Walker, Data Quality Manager
10th April 2018

The Tavistock and Portman NHS
NHS Foundation Trust

Board of Directors : May 2018

Item : 15

Title : Quality Impact Assessments

Summary:
This paper presents Quality Impact Assessments from the Children, Young Adults and Families Directorate and the Adult and Forensic Directorate. We plan to further embed the meaningful use of quality impact assessments of service developments or changes through setting up a forum for discussion, tracking and follow up of issues raised. This is at the scoping stage at present but in principle the forum would include clinical staff and patient representatives for clinical services. Further development could include a similar process for education and training services

This report has been reviewed by the following Committees:
- Management Committee March 2018

This report focuses on the following areas:
(delete where not applicable)

- Quality
- Patient / User Experience
- Patient / User Safety
- Equality
- Risk
- Finance

For : Discussion

From : Director of Quality and Patient Experience

The Tavistock and Portman NHS
NHS Foundation Trust

Quality Impact Assessment Screening Tool

The following assessment screening tool is to ensure a consistent and systematic approach to assessing the impact that proposed changes will have on the quality of services. It will require judgment against the 6 areas of risk in relation to the proposed changes. Each proposal will need to be assessed whether it will impact adversely on patients/staff/ organisations.

SCHEME NAME: ___CYAF PRODUCTIVITY LEAD NAME: SALLY HODGES

Brief description of scheme:

For 2018/19 Budget CYAF are tasked with improving productivity by 2% of overall income. We will achieve our contribution primarily through growth initiatives, but also by careful management of resources. In respect of the latter, there will be some reduced banding of posts and reduced sessions of some posts where a reorganization of resources is desirable. There are also a small number of non-recurrent savings carried forward, where staff will take on additionally funded work but where the relevant staff will not be fully back filled.

Area of Quality	Impact Question Could the proposal impact negatively on any of the following?	Brief details of impact (positive or negative)	Impact 1-5 x	Likelihood 1-5	Score (I x L)
Duty of Quality	Compliance with NHS Constitution, Partnerships, Safeguarding children and adults, NICE Guidance, Duty to promote equality	No impact envisaged	1	1	1
Patient Experience	Patient Survey Results, Patient Choice feedback, Personalised & compassionate care	We have instigated a more localized programme of patient experience measures, as part of the overall quality improvement process, with the aim of getting more relevant service level feedback and engagement	1	1	1
Patient Safety	Safety systems in place to safeguard patients To prevent harm Infection prevention	This is reviewed through the trust structures and there is no additional likelihood of harm. There are some services where additional safeguarding issues are present owing to the huge increase in referrals (GIDS and GIC) and no additional productivity measures will be put into these services	1	1	1
Clinical Effectiveness	Evidence based practice, Clinical Leadership; Engagement; High quality standards	As staffing numbers are not going up in line with increased activity there is some risk to both engagement and the high quality standards the staff set themselves.	2	3	6
Prevention	Self-care and health equality	No impact likely	1	1	1
Productivity and Innovation	Best setting to delivering high quality clinical and cost effective care; Eliminating resource inefficiencies; Proved care pathway	Staff have reported increased pressure through demands that on the whole are unavoidable eg increase data requests, system changes, increased referral numbers	2	3	6

Manager/Clinician undertaking the assessment (name and signature)	Sally Hodges
Date Completed	13th March 2018
Job Title:	Director CYAF

Outcome: Risk scores 9 and above will require a description of the impact, mitigation and action plan (*Tables 3 & 4)*

To assess the impact of the proposed change will have on quality a risk score is calculated using the Tables 1 and 2 below. First identify the **impact (consequence)** of the change on the areas of quality outlined followed by the **likelihood** of that impact (Table1). Calculate the risk score using Table 2. Finally using Table 3 identify the escalation level.

Table 1

Impact		Likelihood
1	Negligible	Very unlikely to occur
2	Minor	Unlikely to occur but potential exists
3	Moderate	Could occur – reasonable chance
4	Severe	Likely to occur – strong possibility
5	Catastrophic	Almost Certain – expected to occur

Table 2

Likelihood	**Almost certain to occur**	**5**	**5**	**10**	**15**	**20**	**25**
	Likely to occur	**4**	**4**	**8**	**12**	**16**	**20**
	Could occur	**3**	**3**	**6**	**9**	**12**	**15**
	Unlikely to occur	**2**	**2**	**4**	**6**	**8**	**10**
	Very unlikely to occur	**1**	**1**	**2**	**3**	**4**	**5**
Risk Matrix			**1**	**2**	**3**	**4**	**5**
			Negligible	**Minor**	**Moderate**	**Severe**	**Catastrophic/ Fatal**
			Impact (Consequence)				

Table 3

Risk level	Risk score	Escalation level
Extreme	**15-25**	**Board of Directors**
High	**9-12**	**Management committee (reporting to Board)**
Moderate	**6-8**	**Directorate/Team**
Low (tolerated risks)	**1-5**	**Team but monitored at Directorate level**

Table 4

Area of Quality	Description of Impact	Mitigation and Action Plan
Overall Quality	Miminal	Monitoring
Patient Experience	Minimal	Improved focus on localized user feedback and engagement projects
Patient Safety	Minimal	In Gender services where risk is greatest, working closely with NHSE to increase funding and collaboration with local providers
Clinical Effectiveness	moderate	Monitoring. Implementation of Thrive/ shared decision making to ensure evidence based treatment first course of action
Prevention	Minimal	Monitoring
Productivity and Innovation	Moderate	Reducing the burden project led by local clinical governance to identify changes that will improve productivity. Local QI projects also used in areas of concern eg outcoming appointments

The Tavistock and Portman NHS
NHS Foundation Trust

Quality Impact Assessment Screening Tool

The following assessment screening tool is to ensure a consistent and systematic approach to assessing the impact that proposed changes will have on the quality of services. It will require judgment against the 6 areas of risk in relation to the proposed changes. Each proposal will need to be assessed whether it will impact adversely on patients/staff/ organizations.

Scheme Name: Productivity AFS

Lead Name: Dr Julian Stern

Brief description of scheme: Cost improvement plans for the AFS directorate 2018-19

Review of Adult and Forensic services in light of reduced budget over the course of 2018-19

In addition to the growth initiatives which will help achieve the contribution required, directorate savings will be made up of staff redundancies with some non-replacements, retirement of senior staff members and review and reduction in the grade of some posts.

Area of Quality	Impact Question Could the proposal impact positively or negatively on any of the following?	Brief details of impact (positive or negative)	Impact 1-5 x	Likelihood 1-5	Score (I x L)
Duty of Quality	Compliance with NHS Constitution, Partnerships, Safeguarding children and adults, NICE Guidance, Duty to promote equality	Less staff available to undertake commissioned work. Greater demands for data increasing work load on remaining staff Various post holders leaving or reducing sessions .This allows for savings and for some recruitment of lower banded, often younger staff members No reduction in clinical availability, but threats to supervisory capacity, to be mitigated by employing some VL staff	2	2	4

QIA Screening Tool Version 1.1 Approved by the Productivity Programme Board 15/11 2015
Once the form is completed please email to Louise Lyon (Llyon@tavi-port.nhs.uk)
References: How To: Quality Impact Assess Provider Cost Improvement Plans - National Quality Board July 2012 ; Delivering sustainable cost improvement programmes – Monitor January 2012

Area of Quality	Impact Question Could the proposal impact positively or negatively on any of the following?	Brief details of impact (positive or negative)	Impact 1-5 x	Likelihood 1-5	Score (I x L)
Patient Experience	Patient Survey Results, Patient Choice feedback, Personalised & compassionate care	We are working closely with the Quality team., PPI and QI colleagues to ensure meaningful and relevant service level feedback and engagement The appointment of APs (Assistant Psychologists) in the past two years in Adult complex Needs has significantly helped this process, as has the increasing understanding of the importance of QI, PPI involvement and Quality measures through the directorate. We continue to monitor ESQ on a quarterly basis	1	1	1
Patient Safety	Safety systems in place to safeguard patients To prevent harm infection prevention	This is reviewed through Trust structures, and there is no additional likelihood of harm	1	1	1
Clinical Effectiveness	Evidence based practice; Clinical Leadership; Engagement; High quality standards	Staff distressed by loss of staff, and specifically uncertainty re: recommissioning of a particular contract; and increased demands at the same time. Significant input to engagement and feedback to mitigate this impact.	2	2	4
Prevention	Self-care and health equality – physical and mental health	No impact likely	0	0	0
Productivity and Innovation	Best setting to delivering high quality clinical and cost effective care; Eliminating resource inefficiencies; Proved care pathway	Whole programme is focused on productivity and innovation in as positive a way as possible. Staff DO report increased pressure through excess OM and data requests/demands, increasing referral numbers etc. The rescheduling project, designed in the *long run* to increase efficiency, is likely to add to stress and unease in staff in the *short and medium term* . I am conscious of complicated staff feedback results from AFS in the current Staff survey, and this project (and other staff reductions) will potentially exacerbate issues. Am already working with HR to mitigate as best as possible	2	2	4

Manager/Clinician undertaking the assessment (name and signature)	Julian Stern
Date Completed	March 20th 2018
Job Title:	Director –AFS

Outcome: Risk scores 9 and above will require a description of the impact, mitigation and action plan (*Tables 3 & 4)*

To assess the impact of the proposed change will have on quality a risk score is calculated using the Tables 1 and 2 below. First identify the **impact (consequence)** of the change on the areas of quality outlined followed by the **likelihood** of that impact (Table1). Calculate the risk score using Table 2. Finally using Table 3 identify the escalation level.

Table 1

Impact		Likelihood
1	Negligible	Very unlikely to occur
2	Minor	Unlikely to occur but potential exists
3	Moderate	Could occur – reasonable chance
4	Severe	Likely to occur – strong possibility
5	Catastrophic	Almost Certain – expected to occur

Table 2

Likelihood	**Almost certain to occur**	**5**	**5**	**10**	**15**	**20**	**25**
	Likely to occur	**4**	**4**	**8**	**12**	**16**	**20**
	Could occur	**3**	**3**	**6**	**9**	**12**	**15**
	Unlikely to occur	**2**	**2**	**4**	**6**	**8**	**10**
	Very unlikely to occur	**1**	**1**	**2**	**3**	**4**	**5**
Risk Matrix			**1**	**2**	**3**	**4**	**5**
			Negligible	**Minor**	**Moderate**	**Severe**	**Catastrophic/ Fatal**
			Impact (Consequence)				

Table 3

Risk level	Risk score	Escalation level
Extreme	**15-25**	**Board of Directors**
High	**9-12**	**Management committee (reporting to Board)**
Moderate	**6-8**	**Directorate/Team**
Low (tolerated risks)	**1-5**	**Team but monitored at Directorate level**

Table 4

Area of Quality	Description of Impact	Mitigation and Action Plan
Overall Quality	Greater demands on fewer staff, which has led to the need for changes in practice	Work with teams to introduce efficiency measures Work on staff engagement Work on streamlining systems to reduce burden on staff eg CAR clinics
Patient Experience		
Patient Safety	Greater demands on fewer staff means attention to safeguarding at risk	Systematic programme of risk assessment training instigated
Clinical Effectiveness	Greater demands on fewer staff means attention to effectiveness at risk	Outcome monitoring programme developed. Outcome monitoring tool developed
Prevention		
Productivity and Innovation	Staff loss due to productivity	Staff engagement programme Efficiency programme put in place

The Tavistock and Portman NHS
NHS Foundation Trust

Board of Directors : 22 May 2018

Item : 17

Title : Organisational Development and People Strategy Assurance Report – Year End

Purpose:
This paper summarises progress being made against the organisational development and people strategy delivery plan.

Incorporated within this paper are the HR directorate's workforce indicators such as staff in post, turnover, stability, sickness and vacancy rates. The report also summarises mandatory training compliance.

This report focuses on the following areas:
(delete where not applicable)

- Quality
- Workforce

For : Noting

From : Craig de Sousa, Director of Human Resources

Organisational Development and People Strategy Assurance Report
Year End – 2017/18

1. Introduction

This paper summarises progress being made against the organisational development and people strategy. The report is designed to appraise a range of committees on what has been achieved over the last year and further work is needed.

The reports reflects on the last year and also present a range of workforce key performance indicators to illustrate what is happening within our organisation.

2. Achievements in the last year

Reflecting on the last year it is evident that a lot of work has been undertaken to implement a number of initiatives, improve our HR processes and systems and change the culture within our organisation.

The following sections detail some of the highlights from 2017/18 and how they have influenced or impacted on staff experience.

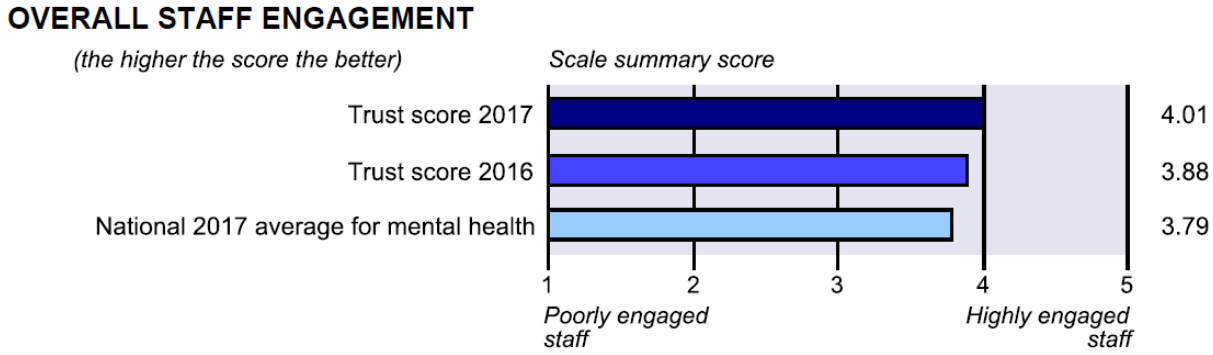
The NHS Staff Survey

The NHS Staff Survey took place between October and December 2017. For a third year running we offered all of our staff the opportunity to respond to the survey using the online questionnaire.

In 2017 the Trust received, yet again, high response rates with 56.4% of those being surveyed submitting a questionnaire. This was a very slight decline from the previous year where 58% of staff responded.

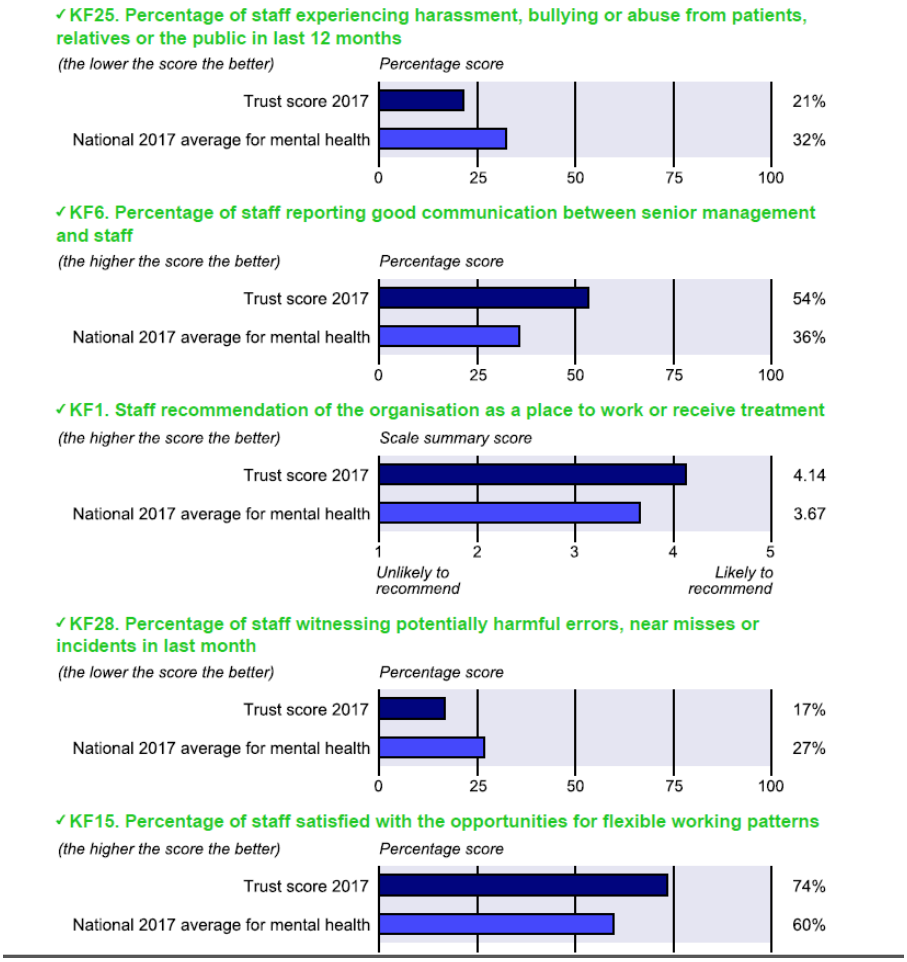
Highlights from the 2017 Survey

It is clear from our results that our staff take exceptional pride in the work that they do with a high proportion recommending the organisation as a place to work and to be treated. In addition to this we have an exceptionally high engagement score.



Having undertaken some extensive analysis of our survey results the Trust ranks as the best performing mental health and learning disability provider in 14 out of the 27 key findings areas.

Summarised below are our top five key result areas.

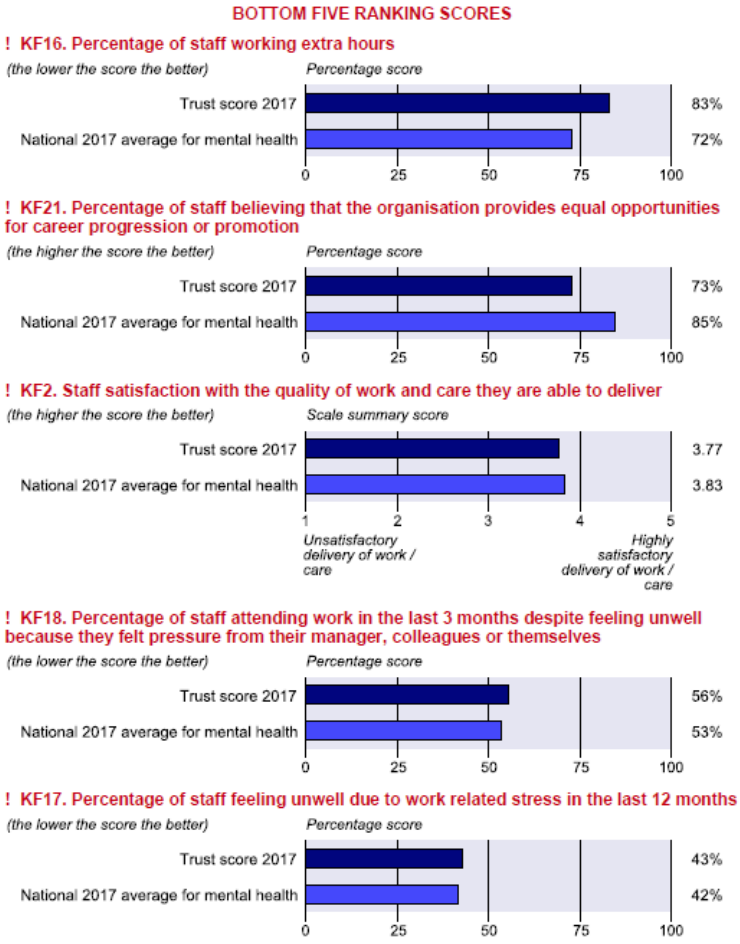


Areas for improvement

Amongst our results there are a number where we need to do further work. Some are themes from previous years which we will continue to engage with staff and managers to address.

We are cognisant that whilst the report highlights a number of areas where we perform less well, we are also aware that there is a clear divergence of experience between black, asian and minority ethnic (BAME) and white staff. The Trust has, in 2017, agreed a three year race equality strategy and an action plan to work to address a number of systemic issues in our organisation and we hope that these efforts will result in positive changes over the coming years. In saying that change will happen over a longer period this reflects our view that cultural change does take time and requires continued visibility and action.

The chart below summarises the five areas where we perform less well compared to other organisations in our peer group.



Improving our results

In 2016 we structured the staff survey data in a way that allowed us to report at Trust, directorate and service line level. We have done the same for 2017 and this has highlighted the services and teams where we need to give support and focused programmes of work.

Our service directors have, for another year, been tasked to discuss their results at a local level and then celebrate positive stories and co-design action plans that will address the concerns areas.

Our race equality strategy

In October 2017 we launched the race equality strategy to set our direction for making cultural change happen in the organisation. Since the strategy was formally launched there have been a number of initiatives or projects implemented which include:

- Formation of a black, asian and minority ethnic (BAME) staff network;
- Agreement of a development programme for BAME staff which will roll forward in to 2018/19;
- Good participation and diverse applications being received on our aspiring leaders programme;

- A series of 'thinking spaces' around race equality have been developed and will be rolled out in 2018/19; and

- The appointment of a race diversity champion.

We recognise that initiatives are only the start and that continuing to make diversity and inclusion issues prominent and regularly spoken about make change happen. Over the coming months we will be thinking and planning carefully about how we measure that change is happening within our organisation and what further work we need to commit to, to create lasting and sustainable change.

The Tavistock and Portman Academy

One of the delivery strands within the organisational development and people strategy was to develop career pathways for our clinical and educational staff.

The Tavistock and Portman Academy is a programme of work which aims to increase our capacity to deliver education and training and grow future faculty.

At the beginning of 2017 a small project team was established to develop our thinking around how we develop future faculty and then implement a programme of development for one of our clinical staff groups.

An output of this programme of work is that a new education development programme will be launched in the summer term specifically for the nursing discipline. Following the first course being delivered, further consideration will happen about how to adapt and launch the programme for other professional groups.

3. Progress against the organisational development and people strategy delivery plan

The following table presents the 2017/18 element of the organisational development and people strategy delivery plan and details that planned delivery dates and what progress is being made against each of the areas.

	On target / complete
	Progressing but behind target
	Significantly behind target
	Not started

		2017/18			
Specific priorities	**Action required**	**Q1**	**Q2**	**Q3**	**Q4**
Workforce planning	Improve and cleanse our existing workforce information	X	X		
	Invest in workforce planning skills			X	
	Develop an annual, directorate and trust level, workforce planning process which is led by managers supported by HR and finance				X
Career pathways	Informed by our workforce plans, look at our clinical, non-clinical and leadership roles and map our desired career pathways				
	Recruit for the future and develop competency frameworks that allow easier progression				
Succession planning	Map the current natural successors for director, heads of service and senior faculty posts				X
	Implement a succession plan review it annually				X
	Extend the succession planning process to lower tiers within the organisation				
	Implement a robust and objective talent management process that identifies current and emerging leaders in the organisation.				
Marketing our offering as an employer	Making best use of our website and social media, promote careers at the Trust	X	X		

		2017/18			
Specific priorities	**Action required**	**Q1**	**Q2**	**Q3**	**Q4**
	Ensure that we capture talent from our students	X	X	X	
Robust performance and appraisal system	Review the appraisal process		X		
	Map appraisal outcomes to the talent and succession plan				
Leadership and management development	Continue to deliver the internal leadership programme	X			X
	Commit to sponsoring staff to undertake national leadership programmes				
	Use the annual appraisal process to commission relevant and timely education and training programmes for our staff	X			
The Tavistock and Portman Academy	Scope the potential and create an academy model	X	X	X	X
	Embed and evaluate the fellowship programme	X	X	X	
	Support, track and monitor our future academic leaders				
Research and Development	Working with the medical director and clinical directors, establish a research and development job offering				X
	Encourage and promote research opportunities				
	Establish an academic faculty				
	Develop a recognition process for joint work				
Developing our commercial skills	Identify areas where the Trust has commercial potential	X	X		
	Scope the skills and capabilities needed to win new contracts and / or commercialise our services			X	
	Invest in commercial skills development				X
Establish a physical and mental health	Constitute a group			X	
	Agree an annual plan				X
	Implement reporting mechanisms				

		2017/18			
Specific priorities	**Action required**	**Q1**	**Q2**	**Q3**	**Q4**
and wellbeing steering group	Embed actions in the quarterly HR reporting with an evaluation of activity				
Promote healthy lifestyles	Work collaboratively with the Trust's occupational health service to promote health lifestyles				X
	Implement monthly healthy lifestyle campaigns using internal communications				
	Hold an annual health and wellbeing event				
Create cultural change	Develop a narrative about what is positive about the trust and where we need to focus for improvement.			X	X
	Commit and provide senior oversight to the diversity and inclusion agenda	X			
	Report regularly on action being taken and positive stories				X
	Embed diversity and inclusion as an integral part of all leadership development programmes	X	X		
Attract and select diversity champions	Develop a role specification		X		
	Seek applications			X	
	Create a specialised development programme				X
	Encourage the champions to develop workplace best practice and share through the diversity and inclusion committee				X
Track career progression of leadership development participants	Record all non-mandatory training data on ESR	X	X		
	Report annually on training uptake		X		
	Create a talent pool of leadership candidates to lead projects and be first to be offered secondments			X	X
Create opportunities for coaching and mentoring	Commission coaching and mentoring services for our staff			X	X
	Monitor and report on the number of staff receiving developmental support				X
	Track the career progress of those accessing support				

4. Workforce indicators

The following workforce indicators are obtained from ESR with each data item being accurate at the last day of each month.

Period: April 2017 - March 2018																
Report Title	**Apr**	**May**	**Jun**	**Q1**	**Jul**	**Aug**	**Sep**	**Q2**	**Oct**	**Nov**	**Dec**	**Q3**	**Jan**	**Feb**	**Mar**	**Q4**
Staff in Post																
Full Time Equivalent Staff in Post (FTE)	570.27	575.52	578.69	574.83	578.69	580.19	579.02	579.30	580.70	580.50	584.09	581.76	592.82	587.03	588.75	589.53
Headcount	677	681	683	680.33	681	685	687	684.33	689	694	700	694.33	718	711	712	713.67
Vacancy Rate	14.76%	13.31%	12.83%	13.63%	12.98%	12.75%	12.93%	12.89%	12.68%	12.71%	12.17%	12.52%	10.85%	11.72%	11.73%	11.44%
Turnover	21.07%	21.16%	20.93%	21.05%	19.98%	19.14%	19.29%	19.47%	20.81%	20.52%	19.76%	20.36%	18.52%	19.33%	17.92%	18.59%
Stability Index	79.97%	80.17%	80.17%	80.10%	80.00%	78.15%	78.06%	78.74%	79.92%	80.25%	80.43%	80.20%	81.86%	81.10%	81.75%	81.57%
Recruitment Lapse Time	4 weeks				8 weeks				7 weeks				6 weeks			
Health, wellbeing and morale																
Sickness Absence Spot Month	0.79%	0.72%	1.57%	1.03%	1.53%	1.28%	1.75%	1.52%	1.87%	1.78%	1.25%	1.63%	1.60%	1.95%	1.44%	1.66%
Sickness Absence 12 month rolling average	1.56%	1.46%	1.47%	1.50%	1.43%	1.39%	1.40%	1.41%	1.42%	1.43%	1.46%	1.44%	1.24%	1.29%	1.34%	1.29%
Training and compliance																
DBS Compliance	98%	98%	98%	98%	99%	99%	99%	99%	99%	99%	99%	99%	97%	97%	97%	97%
Appraisal Compliance	0%	24%	42%	22%	83%	89%	89%	87%	89%	89%	89%	89%	95%	95%	95%	95%
Establishment FTE (From Finance)	**669**	**663.87**	**663.87**		**665**	**665**	**665**		**665**	**665**	**665**		**665**	**665**	**667**	

5. Mandatory Training Compliance

Description	Quarter 1 2017/18	Quarter 2 2017/18	Quarter 3 2017/18	Quarter 4 2017/18
Mandatory Training Compliance – Induction and INSET Attendance	100%	100%	94%	88%
Local Induction Checklists Completed	90%	90%	92%	94%
Basic Life Support	99%	99%	99%	99%
Clinical Risk Training	16%	16%	16%	31%
Conflict Resolution Training	100%	100%	100%	100%
Information Governance	100%	78%	46%	95%
Ladder Safety	100%	100%	100%	100%
Manual Handling	100%	100%	100%	99%
Safeguarding Adults – Level 2			33%	65%

Description	Quarter 1 2017/18	Quarter 2 2017/18	Quarter 3 2017/18	Quarter 4 2017/18
Safeguarding Children – Level 2 & 3 (Combined Training)	94%	81%	89%	93%
WRAP				86%

The Trust has a high level of compliance across a number of the mandatory and statutory training areas. There are two areas where we have a lower level of compliance, the table below summarises the reason for the current performance and remediation plans which are being led by the subject matter experts with administrative support from the HR directorate.

Subject	Reasons for low compliance	Remediation plan
Clinical risk straining	The Trust has, in the past, delivered this type of training but it was not categorised as mandatory and as such there are limited historic records of those training. The requirement was added to the training matrix in 2017.	Work is continuing to deliver face to face training to teams by the associate medical director. In addition to the above, a Health Education England e-learning solution has been shared with the medical director's office to review and consider whether this should be rolled out.
Safeguarding adults training – level 2	The Trust's safeguarding adults lead resigned in the summer of 2017. A replacement was recruited but has since left the organisation for a promotion. A successor has been recruited and will be shortly starting in post and tasked with developing a training schedule.	A plan is being developed with the new safeguarding lead. This includes agreeing resources to support the training, dates, times and booking those who are currently non-compliant.

6. Conclusions and recommendations

Members of the relevant committees are asked to note the contents of this report.

Craig de Sousa
Director of Human Resources
April 2018

The Tavistock and Portman NHS
NHS Foundation Trust

Board of Directors: 22 May 2018

Item : 18

Title : Gifts, Hospitality and Interests Policy

Summary:

This policy is intended to replace the previous Gifts and Hospitality Policy, as well as cover conflicts of interest in a Trust policy.

The document incorporates national guidance from NHS England and includes specific responsibilities around declaring interests for staff at all levels of an organisation.

For : Approval

From : Craig de Sousa, Director of HR & Corporate Governance

The Tavistock and Portman NHS
NHS Foundation Trust

Gifts, Hospitality and Interests Policy

1. Rationale behind the policy

1.1 This policy is a new version of the Gifts and Hospitality Policy and is intended to replace the previous one. It also includes conflicts of interest. This will be the first time the Trust has included this in a formal format. Previously the Trust has adhered to conflicts of interest requirements by requiring Board members and specific members of staff and senior management to make declarations on an annual basis. This policy seeks to make the Trust compliant with revised NHSE guidance which seeks to strengthen the management of conflicts of interest and ensure that the NHS is a world leader for transparent and accountable healthcare. Their guidance was bench marked against best practice in other industries.

1.2 The purpose is to ensure transparency, leaving Trusts and individuals beyond reproach when dealing with any potential or perceived conflict. You may be aware of several high profile cases in recent years, such as a Westminster councillor receiving over 500 gifts in the space of three years, which have highlighted the need to increase the scope and robustness of the guidance.

2. Policy requirements

2.1 The requirements relating to gifts and hospitality will apply to all staff, as per the previous policy. Financial amounts have been amended, in line with the NHS England guidance. As previously small gifts may be accepted and declarations must be made whether a gift is accepted or declined. Any acceptance of cash and vouchers remains prohibited.

2.2 Requirements relating to declaration of any conflicts of interest will be more targeted, with senior and decision making staff making up the majority of those affected, as well as those involved in contract and procurement activities. Declaration requirements, particularly relating to private clinical, consulting and teaching activity, will be discussed with appropriate executive leads to ensure communications are suitably clear and effective for maximum engagement of staff in meeting their responsibilities.

3. Communication to staff

3.1 There will be a structured communications plan implemented, to ensure that staff are aware of their responsibilities under the new policy. It will also be made clear why the scope of staff members covered by the requirement to make declarations has widened, with particular emphasis placed on the need for members of staff and the Trust to be seen as transparent and open. The policy in no way seeks to restrict staff from carrying out other work outside of their Trust employment, but instead intends to protect them from any accusations of improper conduct in relation to any Trust or outside activities.

Prepared by
Terri Burns
Trust Company Secretary

Presented by
Craig de Sousa
Director of HR & Corporate Governance
May 2018

The Tavistock and Portman NHS
NHS Foundation Trust

GIFTS, HOSPITALITY AND INTERESTS POLICY

(February 2018)

Version:	1
Bodies consulted:	Finance, LCFS, HR
Approved by:	Board of Directors
Date Approved:	
Responsible Director:	Director of Finance
Date issued:	February 2018
Review date:	February 2020

Contents

GIFTS, HOSPITALITY AND INTERESTS POLICY

1 Policy Summary

Adhering to this policy will help to ensure that we use NHS money wisely, providing best value for taxpayers and accountability to our patients for the decisions we take.

As a member of staff you should…	As an organisation we will…
• Familiarise yourself with this policy and follow it. Refer to the guidance for the rationale behind this policy https://www.england.nhs.uk/wp-content/uploads/2017/02/guidance-managing-conflicts-of-interest-nhs.pdf • Use your common sense and judgement to consider whether the interests you have could affect the way taxpayers' money is spent • Regularly consider what interests you have and declare these as they arise. If in doubt, declare. • **NOT** misuse your position to further your own interests or those close to you • **NOT** be influenced, or give the impression that you have been influenced by outside interests • **NOT** allow outside interests you have to inappropriately affect the decisions you make when using taxpayers' money	• Ensure that this policy and supporting processes are clear and help staff understand what they need to do. • Allocate the Trust Company Secretary responsibility for: ○ Keeping this policy under review to ensure they are in line with the guidance. ○ Providing advice, training and support for staff on how interests should be managed. ○ Maintaining register(s) of interests. • Audit this policy and its associated processes and procedures at least once every three years. • **NOT** avoid managing conflicts of interest. • **NOT** interpret this policy in a way which stifles collaboration and innovation with our partners

2 Introduction

Tavistock and Portman NHS Foundation Trust (the 'Trust'), and the people who work with and for us, collaborate closely with other organisations, to deliver high quality care for our patients.

These partnerships have many benefits and should help ensure that public money is spent efficiently and wisely but there is a risk that conflicts of interest may arise where staff are offered gifts and/or hospitality or have other interests.

Providing best value for taxpayers and ensuring that decisions are taken transparently and clearly, are both key principles in the NHS Constitution. We are committed to maximising our resources for the benefit of the whole community. As a Trust and as individuals, we have a duty to ensure that all our dealings are conducted to the highest standards of integrity and that NHS monies are used wisely so that we are using our finite resources in the best interests of our service users.

This policy applies to all staff as defined in section 5 of this policy.

The Bribery Act 2010 came into force in July 2011. The Trust fully supports this act and further information can be found in the Trust's Anti-Fraud and Bribery which is published on the Trust's internal Intranet. The Trust is required to maintain proportionate adequate procedures to mitigate the risk of bribery. This includes the appropriate management of gifts, hospitality, sponsorship and interests and is applicable to all persons associated with the Trust.

Board Statement:

The Trust aims to provide excellent public service and needs to ensure propriety and accountability in all matters.

The Trust is determined to protect itself and the public from fraud and bribery and is committed to implementing and maintaining robust policies for the prevention and detection of fraud and bribery.

The Trust has a zero tolerance attitude towards fraud and bribery. The Trust will investigate any suspected acts of fraud, bribery, misappropriation or irregularity and take full and appropriate action against any wrong doing.

3 Purpose

This policy aims to provide clear guidance to all Tavistock & Portman NHS Foundation Trust staff who are offered hospitality, gifts or personal benefits, as a consequence of working for the Trust. It also provides guidance to staff on dealing with other interests which may be considered to compromise their integrity.

This policy sets out how Trust staff will manage gifts, hospitality and interests so that the risk of a conflict of interest is managed effectively by:

- introducing consistent principles and rules;
- providing simple advice about what to do in common situations; and
- supporting good judgement about how to approach and manage interests.

This policy should be considered alongside these other organisational policies:

- Trust Standing Orders.
- Standing Financial Instructions.
- Code of Conduct.
- Trust Anti-Fraud and Bribery Policy.

4 Definitions

A 'conflict of interest' is:

> *"A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold."*

A conflict of interest may be:

- Actual - there is a material conflict between one or more interests; or
- Potential – there is the possibility of a material conflict between one or more interests in the future.

Staff may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see it differently and perceived conflicts of interest can be damaging. All interests should be declared where there is a risk of perceived improper conduct.

5 Interests

Interests fall into the following categories:

- **Financial interests**

  Where an individual may get direct financial benefit[1] from the consequences of a decision they are involved in making.

- **Non-financial professional interests**

  Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.

- **Non-financial personal interests**

[1] This may be a financial gain, or avoidance of a loss.

Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.

- **Indirect interests**

  Where an individual has a close association[2] with another individual, who has a financial interest, a non-financial professional interest or a non-financial personal interest in the Trust, and could stand to benefit from a decision the other individual is involved in making.

6 Staff

At Tavistock & Portman NHS Foundation Trust we use the skills of many different people, all of whom are vital to our work. This includes people on differing employment terms, who for the purposes of this policy we refer to as 'staff' and are listed below:

- All salaried employees – full time and part time including those on fixed term contracts;
- Associated persons such as secondees and those with an honorary contract;
- All prospective employees – who are part-way through recruitment;
- Contractors and sub-contractors;
- Agency staff; and
- Committee, sub-committee and advisory group members (who may not be directly employed or engaged by the Trust).

This policy also applies to Non-Executive Directors of the Trust.

7 Decision Making Staff

Some staff are more likely than others to have a decision making influence on the use of taxpayers' money, due to the requirements of their role. For the purposes of this guidance these people are referred to as 'decision making staff.'

Decision making staff in this Trust are:

- Executive and Non-Executive Directors (or equivalent roles) who have decision making roles which involve the spending of taxpayers' money;
- members of advisory groups which contribute to direct or delegated decision making on the commissioning or provision of taxpayer funded services;
- those at Agenda for Change band 8d and above;
- administrative and clinical staff who have the power to enter into contracts on behalf of the Trust including Estates and Procurement staff; and

[2] A common sense approach should be applied to the term 'close association'. Such an association might arise, depending on the circumstances, through relationships with close family members and relatives, close friends and associates, and business partners.

- Administrative and clinical staff involved in decision making concerning the commissioning of services, purchasing of good, medicines, medical devices or equipment, and formulary decisions – generally this means all budget holders.

8 Identification, declaration and review of interests

8.1 Identification & declaration of interests (including gifts and hospitality)

All staff should identify and declare material interests at the earliest opportunity (and in any event within 28 days of the gift or hospitality or interest arising). If staff are in any doubt as to whether an interest is material then they should declare it, so that it can be considered. Further advice can be obtained from the Trust Company Secretary.

Declarations should be made:

- on appointment with the Trust;
- when staff move to a new role or their responsibilities change significantly;
- at the beginning of a new project/piece of work; or
- as soon as circumstances change and new interests arise (for instance, in a meeting when interests staff hold are relevant to the matters in discussion).

A declaration of interest(s) form is available at Appendix 1 of this policy and on the Trust's Intranet. The form needs to be countersigned by the staff member's line manager.

Completed declaration of interest(s) forms should be submitted to the Trust Company Secretary at TSecretary@tavi-port.nhs.uk or in writing to:

Trust Company Secretary
Tavistock & Portman NHS Foundation Trust
120 Belsize Lane
London
NW3 5BA

The Trust Company Secretary maintains a Register of Interests for each financial year for all staff, which includes Non-Executive Directors. The information from the declaration form will be entered onto the Register of Interests. The Register of Interests will be circulated to the Audit Committee at least once a year.

The Trust Company Secretary will provide advice to staff and line managers on interests that should be declared and how to manage any actual or potential conflicts of interest.

8.2 Proactive review of interests

We will require all decision making staff to complete a declaration of interest form annually. Where there is no declaration to be made, a nil return will be required. There is a process of reminders and escalation to ensure that all decision making staff comply with this requirement.

8.3 What is the fine line between gifts, hospitality and interests, and bribes?

As set out in the Trust's Anti-Fraud and Bribery Policy the Trust has a zero tolerance attitude towards fraud and bribery. Staff should be aware that an offer of gifts or hospitality may constitute a bribe, and this should be considered in all circumstances in order to protect themselves and the Trust from criminal prosecution.

Any inference that gift or hospitality provision was intended as a bribe would be strengthened if:

- there was any unjustifiable 'add-ons', for example to travel or accommodation; or
- the expenditure was related in time to some actual or anticipated business with the recipient, particularly where some form of competitive process is involved.

It is expressly prohibited for a member of staff to accept any gift or benefit from an organisation that is actively involved, or likely to be involved, in a tender process with the Trust. This prohibition commences at the point that an invitation to tender is published and extends to period three months after a contract has been awarded.

9 Records and publications

9.1 Maintenance

The Trust will maintain a Register of Interests, which will include gifts, hospitality and other interests excluding other/secondary employment. This Register of Interests will be maintained by the Trust Company Secretary and shared with the Procurement Team to ensure that all actual or potential conflicts of interest are identified.

A Register for Secondary Employment will be maintained by the Director of HR. This will be shared with the Trust Company Secretary and the Procurement Team to ensure that all actual or potential conflicts of interest are identified.

9.2 Publication

We will publish the Register of Interests on the Trust's public website and internal intranet. This published information will be updated at least quarterly.

In addition the Register of Interests may be accessed upon request to the Trust Company Secretary.

If any member of staff making a declaration has substantial grounds for believing that publication of their interests should not take place then they should contact the Trust Company Secretary to explain why. In exceptional circumstances, for instance where publication of information might put a member of staff at risk of harm, information may be withheld or redacted on public registers. However, this would be the exception and information will not be withheld or redacted merely because of a personal preference.

9.3 Wider transparency initiatives

The Tavistock and Portman NHS Foundation Trust fully supports wider transparency initiatives in healthcare, and we encourage staff to engage actively with these.

Relevant staff are strongly encouraged to give their consent for payments they receive from the pharmaceutical industry to be disclosed as part of the Association of British Pharmaceutical Industry (ABPI) Disclosure UK initiative. The granting of consent for disclosure does not negate the requirement to declare these payments to the Trust in accordance with this policy.

These "transfers of value" include payments relating to:

- Speaking at and chairing meetings;
- Training services;
- Advisory board meetings;
- Fees and expenses paid to healthcare professionals;
- Sponsorship of attendance at meetings, which includes registration fees and the costs of accommodation and travel, both inside and outside the UK; and
- Donations, grants and benefits in kind provided to healthcare organisations.

Further information about the scheme can be found on the ABPI website:
http://www.abpi.org.uk/our-work/disclosure/about/Pages/default.aspx

10 Management of interests - General

If an interest is declared but there is no risk of a conflict arising then no action is warranted. However, if a material interest is declared then the general management actions that could be applied include:

- restricting the staff member's involvement in associated discussions and excluding them from decision making;
- removing the staff member from the whole decision making process;
- removing from the staff member responsibility for an entire area of work; and
- removing the staff member from their role altogether if they are unable to operate effectively in it because the conflict is so significant.

Each case will be different and context-specific, and the Trust Company Secretary will always clarify the circumstances and issues with the individuals involved. The decision

will be recorded in the Register of Interests and individual staff members and line managers should maintain a written audit trail of information considered and actions taken.

Where there is a dispute with the decision of the Trust Company Secretary the issue will be referred to the Executive Team for review and decision.

Members of staff who declare material interests should make their line manager or the person(s) they are working to aware of their existence.

The Trust Company Secretary will work closely with the Procurement Team to ensure that declarations declared as part of a tender exercise are recorded on the Trust registers.

11 Management of interests – Common situations

All staff must declare all gifts, hospitality and interests, unless there is a direct link to working arrangements and a genuine business reason can be demonstrated (please see www.england.nhs.uk/ourwork/coi for examples).

The following sub-sections are examples where declarations may be necessary and set out the principles and rules to be adopted by staff, and what information should be declared.

11.1 Gifts

- Staff should not accept gifts that may affect, or be seen to affect, their professional judgement.
- All gifts, whether accepted or declined, should be declared.
- The Trust will not provide gifts to internal or external parties under any circumstances.

Gifts from suppliers or contractors:

- Gifts from suppliers or contractors doing business (or likely to do business) with the Trust should be declined, whatever their value.
- Low cost branded promotional aids such as pens or post-it notes may, however, be accepted where they are under the value of £6[3] in total, and need not be declared.
- Gifts are prohibited whenever they could affect or be perceived to affect the outcome of a business transaction.

Gifts from other sources (e.g. patients, families, service users):

- Gifts of cash and vouchers to individuals should always be declined.
- Staff should not ask for any gifts.
- Gifts valued at over £50 should be treated with caution and only be accepted on behalf of the Trust and not in a personal capacity. These should be

[3] The £6 value has been selected with reference to existing industry guidance issued by the ABPI: http://www.pmcpa.org.uk/thecode/Pages/default.aspx

declared by the individual member of staff accepting the gift along with a statement of how the gift has been disposed of. Such gifts could be shared with all staff in the team or donated to the Trust's charity.

- Modest gifts accepted under a value of £50 do not need to be declared.
- A common sense approach should be applied to the valuing of gifts (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).
- Multiple gifts from the same source over a 12 month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds £50.

11.1.1 What should be declared

- Member of staff's name and their role within the Trust;
- a description of the nature and value of the gift, including its source.
- the date of receipt.
- Details of previous gifts offered by the source
- Whether the offer was accepted or not
- Reasons for accepting or declining the offer
- any other relevant information (e.g. circumstances surrounding the gift, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.2 Hospitality

- Staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement.
- Hospitality is prohibited whenever it could affect or be perceived to affect the outcome of a business transaction.
- Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors. This can be accepted, and must be declared, if modest and reasonable. Senior approval must be obtained.
- On occasion it might be appropriate for professional relationship reasons to accept hospitality to a purely social event. In this instance, the event should be attended in the member of staff's own time, taking annual leave as necessary. The invitation should be recorded in the Register of Interest whether accepted or declined.
- The Trust may provide hospitality for meetings, conferences and workshops with other organisations where there is a genuine business reason. This hospitality should be modest and appropriate to the occasion and subject to Associate Director approval.

Meals and refreshments

- Under a value of £25 - may be accepted and need not be declared.

- Of a value between £25 and £75[4] - may be accepted and must be declared whether accepted or declined.
- Over a value of £75 - should be refused unless (in exceptional circumstances) senior approval is given. A clear reason should be recorded on the Trust's Register of Interest as to why it was permissible to accept. Even where declined, the offer must be declared.
- A common sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or an estimate that a reasonable person would make to its value).

Travel and accommodation

- Modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared.
- Offers which go beyond modest, or are of a type that the Trust itself might not usually offer, need approval by senior staff, should only be accepted in exceptional circumstances, and must be declared. All offers of this type must be declared and a clear reason for accepting or declining must be recorded on the Trust Register of Interests. A non-exhaustive list of examples includes:
  - offers of business class or first class travel and accommodation (including domestic travel); and
  - offers of foreign travel and accommodation.

11.2.1 What should be declared

- Member of staff's name and their role within the Trust.
- The nature and value of the hospitality including the circumstances.
- Date of receipt.
- Details of previous hospitality offered by the source
- Whether the offer was accepted or not
- Reasons for accepting or declining the offer
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.3 Outside Employment

- Staff should declare any existing outside employment on appointment and any new outside employment when it arises. This declaration needs to be made to the Human Resources Department as set out in the Trust's Code of Conduct.
- Where a risk of conflict of interest arises, the general management actions outlined in this policy should be considered and applied to mitigate risks.

[4] The £75 value has been selected with reference to existing industry guidance issued by the ABPI http://www.pmcpa.org.uk/thecode/Pages/default.aspx

- Where contracts of employment or terms and conditions of engagement permit, staff may be required to seek prior approval from the Trust to engage in outside employment.
- Appropriate liaison will be made between the Director of HR and the Trust Company Secretary for issues to be recorded on the Trust's Register of Interests.
- Any payment that is received for speaking at conferences etc. in Trust time should be paid to the Trust (sometimes referred to as an Honorarium). Trust time is the hours an individual is normally expected to perform their duties in line with their contract of employment. For senior members of staff who are required to do those hours necessary to fulfil their role this may include delivering courses, conferences, seminars or presentations out of the organisation's normal working hours but the work is in the Trust's interest. This means where there is a requirement to use the post holder's job title and their association with the organisation. If you hold roles outside of the Trust or are unsure how this will apply to you, please raise this with your line manager or HR directly for clarification.

11.4 Shareholdings and other ownership issues

- Staff should declare, as a minimum, any shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with the Trust.
- Where shareholdings or other ownership interests are declared and give rise to risk of conflicts of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.
- There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts.

11.4.1 What should be declared

- Member of staff's name and their role within the Trust.
- Nature of the shareholdings/other ownership interest.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.5 Patents

- Staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are on-going, which are, or might be reasonably expected to be, related to items to be procured or used by the Trust.

- Staff should seek prior permission from the Trust before entering into any agreement with bodies regarding product development, research, work on pathways etc. where this impacts on the Trust's own time, or uses its equipment, resources or intellectual property.
- Where holding of patents and other intellectual property rights give rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

11.5.1 What should be declared

- Member of staff's name and their role within the Trust.
- A description of the patent.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.6 Loyalty interests

Loyalty interests should be declared by staff involved in decision making where they:

- Hold a position of authority in another NHS organisation or commercial company, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role.
- Sit on advisory groups or other paid or unpaid decision making forums that can influence how an organisation spends taxpayers' money.
- Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners.
- Are aware that the Trust does business with an organisation in which close family members and relatives, close friends and associates, and business partners have decision making responsibilities.

11.6.1 What should be declared

- Member of staff's name and their role within the Trust.
- Nature of the loyalty interest.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.7 Donations

- Donations made by suppliers or bodies seeking to do business with the organisation should be treated with caution and not routinely accepted. In exceptional circumstances, if an individual believes that it is appropriate or necessary to accept a donation of this type, advance approval must be sought from the responsible Executive Director and a clear reason should be

recorded as to why it was deemed acceptable, alongside the actual or estimated value.

- Staff should not actively solicit charitable donations unless this is a prescribed or expected part of their duties for the Trust, or is being pursued on behalf of the Trust's own registered charity or other charitable body and is not for their own personal gain.
- Staff must obtain permission from the Trust if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign for a charity other than the Trust's own.
- Donations, when received, should be made to a specific charitable fund (never to an individual) and a receipt should be issued.
- Staff wishing to make a donation to a charitable fund in lieu of receiving a professional fee may do so, subject to ensuring that they take personal responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.

11.7.1 What should be declared

- Member of staff's name and their role within the Trust.
- Nature of the shareholdings/other ownership interest.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).
- The Trust will maintain records in line with the above principles and rules and relevant obligations under charity law.

11.8 Sponsored events

- Sponsorship of events by appropriate external bodies will only be approved if a reasonable person would conclude that the event will result in clear benefit to the Trust and the NHS.
- All sponsorship is to be approved by the Director of Finance, with consideration given to the Department of Health published Commercial Sponsorship – Ethical Standards for the NHS, Moving Beyond Sponsorship: joint working between the NHS and Pharmaceutical Industry and the ABPI Code of Professional Conduct
- The acceptance of commercial sponsorship should not in any way compromise any purchasing decisions or be dependent on the purchase or supply of goods or services.
- During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation.
- No information should be supplied to the sponsor from whom they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied.

- At the Trust's discretion, sponsors or their representatives may attend or take part in the event but they should not have a dominant influence over the content or the main purpose of the event.
- The involvement of a sponsor in an event should always be clearly identified.
- Staff within the Trust involved in securing sponsorship of events should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event.
- Staff arranging sponsored events must declare this to the Trust.

11.8.1 What should be declared

- The Trust will maintain records regarding sponsored events in line with the above principles and rules.

11.9 Sponsored research

- Funding sources for research purposes must be transparent.
- Any proposed research must go through the relevant health research authority or other approvals process.
- There must be a written protocol and written contract between staff, the Trust, and/or institutes at which the study will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services.
- The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service.
- Staff should declare involvement with sponsored research to the Trust.

11.9.1 What should be declared

- The Trust will retain written records of sponsorship of research, in line with the above principles and rules.
- Staff should declare:
  - their name and their role within the Trust;
  - the nature of their involvement in the sponsored research;
  - relevant dates and
  - any other relevant information (e.g. what, if any, benefit the sponsor derives from the sponsorship, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.10 Sponsored posts

- External sponsorship of a post requires prior approval from the Trust.

- Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and withdraw if appropriate.
- Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. This should be audited for the duration of the sponsorship. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements if conflicts of interest which cannot be managed arise.
- Sponsored post holders must not promote or favour the sponsor's products, and information about alternative products and suppliers should be provided.
- Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.

11.10.1 What should be declared

- The Trust will retain written records of sponsorship of posts, in line with the above principles and rules.
- Staff should declare any other interests arising as a result of their association with the sponsor, in line with the content in the rest of this policy.

11.11 Clinical private practice, education and training practice and consultancy

As set out in the Trust's Code of Conduct clinical staff should declare all private practice on appointment, and/or any new private practice when it arises[5] including:

- Where they practise (name of private facility).
- What they practise (specialty, major procedures).
- When they practise (identified sessions/time commitment).

Clinical staff should (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed):

- Seek prior approval of the Trust before taking up private practice.
- Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work.[6]
- Not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority guidelines: https://assets.publishing.service.gov.uk/media/542c1543e5274a1314000c56/Non-Divestment_Order_amended.pdf

[5] Hospital Consultants are already required to provide their employer with this information by virtue of Para.3 Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf

[6] These provisions already apply to Hospital Consultants by virtue of Paras.5 and 20, Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf)

Clinicians should not initiate discussions about providing their Private Professional Services for NHS patients, nor should they ask other staff to initiate such discussions on their behalf.

Any staff employed as teaching professionals or consultants by the Trust should declare any relevant employment elsewhere, whether privately or as an employee of another teaching organisation. This includes:

- Where they are employed/practice
- What activities are carried out under this employment/practice
- When this employment/practice takes place

11.11.1 What should be declared

- This declaration needs to be made to the Human Resources Department as set out in the Trust's Code of Conduct.
- Where a risk of conflict of interest arises, the general management actions outlined in this policy should be considered and applied to mitigate risks.

Appropriate liaison will be made between the Director of HR and the Trust Secretary for issues to be recorded on the Trust's Register of Interests.

12 Management of interests – Advice in specific contexts

12.1 Strategic decision making groups

In common with other NHS bodies the Trust uses a variety of different groups to make key strategic decisions about things such as:

- entering into (or renewing) large scale contracts;
- awarding grants;
- making procurement decisions; and/or
- selection of medicines, equipment, and devices.

The interests of those who are involved in these groups should be well known so that they can be managed effectively.

These groups should adopt the following principles:

- Chairs should consider any known interests of members in advance, and begin each meeting by asking for declaration of relevant material interests.
- Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise.
- Any new interests identified should be added to the Trust's Register of Interests.

- The Vice Chair (or other non-conflicted member) should chair all or part of the meeting if the Chair has an interest that may prejudice their judgement.

If a member has an actual or potential interest the chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:

- Requiring the member to not attend the meeting.
- Excluding the member from receiving meeting papers relating to their interest.
- Excluding the member from all or part of the relevant discussion and decision.
- Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate.
- Removing the member from the group or process altogether.

The default response should not always be to exclude members with interests, as this may have a detrimental effect on the quality of the decision being made. Good judgement is required to ensure proportionate management of risk.

12.2 Procurement

Procurement is managed in an open and transparent manner, compliant with procurement and other relevant law, to ensure there is no discrimination against or in favour of any provider. Procurement processes are conducted in a manner that does not constitute anti-competitive behaviour - which is against the interest of patients and the public.

In accordance with the Procurement Policy those involved in procurement exercises for and on behalf of the Trust keep records that show a clear audit trail of how conflicts of interest have been identified and managed as part of procurement processes. At every stage of procurement steps should be taken to identify and manage conflicts of interest to ensure and to protect the integrity of the process.

Regular reconciliation exercises are undertaken between declarations made to the Procurement Team and the Trust Company Secretary.

13 Dealing with Breaches

There will be situations when gifts, hospitality and interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate actions of staff or other organisations. For the purposes of this policy these situations are referred to as ‘breaches’.

13.1 Identifying and reporting breaches

Staff who are aware about actual breaches of this policy, or who are concerned that there has been, or may be, a breach, should report these concerns to the Trust Company Secretary or the Trust's Local Counter Fraud Specialist. The Trust will maintain confidentiality where necessary, appropriate or explicitly requested. Contact details can be found below.

Local Counter Fraud Specialist

Lianna Parker-Carn, RSM UK	Tel:	020 3201 8000
	Mobile:	07800 617 462
	Email:	Lianna.Parker-Carn@rsmuk.com

Trust Company Secretary

Terri Burns	Tel:	020 0938 2001
	Email:	TSecretary@tavi-port.nhs.uk

To ensure that interests are effectively managed staff are encouraged to speak up about actual or suspected breaches. Every individual has a responsibility to do this. For further information about how concerns should be raised consult the Trust's Raising Concerns at Work (Whistleblowing) Policy.

The Trust will investigate each reported breach according to its own specific facts and merits, and give relevant parties the opportunity to explain and clarify any relevant circumstances.

Following investigation the Trust will:

- Decide if there has been or is potential for a breach and if so what the severity of the breach is.
- Assess whether further action is required in response – this is likely to involve any staff member involved and their line manager, as a minimum.
- Consider who else inside and outside the Trust should be made aware.
- Take appropriate action as set out in the next section.

13.2 Taking action in response to breaches

Action taken in response to breaches of this policy will be in accordance with the disciplinary procedures of the Trust and could involve organisational leads for staff support (e.g. Human Resources), fraud (e.g. Local Counter Fraud Specialists), members of the management or executive teams and the Trust auditors.

Breaches could require action in one or more of the following ways:

- Clarification or strengthening of existing policy, process and procedures.
- Consideration as to whether HR/employment law/contractual action should be taken against members of staff or others.
- Consideration being given to escalation to external parties. This might include referral of matters to external auditors, NHS Counter Fraud Authority, the Police, statutory health bodies (such as NHS England, NHS Improvement or the CQC), and/or health professional regulatory bodies.

Inappropriate or ineffective management of interests can have serious implications for the Trust and staff. There will be occasions where it is necessary to consider the imposition of sanctions for breaches.

Sanctions should not be considered until the circumstances surrounding breaches have been properly investigated. However, if such investigations establish wrong-doing or fault then the Trust can and will consider the range of possible sanctions that are available, in a manner which is proportionate to the breach. This includes:

- Employment law action against members of staff, which might include.
  - Informal action (such as reprimand, or signposting to training and/or guidance, in line with the Trust's disciplinary policy).
  - Formal disciplinary action (such as formal warning, the requirement for additional training, re-arrangement of duties, re-deployment, demotion, or dismissal).
- Reporting incidents to the external parties described above for them to consider what further investigations or sanctions might be undertaken.
- Contractual action, such as exercise of remedies or sanctions against the body or staff which caused the breach.
- Legal action, such as investigation and prosecution under fraud and bribery legislation (in line with the Trust's anti-fraud and bribery policy).

13.3 Learning and transparency concerning breaches

The Trust takes the failure to disclose such information as required by this policy seriously. It is an offence under the Fraud Act 2006, for a member or employee to fail to disclose information to the Trust in order to make a gain for themselves or another. It is also an offence to cause a loss or expose the organisation to a loss.

Therefore, where an employee has failed to disclose any relevant interests or who has otherwise breached the Trusts policies and procedures in relation to failing to disclose are subject to investigation and, where appropriate, to disciplinary action and dismissal in accordance with the Human Resources Disciplinary Policy and Procedure.

If an individual becomes aware that someone has failed to disclose relevant and material information, they should raise the matter with the Trust Company Secretary in the first instance. The Trust's Anti-Fraud and Bribery Policy will be consulted and an appropriate referral made to the Local Counter Fraud Specialist where applicable.

Reports on breaches, the impact of these, and action taken will be considered by the Trust's Audit and Risk Committee following conclusion of any investigation.

To ensure that lessons are learnt and management of interests can continually improve, anonymised information on breaches, the impact of these, and action taken will be prepared and published in the Trust's communications to staff as appropriate, or made available for inspection by the public upon request.

14 Review

This policy will be reviewed in two years unless an earlier review is required. This will be led by the Trust Company Secretary. The number, frequency and appropriateness of declarations and escalation of concerns will be reported to the Audit Committee annually, along with the register of declarations.

15 Dissemination and implementation

This document will be circulated to all managers who will be required to cascade the information to members of their teams and to confirm receipt of the procedure and destruction of previous procedures/policies which this

supersedes. It will be available to all staff via the Trust's intranet. Managers will ensure that all staff are briefed on its contents and on what it means for them.

16 Associated documents

- Freedom of Information Act 2000
- ABPI: The Code of Practice for the Pharmaceutical Industry (2014)
- ABPI Code of Business Practice
- NHS Code of Conduct and Accountability (July 2004)
- Raising Concerns at Work (Whistleblowing) Policy
- Anti-Fraud and Bribery Policy
- Trust's Code of Conduct
- Procurement Policy
- Fraud Act 2006
- Bribery Act 2010

17 List of Appendices

Appendix A – Equality Analysis
Appendix B – Declaration of Interests Form & Guidance Notes
Appendix C – Declaration of Gifts and Hospitality Form & Guidance Notes
Appendix D – Declaration of Sponsorship Form & Guidance Notes

Appendix A – Equality Analysis

Completed by	Terri Burns/Terry Noys
Position	Trust Secretary/Director of Finance
Date	February 2018

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

If the answer to *all* of the above 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.

Appendix B – Declaration of Interests Form & Guidance Notes

DECLARATION OF INTERESTS FORM

Holding an interest may be perceived as affecting the individual's judgement in undertaking their professional duties. It may be perceived as an inducement to show favour to a person or organisation in his or her official capacity. It is not always feasible to not have any associations that may be perceived as a conflict of interest therefore these need to be declared. All staff should conduct themselves with integrity, impartiality and honesty at all times and should maintain high standards of proprietary and professionalism. The Trust seeks annual declarations of all interests.

Where there is no interest to be declared, a nil declaration is required. This needs to be made annually.

Name	Role and Service Line	Type	Hours	Pay or Benefits Received	Nil Declaration	From	To	Declaration to be declared and additional comments including mitigating actions required/undertaken
Example John Doe	Clinician CYAF	Outside Employment	18.0	Salary	n/a	01.10.2017		Employed by A N Other Teaching Hospital NHS Foundation Trust, NWX XXX as Consultant, 18.0 hours/week. Salaried position.

The information submitted will be held by Tavistock & Portman NHS Foundation Trust for personnel and/or other reasons specified on this form and to comply with the Trust's policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 1998. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in registers that Tavistock & Portman NHS Foundation Trust holds.

I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to the Trust as soon as practicable and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then internal disciplinary, or professional regulatory, action may result. Should I provide false or misleading information, I understand that a referral may be made to the Local Counter Fraud Specialist for a Criminal Investigation.

I do/do not (delete as applicable) give my consent for this information to be published on registers that Tavistock & Portman NHS Foundation Trust holds. If consent is NOT given please give reasons in the box overleaf.

Signature of Employee:	**Date:**

Line Manager Approval

I approve the action taken as detailed above. **This Interest has been/will be managed as follows:**

Approved By (Signed):		**Job Title**		**Date**	

All fields on this form must be completed.

Please return this form to:

TSecretary@tavi-port.nhs.uk
Trust Company Secretary
Tavistock & Portman NHS Foundation Trust
120 Belsize Lane, London
NW3 5BA

DECLARATION OF INTERESTS FORM - GUIDANCE NOTES

Name & Role	Insert your name and your position/role in relation to Tavistock & Portman NHS Foundation Trust
Description of Interest	Provide a description of the interest that is being declared. This should contain enough information to be meaningful. This information should enable a reasonable person with no prior knowledge to be able to read this and understand the nature of the interest. The type of issues to be declared on this form include: Outside Employment Clinical Private Practice Shareholdings Companies owned Patents and loyalty interests
Financial Interests	This is where an individual may get direct financial benefits from the consequences of a decision they are involved in making.
Non-Financial Professional Interests	This is where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or status or promoting their professional career.
Non-Financial Personal Interests	This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.
Indirect Interests	This is where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit from a decision they are involved in making.
Nil Return	All decision making staff are required to make a return. If there is nothing to declare on your return, please indicate so in the Nil Return column.

Appendix C – Declaration of Gifts and Hospitality Form & Guidance Notes

DECLARATION OF GIFTS AND HOSPITALITY FORM

Receiving benefits, gifts, rewards or hospitality in return for providing services (even if these services are part of a usual role) can be perceived as an inducement to show favour to a person or organisation in his or her official capacity. Staff are advised to decline such offers, but it is acknowledged there may be occasions when this is not feasible. All staff should conduct themselves with integrity, impartiality and honesty at all times and should maintain high standards of proprietary and professionalism.

Details of Employee declaring gifts and/or hospitality	
Name	
Service Line	
Job Title	
Email Address	
Description of Gift or Hospitality	
Value/Estimated Value	
Purpose of the Offer	
Person/Organisation making the offer	
Relationship with the person offering the gift/hospitality	
Acceptance of gifts/hospitality	Yes / No

The information submitted will be held by Tavistock & Portman NHS Foundation Trust for personnel and/or other reasons specified on this form and to comply with the Trust's policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 1998. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in registers that Tavistock & Portman NHS Foundation Trust holds.

I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to the Trust as soon as practicable and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then internal disciplinary, or professional regulatory, action may result. Should I provide false or misleading information, I understand that a referral may be made to the Local Counter Fraud Specialist for a Criminal Investigation.

Signature of Employee:	**Date:**

Line Manager Approval

I approve the gift/hospitality taken as detailed above. Does the acceptance of the gift/hospitality require any special management arrangements? If yes, please explain what arrangements are in place.

Approved By (Signed)		**Job Title**		**Date**	

All fields on this form must be completed.

Please return this form to:

TSecretary@tavi-port.nhs.uk
Trust Company Secretary
Tavistock & Portman NHS Foundation Trust
120 Belsize Lane
London
NW3 5BA

DECLARATION OF GIFTS AND HOSPITALITY FORM - GUIDANCE NOTES

Name & job title	Insert your name and your position/role in relation to Tavistock & Portman NHS Foundation Trust
Description of Gift or Hospitality	Provide a description of the gift/hospitality that is being declared. This should contain enough information to be meaningful. This information should enable a reasonable person with no prior knowledge to be able to read this and understand the nature of the interest. Details of previous gifts offered by the source, whether the offer was accepted or not and reasons for accepting or declining the offer should be included. The type of issues to be declared on this form include: Gifts Hospitality Donations

Appendix D – Declaration of Sponsorship Form & Guidance Notes

DECLARATION OF SPONSORSHIP FORM

Receiving sponsorship in return for providing services (even if these services are part of a usual role) can be perceived as an inducement to show favour to a person or organisation in his or her official capacity. Staff are advised to decline such offers, but it is acknowledged there may be occasions when this is not feasible. All staff should conduct themselves with integrity, impartiality and honesty at all times and should maintain high standards of proprietary and professionalism.

Details of Employee declaring sponsorship	
Name	
Service Line	
Job Title	
Email Address	
Description of Sponsorship	
Value/Estimated Value	
Purpose of the Offer	
Person/Organisation making the offer	
Relationship with the person offering the sponsorship	
Acceptance of sponsorship	Yes / No

The information submitted will be held by Tavistock & Portman NHS Foundation Trust for personnel and/or other reasons specified on this form and to comply with the Trust's policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 1998. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in registers that Tavistock & Portman NHS Foundation Trust holds.

I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to the Trust as soon as practicable and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then internal disciplinary, or professional regulatory, action may result. Should I provide false or misleading information, I understand that a referral may be made to the Local Counter Fraud Specialist for a Criminal Investigation.

Signature of Employee:	**Date:**

Line Manager Approval

I approve the sponsorship taken as detailed above. Does acceptance of the sponsorship require any special management arrangements? If yes, please explain what arrangements are in place.

Approved By (Signed)		**Job Title**		**Date**	

All fields on this form must be completed

Please return this form to:

TSecretary@tavi-port.nhs.uk
Trust Company Secretary
Tavistock & Portman NHS Foundation Trust
120 Belsize Lane,
London
NW3 5BA

DECLARATION OF SPONSORSHIP FORM - GUIDANCE NOTES

Name & Job Title	Insert your name and your position/role in relation to Tavistock & Portman NHS Foundation Trust
Description of Sponsorship	Provide a description of the sponsorship that is being declared. This should contain enough information to be meaningful. This information should enable a reasonable person with no prior knowledge to be able to read this and understand the nature of the interest. The type of issues to be declared on this form include: Sponsored Events Sponsored Research Sponsored Posts
Financial Interests	This is where an individual may get direct financial benefits from the consequences of a decision they are involved in making.
Non-Financial Professional Interests	This is where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or status or promoting their professional career through the sponsorship.
Non-Financial Personal Interests	This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.
Indirect Interests	This is where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit from a decision they are involved in making.

Board of Directors : May 2018

Item: 19

Title: AUDIT COMMITTEE TERMS OF REFERENCE

Summary: Attached are the current ToR of the Audit Committee. The Committee reviewed the ToR at their meeting on 15 May 2018 and, subject to one amendment (highlighted in paragraph 29), the Committee recommends their approval and adoption by the Board.

The Board are also asked to note the intention of the Audit Committee to undertake a more detailed review of the ToR at the Committee's October meeting. As part of this exercise the Committee will also consider the business it carries out at each of its meetings and the number of times that the Committee meets.

For : Approval

From : Terry Noys, Director of Finance
16 May 18

The Tavistock and Portman NHS
NHS Foundation Trust

Audit Committee

Terms of Reference

Ratified by:	Board of Directors
Date ratified:	27 June 2017
Name of originator/author:	David Holt, Committee Chair
Name of responsible committee/individual:	Audit Committee / Committee Chair
Date issued:	28 June 2017
Review date:	May 2018

AUDIT COMMITTEE
TERMS OF REFERENCE

CONSTITUTION

1. The Board of Directors hereby resolves to establish a committee to be known as the Audit Committee (the Committee). This Committee has no executive powers other than those delegated in these terms of reference.

MEMBERSHIP

2. The Committee will be appointed by the Board of Directors.
3. All members of the Committee should be independent Non-Executive Directors of the Trust. For the avoidance of doubt, the Trust Chair shall not be a member of the Committee.
4. The Committee shall consist of at least three members.
5. The Board should appoint the Chair of the Audit Committee from amongst its independent Non-Executive Directors.
6. At least one member of the Audit Committee should have recent and relevant financial experience.

ATTENDANCE

7. The Director of Finance and appropriate External and Internal Audit representatives shall normally attend meetings.
8. At least once a year the External and Internal Auditors shall be offered an opportunity to report to the Committee any concerns they may have in the absence of all Executive Directors and officers. This need not be at the same meeting.
9. The Chief Executive and other Executive Directors shall attend Committee meetings by invitation only. This shall be required particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Director. When an internal audit report or other report shows significant shortcomings in an area of the Trust's operations, the Director responsible will normally be required to attend in order to respond to the report.
10. The Chief Executive should be invited to attend, at least annually, to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement.
11. The Local Counter Fraud Specialist shall attend to agree a work programme and report on their work as required.

QUORUM

12. This shall be at least two members.

SECRETARY

13. A Secretary shall be appointed for the Committee.

FREQUENCY OF MEETINGS

14. The Committee shall meet at least four times per year.

15. The external or internal auditor may request a meeting whenever they consider it necessary.

AGENDA & PAPERS

16. Meetings of the Committee will be called by the Committee Chair. The agenda will be drafted by the Committee Secretary and approved by the Committee Chair prior to circulation.

17. Notification of the meeting, location, time and agenda will be forwarded to Committee members, and others called to attend, at least five days before the meeting. Supporting papers will also be sent out at this time. If draft minutes from the previous meeting have not been circulated in advance then they will be forwarded to Committee members at the same time as the agenda.

MINUTES OF THE MEETING

18. The Committee Secretary will minute proceedings, action points, and resolutions of all meetings of the Committee, including recording names of those present and in attendance.

19. Approved minutes will be forwarded to the Board of Directors for noting.

20. In advance of the next meeting, the minutes and the log of action points will be circulated to all involved, so that the action log can be updated and included in the papers for the meeting.

AUTHORITY

21. The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek information it requires from any employee, and all employees are directed to co-operate with any request made by the Committee.

22. The Committee is authorised to obtain outside legal advice or other professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary.

DUTIES

Governance, Risk Management and Internal Control

23. The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives

24. In particular, the Committee will review the adequacy of:

    24.1 all risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with the Care Quality Commission's *Judgement Framework*), together with any accompanying Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors

    24.2 the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements

    24.3 the policies for ensuring compliance with relevant regulatory, legal, and code of conduct requirements in conjunction with the Clinical Quality, Safety, and Governance Committee

    24.4 the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by NHS Protect

    24.5 the financial systems

    24.6 the Internal and External Audit services, and counter fraud services

    24.7 compliance with *Board of Directors' Standing Orders* (BDSOs) and *Standing Financial Instructions* (SFIs)

25. The Committee should review the Assurance Framework process on a periodic basis, at least twice in each year, in respect of the following:

    25.1 the process for the completion and up-dating of the Assurance Framework;

    25.2 the relevance and quality of the assurances received

    25.3 whether assurances received have been appropriately mapped to individual committee's or officers to ensure that they receive the due consideration that is required; and

    25.4 Whether the Assurance Framework remains relevant and effective for the organisation.

26. The Committee shall review the arrangements by which Trust staff can raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety, or other matters. The Committee should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

27. In carrying out this work, the Committee will primarily utilise the work of Internal Audit, External Audit, the Local Counter-Fraud Service, and other assurance functions. It will also seek reports and assurances from Directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

28. The Committee shall review at each meeting a schedule of debtor balances, with material debtors more than six months requiring explanations/action plans.

29. The Committee shall review at each meeting a report of ~~tenders and~~ tender waivers since the previous meeting.

INTERNAL AUDIT

30. The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee, Chief Executive and Board of Directors. This will be achieved by:

    30.1 consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal

    30.2 review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework

    30.3 consideration of the major findings of internal audit work (and management's response), and ensuring co-ordination between the Internal and External Auditors to optimise audit resources

    30.4 ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation

    30.5 monitoring and assessing the role of and effectiveness of the internal audit function on an annual basis in the overall context of the Trust's risk management framework

    30.6 ensuring that previous internal audit recommendations are followed up on a regular basis to ensure their timely implementation

EXTERNAL AUDIT

31. The Committee shall review the work and findings of the External Auditor appointed by the Board of Governors, and consider the implications and management's responses to their work. This will be achieved by:

    31.1 approval of the remuneration to be paid to the External Auditor in respect of the audit services provided

    31.2 consideration of recommendations to the Board of Governors relating to the appointment and performance of the External Auditor

31.3 discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensuring co-ordination, as appropriate, with other External Auditors in the local health economy

31.4 discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee

31.5 review all External Audit reports and any work carried out outside the annual audit plan, together with the appropriateness of management responses

OTHER ASSURANCE FUNCTIONS

32. The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the Trust

33. These will include, but will not be limited to, any reviews by NHSi, Department of Health arm's length bodies or regulators / inspectors (e.g. Care Quality Commission, NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

34. In addition, the Committee will review the work of other Committees within the organisation, whose work can provide relevant assurance to the Committee's own scope of work. Particularly with the Clinical Quality, Safety, and Governance Committee, it will meet at least annually with the Chair and/or members of that Committee to assure itself of the processes being followed.

35. In reviewing the work of the Clinical Quality, Safety, and Governance Committee, and issues around clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

36. The Audit Committee should incorporate within its schedule a review of the underlying processes for the Information Governance Toolkit and the Quality Accounts production to be able to provide assurance to the Board that these processes are operating effectively prior to disclosure statements being produced.

MANAGEMENT

37. The Committee shall request and review reports and assurances from Directors and managers on the overall arrangements for governance, risk management and internal control

38. They may also request specific reports from individual functions within the Trust (e.g. clinical audit) as they may be appropriate to the overall arrangements

FINANCIAL REPORTING

39. The Committee shall review the Annual Report and Financial Statements before submission to the Board of Directors, focusing particularly on:

39.1 the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee

39.2 changes in, and compliance with, accounting policies and practices

39.3 unadjusted mis-statements in the financial statements

39.4 major judgemental areas

39.5 significant adjustments resulting from the audit

40. The Committee should also ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board of Directors

APPOINTMENT, REAPPOINTMENT, AND REMOVAL OF EXTERNAL AUDITORS

41. The Committee shall make recommendations to the Council of Governors, in relation to the appointment, reappointment, and removal of the External Auditors, providing the Council of Governors with information on the performance of the External Auditor

42. The Committee shall approve the remuneration and terms of engagement of the External Auditors

OTHER MATTERS

43. At least once a year the Committee will review its own performance, constitution and Terms of Reference to ensure that it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board of Directors for approval.

44. The Committee should consider holding a discussion at the end of some meetings with regards to the effectiveness of the committee, considering those areas highlighted within this paper.

SOURCES OF INFORMATION

45. The Committee will receive and consider minutes from the Clinical Quality, Safety, and Governance Committee. The Committee will receive and consider other sources of information from the Director of Finance.

REPORTING

46. The minutes of the Committee, once approved by the Committee, will be submitted to the Board of Directors for noting. The Committee Chair shall draw the attention of the Board of Directors to any issues in the minutes that require disclosure or executive action.

47. The Committee will report annually to the Board of Directors on its work in support of the Annual Governance Statement, specifically commenting on the completeness and integration of risk management in the Trust, the integration of governance arrangements, and the appropriateness of the self-assessment against the Care Quality Commission's *Judgement Framework*.

48. The Committee Chair shall attend the Annual General Meeting (AGM) prepared to respond to any Member's questions on the Committee's activities.

BOARD OF DIRECTORS (PART 1)

Meeting in public
Tuesday 22nd May 2018, 2.00 – 4.30pm
Lecture Theatre, Tavistock Centre, 120 Belsize Lane, London NW3 5BA

AGENDA

PRELIMINARIES				
1.	**Chair's Opening Remarks** Prof Paul Burstow, Trust Chair		Verbal	-
2.	**Apologies for absence and declarations of interest** Prof Paul Burstow, Trust Chair	To note	Verbal	-
3.	**Minutes of the previous meeting** Prof Paul Burstow, Trust Chair	To approve	Enc.	p.1
3a.	**Outstanding Actions** Prof Paul Burstow, Trust Chair	To note	Verbal	-
4.	**Matters arising** Prof Paul Burstow, Trust Chair	To note	Verbal	-
REPORTS				
5.	**Service Line Report – Adult Forensic Service – Complex Needs** Dr Andrew Williams, Consultant Psychiatrist, Associate Clinical Director	To note	Late	-
6.	**Service Line Report – Camden CAMHS** Dr Andy Weiner, Consultant C&A Psychiatrist, Associate Clinical Director	To note	Verbal	-
7.	**Trust Chair's and Non-Executive Directors' Reports** Prof Paul Burstow, Trust Chair	To note	Verbal	-
8.	**Chief Executive's Report Framework** Mr Paul Jenkins, Chief Executive	To discuss	Enc.	p.10
9.	**Board Assurance Framework Report** Mr Terry Noys, Deputy CEO and Finance Director	To approve	Enc.	p.14
10.	**Finance & Performance Report** Mr Terry Noys, Deputy CEO and Finance Director	To note	Enc.	p.45
11.	**Annual Report and Accounts** **a. Annual Report** **b. Annual Accounts** **c. Quality Accounts** **d. External Audit Report** **e. Letters of Representation** Mr Craig de Sousa, Director of HR & Corporate Governance Mr Terry Noys, Deputy CEO and Finance Director Ms Marion Shipman, Associate Director Quality	To approve	To be circulated separately	-

12.	**Annual Self Certifications** Mr Craig de Sousa, Director of HR & Corporate Governance	To approve	Enc.	p.51
13.	**Quality** **a. Quality Performance Dashboard** Ms Louise Lyon, Director of Quality and Patient Experience and Ms Marion Shipman, Associate Director of Quality and Governance **b. CQSG Report and Committee Minutes Q4** Ms Louise Lyon, Director of Quality and Patient Experience **c. Update on the Quality Improvement Programme** Ms Louise Lyon, Director of Quality and Patient Experience	To note To discuss To Note	Enc. Enc. Enc.	p.56 p.75 p.87
14.	**Waiting Times Report** Ms Louise Lyon, Director of Quality and Patient Experience	To note	Enc.	p.95
15.	**Clinical Directorates' Quality Impact Assessments** Ms Louise Lyon, Director of Quality and Patient Experience	To note	Enc.	p.108
16.	**Training and Education Report** Mr Brian Rock, Director of Education and Training / Dean of Post Graduate Studies	To note	Verbal	-
17.	**Organisational Development and People Strategy Report** Mr Craig de Sousa, Director of HR & Corporate Governance	To note	Enc.	p.117
18.	**Gifts, Hospitality and Conflicts Policy** Mr Craig de Sousa, Director of HR & Corporate Governance	To approve	Enc.	p.129
19.	**Audit Committee Terms of Reference** Mr Terry Noys, Deputy CEO and Finance Director	To approve	Enc.	p.164
CLOSE				
20.	**Notice of Future Meetings:** • 12th June 2018, **Leadership Group Conference** 2.00 – 5.00pm, Lecture Theatre • 26th June 2018, **Board Seminar**, 2.00 – 5.00pm, Lecture Theatre • 24th July 2018, **Board of Directors' Meeting** 2.00 – 5.00pm, Lecture Theatre			