NHS
The Tavistock and Portman
NHS Foundation Trust

Board of Directors Part One

Agenda and papers of a meeting to be held in public

Tuesday 27 November 2018

1.30pm–4.20pm
Lecture Theatre, 5th Floor
Tavistock Centre,

120 Belsize Lane,
London,
NW3 5BA

The Tavistock and Portman
NHS Foundation Trust

AGENDA

BOARD OF DIRECTORS – PART ONE
MEETING HELD IN PUBLIC
TUESDAY, 27 November 2018, 1.30pm – 4.20pm
LECTURE THEATRE. THE TAVISTOCK CENTRE, 120 BELSIZE LANE LONDON, NW3 5BA

		Presenter	Timing	Paper No
1 Patient Stories and Service Line Reports				
1.1	Gloucester House Service Line Report	Head Teacher	1.30pm	1
2 Administrative Matters				
2.1	Chair's opening remarks and apologies	Chair	2.00pm	–
2.2	Board members' declarations of interests	Chair		–
2.3	Minutes of the meeting held on 25 September 2018 2018	Chair		2
2.4	Action log and matters arising	Chair		–
3 Operational Items				
3.1	Chair and Non-Executives' Reports	Chair and Non-Executive Directors	2.10pm	–
3.2	Chief Executive Report	Chief Executive	2.20pm	3
3.3	Quality Dashboard	Director of Quality and Patient Experience	2.35pm	4
3.4	Waiting Times Report	Director of Quality and Patient Experience	2.45pm	5
3.5	Finance and Performance Report	Deputy Chief Executive / Director of Finance	2.55pm	6

4 Items for decision or approval				
4.1	Schemes of Delegation	Deputy Chief Executive / Director of Finance	3.10pm	7
4.2	Reference Costs Submission	Deputy Chief Executive / Director of Finance	3.15pm	8
5 Items for information				
5.1	Board Assurance Framework	Associate Director – Quality and Governance	3.20pm	9
5.2	Operational Risk Register	Associate Director – Quality and Governance	3.30pm	10
5.3	Guardian of Safe Working – Quarterly Report	Medical Director	3.35pm	11
5.4	Serious Incidents – Quarterly Report	Medical Director	3.40pm	12
5.5	External Affairs Strategy Update	Director of Marketing and Communications	3.45pm	13
5.6	HR & Organisational Development – Assurance Report	Director of HR & Corporate Governance	3.50pm	14
6 Board Committee Reports				
6.1	Executive Appointment and Remuneration Committee	Committee Chair	3.55pm	15
6.2	Clinical, Quality, Safety and Governance Committee	Medical Director	4.00pm	16
6.3	Training and Education Committee	Committee Chair	4.05pm	17
6.4	Equality, Diversity and Inclusion Committee	Committee Chair	4.10pm	18
6.5	Strategic and Commercial Committee	Committee Chair	4.15pm	–
8 Any other business				

9 Date of Next Meeting	
	29 January 2019 – 1.30pm – 5.00pm – The Lecture Theatre, Tavistock Centre, Belsize Lane, London, NW3 5BA

The Tavistock and Portman NHS Foundation Trust

Report to	Date
Board of Directors	27 November 2018

Gloucester House – Annual Report

Executive Summary

The purpose of this report is to monitor quality, safety and progress of Gloucester House during the academic year 2017-18.

Recommendation to the Board

The Board of Directors is asked to note this report

Trust strategic objectives supported by this paper

All Trust strategic objectives

Author	Responsible Executive Director
Head Teacher	Director of Children, Young Adults and Family Services

Gloucester House, The Tavistock Children's Day Unit

1. Introduction

Gloucester House is a specialist school for children with social, emotional and mental health difficulties. We are a multidisciplinary service across mental health and education. We work with up to 21 children and their families at any one time. We work with children of primary and early secondary age. See www.gloucesterhouse.net for more information.

We have an outreach service attached to the core provision that offers flexible packages developed in collaboration with staff and networks to support the learning and development of SEMH children in schools and other settings.

2017-2018 has been the second year of operation since the introduction of the revised service model in 2014/15.

In this paper we provide an update in relation to progress over the year. We also outline the current position and provide an overview of other significant developments, risks and achievements at Gloucester House.

Key areas of work during the academic year have been:

- Ofsted (November 2017) and Challenge Partner (February 2018) reviews (see Appendix 1 and 2).
- Rebanding of two nursing posts to reflect the responsibility attached to the posts (the clinical lead post and the outreach lead post).
- Development and expansion of Outreach Service/team.
- Staff change/ recruitment.
- This November (2018) we are celebrating the 50th Anniversary of Gloucester House.

2. Occupancy

2.1 - Last year continued the trend of steady occupancy rates and more demand for the service than we were able to accommodate. Table 2.2 gives the figures for the last four years.

2.2 **Occupancy 2014- present:**

	2014/2015			2015/2016			2016/2017			2017/2018		
	Autumn	Spring	Summer	Autumn	Spring	Summer	Autumn	Spring	Summer	Autumn	Spring	Summer
Occupancy	10	15	15	18	15	19	18	18	20	18	20	19
Admissions	2	4	1	5	2	3	3	3	2	2	1	2
Discharges	1	0	1	3	0	3	2	3	3	2	1	5

2.3 - The children came from the following local authorities: Barnet, Hackney, Haringey, Enfield, Lewisham, Harrow, Hackney, Ealing, Hounslow, Merton, Waltham Forest, Brent. Barnet are maintaining their SLA for 6 children.

2.4 – The Outreach Service have worked with Kent, Waltham Forest, Hackney, Islington, Enfield, Haringey, City of London, Hounslow, Barnet, Bromley, Norfolk.

3. **Demand and capacity:**

3.1 – in 2016-17 we had 31 enquiries/referrals and 8 referrals we processed through to admission. In 2017-18 we had 32 enquiries/referrals and 5 processed through to admission.

In the last two years we have had periods closer to capacity but we prefer to work slightly below capacity in order to pace the work and maintain quality, safety and staff work load.

We have maintained numbers to average breakeven over the two year period.

3.2 – The outreach service**:**

The Outreach Service have worked with 26 young people and 5 consultancy/ capacity building **cases** to address systemic institutional issues.

We see a lot of potential development for this part of the service. Last year we developed a business plan with the commercial department and are developing our marketing literature (see appendix 3 – Outreach Leaflet). We are developing an Outcome Report for this part of the service in order to evidence our Outcomes and VFM.

3.3 - Financial position:

In 2014 we recovered from a significant decline in numbers by remodeling the service. We remodeled on the basis of breakeven at 14 in 2014-15. Due to increase in capacity this was revised to 17 for the financial year 2015-16. An additional contribution was factored into our breakeven figure. This year the breakeven crept up to 18. Whilst I am aware of financial pressure across the Trust I am also aware of history and do not want us to set a breakeven figure that makes us vulnerable in the marketplace.

This financial year to date we are maintaining a breakeven average in terms of numbers of children in the service and in terms of income and expenditure across the outreach and core service.

4. Staffing

4.1 - The staffing model was revised in the context of rising pupil numbers and evaluating our capacity gaps. The current staffing model is adequate, however we have been unsuccessful in two rounds of recruitment for a CNS (Clinical Nurse Specialist) and this is a gap that has increased work load for existing staff. I think it is important to keep the model under review to ensure the most cost efficient and clinically and educationally effective service, but also taking into account staff workload and the impact of this type of work.

We have approximately 35 staff (a mixture of FT/PT and trainees) across a full range of clinical disciplines and education.

5. Safety and IRFs

5.1.

	Q1 2017-18	**Q2 2017-18**	**Q3 2017-18**	**Q4 2017-18**
Date	**April- June**	**July- Sept**	**Oct- Dec**	**Jan- March**
Number of children on roll	**20**	**20**	**18**	**19**
Incidents reported by the Gloucester House Day Unit	75	74	61	75
Number of incidents per children on roll	4	4	3	4

Numbers of incidents proportional to the number of children in Gloucester House remain broadly consistent.

6. Areas of Risk and/or Concern:

Potential relocation and uncertainty around relocation has the potential to have a financial and qualitative impact on Gloucester House.

We will attempt to mitigate these concerns through careful planning and consideration.

7. Outcomes 2017-18

7.1 - Outcome measures show that Gloucester House continues to support the educational and social and emotional development of children who attend. (Outcome Report available on request).

7.2 - From low starting points academically (100% of children significantly underachieving in at least two areas and vast majority of children significantly underachieving across the curriculum) the children make expected and above rates of progress**.**

Some children make exceptionally good progress. For example one child increasing their reading age by 6 years in 1 year and another child 3 years progress in 6 months.

7.3 – Clinical data – 100% of pupils increased their CGAS scores (indicating an improvement in general functioning for all). SDQ data indicates a decrease in total difficulties for pupils with particularly strong evidence that the Gloucester House model has a significant positive impact on conduct type problems.

8. Feedback from stakeholders

8.1- Exit data – ESQ (Experience of Service Questionnaires) 100% of pupils and their parents/carers reported that options for care were discussed with them, people were working together to help them and that their care was good.

We got really positive qualitative feedback from parents/carers. For example one parent said 'I like everything they did with my child. I'm glad he came here, he changed completely. This is an amazing place. They did everything they could and accepted him.'

8.2 – Parent carer survey feedback – 100% felt they were well informed about their child's feedback; 100 % felt comfortable about approaching Gloucester House with questions, a problem or a complaint.

9. Significant achievements of 2016- 17

- Maintained good rate of referral to core and outreach service
- Maintained positive feedback from stakeholders
- Maintained good and better outcomes for children and families in the service
- Positive reports from Ofsted and Challenge Partners
- Maintained progress and stability despite a period of absence and/or working from home of headteacher in Spring and Summer term

11. The future:

- Growth of Outreach Service.
- Preparation for relocation.

Nell Nicholson
November 2018

What people say about us

Child: “the teacher listened to me and I could tell him everything.”

Training evaluation comment: “The team provided excellent resources and were very knowledgeable.”

Whole school intervention: “The response was very efficient and this enabled any queries to be dealt with immediately as well as enabling the nurture group to be established robustly.”

SENDCO: “Gloucester House Outreach input provided a personalised approach to the child and family circumstances which led to a positive impact on the child’s social, emotional and mental health needs. They also supported the family in visits to schools and looking at provision that can meet needs.”

Parent: “Getting a holistic view of the situation, developing trusting and supportive relationships to be able to move things forward for the child in a positive way.”

Member of support staff: “I used strategies and ideas with other children I work with ... very useful.”

What are the outcomes?

Young people we work with:

- Have shown significant improvement in their engagement and progress in learning
- Have shown increased capacity to be in a school setting
- Have been supported to remain in their mainstream school settings

Staff have reported:

- better understanding of children and young people’s SEMH needs
- gaining useful strategies and tools to work with children with SEMH needs
- feeling supported
- valuing the reflective practice space offered to think about young peoples’ behaviour and the impact on them
- being better equipped to respond to challenging behaviour in a therapeutically informed way

Find out more

For more information or package pricing information, please contact Nimisha Deakin, Outreach Lead: **ghoutreach@tavi-port.nhs.uk**, 020 7794 3353.

What happens next?

A specialist from our team will arrange an introductory meeting free of charge to discuss the needs of the child and/or school. An Outreach package can then be purchased by local authorities or schools.

Gloucester House continues to demonstrate its willingness and capacity to respond to the economic climate and to service users and commissioners feedback. We strive to continue to develop a cost efficient and responsive service service which, at its core, is child and family centred.

Gloucester House

NHS
The Tavistock and Portman
NHS Foundation Trust

Gloucester House outreach service

Helping children and young people stay in school

Bringing together mental health and education in one unique service

Innovation in mind

What is our outreach service?

We are a standalone service attached to Gloucester House, which is a leading independent special school with a fully integrated specialist clinical team, offering skills and experience in both mental health and education.

Visit our website:
www.gloucesterhouse.net

Gloucester House Outreach Service offers flexible packages developed in collaboration with child, family, staff and wider networks.

We support the learning and development of children with social, emotional and mental health difficulties in schools and other settings. All packages include a multi-disciplinary assessment of needs. Our team then work with you to decide what intensity of intervention is most appropriate.

Packages are bespoke and designed to be capacity building. Work can span from half a term to a full year.

The service offers support at the following levels:

Individual child
We provide psychosocial and educational assessments and interventions; facilitating & coordinating of multi- disciplinary networks around the child.

Institutional
We provide expert advice and consultation for education teams looking to develop or improve Mental Health and Special Educational Needs services in their education settings.

We work alongside existing teams to co-develop structures and practices that bring about better outcomes for children.

Training
We provide bespoke one off or series of trainings which are available following consultation; choose from a menu of twilight or day trainings.

Case studies

Child at risk of exclusion – Gloucester House Outreach worked alongside staff at school to build on existing skills and develop new skills.

Intervention:
- Training and observation, EHCP review, Reflective space, Working with the network to bridge the gaps in the needs of the child

Outcomes:
- Child supported to maintain mainstream placement for past two years (support offered by Outreach decreased over time).

Young person not in school – Working with young person who had not been in school for a number of years.

Intervention:
- Direct 1:1 education with therapeutic approach
- Supporting young person and family to develop strategies to manage distress
- Working with the network around the child
- Offering specialist advice and consultation on appropriate placement
- Training to new school
- Support in developing individual behaviour management plan

Outcomes:
- Young person equipped with strategies to manage and engage in learning
- Support around transition into school
- Increased communication and joint working between all agencies

Institutional – Working with whole school to offer consultation and support in establishing integrated therapeutic understanding into education.

Intervention:
- Observations and feedback, Training, Coaching and Consultation, Sharing strategies and developing systems within the school.

Outcome:
- School had clear systems for behaviour management and responding to challenging behaviour

QUALITY ASSURANCE REVIEW

REVIEW REPORT FOR
Gloucester House

Name of School:	Gloucester House, The Tavistock Children's Day Unit
Head teacher/Principal:	Nell Nicholson
Hub:	North London Special School Hub
School type:	Independent Special School
MAT (if applicable):	NA

Estimate at this QA Review:	Outstanding
Date of this Review:	21-23 February 2018
Estimate at last QA Review	NA
Date of last QA Review	NA
Grade at last Ofsted inspection:	Good
Date of last Ofsted inspection:	14-16 November 2017

Quality Assurance Review

The review team, comprising of host school leaders and visiting reviewers agree that evidence indicates these areas are evaluated as follows:

School Improvement Strategies	Outstanding
Outcomes for Pupils	Outstanding
Quality of Teaching, Learning and Assessment	Outstanding
Area of Excellence	NA
Previously accredited valid Areas of Excellence	NA
Overall Estimate	Outstanding

Please note that a Challenge Partners Quality Assurance Review is not equivalent to an Ofsted inspection, and agreed estimates from the review are not equivalent to Ofsted judgements.

1. Information about the school

- This is an Independent special school run by the Tavistock and Portman Health trust.
- There is a maximum of 21 pupils aged 5-14 taught in three classes.
- The school provides a joined-up health and education provision. The school is led by the headteacher supported by a multidisciplinary team including the deputy headteacher, a clinical nurse specialist and a child psychotherapist.
- All pupils have an education and health care plan or a statement of special educational needs. All pupils have complex and severe social, emotional and mental health difficulties.
- All pupils have had significant interruptions to their education and two thirds came from other alternative or special provision.
- A much higher than average proportion are Looked After Children and nearly half are not living with their birth parents.
- The unit does not receive pupil premium funding directly.

2.1 School Improvement Strategies - Follow up from previous review

- NA

2.2 School Improvement Strategies - What went well

- The senior leadership team evaluate the school highly effectively using a wide range of measures and consult staff, parents and pupils. The annual school development plan is precise and clearly focussed.
- The senior leadership team are very ambitious to continually improve the provision. The current priorities, to improve assessment and further develop the curriculum in mathematics and English are being addressed well.
- Senior leaders are developing the leadership skills of teachers by giving them subject and curriculum development responsibilities. This is driving school improvement priorities effectively.
- Senior leaders have ensured that all staff have excellent opportunities to develop their skills and responsibilities for many day-to-day aspects of the work. This increasing capacity and devolved leadership allows the continual development of the school and the services it runs. Staff receive necessary, regular effective professional supervision and appraisal.
- The senior leaders ensure that moderation of pupils' work takes place both within the school and, most essentially, with staff in special and mainstream schools. This ensures assessment is accurate.
- School staff run an outreach service. This is successful in spreading the excellent practice and expertise with the wider education community. The school is an excellent example of multiagency working between health and education professionals.

- Pupils are fully involved in the development of the school through the community meeting, which is an aspect of therapeutic y practice that the school uses very successfully. Pupils' abilities to articulate their sadness when someone is leaving and their fears when there are changes are exceptional. These comments assist the leadership team in managing the effects of the frequent changes highly effectively so that transitions in and out of the school are as smooth as possible.
- Pupils are fully involved in developing all aspects of the school through the building, restraint and nurture committees. They work with other providers in the trust to improve these aspects of the school.
- Leaders are visionary and continually evolving the work of the unit using an eclectic clinical and educational model. Senior staff use aspects of proven models from other philosophies or working therapeutic communities, testing them out and adapting them to this community so that the pupils can have as successful outcomes as possible.

2.3 School Improvement Strategies - Even better if…

…leaders continued to develop high quality assessment procedures and evaluation tools to benchmark against similar schools and national indicators.

3.1 Quality of Teaching, Learning and Assessment - Follow up from previous review

- NA

3.2 Quality of Teaching, Learning and Assessment - What went well

- Teachers plan the learning in a highly structured way and provide a 'carousel' of activities that pupils work through. This enables teachers to work with individual and small groups in each lesson and to deploy the support workers highly effectively to support learning.
- Teachers plan activities that are exceptionally well matched to each pupil's abilities and their prior achievements. They use a wide range of assessments to check pupils' progress in reading and spelling. The excellent collaboration with clinical colleagues enables an accurate evaluation of pupils' social and emotional development and mental health, so providing measures of the exceptional progress for pupils' holistic development.
- Teachers question precisely and specifically. They carefully judge the difficulty of questions to provide suitable challenge for pupil at any particular time. All staff understand each pupil's individual abilities and needs exceptionally well.

- Teachers' marking and feedback enable pupils to understand what they have achieved and evaluate their own progress. The highly experienced and well-trained staff give constant verbal feedback, both for learning and emotional awareness, that enables pupils to make consistent progress in social, emotional and academic development.
- Teachers use a wide range of visual support to enable pupils to learn and understand. They use symbols, visual timetables and cues to adapt tasks to individual pupil's strengths and learning styles. For example, pupils are given clear guidance on how to construct paragraphs.
- Pupils understand that learning is the priority in lessons and that if their conduct interrupts this they must revisit the work and choose how they will complete it. Pupils review their individual targets each day and can reflect on how well they have worked towards achieving them.
- Teachers plan activities that motivate and enable the pupils to be enthusiastically involved. For example, highly skilled staff enabled a small group playing a mathematics game to be adapted well to each individual pupil's capabilities.
- Teachers plan and adapt the curriculum specifically to pupils' interests. Recent work includes developing knowledge of the marine environment through the 'Blue Planet' television programmes, for example. Pupils are therefore highly motivated.
- The class teams of teachers, therapy and progress support workers work exceptionally well together. They ensure that pupils can access learning activities, and the achieve a good balance of therapy and reflection during the school day.

3.3 Quality of Teaching, Learning and Assessment - Even better if…

…teachers increased the opportunities for pupils to be fully independent learners and work with partners.

4. Outcomes for Pupils

- All the pupils who left during the 2016-17 academic year went on to school provision, half into mainstream settings. Over the last 10 years, half of the pupils have moved to mainstream and special schools that are not provisions for social emotional and mental health needs. Considering pupils' starting points, this is exceptional progress in enabling them to fully participate.
- Assessment information held by the school shows that the majority of pupils make rapid progress in acquiring reading and spelling skills, and make sound progress in mathematics. Staff have high expectations of what pupils can achieve and the progress they will make. Work in pupils' books and talking to pupils show that they are proud of the substantial progress they are making.
- Pupils are motivated to write. Some pupils write at length and enjoy writing stories about their favourite subjects, enthusiastically completing these at home. Pupils understand what they need to do next to improve their work Their books show that they try to incorporate teachers' suggestions in subsequent work.
- Older pupils, studying 'Romeo and Juliet', can clearly and maturely explain the characteristics of Paris and Mercutio and the reasons for their own opinions about them. They understand Shakespeare's text and can update it.
- Younger pupils are keen to become 'writer of the week' and achieve a certificate. They understand how to use and count tally marks and represent quantities as a pictogram. The work in their books shows that they understand and can identify what makes a right angle and how to subtract two-digit numbers.
- The assessment of conduct, learning behaviour and emotional awareness are an integral part of the multidisciplinary work. Therapist's analysis of these show that pupils make excellent progress. Pupils learn to be aware and explain their feelings and manage their reactions highly successfully. They leave the school with emotional maturity and the ability to access learning.
- Clinical measures of mental health show that all pupils improve in general functioning and nearly all make progress in overcoming difficulties.

6. What additional support would the school like from the Challenge Partners network, either locally or nationally?

We would value continued support for assessment and moderation practices and to build links with mainstream schools.

This review will support the school's continuing improvement. The main findings will be shared within the school's hub in order that it can inform future activities.

School report

Gloucester House, The Tavistock Children's Day Unit

33 Daleham Gardens, London NW3 5BU

Inspection dates 14–16 November 2017

Overall effectiveness	**Good**
Effectiveness of leadership and management	**Good**
Quality of teaching, learning and assessment	**Good**
Personal development, behaviour and welfare	**Outstanding**
Outcomes for pupils	**Good**
Overall effectiveness at previous inspection	Outstanding

Summary of key findings for parents and pupils

This is a good school

- The headteacher, well supported by the proprietor, directors, steering group, school leaders and staff, has taken successful steps to improve the school since the last inspection.
- Teaching, learning and assessment are good. Teachers plan interesting activities that enable pupils to achieve well. However, teaching does not always challenge the most able pupils to achieve their best.
- Pupils make strong progress across most subjects. However, they make slower progress in writing for a range of reasons, including teachers not providing them with sufficient opportunities to write longer pieces of work.
- Pupils behave exceptionally well. Through excellent care and support from staff, pupils learn how to relax and control their emotions so that they achieve well.
- Pupils enjoy coming to school and their attendance is significantly better than in their previous schools.
- Staff work very effectively with pupils with complex needs because they are highly skilled at managing pupils' challenging behaviour. This has ensured that pupils behave exceptionally well, feel safe and make great strides in their personal development.
- Pupils' spiritual, moral, social and cultural development is a strength of the school. They gain a good understanding of how people from different cultures contribute to life in modern Britain.
- All safeguarding and child protection procedures meet requirements and a culture of safety helps to keep pupils and staff safe.
- Governance is effective. The steering group are increasingly confident in holding leaders to account for the work of the school.
- Leaders, the steering group and staff do not have full information about pupils' progress in subjects other than English, mathematics, personal and social development to inform their decisions.

Compliance with regulatory requirements

- The school meets the requirements of the schedule to the Education (Independent School Standards) Regulations 2014 ('the independent school standards') and associated requirements.

Full report

What does the school need to do to improve further?

- Improve leadership and management and the quality of teaching so that pupils make substantial progress by ensuring that:
  - the school's assessment system contains a broad enough range of information to enable leaders, staff and directors to check accurately pupils' progress across a range of subjects
  - teachers provide more opportunities for pupils to write at length
  - teachers provide more challenge for all pupils, particularly the most able.

Inspection judgements

Effectiveness of leadership and management	Good

- The headteacher, supported well by directors and staff, has overseen significant changes since the previous inspection. Since that time, the number of pupils on roll has risen and the age range has increased. To ensure that the school continues to meet pupils' needs well, the headteacher has expanded and reorganised the leadership team. Working closely with staff, she has brought about improvements in teaching, pupils' achievement and behaviour, and has ensured that all the independent school standards are met. The headteacher is fully aware of what the school still needs to do to secure outstanding provision.
- The headteacher, senior and middle leaders have established a culture of high expectations where pupils feel safe and secure. Effective teaching has enabled pupils who had lost interest in study to feel valued, make good progress and to behave very well. Leaders acknowledge that teaching needs to be improved even further to ensure that all pupils, including the most able, make substantial progress.
- Staff are given many opportunities to develop their skills and knowledge. Effective training and professional development is tailored to their individual needs and stages of their careers. This has helped to improve the quality of teaching and to extend their experience by taking on new responsibilities. Leaders and directors have ensured that effective systems for the appraisal of staff are in place.
- An effective curriculum helps pupils develop their communication, literacy and numeracy skills. Exciting subjects such as French, well-being and yoga enable pupils to develop additional skills and interests. A range of clubs is available, including break-dancing, games, and music and movement sessions. These activities, together with the annual residential trip, help pupils to confront their own fears, develop their social skills, improve their confidence and self-esteem and become more independent.
- Pupils' spiritual, moral, social and cultural development is promoted well through a wide range of subjects and visits to places of interest in London and locally. These outings, together with the broader curriculum, enable pupils to understand how people from different cultures and backgrounds contribute to life in modern Britain. The marking of festivals from different religions around the world provides pupils with many opportunities to reflect on their feelings and behaviour.
- In the school's own surveys, parents expressed very positive views about the difference that the school makes to their children's attitudes and behaviour.
- Pupils receive helpful and effective careers advice and guidance. Older pupils take part in interesting work-experience placements, ranging from a bus garage to a restaurant. Last summer, all pupils took part in enterprise week. Pupils set up their own classroom shop and designed business cards in preparation for selling different foods and drinks. Such activities help broaden pupils' understanding about their options in the world of work and their progression into it.
- Leaders receive high-quality external support and advice from specialist advisers and consultants, which have ensured that the school continues to improve.
- The school's assessment system provides detailed information about how well individual pupils are achieving in English, mathematics, personal and social development. However,

it provides limited detail and analysis about pupils' progress in other subjects. Leaders and governors have identified the need for more information summarising pupils' achievement in subjects across the curriculum.

Governance

- Governance is effective.
- Membership of the steering group is drawn from a wide field of experience and professional expertise, including education, finance, local government and medicine. There is also a parent representative.
- The steering group works closely with leaders to ensure that the school continues to grow and improve. They visit the school often to monitor its work and share their findings to leaders. They produce short reports that are discussed by the rest of the governing body. This ensures that they have an accurate view of the school's performance.
- Directors oversee the school's system for performance management. They are actively involved in ensuring that any decisions about salary increases for staff are based on secure evidence that is linked firmly to pupils' progress.
- Directors are increasingly confident in challenging senior leaders about the school's performance. They acknowledge that they are not provided with regular summaries of pupils' progress in all academic subjects and so do not have a full picture of the school's performance.

Safeguarding

- The arrangements for safeguarding are effective.
- Safeguarding and the safety of pupils are priorities in the school. Staff have a thorough understanding of the most up-to-date guidance, attend regular training and use it well to remain vigilant and alert to any concerns arising about individual pupils.
- High levels of staff supervision in the school, as well as on trips and visits, help to keep pupils safe.
- Leaders and directors know the risks faced by the pupils and have put in place effective strategies to support them. Strong partnership working with clinicians, fully integrated into the staff team, enable pupils to receive additional assessment and mental health support. This helps pupils to devise effective strategies for regulating their emotions so that they can quickly resume their learning.
- Where pupils display signs of unsafe behaviour, plans are agreed between the pupil, staff and family to ensure everyone's safety. When there are concerns about a pupil, swift action is taken. This includes offering additional school support and making referrals to external agencies.

Quality of teaching, learning and assessment — Good

- Teaching across the school is consistently good, which ensures that pupils make good progress. The headteacher, together with senior and middle leaders, has established a

positive atmosphere for learning and clear expectations of pupils' behaviour and attitudes to work.

- Teachers plan interesting activities designed to improve pupils' reading, communication and numeracy skills. For example, during the inspection, older pupils were preparing to make chicken with rice and a cheesecake. They read the instructions from the recipe, measured and weighed the ingredients and calculated the amount of time the dishes needed to be baked in the oven. Because of the trusting relationships and excellent care and support from the teacher, pupils were able to make a successful product as well as improve their basic skills.
- Throughout the school, pupils have regular opportunities to develop their literacy skills. For example, pupils used a range of persuasive language to extend their answers, both orally and in writing. However, opportunities for pupils to write at length, in a range of genres, are limited. This reduces the pupils' rates of progress in developing their writing skills. Leaders acknowledge that more work is needed in this area and are introducing strategies to address this.
- Mathematics teaching is well planned to develop pupils' knowledge and understanding of skills and concepts. Their skills are frequently applied to their work-related learning, for example, to enterprise and cooking activities.
- The highly successful work of staff who provide a range of therapeutic services has helped pupils to reduce their feelings of anxiety and frustration. The team has made a strong contribution to improving pupils' attitudes to learning and communication skills.
- Teachers' management of pupils' behaviour is excellent. Pupils understand the expectations of their behaviour and are rewarded for meeting them. Occasional incidents of challenging behaviour are skilfully managed by staff, who use effective methods to calm pupils so that they can continue with their learning.
- Overall, good teaching motivates pupils to learn well. However, sometimes, activities do not make sufficient demands to enable all pupils, especially the most able, to make substantial progress.

Personal development, behaviour and welfare — Outstanding

Personal development and welfare

- The school's work to promote pupils' personal development and welfare is outstanding.
- When they arrive, pupils are quickly helped to accept the school's high expectations. This gives them the confidence to become actively involved in their studies.
- Regular participation in sports and physical activities makes a strong contribution to pupils' well-being and to their physical and emotional development.
- Throughout the week, pupils have many opportunities to reflect on their learning with staff. This activity is very beneficial in improving pupils' self-esteem and helping them to understand which strategies help them to learn successfully.
- Pupils feel, and are, safe in the school. They know how to stay safe online, and that staff are always there to help and care for them. As a result, bullying is very rare.

- The assessment of risk for all activities, including trips, residential visits and training away from the school site, helps to keep pupils safe both in and out of school.
- Parents and staff and who communicated with the inspector, or who completed the school's own surveys, stated that the school is a safe place. There were no concerns raised by parents or staff regarding the pupils' safety.

Behaviour

- The behaviour of pupils is outstanding.
- Before they arrive at Gloucester House School, many pupils have experienced significant personal challenges in their lives. Because of the school's high expectations and excellent levels of care and support, relationships between staff and adults are very positive and respectful. Pupils behave well both inside and out of classrooms.
- Pupils attend very regularly. They thoroughly enjoy the many exciting activities on offer to them each day. Attendance is very good.
- Any incidents of challenging behaviour are dealt with professionally, safely and effectively. Situations can arise when pupils feel anxious, frustrated or overwhelmed by something that is different or unexpected. Staff display high levels of patience, care and sensitivity in managing these outbursts successfully. The use of physical intervention is closely documented and monitored. These strategies ensure that pupils are helped to recover calm dispositions so that they are ready to continue with their learning.
- For those pupils who attend training away from the school site, there are effective arrangements for checking their attendance, punctuality, behaviour and safety.

Outcomes for pupils — Good

- All pupils are taught in mixed-age classes and teaching groups are small. For these reasons, information about achievement needs to be interpreted with caution, as analyses of trends or comparisons with national results are likely to be misleading.
- Pupils enter the school with large gaps in their education. This is often due to their poor attitudes to learning, erratic attendance, challenging behaviour and communication difficulties.
- Scrutiny of pupils' work, photographs, project files, visits to classrooms and reports to parents show that, overall, pupils make good progress over time.
- Overall, pupils from different backgrounds, make strong gains in literacy and numeracy because they are well taught. Pupils make particularly strong progress in their reading and speaking skills so that they become confident in expressing themselves.
- All pupils who left the school in the last 12 months went on to maintained special schools or mainstream schools.
- In personal development sessions, pupils learn the importance of maintaining a healthy lifestyle. In support of this work, the school ensures that pupils have a choice of healthy and nutritious meals at lunchtimes, and that exotic fruits are available on 'Funky Fruit Friday'.

- Those who attend off-site training make good progress in their sports and physical fitness courses.
- Pupils achieve well in a range of areas of the curriculum and make strong gains in their personal skills. For instance, they work well together in science or when working cooperatively while cooking. They read regularly, follow recipes and develop independent skills for living.
- Pupils make slower progress in writing than in other subjects because of a range of reasons that include not having sufficient opportunities to write at length. In addition, not all pupils, including the most able, are set challenging enough tasks to ensure that they make substantial progress.

School details

Unique reference number	135167
DfE registration number	202/6401
Inspection number	10035804

This inspection was carried out under section 109(1) and (2) of the Education and Skills Act 2008, the purpose of which is to advise the Secretary of State for Education about the school's suitability for continued registration as an independent school.

Type of school	Other independent special school
School category	Independent school
Age range of pupils	5 to 14
Gender of pupils	Mixed
Number of pupils on the school roll	19
Number of part-time pupils	0
Proprietor	The Tavistock and Portman NHS Foundation Trust
Chair	Paul Burstow
Headteacher	Nell Nicholson
Annual fees (day pupils)	£58,567
Telephone number	0207 794 3353
Website	www.gloucesterhouse.net
Email address	gloucesterhouse@tavi-port.nhs.uk
Date of previous inspection	11–13 February 2014

Information about this school

- Gloucester House, The Tavistock Children's Day Unit, is an independent special school for boys and girls with social, emotional and mental health needs. It provides both a health and education service. It is located close to the Tavistock Clinic in the London Borough of Camden, but serves nine London boroughs.
- All the pupils are referred by local authorities. The school is registered for up to 21 pupils aged from five to 14 years. There are 19 pupils on roll, each of whom has a statement of special educational needs or an education, health and care plan. There are more boys

than girls. Most pupils have had a very disrupted previous education and have not attended school for significant periods of time.

- All pupils have previously been involved with the local child and adolescent mental health services (CAMHS) because of their social, emotional and mental health needs. All pupils at Gloucester House receive CAMHS support as part of the integrated provision from education and mental health staff. One in five children is looked after by the local authority.
- Around two thirds of pupils are from minority ethnic backgrounds, with the remainder being White British.
- Off-site training is made available for pupils to extend their learning experiences. The school offers the following activities:
  - sport and physical education at the Swiss Cottage Leisure Centre, 1 Adelaide Road, Swiss Cottage, London NW3 3NF
  - badminton at the Rec, Fleet Road, Hampstead, London NW3 2QG
  - tennis at The Globe Tennis Club, 190A, Haverstock Hill, London NW3 2AL.
- The school was last inspected in January 2014, when it was judged to be outstanding.
- The school meets the independent school standards for what it must publish on its website.
- The school aims to provide 'pupils with a holistic education that enables them to achieve positive outcomes that prepare them well for their future. Leaders also hope that children and their families will enjoy their time at Gloucester House and leave with positive memories.'

Information about this inspection

- This full standard inspection took place with one day's notice.
- The inspector observed teaching and learning in all classes jointly with the headteacher. He spoke to pupils informally throughout the inspection.
- There were no responses to Ofsted's online questionnaire for parents, Parent View. The inspector spoke with one parent and received two text comments. He also considered the 21 responses to the staff questionnaire.
- The inspector held discussions with the headteacher, staff members and two directors, including the chair. He also spoke to two external consultants by telephone.
- The inspector reviewed documents and policies, including those related to safeguarding, to check the school's compliance with the independent school standards. He scrutinised pupils' books and the school's information about pupils' attainment and progress.

Inspection team

David Scott, lead inspector	Ofsted Inspector

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The Tavistock and Portman NHS Foundation Trust

Board of Director Meeting Minutes (Part 1)
Tuesday, 25 September 2018 – 1330 - 1600

Present:			
Paul Burstow Trust Chair	Dinesh Bhugra Deputy Chair and Non-Executive Director	David Holt Senior Independent Director	Deborah Colson Non-Executive Director
Helen Farrow Non-Executive Director	Rekha Elaswarapu Associate Non-Executive Director	Paul Jenkins Chief Executive	Terry Noys Deputy Chief Executive / Finance Director
Brian Rock Director of Education and Training / Dean of Postgraduate Studies	Julian Stern Director of Adult and Forensic Services	Chris Caldwell Director of Nursing	Dinesh Sinha Medical Director
Louise Lyon Director of Quality and Patient Experience			
Attendees:			
Craig de Sousa Director of HR & Corporate Governance (minutes)	Rachel James Associate Clinical Director (Item 1.1)	Belinda Giles Specialised Systemic Psychotherapist (Item 1.1)	Service User A Service User (Item 1.1)
Service User B Service User (Item 1.1)	Ann Hurley Portfolio Manager (Item 1.3)	Elisa Reyes Associate Dean (Item 1.3)	Student A Student (Item 1.3)
Apologies:			
Jane Gizbert and Sally Hodges			

Actions

AP	Item	Action to be taken	Resp	By
1	2.3.1	Minor amendments to the Board minutes	CdS	Immed
2	5.1.2	Share further details with the Board of Directors what caused a spike in activity during quarter 4 of 2017/18	DS	Nov

1. Patient Experience Stories and Service Reports

1.1 Patient Story

1.1.1 Dr James and Dr Giles opened the presentation and welcomed both of the service users who had attended to share their stories.

1.1.2 Dr Giles noted that both of the parents in attendance had participated on a collaborative clinical intervention designed by the First Step and Fostering and Adoption teams known as non-violent resistance. She particularly emphasised that the intervention was a ten week course for groups of parents.

1.1.3 Both of the service users provided an account of their experiences of adopting and fostering children whose life experiences had caused mental distress. Both of the parents explained the emotional trauma their children had suffered and the consequential impacts that this had, had on the adopted / fostered families. One

noted that the group had been a great support to them as it brought together parents with similar experiences and it was comforting to know that they were not alone.

1.1.4 One of the service users noted that as a result of the programme and meeting parents with similar situations it had given her the confidence to take time out for themselves. Reflecting on this, she explained that as a result she now made time to go out for lunch once a week.

1.1.5 Responding to Prof Burstow, one of the service users noted that prior to becoming a foster carer she had a longstanding career in the higher education sector and that she had decided to stop working in order to support her child.

1.1.6 Reflecting on a question from Mr Jenkins, Dr Giles explained that more funding for non-violent resistance training would help to expand the approach used. Dr James noted that a peer support group for parents was being established with support from the Trust's Public and Patient Involvement Department.

1.1.7 The Board of Directors thanked Dr James, Dr Giles and the service users for sharing their moving accounts.

1.2 Service Line Report – CYAF Complex Needs

1.2.1 Dr James presented the service line report and particularly highlighted that:

- Each of the clinical units within the service line had adopted a cascade strategic objective setting approach and this was presented at the most recent leadership group conference.
- Within the service line, each of the team managers had come together, and continue to do so, to work collaboratively and identify how they can solve common problems in a collective way.
- There is a focus within the service line to build on service user experience and increase co-production.
- The Video Intervention for Positive Parenting (VIPP), developed within the service line, had been shortlisted for a CYP Now Award.
- The service line had identified issues around appointments being added late to CareNotes and this continued to be a focus area.
- A satellite service at Bounds Green had a number of estates issues which related to the fact that the service is not the sole occupant of the building.

1.2.2 Reflecting on a question from Prof Burstow, Dr James noted that there are mixed views amongst commissioners regarding the adoption and implementation of I-Thrive, she reported that it requires each of them to individually buy in to the model.

1.2.3 Responding to Mr Holt, Dr James noted that the VIPP receives referrals but not in huge volumes, she emphasised that it does not form part of a core commissioned service but it equips parents with frameworks to help them reflect and adapt.

1.2.4 Dr James noted that within the Adolescent and Young Adult Service (AYAS) that an audit had been conducted of the types of referrals received within the specialist service and confirmed that there is evidence of increasing need.

1.2.5 The Board of Directors thanks Dr James and noted the report.

1.3 Psychoanalytical Clinical Portfolio Service Line Report

1.3.1 Ms Hurley presented the report and particularly emphasised:

- That in the current and coming year that recruitment to the portfolio's courses had been strong.
- The Trust has been commissioned to deliver a number of programmes for participants from Russia, Tanzania, Kenya and Greece.
- That the future funding model for child and adolescent psychotherapy training is currently under review.

1.3.2 Responding to a question from Mr Jenkins, a student, who was in attendance to support the report, explained that her choice for studying at the Tavistock was a result of a career change from law. She explained that he had participated on a number of courses and valued the phased approach used to start practising clinically.

1.3.3 Dr Stern added that within the clinical couples unit, the service's clinical lead has expressed that more resource is needed to deliver the DET programme.

1.3.4 The Board of Directors thanked Ms Hurley and noted the report.

2. Administrative Matters

2.1 Chair's Opening Remarks and Apologies

2.1.1 Professor Burstow welcomed all of those in attendance.

2.1.2 Apologies were noted and are provided above.

2.2 Board Members' Declarations of Interest

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

2.3 Minutes of the Meeting Held on 25 September 2018

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

2.4 Action Log and Matters Arising

2.4.1 All actions from the previous meeting were noted as completed.

3. Operational Items

3.1 Chair and Non-Executives' Reports

3.1.1 Prof Burstow reported that since the last Board of Directors meeting that he had undertaken two service visits. He noted that he had attended the introductory workshop facilitated by the Charing Cross Gender Identity Clinic (GIC) and had also visited the Life Span team and noted that the team had led on a Trust wide survey about access levels for service users with autistic spectrum conditions.

3.1.2 Mr Holt reported that he had recently attended the Lyndhurst Unit.

3.1.3 Dr Colson noted that she had recently attended the Family Mental Health Team and particularly emphasised the positive working attitude of the staff.

3.1.4 The Board of Directors noted the verbal reports.

3.2 Chief Executive's Report

3.2.1 Mr Jenkins presented his reported and particularly emphasised that:

- The Trust had implemented a new electronic room booking and scheduling solution which has a long term aim to address space utilisation within the Tavistock Centre.

- Student recruitment was nearing completion and that the Trust, at current trajectory, expected to achieve 600 new participants registered. He noted that this would reflect 5% growth.

3.2.2 The Board of Directors noted the report.

3.3 Finance and Performance Report

3.3.1 Mr Noys presented the finance report and noted that the Trust, at the point of reporting, had achieved a £219k surplus to budget. He emphasised that this had been delivered through positive financial outputs from both clinical services and the directorate of education and training. He also noted that the corporate functions were behind budgeted position resulting from increased temporary staffing expenditure in estates and facilities.

3.3.2 Mr Jenkins emphasised that the executive were concerned about the year-end financial outturn and that a high level of vigilance is being put on financial performance to maintain the current surplus trend.

3.3.3 The Board of Directors noted the report.

4. Items for Decision or Approval

4.1 Procurement Strategy

4.1.1 Mr Noys presented the procurement strategy and particularly emphasised that NHS Improvement had increased their focus on this area. He noted that the document had not previously existed and that the strategy sets ambitions to improve the way in which goods and services are procured.

4.1.2 Responding to Mr Holt, Mr Noys noted that the regulator's increased focus on procurement was mainly directed at acute trust procurement efficiencies, however, mental health trusts were also required to follow a similar approach.

4.1.3 The Board of Directors approved the procurement strategy.

4.2 Procurement Policy

4.2.1 Mr Noys presented the new procurement policy. He noted that the policy had been developed to bring together, formally, the introduction of purchase orders before goods and services are procured.

4.2.2 The Board of Directors approved the policy.

4.3 Health and Safety Policy

4.3.1 Mr Noys and Mr Garlington presented the health and safety policy noting that this was a revised document.

4.3.2 Responding to a question from Mr Holt, Mr Noys explained that the Trust is responsible for estates and facilities compliance for the buildings which it owns.

4.3.3 The Board of Directors approved the policy.

4.4 Fire Safety Policy

4.4.1 Mr Noys and Mr Garlington presented a new fire safety policy for consideration. Mr Noys emphasised that the document had been developed following advice from the Trust's authorising engineer.

4.4.2 Responding to a question from Mr Holt, Mr Garlington explained that evacuation plans for staff with disabilities had been identified.

4.4.3 The Board of Directors approved the policy.

4.5 Water Safety Policy

4.5.1 Mr Noys and Mr Garlington presented the new water safety policy noting that the document had been developed following advice from the Trust's authorising engineer.

4.5.2 The Board of Directors approved the policy.

4.6 New Constituencies

4.6.1 Mr de Sousa presented the paper and noted that it was proposed to establish two new constituencies – one for students and another for service users and carers.

4.6.2 Responding to Mr Rock, Mr de Sousa noted that the three year course length eligibility requirement reflected on feedback from the Council of Governor members. He noted, however, that if the constituency would be too small that a reduction to two years could be possible.

4.6.3 The Board of Directors approved, by unanimous vote, to establish the two new constituencies. It was noted, however, that should the eligibility term of two years course length for the student constituency is not be able to be ratified then this would be deferred to a future constitutional amendment process.

5. Items for Information

5.1 Guardian of Safe Working Hours Report

5.1.1 Dr Sinha presented the report noting that there had been a reduction in the number of exception reports from the junior doctor trainees. He particularly emphasised that a recent diary card activity had been undertaken to assess the number of hours the trainees were working during the out of hour on-call periods.

5.1.2 Responding to Mr Holt, Dr Sinha explained that the spike in activity during quarter four was the result of the rota's design, however, he would undertake to understand the issues in greater detail and give a fuller account at the next Board meeting [AP2].

5.1.3 The Board of Directors noted.

6. Board Committee Reports

6.1 Clinical, Quality, Safety and Governance Committee

6.1.1 Dr Sinha presented the summary reporting, particularly noting that:

- The last meeting of the committee was well attended.
- There had been robust and detailed discussions about serious incidents.
- The committee had discussed timings of each meeting and that there was a view to changing the future meeting dates to facilitate better reporting from the workstreams.
- There remains to be compliance issues within estates and facilities and that there Board are sighted on these.
- Business continuity plans are in place for all services.
- Resuscitation training compliance has significantly declined and that the Health and Safety Manager is working hard to address this, with support from the Director of Adult and Forensic Services and Director of Children, Young Adults and Family Services.

6.1.2 Responding to Prof Burstow, Dr Sinha noted that he was undertaking a review of the committee and its workstreams to assess whether the current construct facilitates timely and accurate assurance reports to the Board on all of the areas that it should cover. He noted, that he was conducting this work with Mr de Sousa.

6.1.3 The Board of Directors noted the report.

6.2 Equality, Diversity and Inclusion Committee

6.2.1 Mr de Sousa, on behalf of Prof Bhugra, presented the report and particularly highlighted that:

- The last meeting was well attended and included a detailed discussion about
- Increasing the Race Diversity Champion's hours had been welcomed.
- Work was being undertaking to scope a role for an LGBTQI+ Diversity Champion.
- It is planned to present, for approval, a new equality, diversity and inclusion policy.

6.2.2 The Board of Directors noted the report.

7. Any Other Business

7.1 There was noted other business to discuss.

The Tavistock and Portman NHS Foundation Trust

Report to	Date
Board of Directors	27 November 2018

Chief Executive's Report – Part 1

Executive Summary

This report provides a summary of key issues affecting the Trust

Recommendation to the Board of

The Board is asked to note this report

Trust strategic objectives supported by this paper

All Trust strategic objectives

Author	Responsible Executive Director
Chief Executive	Chief Executive

Chief Executive's Report

1. Scheduling

1.1 Following the go-live of the Scheduling system in September, the project team have been addressing issues with allocation of space around the Tavistock Centre and communication of which spaces are to be used for activities. Where these issues relate to clinical activity this has resulted in occasional interruption of clinical sessions where others believe they have use of the room. While these clashes have been occasional compared to the total numbers of clinical sessions, we do not understate the individual impact this has had on the involved patients and staff and we do appreciate the efforts our clinical and clinical administrative staff have put in to minimise any impact.

1.2 The go-live in September has brought us to a position where all clinical services are utilising the new system, however are still using a reactive booking model. Work has been undertaken to move AFS, CYAF and GIDS to a stable position where this is being consistently followed, maintained and is sustainable until the services are further moved to the ultimate proactive, automated scheduled model. This work is nearing completion with issues mostly stabilised within AFS and GIDS and a new data upload from CareNotes to the Scheduling solution in November is expected to achieve the same for CYAF. It is felt that while some issues are still being addressed the situation has begun to stabilise.

1.3 For the DET timetable similar issues have been encountered. The full year timetable could not be published in Welcome Week as planned as a result of quality issues regarding the data for course requirements entered into the system as well as extensive duplication of activities in the solution resulting in an incorrect perception of no rooms being available. In addition, the selected naming convention for events developed in the summer workshops proved to be inadequate in uniquely identifying events in a manner that was useable by course administrators, course

leads, faculty or students. An extensive piece of work has been undertaken with the project team and the DET course administrators to review all activity requirements and agree the individual event names based on the newly agreed convention. As this is implemented it will address both the issues of incorrect room assignment as well as lessening issues of miscommunication around room allocation from week to week. The project team again notes the efforts of all DET staff to mitigate the impact on students since the beginning of term. The course administrators deserve especial praise for their efforts in providing their usual services to students while also performing weekly timetable checks and working with the project team to develop the new naming convention and activity requirements for the full year timetable.

1.4 The project will now progress into its second phase which will:

- Deliver the 2019/20 DET Timetable in January / February 2019

- Deliver the 2019/20 full timetable, including corporate events in January / February 2019

- Deploy the Publisher module, which allows faculty and students to receive their own personal timetables and subscribe to these on their own email or phone, in a phased rollout between now and Summer 2019

- Prioritise and work with clinical teams to revisit the clinical schedule pathways developed in the summer 2018 workshops and move clinical services, on a team by team basis, from the reactive booking model to the proactive, automated scheduling model for patient appointments. This work is expected to complete in Autumn 2019

2. Care Quality Commission

2.1 The Care Quality Commission (CQC) inspected the Trust over several months this year culminating in a two day well-led review in September. The inspection was led by Jane Ray, Head of Hospital Inspections, supported by a small group of colleagues including two specialist advisers. Over the course of the inspection the CQC met with staff from all over the Trust, patients, carers, our commissioners and other stakeholders. They scrutinised a substantial quantity of information about all our services drawn from a range of sources from within the Trust and external. In August, CQC inspectors conducted on-site inspections of two of our core services, Camden CAMHS and the adult Gender Identity Clinic.

2.2 The final report was published on 16th November 2018. We are pleased to have been awarded an overall rating of Good, with Outstanding in the Effective domain and Good in Safe, Caring, Responsive and Well-led. This is a significant achievement in the context of our doubling the number of patients seen in our clinical services. The inspectors highlighted a number of areas of outstanding practice including our capacity for research and innovation and some areas for improvement. For the most part these covered issues we are actively addressing, for example, through working with commissioners to reduce waiting times in our gender services.

3. Conclusions and recommendations

3.1 The Board of Directors is asked to note this report.

Paul Jenkins
Chief Executive

The Tavistock and Portman NHS Foundation Trust

Board of Directors: November 2018

Report to	Date
Board of Directors	27 November 2018

Quality Dashboard and Commentary

Executive Summary

The purpose of this report is to provide a summary and narrative for quarter 2 quality metrics. It includes information from across the Trust, including DET and communications.

Key points to note are:

- 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.
- HR - Sickness data has remained at 1.3% compared to 1.6% in the quarter 3.
- Quality – Safety: Child safeguarding alerts remain elevated, which reflects the introduction of the new system for reporting.
- There were no serious incidents in Q2 2018/19 reported externally.
- Effectiveness: the Trust-wide DNA rate is 10%, a very slight increase from previous quarter and is now on the trust target of 10%. 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.
- 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.

This report was reviewed by the Clinical Quality and Patient Experience Workstream Meeting

Recommendation to the Board of Directors

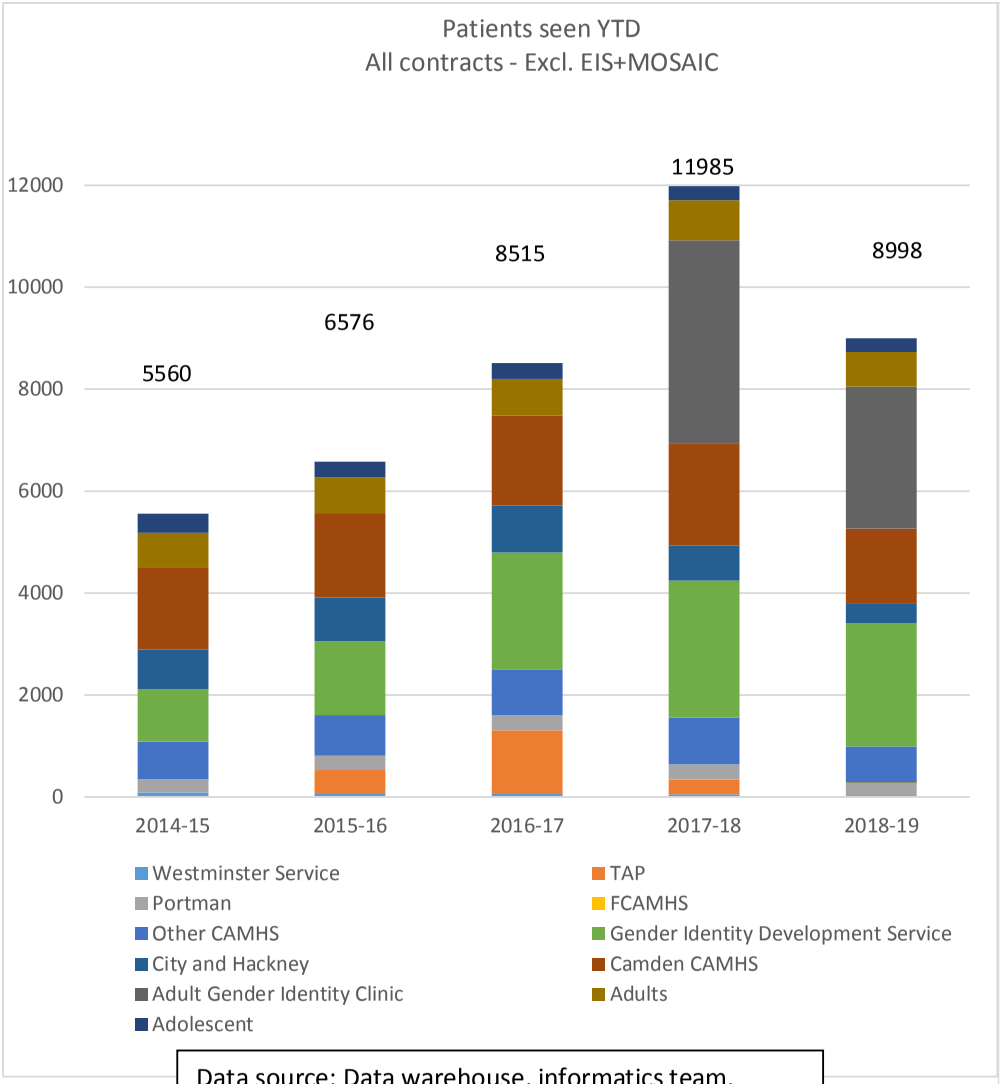
The Board of Directors is asked to discuss the report.

Trust strategic objectives supported by this paper

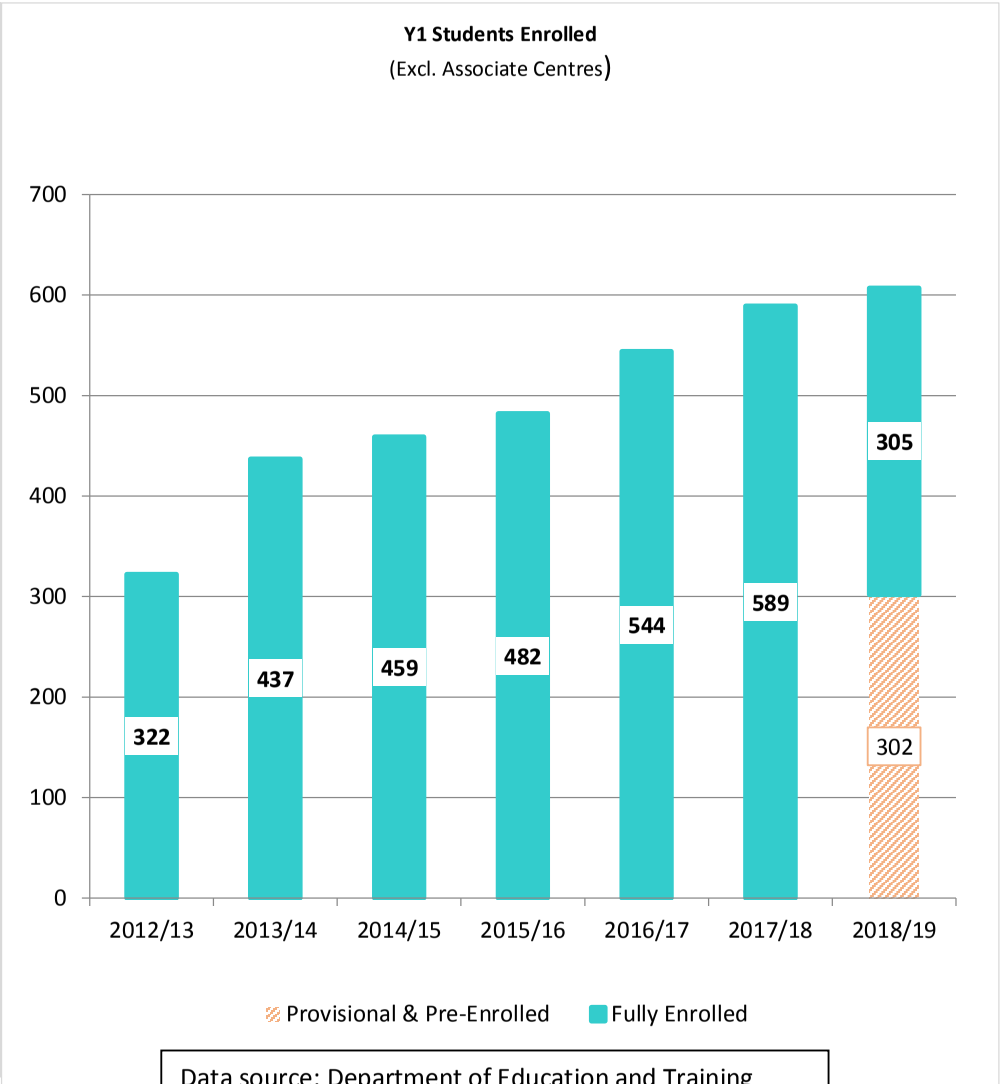
Finance and Governance

Author	Responsible Executive Director
Associate Director Quality and Governance, Data Quality Manager, Assistant Psychologist and Data Officer	Director of Quality and Patient Experience

Q2 2018/19: Trust Reach



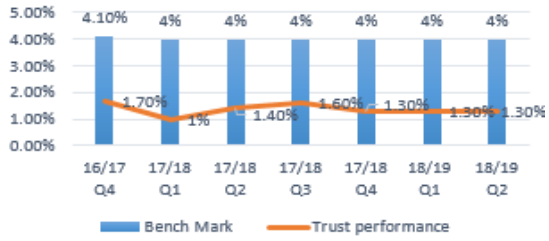
Data source: Data warehouse, informatics team.



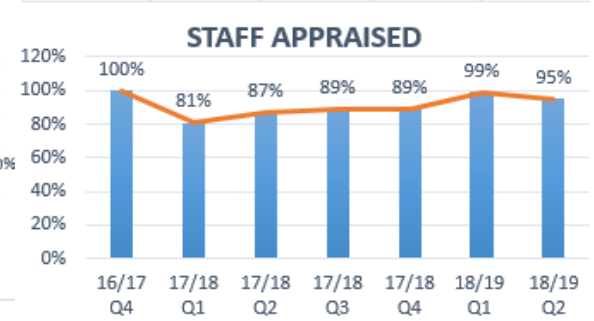
Data source: Department of Education and Training

Q2 18/19: Quality Well-Led

Staff sickness



STAFF APPRAISED



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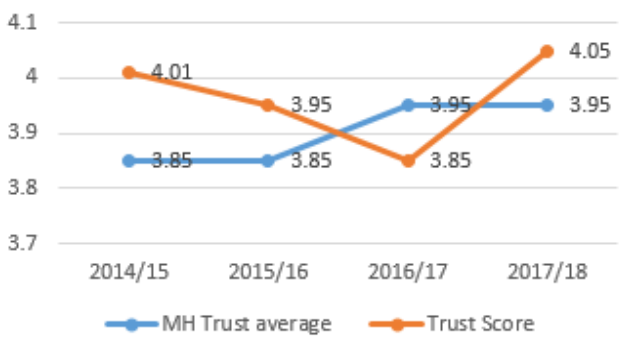

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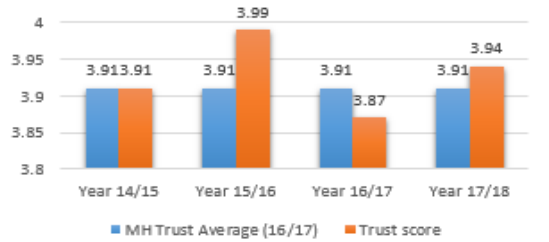
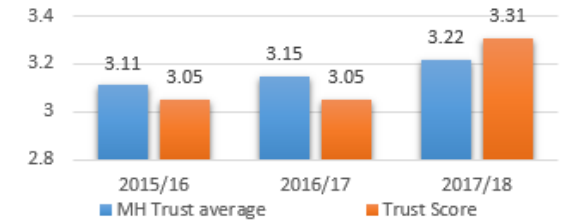
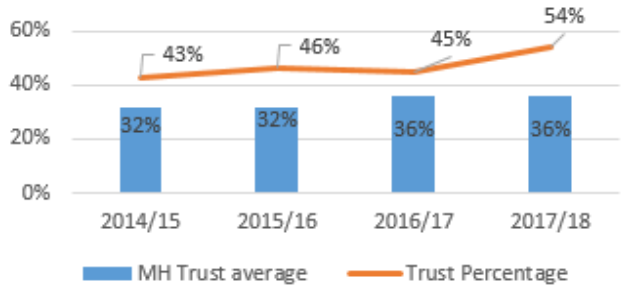


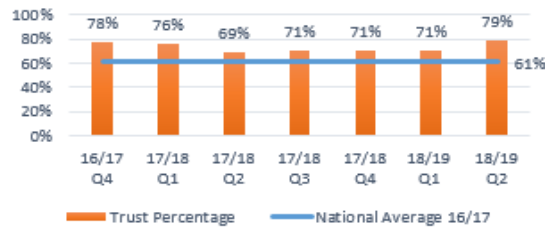
QUALITY OF APPRAISALS



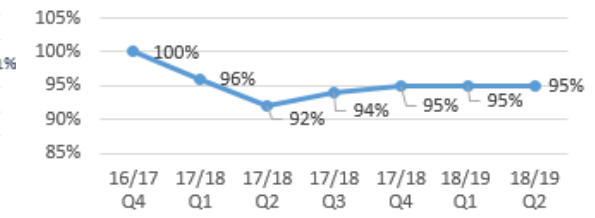
COMMS BETWEEN SENIOR MANAGEMENT AND STAFF



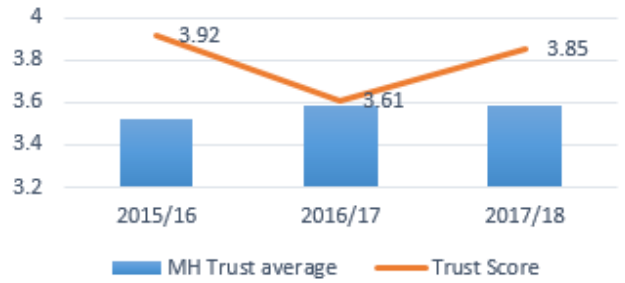
Staff FFT



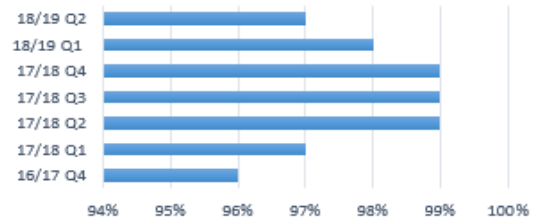
MANDATORY TRAINING (%)



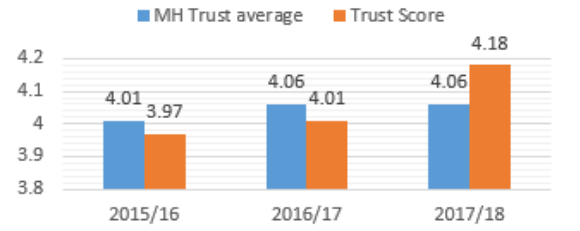
RECOGNITION AND VALUE OF STAFF BY MANAGER AND ORGANISATION



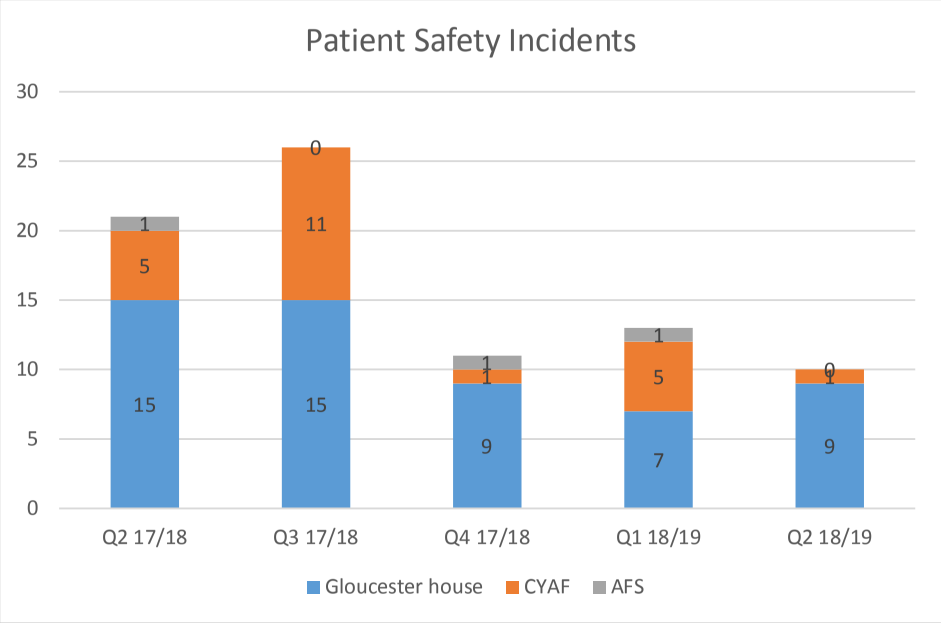
DBS compliance

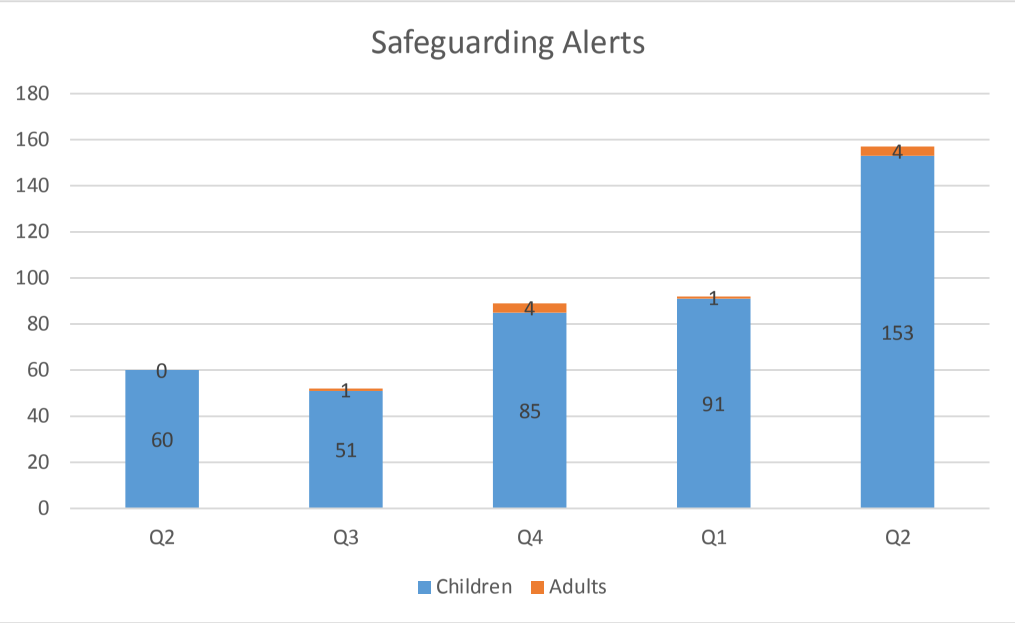


OPINION OF TRAINING



Q2 2018/19: Quality Safety





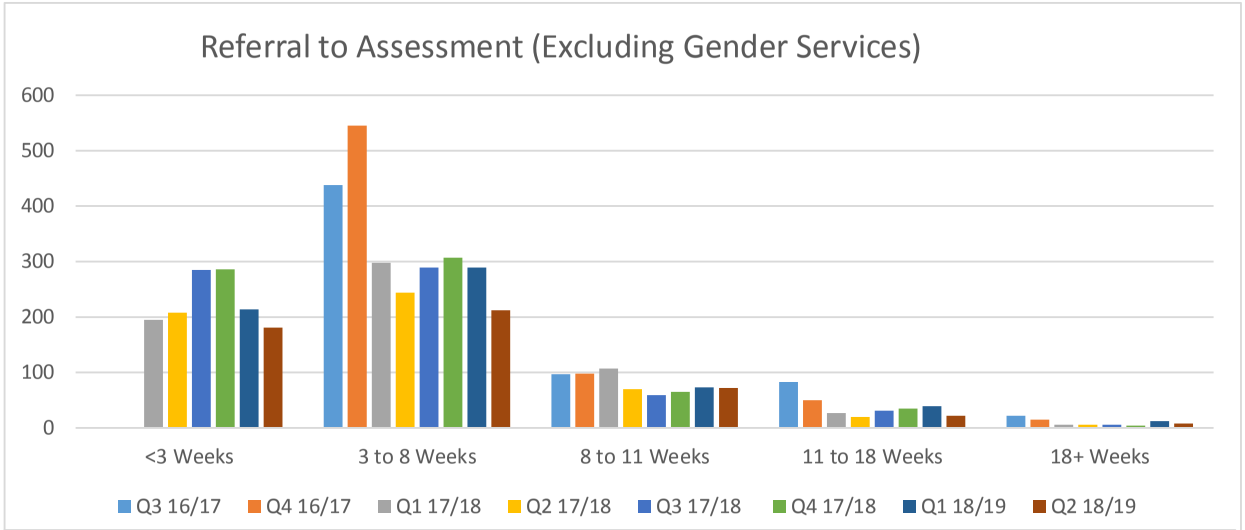
Incidents Reported by Risk Level – Trust wide	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18	Q1 2018-19	Q1 2018-19
15+	2	0	0	0	1	0
9-12	6	3	0	1	7	7
6-8	29	24	79	20	19	38
1-4	70	79	18	70	75	85
Total	107	106	97	91	102	130

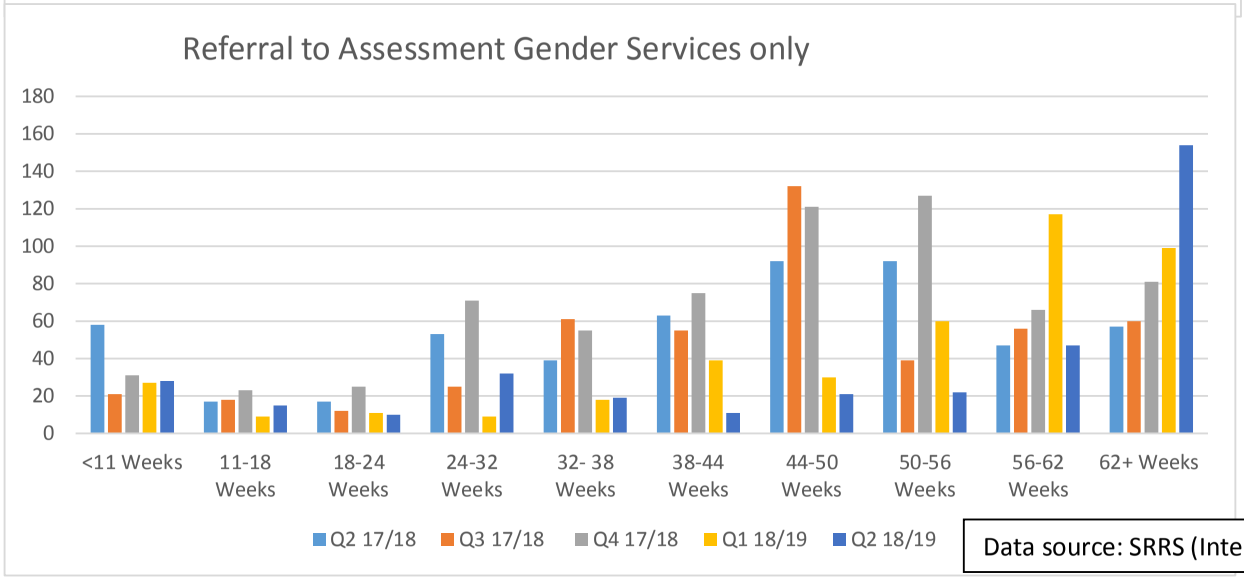
Data source: Quality Portal – Incidents

The 'red' incident in Q1 2018/19 was a reported 'suspected suicide' in the Refugee team. It was investigated and the report sent to commissioners in July. Information has been provided by the Medical Director. The increase in incidents graded 6-8 in Q2 relates specifically to issues relating to the Scheduling system.

Quarter 2 SIS reported = NONE

Q2 2018/19: Quality Responsive





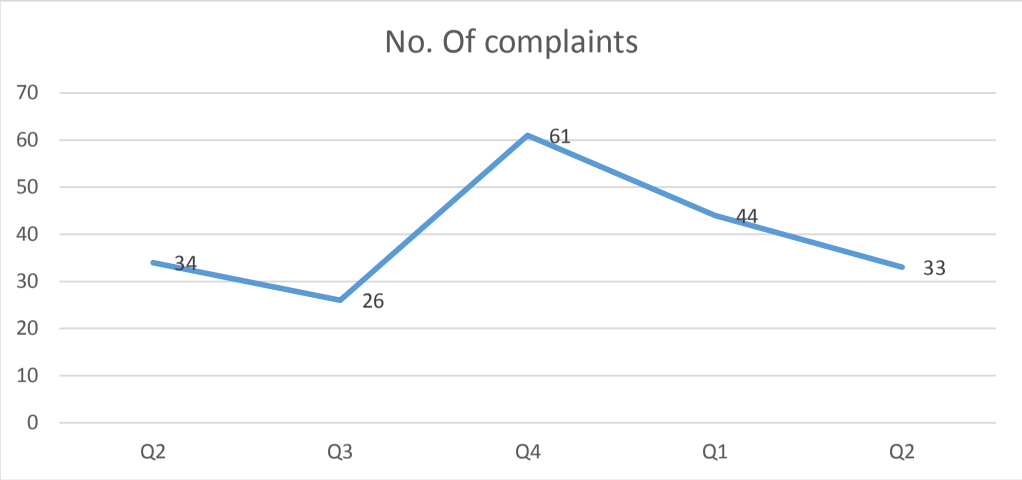
	First attendances in Q2 17/18 - 548
	First attendances in Q3 17/18 - 670
	First attendances in Q4 17/18 - 697
	First attendances in Q1 18/19 - 635
	First attendances in Q2 18/19 - 495

Adult teams: **Adult Complex Needs** Service saw 81.5% of their patients with in their 11 week waiting time target, still exceeding their target by 8.5% almost identical to Q1**. City and Hackney** have reduced their breaches a significant number, whilst managing to see a high amount of patients in quarter 2 as in quarter 1. **Portman** saw 1 of their patients breach their 11 week waiting time target this quarter.
CYAF Teams: **Camden CAMHS** performed consistently well throughout 2017/18 in to 2018/19,however have seen fewer patients off of their waiting list this quarter which is likely to see a higher breach rate in quarter 3. **The FAS (Westminster service)** have seen 100% of their patients with in their waiting time target, but this can fluctuate due to patient population. **Other CAMHS**, saw a dramatic deterioration in the number of people they saw with in their 8 week waiting time target in quarter 1 but this has slightly improved through quarter 2, a team level analysis has been conducted and showed that 14 of the 20 breaches were owed to the Family Mental Health Service, commentary has been provided by Sarah Wynick (Family Mental Health Team Manager) explaining actions that will be taken to improve this.
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 and in to 2018/19. Please see the action plans in the Waiting Times by Team Board report.

Data source: SRRS (Internal Reporting System) Reported by the Quality Team

Q2 2018/19: Quality Responsive

	2017/18				2018/19	
	Q1	Q2	Q3	Q4	Q1	Q2
Quality Responsive (Q4 from ESQ) Views and worries were taken seriously	100%	98%	99%	99%	99%	99%
Quality Responsive (Q13 from the ESQ) Involved in important decisions about my care	97%	97%	99%	98%	97%	98%



Total PALS 01/07/2017 to 30/09/2018

Quarter	Total
Q2	246
Q3	204
Q4	193
Q1	190
Q2	226

Top PALS enquiries for Q1 2018/19 remain the same as for 2017/18 namely:

- Access to treatment
- Communications
- Appointments

GIC, Adult Complex Needs and CYAF continue to be the services receiving most enquiries.

The is a slight difference in figures from the last report due to electronic system

Directorate	2017/ Q2	2017/ Q3	2017/ Q4	2018/ Q1	2018/ Q2
Adult & Forensic Services (A&F)		4	2	6	4
Children, Young Adults and Families (CYAF)	34	20	55	35	28
Corporate		1	1		1
No Directorate			1		
Trust Wide					1
Total	**34**	**25**	**59**	**41**	**34**

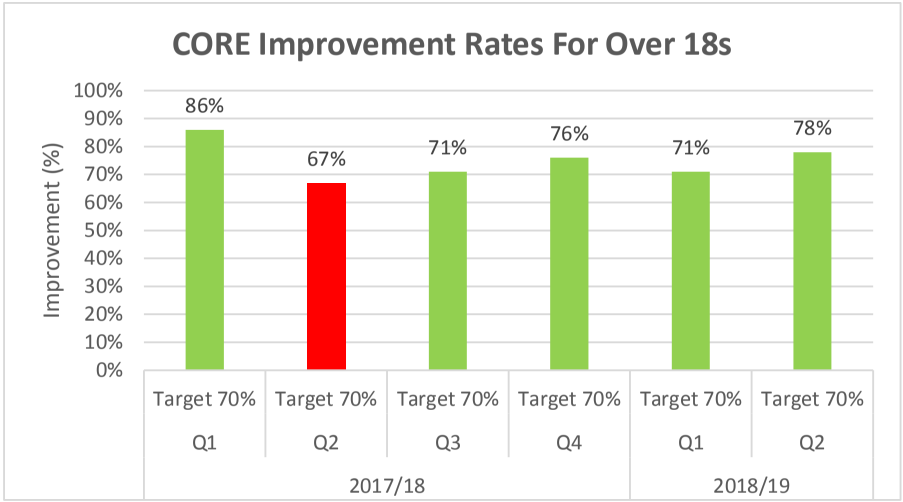
The increase in complaints was most predominately in Q4 of 2017/18. These complaints are primarily from the GIC department. A new administration process was put in place in Q4, this has been a successful implementation as the number of complaints within GIC have decreased.

Q2 2018/19: Quality Effective

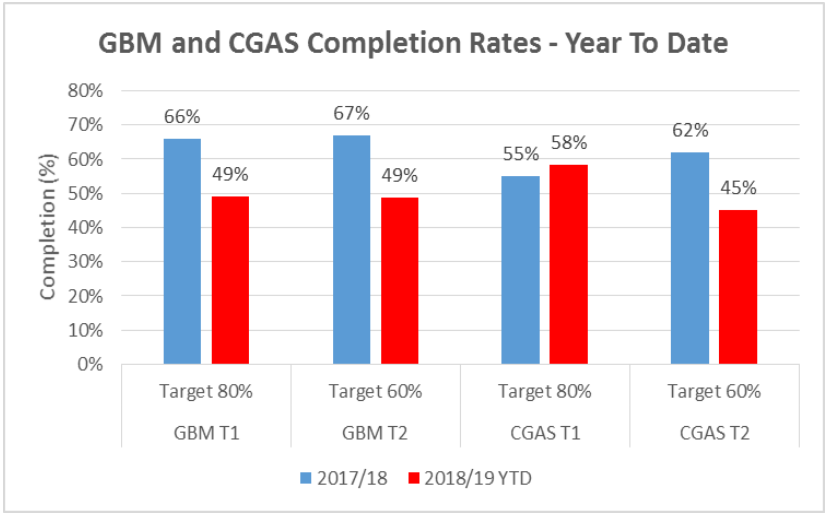
	ESQ Quality Effective					
	2017-18				2018-19	
	Q1	Q2	Q3	Q4	Q1	Q2
Patient Satisfaction (Q6 from ESQ) 'The information I received about the trust before I first attended was helpful' Target 75%	94%	90%	96%	95%	96%	94%
Patient Satisfaction (Q15 from ESQ) 'The overall help I received here is goodl' Target 100%	99%	99%	100%	100%	99%	97%
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%	98%	97%	97%	99%	98%	97%

	DNA - Trustwide					
	2017/18				2018/19	
	Q1	Q2	Q3	Q4	Q1	Q2
Target	10%	10%	10%	10%	10%	10%
Performance	10.6%	11.4%	10.3%	9.2%	9.3%	10.0%

*Please see service based run charts in the commentary section of this report.



Q2



Data source: SRRS (Internal Reporting System) Reported by the Quality Team

2018/19: Directorate of Education and Training (DET)

	Year	13-14 FY Actual	14-15 FY Actual	15/16 FY Actual	16/17 FY Actual	17/18 FY Actual	8/19 FY predicted plan to date	Comments
Course numbers	CPD/E-learning	45	58	70	94	93	90	
	Bespoke work	14	18	10	38	45	16	
	Conferences	18	18	16	4	7	8	
	Perinatal	n/a	n/a	n/a	2	5	5	
	Visitors Programme / international					23	13	focus on group visits and programmes in 18-19 rather than individual visits.
Students	Student Nos	2079	2738	2063	2279	2300	1320	
							Identified Income to Date	
Income	Income	501,917	556,261	493,090	£692,710	£854,710	£839,814	
	Income growth on previous year	35%	16%	-11%	40%	23%		
	Contribution	160,769	158,104	123,616	£197,122	£527,123		
Staffing	Staff number	3	3	2	3.5	3.6	3.6	
						17-18 contribution based on income-direct costs (16-17 included indirect costs therefore reduced contribution		

Data source: Department of Education and Training

Q2 2018/19: Directorate of Education and Training (DET)

Directorate of Education and Training (DET)

The Student Survey (2018) was a local survey, with integrated National Survey questions. The detailed results will be presented to the Education and Training Committee and AGQA Committee after which the update will be provided in the KPI return update for Q3 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"

Data source:

Department of Education and Training

Q2 2018/19: Single Oversight Framework

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

There are five themes under the Single Oversight Framework that NHS Improvement considers when assigning ratings to Trusts. Of these Finance and Use of Resources is covered in the monthly board papers. Our current status for the other four themes is:

Quality of Care: Green

Strategic change: Green

Leadership and Improvement Capability: Green

Operational Performance: Amber

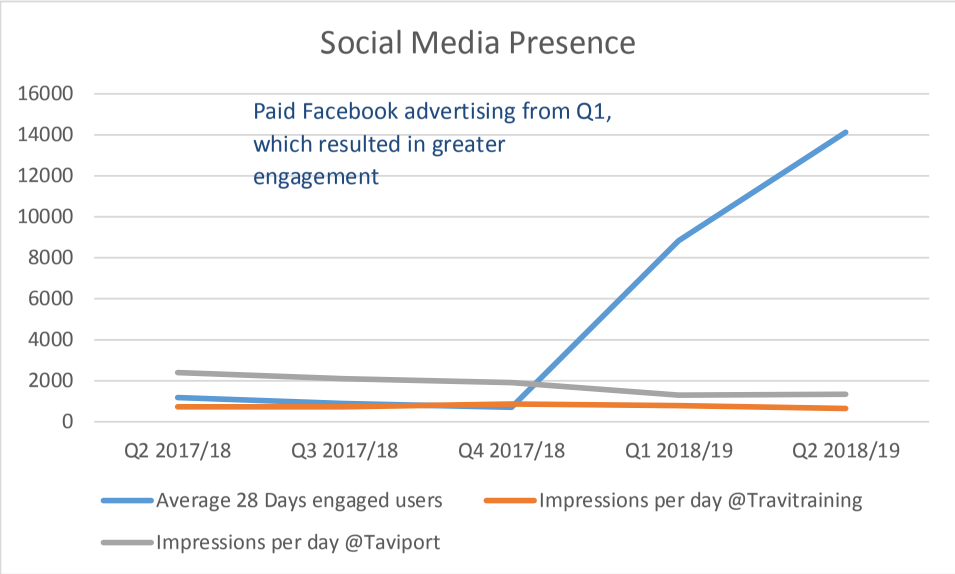
Accommodation and Employment collection has risen in the preceding months since GIC joined the trust, a trust wide effort to increase these figures is now needed. Ethnicity has been declining over the past financial year. The service with the worst collection rates is GIDS having a significant impact on the total figure. Adult complex needs, Portman and Other CAMHS are the other services that are falling slightly below the 85% target.

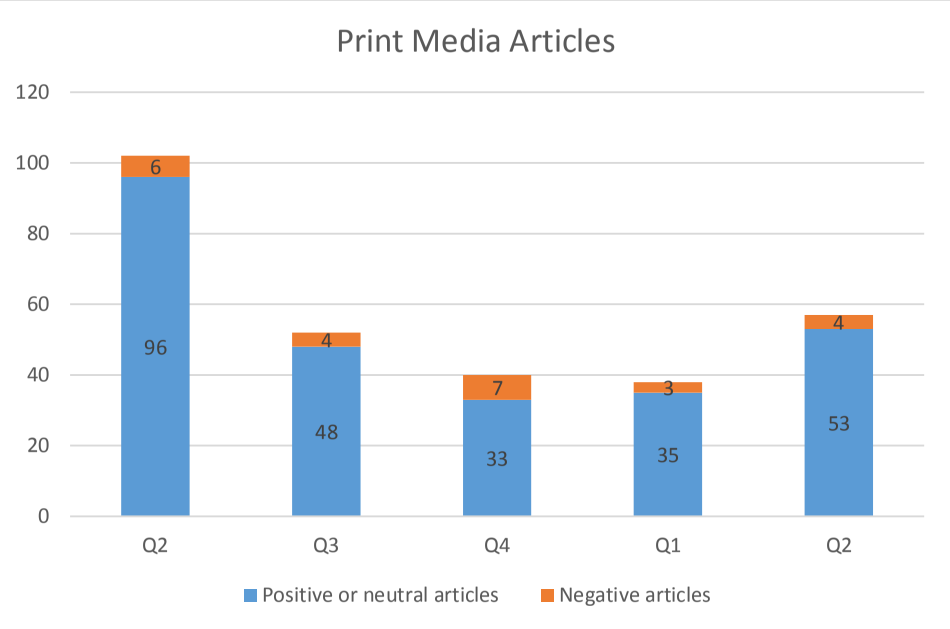
	Target (%)	Month 1 2017/18 (%)	Month 4 2017/18 (%)	Month 7 2017/18 (%)	Month 10 2017/18 (%)	Month 1 2018/19 (%)	Month 4 2018/19 (%)	Current / Future Target
Valid NHS number	95%	**96.2%**	**96.2%**	**99.1 %**	**98.6 %**	**98.6%**	**98.7%**	Current
Valid Postcode	95%	**99.8%**	**99.8%**	**99.8%**	**99.7%**	**99.8%**	**99.8%**	Current
Valid Date of Birth	95%	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	Current
Valid Organisation code of Commissioner	95%	**99.5%**	**99.5%**	**99.5%**	**99.1%**	**99.0%**	**99.2%**	Current
Valid Organisation code GP Practice	95%	**99.1%**	**99.2%**	**99.2%**	**98.2%**	**97.8%**	**98.0%**	Current
Valid Gender	95%	**99.8%**	**99.8%**	**99.8%**	**99.8%**	**99.8%**	**99.7%**	Current
Ethnicity	85%	**83%**	**83.1%**	**79.6%**	**78.4%**	**77.3%**	**76.0%**	Current
Employment Status (for adults)	85%	**26.3%**	**26.3%**	**36.9%**	**43.4%**	**49.1%**	**50.5%**	Current
Accommodation status (for adults)	85%	**26.1%**	**26.1%**	**36.6%**	**42.9%**	**48.5%**	**49.9%**	Current
ICD10 coding	85%	**NA**	**N/A**	**NA**	**NA**	**NA**	**NA**	N/A

*The trust is working towards a 99% target

Data source: Data warehouse, informatics team.

Q2 2018/19: Media





Data source: Communications department

Quarterly Quality Report Commentary Q2 2018/19

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 2 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 amount of people seen with in the waiting time target.

Service	Q3 Performance	Q4 Performance	Q1 Performance	Q2 Performance	Trajectory (+/-)
Adult Complex Needs	86%	79.5%	81.9%	**81.5%**	**Stayed the same**
City and Hackney PCPCS	95%	99%	99%	**97.3%**	**Decreasing (Not a cause for concern)**
Portman	100%	100%	95.3%	**96.2%**	**Improved**
Camden CAMHS	97%	94%	94%	**94%**	**Stayed the same**
Other CAMHS (Excluding first step)	75%	92%	61.7%	**70.1%**	**Improved**
Adolescent	89%	80%	92%	**84%**	**Decreased**
GIDS	14%	18%	10.1%	**18.3%**	**Improved**
GIC	4%	5%	5.7%	**6.3%**	**Improved**
Westminster	100%	67%	71%	**100%**	**Improved**

2.1.1 Adult teams: **Adult Complex Needs** Service has seen 81.5% of their patients with in their 11 week waiting time target, exceeding their target by 8.5% compared to quarter 1 this is almost identical**. City and Hackney** have reduced their breaches a significant amount, whilst managing to see a significant amount of patients in quarter 2 as in quarter 1. **Portman** have seen 1 of their patients breach their 11 week waiting time target this quarter.

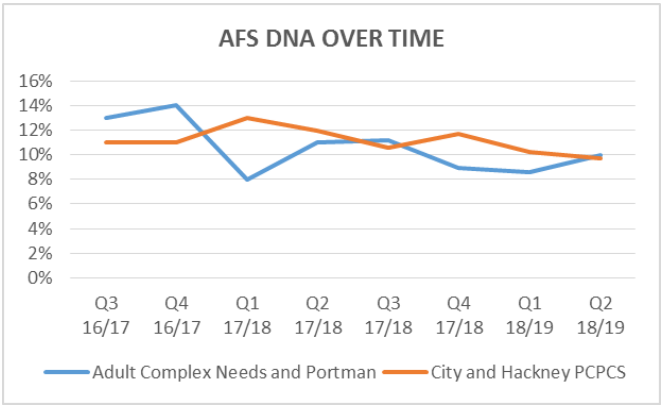
2.1.2 CYAF Teams: **Camden CAMHS** performed consistently well throughout 2017/18 in to 2018/19,however have seen fewer patients off of their waiting list this quarter which is likely to see a higher breach rate in quarter 3. **The FAS (Westminster service)** have seen 100% of their patients with in their waiting time target, but this can fluctuate due to patient population. **Other CAMHS**, saw a dramatic deterioration in the amount of people they saw with in their 8 week waiting time target in quarter 1 but this has slightly improved through quarter 2, a team level analysis has been conducted and showed that 14 of the 20 breaches were owed to the family mental health service, commentary has been provided by Sarah Wynick (Family Mental Health Team Manager) explaining actions that will be taken to improve this.

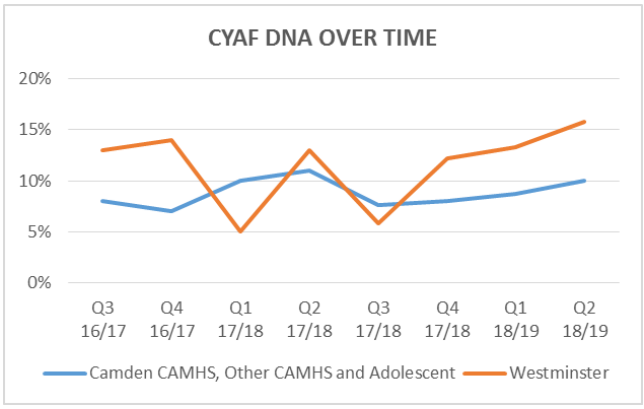
2.1.3 Gender Service Teams: Both the **Gender Identity Clinic** (Over 18) and **Gender Identity Service** (under 18) of these teams continue to breach their 18 wait week targets. Previous plans to bring this in line have now been made obsolete as more referrals than predicted have been made to the gender services in the 2017/18 financial year and in to 2018/19. Please see the action plans in the Waiting Times by Team Board report.

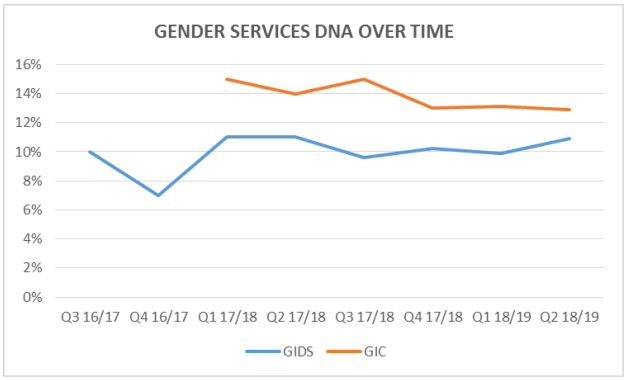
2.2 **Did Not Attend (DNA)**

DNA rates are an average figure and expected to be no larger than 10% (9.96% achieved for Q2). The definition used for DNA figures is **Numerator:** Total DNA / **Denominator:** Total Appointments (Total Attended + Total DNA appointments). CYAF, Adult Complex Needs, Portman services and GIDS all stayed under the 10% trust wide target. However, GIC, 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	Q3 Performance	Q4 Performance	Q1 Performance	Q2 Performance	Trajectory (+/-)
Adult Complex Needs and Portman	11.2%	8.9%	8.6%	**10%**	**Decreasing**
City and Hackney PCPCS	10.6%	11.7%	10.2%	**9.7%**	**Improved**
Camden CAMHS, Other CAMHS and Adolescent	7.6 %	8%	8.7%	**10%**	**Decreasing**
GIDS	9.6%	10.2%	9.9%	**10.9%**	**Decreasing**
GIC	15%	13%	13.1%	**12.9%**	**Improved**
Westminster	5.8%	12.2%	13.3%	**15.8%**	**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 most recent analysis presented is for July's submission. 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' and 'employment status', even though these are up from 25% on quarter at the beginning of the financial year 2017/18.

It was identified in quarter 1 that the internal systems did not match what was being reported externally to NHS Digital, this was because the definition was too technical to match in our internal reporting systems. In this quarter the Quality Team have used the data warehouse information (which is used for external reporting), and data is now in line with what is externally reported. One drawback to this is that it cannot be split up by team, therefore areas of improvement are harder to identify. The internal systems are still used to identify gaps in reporting. It is obvious that GIC are the service that are causing the low reporting rates of accommodation and employment, as this was not collected for any patient before they joined the trust. Every patient that enters the trust is now asked for accommodation and employment data and this is apparent in the rise quarter by quarter. This quarter the Quality

Team will focus on the ethnicity collection rates which have fallen consistently over the preceding quarters. The GIDs service has the worst collection rate for this indicator, however, adult complex needs, Portman Clinic and Other CAMHS are also services which are falling slightly below the 85% target.

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 58.3%, this is under the 2018/19 end of year target by 21.7%. GBM Time 1 collection at 48.6%, again under the 2018/19 target by 31.4%.

2.4.2 The collection of GBM or CGAS Time 2 for any patient with a thrive category of 'getting help' or 'getting more help' and been open longer that 6 months or discharged. CGAS Time 2 currently at 45.2%, 14.8% under the target for 2018/19. GBM Time 2 currently at 48.5%, 11.5% under the 2018/19 target.

2.4.3 In quarter three the changes to the assist panel will be implemented, and reporting brought in line with this. – This should see the trust moving heavily towards meeting the end of year targets for 2018/19

2.4.4 CORE improvement rates are currently at 78%, however this only reflects rates for those collected. Collection rates of this outcome measure are concerning.

2.5 **Quality Priorities**

2.5.1 **<u>Quality Priority 1:</u> Provide effective sleep management information and support to patients and carers of those with sleep disorders**

Quarterly milestone:	**Progress:**
Develop information guides on sleep hygiene with patient, carer and patient representative input	A rough draft of the sleep self-help guide for adults has been written, with the children's guide underway. Once this has been completed, these will be submitted to the Patient and Public Involvement team so that they can ask our stakeholders and Trust members for feedback
Provide sleep hygiene information to Trust practitioners and patients / Carers.	The physical health page has been promoted within team meetings and to Trust staff via email. Clinicians across the Trust have also trained on basic sleep hygiene information as part of their refresher training schedule. New Trust members of staff have also been trained on sleep hygiene as part of their induction training.
Work with parents and carers of children under the age of 13 years with sleep issues to support them in improving sleep.	The CYAF manager and I have agreed on the schedule of the intervention that will be offered to the carers of patients who have sleep difficulties. We are now working together to finalise a way of recruiting patients to this intervention. The intervention is planned for February 2019.

2.5.2 **Quality Priority 2: Improve waiting time access from end of assessment to first treatment session in the Adult Complex Needs Lyndhurst service**

Quarterly milestone:	Progress:
Develop and pilot a new model of care	The new model of 16 sessions has been approved by all senior department staff, and is in keeping with the existing evidence base for brief intervention. There has been some delay in piloting treatments for 2 reasons (i) the generic units are to be reconfigured on 29/10/18 and so the pilot has been put on hold (ii) the has been some delay in agreeing upon which patients are suitable for the new intervention but this has now been agreed upon. Two clinicians are currently carrying out the intervention and the outcomes will be reviewed once complete.
Reduce the number and % of patients waiting more than 9 months for treatment	A more detailed audit of waiting times was recently conducted and it emerged that the average waiting time between assessment and treatment is 7.5 months, which is less than initially thought. We have therefore changed to parameters of the objective waiting time. Instead, this will now be with an aim of reducing the percentage of those waiting more than 7.5 months by 10%.
Obtain feedback from service users about the new model	This will be conducted by semi-structured telephone interviews by assistant psychologists once the pilot treatments have been completed (November/December 2018 onwards)

2.5.3 **Quality Priority 3:** Improve patient and carer involvement in care planning in children, young adult and family services.

Quarterly milestone:	Progress:
Improve quality of patient and / or carer involvement in the development of care plans.	Discussions with the PPI team have been initiated for patients to be asked about the quality of the care plan they have been sent home with (and if they received one in the first place). A number of questions to ask a focus group of children, young people and parents will be drafted in Q3 with the intention of holding the focus group in Q4.
Increase the quality of data recorded of care plans shared with patients and referrers	Of those cases where care plans that had been completed, service wide (Other CAMHS) results were very pleasing, with a high proportion of the fields being 100% complete. The main focus of this priority will lie with in maintaining completion rates and ensuring that the quality of them does not drop.
Increase the percentage of care plans shared with patients and referrers	Unfortunately the compliance rates for care plan completion has declined slightly for all of the services that have been the focus of this quality priority. Due to personal circumstance the lead for this project was on extended leave in quarter 1 and quarter 2. The plan for quarter 3 is to develop a sustainable feedback loop to ensure regular communication regarding team performance. The feedback will be provided on a monthly basis. The quality team send out data regarding the numbers of incomplete care plans on a fortnightly basis, however, the performance on a team level has not historically been communicated directly with under-performing teams. Whilst incomplete forms will continue to be brought to individual clinicians

	attention. It is planned that team performance will now be monitored and reported to team managers (either through email dissemination or presentation in team meetings) on a monthly basis, alongside team performance on other KPIs and CQUINs. Please note that high compliance rates will also be celebrated, and learnings from teams will be identified and shared across the service line and directorate.

2.5.4 **Quality Priority 4: Embed meaningful use of outcome measures in services**

Quarterly milestone:	**Progress:**
80% of children and young people with Thrive categories, 'getting help' and 'getting more help' have a Time 1 goal recorded for the Goal Based measure (GBM) and CGAS measure.	48.6% (GBM Time 1) and 58.3% (CGAS Time1) – These figures are lower than the previous quarter. However informatics have now completed the work on utilising the assist panel with the commissioner's definition, tests will be completed though out October and training brought in line with the new reporting system in November.
Obtain service user feedback on the use of outcome measures to feedback on progress.	Work to be completed in quarter 3
60% of closed cases or cases open longer than 6 months with Thrive categories, 'getting help' and 'getting more help' have a paired Time 2 Goal Based measure and Time 2 CGAS measure.	48.5% (GBM Time 2) and 45.2%. See comments above.
Develop a method of presenting outcome data in a form that can be easily shared with patients and carers to provide timely feedback on their progress and opportunities for review.	A new team in the trust is in the process of being able to use patient view in CareNotes. This means they will be able to fill out their own OM forms and will be able to discuss with their clinicians there improvements as the data will be presented in a visual way. This will be completed through the IAPT form.

2.5.5 **Quality Priority 5, Improve identification and management of high risk patients**

Quarterly milestone:	**Progress:**
Implement an electronic version of the Camden Adolescent Intensive Support Service (CAISS) crisis plan on the electronic patient record system (Carenotes)	Crisis plans have been shared and consulted on with all CYAF clinical teams through the Camden and non-Camden leadership meetings. Agreed that a focus group to add young people (YP) and parents' views was required. Two attempts at a YP focus group over the summer with no attendance. Agreed in CAISS that we will liaise with the HIVE (voluntary sector partner) to access group of young people to gain feedback – this is in progress.
Establish online clinical risk assessment training across the Trust and develop processes to ensure robust recording of training compliance procedures	Online clinical risk presentation reviewed – to be made available in November. Face to face workshop also continuing x3/year in CYAF. Patient safety lead also visits all teams to discuss risk assessment

Ensure 80% of crisis plans in Adult and Forensic services (AFS) have been reviewed / updated in the last six months	All open cases in the Adult Complex Needs department were looked at in terms of updated risk assessment and/or crisis plan between May 18 and Sep 18. Where risk assessment and/or crisis plans were not updated in the last six months, clinicians were asked to update these with patients. 100% of cases were contacted and updated as a result.
Launch Trust's suicide prevention plan and evidence implementation of the action plan	The Trust is planning to hold an internal suicide prevention conference in March 2019. The conferences in the planning stages. The conference aims to provide Trust clinicians with national updates, develop skills I suicide mitigation and look at the relationship between self-harm and suicide. The Trust is planning to hold an internal suicide prevention conference in March 2019. The conferences in the planning stages. The conference aims to provide Trust clinicians with national updates, develop skills I suicide mitigation and look at the relationship between self-harm and suicide. The Trust is planning to hold an internal suicide prevention conference in March 2019. The conferences in the planning stages. The conference aims to provide Trust clinicians with national updates, develop skills I suicide mitigation and look at the relationship between self-harm and suicide. "

2.6 **CQUINs**

Only those due to commissioners this quarter are included below.

2.6.1 **The Living Well CQUIN**

The collection of Physical Health form remains at a constant 81%, this is 1% above the CQUIN target. Referrals and referral details have been reported to commissioners. Self-help written material on mindfulness has been designed according to NICE guidelines and the up-to-date evidence base. This information has been published on the Trust website and intranet. Self-help material on smoking has also been designed according to NICE guidelines and the up-to-date evidence base. This information has also been published on the Trust website and on the staff intranet page. The physical health service has also been fully developed to include behavioural sleep medicine as a treatment, offered to those over age 16 years if appropriate. In the previous Quarter, the Physical Health Form was redesigned to include sleep as an offered treatment.

Q2 Trust Assessment = fully met

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

The case note audit was undertaken as a requirement of the CQUIN for Q2, and showed a good level of discharge planning for cases going to primary care and good level of Joint Agency Transition Planning for cases transitioning between CAMHS and AMHS. Young people were involved in all cases. Not all those who transitioned out of CYPMHS in Q1-Q2 were interviewed or received a questionnaire to assess their readiness to transition. The issue of consent is being discussed with the project board including how those whose first language is not English can be included in a timely manner. Post transition, only one young person (out of three interviewed) felt they had achieved their transition goals.

Q2 Trust Assessment = partially met

2.6.3 GIDS Telemedicine CQUIN

Following extensive testing of the Health Connect system with the Telemedicine lead clinicians; it has been agreed to start scheduling appointments by videolink for the second phase of this project. The first of this new round of appointments by videolink was successfully held in mid-September. Another is scheduled in October.

2 patients this quarter were successfully seen via videolink. The inclusion criteria of accessing participants is as follows:

- Service-users from geographical locations furthest from GIDS:
- Young people and/or parents who are:
  1) In the review/treatment phase (medical or psychosocial)
  2) Are continuing to be seen by the same clinician with whom they have an established relationship
  3) Are not posing a significant risk to themselves or others which would be unsafe to manage over telemedicine
  4) Judged by clinician to be suitable to be seen by telemedicine

Due to technological problems of the project, accessing and continuing further videolink appointments were halted temporarily. There was a network update taking place across the Trust in September. It is anticipated that this should resolve the issues going forward. The outcome of the network upgrade should be clearer by the end of October.
The procedure of identifying which clinicians to train on the videolink system is by a case by case basis. Currently 4 clinical leads have been trained on the system, volunteering themselves on the project. Training has been halted for time being due to technological issues mentioned above. Training of the administrative support team have been considered but not taken forward at this point. This is because of the pilot phase of this project and the fact that administration of appointments can take place without access to the system.
In Q2, this target was partially met. Confirmation of patients to be offered consultations was confirmed. Ongoing training has not been delivered due to technological issues which are being addressed. The training element will be met in Q3.

Q2 Trust Assessment = partially met

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

Lorna Hobbs, undertaking her clinical psychology doctorate, is continuing to gather data via questionnaire from all GIDS graduates who go to Charing Cross GIC. Lorna plans to continue doing this until Q4 at this point.

Data gathered includes information about demographics, satisfaction with different types of treatment, wellbeing, timings and length of process, and feelings about gender identity and body in relation to gender identity. This piece of work, once complete, will be very helpful in providing a picture about cases transferring from GIDS to adult services, though will represent a snapshot in time.

Q2 Trust Assessment = Fully Met

The Tavistock and Portman NHS
NHS Foundation Trust

Board of Directors: November 2018

Report to	Date
Board of Directors	27 November 2018

Waiting Time Analysis by Team	
Executive Summary	
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 Workstream Meeting	
Recommendation to the Board of Directors	
The Board of Directors is asked to discuss the report.	
Trust strategic objectives supported by this paper	
Finance and Governance	
Author	**Responsible Executive Director**
Data Quality Manager	Director of 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 July 2018 to the 30th September 2018.

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 2017 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 81.5% of their patients with in their 11 week waiting time target, exceeding their target by 18.5%. They also saw less patient in this quarter compared to preceding quarters, however, very similar to Q2 of the financial year 17/18. City and Hackney have reduced their breaches a significant amount, whilst managing to see a significant amount of patients in quarter 2. Portman have only seen one of their patients breach.

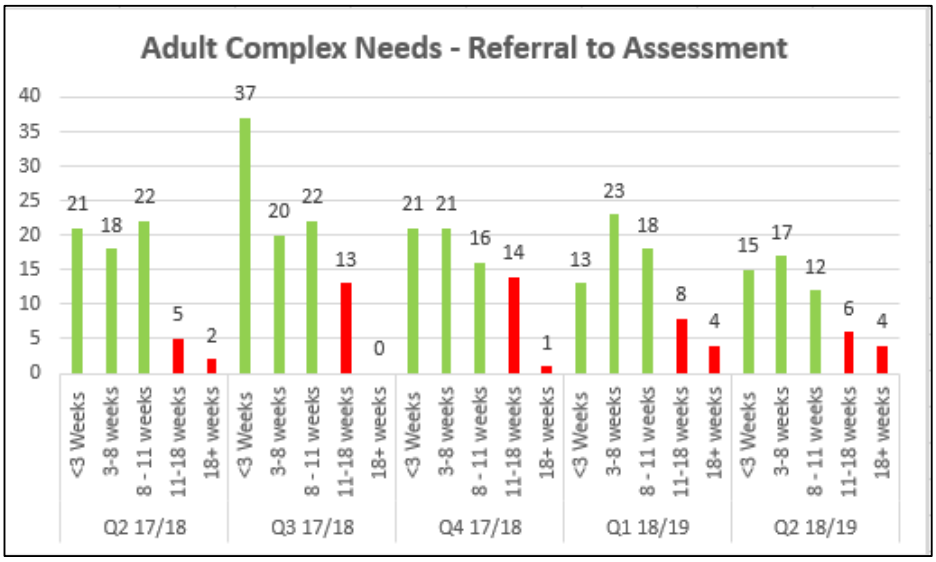
1.7 Other CAMHS, higher breach percentages than the trust target of 10%, with 29.9% of their patients being seen over the 77 day target.

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.

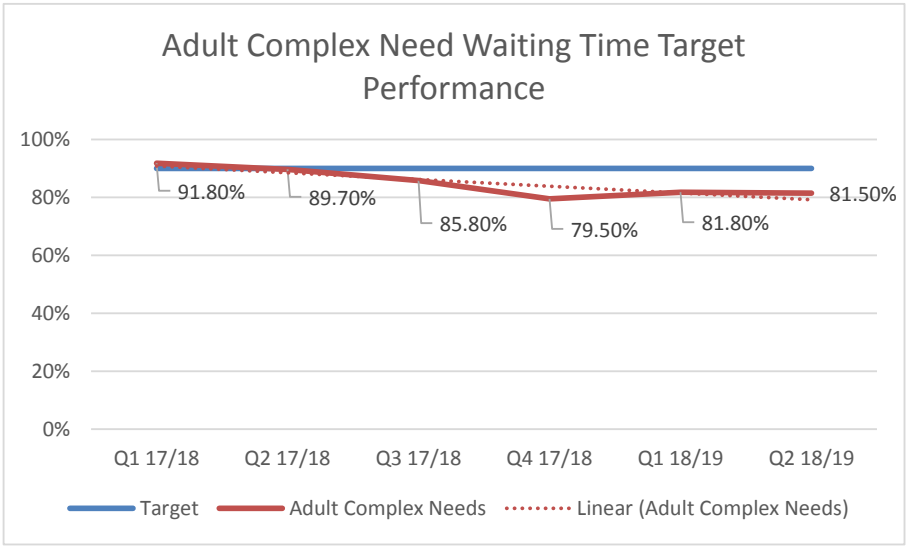
1.9 Camden CAMHS has performed consistently well throughout 2017/18, considering the high volume of patients in the service. The FAS (Westminster service) have fluctuated this financial year, this is due to the patient population.

2. Detailed analysis and commentary

2.1 Adult Complex Needs (All Teams included in analysis)



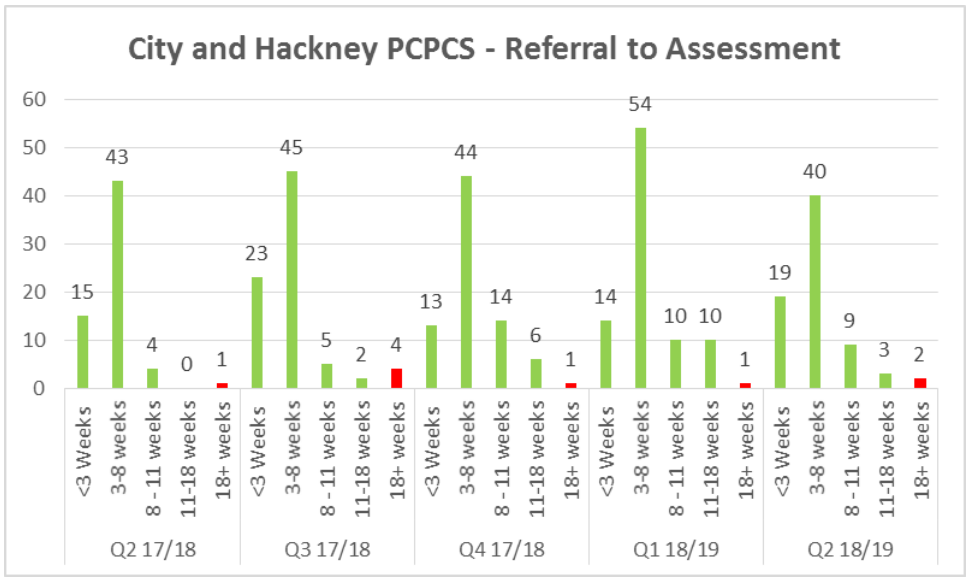
Number of new patients seen in Quarter 2 is 54, a decrease from preceding quarters, although similar to quarter 2 of financial year 17/18. 18.5% of patients breached the 11 week waiting times target, almost identical to Q1. 6 of the 9 (67%) breaches are owed to the Lyndhurst Team. Total open referrals waiting at the end of quarter: 79



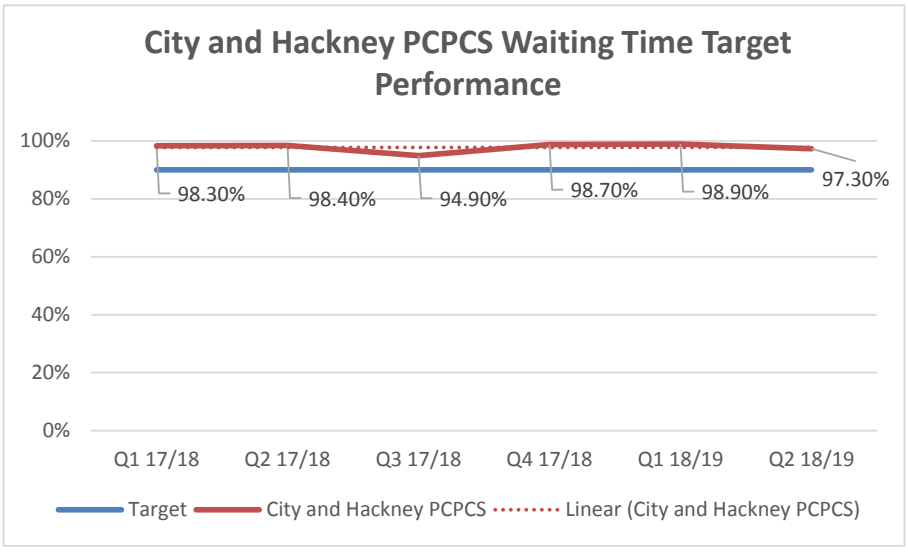
An analysis over time shows a significant decline in performance over the past 6 quarters, the total decline is 10.3%. This has caused Adult Complex needs to fall consistently below the 90% trust waiting time target (allowing for 10% breaches).

ACTION PLAN				
Topic area: Improvement of Adult Complex Needs Target Waiting Time performance				
Objective ***Specify** what are you aiming to achieve from your plan (link to core trust objectives where relevant)*	**Success criteria** ***What measures** of success will be used to determine that the objective has been delivered*	**Plan** *Explain **how** the success criteria will be **achieved** –e.g. outline a **realistic** project plan, and who will monitor progress*	**Timescale** ***When** the plan will be delivered, as a whole or by individual success criteria*	**Lead** ***Specify who** is responsible*
To reduce the number of referrals breaching the 11-week deadline for assessment	*That the number of breached referrals will decrease*	*(i) Appointment of new clinician to 2 session permanent post* *(ii) Appointment of locum to 2 session post* *(iii) Reconfiguration of generic units* *(iv) Movement of additional resource to trauma unit*	*Next Quarter (i.e. Q3)*	*Andrew Williams*

2.2 City and Hackney Service (PCPCS)



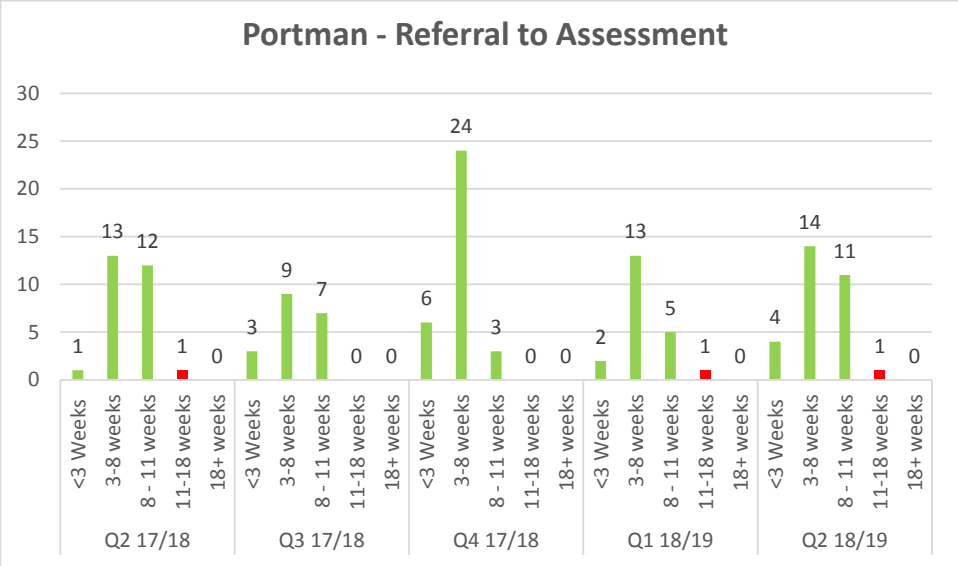
The waiting time target for City and Hackney is 18 weeks with 97.3% meeting this target in Quarter 2. In the Quarter 2 City and Hackney saw 73 patients from the waiting list, which has been consistent over the past four quarters.
Total open referrals waiting at the end of quarter: 56



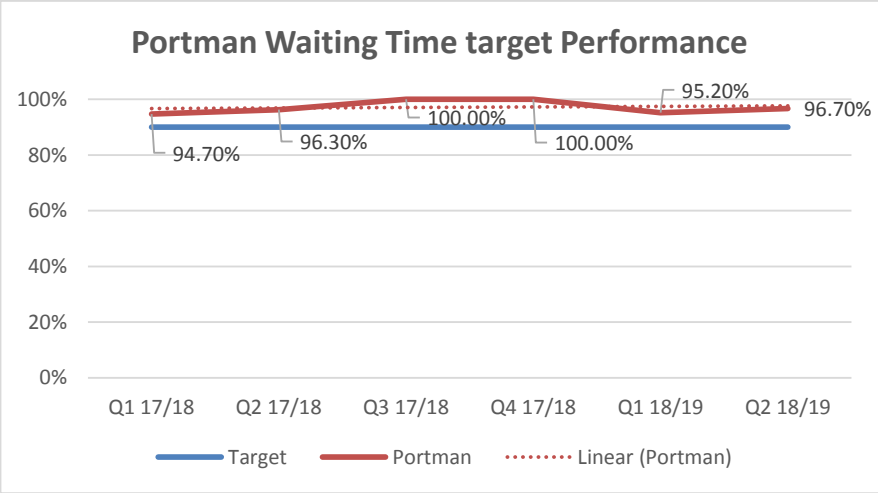
An analysis over time shows that City and Hackney PCPCS have remained above the trust waiting time target of 90% (allowing for 10% breaches)

'The team are very pleased with our figures for this quarter, we have made a huge step forward with waiting times since re-aligning our referral criteria 'back' to the original intentions of the service for GP referral only and with MUS and Frequent attendance as primary criteria. Our GP colleagues also benefit from around 30% of practices being offered professional group consultation to GPs and Primary Care Teams. As the waiting list has reduced to a more manageable level we are able to see patients within an appropriate timescale with reduced risk, less mental pressure on staff and a better sense that GPs can expect to see their patients seen by the service quickly.' Tim Kent, Service Lead.

2.3 Portman Clinic



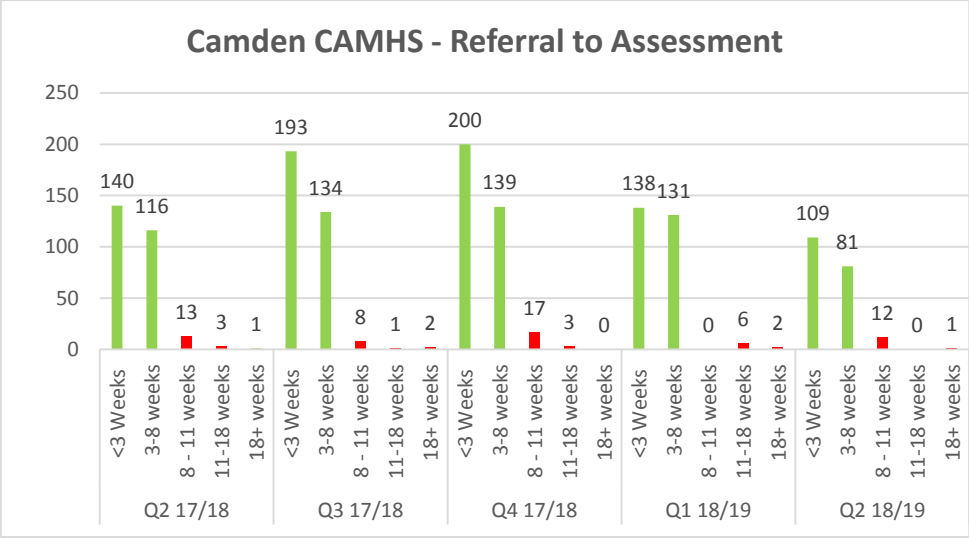
The waiting time target for Portman is 11 weeks with 96.2% meeting this target in Quarter 2, this accounted for 1 breach. Portman have seen 26 patients in Quarter 2. Total open referrals waiting at the end of quarter: 4



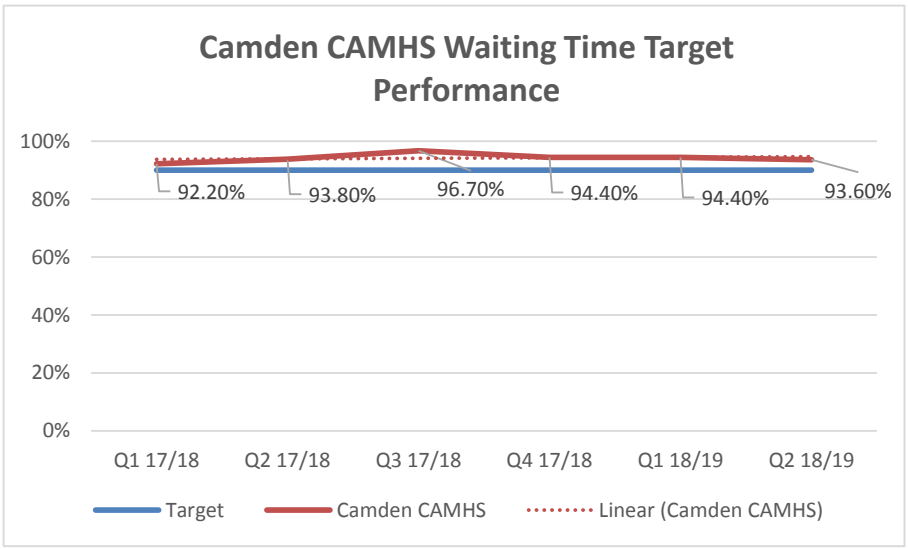
An analysis over time shows that Portman have remained above the trust waiting time target of 90% (allowing for 10% breaches).

We are pleased to reach a 96.2% compliance target with seeing all patients for assessment within the 11 week target following referral, with only one breach. This occurred due to external circumstances given that the patient had not used two offered appointments and the next available one for the clinician doing the assessment was in September. Moreover, the time since the patient requested a next appointment was only 8-9 weeks since the previous one. 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. Jessica Yakeley Service Manager

2.4 CYAF (Camden CAMHS – All Teams Selected)



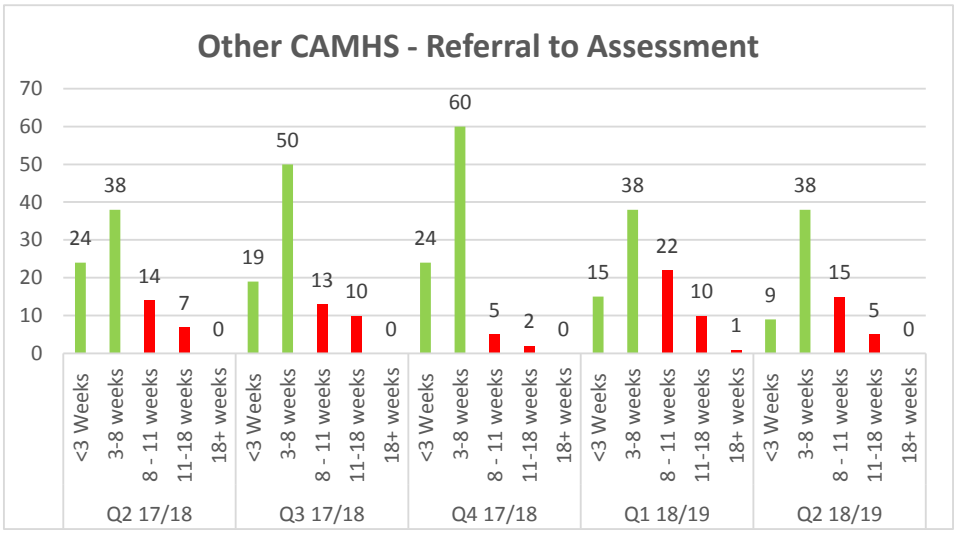
The waiting time target for Camden is 8 weeks with 94% meeting this target in Quarter 2; this has identical to the previous quarter. Camden CAMHS have seen 74 less people off of the waiting list than in Quarter 1.
Total open referrals waiting at the end of quarter: 77 (34% of these were for the North service)



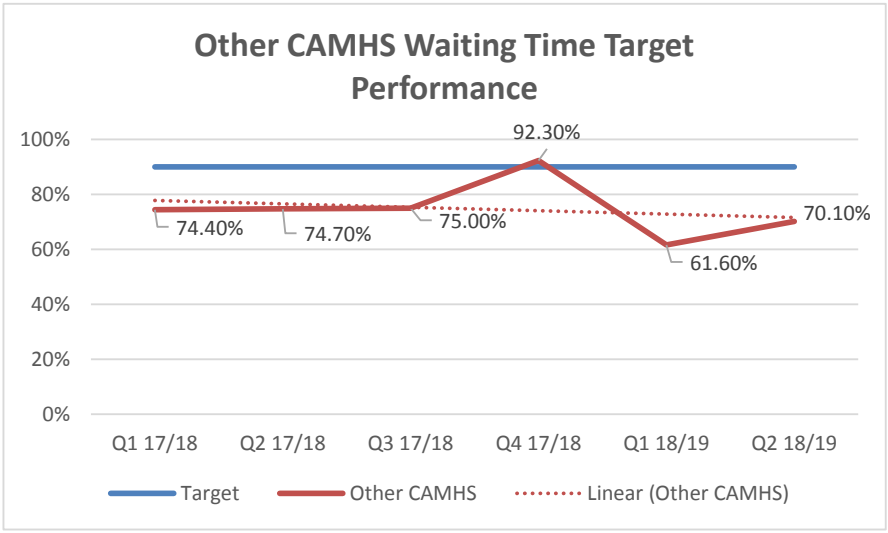
An analysis over time shows that Camden have remained above the trust waiting time target of 90% (allowing for 10% breaches).

'We are pleased the wait time remains low and we have noted the reduction of new cases of the waitlist and this will be looked into, but may relate to additional pressures on the service over this time period.' 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 70.1% meeting this target in Quarter 2, an improvement on the preceding quarters (62%), and Other CAMHS teams saw 57 people off of their waiting list. 14 of the 20 breaches were owed to Family Mental health Service. Total open referrals waiting at the end of quarter: 77

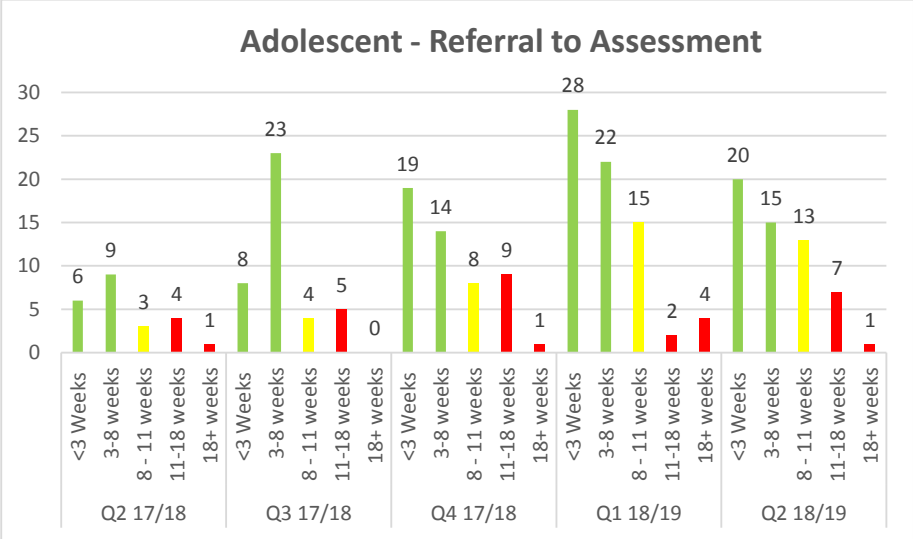


An analysis over time shows Other CAMHS service meeting their waiting time target in average of approx. 75%. Although in Quarter 4 17/18 the service met the trust waiting time threshold of 90% (allowing for 10% breaches) this has again declined over the past two quarters.

'We identified that some Haringey referrals are very reluctant to engage and Jane would sometimes continue to chase them until they'd breached. All bar two of the breaches in Q1&2 fell into this category.

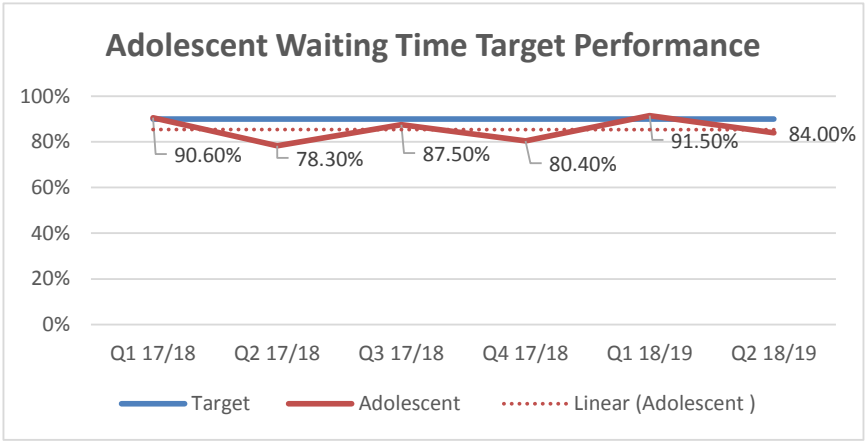
Alima and I agreed a 3 pronged approach: A week of phone calls, then a letter asking them to ring in and then a letter offering a specific CaR appointment. That letter asks them to confirm the appointment within a week or it'll be allocated to someone else. If they don't confirm the appointment, it's outcomed as CBP on CareNotes which resets the clock.
If after that a further round of writing and calling fails we close and notify the referrer.' Sarah Wynick, Family Mental Health Team Manager

2.6 Adolescent Service



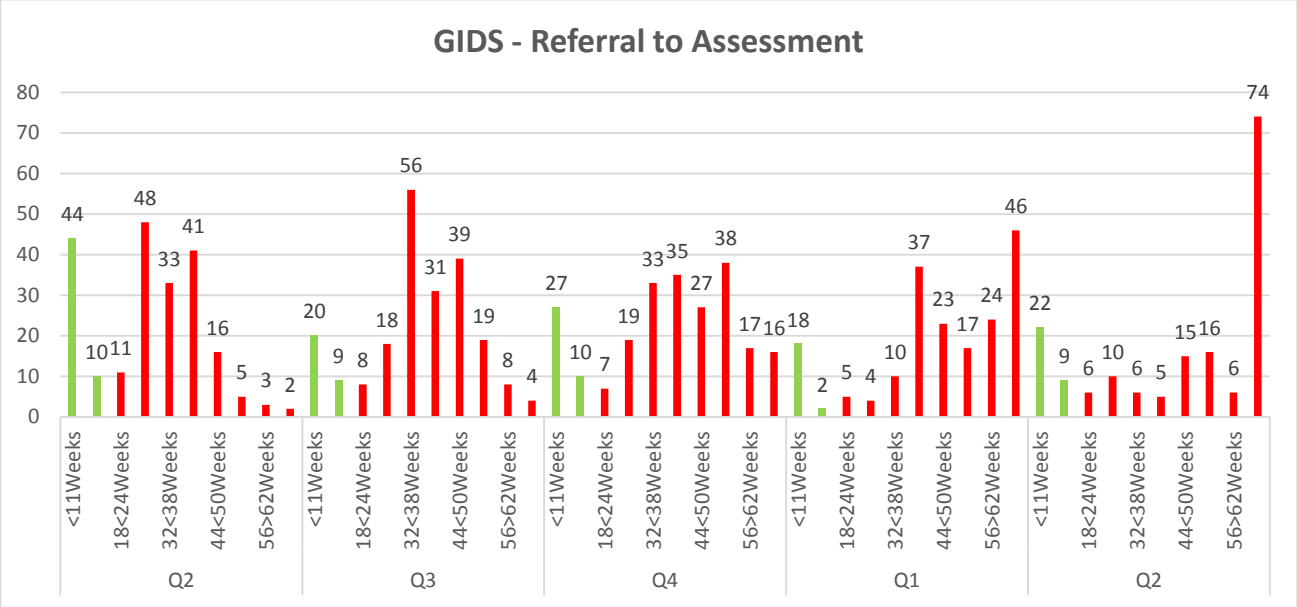
The waiting time target for Adolescent is 8 weeks for those under 18 and 11 weeks for those over 18. With this taken in to consideration 84% of patients were seen with in target waiting times. The adolescent service has seen 56 people off of the waiting list in Quarter 2.

Total open referrals waiting at the end of quarter: 44



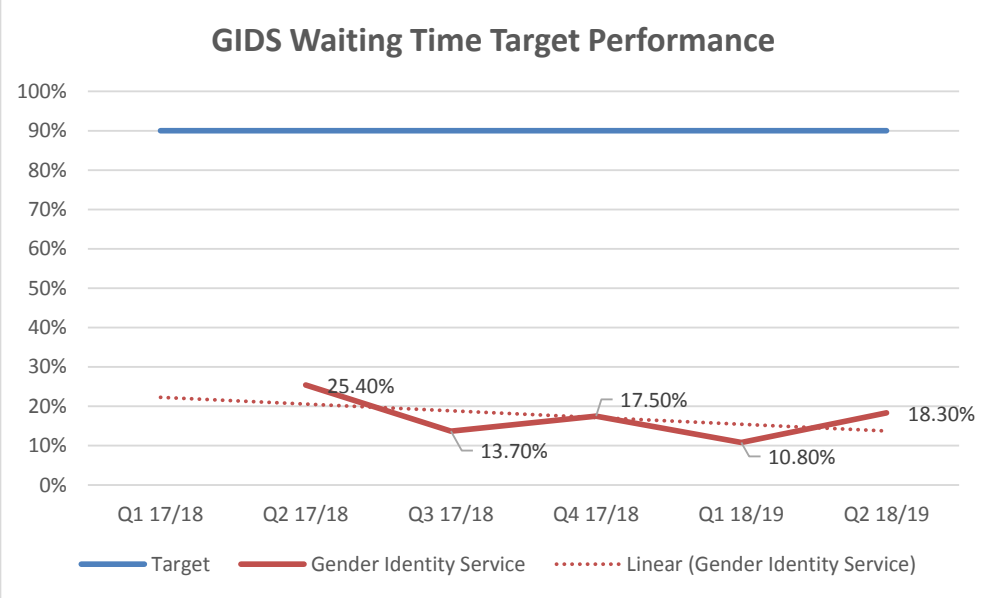
Analysis over time shows the adolescent service varies in the number of patients they see with in their wait time target with the lowest reporting 78.3% and the highest report showing 91.5%. The percentage of targets met usually falls under the 90% trust target. *In the AYAS, we endeavour to see patients as soon as possible. However, because of a recent increase in the number of referrals received, it means that unfortunately, the waiting time for assessments has increased.' Justine McCarthy Woo*

2.7 Gender Identity Development Service



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

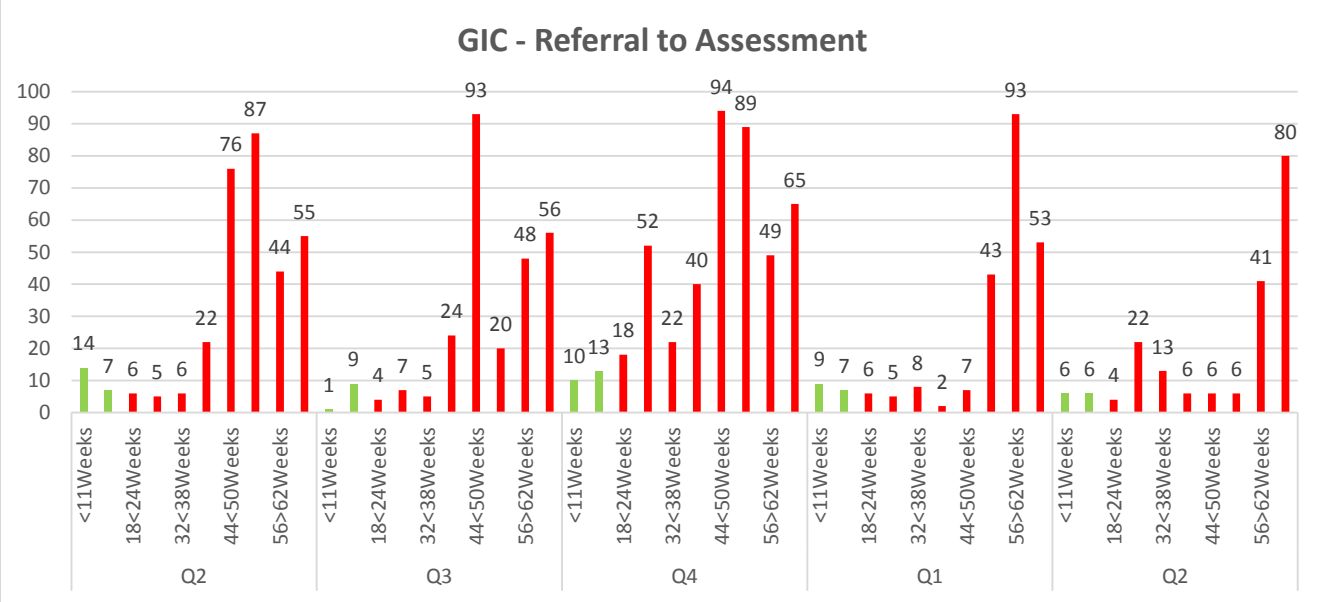
The number of new patients seen in quarter 2 is 169 something that has been decreasing over preceding quarters. 18.3% of patients were seen with in the 18 week target time for GIDS. Total open referrals waiting at the end of quarter: 2207, this is a rise of 25% since quarter 3.



An analysis over time shows GIDS service are meeting their waiting time target in average of approx. 18%. This is due to the sheer amount of referrals the service received and the specialised clinicians it takes to see these patients.

ACTION PLAN				
Topic area: Improvement of GIDS Target Waiting Time performance				
Objective	**Success criteria**	**Plan**	**Timescale**	**Lead**
Higher clinical activity rate.	*Higher clinical activity rate.*	*Staff recruitment drive.*	*Phase one – interviews July 2018. Phase two – interviews Sept/Oct 2018*	*Polly Carmichael*
PILOT INITIATIVE: Establish stronger links with CAMHS to avoid referrals where YP is best treated locally.	*Lower referral rates from targeted CAMHS. Lower number of sessions required per ax as YP better prepared and risk better managed upon arrival.*	*Referral analysis has taken place to establish frequent referrers. 1 regional team (South East) is leading on this pilot. Questionnaires to YP and CAMHS have been drafted. Full pilot activity Jan-June 2019, reporting and reviewing thereafter.*	*Jan-June 2019 – activity July – September 2019 Analysis and reporting to clinic exec.*	*Sarah Davidson*
PILOT INITIATIVE: Link in with families early in ax wait to minimise distress and divert inappropriate cases.	*Reduced referral rates through diverted cases. Reduced number of complaints/increased YP satisfaction. Reduced number of ax sessions due to pre-ax activity.*	*20 cases are identified to pilot this to, and videolinks arranged with network around family. Videolink semi-structured to enable desired outcomes. Surveys designed to capture YP experience, other measurables demonstrated via activity rates and referral figures.*	*As above*	*Rebecca McClaren*
PILOT INITIATIVE: Understand the reasons behind and mitigate against poor referrals, reduce clinical time spend information gathering.	*Reduced time longer term on information gathering. Reduced number of inappropriate referrals.*	*20 poor referrals chosen and families called immediately, semi-scripted interview given to determine suitability for clinic or prior work which needs to be done.*	*As above*	*James Barclay*
Greater understanding of referral trends (temporal, referrers, age ranges) and numbers of sessions averaged per ax and tx over time to better inform clinic modelling.	*Greater clarity to inform future projects.*	*Monthly data metrics circulated to GIDS team on monthly basis and discussed in senior team meeting. Individual reporting to line managers for clinical outputs.*	*Team reporting started September 18, ongoing and in development. Individual reporting on quarterly basis target by Q3.*	*Kathleen Hughes*
Better quality referrals.	*Better quality referrals sent in, less clinical time spent information gathering.*	*The GIDS referral form is in review.*	*Q3-Q4 (revisions in discussion)*	*Garry Richardson*

2.8 Gender Identity Clinic (GIC)

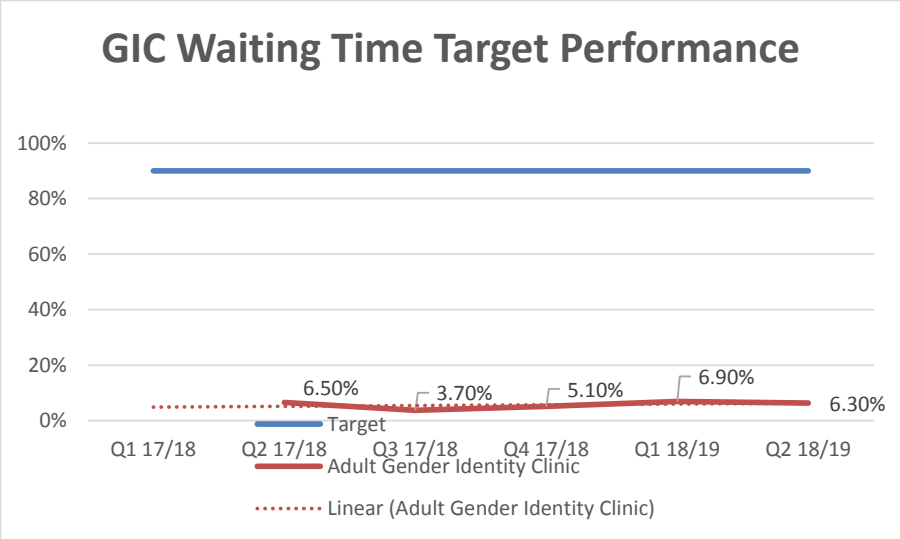


**Please note the difference in reporting the Wait in weeks, this has been agreed with Frances Endres. It will show more clearly when improvements are happening with in the service*

The waiting time target GIC is 18 weeks with 6% meeting this target in Quarter 2. This is a service with a huge number of referrals. GIC saw 190 patients off their waiting list in Quarter 2, 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.

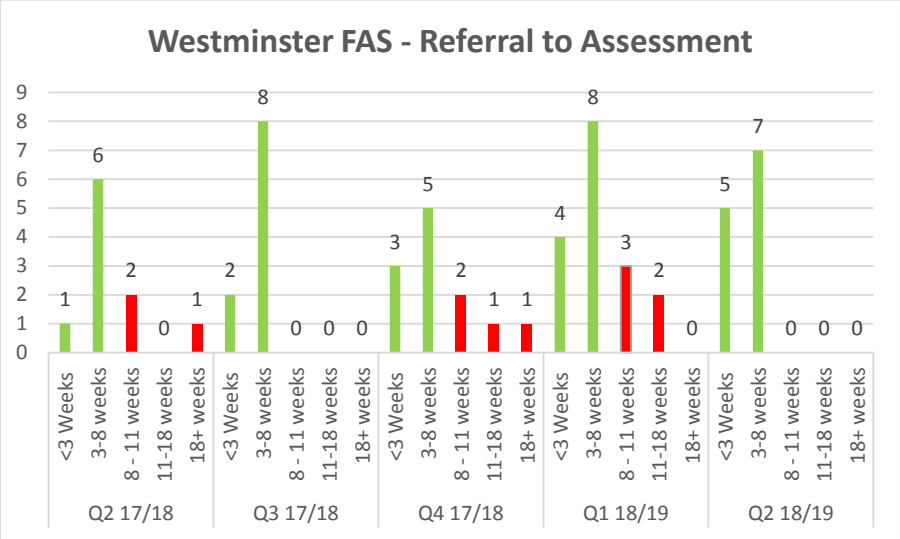
Total accepted waiting at the end of quarter: 2550



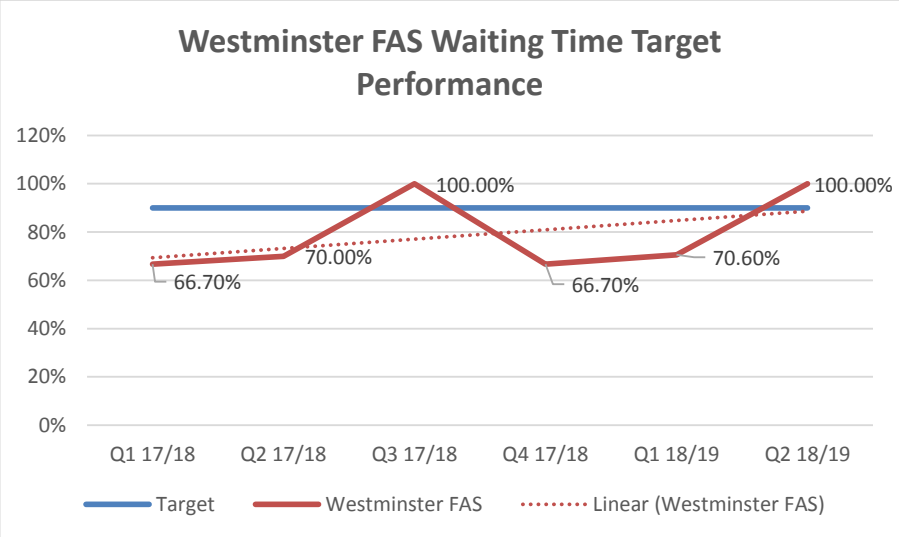
An analysis over time shows GIC service are meeting their waiting time target in average of approx. 6%. This is due to the sheer amount of referrals the service received and the specialised clinicians it takes to see these patients.

The waiting times are a constant source of conversation for all the GIC clinics across the country and something that we speak to our commissioners about regularly. The priority at the moment is reducing the time between clinical appointments as we have reached 13 months which is considered clinically unsafe. For the reason, we are reducing the number of first appointments offered by 60% starting in April 2019 for a period of time until we are happy with the gap between appointments. NHS England are aware of this plan. It is worth noting that we continue to prioritise all GIDS graduates and transfers from clinics where patients are already in care so as to not disrupt their treatment. A priority appointment at the moment is on average a 9-12 month wait currently.
Frances Endres, Manager of Gender Services

2.9 Westminster Service (Family Assessment Service)



The waiting time target for FAS is 6 weeks, 100% meeting this target in Quarter 2. Number waiting at the end of the quarter: 2



Analysis over times shows Westminster FAS dip below and above the trust waiting time target of 90% (allowing 10% of breaches), this is predominantly down to the small case load that the service receives. One breach can account for a drop in compliance.

We are consistently trying to improve the way we receive information from Local Authority through consultation with their Social Workers on the documents that are essential to the case after we have receipt of the referral which often delays the start of our work due to court dates or external information not being forthcoming. This quarter is certainly a reflection on these consultations and documents are being produced without further delay. We hope it will continue, as we are reliant on external factors to keep our wait times at a minimum. Julie Rodgers Office Manager

Report to	Date
Board of Directors	November 2018

Finance and Performance Report – September 2018

Executive Summary

The Finance and Performance Report for September 2018 is attached.
This shows the net surplus of the Trust to be a positive variance of £246k against Budget due to a positive variance on costs.
This over performance is expected to reverse in the second half reflecting lower levels of vacant posts and reduction in budgeted income.

Recommendation to the Board

The Board is asked to note the report

Trust strategic objectives supported by this paper

Finance and Governance

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

The Tavistock and Portman NHS
NHS Foundation Trust

MONTHLY FINANCE AND PERFORMANCE REPORT

Period 6 **Sep-18**

Section

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

Period 6
30 September 2018

	2017/18 Actual **Month** £'000	2018/19 Actual **Month** £'000	2018/19 Budget **Month** £'000	Variance Actual v Budget £'000	2017/18 Actual **YTD** £'000	2018/19 Actual **YTD** £'000	2018/19 Budget **YTD** £'000	Variance Actual v Budget £'000	**Variance Actual v Budget %**
Income	4,652	4,859	4,889	(26)	24,645	**26,401**	26,627	(226)	**(1)%**
Staff costs	(2,931)	(3,106)	(3,384)	277	(17,801)	**(18,737)**	(19,231)	494	**3%**
Non-staff costs	(1,496)	(1,437)	(1,349)	(91)	(5,563)	**(5,971)**	(5,970)	(1)	**0%**
Operational costs	(4,427)	(4,543)	(4,733)	186	(23,364)	**(24,707)**	(25,201)	494	**2%**
EBITDA	225	316	156	**160**	1,281	**1,694**	1,426	**267**	**0**
- Margin	5%	**7%**	3%		5%	**6%**	5%		
	1				3				
Interest receivable	0	4	1	4	0	**13**	3	10	**294%**
Interest payable	(67)	(9)	(2)	(7)	(396)	**(20)**	(13)	(7)	
Depreciation / amortisation	(61)	(99)	(99)	0	(289)	**(596)**	(596)	0	**0%**
Public Dividend Capital	41	(54)	(54)	0	(18)	**(325)**	(325)	0	**(0)%**
Restructuring costs		0	0	0	0	**(25)**	0	(25)	
Net surplus	138	158	1	157	581	**741**	495	**246**	**50%**
- Margin	3%	3%	0%		2%	**3%**	2%		

COMMENTARY

The Trust surplus is £741k, which is £246k above budget.
Revenue is £226k below budget due mainly to shortfalls in DET (new income and savings targets) and AFS (Adult Complex Needs), partially offset by DoH income funding Agenda for Change pay rises received within Corporate.
Pay costs are £494k below budget
Non-staff costs are in line with Budget

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

Period 6

30 September 2018

	May £'000	June £'000	July £'000	Aug £'000	Sept £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000
Intangible assets	194	185	190	196	201						
Land and buildings	18,866	18,934	19,124	19,261	19,357						
IT equipment	2,812	2,863	2,921	2,893	2,923						
Other	0	0	0	0	0						
Property, Plant & Equipment	21,678	21,797	22,045	22,154	22,280	0	0	0	0	0	0
Total non-current assets	21,872	21,982	22,234	22,349	22,481	0	0	0	0	0	0
Trade and other receivables	3,272	3,673	2,426	4,637	4,177						
Accrued Income and prepayments	4,851	5,349	3,936	3,857	4,103						
Cash / equivalents	4,960	3,654	8,006	6,794	6,198						
Total current assets	13,083	12,676	14,368	15,289	14,479	0	0	0	0	0	0
Trade and other payables	(1,566)	(1,817)	(1,065)	(2,209)	(2,291)						
Accruals	(3,012)	(3,152)	(3,497)	(3,094)	(3,347)						
Deferred income	(5,312)	(4,440)	(5,586)	(5,889)	(4,717)						
Provisions	(77)	(231)	(231)	(231)	(231)						
Total current liabilities	(9,967)	(9,640)	(10,378)	(11,423)	(10,586)	0	0	0	0	0	0
Total assets less current liabilities	24,989	25,018	26,225	26,215	26,373	0	0	0	0	0	0
Non-current provisions	(226)	(73)	(73)	(73)	(73)						
Long term loans	(1,000)	(1,000)	(2,000)	(2,000)	(2,000)						
Total assets employed	23,763	23,946	24,152	24,143	24,301	0	0	0	0	0	0
Public dividend capital	3,474	3,474	3,474	3,474	3,474						
Revaluation reserve	12,238	12,238	12,238	12,238	12,238						
I&E reserve	8,050	7,848	8,440	8,431	8,589						
Total taxpayers equity	23,763	23,946	24,152	24,143	24,301	0	0	0	0	0	0
Cash Analysis											
Non-ITFF balance	3,960	2,654	4,794	4,794	4,198	0	0	0	0	0	0
ITFF balance	1,000	1,000	2,000	2,000	2,000	0	0	0	0	0	0
Total cash	4,960	3,654	6,794	6,794	6,198	0	0	0	0	0	0

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

Period 6

30 September 2018

	May Act £'000	June Act £'000	July Act £'000	Aug Act £'000	Sept Act £'000	YTD Act £'000
Net Surplus	214	172	206	(9)	158	741
Depreciation / amortisation	199	99	99	99	99	596
PDC dividend paid	108	54	54	54	54	325
Restructuring costs	0		25	0	0	25
(Increase) / Decrease in receivables	730	(899)	2,660	(2,132)	214	573
Increase / (Decrease) in liabilities	302	(481)	738	1,044	(837)	767
Increase / (Decrease) in provisions	75	1	0	0		76
Interest paid	(1)	2	0	(0)	(6)	(5)
Net operating cash flow	1,626	(1,052)	3,783	(944)	(317)	3,097
Interest received	1	3	2	2	4	13
Interest paid	(4)	(3)	(2)	(2)	(9)	(20)
PDC dividend paid	(108)	(54)	(54)	(54)	(49)	(320)
Restructuring costs			(25)	0	0	(25)
Cash flow available for investment	1,515	(1,105)	3,704	(998)	(371)	2,745
Purchase of intangible assets	(10)		(5)	(6)	(6)	(27)
Purchase of property, plant & equipment	(368)	(200)	(347)	(208)	(220)	(1,342)
Net cash flow before financing	1,137	(1,305)	3,352	(1,212)	(597)	1,375
Drawdown of debt facilities	0	0	1,000	0	0	1,000
Repayment of debt facilities	0	0	0	0	0	0
Net increase / (decrease) in cash	**1,137**	**(1,305)**	**4,352**	**(1,212)**	**(597)**	**2,375**
Opening Cash	3,823	4,960	3,654	8,006	6,795	3,823
Closing cash	**4,960**	**3,654**	**8,006**	**6,795**	**6,198**	**6,198**
	4,960	3,654	8,006	6,794	6,198	6,198
	(0)	(0)	(0)	(0)	0	0

The Tavistock and Portman NHS
NHS Foundation Trust

Report to	Date
Board	27 November 2018

Scheme of Delegation

Executive Summary

The Board reviews its scheme of delegation on an annual basis.
The updated scheme is atached for approval.
The only changes from the previous version are changes reflecting changes in title.
The scheme was reviewed by the Management Team at its meeting on 13 November 2018

Recommendation to the Board

The Board is asked to approve the scheme of delegation

Trust strategic objectives supported by this paper

Finance and Governance

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

Delegated Matter			Reference documents & notes	Chief Executive	Finance Director	Medical Director	Director of Q&PE	Dir. of Education / Dean	Director of HR and Governance	Director of Strategy or AD of Contracts (as appropriate)	Director of HR and Governance	Directors of CYAF / AFS	Director of Technology and ransformation	Line / Dept Manager	Procurement Officer	Budget Holder	Petty Cash Holder	Other
1. Management of budgets	Responsibility of keeping expenditure within budget		SFI 3													■		
2. Maintenance / operation of bank accounts			SFI 5		■													
3. Non-pay revenue and capital expenditure / requisitioning / ordering / payment of goods and services	a) Requisitions		SFI 9															Any individual authorised by Budget Holder and Deputy Director of Finance
	b) Purchase orders		SFI 9												■	■		
	c) Invoices not covered by a purchase order															■		Any Individual authorised by Budget Holder and Deputy Director of Finance
4. Capital schemes	a) selection of architects, quantity surveyors, consultant engineers, and other professional advisors, within EU regulations				■													Relocation Programme Director or Estates Director in conjunction with Director of Finance
	b) financial monitoring and reporting on all capital scheme expenditure				■													
5. Quotation and Tendering Procedures (see also 3(e) above)	a) Obtaining 3 written quotations on the basis of a written specification for goods / services from £10,000 to £60,000		SFI Appendix A 6;												■	■		Other originating Officer
	b) Obtaining at least 3 written competitive tenders for goods/services above £60,000		SFI Appendix A4; SFI AppendixA 5													■		
	c) Waiving of the requirements to obtain quotations or tenders subject to SFIs		SFI Appendix A4.3; SFI AppendixA 6.3	▒	▒													
	d) Opening Tenders		SFI Appendix A5.3; **Note:** Any two Executive Directors, in presence of Trust Secretary	▒	▒	▒	▒	▒	▒	▒	▒	▒	▒					Any two exec. Directors or managers on the list of Designated Officers. This may include the Director 'leading' the procurement
	e) Retaining records	(i) Retaining the *Register of Tenders*	Constitution Annex 5								■							
		(ii) Retaining detailed records of each tender	SFI Appendix A5.3													■		Originating Department
		(iii) Retaining records of competitive quotations obtained	SFI Appendix A6.2; SFI Appendix A6.3												■			Originating Department
6. Contracts for NHS Clinical Services	a) Setting prices		SFI 7; SFI 6.2		■					■								
	b) Signing agreements			▒	▒													Either one may authorise
7. Setting of Fees for Training courses, Consultancy work and other services	a) New training courses		SFI 6.2		■			■										
	b) Annual review of fees for all courses				■			■										
	c) Daily fee rates (range) to be charged for DET consultancy work							■										Director of Tavistock Consulting

Must authorise Either May Authorise

Reviewed annually by Director of Finance (and if necessary by the Board)

Delegated Matter			Reference documents & notes	Chief Executive	Finance Director	Medical Director	Director of Q&PE	Dir. of Education / Dean	Director of HR and Governance	Director of Strategy or AD of Contracts (as appropriate)	Director of HR and Governance	Directors of CYAF / AFS	Director of Technology and ransformation	Line / Dept Manager	Procurement Officer	Budget Holder	Petty Cash Holder	Other
	d) Daily fee rates (range) to be charged for other consultancy work									■		■						
	e) Approval of fees for other services including the Glouceter House Day Unit etc.				■					■		■						Fees below £250k do not require Director of Finance sign off
8. Expenditure of Charitable Funds	a) From grants received for specific purposes (e.g. research grants; donations for specific services)		SFI 16; Charitable Fund Cttee ToR		■											■		
	b) From staff earnings funds								■									
	c) From all other funds:	(i) Up to £20,000		▒	▒													
		(ii) Above £20,000		▒	▒													Charitable Fund Committee
9. Agreements/Licences	a) Letting of premises to, or renting of premises from, outside organisations		SFI 6.2.4	▒	▒													Either one may authorise
	b) Approval of rents to be charged		SFI 9.2.7.1 **Note:** to be based on professional assessment and subject to competitive tendering requirements		■													
10. Condemning & Disposal - items which are obsolete, obsolescent, redundant, irreparable or which cannot be repaired cost effectively	a) with current / estimated purchase price under £200		SFI 13; SFI Appendix A11												■			
	b) with current purchase new price over £200 but expected sale value and current book value (where applicable) both under £1,000												■					
	c) with expected sale value or current book value (where applicable) both over £1,000												■					
	d) with expected sale value or current book value (where applicable) both over £5,000		**Note:** Subject also to competitive quotations or tendering		■													
11. Losses, Write-offs & Compensation	a) Losses due to theft, fraud, overpayment & others Up to £50,000		SFI 13.2; HM Treasury "Managing Public Money"	■														
	b) Fruitless Payments (including abandoned Capital Schemes) Up to £50,000				■													
	c) Bad Debts and Claims Abandoned up to £50,000				■													
	d) Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use, up to £50,000				■													
	e) Compensation payments made under legal obligation (no limit)			■														

Delegated Matter			Reference documents & notes	Chief Executive	Finance Director	Medical Director	Director of Q&PE	Dir. of Education / Dean	Director of HR and Governance	Director of Strategy or AD of Contracts (as appropriate)	Director of HR and Governance	Directors of CYAF / AFS	Director of Technology and ransformation	Line / Dept Manager	Procurement Officer	Budget Holder	Petty Cash Holder	Other
	f) Extra Contractual payments to contractors, up to £50,000																	
	g) Ex-gratia payments to patients and staff for loss of personal effects:	(i) Less than £100																
		(ii) Between £100 and £50,000																
	h) Ex-gratia payments for clinical negligence up to £50,000 (including plaintiff's costs) for negotiated settlements following legal advice and in compliance with guidance																	
	i) Ex-gratia payments for personal injury claims involving negligence, up to £50,000 (including plaintiff's costs), where legal advice has been obtained and guidance applied																	
	j) Other ex-gratia payments, up to £50,000 (but note that the Trust has no delegated authority to make any payments in cases of maladministration where there was no financial loss by the claimant)																	
12. Reporting of Incidents to the Police	a) Where a fraud is suspected		SFI 13.2; Counter Fraud Policy															Local Counter Fraud Service
	b) Violence, theft or any other offence or suspicion		SFI 13.2															Health and Safety Manager and Local Counter Fraud Service
13. Petty Cash Disbursements	a) Expenditure up to £50		SFI 9.2.8; **Note:** Items which cannot be covered from petty cash floats are to be submitted as cheque requests (e.g. for long distance patient fares) or invoices approved for payment)															
	b) Expenditure above £50 and up to £100 per item																	Financial Controller
14. Ensuring that Internal and External Audit, and Local Counter Fraud Specialist recommendations are implemented			SFI 2															Relevant Director
15. Maintenance & Update of Trust Financial Procedures			SFI 3.3															
16. Investment of Funds	a) The Trust's Exchequer funds.		SFI 10.2; Operating Cash Management Policy															
	b) Charitable funds		SFI 16; Charitable Fund Cttee ToR															Charitable Fund Committee

Must authorise Either May Authorise

Reviewed annually by Director of Finance (and if necessary by the Board)

Delegated Matter			Reference documents & notes	Chief Executive	Finance Director	Medical Director	Director of Q&PE	Dir. of Education / Dean	Director of HR and Governance	Director of Strategy or AD of Contracts (as appropriate)	Director of HR and Governance	Directors of CYAF / AFS	Director of Technology and ransformation	Line / Dept Manager	Procurement Officer	Budget Holder	Petty Cash Holder	Other
17. Application to the Department of Health for Advance of Public Dividend Capital			SFI 10.1; Operating Cash Management Policy; **Note:** Any two Executive Directors are required															**Any two exec. Directors.**
18. Borrowing			SFI 10.1; Trust's Operating Cash Management Policy															
19. Human Resources & Pay	a) Authority to fill funded post on the establishment with permanent staff.		Policy & Procedure for Recruitment & Selection															
	b) Authority to appoint staff to long-term post not on the formal establishment.		SFI 8.2.3; Policy & Procedure for Recruitment & Selection															
	c) Additional Increments - The granting of additional increments to staff within budget *on appointment.*		Agenda for Change Conditions of Service															**Finance Director with the HR Director**
	d) Banding, rebanding, and other remuneration matters -All requests shall be dealt with in accordance with Trust Procedure:	(i) Staff listed in "Duties (1)" of the Remuneration Committee Terms of Reference	Remuneration Cttee ToR															**Remuneration Committee**
		(ii) All other staff	Policy & Procedure for Recruitment & Selection															
	e) Establishments:	(i) Additional staff to the agreed establishment with specific external funding	SFI 8															
		(ii) Additional staff to the agreed establishment without specific external funding																
	f) Pay:	(i) Authority to complete standing data forms affecting pay, new starters, variations and leavers	SFI 8															**HR Officer**
		(ii) Authority to authorise overtime																
		(iii) Authority to authorise travel & subsistence expenses																
		(iv) Approval of Performance Related Pay Assessment	Remuneration Cttee ToR															**Remuneration Committee**
	g) Leave:	(i) Approval of annual leave	NHS Terms and Conditions of Service Handbook; Other relevant terms & conditions of service; Leave Policy															
		(iii) Annual leave - approval of carry over in excess of 5 days.																**Director of relevant directorate**

Delegated Matter			Reference documents & notes	Chief Executive	Finance Director	Medical Director	Director of Q&PE	Dir. of Education / Dean	Director of HR and Governance	Director of Strategy or AD of Contracts (as appropriate)	Director of HR and Governance	Directors of CYAF / AFS	Director of Technology and ransformation	Line / Dept Manager	Procurement Officer	Budget Holder	Petty Cash Holder	Other
		(iv) Compassionate leave												■				
		(v) Special leave arrangements							■									
		(vi) Leave without pay												■				
		(vii) Time off in lieu (to be documented)												■				
		(viii) Maternity Leave - paid and unpaid							■									HR Officer
	h) Sickness Absence:	(i) Extension of sick pay on half pay up to three months	Trust Sickness Absence & Rehabilitation Policy & Procedure						■									
		(ii) Return to work part-time on full pay to assist recovery, phased return to work advised by OH	Trust Sickness Absence & Rehabilitation Policy & Procedure;											■				
		(iii) Extension of sickness absence on full pay							■									
	i) Study Leave:	(i) Medical staff study leave	Leave Policy			■			■									
		(ii) All other study leave												■				
	j) Grievance Procedure - All grievances cases must be dealt with strictly in accordance with the Grievance Procedure		Grievance Policy & Procedure						■									
	k) Authorised Mobile Device Users - Requests for new posts to be authorised as mobile telephone users		Mobile Phone & PDA Agreement													■		Subject to approval by Director of Technology and Transformation
	l) Renewal of Fixed Term Contract								■									
	n) Redundancy		Redundancy & Redeployment Policy & Procedure	■	■				■									Chief Executive and Remuneration Committee for senior staff
	o) Ill Health Retirement - Decision to pursue retirement on the grounds of ill-health								■									
	p) Dismissal		Disciplinary Policy & Procedures						■									
20. Authorisation of Sponsorship deals				■	■													Management Committee
21. Authorisation of Research Projects						■												Director of Research & Development
22. Authorisation of Clinical Trials						■												Director of Research & Development
23. Insurance Policies and Risk Management			SFI 18	■	■													
24. Patients & Relatives Complaints	a) Overall responsibility for ensuring that all complaints are dealt with effectively		Trust Policy and Procedure for the Management of Formal Complaints	■														Complaints Officer
	b) Responsibility for ensuring complaints relating to a department are investigated thoroughly											■	■					Relevant Director
	c) Management of the legal aspects of complaints			■														

Must authorise Either May Authorise

Reviewed annually by Director of Finance (and if necessary by the Board)

Delegated Matter			Reference documents & notes	Chief Executive	Finance Director	Medical Director	Director of Q&PE	Dir. of Education / Dean	Director of HR and Governance	Director of Strategy or AD of Contracts (as appropriate)	Director of HR and Governance	Directors of CYAF / AFS	Director of Technology and ransformation	Line / Dept Manager	Procurement Officer	Budget Holder	Petty Cash Holder	Other
25. Relationship with the media			Media Policy	■														Director of Marketing and Communications
26. Patient Services	Variation of clinic sessions			■								■	■					
27. Facilities for staff not employed by the Trust to gain practical experience	a) Professional Recognition, Honorary Contracts, & Insurance of Medical Staff.								■			■	■					
	b) Work experience students								■									
28. Review of fire precautions			Fire Safety Procedures										■					Health and Safety Manager and Fire Saefty Advisor
29. Review of all statutory compliance with legislation on health and safety			Health & Safety Policy										■					Health and Safety Manager
30. Review of *Medicines Inspectorate Regulations*						■												
31. Review of compliance with environmental regulations													■					Estates and Facilities Manager
32. Review of Trust's compliance with the *Data Protection Act*			Data Protection Policy										■					Director of Technology and Transformation
33. Review the Trust's compliance with the *Access to Records Act*			Trust Procedure for the Management of Health Care Records										■					Information Governance Lead.
34. Membership management and Governor elections			Constitution								■							
35. The keeping of registers for the *Declaration of Interests* , the register of members and the *Declaration of Independence*			Constitution, Annex 5								■							
36. Attestation of sealings in accordance with Standing Orders			BDSO 9	▒	▒													Or Officers nominated by CEO and FD
37. The keeping of a register of sealings, and reporting to the Board of Directors			BDSO 9								■							
38. The keeping of the *Gifts and Hospitality Register*			SFI 20								■							
39. Information Governance			SFI 17; Information Governance Policy										■					Data Security and Protection Manager; Senior Information Risk Owner; Caldicott Guardian
40. Clinical Governance						■	■											
41. Review of the Trust's compliance with Monitor's *Code of Governance*			Monitor's Code of Governance								■							
42. Review of the Trust's compliance with NHS Improvement's *Risk Assurance Framework*	a) Financial matters		Monitor's Compliance Framework		■													
	b) Governance declaration			■														
	c) Membership matters										■							
43. Review of the Trust's compliance with the *Codes of Conduct for the Board of Directors and the Board of Governors*			Board of Directors' Code of Conduct; Council of Governors' Code of Conduct								■							

Delegated Matter			Reference documents & notes	Chief Executive	Finance Director	Medical Director	Director of Q&PE	Dir. of Education / Dean	Director of HR and Governance	Director of Strategy or AD of Contracts (as appropriate)	Director of HR and Governance	Directors of CYAF / AFS	Director of Technology and ransformation	Line / Dept Manager	Procurement Officer	Budget Holder	Petty Cash Holder	Other
44. The review and keeping of the *Assurance Framework* and *Risk Register*	a) Strategic Risk Register																	Associate Director of Quality and Patient Experience.
	b) Operational Risk Register																	Associate Director of Quality and Patient Experience.

Must authorise Either May Authorise

Reviewed annually by Director of Finance (and if necessary by the Board)

Report to	Date
Board of Directors	November 2018

2017/18 Reference Costs

Executive Summary

This paper provides a summary of the 2017/18 Reference Costing Exercise.

This shows that the Trust has a Reference Cost Index of 103.

This indicates that the Trust's costs for delivering its clinical services is 3% higher than the national average. However, the Trust's performance is better than most other London providers.

Recommendation to the Board

The Board is asked to note the contents of the document and the approvals noted in section 3

Trust strategic objectives supported by this paper

Finance and Governance

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

2017/18 Integrated Reference Costs Collection Exercise

1. INTRODUCTION

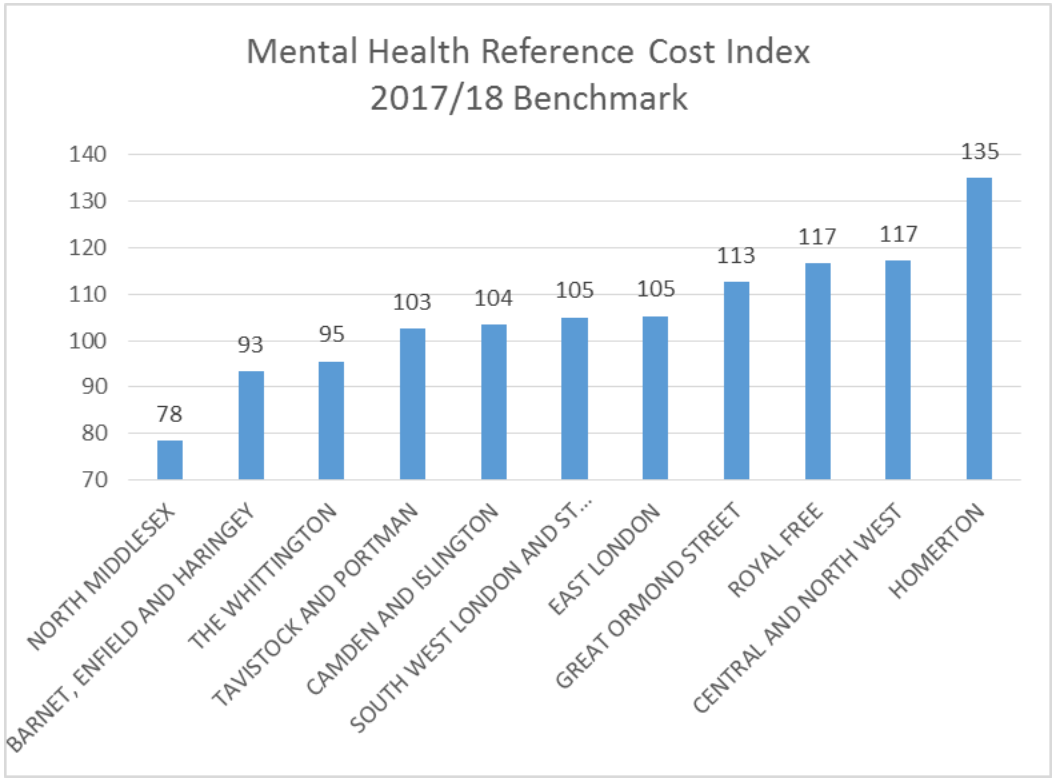
1.1. The Trust is required to submit Reference Cost data to NHSi on an annual basis.

1.2. The basis on which the submission is provided is to be approved by the Board (or a committee of the Board).

1.3. The 2017/18 submission was made on 6 September 2018 and was successfully validated by NHSi.

2. OUTCOME

2.1. The Trust's Reference Cost Index for 2017/18 is 103, which indicates that the Trust is 3% more expensive than the national average for the provision of its relevant clinical services. The table below compares the Trust with other London-based organisations delivering mental health services and shows that compared with its peer group, the Trust's costs for providing its services is better than most of its peer group.



3. APPROVALS

3.1. Whilst the Finance Director is responsible for the accurate completion of the submission, Reference Costing guidance requires that the Board (or appropriate sub-committee) formally confirms that:

- The return has been prepared in accordance with the approved costing guidance, which includes the combined costs collection guidance
- Information, data and systems underpinning the combined costs collection return are reliable and accurate
- There are proper internal controls over the collection and reporting of the information included in the combined costs collection, and these controls are subject to review to confirm that they are working effectively in practice
- Costing teams are appropriately resourced to complete the combined costs collection return, including the self-assessment quality checklist and validations, accurately within the timescales set out in the guidance.

3.2. And that, accordingly, the Finance Director may sign the declaration shown in the Appendix.

3.3. The Finance Director believes that it is appropriate for the Board to confirm the statements above.

4. PREPARATION OF RETURN

4.1. The Reference Cost Index is a reflection / measure of the efficiency of the Trust derived from comparing the expenditure incurred by the Trust for performing certain clinical activities.

4.2. The Trust's costing process is governed by the principles that costs are:

- Calculated on a full absorption basis in order to establish the full cost of services delivered
- Allocated and apportioned accurately by maximizing direct charging, and where this is not possible, using standard methods of apportionment
- Matched to the services that generate them to avoid cross subsidization.

5. Expenditure

5.1. The Trusts reference costs have been calculated using the principles set by Monitor with the three main steps in the calculation of the reference costs being:

- Reconciliation of the Trusts annual accounts to the reference costs expenditure to arrive at a reference cost quantum.
- Apportionment / allocation of costs and resources to the various clinical specialties that utilise them.

- Patient activity & care costing whereby costs are allocated to patients and average unit costs generated for the various services.

5.2. The reference cost quantum for 2017/18 is approximately £25.5m, which approximates to 50% of the Trusts total operating expenses. This is an overall increase on the prior year of 10%.

6. Activity

6.1. There are three patient-level activity feeds required for costing, being:

- Admitted patient care (APC)
- Non-admitted patient care (NAPC)
- Pharmacy.

6.2. The Trust only collects and reports activity on a Non-admitted patient care (NAPC) basis. The Trust's activity is collected and reported via Care Notes except for the Early Intervention Service (EIS) and Mosaic Center activity which are collected and reported separately.

6.3. Reported activity for attendances of children increased by 34% to 70,882 whilst adult cluster days declined by 18% to 447,350.

NOTES ON REFERENCE COSTS

1. The Reference Costing process is an attempt to create a comparable set of cost of treatment data for the Department of Health. This informs the Department's understanding of the costs of providing clinical service costs to NHS patients across the country.

2. Local commissioners can also make use of this data when contracts are due for re-negotiation.

What are Reference Costs?

3. Reference Costs are the average unit costs across the NHS of providing defined services in a given financial year. With regards to mental health services this is the average unit cost per patient cluster for adults (mandated from April 2012) and attendances for children (under 18 years).
4. The main uses of the Reference Cost are to:
   - Support the development of price setting;
   - Develop the scope and design of NHS currencies;
   - Inform payment by results tariffs nationally; and
   - Enable Trusts to benchmark their unit costs against the National average and other Trusts of similar size and settings.

Reference Costs Information

5. The information is presented in three ways:
   - National schedules of Reference Costs: these show the national average unit costs derived from the unit costs of NHS providers
   - NHSI's database of source data: this allows a more detailed analysis of organisation level costs.
   - Reference Cost Index (RCI): a measure of the relative efficiency of NHS providers.

The Reference Cost Index (RCI) & the Market Forces Factor (MFF)

6. The RCI enables a comparison of costs at the aggregate level for each NHS provider. The RCI shows the actual cost of an organisation's case mix compared with the same case mix delivered at national average cost.

7. An organisation with costs equal to the national average will score 100, with higher cost organisations scoring above 100 and lower cost organisations scoring below 100. For example, a score of 110 means that the costs are 10% above the average whilst a score of 90 shows costs are 10% below the average. The RCI is therefore a measure of relative efficiency.

8. The Market Forces Factor is an estimate of unavoidable cost differences between health care providers based on their geographical location. This is factored in when payments are made to NHS providers on an activity basis.

The Future: The Trusts Costing Transformation Process (CTP) or Patient Level Information and Costing Systems (PLICs)

1. Reference Costing is due to be replaced by Patient Level Information and Costing Systems (PLICs) from the financial year 2019/20.

2. Patient-level costing is defined by the ability to measure the resources consumed by individual patients.

3. The program includes:

    - Introducing and implementing new standards for patient level costing.

    - Developing and implementing one single national cost collection to replace current multiple collections.

    - Establishing the minimum required standards for costing software and promoting its adoption.

    - Driving and encouraging sector support to adopt Patient Level Costing methodology and technology.

4. A review of how the Trust integrates activity data collection and financial data is taking place during the remainder of this financial year.

5. An understanding of clinical time taken to deliver to each cluster will be key.

6. Electronic data collection and control checks will need to be developed to improve the quality of data collection.

7. The intention will be to set up the infrastructure and the training required during 2018-19.

Appendix

Statement of directors' responsibilities for the 2017/18 combined costs collection

In producing the annual combined costs collection return the provider must include a statement of the finance director and education leads responsibilities.

This should be kept on site and made available if external auditors request it, in the following form of words:

NHS Foundation Trusts are required in accordance with the NHS Provider License to comply with NHS Improvement's approved costing guidance in the completion of the combined costs collection. In preparing the combined costs collection return the board or relevant sub-committee is required to take steps to satisfy themselves that:

- the cost return has been prepared in accordance with the approved costing guidance, which includes the combined costs collection guidance
- the information, data and system underpinning the return are reliable and accurate
- there are proper internal controls over the collection and reporting of the information included in the combined costs collection, and these controls are subject to review to confirm that they are working effectively in practice
- costing and E&T teams are appropriately resourced to complete the return, including the self-assessment quality checklist and validations, accurately within the timescales set out in the reference costs guidance
- The content of the return is not inconsistent with internal and external sources of information.

The Finance Director confirms to the best of their knowledge and belief the Board has discharged its responsibilities above and the trust has complied with these requirements in preparing the combined costs collection return.

By order of the board

NB: sign and date in any colour ink except black

.....Date.....Finance Director

Report to	Date
Board of Directors	27 November 2018

Board Assurance Framework

Executive Summary

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

There are four risks rated 12. Risks 2, 4, 9 and 12. Risks 4 'Risk that the Trust fails to deliver affordable and appropriate Estates solutions' and 12 'Risk that the Trust fails to deliver its financial plan' were reviewed by the Executive Management Team in September with a reduction in the risk level from 16 to 12. Changes to Risk 4 were as a result of revised and updated policies being in place and Risk 12 changes followed a reforecasting of full year out-turn.

The other two risks rated 12 are: Risk 2, 'that pressures on leadership within the organisation impact negatively on staff morale and engagement' and Risk 9, 'reconciling tension between demand and resources in gender services'.

There has been a reduction in current risk scores for Risks 7, 8 and 10 from 12 to 9. Risks 7 and 8 also reduced Target risks scores from 9 to 6.

The BAF is brought to the Board in November as part of the quarterly reporting timings, having been updated and reviewed by the Executive Management Team on 13th November 2018.

Recommendation to the Board

The board is asked to note the board assurance framework

Trust strategic objectives supported by this paper

All Trust Strategic Objectives

Author	Responsible Executive Director
All Directors, AD Quality & Governance	Deputy Chief Executive & Finance Director

BOARD ASSURANCE FRAMEWORK

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	9 – 12	Amber
5 – 8	Yellow	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 the BAF and confirmed the **initial/ current risk** scores for each risk

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

3. RISK SUMMARY [to be updated once risk information completed]

3.1. Risk 12, 'Failure to comply with regulatory requirements' has increased from 4 to 15 from the previous quarter owing to 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' , Risk 15, 'Longer term risk to the sustainability of the Trust' and now also Risk 12, 'Failure to comply with regulatory requirements' are top three risks.

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

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.

NOVEMBER BAF HEAT MAP

Likelihood							
	Almost certain to occur	5					
	Likely to occur	4			8,9,10		
	Could occur	3			1,6, 7	2,4, 5, 12	
	Unlikely to occur	2				3,11	
	Very unlikely to occur	1					
Risk Matrix			1 Negligible	2 Minor	3 Moderate	4 Severe	5 Extreme
			Consequence				

JULY BAF HEAT MAP

Likelihood							
	Almost certain to occur	5					
	Likely to occur	4			7,8,9,10	4,12	
	Could occur	3			1,6	2,5	
	Unlikely to occur	2				3,11	
	Very unlikely to occur	1					
Risk Matrix			1 Negligible	2 Minor	3 Moderate	4 Severe	5 Extreme
			Consequence				

Board Assurance Framework 2018/19 – Summary

				Current Risk Score				
	Risk	**Owner**	**Strategic Aims**	**July 2018**	**Nov 2018**	**Mar 2019**	**May 2019**	**Target Risk** L = likelihood C= consequence Risk = L x C
1	The risk that the Trust fails to raise its profile as an authority on workforce issues impacting on external reputation and the future viability of the National Training Contract with Health Education England	Chris Caldwell	People	9 (3x3)	9 (3x3)			**Green (1x3)**
2	The risk that pressures on leadership within the organisation impact negatively on staff morale and engagement with consequences for the delivery of the Trust's strategic objectives and the quality of its current services.	Craig de Sousa	People	12 (3x4)	12 (3x4)			**Yellow (2x4)**
3	The risk that the Trust fails to deliver the commitments of its Race Equality Strategy with a negative impact on staff	Louise Lyon	People	8 (2x4)	8 (2x4)			**Green (1x4)**

				Current Risk Score				
	Risk	**Owner**	**Strategic Aims**	**July 2018**	**Nov 2018**	**Mar 2019**	**May 2019**	**Target Risk** L = likelihood C= consequence Risk = L x C
	engagement and the quality of its services.							
4	The risk that the Trust fails to deliver affordable and appropriate Estates solutions with a negative impact on patient, staff and student experience.	Terry Noys	People	16 (4x4)	12 (3x4)			**Yellow (2x3)**
5	The risk that there is insufficient staff capacity with negative consequences in relation to quality of current activities or the ability to bid for and deliver future developments.	Julian Stern/ Sally Hodges/ Brian Rock	Services	12 (3x4)	12 (3x4)			**Yellow (2x4)**
6	The risk that issues with the quality use of data impact on decision making and the quality and effectiveness of the Trust's services.	David Wyndham Lewis	Services	9 (3x3)	9 (3x3)			**Yellow (2x3)**
7	The risk that wider financial pressures in North Central London with consequences for the delivery of the mental health programme in the STP	Paul Jenkins	Services	12 (4x3)	9 (3x3)			**Yellow (2x3)**

				Current Risk Score				
	Risk	**Owner**	**Strategic Aims**	**July 2018**	**Nov 2018**	**Mar 2019**	**May 2019**	**Target Risk** L = likelihood C= consequence Risk = L x C
	and the delivery of the Trust's wider objectives							
8	The risk that Trust does not have skill sets or capacity to deliver new business development opportunities with negative consequences for future income growth and sustainability.	Rachel Surtees	Growth	12 (4x3)	9 (3x3)			**Yellow (2x3)**
9	The risk that it is not possible to reconcile tension between demand and resources in respect of gender services with consequences for safety and patient experience.	Sally Hodges	Growth	12 (4x3)	12 (4x3)			**Amber (3x3)**
10	The risk that the pressure of reactive communications work means that the Trust lacks capacity to deliver the External Affairs Strategy, failing to raise its external profile on the range of issues where it aims to influence public policy	Laure Thomas	Growth	12 (4x3)	9 (3x3)			**Yellow (4x2)**

				Current Risk Score				
	Risk	**Owner**	**Strategic Aims**	**July 2018**	**Nov 2018**	**Mar 2019**	**May 2019**	**Target Risk** L = likelihood C= consequence Risk = L x C
11	The risk that the Trust fails to meet its regulatory responsibilities to CQC and QAA with negative consequences for our reputation and the quality of patient and student experience.	Louise Lyon Brian Rock	Finance / Governance	8 (2x4)	8 (2x4)			**Green (1x4)**
12	The risk that the Trust fails to deliver its financial plan with negative consequences for the delivery of our Control Total and an impact on the quality of our services.	Terry Noys	Finance / Governance	16 (4x4)	12 (3x4)			**Yellow (2x4)**

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

Strategic Aim: People

Corporate Objectives:

1. Position the Trust as a respected authority on workforce development: **Director of Nursing**
2. Implement the People Strategy with the aim of supporting the resilience, development and performance of our staff: **Director of HR and Governance**
3. Implement the Race Equality Strategy: **Director of Quality and Patient Experience**
4. Develop our Estates to deliver the right Estates solution for the work of the Trust: **Director of Technology and Transformation / Deputy CEO**

RISK 1): *The risk that the Trust fails to raise its profile as an authority on workforce issues impacting on external reputation and the future viability of the National Training Contract with Health Education England.*	
Risk Owner: Chris Caldwell	Date reviewed: November 2018
INITIAL risk rating (at identification): Likelihood 3 x Consequence 3 = 9 CURRENT risk rating: Likelihood 3 x Consequence 3 = 9	
Rationale for current score: • The NWSDU and National MH Workforce Development Collaborative are remain in the early stages of development • The Collaborative is being evaluated well by those attending and has delivered some early positive work, member participation is appropriately interest based in working groups but engagement can be variable at Steering group level. • The NWSDU is attracting positive interest and early project outputs are being well received by the HEE National Mental Health, LD & Dementia Board and associated delivery group • The implementation of the MH workforce Strategy at national regional and STP level is at early stages and there are still significant financial challenges and uncertainties potentially impacting against its successful delivery albeit that locally and regionally there is good engagement and significant service improvement and expansion has now begun • National Training Contract (NTC) is annual and HEE have funding pressures which may impact on this, this impact may be wider than just the work and future of the NWSDU	

Controls/Influences *(what are we currently doing about this risk?)*:	Assurances received *(independent reports on processes; when; conclusions)*:
Effective governance coms and engagement strategies and process in place Trust represented at key groups nationally regionally and locally (STP) in relation to MH Workforce strategy and FYFV implementation Processes to monitor impact in place PDC monitors NWSDU project plans monthly HEE steering group established (2-8 times per year) Regular Review of Collaborative performance Refreshed approach to NTC management and monitoring	NWSDU Steering Group with HEE now established to ensure effective governance, engagement and buy in at national level & membership of all appropriate groups/committees (+) Strategy launched for NWSDU (including the Collaborative) with Communications workshop run, website launched and conference planned for Spring (+) NWSDU project plans in place with risks and milestones (+) HEE steering group minutes (+)
Gaps in controls/influences: Early stages of work Limited outputs to communicate Competing pressures on people resources in Trusts and Collaborative limiting activity Mechanisms for measuring impact of STP work still being established nationally Impact of NHSI / HEE closer working and potential changes in strategy and priority with impact on NTC currently unknown Impact of the NHS LTP is currently unknown	Action plans in response to gaps identified: *(with lead and target date)* Negotiation of National Training Contract – scheduled meetings – Autumn / Spring (Contracts team March 19) Developing rollout of national training roadshows in collaboration with lead commissioner & identified regional contacts – (Karen Tanner FY19/20) National Mental Health Workforce Conference (IJT Spring 2019 Collaborative and NWSDU communications strategies and plans (IJT Autumn 2018) Delivery of conference (Spring 2019) Direct engagement with ALBs on NHS Long term plan to raise profile (Autumn 2019)

RISK 2): *The risk that pressures on leadership within the organisation impact negatively on staff morale and engagement with consequences for the delivery of the Trust's strategic objectives and the quality of its current services.*	
Risk Owner: Paul Jenkins/Craig de Sousa	Date reviewed: November 2018
INITIAL risk rating (at identification): Likelihood 3 x Consequence 4 = 12 CURRENT risk rating: Likelihood 3 x Consequence 4 = 12	
Rationale for current score: There are continuing signs through the NHS Staff Survey and from feedback from our staff there continues to be work based pressure which is resulting in stress and a long hours working culture.	
Controls/Influences *(what are we currently doing about this risk?)*: OD and People Strategy Implemented Localised actions plans following each staff survey Leadership Development Programmes launched to improve capacity, capability and resilience Business Development Group established to provide structured oversight of growth opportunities. Quality improvement programme launched. Quality Impact Assessments launched at directorate and service level. Revised appraisal process linked to corporate objectives. Reducing the burden programme launched	Assurances received *(independent reports on processes; when; conclusions)*: NHS Staff Survey 2017 (+ /-) Quarterly Friends and Family Test Results (+) Quarterly HR & OD Assurance Reports (+)

Gaps in controls/influences:	Action plans in response to gaps identified: *(with lead and target date)*
Capacity to engage with structured development. ~~Increased activity through regulatory inspection regime.~~ Succession plans to cope with long periods of absence at service director level.	OD and People Strategy – **HR Director** – 2020 Staff survey action plans – **All Directors** – 2018 Staff Education Programme – **HR Director** – 2018

RISK 3): *The risk that the Trust fails to deliver the commitments of its Race Equality Strategy with a negative impact on staff engagement and the quality of its services.*	
Risk Owner: Louise Lyon	Date reviewed: November 2018
INITIAL risk rating (at identification): Likelihood 2 x Consequence 4 = 8 CURRENT risk rating: Likelihood 2 x Consequence 4 = 8	
Rationale for current score: The Race Equality Strategy was approved by the Board in September 2017. Whilst good progress has been made in delivering on the action plan, we will fail to deliver if we do sufficiently engage staff at all levels, especially white staff currently occupying the more senior positions, in understanding the strategy and implementing those elements which are within their responsibility and authority to do so. Consequence is rated at 4 because if the Trusts fails deliver, BAME staff will lose confidence that the trust is fully committed to equality which could lead to BAME staff disengagement and all staff may lose confidence in management's capacity and integrity which could impact negatively on service delivery	
Controls/Influences *(what are we currently doing about this risk?)*:	Assurances received *(independent reports on processes; when; conclusions)*:

Implementation of the Race Equality Strategy is monitored at the Equality Diversity and Inclusion Committee Race Equality Champion appointed and BAME network established: regular communication between the Champion and the Director of Quality and Patient Experience and the Director of HR provides feedback on the implementation as the Strategy is under review in the BAME network	Workforce Race Equality Standard annual report (+/−) Staff survey (−) CQC informal report noted that staff remained unconfident about progress (−)
Gaps in controls/influences: Further training for managers who have attended Think Space events to ensure clarity about action necessary to implement the strategy at local level	Action plans in response to gaps identified: *(with lead and target date)* Develop training plan for managers, (Director of HR and Governance, October 2019) RES reviewed at Board seminar attended by Board, Management Team BAME champion and further action agreed at Management Team. EDI to review progress at November Committee meeting. Revised action plan to be drawn up (January 2019)

RISK 4): *The risk that the Trust fails to deliver affordable and appropriate Estates solutions with a negative impact on patient, staff and student experience.*	
Risk Owner: Terry Noys ~~/ David Wyndham Lewis~~	Date reviewed: 9 November 2018
INITIAL risk rating (at identification): Likelihood 4 x Consequence 4 = 16 CURRENT risk rating: Likelihood 3 x Consequence 4 = 12	

Rationale for current score: Score reflects balance of short, medium and long term issues. Long term Relocation is looking less probable, whilst remaining at the Tavistock Centre brings its own challenges in terms of health and safety; maintenance back-log; and possible refurbishment / reconfiguration. Need for Scheduling project to succeed and need to overcome cultural inhibitors if real progress to be made. Also challenge around accommodation for Gender Identity Clinic and other activities located in satellite sites.	
Controls/Influences *(what are we currently doing about this risk?)*: Relocation project in train. Asset / stock condition surveys in place. Scheduling Project in train. Revised / Updated policies on Health & Safety, Fire Safety and Water Safety in place	Assurances received *(independent reports on processes; when; conclusions)*: Asset / stock condition surveys in place. (+) Relocation Programme Board reports to main Board (+ / -)
Gaps in controls/influences: Affordability of Relocation still being evaluated. Extent of compliance shortfall still not wholly clear Affordability of solutions for GIC	Action plans in response to gaps identified: *(with lead and target date)* Further work around Relocation 'de minimis' option plus examination of possible alternate financing. ***TN, March 2019*** Authorising engineers reporting on compliance on fire / water / mechanical & electrical systems. ***Ian Garlington, Oct 2018*** GIC Accommodation Task and Finish Group. ***Ian Garlington, June 2019***

Strategic Aim: Services

Corporate Objectives:

5. Implement the Clinical Quality Strategy: **Director of Quality and Patient Experience**
6. Strengthen our collection and use of data to inform decision making and improve the effectiveness and quality of our services: **Director of Quality and Patient Experience**
7. Extend existing and develop new services in AFS/ CYAF /DET to respond to changing demand / new opportunities including, where appropriate, the use of technology: **Director of AFS; Director of CYAF; Director of DET**
8. Contribute to the development of North London Partners in Health and Care: **CEO**

RISK 5): *The risk that there is insufficient staff capacity with negative consequences in relation to quality of current activities or the ability to bid for and deliver future developments.*	
Risk Owner: Julian Stern/Sally Hodges/Brian Rock	Date reviewed: July 2018
INITIAL risk rating (at identification): Likelihood 3 x Consequence 4 = 12 CURRENT risk rating: Likelihood 3 x Consequence 4 = 12	
Rationale for current score: The environment that the Trust is operating within is constrained financially and has high expectation requirements to deliver against commissioner orientated performance standards. Added with the Trust's ambition to grow and concurrently undertake transformational change is putting pressure on staff at all levels across the organisation to balance delivering business as usual and to pursue growth.	
Controls/Influences *(what are we currently doing about this risk?)*: Clinical quality strategy to set out the direction of travel. Strengthen business development functions to conduct due diligence and support growth in a planned way.	Assurances received *(independent reports on processes; when; conclusions)*: HR & OD Quarterly Assurance Report (+ -) Finance and Performance Report Monthly (-) Quality Dashboard (+)

Established a business development group to provide operational oversight to growth and contract maintenance. Established directorate executive teams (AFS, CYAF and DET) to operationally manage challenge. Appointment to DET senior management role with Nov 2018 start date focusing on increased delivery of existing and development of new product areas Board Awayday focused on preferred growth areas to enable directors to plan ahead for capacity	Waiting Times Report (+ -)
<u>Gaps in controls/influences</u>: Staff survey results highlight continued pressure on staff Gaps within the cost improvement programmes	<u>Action plans in response to gaps identified</u>: *(with lead and target date)* Reducing the Burden Programme – *this is currently being actioned under the Quality and Patient Experience Directorate , December 2018* DET Task and Finish Group focusing on changes to the delivery model for long course provision to reduce cost base and review course profitability including fee reviews. AY19/20 focussed on increasing group sizes and introducing Associate Lecturer roles. ***Brian Rock / Terry Noys – AY 2019/20***

RISK 6): *The risk that issues with the quality use of data impact on decision making and the quality and effectiveness of the Trust's services.*	
Risk Owner: David Wyndham Lewis	Date reviewed: November 2018
INITIAL risk rating (at identification): Likelihood 3 x Consequence 3 = 9 CURRENT risk rating: Likelihood 3 x Consequence 3 = 9	
Rationale for current score: The Trust Board has received reports over an extended period that indicate a perception that poor data quality is proving a challenge to delivery of operational objectives, as well as limiting the opportunity for detailed understanding on existing performance of Trust services as a means of both performance management and quality improvement. Initial investigations, summarised as a paper to be presented to EMT in July 2018, indicate that there are challenges at each stage of the clinical pathway. Equally the implementation of MyTAP is highlighting similar issues present in our education and training services. Initial investigations indicate the primary cause for the data quality issues is unwarranted variation in practice in both clinical directorates and DET.	
Controls/Influences *(what are we currently doing about this risk?)*: Ongoing monitoring and reactive improvement works undertaken by the Data Quality Team for clinical data. Ongoing monitoring and reactive improvement works undertaken by the Contracts Team for performance management covering clinical directorates. Interim improvements to management and consistency of reports made available by Informatics team to Trust using existing legacy data warehouse.	Assurances received *(independent reports on processes; when; conclusions)*: Initial data quality report created for presentation to EMT in July 2018 (+) Documentation of problem areas, including indication that most are already subject to some iterative improvement work being led by Data Quality Team (+)

Data Quality Project commissioned and initial report on problem areas produced. ~~Third party commissioned to review existing data sets to validate findings of the internal report.~~	HESA have now declared our submission credible and signed off the data so we have successfully completed the return within the deadline (Nov 2018) (+)
Gaps in controls/influences: Data Quality Improvement Project ongoing and focussed primarily on clinical activity. While problem areas are highlighted and an approach where remediation is achieved vertically by clinical team rather than horizontally across the organisation, no structured work streams have started. Work commencing to review practice and data quality within MyTAP to understand where issues exist within DET. This will be associated to the HESA and HESIS reporting currently required and evolving as we move from HEFCE to OfS.	Action plans in response to gaps identified: *(with lead and target date)* Data Quality Improvement Project – third party review of data complete and action plan / project initiations signed off by EMT (November 2018). Note that third party review is no longer seen as immediately valuable, hence this action will complete with the full initiation of the project including brief and milestones). Completion of agreed projects for clinical activity (TBC in Project Brief and Milestones) Initial review of DET data for HESA return linking with internal audit by Essex (underway) (December 2018)

RISK 7): The risk that wider financial pressures in North Central London with consequences for the delivery of the mental health programme in the STP and the delivery of the Trust's wider objectives	
Risk Owner: Paul Jenkins	Date reviewed: November 2018
INITIAL risk rating (at identification): Likelihood 4 x Consequence 3 = 12 CURRENT risk rating: Likelihood 3 x Consequence 3 = 9	
Rationale for current score: Wider financial pressures across the STP have impacted negatively on resources available to deliver mental health priorities within the STP. Funding pressures experienced by all CCGs across the patch with Camden particularly affected by the	
Controls/Influences *(what are we currently doing about this risk?)*: Strong engagement with the STP with CEO as SRO for Mental Health Work close with partner provider organisations Modified Delivery Plan for focus on areas of greatest priority Focus on collecting evidence across workstreams to show positive economic impact of mental health interventions Understanding future ambitions/plans for organisational change to support integrated working	Assurances received *(independent reports on processes; when; conclusions)*: Updated MH Delivery plan (+) Close to securing agreed way forward on MH Liaison (+) Recruitment underway for nurse led Crisis Service (+) Report of simulation event for integrated working in NCL(+)
Gaps in controls/influences: Decisions of the regulators	Action plans in response to gaps identified: *(with lead and target date)* Task and Finish Group on MH Liaison – Autumn 18 Action plans on CAMHS crisis provision and local commissioning of Tier 4 – Autumn 18

RISK 8): *The risk that Trust does not have skill sets or capacity to deliver new business development opportunities with negative consequences for future income growth and sustainability.*	
Risk Owner: Rachel Surtees	Date reviewed: November 2018
INITIAL risk rating (at identification): Likelihood 4 x Consequence 3 = 12 CURRENT risk rating: Likelihood 3 x Consequence 3 = 9	
Rationale for current score: The profile of Trust services is such that we should anticipate a year-on-year financial short fall which will need to be met securing new business development opportunities. Converting new business prospects into full credible proposals requires high levels of resource from Business Development and clinical/DET teams. Clinical and DET staff have limited dedicated development sessions, meaning work towards the growth agenda needs to be fitted in 'on top of the day job'. For tendered opportunities in particular, resource needs to be made available at short notice to be able to meet externally driven deadlines. An area being actively explored is the development of new revenue streams through the commercialisation of 'products' developed through our services or courses. The Trust does not have the in-house skill sets to lead commercial contract or partnership negotiations in relation to IP; revenue/royalty shares etc. If identified as a viable major growth area this will need to be addressed, however, 'new product sales' are not currently being considered in the new business income forecasts. Implementation of new services is managed through the Business Development team and is a resource intensive process generally lasting ~6 months. Every 'win' therefore reduces BD capacity to maintain the new business pipeline as resource is diverted to support service mobilisation. Experience and skills in CYAF, AFS and DET to support business development opportunities is typically held by the senior management teams. Limited capacity remains a risk, but is currently slowing the rate of growth as opposed to blocking growth.	

Controls/Influences *(what are we currently doing about this risk?)*: -Active management of pipeline to have even spread of prospects across the three directorates and at different stages of development (prospect development; proposal writing; in implementation). -Regular discussion and review of individual prospects and overall pipeline at Business Development Group (BDG). -Developing strategic development plan to enable better focus and prioritisation on our target routes to growth. -Moving away from a culture of pursuing high numbers of smaller prospects that deliver incremental gains, to focus on larger or scalable opportunities	Assurances received *(independent reports on processes; when; conclusions)*: Pipeline report to Business Development Group on a monthly basis and SaCC on quarterly basis (+/-) Contribution forecast report to Business Development Group on a monthly basis and SaCC on quarterly basis (+/-) Regular Business Development representation at CYAF; AFS & DET Executive Management Team meetings (+/-)
Gaps in controls/influences: Maintaining the pace of the pipeline means there is very limited capacity in the Business Development Team to find opportunities to diversify the income base and reduce the Trust's reliance on tendered services. Increasingly fewer opportunities to 'free up' CYAF; DET or AFS staff without impacting clinical/training delivery. Pipeline heavily impacted by external factors outside of the Trust's control.	Action plans in response to gaps identified: *(with lead and target date)* -Creating processes to support more active linking of external policy environment to identified priority growth areas to give earlier sight of where capacity needs to be found – Rachel Surtees (Oct 18) -Overhauling all BD processes from prospect identification and pipeline management, to decision making and due diligence – Rachel Surtees (Dec 18) -Identifying staff from clinical and DET working in key growth areas who could be trained and supported to take up more active role working with BD – Sally Hodges; Julian Stern; Brian Rock (Nov 18) -Identified staff to be trained and supported for active role with BD – Rachel Surtees (March 19)

Strategic Aim: Growth and Development

Corporate Objectives:

9. Develop the Trust's position in national and transnational education including the launch of a Digital Academy: **Director of DET**
10. Develop an effective model for systemic support for organisational wellbeing and secure its implementation in at least one setting: **CEO**
11. Respond to the national procurement of gender identity services with the aim of establishing the Trust as an international centre of excellence for gender work: **Director of CYAF; Director of Strategy**
12. Implement our social investment model for FDAC and explore other opportunities for innovative financing of our services: **CEO**
13. Raise our public profile as a thought leader and influencer in line with our External Affairs Strategy and building on the outputs from research: **Director of Communications and External Affairs**

RISK 9): *The risk that it is not possible to reconcile tension between demand and resources in respect of gender services with consequences for safety and patient experience.*	
Risk Owner: Sally Hodges	Date reviewed: 7 November 2018
INITIAL risk rating (at identification): Likelihood 4 x Consequence 3 = 12 CURRENT risk rating: Likelihood 4 x Consequence 3 = 12	
Rationale for current score: Referrals are still coming into both Gender Services at a rate and number greater than predicted and therefore funding has continued to be less than required to meet access targets A focus on achieving first appointments (reducing wait times), particularly in the adult gender service, has put huge pressure on the service leading to increasing length of time between appointments. This has increased risk as we cannot ensure continuity and smooth process through the service. In the children's service, the profile of children and young people has shifted, meaning that increased resources need to go into managing risk, putting further pressure on the growing waitlist.	

Controls/Influences *(what are we currently doing about this risk?)*: For GIDS; running waiting list groups, providing as much information about waiting list services as possible, communicating regularly with NHS England about the issues, developing telemedicine approaches, building the research basis about outcomes to better inform practice going forward. NHS E will be allocating a resource to GIDS from December to look at all possible influences as they consider how best to support the service with this. For GIC; Running information workshops for patients on the waiting list, providing information on the website and communicating regularly with NHSE about the issues. Weekly review of referrals to both services to identify changes to profiles	Assurances received *(independent reports on processes; when; conclusions)*: Board oversight of the waiting list with a regular report (+/-) Quarterly meetings with NHSE (+/-) Both services have regular governance meetings (+/-) The Service manager in both services reviews the referral numbers and rates on a weekly basis in order to ensure early identification of any change in profile of referrals (+/-)
Gaps in controls/influences: Numbers of referrals continue to rise, with no possibility of determining when flow may reduce Profile of children and young people referred is increasingly risky Staff leaving the service on a regular basis reduces the capacity Recruiting and training also reduces capacity over a significant period Current focus on the service through the service review and media interest is taking up additional resources.	Action plans in response to gaps identified: *(with lead and target date)* -The service is working closely with local CAMHS to improve capacity to manage risk - Service Director and CYAF Director (ongoing) -Work with NHSE to develop training programmes to ensure greater recruitment field - Service Director and CYAF Director -Both services have an ongoing recruitment programme. GIDS over recruits because of the recent profile of staff turnover GIDS and GIC Directors (Ongoing) -Additional leadership and ongoing communications support to the team is in place (ongoing)

RISK 10): *The risk that the pressure of reactive communications work means that the Trust lacks capacity to deliver the External Affairs Strategy, failing to raise its external profile on the range of issues where it aims to influence public policy*	
Risk Owner: Laure Thomas	Date reviewed: November 2018
INITIAL risk rating (at identification): Likelihood 4 x Consequence 3 = 12 CURRENT risk rating: Likelihood 3 x Consequence 3 = 9	
Rationale for current score: The discourse around trans issues is becoming increasingly toxic and the discussion around the GRA review are reinforcing divides between two seemingly warring factions. None of this discourse helps our patients or their families and we have a duty to remain thoughtful and mindful of the strength of feelings in this area. Both 'sides' are at once critical of our work and seeking to co-opt our comments to suit their ends. There is a concern that elements of the trans community may not support us running gender services nationally or a national unit and share their views with commissioners. The uncertainty around the future of the FDAC NU is threatening our capacity to press ahead with documentary plans.	
Controls/Influences *(what are we currently doing about this risk?)*: Developing a Gender Communications Strategy, including stakeholder engagement. Keeping all relevant internal parties and stakeholders sighted on new and emerging gender-related issues, & adopting a thoughtful approach to comms. Direct communications lines established between FDAC London, Coventry and the Trust. Speaking to other production companies about other topics.	Assurances received *(independent reports on processes; when; conclusions)*: Taking part in GIDS sounding board. Working closely with commercial team on tenders. Reporting back to External Affairs Committee. Gender Recognition Act (GRA) consultation response submitted to Government.

Gaps in controls/influences:	Action plans in response to gaps identified: *(with lead and target date)*
Ensuring all staff (mainly across gender services) are aware of lines and plans and do not comment publicly on gender related issues. Loss of expertise, links and support when FDAC NU closes at the end of Sept 2018.	Gender communications strategy to be developed (M Smith ~~Sept~~ December 18)

Strategic Aim: Finance and Governance

Corporate Objectives:

14. Continue to meet regulatory standards with QAA: **Director of DET**
15. Continue to meet regulatory standards with CQC: **Director of Quality and Patient Experience**
16. Meet our Control Total for 2018/2019: **Director of Finance**
17. Develop the Governance and leadership of the Trust, implementing effectively the review of Board Business: **CEO**

RISK 11): *The risk that the Trust fails to meet its regulatory responsibilities to CQC and QAA with negative consequences for our reputation and the quality of patient and student experience.*	
Risk Owner: Louise Lyon/Brian Rock	Date reviewed: November 2018
INITIAL risk rating (at identification): Likelihood 2 x Consequence 4 = 8 CURRENT risk rating: Likelihood 2 x Consequence 4 = 8	
Rationale for current score: For CQC, compliance is regularly monitored internally but potential gaps have emerged in the course of more detailed preparation for inspection which it may not be possible to address before the inspection is completed in September 2018. Failure in compliance with CQC standards would raise serious questions about the safety and quality of our services which would in turn undermine public confidence and negatively impact on our reputation. For QAA, compliance is monitored through annual monitoring visits through reviewing progress our QAA action plans. Student engagement is a key influencer here, so the monitoring and addressing of areas of satisfaction and improvement through our annual student survey is another important area. Institutional reviews conducted by our university partners contribute to our understanding of	

areas of positive performance and areas requiring improvement. Concerns in relation to the QAA requirements would undermine confidence in our educational provision and negatively impact our reputation.	
Controls/Influences *(what are we currently doing about this risk?)*: We completed a well-led assessment in line with CQC/NHSI guidance and developed action plans to address identified gaps. ~~We have employed a CQC compliance manager to prepare clinical teams and the senior management team for inspection through review of our current arrangements to ensure compliance with CQC standards and to recommend remedial action where required.~~ We are actively working through on our action plans from our QAA review and have established plans from recent university partner institutional reviews (Essex and UEL). Annual student survey completed and is being reported through Education 7 Training Committee in December 2018. Early indications are positive with high levels of student engagement.	Assurances received *(independent reports on processes; when; conclusions)*: Work streams reporting to the Board level Clinical Quality Safety and Governance Committee provide assurance of compliance and raise issues of risk to compliance with CQC(+) Informal CQC rating Good overall, Outstanding Effective. All other ratings are good in all areas with Requires Improvement in gender services for Responsiveness because of waiting times Excellent outcome from 2018 QAA monitoring visit (+) Positive university partner institutional reviews commending course provision and faculty expertise and commitment (+) HESA have now declared our submission credible and signed off the data so we have successfully completed the return within the deadline (Nov 2018) (+) MyTaP triple upgrade successful with implementation of system developments (+)

Gaps in controls/influences:	Action plans in response to gaps identified: *(with lead and target date)*
Risk management maturity Information flow from bottom to top/ top to bottom of the Trust HESA data processes and reporting requires improvement to satisfy university partner and Office for Students (OfS) requirements.	Continue to roll out risk management training across the trust to embed risk management culture, Associate Director of Quality and Governance, ongoing – completion Nov 2018 Information flow review and clarification, Medical Director and Associate Director of Quality and Governance (Sept 18) Data warehouse capabilities being scoped to support HESA data returns through more timely reporting to drive operational compliance – Brian Rock / David Wyndham-Lewis (Dec 18)

RISK 12: *The risk that the Trust fails to deliver its financial plan with negative consequences for the delivery of our Control Total and an impact on the quality of our services.*	
Risk Owner: Terry Noys	Date reviewed: 9 November 2018
INITIAL risk rating (at identification): Likelihood 4 x Consequence 4 = 16 CURRENT risk rating: Likelihood 3 x Consequence 4 = 12	
Rationale for current score: Budget for 2018/19 assumes vacancy factor of £0.9m, contribution from 'new' income sources of £0.7m and savings in DET of £0.3m. Each of these was considered a challenging but achievable goal. In the period to date, DET has not yet achieved its savings target and there is some risk over existing income, notably £0.2m for TAP. A review of historic trends suggests additional new income should flow in Q3 and Q4	
Controls/Influences *(what are we currently doing about this risk?)*: Board approved Budget (setting out key assumptions) Management accounts reviewed monthly by EMT and Board Regular reforecasting of full year out-turn Business Development Group and Strategic and Commercial Committee review new business pipeline	Assurances received *(independent reports on processes; when; conclusions)*: Management accounts reviewed monthly by EMT and Board (+ / -) Reforecast out-turn reviewed by EMT and Board (+ / -) Reports by DET Task and Finish Group (+ / -)
Gaps in controls/influences: DET savings target not yet achieved Uncertainty over income from TAP	Action plans in response to gaps identified: *(with lead and target date)* Full year reforecast to be undertaken (TN: Nov 2018) Additional controls placed around recruitment (CdS) Additional income opportunities being sought (RSt)

The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Board of Directors	27 November 2018

Operational Risk Register

Executive Summary

Operational risks graded 9+, exceptions and new risks are brought to the attention of the Board. All changes are highlighted in Red.

Both the Estates and Facilities and Information Management Technology risk registers have been migrated across to the Trust template in preparation for migration to the new electronic risk register. Further updating and validation continues across all operational risks. It is anticipated the new module will be live by the end of the calendar year, with migration and training to follow in the new year.

There are now 105 risks on the Operational Risk Register of which 34 have a current risk level of 9-12 and 6 have a risk level 15-25. This includes two new FNP risks which were added in November 2018 with risk levels of 20.

Risks changes include:

- New risk: Risk 113 FNP, new information system
- New risk: Risk 114 FNP, Service procurement contract
- Risk 40 relating to the waiting list for PCPCS services has now closed. A new contract with commissioners has set a more realistic number of expected patients with agreed new referral criteria.
- Risk 84 relating to completion of the M&E Survey is now closed
- Ten risks have reduced risk ratings as follows:
    - Risk 33 Clinical trainee supervision 6 to 4
    - Risk 88 Workload planning issues (estates) 15 to 9
    - Risk 93 Disruption of services due to E&F work 16 to 9
    - Risk 98 Asbestos 10 to 8
    - Risk 99 Electricity 10 to 8
    - Risk 100 Gas 10 to 8
    - Risk 101 Absence of standby generation 10 to 5
    - Risk 102 Lifts 10 to 8
    - Risk 103 Reception services 10 to 8
    - Risk 111 Overall building condition 16 to 12
- No other current scores changed

The Board is asked to note the updates and the actions in place to address risk.

Risks are reviewed by a relevant forum in line with monitoring timescales. This process needs further embedding in respect of clinical governance forums as identified in a recent internal audit. Risks 9+ are reviewed via the relevant governance work streams on a quarterly basis: Patient Safety and Clinical Risk; Corporate Governance and Risk; Information Governance and reported to the Clinical Quality Safety and Governance Committee.

The Operational Risk Register was reviewed by the Executive Management Team on Tuesday 20th November 2018.

Recommendation to the Board	
The Board of Directors is asked to note this report.	
Trust strategic objectives supported by this paper	
Finance and Governance	
Author	**Responsible Executive Director**
Associate Director of Quality and Governance	Deputy Chief Executive / Director of Finance

Target Risk	6	4	4
C	3	2	2
L	2	2	2
Governance and reporting group	Board of Directors	Clinical Quality Patient Experience Workstream	Clinical Quality Patient Experience Workstream
Next review	15 December 2018	'September 2018	1 December 2018
Last reviewed	Nov-18	01 March 2018	01 March 2018
Review Cycle	Monthly	Quarterly	Quarterly
Operational monitoring group	Board of Directors	AFS Clinical Governance Group	AFS Clinical Governance Group
Operational Lead	Terry Noys	Jo Stubley/Andrew Williams	Andrew Wiliams
Actions update (updated along with the current risk position)			
Action Plan (Ensure date and action owner are identified)	Regular full year reforecasts to be provided. Close scrutiny of income initiatives by Strategic and Commercial Committee	Working with commercial team to produce a viable strategy 2017-18 (December 2017) Working closely with Business Dev team to: a) proceed with winning new large pieces of business. B) ensure all smaller piece of work are properly costed and funded. C) reorganise and enhance the staffing of the trauma serive to allow rapid reponse to possible requests for work. Review staffing requirements (30/12/17)	Working with commercial team to procude a viable strategy 2017-18 (31st December 2017)
Current Risk	15	9	9
C	5	3	3
L	3	3	3
Gaps (what is the gap between initial and target risk rating? What other controls are needed(?)	Risk of failure in generating required new income Risk of unexpected expenditure Potential uncertainty around Relocation	Skilled and less skilled staff	Skilled and less skilled staff. Waiting list currently closed, but open to Named Patient Agreement (i.e. outside contracted regions) referrals. A review of options to improve the situation is underway (April 18)
Assurance (evidence of the controls)	Board papers in January and March 2018 set out the factors contributing to this position and the risks and their mitigation / management. Regular monthly management r reports will be provided.	Intake meetings review referrals Staffing increase by 0.2wte Three new honorary staff have now been recruited to trauma unit in order to reduce waiting times.	Intake meetings review referrals
Controls (measures in place to reduce the risk)	Budget presented to Board and approved March 2018, with £1,034k surplus Ongoing monitoring and scrutiny of management accounts and active management of income and costs by EMT	Case by case review of high risk patients Staffing requirements reviewed	Case by case review of high risk patients
Initial Risk	20	9	9
C	5	3	3
L	4	3	3
Risk Category	Financial, reputation and delivery	Reputation	Reputation
Current Status	Open	Open	Open
Scope of risk	Trustwide	AFS-Complex Needs and Trauma Unit	AFS Fitzjpohns Unit
Risk Owner	Finance Director	Director of AFS	Director of AFS
Link with strategic aims	16) Meet our Control Total for 2018/19	(2) Maintaining & developing the quality & reach of our clinical services	(2) Maintaining & developing the quality & reach of our clinical services
Objective the risk impacts on			
Date raised		Sep-16	Sep-16
Risk raised by whom?	Finance	AFS-Complex Needs and Trauma Unit	AFS Fitzjpohns Unit
Old ref	1	4	5
Ref	1	4	5

Target Risk	9	9	6
C	3	3	3
L	3	2	2
Governance and reporting group	TBC	TBC	Information Governance workstream & CQSG
Next review	September 2018	September 2018	'September 2018
Last reviewed	27 June 2018	27 June 2018	09 May 2018
Review Cycle	Quarterly	quarterly review	Quarter
Operational monitoring group	FNP National Unit, reporting to CYAF Director	FNP National Unit, reporting to CYAF Director	Clinical Governance Groups AFS and CYAF
Operational Lead	Ailsa Swarbrick	Ailsa Swarbrick	David Wyndham -Lewis
Actions update (updated along with the current risk position)			
Action Plan (Ensure date and action owner are identified)	Keep PHE Governance Boards and CYAF Director informed on commissioning status and funding issues and seek their engagement on strategic development. NU actively engaged in delivering agreed strategy to focus on innovation, adaptation, integrating FNP with wider services, building public profile. Develop income generating capacity within the FNP NU	Regular review of ADAPT programme plan and its link with FNP Strategic plan. Delivery of ADAPT 2 now started, with lessons learned embedded and a clear communications strategy. Monitoring of activities to ensure in keeping with the overall plan, which will allow good data to evaluate adaptations.	Maintain IG training and promotion of relevant Trust policies and procedures Plan to move to Office 365 approved July 2016. This will allow enabling of data leak protection for email. 05/2018 - project for implementation of data leak protection is delayed by other operational pressures. Likely completion in Q3 2018/19 05/2018 - project to improve to full compliance with IG and data security training has been very successful in 2017/18. Plans in place to include bring compliance checks for this onto the ESR platform training compliance system
Current Risk	12	9	9
C	4	3	3
L	3	2	3
Gaps (what is the gap between initial and target risk rating? What other controls are needed(?)	Site reduction was approx 28% when compared with previous year's data of the same period. Similarly commissioned number of places reduced by 32% when compared with Q3 of financial year 2016-17. FNP NU to secure additional funding to mitigate the effects of PHE budget reductions	Dealing with unforeseen events that are out of FNP's control - e.g. additional costs not known at the time of budget setting. Ability to adopt new learning and adapt to change within the NU and in the wider system at pace. Ability to deliver key results and outcomes by project end date –31 March 2020	Some external parties (e.g. solicitors, local authorities) may send us info by less secure means. We cannot prevent this, but we draw their attention to it and request them to avoid recurrence.
Assurance (evidence of the controls)	Strong financial controls and monitoring are in place to take proactive steps in managing reducing resources. Site commissioning status is a standing item on the agenda of all key meetings; Heads of Functions (HOF) review bi-monthly All contract 2017-18 issues were resolved and invoices (including Q4) were fully paid by PHE. Two year extension to NU contract agreed with PHE. NU restructure completed, reducing headcount and pay costs; non pay costs also reduced.	Project Board (overseeing body) meets regularly (approximately 4-6 weeks) to review progress and approve key decisions of the Project Team. Ongoing workshops (every 3 months) are taking place to review outputs and feeding back into the testing cycle. FNP ADAPT interim report released to the wider FNP community and key national stakeholders February 2018, followed by successful stakeholder event in May 2018. Developed and agreed with PHE, ADAPT sites and others a plan and timeline for "ADAPT" 2, which has now launched with 10 more sites (bringing the total to 20), running to 31 March 2020.	Attendance at induction and inset records held by HR. Feedback from Caldecott Guardian Staff sign for policy issued on employment. Procedure publicised frequently. Trust e-mail has a block to prevent data in certain formats being sent. IG workstream review of incidents, Board and external review of SI reports Pass rate for IG training at 90% for 2017/18
Controls (measures in place to reduce the risk)	Decommissioning risk assessment informs actions of Improvement Development team and NU. NU strategy includes further devlopment of non FNP offers, and a fundraising element. Robust income and expenditure business planning scenarios and simulations informing on funding constraints to aid prioritisation. FNP scoping and feasibility studies exercise for a sustainable system wide offer. Active project work started in November and plans to engage with partners	A dedicated Programme Team is in place for co-ordinating project. The National Unit is working with FNP consortium partner the Darrington Service Design Lab (was Darrington Social Research Unit) to use sound design and iterative testing methodologies. The project is highly complex and work is progressing at a steady pace, whilst reflecting on learning and new inputs from the journey of discovery. Testing of innovation projects are well underway and providing insights relevant to wider services.	Attendance at induction which includes training on confidentiality. Availability of Caldecott Guardian and IG Lead for advice. Confidentiality Code of Conduct Procedure on sending person identifiable information by e-mail requires the use of nhsmail accounts (not Trust e-mail), with restrictions on the recipients' accounts. Alternative (Cryptshare) is provided where this is not possible. Incident reporting and investigation. Information governance e-learning assessment
Initial Risk	12	9	9
C	4	3	3
L	3	3	3
Risk Category	Financial, reputation and service delivery	Financial, reputation and service delivery	Safety and Reputation
Current Status	Open	Open	Open
Scope of risk	FNP	FNP	All clinical services
Risk Owner	Director of CYAF	Director of CYAF	Deputy SIRO
Link with strategic aims		No	No
Objective the risk impacts on			
Date raised			September 2015
Risk raised by whom?	FNP	FNP	Finance Director
Old ref	6	7	11
Ref	6	7	11

Target Risk	8	6	6
C	4	3	3
L	2	2	2
Governance and reporting group	Education and Training Executive	Education and Training Executive	Patient Safety Clinical Risk work stream
Next review	1 February 2019	1 February 2019	
Last reviewed	16 November 2018	16 November 2018	09 May 2018
Review Cycle	Quarter	Quarter	Quarter
Operational monitoring group	DET operational group	DET operational group	IT Forum
Operational Lead	Simon Carrington	Isabelle Bratt	Ndumbe Shu
Actions update (updated along with the current risk position)			
Action Plan (Ensure date and action owner are identified)	Ensure that international students receive CAS letters to cover the full duration of their programme including all clinical work (S Carrington, B Nicholson) DET to specifically review the progress of all tier 4 students annually with reference to their likelihood of successful and timely completion. Where issues are raised Course Leads to provide development plans. No students will be issued CAS letters to request extensions to their study visas. Any students not completing their studies by the time their visa expires will need to complete their studies from their home country (where this is possible)	Identify if all clinical placements are on the list and update if required. IB is continuing to work with CAS and CLS to update the record of who is on placement within the Trust through the governance passport log. IB to establish a working group to consider how to identify and record all clinical placements, both within and outside the Trust, including whether this can be done through SITS. A comprehensive action plan has been drawn up to take this forward.	Complete tasks to demonstrate compliance with IGT 400s and 500s to level 3 Implementation of network replacement 05/18 - hardware replacement is delayed due to operational pressures but will now complete in May 2018. 05/18 - tasks to demonstrate compliance with IGT400s and 500s are all complete and have been assessed as such in the IGT14.1
Current Risk	12	9	9
C	4	3	3
L	3	3	3
Gaps (what is the gap between initial and target risk rating? What other controls are needed(?)	We need to work with the specialist lawyers to get UKVI approval to continue to recruit overseas students to our non-validated programmes. We need to expand the amount of training available and delivered around visas to all staff of all grades who have dealings with international students	A process of checking the quality of placements, inviting feedback from students and the placement providers on their experience, is required. The Dean's Office do not know if all clinical placements are on the list. Without this information, we are unable to provide students with adequate support in arranging placements meaning that they may not feel secure enough to accept their offer. Placements can fall through, and if we do not have an accurate list of placements we cannot assist in finding new placements.	Partial compliance with IGT 400s and 500s to level 3
Assurance (evidence of the controls)	The Head of Academic Governance and Quality Assurance has developed an action plan in this area. We have also entered into discussions with the University of Essex with regards to devising specific international versions of courses that can be amended and therefore advertised as full time. The intermission form requests students to identify if they have a tier 4 visa and advises that they may have limited opportunity to take a break from their studies. Advice has been received from immigration lawyers and we have taken decisions about specific courses as a result. We recently got full compliance from UKVI and CAS letters for all our international students for 2017/18. We are being more systematic in the way we consider suitability of prospective international students, have increased expertise in our CA group and have reduced the number of rejected applicants.	Student placements will be recorded within the new student record system to ensure a central, consistent record will be available of all placements. Data is provided by all relevant course teams and entered into the student record system SITS (MyTAP)	IT systems blocks notify user that downloading and administration rights held by IT staff only Information Asset acceptance and registration procedure
Controls (measures in place to reduce the risk)	A renewed licence granted in 2017. All overseas applicants must present passports, qualifications and other forms of ID & evidence of adequate funding. Once satisfied, DET issue a CAS letter which the student submits for a VISA. Once in training attendance is monitored, and action taken if 2+ absences occur. Absences are reported to the UK Visas and Immigration Service. International students will have to apply by 15th June to ensure we comply with visa requirements and visas are in place for students to commence their training. The Trust will not issue CAS letters to students who do not complete their programmes during the timeframe given by their original visa.	Dean's Office have a log of all clinical placements in the Trust which is linked to clinical governance training. Recording ensures safety of patients and quality of training.	Restriction of downloading ICT applications , 'apps', through the Servers firewalls Relevant IT purchasing procedure network replacement project has completed procurement phase with a supplier now appointed.
Initial Risk	12	9	9
C	4	3	3
L	3	3	3
Risk Category	**Reputation and Financial**	**Safety and Reputation**	Reputation and Compliance/Regulation
Current Status	Open	Open	Open
Scope of risk	DET	All services	IT
Risk Owner	Associate Dean for Academic Governance and Quality Assurance	Associate Dean for AGQA	Deputy SIRO
Link with strategic aims			No
Objective the risk impacts on			
Date raised		01/07/2017	Sep-15
Risk raised by whom?	**DET**	**All services**	IT
Old ref	24	30	36
Ref	24	30	36

Target Risk	4	3	4	9	6
C	2	3	4	3	3
L	2	1	1	3	2
Governance and reporting group	CQPE	Confirm with DWL	Confirm with DWL	Confirm with DWL	Confirm with DWL
Next review	Closed	13/06/2018	13/06/2018	13/06/2018	01/02/2019
Last reviewed	10.10.2018	02/05/2018	02/05/2018	13/11/2018	06/11/2018
Review Cycle	On-going with monthly reviews	Quarter	Quarter	Quarter	Quarter
Operational monitoring group	Clinical Governance Group AFS	IM&T Forum	IM&T Forum	IM&T Forum	IM&T Forum
Operational Lead	Tim Kent	David Wyndham -Lewis	Ade Sulaiman	Ade Sulaiman	Muhammad Akram
Actions update (updated along with the current risk position)	Waiting times are now 95% within statutory limits and practically around 3 months only.	Ongoing	Ongoing	Ongoing	Ongoing
Action Plan (Ensure date and action owner are identified)		Conduct capability and capacity assessment for IM&T and adapt accordingly 21/11/2016 - review in draft and discussing further work on capacity review in particular	Implement improved power supplies and protection in computer room and to support key infrastructure 21/1/2016 - new three phase power installed but services not yet migrated. Will be scheduled as part of the remediation project. 03/10/17 - awaiting aprroval for work to commence. New quotes required. Network refresh will mitigate some of the risk as the core switches will be split between floors.	Upgrade network 21/11/2016 - network replacement procurement has commenced. Due to complete in March 2017 03/10/17 - Procurement stage complete, network managed service contract to be singed very soon.	Re-host external server and migrate apps and databases 21/11/2016 - no activity 8/11/2017 - MA 1&1 server's needs switching off once the CPD functions have moved to SITS in November. However Library function for payment is still required as not supported. 06/11/2018 - MA, Library is now building a seperate system to manage the membership, once recived confirmation of go-live for library, and CPD confirms all fucnitons now operate via SITS. 1&1 hosting will be terminated.
Current Risk	4	9	12	9	9
C	2	3	4	3	3
L	2	3	3	3	3
Gaps (what is the gap between initial and target risk rating? What other controls are needed(?)					
Assurance (evidence of the controls)	Waiting list data GP/ Commissioner feedback HR staffing evidence New Outlook based administration diary for clinicians in place New contract with CCG has set a more realistic number of expected patients. Agreed new criteria for service which excludes people who should be seen in other services but have been 'taken in' by PCPCPS due to systemic gaps in provision. Demand and Capacity information now updated with team memebrs, CCG and Contracts. A plan was put in place and the service was rewarded with a CQUIN grant of £5000 .				
Controls (measures in place to reduce the risk)	Co-construction of ongoing strategy agreed with CCG colleagues Quarterly reviews and internal audit Staffing now full, with no temp contracts or bank staff Administrators have greater control over clinical work Waiting times significantly reduced March 2018 Training for all staff who use the site				
Initial Risk	4	9	12	9	9
C	2	3	4	3	3
L	2	3	3	3	3
Risk Category	Service Delivery and Reputation	Delivery	Delivery	Delivery	Delivery, Financial, Reputation
Current Status	Closed	Open	Open	Open	Open
Scope of risk	PCPCS	IM&T	Trustwide	Trustwide	DET
Risk Owner	Director Adult and Forensic Services	DoTT	HoICT	HoICT	HoInf
Link with strategic aims	(5) Delivering a sustainable financial future for the Trust				
Objective the risk impacts on					
Date raised	Dec-15	01/09/2015	05/10/2015	05/06/2015	08/03/2016
Risk raised by whom?	PCPCS	IM&T	IM&T	IM&T	IM&T
Old ref	40	IMTR0012	IMTR0014	IMTR0017	IMTR0019
Ref	40	54	56	59	61

Target Risk	4	4	6	4	3
C	2	2	3	2	3
L	2	2	2	2	1
Governance and reporting group	Confirm with DWL	Corporate and Governance Workstream	Corporate and Governance Workstream	Corporate and Governance Workstream	Corporate and Governance Workstream
Next review	13/06/2018	15/01/2019	15/12/2018	15/02/2019	15/01/2019
Last reviewed	13/11/2018	15/11/2018	15/11/2018	15/11/2018	15/11/2018
Review Cycle	Quarter	Quarter	Monthly	Quarter	Quarter
Operational monitoring group	IM&T Forum	Estates and Facilities Forum	Estates and Facilities Forum	Estates and Facilities Forum	Estates and Facilities Forum
Operational Lead	Ade Sulaiman	Ian Garlington	Ian Garlington	Ian Garlington	Ian Garlington
Actions update (updated along with the current risk position)	Ongoing	two site have contract cleaning regimes. Recruitment active for management posts. Employed staff centralised and deployed at TC, with new rotas in producion.			
Action Plan (Ensure date and action owner are identified)	The at risk domain have to secure their email systems otherwise the Trust should remove the whitelist on the Trust's email hygene solution.	Develop service catalogue to include review of service requirements. Commission Housekeeping service. Staffing restructure Appoint additional interim resource requirements for specific roles (e.g. compliance).			procurment of NHS framework contractor
Current Risk	9	10	15	10	12
C	3	2	3	2	3
L	3	5	5	5	4
Gaps (what is the gap between initial and target risk rating? What other controls are needed(?)		Service requirements not fully captured. Housekeeping service not commissioned. Staffing restructure to align to new service catalogue. Additional interim resource requirements for specific roles (e.g. compliance) required.	Contract arrangements being put in place for permanent third party provision of hard services. Reactive and emergency maintenance servicewith Target Bulling Solutions for an interim service of 3 months while service specification is produced for a permanent service arrangement. Compliance remediation programme in progress	Training matrix in draft for cleaners - needs populating for individuals. Middle tier skills absent and will need recruiting (supervisor and officer). No training yet in place for management skills for team leads. Literacy and numeracy and IT skills training is being arranged.	
Assurance (evidence of the controls)		Interim site supervisor in post. Interim increase in cleaning staff in place ahead of review. Interim morning cleaning team lead in place.	3 month contract let to Target Building Solutions to maintain compliance. NHS Framework procurment in place to go live Jan 2019 Alcumus compliance report and M&E report completed. Authorising engineers appointed.	Full training programme in place for professional skills for cleaners. Partial training programme for other Estates personnel.	BICS certificates, Insurance and certification of contracted operatives
Controls (measures in place to reduce the risk)		PPM & reactive maintenance contract in place pending framework procurement in Jan 2019. Director and Head posts in recruitment	Interim arrangement in place. Works that were being undertaken by local staff that they were not qualified to perform have been stopped. Reports completed and appointments made.	Estates staff training in place	Mandatory training (BICS) complete, trades person qualification outsourced
Initial Risk	15	10	15	10	12
C	5	2	3	2	3
L	3	5	5	5	4
Risk Category	Delivery, reputation and financial	Delivery	Delivery	Delivery; Safety and Financial	Safety, Delivery, Reputation & Financial
Current Status	Open	Open	Open	Open	Open
Scope of risk	Trustwide	Trustwide			
Risk Owner	HoICT	HoEFM	HoEFM	DoEFC	DoEFC
Link with strategic aims					
Objective the risk impacts on					
Date raised	04/12/2017	13/04/2018	13/04/2018	13/04/2018	13/04/2018
Risk raised by whom?	IM&T	Estates and Facilities	Estates and Facilities	Estates and Facilities	Estates and Facilities
Old ref	IMTR0029	EFR0001	EFR0002	EFR0003	EFR0003
Ref	71	73	74	75	76

Target Risk	10	3	2
C	2	3	2
L	5	1	1
Governance and reporting group	Corporate and Governance Workstream	Corporate and Governance Workstream	Corporate and Governance Workstream
Next review	15/01/2019	15/02/2019	15/06/2019
Last reviewed	15/11/2018	15/11/2018	12/11/2018
Review Cycle	Quarter	Quarter	Quarter
Operational monitoring group	Estates and Facilities Forum	Estates and Facilities Forum	Estates and Facilities Forum
Operational Lead	Ian Garlington	Ian Garlington	Ian Garlington
Actions update (updated along with the current risk position)			
Action Plan (Ensure date and action owner are identified)	JDs and person specs being moved to new template and checked for consistency	implementation of RSM Audit report on control of contraxctors implemented	Develop a full service catalogue. Document the existing services.
Current Risk	10	9	9
C	2	3	3
L	5	3	3
Gaps (what is the gap between initial and target risk rating? What other controls are needed(?)	Updated JDs and person specs	Full contract schedule and review.	Require a full service catalogue.
Assurance (evidence of the controls)	Domestic staff JDs in place. Front of house staff in production	Due diligence r eports	
Controls (measures in place to reduce the risk)		Due diligence on all incumbent suppliers to confirm accreditations completed and all non compliant suppliers replaced	Many contracts already replaced as required by ad hoc review
Initial Risk	10	9	9
C	2	3	3
L	5	3	3
Risk Category	Delivery	Delivery & Financial	Delivery & Financial
Current Status	Open	Open	Open
Scope of risk			
Risk Owner	DoTT	DoEFC	DoEFC
Link with strategic aims			
Objective the risk impacts on			
Date raised	13/04/2018	13/04/2018	13/04/2018
Risk raised by whom?	Estates and Facilities	Estates and Facilities	Estates and Facilities
Old ref	EFR0004	EFR0006	EFR0008
Ref	77	78	80

Target Risk		4	4	CLOSED
C		4	4	CLOSED
L		1	1	CLOSED
Governance and reporting group	Corporate and Governance Workstream	Corporate and Governance Workstream	Corporate and Governance Workstream	Corporate and Governance Workstream
Next review	15/01/2019	15/01/2019	15/01/2019	15/06/2019
Last reviewed	15/11/2018	15/11/2018	15/11/2018	15/11/2018
Review Cycle	Quarter	Quarter	Quarter	Quarter
Operational monitoring group	Estates and Facilities Forum	Estates and Facilities Forum	Estates and Facilities Forum	Estates and Facilities Forum
Operational Lead	Ian Garlington	Ian Garlington	Ian Garlington	Ian Garlington
Actions update (updated along with the current risk position)		Schedule under development of all policies required and the updates necessary	Schedule under development of all procedures required and the updates necessary	
Action Plan (Ensure date and action owner are identified)	Develop an Estates and Facilties strategy. Complete options appraisal and due diligence as part of Relocation programme	Review of existing policies and development of new structure for integration between policies.	Review of existing procedures and development of new structure for integration between policies and procedures.	Each item assessed to be allocated a maintenance strategy
Current Risk	9	12	12	9
C	3	3	3	3
L	3	4	4	3
Gaps (what is the gap between initial and target risk rating? What other controls are needed(?)	Estates and Facilties strategy Options appraisal and due diligence as part of relocation programme.	Gaps in policies		Items identified in M&E survey not assessed to allocate a maintenance strategy relevant to the length of life of the Estate given Estates / Relocation Strategy
Assurance (evidence of the controls)	In production and will be complete Jan 2019	Adopted through appropriate governance route (Policy, procedure. SOP)	Adopted through appropriate governance route (Policy, procedure. SOP)	All items identified in M&E survey - report
Controls (measures in place to reduce the risk)	Produce a strategy that supports the redevelopment / refurbishment aspirations in support of the Trusts strategic service delivery	Authorising engineers reports are commissioned	Authorising engineers reports are commissioned.	Completed the M&E survey
Initial Risk	9	12	12	9
C	3	3	3	3
L	3	4	4	3
Risk Category	Delivery, Financial, Compliance/Regulation	Safety, Delivery, Reputation & Financial	Safety, Delivery, Reputation & Financial	Financial and Delivery
Current Status	Open	Open	Open	Open
Scope of risk				
Risk Owner	DoTT	DoEFC	HoEFM	DoEFC
Link with strategic aims				
Objective the risk impacts on				
Date raised	13/04/2018	13/04/2018	13/04/2018	13/04/2018
Risk raised by whom?	Estates and Facilities	Estates and Facilities	Estates and Facilities	Estates and Facilities
Old ref	EFR0009	EFR0010	EFR0011	EFR0012
Ref	81	82	83	84

Target Risk	4	9	9	6	6
C	2	3	3	3	3
L	2	3	3	2	2
Governance and reporting group	Corporate and Governance Workstream	Corporate and Governance Workstream	Corporate and Governance Workstream	Corporate and Governance Workstream	Corporate and Governance Workstream
Next review	15/06/2019	15/01/2019	15/01/2019	15/01/2019	15/11/2018
Last reviewed	15/11/2018	15/11/2018	15/11/2018	15/11/2018	15/11/2018
Review Cycle	Quarter	Quarter	Quarter	Monthly	Monthly
Operational monitoring group	Estates and Facilities Forum	Estates and Facilities Forum	Estates and Facilities Forum	Estates and Facilities Forum	Estates and Facilities Forum
Operational Lead	Ian Garlington	Ian Garlington	Ian Garlington	Ian Garlington	Ian Garlington
Actions update (updated along with the current risk position)	all new occupations are being appropriately documented and historical once are being addressed		Capital project prioritisation exercise between E&S capital projects and boarder Transformation (IMT) capital projects is being undertaken alongside development of new Transformation Strategy and programme		Report recieved
Action Plan (Ensure date and action owner are identified)		Active planning in place and co-ordination with IM&T workstreams	Undertake capital project prioritisation exercise between E&S capital projects and boarder Transformation (IMT) capital projects (DATE) Develop Transformation Strategy and programme (DATE)		Undertake Estates and FM risk review, based on fabric and M&E surveys to document the known interdependencies between items and other projects (DATE)
Current Risk	9	9	9	20	20
C	3	3	3	5	4
L	3	3	3	4	5
Gaps (what is the gap between initial and target risk rating? What other controls are needed (?)			Capital project prioritisation exercise between E&S capital projects and boarder Transformation (IMT) capital projects is required		Gap in knowledge of interdependencies between items and other projects
Assurance (evidence of the controls)	Estates terrier in place - outstanding sites identified			Bid for financial support issued to NCL STP Fabric and M&E survey reports	Fabric and M&E survey reports
Controls (measures in place to reduce the risk)	Spreadsheet with site information avaiable			Full understanding of the detail of backlog including interdependencies commissioned. Fabric and M&E surveys complete	Fabric and M&E surveys complete
Initial Risk	9	15	15	20	20
C	3	3	3	5	4
L	3	5	5	4	5
Risk Category	Delivery and Compliance/Regulation	Delivery	Compliance/Regulation	Financial	Financial
Current Status	Open	Open	Open	Open	Open
Scope of risk					
Risk Owner	DoEFC	DoEFC	DoTT	DoTT	DoTT
Link with strategic aims					
Objective the risk impacts on					
Date raised	13/04/2018	13/04/2018	13/04/2018	13/04/2018	13/04/2018
Risk raised by whom?	Estates and Facilities	Estates and Facilities	Estates and Facilities	Estates and Facilities	Estates and Facilities
Old ref	EFR0015	EFR0018	EFR0019	EFR0021	EFR0022
Ref	85	88	89	91	92

Target Risk	6	2	5	5	5
C	2	2	5	5	5
L	3	1	1	1	1
Governance and reporting group	Corporate and Governance Workstream	Corporate and Governance Workstream	Corporate and Governance Workstream	Corporate and Governance Workstream	Corporate and Governance Workstream
Next review	15/01/2019	15/01/2019	15/01/2019	15/01/2019	15/01/2019
Last reviewed	15/11/2018	15/11/2018	15/11/2018	15/11/2018	15/11/2018
Review Cycle	Quarterly	Quarterly	Quarterly	6 months	6 months
Operational monitoring group	Estates and Facilities Forum	Estates and Facilities Forum	Estates and Facilities Forum	Estates and Facilities Forum	Estates and Facilities Forum
Operational Lead	Ian Garlington	Ian Garlington	Ian Garlington	Ian Garlington	Ian Garlington
Actions update (updated along with the current risk position)		Authorising engineers commissioned to produce risk mitigation approaches.	Compliance assessment for Gloucester House being instructed. - completed		
Action Plan (Ensure date and action owner are identified)		Consider staffing model and level of resource (DATE) Implement PAM model (DATE) Authorising engineers to produce risk mitigation approaches (DATE)	Consider staffing model and level of resource (DATE) Implement PAM model (DATE) Authorising engineers to produce risk mitigation approaches (DATE) Complete compliance assessment for Gloucester House (DATE) Instigate Planned Preventative Maintenance at Gloucester House (DATE)	Bi-annual review of asbestos register commissioned in line with policy	
Current Risk	9	10	10	8	8
C	3	5	5	4	4
L	3	2	2	2	2
Gaps (what is the gap between initial and target risk rating? What other controls are needed(?)		Estates staffing and resource review required PAM model not yet implemented Risk mitigation approaches not yet produced by authorising engineers	Revised PAM in production to support compliance audits and actions		
Assurance (evidence of the controls)	Control of Contractors policy	Authorising engineers appointed Fire and water safety now addressed on safety agenda via CGR	Appointed authorising engineers. CGR meeting papers. Compliance audit report. M&E Asset verification exercise report. Evidence of remediation of high risk compliance issues.	Risk register in place identifying all asbestos in all Trust sites. Permit to work arrangements covering access to areas that contain asbestos in place	Appointed authorising engineer M&E. Evidence of fixed wire testing for all sites. Evidence of completed 2017/18 PAT testing - Semi intrusive survey undertaken
Controls (measures in place to reduce the risk)	Normal acivity in a live hospital environment. Schemes of work design around clinical care		Apponted authorising engineers. Fire and water safety now addressed on safety agenda via CGR. Compliance audit complete. M&E Asset verification exercise complete.	All asbestos identified in all Trust sites Permit to work arrangements covering access to areas that contain asbestos in place	Appointed authorising engineer M&E. Undertaken fixed wire testing for all sites. PAT testing complete for 17/18 and to be repeated for new equipment and reactively every three years
Initial Risk	16	15	15	15	15
C	4	5	5	5	5
L	4	3	3	3	3
Risk Category	Delivery, Safety	Safety	Compliance/Regulation	Safety and Compliance/Regulation	Safety and Compliance/Regulation
Current Status	Open	Open	Open	Open	Open
Scope of risk					
Risk Owner	DoEFC	DoEFC	DCEO	DoEFC	DoEFC
Link with strategic aims					
Objective the risk impacts on					
Date raised	13/04/2018	13/04/2018	13/04/2018	13/04/2018	13/04/2018
Risk raised by whom?	Estates and Facilities	Estates and Facilities	Estates and Facilities	Estates and Facilities	Estates and Facilities
Old ref	EFR0023	EFR0024	EFR0025	EFR0028	EFR0029
Ref	93	94	95	98	99

Target Risk	5	5	5	5
C	5	5	5	5
L	1	1	1	1
Governance and reporting group	Corporate and Governance and Risk Workstream	Corporate and Governance and Risk Workstream	Corporate and Governance and Risk Workstream	Corporate and Governance andc Risk Workstream
Next review	15/01/2019	15/06/2019	15/06/2019	15/06/2019
Last reviewed	15/11/2018	15/11/2018	15/11/2018	15/11/2018
Review Cycle	6 months	6 months	6 months	6 months
Operational monitoring group	Estates and Facilities Forum	Estates and Facilities Forum	Estates and Facilities Forum	
Operational Lead	Ian Garlington	Ian Garlington	Ian Garlington	Ian Garlington
Actions update (updated along with the current risk position)				
Action Plan (Ensure date and action owner are identified)			Evacuation and emergency release training to be provided all local Estates staff	Consider the design of the front reception and waiting areas as a component of the Patient Check In and Flow project (DATE)
Current Risk	8	5	8	8
C	4	5	4	4
L	2	1	2	2
Gaps (what is the gap between initial and target risk rating? What other controls are needed (?)	Gas Safe infrasture inspection commissioned due Dec 2018		Gap in evacuation and emergency release training for all local Estates staff.	Consideration to be made of the design of the front reception and waiting areas as a component of the Patient Check In and Flow project
Assurance (evidence of the controls)	Appointed authorising engineer M&E. Confirmation that all boilers (sole gas items) are up to date on servicing and safety checks. Confirmation that insurance checks are being performed on boilers		Reports as evidence	
Controls (measures in place to reduce the risk)	Authorising engineer M&E Confirmation that all boilers (sole gas items) are up to date on servicing and safety checks. Confirmation that insurance checks are being performed on boilers	Operational check with IM&T on business continuity, identified the need to review UPS but no need for generated backup	Regular maintenance is in place and reporting arrangements confirmed.	
Initial Risk	15	10	15	10
C	5	5	5	5
L	3	2	3	2
Risk Category	Safety and Compliance/Regulation	Delivery	Safety	Safety
Current Status	Open	Open	Open	Open
Scope of risk				
Risk Owner	DoEFC	DoTT	DoEFC	HoEFM
Link with strategic aims				
Objective the risk impacts on				
Date raised	13/04/2018	13/04/2018	13/04/2018	13/04/2018
Risk raised by whom?	Estates and Facilities	Estates and Facilities	Estates and Facilities	Estates and Facilities
Old ref	EFR0030	EFR0031	EFR0032	EFR0033
Ref	100	101	102	103

Target Risk	3	4	3	3
C	3	4	3	3
L	1	1	1	1
Governance and reporting group	Corporate and Governance and Risk Workstream	Corporate and Governance and Risk Workstream	Corporate and Governance and Risk Workstream	Corporate and Governance and Risk Workstream
Next review	15/06/2019	15/06/2019	15/06/2019	15/06/2019
Last reviewed	15/11/2018	15/11/2018	15/11/2018	15/11/2018
Review Cycle	Quarterly	Quarterly	Quarterly	Quarterly
Operational monitoring group	Estates and Facilities Forum	Estates and Facilities Forum	Estates and Facilities Forum	Estates and Facilities Forum
Operational Lead	Ian Garlington	Ian Garlington	Ian Garlington	Ian Garlington
Actions update (updated along with the current risk position)				Commissioned an interim report and plan for 2017/18 and 2018/19. Commissioned full sustainability strategy work up with external support
Action Plan (Ensure date and action owner are identified)	Review process for building access as a component of the Patient Check in and Flow project. (DATE)	Lone worker badges (Reliance) to be provided and mandated for all staff who work alone. (DATE) Reliance training to be provided to all relevant staff (DATE)	Amend centralised procurement processes to include goods in and receipting of good in development to include automated delivery system for internal and external mail (Dec 2018)	Undertake an interim sustainability strategy report and plan for 2017/18 and 2018/19 (DATE) Undertake a full sustainability strategy work up with external support (DATE)
Current Risk	9	12	9	9
C	3	4	3	3
L	3	3	3	3
Gaps (what is the gap between initial and target risk rating? What other controls are needed(?)	Consideration to be made of the process for building access as a component of the Patient Check in and Flow project. Consideration for control of room access as part of the Scheduling project	Lone worker badges (Reliance) to be provided and mandated for all staff who work alone. Reliance training to be provided to all relevant staff	New centralised procurement processes to include goods in and receipting of good in development	Undertake an interim sustainability strategy report and plan for 2017/18 and 2018/19 and a full sustainability strategy work up with external support
Assurance (evidence of the controls)	Visitor passes being issued by reception staff for non-patient visitors	Lone working proceedure Lone worker training provided by H&S Manager	Goods in areas clear New process implemented for tracking goods in tracking Access to goods in areas limited to Estates staff	
Controls (measures in place to reduce the risk)	Reinforced procedure with reception staff for the issue of visitor passes for non-patient visitors	vistor ID badges have risk assessment section for completion by operatives	Cleared good in areas. New process implemented for goods in tracking implemented. Access to good in areas now limited to Estates staff	
Initial Risk	9	6	12	9
C	3	3	3	3
L	3	2	4	3
Risk Category	Safety	Safety	Financial	Financial and Reputation
Current Status	Open	Open	Open	Open
Scope of risk				
Risk Owner	HoEFM	HoEFM	HoEFM	DoTT
Link with strategic aims				
Objective the risk impacts on				
Date raised	13/04/2018	13/04/2018	13/04/2018	13/04/2018
Risk raised by whom?	Estates and Facilities	Estates and Facilities	Estates and Facilities	Estates and Facilities
Old ref	EFR0034	EFR0035	EFR0037	EFR0039
Ref	104	105	107	109

Target Risk	8	6	15
C	4	2	5
L	2	3	3
Governance and reporting group	Corporate and Governance and Risk Workstream	TBC	CGR workstream
Next review	15/02/2019		6 December 2018
Last reviewed	15/11/2018	Nov-18	06/11/2018
Review Cycle	Quarterly	Monthly	Monthly
Operational monitoring group	Estates and Facilities Forum	EMT	FNP National Unit group
Operational Lead	Ian Garlington	Ailsa Swarbrick	Ailsa Swarbrick
Actions update (updated along with the current risk position)		Risk reviewed and approved by EMT 6 November 2018. To update EMT 13 Nov 2018 with actions.	Risk reviewed and approved by EMT 6 December 2018. Ongoing monitoring within the directorate
Action Plan (Ensure date and action owner are identified)	Procurement of planned preventative maintenance service and reactive maintenance service (IG; 31 January 2019)	Hire a Business Analyst to write a specification (DoIM&T, Nov 2018) Procure a new information system (Alex Stevenson, April 2018)	Continued engagement with PHE (Director NU, DATE)
Current Risk	12	20	20
C	4	5	5
L	3	4	4
Gaps (what is the gap between initial and target risk rating? What other controls are needed(?)	Procurement against specification	Despite control measures being agreed, progress to implement is slow, thereby increasing the risk and likely consequences.	None identified
Assurance (evidence of the controls)	Fabric survey and risk assessment reports. Commissioned an interim reactive maintenance service Procurement specification developed for planned preventative maintenance service and reactive maintenance service	Commissioned an interim reactive maintenance service	
Controls (measures in place to reduce the risk)	Asset lifecycle report in place PPM schedule in place	Dedicated project to oversee the procurement and implementation of a new information system.	Ongoing contract meetings with PHE to ascertain their intentions to re-procure a service and business development to identify other funding sources
Initial Risk	16	20	20
C	4	5	5
L	4	4	4
Risk Category	Financial and Delivery	Financial, Delivery	Financial, Delivery
Current Status	Open	Open	Open
Scope of risk		CYAF, FNP National Unit, FNP teams	FNP National Unit, CYAF
Risk Owner	DoEFC	DoIT	FNP NU Director and CYAF Director
Link with strategic aims		Aim: Services Acton 6: Strengthen our collection and use of data to inform decision making and improve the effectiveness and quality of our services	Aim: Services Acton 7a: Extend existing and develop new services to respond to changing demand / new opportunities, including, where appropriate, the use of technology (Tavi)
Objective the risk impacts on		Maintain the FNP National footprint; Refine organisational model and governance (FNP NU)	Maintain national FNP footprint and refocus FNP support (FNP NU)
Date raised	13/04/2018	26/10/2018	26/10/2018
Risk raised by whom?	Estates and Facilities	FNP	FNP
Old ref	EFR0041	FNP	FNP
Ref	111	113	114

The Tavistock and Portman NHS Foundation Trust

Report to	Date
Trust Board	14th November 2018

Guardian of Safer working hours report Quarter 2: 01/07/18 – 30/09/2018

Executive Summary

The new junior doctor's 2016 contract has now been correctly implemented by HR.
All trainees have a contract and generic work schedule for all elements of their employment.
The Child and Adolescent Psychiatry higher trainees now have a proportion of their on-call pay paid prospectively.
There was only 1 exception report made over this quarter.
It is expected that there will be more exception reports in the 3rd and 4th Quarters of 2018 /2019. This is due to trainees being able to exception report against the hours provided in the generic work schedule.

Recommendation to the [Board / Committee]

The Board is asked to note this report

Trust strategic objectives supported by this paper

Author	Responsible Executive Director
Dr Sheva Habel	Medical Director

1. Introduction

The Guardian of safer working hours provides a report for the trust board on a quarterly and annual basis. This is the report for Q2.

2. Section 2

2.1 Exception reports (with regard to working hours)

- Total Exception reports 1
- Exception report: Educational 0
- Exception report: Clinical 1
- All exception reports related to less than 5 hours rest period overnight on the CAP NROC OOH Rota.

2.2 Work schedule reviews

- The numbers staffing the non-resident out of hours on call rota remains 1 in 8 against the minimum level of 1 in 10.
- HR have proposed a 17-hour prospective pay component to the out of hours work schedule.
- This works out to around 4 ¼ hours on a weekday on call and 8 ½ hours for a weekend 24 hour on call. These hours will all be paid at the enhanced rate.

2.3 Vacancies

There are no vacancies on the Child and Adolescent Psychiatry Higher training scheme.

2.4 Locum

The NROC is currently being staffed by Trainees and by other doctors working in the trust or on bank contracts offering Locum cover.

	Number of shifts	Number Covered	Number Vacant	Clinicians
July	8	8	0	Trainees, LAS & staff grade, CAP Consultant
August	8	8	0	
Sept	6	6	0	

2.5 Fines

No fines have been levied to date. It is possible that fines will start to be levied now that the work schedules have been agreed.

2.6 Junior Doctors Forum (JDF)

- All junior doctors now have contracts.
- All junior doctors now have generic work schedules
- HR has noticed some pay irregularities and will be working with payroll to rectify these.

The JDF developed guidelines as when to exception report. These guidelines have been circulated to all Child and Adolescent Psychiatry Higher Trainees and will be trialled over the next quarter and impact discussed at the next JDF in January.

2.7 Local Negotiating Committee (LNC)

This report will be shared with the Joint LNC.

2.8 Issues arising & Actions taken to resolve issues

There are no safety issues arising from any work schedules at present

HR has worked extremely hard over the last quarter to get all aspects of the contract implemented correctly.

The Guardian will be working with the Assistant Director of Finance to develop a pathway for fines to be accrued and paid out as required.

S. Habel

Dr Sheva Habel
Guardian of Safer Working Hours
21st October 2018

Appendix 1

Synopsis of issues presenting in relation to the NROC rota between October 2017 – present and their resolution.

The NROC rota has been in place for many years. Prior to the new contract the junior doctors were paid a banding of 20% for the work they undertook on call. This was based on the frequency of on-calls set at 1 in 10 and the intensity of the work undertaken. This was monitored using diary card exercise's and re-banding would only occur if certain parameters were met in terms of intensity. When locums were required, they were provided by the trainees on the training scheme.

The new junior contract did away with the banding system and implemented additional rules around permitted frequency of on-calls, maximum hours worked in a week and maximum average hours worked over a prescribed time period.

Towards the end of 2017 the number of high child and adolescent psychiatry trainees available to populate the NROC decreased due to a large number of trainees leaving the scheme having completed their training and some trainees being "out of program". When a trainee leaves the training scheme there is always a delay in filling the place on the training scheme and the recruitment process is manage by Health Education England.

The reduced number of trainees led to a significant number of rota gaps occurring and trainees being on call multiple times a week and trainees feeling obliged to take on locums. It was impacting on the type of experiences trainees were able to take up in their daytime placements. The morale of the trainees was low, there was a growing risk that trainees would break the 40 hours average maximum and trainees were on occasion on call more than 3 times a week which is not aligned with the TCS of the new contract.

These challenges came to light in late 2017 / early 2018 and were discussed in a number of forums where trainees meet with consultants in the acute trusts covered by the NROC rota and with Rob Senior and the Head of Psychiatry Sarah Wynick. In these meetings it was agreed that trainees should not feel obligated to take on more locums than they wanted and that the number of locums taken by trainees should be capped at one per month to ensure that out of hours work was not negatively impacting on the trainees daytime training opportunities.

The situation regarding number of trainees populating the NROC rota became more acute in March when a number of trainees went on maternity leave and a number of trainees were unable to work overnight due to medical restrictions. In response to this situation it was agreed that consultants would opt into the middle grade locum gaps when required. The locums were paid at a fixed rate which was proposed by HR and agreed by the consultant group at the time. There were 2 - 3 occasions when an agency locum was required to cover the on call and a protocol to manage this possibility was drafted and HR took up the responsibility of recruiting locums with clinical support (to assess suitability of locums held by head of psychiatry).

Since October 2018 the number of trainees on the rotation has increased resulting in a smaller number of locums being required per month. It was agreed in the last JDF

that locums will be provided by trainees in the first instance and only circulated to consultants if they cannot be covered within the trainee group.

The nature of the work on call means that much of work is of an unpredictable nature however it is known that the intensity of the work has increased over the years in line with national trends of mental health presentations in young people, particularly those in crisis. Over the next quarter a more detailed understanding of the number of hours worked will be possible as exception reporting will now be against a specified number of prospective hours worked per month.

The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Board of Directors	27 November 2018

Serious Incidents – Quarterly Report

Executive Summary

This quarterly serious incident summary report for the Board covers both Q1 and Q2 of 2018-19.

There were 2 known patient deaths during Q1 2018-19 and both deaths occurred in May 2018.

The first was the death of a patient was for a young unaccompanied minor from Eritrea who was referred to our Refugee Service in May 2018 and this has been investigated under the Trust Serious Incident Investigation Procedure. The investigation report is available, an action plan has been completed and lessons learned meeting has taken place with the team involved. The incident investigation has been forwarded to NHS E (via STEIS report) and to Camden CCQ. The outcome of the serious incident investigation was that no root causes were identified that could have predicted or prevented the final event (presumed suicide). The patient was previously known to the Trust service and the case was closed in March 2017. A re-referral was received on 2 May 2018, an appointment offered for 18 May 2018, but the patient died on 10 May 2018. HM Coroner has requested witness statements and a copy of the Trust investigation report.

Also, in May 2018, a patient who was on the waiting list at the Gender Identity Clinic was found dead at home. The findings of the inquest are awaited. This has also been investigated under the Trust Serious Incident Procedure and has been uploaded to STEIS and sent to the CCG.

In Q2 there was one serious incident reported which related to a safeguarding allegation made against a member of staff which has been investigated by the line manager with support from the Trust's HR team.

Recommendation to the Board

The Board of Directors is asked to note this paper

Trust strategic objectives supported by this paper

Services

Author	Responsible Executive Director
Clinical Governance and Quality Manager	Medical Director

The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Board of Directors	27 November 2018

External Affairs Strategy Update

Executive Summary

The following paper provides an update on progress against the Trust's external affairs strategy.

Recommendation to the Board

The Board is asked to note the contents of this paper.

Trust strategic objectives supported by this paper

Services

Author	Responsible Executive Director
Director of Marketing and Communications	Director of Marketing and Communications

EXTERNAL AFFAIRS UPDATE

NOVEMBER 2018

GENERAL

The piece of work around the membership of the group is still ongoing. We are awaiting confirmation of which Governor will replace Celestine on the group and also working to shift dates to allow both the Chair and our NED member to attend.

The restructuring of the Communications Team around thematic lines has allowed us to give greater focus to strategic non-gender themes. We had 38 substantial pieces of coverage in Quarter 1 this year (as against 40 in the previous quarter), but the sentiment of coverage increased – 92% positive or neutral compared to 82.5% in previous quarter. There was again an increase stories about our non-gender identity services (58% non-GIDS coverage in Q1, compared to 45% in Q4, 25% in Q3, and 12% in Q2), showing that our efforts to proactively highlight our staff and services are starting to make an impact and resulting in a consistent upward trend. Efforts to minimise sensationalist coverage of GIDS issues have had a positive result this period, nonetheless, controversy continues to plague this area of our work and it remains an onerous task for all involved. While we are striving to minimise distraction for senior GIDS clinicians and the Trust leadership through new ways of working, this still represents a lot of work for all involved.

The filling of the Senior Communications Officer and Communications & Marketing Officer have helped, but with a greater focus on internal communications to support, we are still incredibly stretched as a team. It is hope that the introduction of a monthly staff magazine will help raise the profile of our external affairs work internally. The support for both the Portman-themed AGM and the Gloucester House 50th anniversary conference have also allowed us to use our owned platforms to promote ourselves. The substantial work which has gone into both those projects will feed into the centenary work which is picking up.

THEME 1 - CHAMPIONING A PSYCHOTHERAPEUTIC APPROACH

NICE DEPRESSION GUIDELINES

Our main focus is still on the upcoming publication of the NICE guidelines on Depression in adults: treatment and management. As you know, the Trust thought the draft guidelines were both disappointing from the point of view of promoting choice and giving patients with chronic depression a chance at a meaningful psychodynamic treatment. We also set out, in partnership with a host of other key stakeholders in this space, some fundamental problems with how the evaluation of various treatments was carried out.

NICE delayed publication of the guidelines pending a meeting with a coalition of which the Trust is part and coordinated by Dr Felicitas Rost from the Portman. Following on from this NICE concede to re-opening the consultation for a further four weeks, closing on June 12. While an eventual publication timeframe of ‘this autumn’ was given for publication. They have since confirmed they will re-open the consultation and welcome more recent evidence. There is still considerable concern

that there seems to be no proposal by NICE to review their approach or methodology. Without this it is hard to see what will change.

The campaign over the summer stretched to Parliament and the media leading to an interview of Dr Rost on You and Yours and further articles in trade publications citing her. The parliamentary work is ongoing and the coalition is also recruiting new signatories.

THE PORTMAN CLINIC

The Portman Clinic was at the centre of our AGM this year. The event was well received. A BBC London piece has also finally now aired.

THEME 2 – LIFE CHANCES AND VULNERABLE CHILDREN

FDAC NATIONAL UNIT

The failure of our Life Chances Fund FDAC bid to materialise in light of differences with our social investment partners dealt a blow to the ongoing funding for the FDAC National Unit and ultimately its winding down. This led to some difficult media handling but ultimately did allow us and other stakeholders to make the case for funding interventions which support vulnerable children and their families yet again.

We are hosting – and will be promoting – the launch of Justice for Children and Families, the new book co-edited by Mike Shaw and Sue Bailey due to take place early in the new. Combined with the footage we have from a recent FDAC event of Sir Andrew McFarlane, the new President of the family division, we will be using our owned channels to raise the profile of the service, particularly among key stakeholders.

FDAC DOCUMENTARY

We have been working with Century Films (CF), the makers of Kids on the Edge, for over a year to explore the possibility of doing another documentary or series, this time around our Family Drug and Alcohol Court services. After initial great strides, we were struggling to progress plans because of uncertainties plaguing both the Kent FDAC and the National Unit.

We have now switched our location for the documentary to the London FDACs and CF have attended hearings at the Central London court, including a graduation, for research purpose. These visits went very well. We are now pressing ahead with this project once again. In the absence of National Unit staff, the comms team are liaising directly with the London FDAC team. We had also approached Coventry FDAC who have come back positively after seeking LA support for the project in principle. We would have less input into something in Coventry so we are trying to pursue both while maximising our chances of securing positive coverage for the Trust and not just the service.

CAMHS GREEN PAPER IMPLEMENTATION

DH officials stayed in touch with us following our meetings, visits and submissions (both formal and behind the scenes follow-ups to their questions. This has helped position the Trust as a leading provider of CAMHS in schools with much expertise to impart. These discussions and information flows also further strengthened our relationships with local commissioners and partners. Our bid to become a trailblazer site during the first phase of the Green Paper implementation has been successful off the back of this. Having robust measurable outcomes and evaluation tools has been a

key focus. We will have to manage the impact such an award could have on STP relations given rivalry in this space.

THEME 3 – GENDER

Our gender services, and in particular GIDS, are continuing to face a particularly factious time. The divide in the public debate between those who press for quicker interventions and a fully affirmative approach and those who were highly critical of a children's gender service in particular is becoming greater every day. There are also exciting opportunities presenting around a possible National Unit and providing more training in this area. We are working to ensure the BD team, DET and comms continue to work closely together on these projects as there are lots of cross-cutting issues and potential for overlap.

GIDS

The GIDS sounding board met again in July to explore the ethical issues the service face. As a result further work will be done to update and bring together service guidelines and sops to create a sort of GIDS manual. There is also a hope these discussions will help us arrive at and disseminate policy positions and lines for the service to help address both internal and external factiousness.

We are still developing a communications strategy for GIDS. There will be an increasingly strong element around stakeholder engagement, though timings around a possible National Unit for gender have complicated things slightly in this respect and recent engagement has not proved hugely helpful.

The comms team presented at the GIDS away day on 16th October on communications, social media and media handling in this space. The aim was to reassure clinicians we are there to support them as we do with senior members of staff, establish how we work currently and hear from them about how they might like to be involved or what else they might like us to do. The session was well received (4.8/5) and gave staff a chance to air their feelings about the unhelpful climate and toxic discourse being generated at the moment.

GIC

A joint meeting of senior GIDS and GIC clinicians allowed us to explore what a Trust view might be around the Gender Recognition Act. It was agreed GIC would lead on drafting a response to the consultation respecting the lines agreed at the meeting – mainly no change for the under-16s. This has been submitted to the GRA consultation.

The work around a National Unit for Gender will involve stakeholder consultation. Working across clinical leads, comms and BD, we will ensure this is judiciously handled.

THEME 4 – RESILIENCE

The work of the National Workforce Skills Development Unit continues to establish the Trust as a leading voice in this area. The Trust is taking a leading role in supporting the creation of a Collaborative website and workplace resilience will form the bulk of our initial content. This is being timed around programmed media activity we are supporting on later this winter and has been agreed by all comms leads across the collaborative.

The Trust was successful in its Challenge Fund bid to develop and implement a mental health in the workplace assessment tool and related bespoke interventions. Communications is supporting the project and sits on the implementation team.

The Tavistock and Portman NHS Foundation Trust

Report to	Date
Board of Directors	16 October 2018

Organisational Development and People Strategy Assurance Report

Executive Summary

In April 2017 the Trust launched and commenced implementing its ambitious three year organisational development and people strategy. This report provides the 2018/19 quarterly update on progress against the, refreshed, delivery plan.

The report also provides oversight of the Trust's workforce indicators including mandatory and statutory training compliance.

Recommendation to the Board

The board of directors is asked to note this report.

Trust strategic objectives supported by this paper

People

Author	Responsible Executive Director
Director of HR & Corporate Governance	Director of HR & Corporate Governance

Organisational Development and People Strategy Assurance Report Quarter 2 – 2018/19

1. Introduction

The organisational development and people strategy was launched in April 2017 and set a direction of travel for the next three years. An initial delivery plan was developed setting out the specific actions across the life time of the strategy.

Now in the strategy's second year, the delivery plan has been incorporated in to this report and refreshed reflecting the work undertaken in the previous year and new emerging requirements for the second year.

2. Quarter two strategy delivery plan summary

The strategy delivery plan is progressing well in the first quarter and a new programme of work has commenced to implement the second year priorities.

In quarter two there has been some slippage on delivering four aspects of the strategy delivery plan, the HR senior team are working carefully to plan how to bring these actions back on track to ensure that the key activities are completed by the end of the financial year.

Education commissioning

The Trust has received confirmation from Health Education England its continuing professional development financial allocation for 2018/19. Following completion of the annual appraisal round, the personal development plans have been analysed and the education requirements have been scoped.

The HR and staff development manager is currently obtaining quotations to commission education and training programmes and these will be promoted from quarter three. To continue on the strategy theme of

developing aspiring and existing leaders the aspiring leaders and middle manager leadership programmes will be recommissioned.

Tavistock and Portman Academy

The first cohort of the foundation teaching programme has now been concluded and evaluated. Participants shared that they felt the programme has delivered on its aims and two individuals have now been engaged in shadowing and delivering training through the directorate of education and training.

The deputy dean, director of nursing and director of HR and corporate governance met in July to discuss and agree the continuing and further development of the programme with a specific focus of attracting participants interested in pursuing education careers within the systemic portfolio, where there existing risks surrounding succession planning.

Occupational Health

A procurement activity for the Trust occupational health and wellbeing contract took place in September 2018. Whilst the activities set out in the delivery plan were completed, on time, the tender has resulted in no suppliers submitting a bid for the service.

The director of HR and corporate governance will be working with the Trust's procurement consultant to agree a plan to expedite a solution to ensure there is service continuity when the existing contract comes to an end on 31 March 2019.

Health and Wellbeing

The sub-group of the joint staff consultative committee reformed in quarter two and has agreed a work plan for its activities. The group have worked with the communications team and agreed a set of promotion activities which will be formally launched in the October in mind staff magazine.

In addition to the above, a flu plan has been developed and the vaccination programme will commence in October following a similar format to the approach used in the previous year, which achieved a significantly increased uptake rate.

3. Work programmes not featured on the strategy

Workforce information

During the summer the HR team have been working collaboratively with the finance directorate to start the process of aligning workforce and financial information. This work activity is intended to split all of our staff records and align them correctly against the organisation's service line hierarchy.

Good progress has been made against this piece of work, but there is still a small amount of data cleansing to be completed. Once this has concluded the HR directorate will be implementing directorate and service line workforce information scorecards and starting the roll out of the live data dashboard which is provided through the electronic staff record (ESR).

The above work will also facilitate the roll out of manager self service functionality within ESR. It is hoped that a first pilot wave of roll out will have commenced by the end of December 2018.

Clinical role review

The director of CYAF has initiated a programme of work to undertake a service wide review of clinical roles. A task and finish group has been established to scope all of the roles which exist across the clinical services and seek to agree generic job descriptions and to clarify the boundaries around each of the roles.

The group has met and is due to conclude its work by the end of the calendar year.

Pay and conditions changes

The changes to the agenda for change terms and conditions was successfully implemented with the new payscales being loaded in to ESR. All staff on the national terms and conditions of service have been migrated to the new pay rates and had received their pay arrears.

The working group to determine the performance criteria has been identified and meetings will be set up from November 2018 to develop and propose revisions to the appraisal process to the January joint staff consultative committee and for final approval by the executive management team in the same month.

4. 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			
Strategy Theme	Specific priorities	Action required	Q1	Q2	Q3	Q4
Attract, recruit and select talent in to the organisation	Workforce planning	Develop and agree a service led workforce planning methodology and process		X		
		Implement the workforce planning processes to inform the annual operational plan			X	X

			2017/18			
Strategy Theme	Specific priorities	Action required	Q1	Q2	Q3	Q4
	Market our offering	Explore opportunities to case study careers at the Tavistock and Portman using video and digital media				X
Develop, promote, reward and recognise our existing workforce	Career pathways	Engage the heads of discipline in planning an approach to map the Trust's existing and future career pathways	X			
		Develop a clinical rotation programme to support career diversity and longer term retention.		X	X	
		Commence recruitment to rotational roles.				X
	Succession planning	Undertake an initial review of executive level succession plans.	X			
		Expand the succession planning process to director's direct line reports.		X		
		Review the Trust's appraisal process to incorporate performance measurement.			X	

			2017/18			
Strategy Theme	Specific priorities	Action required	Q1	Q2	Q3	Q4
		Launch the 2019/20 appraisal process with the performance rating methodology.				X
	Leadership and Management Development	Conduct the annual learning needs analysis informed by the 2018/19 appraisal data and commission requirements.		X		
		Launch and deliver the annual staff education, learning and development programme.			X	X
	Tavistock and Portman Academy	Review the pilot foundation teaching programme		X		
		Plan and launch the expansion of the academy programme to other core disciplines.			X	X
		Explore and agree the future year priorities.				X
	Health and Wellbeing Group	Develop the annual staff wellbeing plan	X	X		

			2017/18			
Strategy Theme	Specific priorities	Action required	Q1	Q2	Q3	Q4
Protecting the health and wellbeing of our workforce	Occupational Health Service	Develop and agree a new health at work service tender specification for commencement in 2019/20.	X			
		Conduct and conclude service procurement.		X	X	
		Plan and prepare for service transitioning to new contract.				X
Respect and value diversity	Race equality strategy	Produce, analyse and publish WRES and agree the action plan	X	X		
		Train and develop race diversity interviewers to participate on selection processes.			X	
		Transition from HR business partners to the new arrangements			X	X
		Launch and deliver a series of cultural intelligence workshops for senior managers.			X	X
	LGBTQI+	Develop a role specification for an LGBTQI champion.		X		

			2017/18			
Strategy Theme	Specific priorities	Action required	Q1	Q2	Q3	Q4
		Seek applications and conduct a selection process.			X	
		Appoint and induct the new champion,				X
	Disability	Undertake scoping work about best practice and challenges that individuals with ASD face in employment.		X		
		Establish links with appropriate partners (e.g. charities) and develop a work programme.			X	
		Launch a series of activities to implement the work programme.				X

5. 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 2018 - Sep 2018								
Report Title	**Apr**	**May**	**Jun**	**Q1**	**Jul**	**Aug**	**Sep**	**Q2**
Staff in Post								
Full Time Equivalent Staff in Post (FTE)	590.35	593.31	591.04	591.57	592.69	589.28	594.28	592.08
Headcount	713	713	711	712.33	711	707	716	711.33
Vacancy Rate	11.49%	11.05%	11.39%	11.31%	11.14%	11.65%	10.90%	11.23%
Turnover	19.79%	19.28%	19.79%	19.62%	20.68%	20.20%	19.01%	19.96%
Stability Index	81.57%	82.70%	81.67%	81.98%	82.13%	81.78%	81.77%	81.89%
Health, wellbeing and morale								
Sickness Absence Spot Month	2.11%	2.22%	1.42%	1.92%	0.81%	0.99%	0.80%	0.87%
Sickness Absence 12 month rolling average	1.54%	1.69%	1.68%	1.64%	1.56%	1.51%	1.45%	1.51%
Training and compliance								
DBS Compliance	98%	98%	97%	98%	98%	98%	96%	97%
Appraisal Compliance	5%	17%	48%	23%	89%	89%	92%	90%

Establishment FTE (From Finance)	**667**	**667**	**667**		**667**	**667**	**667**	

6. Mandatory Training Compliance

The trust has now aligned all its mandatory and statutory training requirements with other provider organisations in the north central London footprint.

Compliance with the mandatory and statutory training that applies to all staff remains high.

Description	Quarter 1 2018/19	Quarter 2 2018/19
Mandatory Training Compliance INSET Attendance	94%	94%
Trust-wide Induction	96%	93%
Local Induction Checklists Completed	97%	96%

The table below provides an overview of role specific mandatory and statutory training. There are a number of areas with low compliance which are the result of a number of staff having now gone beyond their refresher period.

Whilst significant progress was made to increase safeguarding adults level two training earlier in the year, new intercollegiate guidance has been issued introducing a new training framework. The adult safeguarding lead has developed a plan to incorporate and implement this new training requirement.

Description	Quarter 1 2018/19	Quarter 2 2018/19
Basic Life Support - First Aiders	100%	100%
Basic Life Support - Medical & Nursing	63%	63%
Clinical Risk Training	31%	22%

Description	Quarter 1 2018/19	Quarter 2 2018/19
Conflict Resolution Training	100%	100%
Information Governance Awareness	94%	94%
Data Security Awareness (online IG)	95%	94%
Ladder Safety	48%	48%
Manual Handling	0%	40%
Safeguarding Adults – Level 2	65%	65%
Safeguarding Adults – Level 3		0%
Safeguarding Children – Level 2	94%	90%
Safeguarding Children – Level 3		
WRAP (PREVENT L3)	89%	90%

7. Conclusions and recommendations

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

Craig de Sousa
Director of HR & Corporate Governance
October 2018

The Tavistock and Portman NHS Foundation Trust

Report to	Board of Directors
Report from	Executive Appointments and Remuneration Committee – 30 October 2018

Key items to note

The executive appointments and remuneration committee convened a meeting following the October board seminar.

The meeting's topic of discussion was to agree the annual cost living awards for executive directors.

Actions required of the Board of Directors

To note the contents of this report.

Report from	Trust Chair
Report author	Director of Human Resources and Corporate Governance
Date of next meeting	30 April 2019

The Tavistock and Portman
NHS Foundation Trust

Report to	Board of Directors
Report from	Clinical Quality, Safety and Governance Committee (CQSGC) for Q2 2018/19

Key items to note

The CQSG Committee met on 7th November 2018 to consider the Q2 reports from the following work streams, which included the introduction of the new work stream for Estates and Facilities which is held by Terry Noys with Ian Garlington, Estates Consultant presenting the report:

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

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

Information Governance Update:

- With the introduction of the new data security and cyber security toolkit platform there is greater focus on technicalities rather than procedures and a number of the standards are no longer mandatory, but which are now embedded in day to day practice. This is further work to do to ensure the new reporting template for this detailed work stream is formatted in a clear and accessible way.
-

There were no specific IG risks identified in Q2 and the work stream was rated green.

Patient Safety & Clinical Risk Update:

- Unfortunately, there were four patient deaths in Q2, and these have been appropriately investigated and externally reported where required on STEIS.

- The number of complaints for Q2 was 37, with 95% of those coming via the GIC service. A role for a safeguarding lead in GIDS is being investigated to help manage and mitigate any patient related issues.
- Documenting safeguarding supervision remains an issue and will be monitored to ensure compliance.
- In Q2 there were 20 clinical incidents logged via the new Quality Portal central reporting system and all were investigated appropriately.

There were no specific patient safety risks identified in Q2 and the work stream was rated amber.

Clinical Quality and Patient Experience Update:
The Clinical Quality Strategy is on track for Q2 and making good progress in all five areas of our quality priorities and noted that the quality improvement projects across the Trust are increasing in number and all are now logged on our central reporting system, the Quality Portal. However, it was highlighted that there are three main areas that require working through to improve performance:

a) Trust governance structures – these need to be robust, clear and clearly communicated to staff and students.
b) Data dashboards – the introduction of data dashboards would enable the Trust to see and report on live data in a clear and readily available format.
c) Communication across the Trust – this needs to improve in many areas to ensure as much communication as possible reaches all areas of the Trust for both staff and students, including our satellite sites.

There were no specific quality/patient related risks identified in Q2 and the work stream was rated amber.

Corporate Governance and Risk Update:
This work stream highlighted two main issues:

a) Mandatory Training: Ensuring compliance with mandatory training remains an issue in many parts of the Trust and there was much discussion around which trainings are mandated within the NHS contract, but also on how best to ensure staff compliance and the sanctions that will be applied for non-compliance.
b) It was also noted that the CQC inspection again picked up the toy cleaning issue, which is being addressed now to ensure compliance.

There were no specific corporate governance related risks identified in Q2 and the work stream was rated amber.

Estates and Facilities Update:
It was confirmed that this work stream would provide all estates and facilities compliance but would not include the relocation project. It was further noted that this work stream topics are generated to ensure compliance with our Health and Safety policies and procedures.
There were no specific estates and facilities related risks identified in Q2 and the work stream was rated red, however It was confirmed that the red rag rating related to actions that needed to be completed rather than the level of risk attached to the work stream.

This report confirms there were no exceptional risks to report to the Board for Q2.

Actions required of the Board of Directors

For information, discussion and noting.

Report from	Dinesh Sinha, Medical Director
Report author	Irene Henderson, Clinical Governance & Quality Manager
Date of next meeting	

NHS
The Tavistock and Portman
NHS Foundation Trust

Report to	Board of Directors
Report from	Education and Training Committee – 8 October 2018

Key items to note

The Education and Training Committee met in October conducting its normal business obtaining assurance and updates in relation to various workstreams. The committee particularly noted the following.

MyTap

Following the close of phase one of the project in November last year, the auditors are currently assessing the effectiveness of that project. Delivery of phase two has commenced with a series of refinements, but there is also continuing wash-up from the main project, moving onto a stable platform with a consistent version of the software (the software is upgraded twice a year). A triple upgrade was successfully completed in September and the usual annual upgrade is planned for December subject to the confirmation of timings by the supplier Tribal.

An issue identified is the provision of operational support and recruitment for that within the constraints of the agenda for change pay banding. This will be addressed by inhouse training of Trust staff.

Scheduling and Timetabling

There have been a number of issues which have contributed to not being able to produce a full long course timetable at the beginning of Welcome Week; such as data quality collection and confusion over coding and requirements for course activities. There has been duplication and triplication of room bookings. This was exacerbated by some of the decisions taking by a past member of the project team staff before exiting the project. There have also been issues with booking clinical supervision into staff offices – this is being addressed with directorate leads. This has caused disruption and difficulties, however members of the DET exec, including the Dean's Office Manager, are working closely with the Director of Technology and Transformation and the scheduling project team to be in a position to release the full timetable as soon as possible.

Student Recruitment

The committee noted that although the marketing of Trust courses has significantly improved, there is a need to do more to understand our market and student profile. It was noted that the move to online education with the digital academy would take time to plan and develop but would provide analytic data to understand our markets and customers better. It was agreed that there is a need to grow our provision and be more diverse in our range of programmes, including considering developing undergraduate courses. The committee also discussed HEE's requirement for us to strive to have a presence elsewhere geographically. There is a need to build relationships in the regions before developing provisions and HEE will be facilitating dialogue to aid our reach and impact.

Annual Student Survey

An interim report was received from the Academic Governance and Quality Assurance Unit outlining the headlines from the annual student survey. There has been a 10% improvement in student engagement with the survey. Student satisfaction, equality, student support and ethical approval all showed improvement. There did appear to be a lower satisfaction level in relation to

research, and the unit will be working to ascertain why this might be the case. The final report will be presented to the December ETC.

It was agreed that issues of wellbeing and mental health and diversity will be included in the next iteration of the survey. It was agreed that there should be discussions with Craig de Sousa, Director of HR & Corporate Governance, in relation to developing an action plan and how to follow that up (given his experience of the staff survey).

Fee Review

The Head of Academic Governance & Quality Assurance and a Portfolio Manager are conducting a fee review which will look at how fees are set, how other providers set their fees, what is considered good practice, as well as addressing issues around communicating fees to ensure consistency and clarity across all channels including the Prospectus and the website; and further refining the Trust's terms and conditions for course fees.

DET Task & Finish Group Phase 1 Review and Phase 2 Plan

The aim of phase 1 of the Task & Finish Group was to identify cost savings of £250k and to develop actions and solutions to aid financial sustainability. It was noted that there has been good engagement from the portfolio managers. Each of the portfolios was reviewing, along with ongoing fee reviews, and DET's discount and deposit policies. This work will carry on until the end of this financial year, in preparation for the next academic year.

Actions required of the Board of Directors

The Board of Directors is asked to note this paper.

Report from	Paul Burstow
Report author	Brian Rock, Director of Education & Training / Dean of Postgraduate Studies
Date of next meeting	2 December 2018

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Report to	Board of Directors
Report from	Equality, Diversity and Inclusion Committee – 15 November 2018

Key items to note

The EDI committee met this month and dedicated a large portion of its agenda to focusing on the progress made to deliver the race equality strategy. The key highlights of the meeting are summarised below.

Workforce Disability Equality Standard
The committee noted that detailed guidance is still awaited, however, the committee noted that the reporting timetable of this new standard will be August 2019.

Gender Pay
The committee tasked the director of quality and patient experience and the director of HR and corporate governance to consider whether a specific champion role should be created. Having explored this, it was agreed a role would not be created by continued focus will be given to this area.

LGBTQI+
A job description for an LGBTQ+ diversity champion was agreed and recruitment for the role will commence in the coming weeks.

Race diversity
The race diversity champion shared feedback from the BAME network about progress being made against the race equality strategy and areas that could be considered to further develop this work. The director of HR and corporate governance agreed to attend the next network meeting to explore the suggestions further. It was also agreed that the committee will host an away day in the new year to reflect on the work undertaken to date and the future priorities.

Actions required of the Board of Directors

The executive appointments and remuneration committee should consider, at its next scheduled meeting, whether having a balance board (relating to sex diversity) was its continued aim or whether it should aspire to recruiting more women. This specifically relates to a challenge that the Board is not representative of the wider workforce composition.

Report from	Dinesh Bhugra, Deputy Chair and Non-Executive Director
Report author	Craig de Sousa, Director of HR & Corporate Governance
Date of next meeting	10 January 2019

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AGENDA

BOARD OF DIRECTORS – PART ONE
MEETING HELD IN PUBLIC
TUESDAY, 27 November 2018, 1.30pm – 4.20pm
LECTURE THEATRE. THE TAVISTOCK CENTRE, 120 BELSIZE LANE LONDON, NW3 5BA

		Presenter	Timing	Paper No
1 Patient Stories and Service Line Reports				
1.1	Gloucester House Service Line Report	Head Teacher	1.30pm	1
2 Administrative Matters				
2.1	Chair's opening remarks and apologies	Chair	2.00pm	-
2.2	Board members' declarations of interests	Chair		-
2.3	Minutes of the meeting held on 25 September 2018 2018	Chair		2
2.4	Action log and matters arising	Chair		-
3 Operational Items				
3.1	Chair and Non-Executives' Reports	Chair and Non-Executive Directors	2.10pm	-
3.2	Chief Executive Report	Chief Executive	2.20pm	3
3.3	Quality Dashboard	Director of Quality and Patient Experience	2.35pm	4
3.4	Waiting Times Report	Director of Quality and Patient Experience	2.45pm	5
3.5	Finance and Performance Report	Deputy Chief Executive / Director of Finance	2.55pm	6
4 Items for decision or approval				

		Presenter	Timing	Paper No
4.1	Schemes of Delegation	Deputy Chief Executive / Director of Finance	3.10pm	7
4.2	Reference Costs Submission	Deputy Chief Executive / Director of Finance	3.15pm	8
5 Items for information				
5.1	Board Assurance Framework	Associate Director – Quality and Governance	3.20pm	9
5.2	Operational Risk Register	Associate Director – Quality and Governance	3.30pm	10
5.3	Guardian of Safe Working – Quarterly Report	Medical Director	3.35pm	11
5.4	Serious Incidents – Quarterly Report	Medical Director	3.40pm	12
5.5	External Affairs Strategy Update	Director of Marketing and Communications	3.45pm	13
5.6	HR & Organisational Development – Assurance Report	Director of HR & Corporate Governance	3.50pm	14
6 Board Committee Reports				
6.1	Executive Appointment and Remuneration Committee	Committee Chair	3.55pm	15
6.2	Clinical, Quality, Safety and Governance Committee	Medical Director	4.00pm	16
6.3	Training and Education Committee	Committee Chair	4.05pm	17
6.4	Equality, Diversity and Inclusion Committee	Committee Chair	4.10pm	18
6.5	Strategic and Commercial Committee	Committee Chair	4.15pm	–
8 Any other business				

The Tavistock and Portman
NHS Foundation Trust

	Presenter	Timing	Paper No
9 Date of Next Meeting			
	29 January 2019 – 1.30pm – 5.00pm – The Lecture Theatre, Tavistock Centre, Belsize Lane, London, NW3 5BA		