The Tavistock and Portman **NHS**

NHS Foundation Trust

Board of Directors Part One

Agenda and papers
of a meeting to be held in public

2.00pm–4.00pm
Tuesday 25th November 2014

Board Room,
Tavistock Centre,
120 Belsize Lane,
London, NW3 5BA

The Tavistock and Portman **NHS**
NHS Foundation Trust

BOARD OF DIRECTORS (PART 1)

Meeting in public
Tuesday 25th November 2014, 14.00 – 16.00
Board Room, Tavistock Centre, 120 Belsize Lane, London NW3 5BA

AGENDA

	PRELIMINARIES			
1.	**Chair's Opening Remarks** Ms Angela Greatley, Trust Chair		Verbal	-
2.	**Apologies for absence and declarations of interest** Ms Angela Greatley, Trust Chair	To note	Verbal	-
3.	**Minutes of the previous meeting** Ms Angela Greatley, Trust Chair	To approve	Enc.	p.1
3a.	**Outstanding Actions** Ms Angela Greatley, Trust Chair	To note	Enc.	p.11
4.	**Matters arising** Ms Angela Greatley, Trust Chair	To note	Verbal	-
	REPORTS & FINANCE			
5.	**Trust Chair's and NED's Report, including NED Committee Memberships** Non-Executive Directors as appropriate	To approve	Enc.	p.12
6.	**Chief Executive's Report** Mr Paul Jenkins, Chief Executive	To note	Enc.	p.14
7.	**Finance & Performance Report** Mr Simon Young, Deputy Chief Executive & Director of Finance	To note	Enc.	p.18
8.	**Training and Education Management Board Report** Mr Malcolm Allen, Dean	To note	Enc.	p.29
9.	**SAAMHS Service Line Report - Complex** Mr Marcus Evans, Associate Clinical Director, Complex Needs	To discuss	Enc.	p.41
10.	**CQSG Quarter 2 Report** Dr Rob Senior, Medical Director	To approve	Enc.	p.58
	STRATEGY			
11.	**Action Plan for addressing Bullying and Harassment** Ms Susan Thomas, Director of Human Resources & Ms Judith Bell, Director Tavistock Consulting	To discuss	Enc.	p.77
12.	**Education and Training: Student Information Management System proposal** Mr Malcolm Allen, Dean	To approve	Enc.	p.81

13.	**Research Strategy Update** Dr Rob Senior, Medical Director	To discuss	Enc.	p.114
PATIENT STORY				
14.	**Patient Story**	To note	Verbal	-
CONCLUSION				
15.	**Any Other Business**		Verbal	-
16.	**Notice of Future Meetings** • Tuesday 2nd December 2014: Leadership Strategic Conference, 10.00am to 4.00pm, Danubius Hotel Regents Park. • Thursday 4th December 2014: Council of Governors Meeting, 2pm-5pm, Board Room, Tavistock Centre		Verbal	-

Board of Directors

Meeting Minutes (Part One)
Tuesday 28th October 2014, 2.00 – 4.15pm

Present:			
Ms Angela Greatley Trust Chair		Mr Martin Bostock Non- Executive Director (Senior Independent Director)	Dr Rita Harris CAMHS Director (non-voting)
Mr David Holt Non-Executive Director	Mr Paul Jenkins Chief Executive	Ms Lis Jones Director of Nursing (non-voting)	Ms Louise Lyon Trust Director
Dr Ian McPherson Non-Executive Director (Deputy Trust Chair)	Ms Joyce Moseley Non-Executive Director	Dr Rob Senior Medical Director	Mr Simon Young Deputy Chief Executive & Director of Finance
Attendees:			
Mr Gervase Campbell Trust Secretary (minutes)	Governor Ms Kate Davies	Ms Nell Nicholson Headteacher (item 9)	Ms Edna Murphy
Ms Jane Gizbert			
Apologies:			
Ms Caroline Rivett Non-Executive Director	Mr Malcolm Allen Dean		

Actions

AP	Item	Action to be taken	Resp	By
1	7	Circulate GIDU expansion plan	LL	Nov
2	7	Look into underspend in Complex Needs	LL	Nov
3	10	Invite NEDs to attend INSET training	GC	Nov
4	16	Look into possibility of circulating the patient story	GC	Nov

1. Trust Chair's Opening Remarks
Ms Greatley opened the meeting and welcomed everyone, introducing Ms Jane Gizbert and Ms Edna Murphy, who were present to observe the meeting and would be starting their roles as Non-Executive Directors in November.

2. Apologies for Absence and declarations of interest
Apologies as above.

3. Minutes of the Previous Meeting
The minutes were agreed.
There was a discussion on how to minute Patient Stories, and it was agreed that in the future they would be anonymised as a matter of course, and the details of the story only included in so far as they were pertinent to the discussion and lessons learned.

4.   Matters Arising

Action points from previous meetings:
AP1 – it was agreed the cash flow query would be recirculated.
Outstanding AP6 – the staff survey follow up is on the agenda of this meeting.

5.   Trust Chair and NEDs' Report

Ms Greatley expressed her personal thanks to Mr Bostock and Ms Moseley for all their work at the Trust, the Board echoed her thanks wholeheartedly.

Dr McPherson reported that he had attended a meeting of the London Crisis Care Concordat, and noted that the Trust could contribute best by supporting those who cope with people in crisis, for example the police and A&E staff.

Mr Bostock reported that he had presented at a seminar at the King's Fund on the role of the Senior Independent Director, and had been struck by the different ways Trusts handled the role, and would be happy to pass on what he had learnt about the role.

6.   Chief Executive's Report

Mr Jenkins drew attention to the email, in the appendix, which had been sent to staff to update them on the work being done on the Shaping Our Future agenda, in order to give them a sense of how things were moving forward and to keep them involved.

Mr Jenkins explained that he had invited Mr David Gilbert, Co-Director of the Centre for Patient Leadership, to do some work alongside Dr Hodges, Ms Lyon and the PPI Committee on how to take the lived experience agenda forward.

Mr Jenkins noted that he had met briefly with Mr Norman Lamb, MP, and discussed some of the work the Trust was doing with children and young people. Mr Lamb had been especially interested in the work we were doing consulting with schools, and had suggested arranging a round table with headteachers to discuss the issues.

The Board **noted** the report.

7.   Finance & Performance Report

Mr Young noted that he had attended the London region Tripartite meeting of Monitor, NHS England and the NHS TDA, where an inspirational address from Mr Simon Stevens, NHS Chief Executive, on the Five Year Forward View had been followed by presentations from Trusts looking at some of the actions required at local levels to implement its aspirations.

Mr Young introduced his report by noting that the situation was little changed from last month, with most of the risk to the overall plan down to FNP, which was being addressed but was concerning. Mr Young noted that assuming a solution to the FNP situation could be found he was forecasting a surplus somewhat ahead of plan, and that the current position was somewhat ahead of that again due to the timing of various projects. He noted that the capital expenditure was slightly below target at the moment due to delays to projects, but this was not significant.

Mr Bostock noted that paragraph 2.2.7 showed that GIDU anticipated being £140k underspent at the end of the year, and commented that with the increase in referrals, it was a great shame if recruitment was falling behind. Ms Lyon commented that the unit was recruiting, and had grown its numbers, but its expansion was exponential and the increase in referrals unpredictable. She noted that there was a plan in place to handle the expansion, and offered to circulate it to the Board.

AP1

Mr Bostock asked about the delay in raising invoices mentioned in para. 2.5.1, and Mr Young explained that with a small team only one or two people handle each role, so sickness can cause delays despite their best efforts to cover. In this case the delays were not ideal, but the team had now caught up.

Ms Moseley noted the mention of CQUIN targets in para. 4.1.1 and enquired how important meeting them was to the finances of the Trust, and whether quarterly reviews were sufficient. Mr Young explained that they represented about £200k in total, but only a fraction of this was ever at risk, as the targets were agreed with commissioners to be achievable. Ms Lyon noted that the targets were monitored more frequently at the team level. Ms Greatley noted that it was not just a financial question, but of our reputation with commissioners. Dr Harris noted that there was an ongoing conversation with commissioners over targets and performance, and missing them was not so much a question of failure as a prompt for discussion.

Dr McPherson noted that in para. 2.2.8 Complex Needs were forecasting a £120k underspend due to vacancies, and that in his recent visit to the Fitzjohns Service staff had mentioned there were staff cuts. Ms Lyon stated

AP2

that there were definitely no cuts in progress, but that she would look into why the team felt that way, and she commented that part of the underspend was due to the vacant service manager post, the money for which was being redirected to supporting the Adolescent move to CAMHS, but she would look into the reasons for the rest of it.

Mr Holt noted that section 2.3 showed the NHS Contract payments were a month in arrears, and asked whether this was also the case for other NHS trusts and if there was more we could do. He also asked whether the £0.5M outstanding from last year was a risk. Mr Young replied that the delay seemed to be the de facto norm now, in part due to changes to systems within the commissioners, but whether it was also the case for other Trusts he didn't know. With regards to the sum outstanding from last year he noted that a couple were disputed and we might have to agree to a reduction on them, but the risk was low.

The Board **noted** the report.

8. Training and Education Programme Management Board – October Report

Mr Jenkins noted that the programme board was working well, and it was important to have a good flow of information to the Board, so he would welcome comments on the format of the report as well as its contents.

Mr Jenkins highlighted that the programme board had started consultation on changes to the structure of education and training, which included creating a direct management line from the director to the staff and teams on the ground, through the associate deans and new portfolio leads. Two consultation meetings had been held: there had been a positive reaction to increasing the profile of E&T; a spectrum of views on the shift in line management, but generally accepting; and an interesting debate on the portfolio groupings, with a suggestion for more lopsided groupings that would allow some leads to focus on new business, which would considered by the programme board. The aim was to implement the new structures as soon as possible, to reduce the uncertainty for staff.

Mr Jenkins noted that recruitment for 2014/15 was 50 students short of the target. This highlighted fundamental problems with the current system where recruitment started too late in the year and did not involve an overview of the market to allow the correct promotion of courses. The recruitment cycle for 2015/16 would be brought forward to start correcting these problems.

Mr Jenkins noted that a key question the programme board had considered

was the national training contract, and the need to strengthen our position and to tell our national provision story better. To do this we needed visible regional training centres, and in seeking to set these up it might be best to follow the way Health Education England divide the country. Our start could be the existing successful Northern School hosted by Leeds and York Partnerships NHS Foundation Trust. Dr McPherson welcomed the focus on regional development, and noted that the Governors representing the Rest of England had expressed interest in being involved with this, and he could liaise with them over it when suitable. Mr Young commented that one reason the Northern School had been successful was the local provider had wanted it, and had supported its establishment by funding a skilled manager to set it up and initially lead it.

Mr Jenkins concluded by noting that tomorrow we would hold the interviews for the Education and Training Director post, and the University partnership proposal would go to the University of Essex senate.

Ms Moseley praised the proposed changes, and asked whether the 'radical shift in practices' mentioned in para. 4.3 concerned back office staff, and if so whether there were lessons for the wider Trust. Mr Jenkins answered that the shift was more about looking to E&T to make the interface between clinical and training work, and having a more strategic focus on recruitment which might allow, for example, doubling up courses that prove particularly popular.

Mr Bostock asked what the financial implication of being under target on student numbers was, and whether it had been factored into the financial report. Mr Holt followed up by asking whether the profitability and margin of individual courses should be included in the report for decision making. Mr Young confirmed an estimate of the student shortfall had been included in the finance report, and Mr Jenkins commented that margins would be an issue as they looked at courses for 2015/16, and that the agenda of the programme board had initially been dominated by the backlog of strategic issues, but routine monitoring of the KPIs would be introduced.

The Board **noted** the report.

9. Gloucester House Day Unit Annual Report

Ms Nell Nicholson introduced the report by highlighting the different situation the Day Unit was in compared with a year ago, and her feeling that they had turned a corner and the new model was working, both financially and engaging staff, with opportunities to build positively. She noted that the staff had been working very hard throughout the

implementation stage, and they were dedicated, but it would be important to keep an eye on their workload.

Dr McPherson commended them on involving children on the interview panels, and congratulated them on the recent article in the Guardian, which had shown the complexity of the work in a clear way. Mr Bostock agreed and noted that there was always a risk when journalists were invited in, but it was something we should do more of in the Trust, even if the outcomes would not always be this positive.

Mr Bostock asked when the staff survey on workload had been done, and whether another one might be helpful. Ms Nicholson replied that the survey had been done in March and it would be good to repeat it once all the referrals were in and the systems bedded down, so perhaps in March 2015, and noted that there were support systems in place for staff.

Dr Senior echoed the positive reaction to the report, but noted that there continued to be significant challenges, in introducing Key Stage 2 children, in broadening provision to other boroughs that would bring transport problems, and the question of the facilities being fit for purpose. Ms Nicholson noted that the most recent Ofsted inspection had been happy with the premises, which reflected the importance of the ongoing cycle of cosmetic refurbishment that had been put in place with Pat Key.

The Board **noted** the report.

10   Annual Safeguarding Children Report

Dr Senior summarised that the Trust was meeting its obligations regarding external scrutiny and regulation, but there was always more that could be done, which would require more resources. He noted that recording which children were subject to protection plans or section 17 could not be done in Rio, and so was done separately by hand at present, which was time consuming, and in addition there were many consultations and requests for advice that he and Sonia Appleby were currently handling, so overall they were modestly resourced but doing a lot with what they had. Ms Greatley commented that it was an important consideration for the CQC, and many Trusts struggled with it, so more resources might be required in the move to IDCR.

Mr Holt enquired what the right level for the training percentage was, and whether it should be 100%. Dr Senior commented that it was never possible to reach 100%, due to staff missing training sessions due to sickness, maternity leave or clinical crises, but a figure in the 90s was necessary and 97% was a good aspiration, and to achieve it would require more chasing and reminding of a small number of clinicians. Directors do follow up and take action, and there were serious sanctions available that had been employed where necessary.

Mr Bostock noted that it was sobering how low the take up of the Safer Recruiting training had been before it was made mandatory, and what it might say about the culture of the Trust. Dr Senior commented that many people questioned the value of Safer Recruitment training in the context of our work, as it was a basic tool which looked at gaps in employment history, and so was most suitable to organisation employing non-clinicians, for example transport drivers, and less so for their employment pool of clinicians coming from training backgrounds that necessitated detailed histories. However, whilst he appreciated the sentiment of staff, it was important to comply with this external requirement and they would do so.

AP3   Ms Greatley noted that NEDs, and on occasion Governors, sat on interview panels they would require safer recruitment training too, and that NEDs should be invited to attend INSET so that they received basic training including safeguarding level 1.

The Board **noted** the report.

11   Quarter 2 Quality Report

Ms Lyon flagged up the links with physical health coming up the agenda, and noted that Dr Caroline McKenna and Dr Julian Stern were the Trust's

leads on physical health, and were looking at how it could be integrated, given our staffing types and client groups. She noted that there would be a Scientific Meeting in January with Dr Jonathan Campion of SLAM addressing mental health and smoking.

Ms Lyon drew attention an error in the report – on page 61 the colour coding for VI – cancellation rates – should be green rather than amber.

Ms Lyon addressed the complaints figure, which unusually was red for Q2, explaining that this was down to two unusual incidents and in her opinion did not indicate the start of a trend or a reason for further concern. The first complaint had initially not been sent to the Trust at all, but instead to various other bodies, and as a result it had not been treated as a complaint from the start, and so had been delayed. Lessons had been learnt from the way it was handled. The second complaint had been delayed due to a mosaic of circumstances, but in large part it was down to a desire to not send the letter giving the response until the patient's clinician would be available to speak to the patient when the response was received.

Mr Holt noted on p. 72 the 5 cases where a patient had breached the 11 week waiting period, all due to causes outside the Trust's control, and asked whether there was anything we could do about this and what support was available to patients in this situation. Ms Lyon explained that in most cases the delay was due to no arrangement for payment being in place, usually a Named Patient Agreement was required. Dr Harris added that in each case the patient was being referred from an existing care network, so there was already support in place for them. Dr McPherson added that it would be a breach of good practice to take on a patient without having an agreement in place, so there was no reputational risk to the Trust from these cases.

The Board **noted** the report.

12   Documentary Project

Mr Jenkins introduced the report by noting that the Trust had been approached by broadcasters before, but this proposal seemed to be worth looking at more closely as it involved both a production company and also the commissioning editor from Chanel 4 who had previously been involved with the Bedlam series, which had been well received for its realism and the respect it showed for people experiencing mental health difficulties. The proposal was in two phases, and to agree to the first research phase did not involve any commitment to commissioning. Mr Jenkins recognised the risk involved in such a project, but given the potential benefits both for the

Trust and also more widely to reducing stigma by showing a realistic portrayal of users and their engagement with services, he recommended they proceed.

The Board **approved** the recommendation to proceed with the research phase.

13   Q2 Governance Declaration

Mr Young introduced the report by commenting that it was similar to those of previous quarters and had been reviewed by the Management Team. He noted that the Board was asked to declare that they would maintain the continuity of service rating for the next 12 months, but that the detailed finance reports they had received only covered the next 3 months, and though the Strategic and Operational plans went out beyond that they were not so detailed. The Board debated the declaration they were asked to make, and agreed that whilst they did not make light of the challenges they faced, there were plans in place that were being followed to address them.

The Board **approved** the three elements of the Governance Statement to be submitted to Monitor for Q2.

14   Duty of Candour and Fit and Proper Person Test

Ms Greatley introduced the report, noting that the legislation was not yet in place but it was important for the Board to be aware of what was coming, and confirmed that the Trust was working to ensure it would meet the requirements of the legislation. Mr Campbell explained that the legislation was due to take effect from mid-November, and that better joint guidance from Monitor and the CQC was expected very soon.

Ms Lyon queried whether the good character requirement would mean checking registers other than those of professional clinical organisations. Mr Campbell confirmed that this would be the case, and that the list of disbarred directors held by Companies House, and the Insolvency list would both be checked.

The Board **noted** the report.

15   Charitable Fund Terms of Reference

The Board **approved** the Terms of Reference.

16   Patient Story – Ms C, written story

Ms Greatley introduced the story by noting that the patient had not been

able to attend in person due to child care difficulties, but instead had kindly written their story for the Board, and so this was an opportunity to consider a new way of receiving stories.

The Board took a few minutes to re-read the story together.

Ms Lyon began the discussion and various board members contributed their insights. Some of the key points taken were:

- The importance to the patient of the ethnic origin of the therapist, of having a therapist from a minority background. Whilst this may not be the case for everyone, it highlights the importance of attempting to have our clinical workforce reflect the population we serve, in all aspects of diversity.

- The length of the treatment, and the variety of treatments we offered. This is a very positive aspect of the way we help people, and we should highlight the way we put together a range of different support services for families, and the flexibility we exhibit in listening to feedback and adjusting what we do.

- How long it took for the child to reach our services. This isn't something under our control, but it is distressing that the child could have received help earlier, and perhaps there is more we could do with consultations for teachers as well as educating them on our services and referrals, or indeed in getting involved in training teachers to help them manage the emotional wellbeing of their pupils.

AP4   Mr Jenkins summarised the discussions by noting that having a patient story in a written form could be just as effective as hearing the story face to face, and might encourage a wider range of stories as it would be less imposing for the patient. He commented that he would like to circulate the story to staff, both as a nice way to show the appreciation of a patient, but also because of the well-crafted insights it contained. It was agreed to follow this up with PPI. Ms Greatley added that once they had heard the first four patient stories and considered them all together it would be beneficial to share the lessons learnt with all staff.

Part 1 of the meeting concluded at 4.15pm.

Outstanding Action Part 1

Action Point No.	Originating Meeting	Agenda Item	Action Required	Director / Manager	Due Date	Progress Update / Comment
3	Apr-14	8. Annual Complaints Report	Time to respond to be added to future complaints reports	Jane Chapman	2015	Confirmed that Ms Chapman is still responsible for the report.

Outstanding Actions

The Tavistock and Portman **NHS**
NHS Foundation Trust

Board of Directors : November 2014

Item : 5

Title : Chair's Report – NED Key Committee Memberships

Purpose:

To seek approval for non-executive key roles on the Board of Directors:

- Deputy Chair
- Chair and membership of Audit Committee
- Membership of the CQSG Committee
- Chair of Strategic and Commercial Programme Board
- Remuneration Committee membership
- Senior Independent Director

This report focuses on the following areas:

Corporate Governance

For : Approval

From : Angela Greatley, Chair

Following the recent changes of non-executive directors, I would like to propose the following appointments:

Senior Independent Director
I should like to propose that David Holt take on the role of Senior Independent Director.

Membership of the Audit Committee
I should like to propose David Holt continues to chair the Audit Committee.

I should like to propose Edna Murphy as a new member of the audit committee, joining Ian McPherson. We agreed this new appointment by email at the beginning of the month.

Membership of the CQSG Committee
I should like to propose Dinesh Bhugra and myself as new members of the CQSG committee. We agreed by email at the beginning of the month that Dinesh and I would join this committee, and we attended their meeting on the 4th November.

Remuneration Committee
I confirm all non-executive directors as members of the Remuneration committee: Angela Greatley (Chair), David Holt, Ian McPherson, Edna Murphy, Jane Gizbert and Dinesh Bhugra.

Membership of the Strategic and Commercial Programme Board
I should like to propose David Holt continue as acting chair of the Strategic and Commercial Programme Board, to be reviewed in the new year in light of new memberships.

I should like to propose Ian McPherson and Edna Murphy as new members of the committee.

Deputy Chair of the Trust
I should like to propose Ian McPherson continue to serve as Deputy Chair of the Board of Directors, as appointed by the Council of Governors.

Training and Education Programme Management Board
I should like to propose that Edna Murphy, Ian McPherson, Dinesh Bhugra and Jane Gizbert join the Training and Education Programme Management Board.

Recommendation:

The Board of Directors is asked to approve these appointments with immediate effect

Angela Greatley
Chair

Board of Directors : November 2014

Item : 6

Title : Chief Executive's Report

Summary:

This report provides a summary of my activities in the last month and key issues affecting the Trust.

For : Discussion

From : Chief Executive

CEO's Report

Chief Executive's Report

1.   Feedback on Board meeting

1.1   As agreed with the Board of Directors we issued the first staff update about the October Board meeting. This appeared to be well received by staff.

2.   Training and Education

2.1   There have been a number of significant developments in the last month relating to Training and Education. These are covered in more detail in report on the third meeting of the Training and Education Programme Board which is included in the agenda for this meeting.

2.2   In particular the Board of Directors will want to note:

- the appointment of Brian Rock as the new Director of Education and Training and Dean of Postgraduate studies. Brian will be taking up post at the beginning of the New Year but is beginning to be involved in key issues before then.

- continued consultation has taken place on the proposed new structures for Education and Training. These have generally been well received. Some further work has been undertaken, in the light of feedback, to tweak the proposed configuration of portfolio groupings. These will be presented to the Education and Training Programme Board for final agreement on 1st December.

- the proposal for a strategic partnership with Essex University was ratified by their University Senate on 29th October. A number of meetings have taken place to start the detailed planning work for the migration of our current portfolio.

- The post of Director of Marketing and Communications has now been advertised and interviews will be held on 18th December.

2.3   The Board may wish to take the opportunity to put on record its appreciation of the work of Malcolm Allen who will be leaving the Trust at the end of the year. Malcolm has made an extremely important contribution to the development of education and training at the Tavistock and Portman.

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3. Finance

3.1 As is highlighted later in the agenda, the current financial position of the Trust is positive with a current in year surplus of £433,000 and a forecast end year surplus of £33,000. As Directors are aware we face, in line with our 2 and 5 year plans, the need to find savings between £1.2m and £1.6m to meet anticipated efficiency savings in 2015/6. Work is currently in hand to address this and we are aiming to present our plan for the delivery of a balanced budget at the January Board. At this stage, while very aware of the scale of the challenge, I am confident of us being able to achieve this.

4. CAMHS bids

4.1 We have now submitted our bid for the Essex CAMHS tender. This entailed a very significant effort from staff across the organisation, and in particular Commercial Directorate and CAMHS. We have had, earlier in the month, a very constructive initial dialogue meeting with the commissioners.

4.2 We have been invited to make a presentation on our CAMHS bid in Hampshire on 3rd December.

5. Documentary

5.1 We have communicated to Century Films and Channel 4 the Board's decision to support a period of research to explore the potential to produce a documentary about the work of the Trust. A kick off meeting is being held on 20th November.

6. London Mental Health Chief Executives

6.1 The London Mental Health Chief Executives Group has commissioned Freshwater Communications to develop a programme of communications to raise the profile of mental health in London.

6.2 Freshwater presented to both Chief Executives and Chairs on 14th November. Their work will include the production of a "London Mental Health Fact Book", the training and support of a rota of

clinical and management spokespeople who can react to important mental health stories and a range of digital communications activity. With Maria Kane from BEH I will oversee this work on behalf of the group.

7.   External Engagement

7.1   In the last month I have had the chance to attend a range of external engagement events including an Foundation Trust Network dinner with Simon Stevens and the annual Health Services Journal Summit. Much of the conversation has focused on the financial challenges facing the service over the next couple of years. I have taken the opportunity on both occasions to highlight the importance of addressing the need for integration between mental and physical health.

Paul Jenkins

Chief Executive

17th November 2014

Board of Directors : November 2014

Item :   7

Title :   Finance and Performance Report

Summary:

After seven months a surplus of £433k is reported before restructuring and assuming that the FNP underspend is deferred; this is £310k above the revised budget surplus of £124k. Income from training and consultancy has fallen below expectations, but this has been offset by underspends across a number of services.

The current forecast for the year is a surplus of £33k (before restructuring costs of £29k).

The cash balance at 31 October was £5,695k which is above plan due to salary payments being lower than anticipated in addition to old year payments from commissioners. Cash balances are expected to be lower by the end of the financial year but will remain above plan.

The Service Line Report is shown in Appendix C.

This report has been reviewed by the Management Team on 13 November.

This report focuses on the following areas:
- Risk
- Finance

For :   Information.

From : Deputy Chief Executive and Director of Finance

Finance & Performance

1. External Assessments

1.1 Monitor

1.1.1 The Monitor submission for the second quarter was submitted at the end of October. The continuity of service risk rating (CoSRR) is expected to remain at 4, which is on plan; and governance rating of Green. The CoSRR is expected to reduce to 3 by the end of the financial year, but this remains satisfactory.

1.1.2 Monitor's assessment of our Strategic Plan has not yet been published.

2. Finance

2.1 Income and Expenditure 2014/15

2.1.1 After October the trust is reporting a surplus of £433k before restructuring costs, £310k above budget. FNP are currently £476k underspent, but the corresponding amount of income has been deferred: action is being taken to allow such a deferral at year-end. Income year-to-date is £508k below budget (mainly due to the FNP deferral), and expenditure £813k below budget.

2.1.2 Income is balanced to budget overall for the month. The FNP deferral was reduced by £59k due to increased expenditure for the month which was offset by reduced fee income in CAMHS & SAMHS Training. DET Training Fees are £114k under budget cumulatively but this is expected to improve by the end of the financial year. TC income is cumulatively £34k below target across Consultancy and Training but this is offset by an under spend of £38k on expenditure.

2.1.3 CAMHS Clinical was £10k below target cumulatively due to the Day Unit but this forecast to improve as new pupils have started the next academic year. These main income sources and their variances are discussed in sections 3, 4 and 5.

2.1.4 For an externally funded Finance project, the £2k under spend to date (within the Finance line) is matched by a £2k adverse variance on Other Income, since the funding is released in line with costs.

2.1.5 The key financial priorities remain to achieve income budgets; and to identify and implement the additional savings required for future years.

2.1.6 The adverse movement of £100k on the expenditure budget was due mainly to increased expenditure on FNP for October. Finance, ICT and Informatics are overspent in month by £46k due to the CAMHS PbR project (mentioned above in 2.1.2) and ICT non pay expenditure. The cumulative under spend of £813k is primarily due to FNP at £476k and unused reserves totalling £242k.

2.2 Forecast Outturn

2.2.1 The forecast surplus before restructuring of £33k is £7k below budget. FNP are currently predicting a £435k under spend; we have assumed we can agree with the commissioner to defer the corresponding income to 2015/16, the effect on

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the Trust's surplus has been removed.

2.2.2 Clinical income is currently predicted to show £69k above budget due the release of deferred income from GIDU and Portman Mentalisation Based Therapy. The Portman MBT contract for 2014/15 was also significantly greater than the original budget; this has also been reflected in the Portman expenditure forecast.

2.2.3 GIDU are currently over-performing against the agreed contract volume and we are in discussion with PHE regarding a payment mechanism for this.

2.2.4 CAMHS Training fees are currently £76k above budget and are expected to be £165k above budget by the end of the financial year.

2.2.5 SAAMHS Training is expected to be £214k adverse due to student numbers.

2.2.6 TC consultancy income is currently £24k below budget but they expect to be on target at the end of the financial year

2.2.7 Day Unit is £11k above budget after October and expect to achieve the £650k annual target, with higher income after the start of the academic year

2.2.8 GIDU are currently £85k under spent but expect to have a balanced expenditure budget at the end of the year.

2.2.9 Complex Needs are forecasting £105k underspend on vacancies. Offsetting this, there is £77k additional BUPA expenditure, which is covered by £77k additional SAAMHS Consultancy income.

2.2.10 SAAMHS identified £105k income from Clinical Income growth of which only £14k is expected in 2014/15.

2.2.11 CAMHS identified £96k income from Clinical Income growth of which only £35k is expected in 2014/15.

2.2.12 R&D Expenditure is expected to be £128k below budget due to Anna Freud recharge finishing. R&D income is forecast to be £93k above target due to 2013/14 income being invoiced in 2014/15.

2.2.13 The forecast allows for the investment reserve of £120k to be fully utilised (further decisions on allocation are to be made shortly); and also for the remaining contingency reserve of £150k to be needed.

2.2.14 Depreciation is expected to be £31k above budget.

2.3 <mark>Cash Flow (Appendix D)</mark>

2.3.1 The actual cash balance at 31 October was £5,695k which is an increase of £3,048k in month, due to the HEE and the FNP quarterly funding having been paid in advance in October. The position is £1,884k above plan due payments for 2013/14 NHS contracts which were excluded from the plan, in addition to the current 2014/15 surplus.

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2.3.2 The cash forecast is to be £2m above plan. This is due to the additional NHS old year payments (£0.5m is still outstanding), the FNP deferral/underspend and the forecast surplus.

	Cash Flow year-to-date		
	Actual	Plan	Variance
	£000	£000	£000
Opening cash balance	**2,757**	2,757	0
Operational income received			
NHS (excl SHA)	**12,273**	10,974	1,299
General debtors (incl LAs)	**4,686**	4,337	349
SHA for Training	**8,373**	8,145	228
Students and sponsors	**1,823**	1,725	98
Other	**0**	0	0
	27,155	25,181	1,974
Operational expenditure payments			
Salaries (net)	**(9,333)**	(9,802)	469
Tax, NI and Pension	**(7,272)**	(7,258)	(14)
Suppliers	**(6,525)**	(6,048)	(477)
	(23,130)	(23,108)	(22)
Capital Expenditure	**(919)**	(800)	(119)
Interest Income	**7**	3	4
Payments from provisions	**0**	(11)	11
PDC Dividend Payments	**(175)**	(211)	36
Closing cash balance	**5,695**	3,811	1,884

3. <mark>Training</mark>

3.1 Income

3.1.1 Training income is £610k below budget in total after seven months. Details are below. FNP income and expenditure is currently being reported as £475k below budget as it is assumed that this will be deferred to next year. Overall student numbers are marginally below target for the new academic year.

LDA income (lines 4-7 appendix B)	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Forecast £'000
NHS London Training Contract	4,232	4,232	0	0
Child Psychotherapy Trainees	1,253	1,237	-16	0
Junior Medical Staff	558	589	31	0
Postgraduate Medical and Dental (budget incl. study leave)	55	24	-31	0
Sub Total	**6,098**	**6,082**	**-16**	**0**
Fees and academic income (lines 8-11 Appendix B)				
DET	1,155	1,041	-114	-83
CAMHS	1,754	1,830	76	165
FNP	2,607	2,132	-475	-435
SAAMHS	837	766	-72	-214
TC	122	112	-9	-52
Sub Total	**6,475**	**5,880**	**-594**	**-618**
Grand Total	**12,573**	**11,963**	**-610**	**-618**

3.1.2 If we exclude FNP, then training income is £135k below target year to date. This is mainly due to an LCCPD shortfall which has been partially offset by HEFCE and short course income.

3.1.3 The National Training Contract will be increased in Qtr3 by short term funding of £166k to support development posts to 31st March 2015. The full year budget has been revised accordingly.

3.1.4 The Training income forecast excluding FNP is £183k adverse. This is primarily due to fee income. Student course fee income for the financial year is forecast to be £114k below Plan. Fee income for the full academic year 2014-15 is currently forecast to be £229k below Plan, made up of a shortfall of £268k in SAAMHS and £45k in TC offset by £84k favourable fee income variance for CAMHS.

3.1.5 The postgraduate medical and dental education income is £31k adverse to budget, as the income for study leave is now incorporated in the junior medical staff tariff.

3.2 Expenditure

3.2.1 Expenditure is currently £53k under spent at the end of October. The forecast at the end of the financial year is a £50k over spend.

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4. Patient Services

4.1 Activity and Income

4.1.1 Total contracted income for the year is expected to be in line with budget, subject to meeting a significant part of our CQUIN[†] targets agreed with commissioners; achievement of these is reviewed on a quarterly basis.

4.1.2 Variances in other elements of clinical income, both positive and negative, are shown in the table below. However, the forecast for the year is currently in line with budget in most cases, not in line with the extrapolated figures shown as "variance based on year-to-date."

	Budget £000	Actual £000	Variance %	Full year		Comments
				Variance based on y-t-d	Predicted variance	
Contracts - base values	7,662	7,670	0.1%	14	79	GIDU and MBT income deferred from 13/14. Offset by new projects
Cost and vol variances	190	190	0.0%	0	0	
NPAs	64	86	33.0%	64	0	
Projects and other	727	719		–	0	Income matched to costs, so variance is largely offset.
Day Unit	378	389	3.1%	20	0	
FDAC 2nd phas	451	443	-1.8%	-14	0	Income matched to costs, so variance is largely offset.
Court report	16	14	-15.7%	-4	-10	
Total	9,488	9,510		80	69	

4.1.3 The income budget for named patient agreements (NPAs) was reduced this year from £196k to £131k. Up to October actual income is £16k above budget.

4.1.4 Court report income has a reduced budget from £113k for 2013/14 to £28k in 2014/15. There has been £14k income to date, so we are £2k below budget. This income stream is expected to be £10k below budget at the end of the year.

4.1.5 Day Unit Income target was reduced by £210k in 2014/15 and is £11k above target after October. As expected, the additional income required to meet their revised target has begun to be achieved from the start of the academic year.

[†] Commissioning for Quality and Innovation

4.1.6   Project income is forecast to be balanced for the year. When activity and costs are slightly delayed, we defer the release of the income correspondingly.

5.   <mark>Consultancy</mark>

5.1   TC are £4k net above their budgeted target after seven months. This consists of expenditure £38k underspent, TC Training Fees £9k below budget and consultancy £24k below budget. TC are currently expecting to have a balanced budget by the end of the financial year.

5.2   Departmental consultancy is £15k below budget after October; SAAMHS are currently £14k below budget. However, SAMHS expect to be ahead of budget for the year.

Carl Doherty
Deputy Director of Finance
17 November 2014

Finance & Performance

THE TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST

INCOME AND EXPENDITURE REPORT FOR THE FINANCIAL YEAR 2014-15

		Oct-14			CUMULATIVE			FULL YEAR 2014-15		
		BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	REVISED BUDGET £000	FORECAST OUTTURN £000	BUDGET VARIANCE £000
INCOME										
1	CLINICAL	1,408	1,400	(9)	9,488	9,458	(30)	16,211	16,280	69
2	TRAINING	1,681	1,673	(8)	12,573	11,963	(610)	21,527	20,908	(618)
3	CONSULTANCY	146	125	(22)	856	816	(40)	1,492	1,490	(2)
4	RESEARCH	10	30	20	72	154	82	123	175	53
5	OTHER	86	107	21	413	502	90	893	984	91
TOTAL INCOME		**3,332**	**3,335**	**3**	**23,401**	**22,893**	**(508)**	**40,245**	**39,838**	**(408)**
OPERATING EXPENDITURE (EXCL. DEPRECIATION)										
6	CLINICAL DIRECTORATES	1,363	1,376	(13)	9,104	9,080	25	15,604	15,601	3
7	OTHER TRAINING COSTS	1,146	1,198	(52)	8,668	8,094	574	15,011	14,629	382
8	OTHER CONSULTANCY COSTS	90	98	(9)	459	417	42	787	787	0
9	CENTRAL FUNCTIONS	646	640	5	4,292	4,293	(1)	7,468	7,521	(53)
10	TOTAL RESERVES	(23)	0	(23)	190	0	190	370	270	100
TOTAL EXPENDITURE		**3,222**	**3,312**	**(91)**	**22,714**	**21,884**	**830**	**39,239**	**38,807**	**432**
EBITDA		**110**	**22**	**(88)**	**687**	**1,009**	**322**	**1,006**	**1,030**	**24**
ADD:-										
11	BANK INTEREST RECEIVED	0	1	(0)	3	7	(4)	5	5	0
LESS:-										
12	DEPRECIATION & AMORTISATION	46	56	(10)	321	337	(16)	550	581	31
13	FINANCE COSTS	0	0	0	0	0	0	0	0	0
14	DIVIDEND	35	35	0	246	246	0	421	421	(0)
SURPLUS BEFORE RESTRUCTURING COSTS		**30**	**(68)**	**(98)**	**124**	**433**	**310**	**40**	**33**	**(7)**
15	RESTRUCTURING COSTS	0	0	0	0	29	(29)	0	29	(29)
SURPLUS/(DEFICIT) AFTER RESTRUCTURING		**30**	**(68)**	**(98)**	**124**	**404**	**281**	**40**	**5**	**(35)**
EBITDA AS % OF INCOME		3.3%	0.7%		2.9%	4.4%		2.5%	2.6%	

THE TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST										APPENDIX B
INCOME AND EXPENDITURE REPORT FOR THE FINANCIAL YEAR 2014-15										
All figures £000		Oct-14			CUMULATIVE			FULL YEAR 2014-15		
		BUDGET	ACTUAL	VARIANCE	BUDGET	ACTUAL	VARIANCE	OPENING BUDGET	REVISED BUDGET	FORECAST	REVISED BUDGET VARIANCE
	INCOME										
1	CENTRAL CLINICAL INCOME	593	602	8	4,198	4,244	47	7,054	7,163	7,388	225
2	CAMHS CLINICAL INCOME	319	346	26	2,267	2,256	(10)	3,987	3,863	3,776	(87)
3	SAAMHS CLINICAL INCOME	496	452	(44)	3,024	2,958	(67)	4,398	5,185	5,116	(69)
4	NHS LONDON TRAINING CONTRACT	605	605	(0)	4,232	4,232	(0)	7,254	7,420	7,420	0
5	CHILD PSYCHOTHERAPY TRAINEES	179	169	(10)	1,253	1,237	(16)	2,148	2,148	2,148	0
6	JUNIOR MEDICAL STAFF	80	76	(4)	558	589	31	1,022	957	957	0
7	POSTGRADUATE MED & DENT'L EDUC	8	5	(3)	55	24	(31)	94	94	94	0
8	DET TRAINING FEES & ACADEMIC INCOME	19	34	15	1,155	1,041	(114)	1,739	1,362	1,279	(83)
9	FAMILY NURSE PARTNERSHIP	372	431	59	2,607	2,132	(475)	4,469	4,469	4,034	(435)
10	CAMHS TRAINING FEES & ACADEMIC INCOME	256	224	(32)	1,754	1,830	76	2,274	3,033	3,198	165
11	SAAMHS TRAINING FEES & ACADEMIC INCOME	139	111	(27)	837	766	(72)	1,530	1,787	1,573	(214)
12	TC TRAINING FEES & ACADEMIC INCOME	24	19	(6)	122	112	(9)	282	257	205	(52)
13	TC INCOME	99	95	(4)	525	501	(24)	925	925	925	0
14	CONSULTANCY INCOME CAMHS	7	0	(7)	51	50	(1)	110	87	87	1
15	CONSULTANCY INCOME SAAMHS	40	30	(10)	280	266	(14)	492	480	477	(3)
16	R&D	10	30	20	72	154	82	123	123	175	53
17	OTHER INCOME	86	107	21	413	502	90	1,159	893	984	91
	TOTAL INCOME	**3,332**	**3,335**	**3**	**23,401**	**22,893**	**(508)**	**39,059**	**40,245**	**39,838**	**(408)**
	EXPENDITURE										
18	COMPLEX NEEDS	298	279	19	2,085	2,002	83	3,560	3,575	3,566	10
19	PORTMAN CLINIC	194	174	20	857	852	6	1,225	1,507	1,382	125
20	GENDER IDENTITY	126	142	(16)	879	794	85	1,253	1,506	1,506	0
21	DEV PSYCHOTHERAPY UNIT	9	17	(8)	66	96	(30)	114	113	153	(40)
22	NON CAMDEN CAMHS	337	328	9	2,361	2,426	(65)	4,231	4,049	4,055	(7)
23	CAMDEN CAMHS	356	398	(43)	2,560	2,572	(13)	4,350	4,340	4,349	(9)
24	CHILD & FAMILY GENERAL	43	38	6	297	338	(41)	503	513	589	(76)
25	FAMILY NURSE PARTNERSHIP	339	395	(56)	2,371	1,896	476	3,575	4,066	3,631	435
26	JUNIOR MEDICAL STAFF	83	85	(3)	579	544	35	966	993	993	0
27	NHS LONDON FUNDED CP TRAINEES	179	173	6	1,253	1,240	14	2,148	2,148	2,148	0
28	TAVISTOCK SESSIONAL CP TRAINEES	2	3	(1)	11	18	(7)	19	19	31	(12)
29	FLEXIBLE TRAINEE DOCTORS & PGMDE	25	17	8	178	176	2	394	306	296	10
30	EDUCATION & TRAINING	197	197	0	2,299	2,214	84	3,447	3,641	3,608	33
31	VISITING LECTURER FEES	125	121	4	605	568	37	1,229	1,229	1,211	18
32	CAMHS EDUCATION & TRAINING	118	132	(14)	827	914	(87)	1,429	1,420	1,535	(115)
33	SAAMHS EDUCATION & TRAINING	78	71	6	543	520	23	939	1,189	1,172	18
34	TC EDUCATION & TRAINING	0	3	(3)	0	4	(4)	0	0	4	(4)
35	TC	90	98	(9)	459	417	42	815	787	787	0
36	R&D	20	8	13	140	43	97	169	241	107	134
37	ESTATES DEPT	173	180	(7)	1,209	1,274	(65)	2,078	2,072	2,162	(90)
38	FINANCE, ICT & INFORMATICS	162	208	(46)	1,135	1,194	(59)	2,326	1,946	1,987	(41)
39	TRUST BOARD, CEO, DIRECTOR, GOVERN'S & PPI	83	86	(3)	580	570	10	998	995	990	5
40	COMMERCIAL DIRECTORATE	60	68	(8)	506	461	45	738	837	822	15
41	HUMAN RESOURCES	104	41	63	419	432	(13)	632	681	756	(75)
42	CLINICAL GOVERNANCE	43	50	(6)	303	319	(16)	587	696	696	0
43	PROJECTS CONTRIBUTION	0	0	0	0	0	0	(73)	0	0	0
44	DEPRECIATION & AMORTISATION	46	56	(10)	321	337	(16)	550	550	581	(31)
45	IFRS HOLIDAY PAY PROV ADJ	8	0	8	58	0	58	100	100	0	100
46	PRODUCTIVITY SAVINGS	0	0	0	0	0	0	(134)	0	0	0
47	INVESTMENT RESERVE	10	0	10	70	0	70	120	120	120	0
48	CENTRAL RESERVES	(41)	0	(41)	62	0	62	315	150	150	0
	TOTAL EXPENDITURE	**3,268**	**3,368**	**(100)**	**23,035**	**22,221**	**813**	**38,603**	**39,789**	**39,388**	**401**
	OPERATING SURPLUS/(DEFICIT)	**65**	**(33)**	**(98)**	**366**	**672**	**305**	**456**	**456**	**449**	**(7)**
49	INTEREST RECEIVABLE	0	1	0	3	7	4	5	5	5	0
50	DIVIDEND ON PDC	(35)	(35)	0	(246)	(246)	0	(421)	(421)	(421)	0
	SURPLUS/(DEFICIT)	**30**	**(68)**	**(97)**	**124**	**433**	**310**	**40**	**40**	**33**	**(7)**
51	RESTRUCTURING COSTS	0	0	0	0	29	(29)	0	0	29	29
	SURPLUS/(DEFICIT) AFTER RESTRUCTURING	**30**	**(68)**	**(97)**	**124**	**404**	**281**	**40**	**40**	**5**	**(35)**

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SLR Report M7 2014-15

	Trust Total		SAMHS		CAMHS	
	Budget M7 2014-15	Actuals M7 2014-15	Budget M7 2014-15	Actuals M7 2014-15	Budget M7 2014-15	Actuals M7 2014-15
	£000	£000	£000	£000	£000	£000
Clinical Income	9,630	9,616	4,223	4,223	5,408	5,393
Training course fees and other acad income	7,186	6,659	1,684	1,575	5,502	5,085
National Training Contract	4,232	4,232	1,424	1,424	2,808	2,808
Total Training Income	11,418	10,891	3,107	2,998	8,310	7,893
Consultancy Income	677	581	666	574	12	7
Research and Other Income (incl Interest)	106	191	44	76	62	115
Total Income	**21,831**	**21,279**	**8,039**	**7,871**	**13,792**	**13,408**
Clinical Directorates and Consultancy	13,178	12,673	4,826	4,606	8,351	8,066
Other Training Costs (in DET budget)	2,614	2,518	826	783	1,788	1,734
Research Costs	188	90	72	34	116	56
Accommodation	1,468	1,525	702	730	766	796
Total Direct Costs	**17,448**	**16,806**	**6,426**	**6,154**	**11,022**	**10,652**
Contribution	4,383	4,473	1,613	1,717	2,770	2,756
Central Overheads (excl Buildings)	5,719	5,661	1,938	1,927	3,780	3,733
Central Income	1,573	1,621	473	496	1,100	1,124
Surplus (deficit)	**238**	**433**	**148**	**286**	**90**	**147**
Unallocated Contingency	114					
Total Surplus	**124**					
SURPLUS as % of income	1.1%	2.0%	1.8%	3.6%	0.6%	1.1%
CONTRIBUTION as % of income	20.1%	21.0%	20.1%	21.8%	20.1%	20.6%

2014/15 Plan

	April £000	May £000	June £000	July £000	August £000	Sept £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	March £000	Total £000
Opening cash balance	2,757	5,732	4,794	3,240	4,488	3,337	1,761	3,811	2,736	1,362	3,167	2,395	2,757
Operational income received													
NHS (excl SHA)	2,908	1,468	1,239	1,414	1,338	1,308	1,299	1,337	1,309	1,299	1,338	1,309	17,566
General debtors (incl LAs)	671	502	506	663	737	537	721	692	769	664	1,032	868	8,362
HEE for Training	2,567	142	79	2,567	143	79	2,567	142	79	2,567	143	79	11,156
Students and sponsors	325	150	150	100	0	200	800	250	100	750	100	100	3,025
Other	0	0	0	0	0	0	0	0	0	0	0	0	0
	6,471	2,262	1,974	4,744	2,218	2,124	5,387	2,421	2,257	5,280	2,613	2,356	40,109
Operational expenditure payments													
Salaries (net)	(1,346)	(1,346)	(1,408)	(1,407)	(1,408)	(1,428)	(1,459)	(1,445)	(1,442)	(1,436)	(1,436)	(1,436)	(16,997)
Tax, NI and Pension	(991)	(995)	(1,045)	(1,053)	(1,053)	(1,053)	(1,068)	(1,092)	(1,081)	(1,079)	(1,075)	(1,075)	(12,660)
Suppliers	(1,159)	(860)	(966)	(934)	(709)	(709)	(709)	(709)	(709)	(709)	(709)	(709)	(9,594)
	(3,496)	(3,201)	(3,419)	(3,394)	(3,170)	(3,190)	(3,236)	(3,246)	(3,232)	(3,224)	(3,220)	(3,220)	(39,251)
Capital Expenditure	0	0	(100)	(100)	(200)	(300)	(100)	(250)	(400)	(250)	(166)	(450)	(2,316)
Loan	0	0	0	0	0	0	0	0	0	0	0	0	0
Interest Income	0	1	0	1	0	1	0	0	1	0	1	0	5
Payments from provisions	0	0	(9)	(2)	0	0	0	0	0	0	0	0	(11)
PDC Dividend Payments	0	0	0	0	0	(211)	0	0	0	0	0	(210)	(421)
Closing cash balance	5,732	4,794	3,240	4,488	3,337	1,761	3,811	2,736	1,362	3,167	2,395	871	871

2014/15 Actual/Forecast

	April £000	May £000	June £000	July £000	August £000	Sept £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	March £000	Total £000
Opening cash balance	2,757	4,441	3,357	4,330	5,086	3,884	2,647	5,695	4,820	3,446	5,351	4,380	2,757
Operational income received													
NHS (excl SHA)	1,852	1,312	3,498	691	1,548	987	2,385	1,537	1,209	1,399	1,138	1,074	18,630
General debtors (incl LAs)	1,016	564	412	442	971	466	815	692	769	664	1,032	868	8,711
HEE for Training	2,443	78	128	2,552	17	162	2,993	142	79	2,567	143	79	11,384
Students and sponsors	277	104	98	105	105	396	738	250	100	750	100	100	3,123
Other	0	0	0	0	0	0	0	0	0	0	0	0	0
	5,588	2,058	4,136	3,790	2,641	2,011	6,931	2,621	2,157	5,380	2,413	2,121	41,848
Operational expenditure payments													
Salaries (net)	(1,344)	(1,396)	(1,401)	(1,275)	(1,290)	(1,285)	(1,342)	(1,445)	(1,442)	(1,436)	(1,436)	(1,436)	(16,528)
Tax, NI and Pension	(1,033)	(1,052)	(1,060)	(1,093)	(1,011)	(1,018)	(1,005)	(1,092)	(1,081)	(1,079)	(1,075)	(1,075)	(12,674)
Suppliers	(1,499)	(679)	(660)	(607)	(1,240)	(524)	(1,316)	(709)	(709)	(709)	(709)	(709)	(10,072)
	(3,876)	(3,127)	(3,121)	(2,975)	(3,541)	(2,827)	(3,663)	(3,246)	(3,232)	(3,224)	(3,220)	(3,220)	(39,274)
Capital Expenditure	(29)	(16)	(43)	(60)	(303)	(247)	(221)	(250)	(300)	(250)	(166)	(250)	(2,135)
Loan	0	0	0	0	0	0	0	0	0	0	0	0	0
Interest Income	1	1	1	1	1	1	1	0	1	0	1	0	9
Payments from provisions	0	0	0	0	0	0	0	0	0	0	0	0	0
PDC Dividend Payments	0	0	0	0	0	(175)	0	0	0	0	0	(210)	(385)
Closing cash balance	4,441	3,357	4,330	5,086	3,884	2,647	5,695	4,820	3,446	5,351	4,380	2,821	2,821

Finance & Performance

Board of Directors : November 2014

Item : 8

Title : Training & Education Programme Management Board November 2014 report

Purpose:
1) To report on issues considered and decisions taken by the Training & Education Programme Management Board at its meeting of 3 November
2) To give a summary report on student recruitment and admissions for the academic year 2014-15 and the impact on financial performance for the financial year.

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

This report has been reviewed by the following Committees:
- Management Team, 13 November 2014

This report focuses on the following areas:
- Quality
- Risk
- Finance

For : Noting

From : Malcolm Allen, Dean of Postgraduate Studies

TEPB Report

Training & Education Programme Management Board Report
November 2014

1.   Introduction

1.1   The Training & Education Programme Management Board (TEPMB) had its third meeting on 3 November.

1.2   The meeting welcomed two new non-executive directors on to the board: Dinesh Bhugra and Edna Murphy.

1.3   Also included is a summary report on student recruitment and admissions for the academic year 2014-15 that was not considered by the board.

2.   New structure for training and education delivery

2.1   The dean reported on the consultation process for the proposals outlined in the consultation paper agreed by the TEPMB in October. The proposals had been extensively discussed at a meeting of the Clinics Committee and two special consultation meetings.

2.2   The proposals had been broadly welcomed from all sections of the trust. Many people, as we had anticipated, were concerned about how we protected and maintained the interrelationship between our clinical work and training, but this was not put forward as a counter-argument to the proposals.

2.3   We were also clear that the specific proposals for the portfolio groupings were our best effort so far, were provisional and we were very open to further thought on what these should look like. One thought that attracted a degree of consensus was to see if there was a way of organising the groupings so that the larger, well-established courses would be properly looked after, while attention might be focused elsewhere on completely new developments. The Training and Education Executive would be giving further thought to this point

2.4   There was some discussion about how technology-enhanced learning would fit with the new structure and about international developments.

2.5   There was also a discussion around the question of the benefits that the new structure would bring. The dean and others held the view that the proposed structure would provide a more cohesive, integrated structure capable of faster and more authoritative

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decisions and would be more able to develop and implement bold and innovative proposals.

2.6 A paper outlining the final proposals on the new delivery structure would be presented for approval at the TEPMB meeting on 1 December.

3. Planning and recruitment cycle 2015-16

3.1 The dean presented a report that set out the sort of annual cycle of activity that should be put in place for the future, ready for the academic year 2016-17. The objective was to reverse the 'eleventh hour' culture of late marketing and recruitment that has so beset training and education for a long time, with the bulk of interviews and enrolments taking place up to the wire in September.

3.2 We have taken the point made in the consultation process on the structural proposals that many of our prospective trainees are genuinely undecided about their course of action until that time. It is therefore crucial that we are able to accommodate this cohort of late recruiters. However, we nevertheless suspect that there will be a significant cohort who, in common with most postgraduate applicants, will want to secure their position before the summer.

3.3 However, this would not be possible in all respects for the next academic year 2015-16. However, the objective is nevertheless to bring forward the main programme of interviews and enrolments into the summer term, whilst recognising that we will still need to be interviewing (hopefully) a minority as late as September immediately before the academic year.

3.4 We have now initiated a process of detailed target setting for student numbers for the academic year 2015-16 and for short courses running across the financial year. This exercise will be putting detailed planning targets (numerical and financial) in line with the broad growth objectives that have been set out in various strategic planning statements. This has traditionally happened in February when the trust's budget gets set.

3.5 This exercise is led by the associate deans who will discuss and agree these detailed targets with cluster leads and course tutors. They will report back by 21 November. We will then be able to take a considered look at the balance of our portfolio and assess the contribution of each course against factors such as profitability.

3.6 We will then have the time to properly assess the possibility of, for example, expanding or even replicating some of our more successful courses, whilst possibly dropping some of our less profitable courses.

This will also impact on how we prioritise our marketing resources and room booking strategy.

4. Academic partnership review

4.1 The dean was able to confirm that a meeting of the University of Essex's Senate had now formally agreed the academic partnership with the trust.

4.2 A number of things now needed to happen fairly quickly:
- A meeting to work out the schedule of validations that were necessary to migrate our academic programmes over to Essex. We were currently estimating that this would need to be done over the space of two years.
- Work to finalise the financial arrangements and the partnership agreement as soon as possible.
- A meeting to work out the arrangements for the partnership at a strategic level, e.g. the formation of a strategic partnership board, taking the research agenda forward.

4.3 The dean had also met with Nora Colton, Deputy Vice Chancellor (Academic), from UEL. He was greatly encouraged that, whilst UEL was disappointed, she respected our decision and was wholly committed to managing the transition with maximum goodwill. UEL's main preoccupation was the QAA audit due to take place in 2016 which would include auditing the details of the partnership with the trust. I stated that we clearly had a stake in ensuring this went well and that the trust would do everything on its part to ensure a successful audit.

5. A new IMT system for DET

5.1 Will Bannister, Associate Director for DET, presented a proposal to purchase a new IMT system for DET. He stated that our current system was at the end of its life and was now a major barrier to the ambitions for training and education. The cost would be £593k over five years.

5.2 The board registered the advice given by Edna Murphy that more standardised and 'off the shelf' solutions tended to be significantly more cost-effective and less prone to problems than more customised solutions.

5.3 The project was being managed by a Project Board with membership from DET, Information Governance, IT and Finance.

5.4 With support from the TEPMB, the proposal would be put to the Board of Directors at its meeting later in November.

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6. Technology-enhanced learning

6.1 Simon Kear, Head of Technology-Enhanced Learning, gave a verbal report to the board on this area of work. This included: improvements in the virtual learning environment (Moodle); the virtual classroom (using Adobe Connect); electronic management of assessment; developments in blended and on-line learning.

6.2 In response to questions, Simon expressed optimism about the cultural change that was taking place around this area and cited the examples of recent webinars that had attracted a lot of interest. He reported that students can now submit work for assessment electronically. He said that this system supported and was not a substitute for face to face feedback that was highly valued, but that students also appreciated the value of instant feedback that the system provided.

6.3 There was a discussion around the use of Skype for, amongst other things, clinical supervision and the advice that had been circulated that this did not provide adequate security for confidential information. As the use of Skype had grown significantly, many staff were now unsure to what extent they could be using Skype. Simon Young stated that we should investigate this area further and it should be further discussed by the Management Team.

7. Strategic transformation programme action plan and risk register

7.1 The dean presented an updated version of the strategic transformation programme action plan and risk register which the board noted.

8. Report on student recruitment and admissions for academic year 2014-15

8.1 Our reckoning of student enrolment figures for long courses for the current *academic year* at the time of writing is presented in Appendix 1. The overall figure (all years) is 1055 excluding associate centres. This is 8 short of the target figure of 1063, though final numbers, especially for years 2+, are still being pinned down. We may yet meet this target. We are 12 down on last year's figure of 1067, though we had exceptionally healthy recruitment that year (with a 25% increase on year 1 recruitment reported to the board in November 2013).

8.2 This is a global figure, and disguises large variation between individual courses, as well as between the delivery directorates.

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TEPB Report

Within the directorates, CAMHS was 32 above target, SAAMHS 30 below target, and TC 10 below target.

8.3 We are 45 below target on year 1 recruitment (460 as against 505) and 15 below last year's figure of 475.

8.4 Clearly, whilst recruitment numbers have broadly held up, the expansionist ambitions of the portfolio review have yet to work through. Some of our new offers, such as the adult version of D24, which we believe should have the same potential for success as the child and adolescent version, have not had sufficient time to penetrate the market.

8.5 If anything, the portfolio review has had a short-term negative impact on this academic year, as we took the decision to close a number of the least profitable courses. Whilst this was the right decision in terms of an overall rebalancing of the portfolio, this contributed to the shortfall on target numbers, as targets had been set at an earlier date. This year should be seen as a transition year for the portfolio review, as the benefits for the changes we have put in place and continue to put in place start to work through.

8.6 Without wishing to overemphasize the impact, the absence of a dedicated marketing officer and the uncertainty over the marketing budget during the critical period of January to June is likely to have been a factor, however large or small. A level of marketing activity was maintained throughout this period from a dedicated team, but the high level of interactive activity between training and education and marketing which, I believe, contributed to the success of the previous year was missing.

8.7 There has been some discussion around a perception that a number of courses were significantly oversubscribed. Having done the analysis, the only course where this was the case was D58, where in the end most applicants were accommodated. This is unlikely to have been a major factor in the overall numbers. However, there is an issue here which the new structure will be able to address more effectively, that is a culture wherein courses feel they have a certain autonomy in deciding appropriate maximum numbers.

8.8 In terms of the projected financial performance for the *academic year*, there is likely to be a £229k adverse variance against target for long course fee income. However, the estimate of £3,308k fee income still represents a 13% increase on last year. This translates into an adverse variance against target for the *financial year* in this area of £111k. This is partially offset by a healthy level of HEFCE funding which has a £51k positive variance for the financial year. Combining fees and HEFCE funding, we are £60k short of target.

8.9 A more difficult area is the London CPPD contract which has been a shrinking market (with less funding overall). Nevertheless, the projection for the academic year is 51k above target. The adverse variance of £129k for the financial year in this area is mainly a function of the timing of activity with the financial benefit falling into the next financial year.

8.10 Short courses during the financial year are broadly on target.

Malcolm Allen
Dean of Postgraduate Studies

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Student number and training income summary

	Actual AY13/14	Budget AY14/15	Forecast AY14/15	Variance AY14/15	Actual FY13/14	Budget FY14/15	Forecast FY14/15	Variance FY14/15
Students enrolled - Year 1	16	28	24	-4				
Students enrolled - Total	44	58	48	-10				
Associate Centres	0	0	0	0				
Fee Income (incl. Associate Centres)	£135,240	£238,700	£194,165	-£44,535	£129,949	£197,292	£171,313	-£25,979
LCPPD	£87,865	£15,348	£68,990	£53,642	£68,679	£8,133 £13,522	£0	-£21,655
HEFCE	£43,625	£29,520	£26,850	-£2,670	£30,796	£27,753	£33,839	£6,086
Short courses (incl. e-CPDs)					£12,020	£10,000	£0	-£10,000
Total	£266,730	£283,568	£290,005	£6,437	£241,444	£256,700	£205,152	**-£51,548**

ANNUAL PLAN 14/15 | **SAAMHS**

Student number and training income summary

income summary	Actual AY13/14	Budget AY14/15	Forecast AY14/15	Variance AY14/15	Actual FY13/14	Budget FY14/15	Forecast FY14/15	Variance FY14/15
Students enrolled - Year 1	184	234	195	-39				
Students enrolled - Total	384	416	386	-30				
Associate Centres	12	10	15	5				
Fee Income (incl. Associate Centres)	£957,503	£1,339,567	£1,100,377	-£239,190	£996,098	£1,141,582	£1,001,753	-£139,829
LCPPD	£58,538	£38,713	£47,602	£8,889	£98,828	£49,949 £484	£53,405	£2,972
HEFCE	£80,677	£108,594	£97,395	-£11,199	£131,345	£107,336	£106,000	-£1,336
Short courses (incl. e-CPDs)					£163,343	£200,500	£144,448	-£56,052
Total	£1,096,718	£1,486,874	£1,245,374	-£241,500	£1,389,614	£1,499,851	£1,305,606	**-£194,245**

08b BD Nov14 education and training programme board income - appendix

CAMHS | **Non**

Student number and training income summary	Actual AY13/14	Budget AY14/15	Forecast AY14/15	Variance AY14/15	Actual FY13/14	Budget FY14/15	Forecast FY14/15	Variance FY14/15
Students enrolled - Year 1	275	243	241	-2				
Students enrolled - Total	639	589	621	32				
Associate Centres	213	200	180	-20				
Fee Income (incl. Associate Centres)	£1,831,717	£1,959,267	£2,013,527	£54,260	£1,901,365	£1,896,966	£1,951,422	£54,456
LCPPD	£52,135	£26,779	£43,858	£17,079	£44,011	£28,217 -£6,001	£29,004	£6,788
HEFCE	£511,281	£395,162	£435,900	£40,738	£531,208	£425,523	£471,990	£46,467
Short courses (incl. e-CPDs)					£291,118	£310,764	£359,564	£48,800
Total	£2,395,133	£2,381,208	£2,493,285	£112,077	£2,767,702	£2,655,469	£2,811,980	**£156,511**

08b BD Nov14 education and training programme board income - appendix

TEPB Report

Student number and training income summary	Service Line	Actual AY13/14	Budget AY14/15	Forecast AY14/15	Variance AY14/15	Actual FY13/14	Budget FY14/15	Forecast FY14/15	Variance FY14/15
Students enrolled - Year 1									
Students enrolled - Total									
Associate Centres									
Fee Income (incl. Associate Centres)									
LCPPD		£25,486	£56,979	£28,875	-£28,104	£17,764	£161,819	£43,867	-£117,952
HEFCE					£0	£0	£0	£0	£0
Short courses (incl. e-CPDs)						£60,868	£0	£16,801	£16,801
Total		£25,486	£56,979	£28,875	-£28,104	£78,632	£161,819	£60,668	-£101,151

08b BD Nov14 education and training programme board income - appendix

Student number and training income summary	Total							
	Actual AY13/14	Budget AY14/15	Forecast AY14/15	Variance AY14/15	Actual FY13/14	Budget FY14/15	Forecast FY14/15	Variance FY14/15
Students enrolled - Year 1	475	505	460	-45				
Students enrolled - Total	1067	1063	1055	-8				
Associate Centres	225	210	195	-15				
Fee Income (incl. Associate Centres)	£2,924,460	£3,537,534	£3,308,069	-£229,465	£3,027,412	£3,235,840	£3,124,488	-£111,352
LCPPD	£224,024	£137,819	£189,325	£51,506	£229,282	£248,118	£126,276	-£129,847
HEFCE	£635,583	£533,276	£560,145	£26,869	£693,349	£560,612	£611,829	£51,217
Short courses (incl. e-CPDs)	£0	£0	£0	£0	£527,349	£521,264	£520,813	-£451
Total	£3,784,067	£4,208,629	£4,057,539	-£151,090	£4,477,392	£4,565,834	£4,383,406	-£190,433

Board of Directors: October 2014

Item: 9

Title: Service Line Report – Complex Needs, SAMHS

Purpose:

The purpose of this report is to inform the Board of the activities of the Complex Needs service, SAAMHS

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

This report has been reviewed by the following Committees:

• Management Team – 13 November

This report focuses on the following areas:

• Quality
• Patient / User Experience
• Patient / User Safety
• Risk
• Finance

For: Discussion

From: Marcus Evans, Associate Clinical Director, SAAMHS

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Service Line Report
Complex Needs

Executive Summary

1. INTRODUCTION

The Complex Needs Service consists of several different teams providing a range of treatment modalities for patients aged from 14 upwards. The service has contracts with twelve CCGs, and has a number of additional services run in conjunction with partners, including the Royal Free Hospital, Home Base and the British Red Cross. The staff team is multi-disciplinary (including child and adolescent and adult psychotherapists, psychologists, psychiatrists, social workers, nurses, and a significant number of staff in post qualification training posts). The service provides apprenticeship clinical trainings, which account for approximately 65% of the clinical work undertaken on the generic contracts. The clinical service and the clinical trainings are completely interdependent and one could not run without the other as currently configured.

2. AREAS OF RISK AND/OR CONCERN

2.1 The service provides apprentice type trainings for a range of trainees at different levels. We have a good system of supporting trainees in their work while ensuring that patients receive a high quality clinical service. We have a highly motivated and well-trained group of senior clinical practitioners supporting this clinical training structure. In the context of the savings required for the coming financial year, it is important to ensure that we continue have enough senior staff to support this structure. The new training structure will create growth in training and we will need to ensure that pressures on clinical and training management does not undermine the joined up platform necessary to maintain high quality training for trainees and treatment for patients.

2.2 The existing clinical contracts have held up well to date. We continue to provide data on clinical quality, safety and effectiveness for commissioners to support our work. The new informatics systems will help us provide good quality data on a regular basis.

2.3 We also need to ensure that we keep up good relations with the GP mental health leads and commissioners.

2.4 All of our referrals are controlled through a Single Point of Entry (SPE) The Trust receives large numbers of patients with chronic and complex psychological conditions. Pressure on mental health trusts means that they are referring these patients back to primary care. This particular patient population often require consultant-level oversight and can pose considerable clinical problems in terms of treatability, risk factors, and chronicity. This has changed the risk profile of the service, and we need to ensure that our risk management is as good as it can be for this patient population.

2.5 MedNet, our service for doctors and dentists with difficulties, which has been provided by the Trust, will be put out to tender from April 2015.

2.6 Marcus Evans has announced his intention to step down as Associate Clinical Director and will not be taking up a second term of office. Brian Rock, Primary Care Lead for SAAMHS has been appointed Director of Education and Training. Following the Shaping our Future consultation, the Adolescent and Young Service is moving out of Complex Needs and over

to the children and young people's services. The overall shape of SAAMHS is changing as the GID service is also moving to children and young people's services and education and training is moving under the direct leadership and management of the Director of Education and Training

3. PROPOSED ACTION PLAN

3.1 We will mitigate the areas of concern mentioned above in the following ways:

a) Ensure that we continue to employ experienced clinical practitioners that manage and supervise the clinical apprenticeship trainings. With the need for development in the training area we need to ensure that our management systems support the clinical training structure and that staff are not pulled between competing systems.

b) Complex needs staff have played a leading role in the development of the new Integrated Digital Care Record (IDCR) system, ensuring that there has been active engagement between the project team and the workforce. The City and Hackney service is one of the pilot implementation sites. All staff will need to be trained and prepared to sue the new system by May 2015.

c) We are developing a clinical service in response to the choice agenda with the aim that GPs may refer straight into the service. We anticipate this may redress the balance of patients referred into the service towards those with less chronic and complex difficulties.

d) We are preparing to bid for the retendered Occupational Mental Health Service for postgraduate doctors and dentists (Mednet).

e) The Director of Adult services has begun a consultation with Complex Needs staff to review the strategic direction of the service in view of staff changes and the demands of efficiency savings and growth. Two strategic half days are planned, the first for early December.

4. OVERVIEW OF THE SERVICE

The purpose of the service is to provide psychological therapy. Most patients referred to the service have either been through IAPT, local psychology services, or they have been treated by within a mental health trust. A large proportion of the patients referred have long standing personality difficulties in addition to their primary diagnosis.

The service has also developed different models of delivering psychological services in different settings, including with the Red Cross, Home Base, City and Hackney, the Royal Free Pain Clinic, and MedNet.

The service also supports post qualification trainings in psychotherapy. Many graduates of the trainings go on to run or supervise psychological and psychotherapy services in mental health trusts.

The service should also look to build on the success of the Tavistock Adult Depression Study with a further research program. The service will continue to look to innovate and develop new and imaginative forms of service delivery that fit with the changing market.

We have contributed to the Camden mental health transformation project through the work on improving services for the transition age range and through membership of the

primary care development sub-group of the transformation project. An invitation to tender to provide a 'Team around the Practice' will come out soon. The new service is largely modelled on our City and Hackney service and we intend to submit a strong bid.

5. CLINICAL SERVICES AND ACTIVITY DATA

5.1 Waiting Times

Adult and adolescent services have a waiting time target of 11 weeks. For Quarter 1 (i.e. to end of June 2014) there were no waiting time breaches for assessments for either Adolescent or Adult. At Quarter 2 (i.e. end of September) there was no breach for Adolescent. There was one breach for Adult – NPA, for which funding was approved after the breach date.

5.2 DNA Rates

The Trust's DNA target is 10% maximum. At Month 6, the Trust was beating this target with a DNA rate of almost 5%. This is down very marginally from this point last year.

Table 1: Appointments 2014/15 to Month 6

Service	Booked	Attended	Cancelled by Client	Cancelled by Trust	DNA
Adolescent	3,842	2,496	733	75	538
Adult	6,552	4,925	1,070	140	417
Total	**10,394**	**7,421**	**1,803**	**215**	**955**
	100.00%	71.40%	17.35%	2.07%	9.19%

5.3 Ethnicity

The service's ethnicity data is below. From the data we have, it appears that the vast majority of our clients are white. However, a significant amount of data is missing. Although we do ask, it is not mandatory for the patient to state their ethnicity, so many patients choose not to fill this in, e.g. at Month 6, 55% of patients chose not to fill in this part of the form. A revised patient information form is now in place and we have amended our policy to treat all missing information as being deliberately missing; that is to say, if a patient has not entered their ethnicity, this is treated as a conscious decision not to inform us and is recorded as "client refused". However, the service's statistics are skewed by the way in which nil returns are treated on RiO. The previous practice was to only fill in the information given. This meant that the system automatically marked any areas not completed as "not requested", when in fact, this was not the case. In future we anticipate improved data with the above measures in place.

Table 2: Ethnicity 2014/15 to Month 6

Ethnic Group	Adolescent	Adult	Total	
Asian or Asian British	3	4	7	2%
Black or Black British	1	4	5	2%
Mixed	7	2	9	3%
Other Ethnic Groups	4	3	7	2%
White	41	53	94	29%
Not known (not requested)	48	133	181	55%
Not known (unable to request)	14	0	14	4%
Not known (client refused)	3	7	10	3%
Not stated (client unable to choose)	0	0	0	0%
Total	**121**	**206**	**327**	100%

Table 3: Census Ethnicity Data 2011

Ethnic Group	Trust	Camden	Inner London	England & Wales
Asian or Asian British	6%	16%	8%	8%
Black or Black British	4%	8%	8%	3%
Mixed	7%	6%	6%	2%
Other Ethnic Groups	6%	4%	2%	1%
White	77%	66%	75%	86%

The service's ethnicity data does not closely match borough, London, or national profiles, but no firm conclusions can be drawn on the basis of the current data given the large number of patients who did not state their ethnicity.

5.4 Supervision

Clinical supervision is a central and valued activity within the Trust, contributing to our reputation as a centre of excellence for teaching, training and providing clinical services in mental health. We provide a range of types of supervision, included one-to-one, and peer group supervision. Most clinicians receive two or three different types of supervision. The frequency of supervision varies greatly across the Trust and disciplines. The majority of staff received at least monthly supervision. Supervision also differs according to seniority, with trainees tending to receive the most supervision.

6. NEW DEVELOPMENTS

6.1 Choice Clinic

The Adult Complex Needs Service is developing a new service to respond to the patient choice agenda. This would allow patients, at a consultation with their GP, to phone in directly and book a preliminary assessment with an experienced clinician. This would be followed by a 16-session brief multi-modal therapy intervention or a transfer to our standard treatments. Following the brief therapy, longer term treatment could be offered if appropriate. This is similar to the City and Hackney model which has been externally evaluated and is proving accessible, acceptable to GPs and patients, and effective

The choice clinic in the first instance would apply to GPs in contract areas where only Single Point of Entry (SPE) referrals through the local mental health trust are currently available. This gate keeping has severely restricted both the type and numbers of referrals. The use of an SPE also hampers the development of the psychotherapy trainings by restricting referrals to the most risky and complex and chronic patients. Screening protocols to ensure that patients are seen appropriately are being developed to assist GPs and patients and the resources for an initial launch of the clinic are being identified. Regular audit reports will monitor the uptake of the service and the impact of proscribed brief therapy will be audited.

This service will initially be provided within the existing contract arrangements.

6.2 **Tottenham Thinking Space**

Tottenham Thinking Space is a pilot mental health and community well-being project based on a model of intervention, developed in Brazil called "community therapy". TTS was launched in October 2013 and aims to improve mental health and community well-being by enabling local residents to come together to reflect on their experiences, and support each other to improve themselves and their community. It is funded by Haringey's Directorate Public Health Directorate (approx. £86k) and is being independently evaluated by UEL.

The Project facilitates four thinking space meetings for the Tottenham community: a weekly meeting open to all members of the community; a weekly Tea & Coffee morning for isolated mothers; a fortnightly women's health & well-being group; and a fortnightly men's group.

A positive interim evaluation report in June 2014, led Haringey to fund the project for a second year. The evaluation of the project will be completed in January 2015 and this will determine whether the Project receives further funding.

7. **FINANCIAL SITUATION**

7.1 **Year-to-date Financial Situation**

Financially, the service is doing well. The deficit has reduced year-on-year and is forecast to be significantly below the budget plan at year end. At directorate level, SAAMHS is on track to produce a surplus at the end of the year.

8. **FEEDBACK**

Routine feedback is sought from all patients after assessment and on a six monthly basis. One of our adult current patients, who sits on the Patient & Public Involvement Committee, helps analyse the data. The number of responses has increased steadily over the last two years and is currently over 30%, which compares favourably with the response rate to the national mental health survey. However, this rate needs to be improved and the new record system will enable better organisation to seek this data on a consistent basis. Our overall satisfaction rate was high.

The Trust recently appointed a SAAMHS PPI lead, Claire Shaw, who has been working hard to develop creative ways of seeking feedback and enabling engagement with adolescent and adult patients. She has led, with support from the Directorate, on a number of developments, such as a monthly reference group which is open to all adult patients and has been widely advertised. The group has had three meetings to date.

9. SERIOUS UNTOWARD INCIDENTS AND SAFETY ISSUES

After many years of having no recorded suicides we have had six in the past year. Dr Tony Garelick has worked with Jane Chapman, Governance and Risk Advisor to investigate and report on each case. A series of recommendations have been made and action plans drawn up and in process of implementation. We are being referred a higher proportion of patients with complex and chronic problems and high risk factors.
We have arranged a meeting with Camden and Islington consultants in order to try and establish principles under which joint care might best be arranged and maintained.

10. RESEARCH

The Tavistock Adult Depression Study (TADS) has reached the final stage of data preparation of a full dataset for analysis and the preparation of several papers for publication.

It is one of the great strengths of TADS that it has triangulated robust measures of symptomatic and social functioning outcomes with both clinical evaluations and patients' own reported experiences gathered through formal qualitative methodology. Furthermore a rich dataset of recorded therapy sessions and the availability of Psychotherapy Process Q-sort ratings for a selection of sessions provide opportunities to carry out important process research. The first qualitative analysis on the patients' private theory of their depression is under way with the aim to publish the findings early next year. David Taylor is overseeing and leading on the clinical output.

We are keen to keep the research momentum going through smaller scale research and audit projects. Key areas for investigation include Complex Trauma, Psychosis and medically unexplained symptoms. Initially we wish to investigate how best to make use of data we already collect and we are in discussion with the Director of R&D and Medical Director about resourcing this.

11. CONSULTANCY

Local authority and mental health trusts have cut down on consultancy due to financial constraints although we continue to receive requests for supervision.
We have started a small project in which clinicians from the Fitzjohn's Unit see parents of children being treated in the CAMHS Directorate. This was to avoid the problem of referral to our adult services where we cannot take on parents as patients within adult contracts unless they meet criteria for referral though the relevant SPE.

12. STAFFING AND HR ISSUES

The service consists of a broad range of staff, including social workers, psychologists, nurses, adult and child and adolescent psychotherapist and psychiatrists.

Productivity and efficacy savings pose a numbers of dilemmas; the need to maintain sufficient expertise to support complex clinical and training services, ensuring that there are sufficient resources both to run the core services safely and effectively at the same time as resourcing work on new projects.

Marcus Evans

Appendix A

Complex Needs Services

1. COUPLES UNIT

The Couples Unit receives approximately sixty referrals per year. Of these couples 80% have children at home. We see a range of couples in the service, for example couples where there is domestic violence, couples who display high levels of expressed emotion and many couples where children become overly exposed to parental disturbance and are subsequently at developmental risk.

There is empirical evidence that the state of the relationship between parents has a significant impact on all aspects of children's development, and also that intervention focused on the parent's relationship as a couple makes more difference than intervention aimed only at 'parenting'.

The couples unit developed a course, which successfully ran last year. The course was developed for experienced practitioners who took cases of the couple's waiting list as part of their training. The course recruited well and was well reviewed however lack of marketing last year and a confusion between the Tavistock couples course and the Tavistock Centre for couples relationships meant that the course failed to attract enough trainees.

1.1 Opportunities

Evidence suggests that GPs want a service for couples in 'trouble' precisely because of the impact on family health, both physical and mental.

Consideration could be given to establishing a 'Couples in Trouble' service. This might be concerned with parenting issues, with fraught / violent couple relationships, with the demand of ageing parents, with family ill health or infertility. This service could be subject to contract or offered for a fee. It would be essentially short term.

1.2 Risks

The failure to recruit to the course for another year would damage the unit's capacity to deliver training and a clinical service.

Although the GPS want the service, commissioners are reluctant to pay for the service. Thus the couple's treatment has to come out of the generic contracts.

Failure to identify clinical resources and failure to recruit to the course means that the clinical service is stretched and questions about its viability remain.

2. TRAUMA SERVICE

2.1 Overview

The service accepts referrals related to the full spectrum of trauma presentations / diagnoses including, complicated bereavement, and complex and developmental trauma. The service offers consultations, brief work, intermittent work, and once weekly therapy. The treatment modalities include psychoanalysis, trauma-focussed CBT, and EMDR.

We have experience of working in partnerships with the non-statutory sector. This includes working with Homebase, a charity for homeless veterans which funds a five-session post. We have established a partnership and MoU with the British Red Cross where we have set up an award winning service for refugees using D58/9 trainees on placement. We also offer consultations to organisations that have been traumatised as well as those who work with a high likelihood of traumatisation in the workplace. We are currently developing an e-learning trauma course.

We offer a clinical service that remains responsive to patients' needs. We do not use waiting lists and we offer flexibility of treatment modalities and packages. We attend to psychosocial factors and link closely with the PALS officer who is now a member of the team. We use interpreters if needed and work closely to train the interpreters in our style of work.

2.2 Opportunities

A broader training package that incorporates e-learning and increases access to training.

Our training in EMDR will increase our therapeutic options and our training skills. This will increase patient choice and is also likely to increase NPAs.

We are also looking into the possibility of a research project on complex trauma patients that would use the TADS model. Research building on the TADS model is vital at this stage when ICD11 is about to recommend Complex Trauma as a diagnosis and so will put us ahead of the field in demonstrating our model is evidence-based.

2.3 Threats

Opportunities all require resourcing, which limits us in pursuing the opportunities in a robust way.

We continue to address training but have a significant difficulty in that our package of working to include clinical, consultation, training and supervision (internal and external) has been disrupted by the trauma course being suspended, pending further development, as a result of the recent profitability review

3. MEDNET

3.1 Overview

MedNet is a specialist confidential service for doctors funded by London Deanery LETBs. We have treated over 2000 doctors over 20 years. The service has high user satisfaction. We have published in peer reviewed journals and presented at several international conferences. Service highly regarded by medical profession

3.2 Opportunities

We are planning to market the service and extend to other disciplines and organisations.

3.3 Threats

Uncertainty over the nature of future contracts, tendering, and competition. We are taking active steps to clarify future contracting intentions.

4. **FITZJOHN'S UNIT**

4.1 **Overview**

The Fitzjohn's Unit is a specialist service for adults suffering from severe and enduring mental health problems. The service provides treatment for various severe disorders including personality disorder, affective disorders such as severe chronic depression and manic-depressive disorder, eating disorders and certain psychosomatic disorders. Some patients have suffered from major psychotic episodes. Many of our patients have multiple diagnoses; this often arises from changes in symptom pattern. However, the underlying dynamic structure remains the same. Our work is informed by the understanding that events of illness (which may take on different forms at different times) emerge form an underlying structure of the personality and so our aim is to understand the whole person.

The core of the treatment is twice weekly individual psychotherapy for two years, followed by once weekly group psychotherapy (in specialist groups run by senior staff) for about 2-3 years, sometimes longer. This treatment is thus in keeping with our understanding of this work as a developmental process.

We also recognise the need to have a degree of flexibility. Some patients feel too threatened by twice weekly sessions (usually because of paranoid or claustrophobic anxieties) and so start on a once weekly basis.

The average waiting time over the past year has been about one year.

The service is well known within the Trust and the provision of consultation to other services within the Trust has become a standard part of our activity. Sometimes when a patient is referred, we make a decision that as a first approach it would be better to meet some of the staff involved to discuss the current situation and sometimes intervention at that level proves to be the most appropriate; that is through consultation we can advise on the better management the patient and so referral may then become unnecessary.

The service provides on-going educational input as part of its consultation work with other services both within and outside SAAMHS. We usually have at least one psychiatric specialist registrar attached to the Unit. This is regarded as a specialist placement.

We have a CPD course for qualified psychotherapists, which started in 2013. Participants in the course become Honorary Psychotherapists in the service and provide psychotherapy for at least one patient. They also receive regular theoretical teaching. Currently we have three course participants.

In addition we have a constant flow of visitors some who come for only a short time and others who may stay for a number of months.

A book about the service is well under way and we hope will go to Press towards the end of 2015

4.2 **Opportunities**

Expansion of the Unit – We have been able to increase our staff resources partly as a result of attracting NPAs. We may be able to attract more NPAs but this is a difficult area as Trusts are of course very concerned, in the current environment, about agreeing any extra expenditure. If we do attract further NPAs this money can be used to provide further

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staffing (in the current context of course all such new staff contracts are time-limited). It is therefore reasonable to consider the pros and cons of a larger expansion of the service. There may be a critical mass beyond which the service would become too difficult to manage in its current form, as cohesion of the service is fundamental to its success.

Establishing closer links with the CAMHS - It is well known that many of the children referred to the Trust live in families where there is serious psychological disturbance in one or both parents. In addition, a significant number of adults seen within the Unit are carers for children and thus there is real concern as regard the impact of the adult disorder on the child. There is thus a clear case for developing closer on-going liaison between our service and CAMHS.

4.3 Threats

The uniqueness of the service, is an important strength particularly as it is perhaps being increasingly recognised that short term 'quick fix' treatments are inappropriate and damaging to this group of patients.

A very major ongoing issue arises from managing the pressure to take on increasing numbers of patients when, we do not have the staff resources to do so. It is, we believe, not appropriate for these patients to be accepted for treatment after consultations only to languish on a waiting list for over a year. Where patients remain on the waiting list for long periods it becomes important to review them from time to time in order to provide adequate containment, but this, of course, puts a strain on our resources.

Given the nature of this patient group and the fact that we accept patients who have made complaints against another Trust, we are exposed in an ongoing way to the risk of serious complaints and where this occurs it of course imposes a large burden on resources.

This group of patients are disproportionately disadvantaged by our current mental health system which is increasingly fragmented, lacks real ongoing support and containment (for example no day hospitals, virtually no provision of support in an ongoing way from community psychiatric nurses).

5. CITY & HACKNEY PRIMARY CARE PSYCHOTHERAPY CONSULTATION SERVICE

5.1 Overview

The City & Hackney Primary Care Psychotherapy Primary Care Service (PCPCS) was established from a competitive tender by the then City & Hackney PCT in 2009. The service was designed to respond to the difficulties faced by patients with complex needs, including so-called Medically Unexplained Symptoms (MUS), personality difficulties, and chronic mental health problems. It thereby created an adjunct to IAPT provision and a bridge to secondary care services. Building capacity in the primary care workforce is a focus too. With its link to the Complex Needs Service, PCPCS supports patients primarily in clusters 4 – 8 through the application of psychodynamic and systemic thinking. The service has been positively independently evaluated on two occasions; the most recent culminated in a favourable publication by the Centre for MH showing costs savings, good clinical outcomes and high satisfaction rates among GPs.

The size of the core contract has grown over the past two years. The service is making a significant contribution to the work undertaken by the CCG in integrating psychological therapies more effectively across the boroughs. It has also developed a growing community

project working with non-English speakers in collaboration with Spitalfields City Farm. The service has also led on an A&E project that has resulted in two staff members being seconded to work in a RAID type service based at the Homerton University Hospital (HuH).

This financial year has seen an increase in referrals by approximately 30%. This reflects the regard with which the service is held by GPs and other providers. However, it has also created additional pressure on the service to meet the demand.

The PCPCS presented its work at the AGM on 22nd October 2014.

5.2 Opportunities

Two additional areas of the service are being developed from non-recurrent funding for a care planning service (340k over two years) and a service for frail, elderly patients (180k. These streams will be linked to the core service to effect synergies and build on the foundation that has already been established.

In association with the e-learning team of DET, an e-learning module has been developed for City & Hackney GPs. This was launched locally on International World MH day on 10th October.

6. ADOLESCENT AND YOUNG ADULTS SERVICE

6.1 Overview

The Adolescent and Young Adult Service is for young people between the ages of 14 and 25. It aims to meet some of the variety of needs specific to young people between these ages who are struggling with mental health issues. As such, the Service bridges the gap between CAMHS and AMHS.

The service is multi-disciplinary, staffed by a team with expertise in the psychological and emotional difficulties of this age range. The service aims to offer a flexible and accessible service, including a range of interventions from very brief (4 sessions), to longer term psychotherapy, either individual, family or group. Help is also offered to parents of adolescents and young adults, where this is more appropriate or can support the young person's therapy here.

The Service attends particularly to issues around engagement, as this can be a group who are difficult to engage in psychological help, who may feel particularly ambivalent about psychological therapy and mental health services.

The Service comprises a number of specialist teams, for instance, trauma, complex needs, family therapy, as well as the four-session self-referral service – the Young People's Consultation Service, and the Young Black People's Consultation Service.

This early intervention approach is informed by the fact that 75% of mental health disorders emerge for the first time before the age of 25; incidence rises sharply after puberty, with a peak in the early 20s.

This Service is moving out of Complex Needs and into CAMHS, where opportunities for development will be further considered.

7. YOUNG PEOPLE'S CONSULTATION SERVICE (YPSCS)

7.1 Overview

The Young People's Consultation Service (YPCS) continues to operate within the Adolescent and Young Adult Service. The YPCS is distinctive in being a self- referral only, four session service, for young people aged between 16 and 30, who are experiencing an emotional or psychological difficulty, which they would like to talk about with one of the service's consultants. Most referrals come from Camden, Islington and Barnet: contractual restrictions mean self- referrals cannot be accepted from all areas. The Service is supported by 2 clinical seminars, where the work is presented; the clinical work is primarily carried out by staff undertaking further training in the Service, e.g. child psychotherapy and clinical psychology trainees. The service aims to be easily accessible, and responsive, with short waiting times. The Service has been described in a number of published papers, including with positive outcome data.

8. PAIN MANAGEMENT SERVICE, ROYAL FREE HOSPITAL, LONDON

8.1 Overview

The psychological therapies team (PTT) is imbedded in the multi-disciplinary pain management service (PMS). The PMS includes consultants in pain management, specialist physiotherapists, clinical and - health psychologists and nurse specialists.

The RF appointed psychologists offer individual cognitive-behavioural therapy (CBT) and group pain management programs (PMP), as is standard in most pain management services. The psychoanalytic input offered in addition to traditional pain management psychological help and is unique to the RF. Psychoanalytic clinicians offer consultations to other members of the PMS and extended consultations and supportive psychoanalytic psychotherapy for complex patients whose chronic pain and psychological disorder are linked and who are often not open to referral to psychology or mental health services.

8.2 Opportunities

In July 2014 the Royal Free London acquired Barnet and Chase Farm Hospitals. The ramifications of the acquisition and organisational restructuring for the PMS are a yet unclear. The aspiration of the service would be to expand the psychoanalytic input Trust-wide. The noted vision might be at odds with that of management in the newly configured Therapies and Pain Management Division.

9. OUTREACH PROJECTS IN SECONDARY SCHOOLS (through the Adolescent and Young Adult Service)

9.1 Overview

This is a long-standing and well-established child psychotherapy-led project currently operating in two secondary schools in Westminster. Within the project we offer a broad menu of resources to the schools which includes; individual and group work with students (brief and longer term); individual consultations to staff, work discussion groups for staff, liaison and support in relation to referrals to Westminster CAMHS and/or other external agencies.

The project employs qualified child psychotherapists to lead the project (managed by Emil Jackson). They support additional work in the schools offered through assistant

psychotherapists on honorary placement contracts – typically those studying on M7 or another pre-clinical training course.

The project is entirely self-funding and income generating with contracts agreed with the schools directly. Agreed contracts for the current academic year total £26,189 and £29,000 for the two schools respectively.

9.2 Opportunities

This remains a largely under-tapped and potentially big growth area. Secondary schools in particular have access to large budgets and often direct some funds towards counselling and/or psychotherapy work

Clinical based therapists offer a much better backed up service to schools than 'lone counsellors' who do not have the same sense of team and supervision to back up their work and thinking.

9.3 Threats

Development of these projects requires people to develop relationships with those in senior positions in schools who are in charge of inclusion (usually). This takes time and resources.

Schools invariably and understandably are reluctant to commit funding for more than one academic year at a time. This means that projects can only look one year into the future and always face the threat of reduction or termination.

The two current projects did reduce in size this year – both by approximately 50%. With considerable work and support it was possible to avoid any redundancy payments and to negotiate an outcome that seemed to work well for all concerned. However, this remains a risk that needs to be considered.

10. COMPLEX MEDICAL CASES SERVICE

10.1 Overview

The Complex Medical Cases service is a clinical resource for patients with Complex Medical Conditions and psychological co-morbidity. Headed by Dr Julian Stern -with many years' experience in St Mark's hospital (a Gastroenterology hospital) and now in the Tavistock primary care service in City & Hackney, and Shirley Borghetti-Hiscock with many years' experience at the Royal Free hospital Pain clinic, the Service attracts numerous "named referrals" to the Tavistock. Recently the clinical service has been highlighted in the document "Physical Health – Specialist Services across Camden & Islington", a guide for Clinicians published by C and I iCope (Psychological Therapies service).

The two leads of the Service were centrally involved in producing the e-learning course described above (City and Hackney) for the C and H CCG, and for the future course with the RCGP.

11. GROUP PSYCHOTHERAPY SERVICE

11.1 Overview

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The group psychotherapy service can provide up to 14 groups and thus is able to provide a substantial number of vacancies per year. There are five groups conducted by senior staff, these are ongoing groups two of which provide for Fitzjohn's patients, the other three for patients with severe mental health problems. The remaining groups are of three year's duration, led by trainee psychotherapists providing a safe context for patients who are often isolated and who experience complex and longstanding difficulties. Group Therapy is a powerful way to treat difficulties with several patients working together at the same time.

There are a range of presenting problems including depression, anxiety, relationship difficulties and post traumatic symptoms amongst others.

11.2 Opportunities

We provide clinical training both in relation to group psychotherapy and group relations.

This year we have started a year's introduction to group psychotherapy open to those wishing to understand more about groups but also to those wishing to set up psychotherapy groups. This clinical training is in conjunction with the visitors' programme. The current cohort include a range of mental health professionals.

There is another international group relations conference arranged for Summer 2015 in conjunction with fellow professionals from the USA. This aims to build on similar previous conferences.

11.3 Threats

Under investment

The loss of three groups led by senior staff has entailed a reduction in patient vacancies over the year. Thus the movement of patients to join existing groups is substantially delayed. This is being addressed by patients being held with the original assessor via review appointments until the next group is available.

The importance of trainee led groups, which has always been a significant feature of our service provision, remains a key feature in providing an accessible service. However, with an increasing number of medical trainees at the Tavistock for only two years before rotation this will have implications for the level and duration of service we would like to provide.

12. TAVISTOCK, SLAM & BUPA PARTNERSHIP

12.1 Overview

Following an initial consultation to Bupa almost three years ago, the partnership was fully established in July 2013, and has been working on the following areas:

a) Developing self-referral systems to remove obstacles to accessing help.

b) Enhancing the range of supports for those with long-term conditions, using health coaches, online services and intelligent signposting.

c) Working to remove limits to policies, such that members are able to access evidence-based therapies for the necessary time period.

d) Working with providers to increase range and flexible and intensive outpatient services that can be accessed at weekends and during evenings, and creating new packages of care that can be authorised for members through use of eligibility criteria at point of entry.

e) Managing over-treatment in all conditions, especially in physical health.

f) Setting governance framework for remote service delivery of psychological therapies using Skype and Facetime.

g) Development of procurement tool to evaluate digital solutions in health (which has attracted interest from DH)

h) Advising the EAP service on its services, and Bupa's chairing of the Business in the Community programme.

i) Creating systems to improve access to psychological services, for those with chronic pain, musculoskeletal problems, and irritable bowel symptoms. The aim is to make access to mental health services as 'easy' as to physical health services.

12.2 Opportunities

a) Learning how to engage employers and develop services for the workplace.

b) Developing innovative intensive out-patient services as alternative to in-patient care.

c) Working in the preventative space, and identifying digital solutions to support members before there is a need for more intensive help.

d) Gaining expertise in the various clinical care guideline systems that are of increasing interest to CCG Commissioners.

e) Engaging with a different part of the health sector, and learning of different issues that may present, as well as how providers offer services for them.

f) Engaging with health psychologists, physicians and surgeons, to facilitate integrated care.

Marcus Evans,
November 2014

Board of Directors : November 2014

Item : 10

Title : CQSG Report, Q2, 2014/15

Purpose:

The purpose of this report is to give an overview of performance of clinical quality, safety, and governance matters in the opinion of members of the CQSG. The Board of Directors is asked to confirm whether this paper is accepted as adequate assurance, and where not, whether the Board of Directors is satisfied with the action plans that have been put in place.

This report is based on assurance scrutinised by the following Committees:

- Clinical Quality, Safety, and Governance Committee
- Management Team

The assurance to these committees was based on evidence scrutinised by the work stream leads and the Management Team.

Please note the recommendation in the appendix for the addition of a temporary work stream to take forward the Trust's aspirations linked with, but not limited to, the forthcoming CQC visit.

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

For : Discussion

From : Rob Senior, CQSG Chair

CQSG Q2 Report

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CQSG Report, Q2, 2014/15

1. Introduction

1.1 The overview summary of areas already considered by the CQSG is set out in Appendix 1; the Board of Directors is reminded that ratings are not given in the same way as for the Risk Register.

1.2 The focus in this narrative is on areas of concern and interest to which the board should pay particular attention; it is not simply an amplification of red and amber rated elements.

2. Findings

2.1 Appendix 1 sets out the detail by reporting line, the expected rating in column on the right of the table may change over that reporting period.

2.2 Having considered and discussed the reports, the committee set the level of assurance as demonstrated; this is recorded below.

2.3 Corporate Governance and Risk

2.3.1	*Substantial assurance was demonstrated*
2.3.2	All areas green
2.3.3	the new higher training targets had been met
2.3.4	Further improvement had been undertaken to the physical environment as scheduled
2.3.5	Emergency planning exercises have taken place as had training
2.3.6	There have been fewer incidents YTD compared with last year though no long-term trend is apparent

2.4 Clinical Outcomes

2.4.1	*Adequate assurance was demonstrated*
2.4.2	A general improvement was perceived
2.4.3	Much of this work relates to the drive to show CQC related compliance; a recommendation to join a benchmarking network has been made a decision is awaited
2.4.4	Externally set targets seem to be set for a single year only; this does not aid long term planning and management

2.4.5 The committee was not satisfied with a 70% variable engagement in OM rate, and commissioned a report containing more details and a CAMHS-SAMHS breakdown

2.4.6 The committee was not satisfied that Portman staff had not engaged with OM and noted that this approach had not been sanctioned by the Trust; work on 'dashboard' presentation might be useful in engaging staff. An update to be made at the next meeting

2.5 Clinical Audit

2.5.1	*Adequate assurance was demonstrated*

2.5.2 The committee felt that the work needed greater prominence in the Trust; work preparing for the CQC inspection had provided some momentum

2.5.3 Was concerned to note that resources had been raised as an issue yet no plan was in place; the committee directed that a proposal be put to the MT

2.6 Patient Safety and Clinical Risk

2.6.1	*Substantial assurance was demonstrated*

2.6.2 A campaign to encourage incident reporting had yielded a small increase in reports

2.6.3 Work is underway with a neighbouring trust to develop suicide prevention measures

2.6.4 The committee was concerned that data requested for an audit on clinical supervision had been poor

2.6.5 Work to improve safeguarding recording between the Trust and local authorities is continuing

2.7 Quality Reports

2.7.1	*Substantial assurance was demonstrated*

2.7.2 Arrangements were in place for all departments for all targets

2.7.3 The annual work plan has been agreed with the CQRG

2.7.4 The recommendations made by the External Auditors on the 2013/14 report had been accepted and addressed

2.8 Patient and public involvement

2.8.1	Substantial assurance was demonstrated
2.8.2	That there had been enthusiasm from some dedicated users in engaging in the Trust's work
2.8.3	The work of PPI and related work was evolving fast
2.8.4	All targets were being met
2.8.5	The committee explored the ongoing need for PPI activity in its current form, and the work stream in its current form; it was agreed that things had evolved considerable and that it was time to reconsider how best to manage the elements of this work in new ways whilst looking at expanding it where necessary
2.8.6	was keen that the Trust engage in the wider debate about mental health in external domains
2.8.7	noted the challenge in engaging young children in PPI work

2.9 Information Governance

2.9.1	Adequate assurance was demonstrated
2.9.2	The long-standing issue regarding data storage for research students have yet to be resolved
2.9.3	Director of Quality to set up a group reviewing clinical data
2.9.4	Work is underway to ensure that IG systems and outputs can be aligned with CQC requirements
2.9.5	Not all areas are predicted to be green, that is, compliant by the end of Q4, as insufficient evidence was received [though some improvement had been generated since the quarter end].

3. Conclusion

3.1 This report gives a comprehensive overview and summary of the level of assurance in the opinion of members of the CQSG

3.2 The pressing need to establish systems and structures to meet our CQC obligations necessitates a dedicated temporary work stream

3.3 A review of all work streams is indicated to ensure effective and efficient Trust-wide working to meet the Trust's objectives and demonstrate quality outcomes and practice to external stakeholders

4 Recommendation

That the changes to the terms of reference be agreed by the Board (see appendix 2).

Corporate Governance and Risk Work stream, Q2 2014/15 🟩

Task	Q3	Q4	Q1	Q2	Comment and action plan for amber and red risks	Predicted position for end of Q4, 14/15
To maintain CQC registration without qualification	G	G	G	G	This area has been transferred to the Director of Quality and Patient Experience and Adult Services. A new temporary CQC work stream will be established and will report from Q3.	G
To maintain a green governance rating with Monitor	G	G	G	G	Monitor's rating of the Trust remains green.	G
To maintain a highly effective workforce	G	G	G	G	All training targets achieved or exceeded.	G
Estates and Facilities infrastructure improvement	G	G	G	G	All estates projects were completed on schedule.	G

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Item					Status	Comment
s and CQC and NHSLA compliance					G	
Managing responses to recommendations and requirements of external bodies	G	G	G	G	G	Schedule up to date; no deadlines missed.
Maintain compliance with current NHSLA rating	G	G	G	G	G	Standards are being maintained pending the external introduction of a new system.
Non-clinical incident reports	G	G	G	G	G	Monitoring via work streams working well.
Specific case reports (serious incidents / SUIs)	G	G	G	G	G	No issues to report.
Central alert broadcast advice	G	G	G	G	G	No issues to report.
Operational Risk Register	G	G	G	G	G	No issues to report.

Relocation of Day Unit			This was on hold pending further consideration by the Board of Directors at their October meeting of the options for the day unit [this line to be discontinued following October Board meeting]

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Clinical Outcomes Work Stream, Q2 2014/15 ■

Task	Q3	Q4	Q1	Q2	Comment and action plan for amber and red risks	Predicted position for end of Q4, 14/15
Implementation of OM project plan	A	A	G		Reporting line discontinued	
Local ownership of outcome monitoring	A	A	A	A	SAMHS and CAMHS directors need to find out what proportion of their staff are fully engaged and using the system	A
Processes for data collection are robust.	A	A			Reporting line discontinued	
CQUIN targets CAMHS and SAAMHS	A	A	A		Reporting line discontinued	G
Data collection and data quality monitoring systems effective		A	A	A	Processes were reviewed; benchmarking planed for Q3	A

Clinical Audit work stream, Q2 2014/15 ■

Task	Q 2	Q 3	Q 4	Q 1	Comment and action plan for amber and red risks	Predicted position for end of Q4, 14/15
NICE compliance	A	A	A	A	An update of the procedure is outstanding. A plan is in place for activity to March 2015.	A
National audit requirements	G				Reporting line discontinued	
Compliance with plan	A	G	G	G	Activity was found across the Trust; capacity is limited and a proposal will be put to the MT.	G
Audit tracking	G	A	A	G	An effective register is in place; action plans are stored centrally.	G
Implementing improvements recommended in audit reports		G	G	G	Termly meetings are scheduled.	G

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Patient Safety and Clinical Risk Work stream, Q2 2014/15 ■

Task	Q3	Q4	Q1	Q2	Comment and action plan for amber and red risks	Predicted position for end of Q4, 14/15
Clinical incidents	A	A	G	G	No incidents rated 9+ were reported, there were 61 other incidents, of which 34 were clinical. Reports are now being followed-up so learning to prevent reoccurrence is in place.	G
Specific case reports (serious incidents / SUIs)	A	A	A	A	There were three SUIs and each involved a death: two were patients, and one was a former patient. Investigations are underway for the Trust's patients, and the Trust is providing information on the other case.	G
H/C acquired infections	G	G	G	G	No incidents reported.	G
New Clinical claims	G	G	G	G	None.	G
Complaints responses	G	G	G	G	3 new complaints were received.	G
PSCR NHSLA compliance	G	G	G		Reporting line discontinued	
PSCR CQC compliance	G	G	G		Reporting line discontinued	
Central Alert Broadcast advice	G	G	G	G	No areas of concern noted.	G

Supervision of clinicians	A	G	G	G	An audit is underway but findings are not yet available.	G
Revalidation	G	G	G	G	Contrary to the Q1 report, two appraisals are outstanding. An internal audit made recommendations for improvement; these were accepted and an action plan is in place. Until the actions have been completed there remains risk that capability and procedures are not fit for purpose.	G
PSCR risk review	G	G	G	G	There are no 9+ risks	G
Safeguarding children	A	A	G	A	The lack of resources for administrative processes is a concern.	A
Safeguarding adults	G	G	G		One referral was made to enhance care already being provided at the Trust	G

CQSG Q2 Report

Quality reports work stream, Q1 2014/15

Task	Q3	Q4	Q1	Q2	Comment and action plan for amber and red risks	Predicted position for end of Q4, 14/15
CQUINS and KPI targets are agreed for 2014/15	G	G	G	G	Agreed; action plan agreed.	G
Arrangements in place to report on CQUINs and KPIs for SAAMHS	A	G	A	G		G
Arrangements in place to report on CQUINs and KPIs for CAMHS	A	G	A	G		G
Meeting Quality Priorities	G	G	A		These are being reported in other work streams	
Meeting quality reporting requirements of CCG	G	G	A	G	A plan has been agreed with the CSU	G
Quality report Recommendations from 2013-14	A	R	A	G	These have been completed.	G

| Preparation for Quality Report 2014-15 | G | G | G | G | A draft schedule has been drawn up | G |

PPI work stream, Q1 2014/15

Task	Q3	Q4	Q1	Q2	Comment and action plan for amber and red risks	Predicted position for end of Q4, 14/15
CQC compliance	G	G	G	G	Data was reported.	G
Providing assurance that the Trust adheres to all PPI related procedures	G	G	G	G	Departmental PPI leads promote procedures to teams	G
Discussing PPI issues arising from PALS, complaints or other forms of PPI input and making recommendations	G	G	G	G	These are analysed annually following local investigation/ resolution.	G
Discussing the findings of the experience of service questionnaire and ensure delivery of action plans	G	G	G	G	Findings and action plans considered quarterly.	G
To ensure 3 issues identified at stakeholder meetings	G	G	G		Reporting line discontinued	

were addressed by March 2015						
To hold 3 patient forums	G	G	G	G	3 have been held	G
To audit accessibility of modality leaflets	G				Reporting line discontinued	
Ensure that quality is continually improved through the development of patients centred services and within the organisation's culture [with QR lead and others]	G	G	G	G	Interviews are held with service users; patient experiences are relayed to the Board.	G

Information Governance Work Stream : Q1 2014/15 ■

Reporting topic	Q1	Q2	Comments	Predicted position for end of Q4, 2015
1: Strategic IG management				A
a) Policy and procedures	G	A	Two policies or procedures due for review by 30 Sept have not yet been reviewed; procedures due for review in Q3 have been identified.	
b) Basic mandatory training			The 2014/15 basic mandatory training programme has begun; but progress does not yet merit a green rating, figures being behind where they were this time last year.	
			DET and IT must complete the longstanding project to provide secure storage for research data collected by students; this matter is on the risk register.	
2: Confidentiality and data protection			Comprehensive Caldicott Guardian Plan in place.	G
a) Subject access requests management	G	A	Exception report on group therapy notes received by SIRO following complaint to ICO; clinical team are yet to provide a comprehensive account of their group management systems.	
b) Confidentiality audit			One procedure from the Commercial Directorate is required, so this standard is not met.	
c) New systems and services control				

Reporting topic	Q1	Q2	Comments	Predicted position for end of Q4, 2015
3: IT Security Assurance a) Annual plan b) Risk assessments for information assets c) Incidents report d) Network controls e) Information asset report	G	A	Incidents being managed appropriately; no outstanding concerns. Improvement plans to meet technological threats are being developed but have not been implemented (including better web and email controls) It is anticipated that the CareNotes system will improve security, as it will hold the full clinical record (replacing a combination of RiO and paper records) and it has some improved security controls.	G
4: Secondary use assurance a) Data input checks b) Data completeness checks c) Clinical validation of input d) Clustering	A	A	A forum for the consideration and validation of data quality evidence is required. This area is of particular interest to potential commissioners.	G

CQSG Q2 Report

Reporting topic	Q1	Q2	Comments	Predicted position for end of Q4, 2015
5: Clinical information assurance			Following guidance that missing files will be reported as data loss incidents from Q2, there have been no more such losses.	**A**
a) Healthcare records management	A	A	A forum for the consideration and validation of data quality evidence is required; and we will need to agree what evidence it will be presented with.	
b) Records audit			Capacity needs to be reviewed to ensure the Trust can meet the challenges following recent staffing changes.	
6: Corporate Records			The Trust archives are full; however, with the advent of paperless records this could be managed.	**G**
a) Management systems	G	G		
b) Lifecycle management and archiving				

Appendix 2 : proposed interim changes to CQSG terms of reference

Membership

Change membership of *Trust Director* to *Director of Quality and Adult Services*

Remove from attendees *Director of Service Development and Strategy* and *Governance and Risk Lead* (posts obsolete)

Duties

CGR

Remove CQC reporting arrangements from this work stream.

Add CQC as a temporary work stream with the following duties

- Review policies and procedures to ensure new requirements are addressed

- Review data collection, storage and report writing systems are fir for purpose

- Review staffing structure to ensure sufficient capability and capacity exist to manage this work

- Review mandatory training and ensure staff are trained to handle an inspection as is commensurate with their role

- Review systems and make recommendations for change to integrate CQC work as business-as-usual

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Board of Directors: 25 November 2014

Item : **11**

Title : **Follow up to Staff Survey - Action Plan**

Purpose:

A paper detailing the results of the internal survey conducted in CAMHS regarding bullying and Harassment was presented to the board in October 2014.

This paper is written in response to the request by the Board that action plans should be put in place, to address the issues of concern arising out of the survey.

This report focuses on the following areas:

- local bullying and harassment survey – Action Plans
- Implementation Process

For : Discussion and Approval

From : Susan Thomas, Director of HR

Bullying and Harrassment

1. Introduction

1.1 The National Staff Survey which took place between October and December 2013 and the confidential CAMHS survey undertaken in September 2014, identified some issues regarding bullying and harassment in the Trust.

1.2 At the Trust Board meeting in October 2014, where the findings from the CAMHS survey were discussed, the board requested that actions plans should be put in place to address the issues identified from both surveys.

1.3 This paper details these actions, including timescale's for implementation of a number of initiatives to tackle inappropriate behaviour.

2. Recommended Actions

2.1 The CAMHS survey identified that a number of staff had experienced inappropriate behaviour including bullying at the Trust in the last year, both from colleagues and senior managers. The survey findings also showed that staff were not reporting these incidents.

In order to address this, the following actions are being recommended –

- Issues pertaining to inappropriate behaviour including bullying and Harassment at work will be discussed at Mandatory Trust Training events (INSET and Induction). Presentations at these events will highlight clearly what can be classed as bullying and how this can impact on staff and service provision.
- A confidential bullying and harassment support service will be put in place, with a confidential support telephone line managed and run by external consultants. Tavistock Consulting (TC) is currently being considered for this which would be run by associates and discussions are taking place (see next section)
- Regular e-mails will also be sent to staff with information on how to raise concerns, alongside strong statements stating that the Trust takes issues of bullying and harassment seriously.
- The Staff and Advice and Consultation Service (SACS) has also been recently re-launched and a revised staff list with 30 consultants is now available on the Trust Intranet.

3. Implementation process

3.1 Discussions at Mandatory Events

3.1.1 The Human Resources Department will design a short training session for all staff to be delivered at Induction and INSET events highlighting the effects of bullying, what to look out for and how to prevent and manage incidents. This training session will be tailored so it can delivered not just at mandatory events but also in teams, at team events such as committee meetings and department meetings.

3.1.2 It is anticipated that this programme should be available by the 1st of January 2015 and will be delivered at mandatory events taking place after that date.

3.2 Confidential Support Service

3.2.1 The HR Director is currently in discussions with the Tavistock Consulting Director, in terms of setting up a confidential support line to be used specifically as a contact point for staff with concerns relating to inappropriate behaviour including bullying and harassment. This contact service will be managed by TC with external TC consultants/Associates providing advice, support and assistance to staff.

3.2.2 The advantage of this service is that staff can get immediate advice and discuss issues in a confidential manner before making a decision whether to raise issues formally.

3.2.3 The details of what will be offered within this service, including any additional services are currently being discussed with the TC Director. The Trust's Staff side lead will also be involved in some of these discussions.

3.2.4 To ensure that the system which is implemented is cost effective and offers good value for money, comparisons with other external providers are also being looked into. Feedback is also being sought from other NHS Trusts who use the services of one of these external providers, to see how this is working for them.

3.2.5 It is expected that this confidential support service will be up and running early in the New Year and by the 31st of January at the latest.

3.3   Staff E-mails

3.3.1   Following on from the recent CEO and Chair e-mail about taking bullying and Harassment seriously, it is important that regular updates continue. These should highlight the new interventions being put in place such as the confidential reporting service. General updates about what constitutes bullying and harassment and examples of such conduct should be regularly provided. Human Resources in conjunction with the Trust Communications team will work on these e-mail briefings.

3.3.2   These communication briefings will commence immediately.

4.   Conclusion

4.1   It is recommended that the Board accepts these proposals and that this is reviewed in six months time, when a report will be provided to the board evaluating the impact of the actions which have been implemented.

The Tavistock and Portman **NHS**
NHS Foundation Trust

Board of Directors : November 2014

Item : 12

Title : New Student Information Management System for Directorate of Training & Education

Summary: A Summary paper with Business Case for agreement at the Board of Directors meeting, 25th November. The paper and business case outline the need for investment in a new Student Management Information system to support the management of Training & Education activities in the Trust.

A decision at the Training and Education Programme Board on 3 November 2014 was taken to fully support the case to purchase a new student management information system.

This report has been reviewed by the following Committees:
- Management Team, 13th November 2014
- Training and Education Programme Board, 3rd November

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

This report focuses on the following areas:
- Training & Education Quality
- Student Experience
- Risk
- Finance

For : Approval

From : Malcolm Allen, Dean of Postgraduate Studies, DET

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E&T Student IT System

Student Information Management System

1. Introduction

1.1 Following consideration at the Training and Education Programme Board on 3 November 2014 and Management Team on 13th November, a decision was supported to agree the purchase of a new student information management system. This paper seeks the agreement of the Trust Board to proceed with the procurement to support the training and education activities within the Trust. The attached business case justifies the investment in future system *(See Appendix A - Business Case).*

2. Rationale for Change

2.1 The current ICT (student records) system utilised by the Department of Education and Training (DET) is highly fragmented which limits the expansion of functionality necessary to remain competitive and to meet a new teaching and learning strategy.(see Appendix A – Business Case)

3. Context

3.1 The Information Communication Technology (ICT) Project was initiated as one part of the Training and Education Transformation Programme to gain efficiencies in process delivery that will (a) translate into greater capacity to handle increased numbers of learners and (b) improve the quality of service offered to learners leading to increased levels of retention.

3.2 The proposal for the procurement of a new SIMS system to support and enhance the Training and Education activities within the Trust was first received in November 2013. It was agreed that a Project Board be convened to explore the options available. A Project progress report was presented to Management Team in May 2014 outlining a final specification, costings, procurement process and timeline. Following comments and queries from the Management Team, updated progress reports were presented in June and September 2014. At the September 2014 meeting, it was agreed that a final recommendation and report be presented to the Training & Education Programme Board for agreement.

4. Solution

4.1 To address the problem a new commercial SIMS system is recommended. The Project team explored three options: Do Nothing; Develop current in-house system further; Purchase a new off-the-shelf

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package from Commercial Supplier. The process of identifying the best possible options were examined and reported on to Management Team. Critical business processes will be re-engineered to improve administrative efficiency and effectiveness.

5. Procurement

5.1 An independent Procurement Specialist from the London Procurement Partnership (LPP) will be engaged to ensure the mini-competition process has been followed according to the formal Framework guidelines from the Crown Commercial Services, backed by the UK Government. The framework will therefore be fully UK/EU compliant and the route to market via OJEU approval process will be avoided. The proposed bespoke services together with procurement timescale are presented in the business case *(See Appendix A: Business Case- point 7.1.Procurement Timeframe and 7.2.4 LLP Services).*

6. Project Timescale

6.1   Procurement: between 3 to 6 months
        System solution: between 6 -12 months

7. Major risks

7.1   Further delay in the procurement of a new Training & Education SIMS system the Trust will effectively mean a delay in new business processes being adopted to improve the learner experience. Additionally further delay will impact on the achievement of milestones and timeframes for other Projects in the Programme of Transformation. *(For full details of project and product risk assessment see Appendix A: Business Case – point 10 for Major Risks and Appendix 4 for Project Risk and Product Risk Assessment*

8. Cost

8.1   Procurement: The total cost for the proposed 30 days services by LPP consultant are £26000 (including VAT).

8.2   System solution: Based on the preliminary research, the set up and implementation costs are estimated to require a **capital budget** of £360,000 including VAT and a contingency budget of £15,000.

8.3   The current and projected annual running costs are summarised below and demonstrate that an **additional expenditure budget of £36,708** is requested over the 5 year period:-

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	**Total**
Current (Unit4)annual maintenance	£9,000	£9,000	£9,000				£ 27,000
Projected hosting cost (per Appendix 2)	£30,000	£30,000	£30,000	£30,000	£30,000	£30,000	£180,000
Projected support and maintenance (per Appendix 2)	£36,036	£36,036	£36,036	£36,036	£36,036	£36,036	£216,216
Training (per Appendix 2)	£21,600						£21,600
Total annual costs	**£96,636**	**£75,036**	**£75,036**	**£66,036**	**£66,036**	**£66,036**	**£444,816**
Current budget	£70,000	£70,000	£70,000	£70,000	£70,000	£70,000	£420,000
Additional expenditure budget needed	**£26,636**	**£ 5,036**	**£ 5,036**	**£0**	**£0**	**£0**	**£36,708**

Note: All figures in the table above are inclusive of VAT but exclude a recommended contingency of £30,000.

8.4 The Trust's liquidity ratio should remain acceptable with this additional cost, if approximately half does not occur until 2015-16.

9.   Investment appraisal

9.1 The need for investment in a new Student Information Management system is business critical to the on-going sustainability of current Training and Education activities in the Trust. Without it our current outdated systems will become increasingly unfit for purpose and pose increasing risk to the delivery and quality of training at the Trust. Additionally, investment in the new system is a necessary key factor in delivering the Programme of Strategic transformation for Training & Education. Without it, many of the strategic objectives around growth in Education and Training activity and income will be harder to achieve.

9.2 It is felt that a new system will enable increased staff capacity and reduce other departmental non-pay expenditure.   The ROI calculations (Appendix A: Business Case, Appendix 3 for the ROI calculation for the proposed new system) can be used for illustrative purposes to demonstrate that a new system would free up internal staff capacity to deal with increased numbers of applications and students which are processed through the system assuming all other resources stayed the same. It is felt that a student centred application and enrolment system would enhance the student experience from the very beginning and hence also increase conversions.

10.   Partnership with University

10.1 The feasibility of a shared service in the area of information technology with University Partners has been discussed and rejected for the following reasons: risk to the growth strategy and student centric business model, operational challenges posed by ownership of the system and business processes, data ownership, and independence of Trust's Training & Education activities.

11.   Implementation

11.1 The high level implementation plan is outlined in Appendix A: Business Case – see point 7.2.10 implementation timescale.

12.   Governance

12.1 Details of the project organisation are outlined in Appendix A: Business Case – see point 11. Existing staff would integrate the tasks into their responsibilities. Project accountability for costs and progress would be to the Training and Education Programme Board who would ensure governance and performance of the implementation. Surveys and consultations will be used to assess effectiveness of the actions.

Will Bannister
Associate Director, DET
17th November 2014

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E&T Student IT System

The Tavistock and Portman **NHS**

NHS Foundation Trust

Business Case

Project Name:	Information Communication Technology (ICT)		
Date:	14 November 2014	**Release:**	Final
Author:	The ICT Project Board		
Owner:	Malcolm Allen		
Client:	The Department of Education and Training (DET)		
Document Version:	2.0		

14/11/2014

Contents

Abbreviations

BPP – Baseline Project Plan

CPD – Continual Professional Development

DET - Directorate of Education and Training

HE – Higher Education

ICT - information communication technology system

ITT – Invitation to Tender

LPP – London Procurement Partnership

ROI – Return on Investment

SIMS SOR - Student Information Management System. Statement of Requirements

VLE – Virtual Learning Environment

1. Introduction

1.1. This is the business case to select a suitable Student Information Management System (SIMS), to be implemented during Academic Year 2015/16.

1.2. This document contains the information that is necessary for the Trust Management's approval for investment in a new student system. The new system must continue to provide security and safeguard confidentiality and the increased dependence on it means that there must be resilience and support at all times when it is being used.

1.3. The procurement of this new system will be through a mini competition process via the framework agreement managed by Crown Commercial Services, which is backed by the UK Government. The framework will therefore be fully UK/EU compliant and the lengthy and resource heavy route to market via OJEU approval process will be avoided.

1.4. This business case justifies the investment in future system. Our aim is for the future system to be deployed across all education and training services in the Trust. This will help us overcome some of the current information and operational challenges the Department of Education and Training within the Trust (DET) faces internally and externally.

2. Rationale for change

2.1. This section explains the need for a replacement of the current Information Communication Technology (ICT) system and organisational contexts.

2.2. External context

2.2.1. The NHS is under pressure to improve efficiency (Deloitte & Reform, 2012). Healthcare education providers have to deliver *"education and training that is truly world class and quality assured"* (Department of Health [DH], 2012). This indicates consequences for DET. A question for DET was how to grow and sustain business based on delivering high quality services. The department had the responsibility for the provision and development of multidisciplinary training. DET attempts to improve its position in the marketplace, characterised by regulatory changes and greater accountability from the Health Education England and Quality Assurance Agency. The achievement of "excellence and continuous improvement in the quality of education and training *of the health workforce"* (DH, 2012) requires re-design of the workflow and an investment in the technology to support the growth strategy.

2.3. Internal context

2.3.1. In response to greater accountability from the Health Education England, DET devised a new strategy in 2013 to "*provide a strategic framework to guide and shape the work*" (Allen, 2013a, p.8). A programme of transformational change projects was commenced in an attempt to improve productivity and meet the departmental ambitions for education and training (DET, 2013). These strategic projects were formulated *"to enrich the student experience by achieving greater consistency of practice"* (Allen, 2013b, p.11).

To achieve the new strategy, DET appointed consultants from the Higher Education Academy to review its capabilities. Their analysis highlighted lack of communication, staff resistance to change and fragmentation of system infrastructure Additionally, the internal review triggered concerns regarding departmental workflow, internal communication, established workarounds, lack of adequate reporting and poor information-sharing (Daci, 2014).

The current ICT system utilised by DET is fragmented which limits the expansion of functionality necessary to remain competitive in the higher education market and to meet the new teaching and learning strategy. The current various applications are not fully integrated and require manual processing, reconciliation and manipulation activities. In addition, current reporting functionality is limited and not user friendly.

2.3.2. DET is looking to improve the quality of service to DET customers by assisting staff to do their jobs by increasing their capacity to perform. DET views teaching and administrative support employees as internal stakeholders and the students, the commissioners, the government and the wider Trust's community as external stakeholders.

2.4. Solution

2.4.1. To address the challenges, DET will implement the new commercial student information management system to deliver improved customer service to students and staff and to secure an increase in high calibre applicants.

2.5. Drivers

2.5.1. The new enhanced system will allow DET to comply with its targets and drivers both at the national and local level. The aspiration is to use digital systems with the clear benefits of enhancing student centred services and improved visibility of outcomes.

2.5.2. The Trust will be in a better position to understand how investing in, then effectively using, information technology can achieve better not only student outcomes but

E&T Student IT System

also wider Health Education England's education outcomes (Figure 1 below), reduce bureaucracy, and deliver efficiencies. In addition, the new system will enable improved and informed decision-making, ultimately improving student engagement.
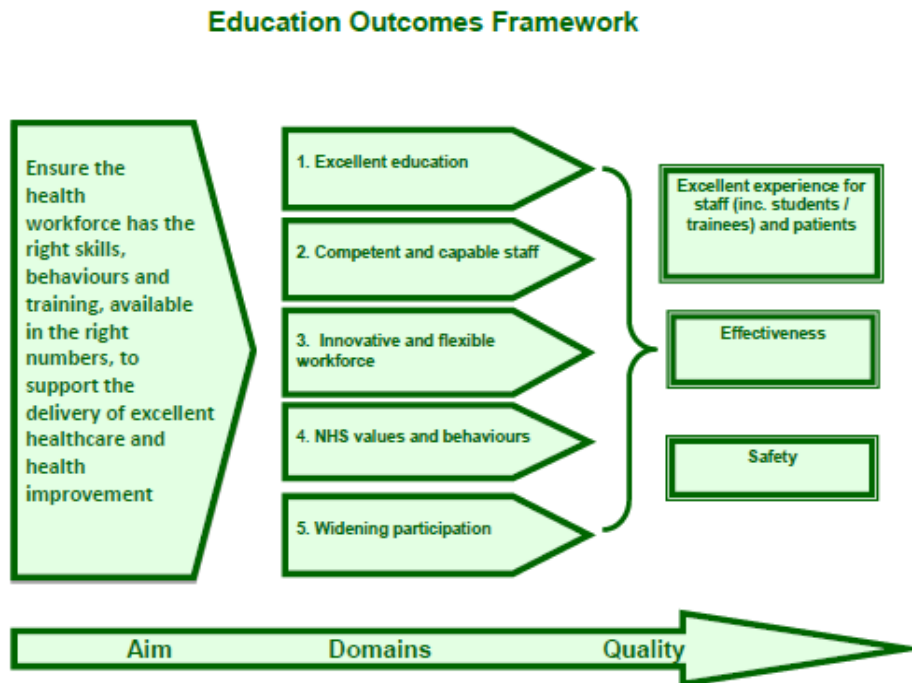

Figure 1 The Education Outcomes Framework (Source: DH (2012, p.13)).

2.6. Scope

2.6.1.   It is expected that all internal and external stakeholders of the new system should use it for managing training and education services in the Trust. This will help to overcome some of the challenges of the current decentralised information storage that DET faces internally.

2.7. Constraints and assumptions

2.7.1.   Constraints
- cost of purchasing a new system
- limited staffing resources and capabilities. It may be difficult to free up the required internal staff when needed.
- risk of data loss during data migration
- maintenance, training, licensing and technical support costs
- on-going costs for enhancement and future development
- cultural and change management issues / office culture
- selecting type of software, maintenance, support

- other DET projects may gain priority
- Difficulty of involving staff already involved in balancing priorities between the "day job" and productivity programmes.
- Concerns with confidentiality and control of access to data within an off-site data centre
- The timeline must be met to decommission legacy system before support stops.

2.7.2. Assumptions

- No additional hardware will be required as the solution is an externally host-based solution within the European Union. Vendors will be required to adhere to the Trust's technical specifications. These are listed in the Student Information Management System Statement of Requirements document (document reference number: SIMS/201402/SOR).
- Sufficient internal staff resources will be made available to the project team including the recruitment of the new hire: the project administrator. Representatives of the Trust's technical member of IT and Informatics are on the Project's working group and the Project Board. Representation from each business unit within DET and course tutors from SAMHS and CAMHS will also be part of the Project's working group and the Project Board.
- Required software enhancements will be made to meet growing DET business needs in relation to the following key business processes: Marketing, Student Contact and Enquiries, Admissions (including Research Students) and Registration, Alumni

2.8. Project Interdependencies

- Migration of historical data
- DET commitment to the project and its objectives
- Time commitment required of the project board to ensure that the project is completed on time and the benefits of this project are delivered.
- Securing a high quality, committed project team, for the course of the project, who are able to dedicate sufficient time to the project.
- Engagement of key stakeholders, including not only DET but also other stakeholders who will be expected to use the new system and their capacity to commit the time e.g. for configuration workshop and training for the duration of the project.
- Fully operational infrastructure that meets the system requirements. The hardware and software specifications are listed in the Student Information Management System Statement of Requirements document (document reference number: SIMS/201402/SOR). Vendors will be required to meet the Trust's requirements.
- Agreement of Trust to release staff for the required training (a minimum of 1 day per member of staff).
- Coordinated and consistent approach to the adoption and implementation of policies and working practices by all stakeholders.
- A commitment by staff to the changes in working practices that is necessary to fully integrate the new system into operational practices.
- A willingness by users to enter data into the new system themselves.

- Approved approach to maintaining the security and confidentiality of electronic care records that is properly used and enforced.
- The current Programme of Strategic Transformation in the Department of Education and Training to achieve the growth strategy (Please see an Appendix 1 for list of projects).
- Portfolio and Curriculum Review project and the outcomes arising from this project in relation to student journey

3. Business Requirements

The education and training agreed business requirements are:
1. improve the efficiency of relationship management with applicants, students and alumni
2. provide seamless integration between key business processes
3. handling pre-entry (recruitment and admission) and post-entry (induction, registration, enrolment, student invoicing, graduation) stages of the student journey
4. facilitate student/sponsor invoicing and payments of tuition fees, including instalments and debt management
5. automatically create timetables
6. maintaining records of attendance
7. handling records of assessments and academic progression
8. expedite research proposal submission and increase proposals success rates
9. support doctoral researchers to work towards a timely and successful completion of their research degree programme
10. support the registration process and communications, from invitation to the post event follow up
11. record and enable automation of communications
12. minimise data entry and reduce manual effort
13. workflow automation through a combination of task lists, calendars, alerts and templates
14. produce routine, detailed, and voluminous information reports specific to each user's areas of responsibility for decision-making purposes
15. aid easy access to data analysis and projections for internal and external stakeholders

In scope

- Enquiry
- Admission
- Registration and Enrolment
- Timetabling
- Reenrolments
- Assessment
- Graduation
- Research students

- Library
- Visitors programme
- Events management – including short courses, conferences, teaching events, open days, induction events, surveys
- Student finance
- Analytics and Reporting
- Student Portal (including integration with VLE and other Trust's systems)

4. Expected Benefits of the implementation of new system

4.1. Major expected benefits from the implementation of new system are presented in the table below:

Investment objective	Main benefits
To enhance the student-led processes and improve learners' experience	• Targeted automation and integration of all, usually ad-hoc developed in-house applications • Cost effectiveness in the use of all resources. • Established and improved analytics and business reporting
To enable users to provide efficient, responsive, and student-oriented administrative services and increased job satisfaction	• accuracy of reporting, statistics and analytics • Easy to use and friendly system that can be tailored to courses' various requirements • An improvement in management planning and control • Increased integration of applications within the system to allow for more timely information
Greater staff capacity to handle increased numbers of learners	• Increased efficiency of business operations with data-driven decision-making and increased communication between internal users • Elimination of redundant data entry and an error reduction in the handling process • More timely information and an increase in flexibility and speed of activities, thus contributing to the productivity savings
To enhance the quality of service offered to learners	• Increase in recruitment from outside the M25 corridor • Higher student satisfaction as expressed in annual student feedback exercise • Improved student retention, and improved communication and marketing
To help with accountability	• By collecting more information centrally than previously and therefore ability to report will be improved for commissioners, marketing and business development purposes and regulatory purposes

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4.2. Some benefits will not be realised immediately since they depend on future versions and developments of ICT System selected once supplier engagement starts following contract award. Furthermore, in many instances it will be necessary for all stakeholders, including those who currently do not use the applications, to use the new system directly in order to realise the benefits. Exactly how this might work in practice will be considered during the configuration stage of the project. A more detailed analysis of these benefits will be completed as part of the implementation processes.

4.3. One objective of the project is to save staff time and effort thus increasing their capacity to manage increased client numbers. Savings in staff time will be monitored and assessed i.e. what are the baselines, does it/how does it take less time to undertake existing tasks related to information systems, and team processes? Ensuring savings are made will be a key objective of the project. It should be noted that the project may expand data collection and will certainly increase information analysis and time taken to improve data quality during the initial use of the new system. Therefore some capacity savings may be offset by additional work. However clear decision making processes will be in place to authorise these changes and impact on time. The DET operational management team will be responsible for this.

5. Expected Dis-benefits of the implementation of new system

- Period of full adaptation and functioning
- Perceived negative issues with external based hosting
- Maintenance, upgrades and integration costs; reduced time for developmental work; decreased level of integration of various ad-hoc developed systems
- Response to urgent internal and external requirements/changes is slow
- Overreliance on in-house developer has negative consequences on flexibility to adapt to the growing business needs.
- Trust's reputation is at risk due to inefficient fragmented current ITC system
- Lack of market intelligence with regards to marketing
- Response to urgent internal and external requirement and changes is slow
- Further customisation costs as a response to external and internal changes in requirements
- Drop in productivity during the transition period from the old to the new system due to training and familiarisation with the new system

6. Business Options

6.1. Option 1: do nothing

6.1.1. In-house development is perceived to be a more time consuming and lengthier process compared to buy-based decisions. With the growing business needs of DET, the current in-house built system cannot be maintained by one person, which has proved to be inefficient and effective. Overreliance on the in-house programmer model created difficulties associated with keeping pace with the market competitiveness and significant delays in implementation of solutions to the key business processes. It is therefore recommended not to continue with this model in the longer term.

6.1.2. Sustainability of Unit 4 Agresso products is not being reassured. A detailed demonstration of Unit 4 Agresso products was organised. It was assessed by users as *"reasonable coverage of functionality (Partially Met)"*.
Key limitations of the current provider are:
- Limited reporting functionalities without additional in-house SQL input
- Limited automation of the registration process for the conferences, CPD and short courses
- Sustainability of the software
- Poor historical and current Unit4 customer service and support

6.2. Option 2. Buy a commercial product

6.2.1. Cost effectiveness is one of the major factors of purchasing an integrated solution. This factor includes both implementation costs and ongoing costs. Straight forward applications in the form of 'ready-made' business templates can be brought into operation within relatively short time (between 6 to 12 months). This requires minimal customisation, which is the aim of the project.

6.2.2. Support from the vendor is another factor in determining the viability of the buy option. All design, development, testing is handled by vendor and there is low local support required in the configuration stage of the project.

6.2.3. The new system will be able to deliver at least 2% growth each year in student numbers and fee income, excluding additional investments e.g. in marketing of the courses. The percentage figure is based on the numbers given by the vendors who were initially contacted during the market research and feasibility study of the ICT project. The benefits from the new system are presented in the section: Investment.

6.2.4. Procurement of the commercial product
There are 2 routes: procure via the established government backed framework and the other option is to go direct with a suitable supplier by calling off from the Agreement Framework. This would however mean that Trust would have to go through the long process of pre-qualifications, Invitation to tender, product demonstrations and evaluation. This option seems counterproductive, when huge

progress has been made under the Crown Commercial Services and Agreement Framework.
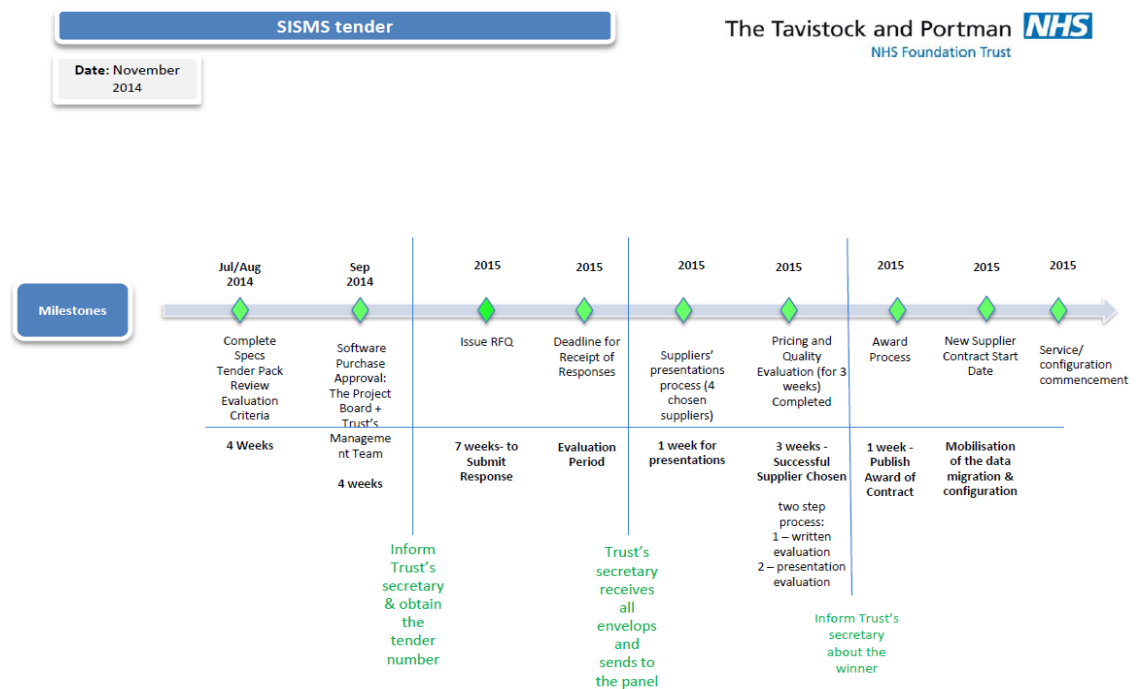
6.3. Evaluation of all options.

As a result, option 1 is not justifiable as this puts pressure on the staff to go through unnecessary further Unit 4 Agresso system change project in the near future, and is more disruptive and non-productive.

With low internal support required and cost effectiveness, the packaged product fits well with the strategic DET plans and the need to automate the key business processes. From these 2 routes to procure a new system, it is clear that the option to proceed via the framework will best suit the Trust's needs and work towards a timescale and process which will ensure that suitable future system supplier is awarded a contract in a timely manner.

6.3.1. **Recommendation:** Option 2 - purchase a commercial product with full functionality.

7. Timescale

7.1. Procurement timeframe – between 3 months and 6 months

7.2. Procurement process

7.2.1. The project will engage an independent Procurement Specialist from the London Procurement Partnership (LPP) to ensure the mini-competition due process has been followed according to the formal Framework guidelines from the Crown Commercial Services. The project team will utilised the LPP's system to:

- Commence the Mini-competition
- Issuing the Invitation to Tender (ITT) documentation - Statement of Requirements, further details
- Communication which each supplier in a transparent way
- Clarification questions posted and tracked
- Audit trail of queries, questions and responses received

7.2.2. The benefit of LPP support and access to the system tool minimised risks of misunderstandings, challenges from unfairness through lack of transparency and delays to the project delivery plans.

7.2.3. LPP services:

A proposal for bespoke services for the DET are as follows:

SECTION	TASK/ACTIVITIES	TRUST				LPP				DURATION
		R	A	C	I	R	A	C	I	
PROJECT INITIATION	• Produce procurement strategy document		X			X				3 days
	• Produce detailed procurement plan		X			X				
	• Identify scope of requirement		X			X				
	• Establish project board and stakeholder groups	X							X	
PREPARE INVITATION TO TENDER	• Develop and agree evaluation criteria		X			X				7 days
	• Finalise ITT documentation		X			X				
	• Sign off ITT with project board	X						X		
FURTHER COMPETITION	• Issue ITT documents		X			X				10 days
	• Coordinate and chair supplier briefings		X			X				
	• Co ordinate and manage supplier clarifications		X			X				
	• Receive suppliers' ITT responses		X			X				
	• Support the evaluation process		X			X				
	• Co-ordinate Supplier presentations		X			X				
	• Chair moderations session		X			X				
	• Selection of preferred bidder		X			X				
CONTRACT AWARD & DEPLOYMENT	• Produce recommendation documents		X			X				10 days
	• Support presentation to relevant boards	X						X		
	• Issue Notification of Award and conduct debriefs		X			X				
	• Support contractual negotiation with preferred supplier	X						X		
	• Produce contract documentation	X	X					X		

NHS London Procurement Partnership
Commercial advantage for the NHS by the NHS

7.2.4. Legal Framework: it will be a framework agreement via Crown Commercial Services. A Framework Agreement is an arrangement whereby one or more suppliers can provide a 'Client' such as The Tavistock and Portman NHS Foundation Trust with a pre-agreed range of services and or products, which have had their terms and

conditions, plus the maximum agreed prices permitted, pre-agreed for the duration of the contract. The final pricing (actual) is then agreed by running the mini-competition event between the nominated Framework suppliers, which will focus more clearly the pricing against those more specific to the Tavistock and Portman NHS Foundation Trust requirements. This has also covered other selection criteria and values that are important to The Tavistock and Portman NHS Foundation Trust, such as; different system features and system ability, mobile working, assurance, up-time serviceability levels and reporting. It should be noted that the award criteria will remain consistent with those employed at the time the Framework arrangements were put in place.

7.2.5. <u>Supplier Challenges</u>: the procurement process via framework will ensure that all of the processes and methodology utilised throughout have been open, fair, transparent and as equally important, consistent. This will ensure that in the unlikely event of a supplier challenge going forward, that every precaution (to include a full audit trial), has been taken to safeguard the framework members.

7.2.6. <u>Contract Award</u>: the DET has used the Framework Agreement when establishing their specific IT requirements; to then re-open competition by way of a mini-competition event.

7.2.7. <u>Deployment:</u> A major aspect of planning the project is to decide how the system will be deployed in terms of switch over from the current system to the new system. Planning the transformation will be developed in collaboration with the supplier. The Project team will require a significant amount of planning and resource availability to ensure a smooth transition.

7.2.8. The project is based on a generic framework of PRINCE2 that is intended to provide a consistent approach to managing the project whilst ensuring that proper "checks and balances" are applied at key decision points. The phases of the project provide a framework to direct the project and monitor progress. The deployments of the new system to users are to be determined once engagement with a supplier commences. Depending on the particular points in the academic year cycle, the project team may choose to deploy and go live with the solution with all users or stage it. Work streams run throughout the project from start to finish. Work streams focus on the specific areas of necessary to complete the deployment e.g. data migration and testing work stream.

7.2.9. As part of business continuity planning in collaboration with the selected supplier the project will ensure that there is minimum disruption, if any to reporting timelines internally and externally to the Trust. We envisage, as part of design requirements, to have some reporting functionality built in to the solution.

7.2.10. <u>High level implementation plan</u>
Please note that the plan do not consider any customised functional requirements the potential vendors may need to develop for us from scratch.

The assumption is that that the vendors will offer functional systems that fulfil DET requirements as a standard training organisation, and may only need to do limited configurations.

Implementation timeframe – between 6 to 12 months, assuming that standard business templates are implemented with minimal customisation.

Phase	Description	Status	Estimate duration (including contingency)

1-	Project Plan
	    a. Requirements Analysis
	    b. Equipment Analysis
	    c. Risk Analysis
	    d. Budget study
	    e. Return on Investment
	    f. Project brief assessment
	    g. Market research
	    h. Preparing tender dossier
		Done	

2-	Procurement: Advert, Offers assessment / Vendor Selection / Awarding Decision / Order to Start; formalities	**To do**	3-6 months
3-	Implementation: **(Legacy Data)** - Data Gathering - Data migration from legacy systems	**To do**	1-2 month
4-	Implementation: **(New system configuration)** - System Configuration (Tavistock and Portman configuration and settings) - Environment Setup (Software and Hardware requirements)	**To do**	1-2 month
5-	Implementation: (**Setup/Installation/Testing**) - Tools installation - User Acceptance Testing - Technical assessment	**To do**	2-4 weeks
6-	Training - Basic Training - Extensive training - Mock trials	**To do**	10 weeks (2 and a half months): Basic Training (2 weeks) Extensive training and mock trials (2 months)
7-	Pilot – Soft Launching	**To do**	3 months
8-	Go Live date		

8. Costs

8.1. Indicative costs and required investment

At this early stage of the project it is not possible to give a complete projection of project costs until a contract is negotiated and finalised with a perspective supplier through mini competition process. However at the end of this document a "Summary of Costs as Stated by Suppliers in confidence" is presented in the Appendix 2. These indicative costs were obtained during initial discussions with potential suppliers. Prices reflect a range of costs based on three factors:
- Service level required
- Number of users
- Supplier solution/product

They are an estimate based on proposed supplier costs. These figures will be finalised when the tender is complete. These prices in the framework are the maximum that each supplier will be able to quote. In the mini-competition, the suppliers are able to tender lower prices than this if they wish.

The table below is based on the supplier quote in Appendix 2.

The set up and implementation costs are estimated to require a capital budget of £360,000 including VAT. Please refer to note 8.3 for further details.

The current and projected annual running costs are summarised below and demonstrate that an **additional expenditure budget of £36,708** is requested over the 5 year period:-

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	**Total**
Current (Unit4 Agresso)annual maintenance	£9,000	£9,000	£9,000				£ 27,000
Projected hosting cost (per Appendix 2)	£30,000	£30,000	£30,000	£30,000	£30,000	£30,000	£180,000
Projected support and maintenance (per Appendix 2)	£36,036	£36,036	£36,036	£36,036	£36,036	£36,036	£216,216
Training (per Appendix 2)	£21,600						£21,600
Total annual costs	**£96,636**	**£75,036**	**£75,036**	**£66,036**	**£66,036**	**£66,036**	**£444,816**
Current budget	£70,000	£70,000	£70,000	£70,000	£70,000	£70,000	£420,000
Additional expenditure budget needed	**£26,636**	**£ 5,036**	**£ 5,036**	**£0**	**£0**	**£0**	**£36,708**

Note: All figures in the table above are inclusive of VAT.

8.1.1. To summarise:-

8.2. Procurement costs

The total **procurement cost** for the proposed 30 days services by LPP consultant are **£26,000 (including VAT)**. If this process commences before 31st March 2015, a proportion of the total procurement costs will be reflected this financial year.

8.3. Capital expenditure

The **capital funding** required for the project is estimated at **£360,000 (including VAT)** in year 1 of the project. These costs will be depreciated over five years from implementation year.

In the event that data migration costs and supplier project management and disbursement charges are incurred, a further **contingency for capital expenditure** is estimated at **£15,000.**

8.4. Revenue expenditure

The **revenue funding** required for the project will consist of the remainder of the costs from the preferred supplier to cover the anticipated annual costs to the Trust. These are estimated at £444,816 (including VAT) to the end of year 5. An additional expenditure budget totalling **£36,708 is required from year 0 to 2** as shown in the table.

In addition to the investment above, an **exceptional contingency budget** of approx. **£30,000** is recommended to cover the event of the supplier going into bankruptcy during the period of the contract when we would require the option to buy the source code.

8.5. Savings: Staff capacity

There may be some savings in time as a new system aims to automate the current manual processes but this has yet to be quantified. It is aimed that any increased capacity will be redeployed to manage increased workloads derived from additional students.

9. Investment

9.1. The investment in a new ICT system for Education and Training is seen as business critical. The current system is not fit for current or future purpose and is seen as a risk to maintaining current operations at a steady state level and to achieving the improved student centred service we are aiming to deliver. A new system is necessary to underpin the proposed planned expansion of education and training activity and the portfolio of projects which is currently being rolled out. The ROI calculations for a new system in Appendix 3 can be used for illustrative purposes to demonstrate that a new system would free up capacity to increase the number of applications and students which are processed through the system assuming all other resources stayed the same. It is felt that a student centred application and enrolment system would enhance the student experience from the very beginning and hence also increase conversions.

Whilst a small return on investment is projected, the Project Board feel it is essentially the risks of not investing which need to be carefully considered.

10. Major Risks

10.1.   <u>Risk Approach</u>

The Trust's risk management approach will be used. The ITC project approach is the PRINCE2 methodology.

10.2.   <u>Risk Register</u>

A risk register for the project will be maintained and updated monthly and key risks reported to the ICT Board. Risks that exceed pre-defined risk assessment are automatically escalated to the board and if necessary to seek support from the Board. The risk register will be part of the Trust wide risk register and consequently key risks will also be reported to the Trust Management Committee on a quarterly basis. The project manager will be responsible for maintaining the risk register. A risk register is enclosed in the Appendix 4.

10.3.   <u>Risk Management</u>

Risk mitigation and action plans will be regularly monitored and reported to the project board in the report by the project manager. The project manager will also submit a post project evaluation report to the project board to report the handover of project deliverables, highlight changes to the business case, report progress against the baseline project plan and describe the lessons learned.

10.4.   <u>Timescale</u>

The major risk of the ICT project is timescale. The current timeframe lags due to approval processes changing and any further delay will mean that DET will not be able to implement and complete training stages efficiently before the start of September 2016. In order to effectively use the system the configuration should be completed in January the latest before the start of the new academic year, in order for the recruitment data to be entered and the student journey to be tracked fully during the full academic cycle.
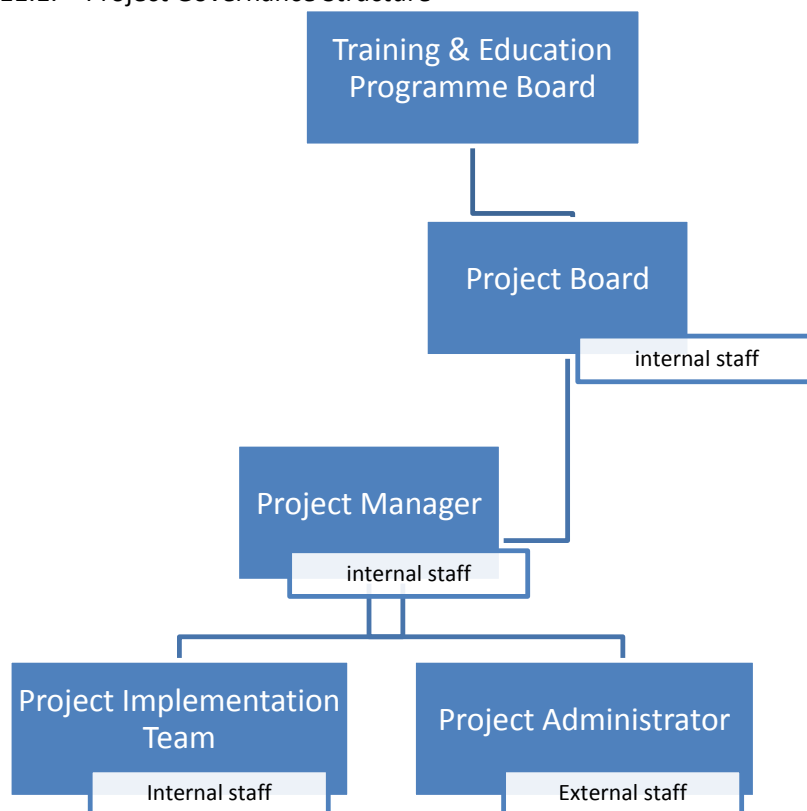
10.5.   <u>DET's growth strategy</u>

Another major risk relates to the successful implementation of the Programme of Strategic Transformation. The key aspects of the growth strategy are underpinned by the effective running of the new system. Therefore, the risk of not having a new effective and efficient system poses the greatest risk to the Trust's education and training business.

11.   Project organisation

Project Manager	Joanna Daci
Project Board	• The current established Operational Management Team (OMT) in Education and Training (DET), including representation from Systems, Conference & CPDs, Quality Assurance, Technology Enhancement, Management Accounts, Registry and Finance • IT and Informatics representatives • Governance representation • Cluster lead representation • Users representative
Project implementation team	• Conference & CPDs team representative • Course Administration team representative • Quality Assurance team representative • SAAMHS representative • CAMHS representative • E-learning team representative • IT representative • Informatics representative • Marketing/Communication and Commercial representative • Credit control/ finance representative • Registry Unit representative • Library Representative

11.1.   Project Governance Structure

E&T Student IT System

12. Communication plan

What	Who	Purpose	When/Frequency	Type/Method(s)
Initiation Meeting	Project Board	Discuss and agree the ITC Baseline Project Plan (BPP)	FIRST: Before Kick Off Meeting One-time only	Face-to-face Meeting
Distribute ITC BPP	All stakeholders	Distribute BPP to alert s of project scope and to gain buy in.	Before Kick Off Meeting	Document distributed electronically
Kick off meeting	Project implementation team	Communicate BPP and agree roles/responsibilities	One-time only	Face-to-face Meeting
Status Reports	Training and Education Programme Board	Update stakeholders on progress of the project.	Monthly	Distribute electronically (email) Template: Status Report
Team Meetings	Project working meetings; sub-teams: technical teams as appropriate.	To review detailed plans (tasks, assignments, and action items).	Regular weekly is recommended for project working team. Bi-weekly for sub-teams as appropriate.	Face-to-face Meeting Template: Detailed Plan
Project Board Meetings	Project Board and Project Manager	Update Project Board on status and discuss critical issues. Work through issues and change requests here before escalating to the Sponsor.	Monthly	Face-to-face Meeting
Executives/ Sponsor meeting	Training and Education Programme Board and Project Manager	Update Sponsor on status and discuss critical issues. Seek approval for changes to Project Plan.	As needed when issues cannot be resolved or changes need to be made to Project Plan.	Face-to-face Meeting (at the Training Executives)

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Technical design	Project Manager; Vendors; Trust Technical staff	To configure the IT applications	As in the plan agreed with the vendor	Face-to-face Meeting Conference calls Emails
Periodic Demos and Target Presentations as Project reviews	End Users.	To gain input from users and keep them abreast of the Project's status.	Once critical phases or major enhancements completed.	Power point Presentation/ Discussion Face-to-face Meeting
Announcements	Project Manager	To keep stakeholders informed	As needed	Email
Post Project Review	Project Manager, users, and Training and Education Programme Board	Identify improvements, lessons learned, what worked and what could have gone better. Review accomplishments.	End of Project or end of major phase	Meeting/Report Template: Project report.

13.   Inferences

Communication between users and new system will be performed trough a browser. For the time being the decision on the system architecture showing the distribution of functions across system modules is yet to be taken. The final decision on the system architecture will be made in the configuration phase of the project.

A browser will be used as a graphical user interface. In the configuration phase of the new system, the lay out of the required screen formats, report layouts and menu structures will be decided on. The Interface Agreement between the Trust and the vendor will describe the unique interfaces involved with the new system. It will present the systems functional, technical, and operational design.

The new system will use the HTTP protocol for communication over the internet. The user interface for the new system will be compatible to any browser such as Internet Explorer, Mozilla, Netscape Navigator, Firefox, Safari, Chrome by which user can access the new system. Since the new system must run over the internet, all the hardware shall require to connect internet will be the Trusts hardware interface for the system.

Appendix 1. Programme of Strategic Transformation in DET

Programme of Strategic Transformation

1. **New structure for effective delivery of Education and Training**
2. **Curriculum development** –
   new and revised courses (long, short, CPD, and online)
   enhancing the learner experience
   community of practice
3. **Planning Cycle**
4. **International**
5. **Technology Enhanced Learning**
   Technology Enhanced Learning strategy
   staff development programme
   course development
6. **University Partnerships**
   Essex/University of East London transition
7. **Regional Development**
   Associate Centre review
   Regional Development Strategy
8. **Marketing**
   Workforce mapping exercise
   Marketing strategy and plans
9. **Business Processes and Systems**
   New ICT system for DET
   Review DET structures
   Review DET processes

Appendix 2. Summary of Costs as Stated by Suppliers in confidence

Costing for Tribal Group (SITS): potential provider

Item	Number of days	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Total £ per item
Product Name SITS vision								
Total cost for implementation services including all expenses (one-off cost)	156.5	£140,850						£140,850
Project Management (one-off)	TBC							£0
Licence fee		£150,150						£150,150
Annual Hosting		£25,000	£25,000	£25,000	£25,000	£25,000	£25,000	£150,000
Annual Subscription including: support, maintenance etc. (ongoing)		£30,030	£30,030	£30,030	£30,030	£30,030	£30,030	£180,180
Training and materials costs	20	£18,000						£18,000
Upgrade costs (Non-bespoke changes)	0 - covered under hosting							£0
Change management/bespoke changes to software/application	tribal costs covered in implementation							£0
Data Migration costs	TBC							£0
Any other costs (preventative maintenance)	TBC							£0
Contingency Plan: project consultancy days	10	£9,000						£9,000
Other consultancy days	TBC							£0
Other costs (travel, catering, stationery etc.)	Charged as incurred							£0
Total (excl. VAT)		£373,030	£55,030	£55,030	£55,030	£55,030	£55,030	**£648,180**
Total (incl. VAT)		£447,636	£66,036	£66,036	£66,036	£66,036	£66,036	**£777,816**
Capital (incl. VAT)		£360,000						**£360,000**
Revenue (incl.VAT)		£87,636	£66,036	£66,036	£66,036	£66,036	£66,036	**£417,816**

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Appendix 3. ROI calculations for a new system

Assumptions for ROI calculations

INFORMATION FOR THE CURRENT YEAR:	
Other Costs - DET non-pay finance costs (excl Visiting lecturers and Dfe expenditure)	£400,000
Estimated annual maintenance and service costs as provided by suppliers	£66,000
Project staff support during implementation year	£15,000
Application Numbers (based on current AY13/14 numbers)	830
New First year Students (target AY14/15)	500
Other Income - Yr2+, CPD and Conferences	£2,525,000
Average Annual Course Fee as per AY13/14 fee matrix	£3,000
Teaching costs from FY14-15 budget and assumed increase of 2% per year	£1,288,840
Total DET Staff	35

PROPOSED PRICING INFORMATION:	
Total Cost of Proposed New System Solution (one-off investment). Calculations assume equal payments over five years.	£600,000

DESIRED RESULTS:	
Desired 5-Year Increase in First Year Enrolment by five years from now	8.00%
Hours of additional capacity from each staff by streamlining processes & reducing TOIL hours	3

OTHER ASSUMPTIONS IN CALCULATIONS:
Number of Y1: applications and enrolment grow equally in each year of the analysis.
Income relates only to tuition fees. It excludes training contract income.
Retention rate: a student retained to next year continue on throughout all years of the analysis.
Course fees: the average course fee is calculated and remains constant throughout all years of analysis.
Contract: a five year agreement with equal payments over each year of the agreement.

ROI Calculator for NEW SYSTEM

	Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL
INCOME						
Course fee Income Y1	£1,500,000	£1,530,000	£1,560,600	£1,591,812	£1,623,648	£7,806,060
Incoming Y1 students	500	510	520	531	541	2602
Retained Student Fee Income year 2+ and short courses	£2,525,000	£2,575,500	£2,627,010	£2,679,550	£2,733,141	£13,140,201
Total Income	£4,025,000	£4,105,500	£4,187,610	£4,271,362	£4,356,789	£20,946,262
Gain in year compared with year 1	**£0**	**£80,500**	**£162,610**	**£246,362**	**£331,789**	
EXPENDITURE						
Teaching costs	-£1,288,840	-£1,304,951	-£1,318,000	-£1,331,180	-£1,344,492	-£6,587,462
Project staff support	-£15,000					-£15,000
Annual maintenance and services costs		-£66,000	-£67,980	-£70,019	-£72,120	-£276,119
Total Expenditure	**(£1,303,840)**	**(£1,370,951)**	**(£1,385,980)**	**(£1,401,199)**	**(£1,416,612)**	**(£6,878,582)**
Increased expenditure in year compared to year 1	**(£15,000)**	**(£67,111)**	**(£82,140)**	**(£97,359)**	**(£112,772)**	
Cumulative expenditure	**(£15,000)**	**(£82,111)**	**(£164,251)**	**(£261,610)**	**(£374,382)**	
SAVINGS AND INCREASED STAFF CAPACITY						
Increased staff capacity net of increased enrolment	£0	£64,314	£64,314	£64,314	£64,314	£257,255
Other savings on non-pay expenditure	£0	£12,000	£12,000	£12,000	£12,000	£48,000
Total Savings	**£0**	**£76,314**	**£76,314**	**£76,314**	**£76,314**	**£305,255**
Annual total: income - costs	£2,721,160	£2,810,863	£2,877,944	£2,946,477	£3,016,491	
Annual total: Cumulative value		£5,532,023	£8,409,967	£8,635,283	£8,840,912	
Net gain from a new system	£0	-£5,797	-£87,937	-£185,296	-£298,068	
Net cumumlative gain from a new system		-£5,797	-£93,734	-£279,030	-£577,098	

INVESTMENT	Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL
Investment	**(£381,600)**					**(£381,600)**

RESULTS WITH A NEW SOLUTION	Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL
Income gain	£0	£80,500	£162,610	£246,362	£331,789	**£821,262**
Increased capacity and other savings	£0	£76,314	£76,314	£76,314	£76,314	**£305,255**
Increased expenditure	(£15,000)	(£67,111)	(£82,140)	(£97,359)	(£112,772)	**(£374,382)**
Total gain from new system	(£15,000)	**£89,703**	**£156,784**	**£225,317**	**£295,331**	**£752,135**
Gain from investment	**(£396,600)**	**£89,703**	**£156,784**	**£225,317**	**£295,331**	**£370,535**
Gain from investment: Cumulative Over Contract	**(£396,600)**	**(£306,897)**	**(£150,113)**	**£75,203**	**£370,535**	

GAIN FROM INVESTMENT (NET RETURN)		**£370,535**
BREAKEVEN POINT		**4th Year**
ROI (Duration of Contract - in %)	*return on investment (%) = (Net return / Investment) × 100*	**34%**
ROI (Duration of Contract - per pound spent)	*return on investment = (gain from investment - cost of investment) / cost of investment*	**£0.34**

Definitions:
Net Return – this is the amount gained by the Trust through the use of the new solution after the cost is subtracted

Percent Return (ROI) – This is the amount percent return on each pound spent on the new solution
Return Per Pound Spent (ROI) – This is the number of pounds received for each pound spent on the new solution
Breakeven Point – The point in time where the new solution has paid for itself and is now earning the Trust money.

$$ROI = \frac{(Gain\ from\ Investment\ -\ Cost\ of\ Investment)}{Cost\ of\ Investment}$$

Notes: The increased (re)enrolments generated by the system only over 5 years, excluding increased investment in marketing activities, would bring estimated £1,126,517 in increased income and capacity combined. This figure would be generated by increased number of students, savings on staff capacity and other DET non-pay expenditure.

Appendix 4. Risk Register

I.   Project Risk Assessment

SWITF Risk Assessment	
Section / Task	DET
Description of section / task to be analysed	To manage the implementation of ICT student records system that aims to enhance the functionality of the system for managing the Trust's provision of education and training to current and prospective students
Asset owner:	Malcolm Allen

What if?	Causes	Consequences	Safeguards	Risk C L R
Inability to achieve key milestones	Lack of clarity regarding scope and sequence of rollout Lack of agreement,	decision making process is lengthened Deadline will not be met.	Provide regular status reports, closely monitor project milestones, adjust resources to meet timeline.	3 2 6
	Changes to the current workload and use of technical tools. Members of trust already having to accept wholesale change may not be very happy.	Outcomes will not be met and actual cost exceeds budget because planned implementation and installation costs will increase due to revised specification requirements	Identify project champions to assist with change management. Redefine job descriptions and communicate all modifications to those affected. Identify and involve stakeholders, ensure users are adequately trained on the tools, promote the benefits. have a clear strategic plan and a defined timeframe plus end user requirements	
	Lack of human capacity : Sickness, holiday and any other unexpected absences which prevents the implementation;	Delays in the project implementation	Interview the key members of staff to determine busy times and include it in the project plan. Negotiate the time needed for the project Manage the project as planned and factor contingency to ensure project is completed successfully	
Loss of confidential information	Vendor policy states that the company has access rights to our data	Being unable to retain or control data.	Check access to data and policies from local government agencies. Communicate and agree with vendor on data ownership.	1 2 2

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II. Product Risk Assessment

SWITF Risk Assessment	
Section / Task	DET
Description of section / task to be analysed	A new product purchase
Asset owner:	Malcolm Allen

What if?	Causes	Consequences	Safeguards	Risk C	L	R
A new software purchased does not fulfil its intended use	Incomplete Statement of Requirements:	Disruption to business: the number and/or size of changes is higher than initial anticipated; Test specifications are not set up correctly cost overruns; time-consuming and expensive system development process	Capture critical inputs from all stakeholders Work with vendor and Trust IT/informatics A robust configuration management Identify control activities that are key to delivering a project on time and within budget. Freeze the requirements and build the system capabilities around specifications, so that the risk of changing requirements can be minimized. Design and agree with the supplier the testing plan; A testing and verification environment will be deployed where the performance of the system can be verified before it is deployed	2	1	2
	System design flawed: System is prone to bugs and slow; The supplier does not have sufficient experience in HE. Some key system features and function that DET specified are missed;	Failure to adequately maintain student records system the system cannot handle the workload required to complete the project; It is unreliable and frequently fails to work;	A disciplined approach to system development; Check with the supplier if they offer any form of evaluation system so that we can try before buying: Defined system quality plan including design, programming, and testing; Check with suppliers if there is an active independent user group/previous buyers where experience and ideas can be freely exchanged			
Requirements will change in the future to accommodate the DET's growth strategy	System is not fully fit for purpose against the original specifications.	Further developmental costs and time	Get reassurance from suppliers that the system is scalable and check if the supplier can provide references for businesses in HE sector using their system. Also supplier present a case/provide	2	2	4

			assurance how this product could meet DET needs against specifications (reporting etc.). The agreement between the provider and DET on the architecture of the system and its adaptability to the needs.			
Confidential data are lost	Product does not have security levels/roles as required by DET.	It will be breach of Data protection Act, along with other Information governance rules and guidance.	System should provide full audit trail of access, which should be managed and audited by System Admin and any breaches reported to line managers	1	2	2
Vendor ceased to trade	Bankruptcy	Loss of access to the hosted data	Negotiate with the vendor the contract and reassure backup and purchase of the source code	2	1	2

References

Allen, M. (2013a, January). *Education and Training Report* (13). Internal DET document.

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Deloitte & Reform. (2012). *The State of the State 2012* (Deloitte & Reform report). Retrieved from the NHS evidence website http://www.deloitte.co.uk/thestateofthestate.pdf

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E&T Student IT System

Board of Directors: November 2014

Item : 13

Title : Developing an R&D Strategy

Purpose:

A response to 'Shaping Our Future', outline for developing a research and development strategy.

For : Discussion

From: Dr Rob Senior, Medical Director and Dr Eilis Kennedy, Director of R&D

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1. INTRODUCTION

In his 'Shaping Our Future' document, Paul Jenkins made the following points about research in the Trust:

Our profile on research is relatively invisible given our wider aspirations as a centre of excellence in training and the provision of high quality clinical services. The factors affecting this appear to be:

1.1. A failure to achieve our former level of income from the new system of research funding despite involvement in major funded research studies such as IMPACT and SHIFT.

1.2. Weak alignment between the scale and character of our clinical services and our research endeavours. We cannot recruit subjects from our own services in sufficient numbers for larger studies to answer fundamental scientific questions.

1.3. A dependence in the past on certain well placed individuals and the lack of a systematic approach to developing research capability and funding streams.

1.4. Some resistance to the empirical evaluation, including manualisation, of interventions in a way which fits in with research protocols.

1.5. This affects both our reputation and standing but also the ability of the wider psychotherapy community to justify the effectiveness of its interventions.

1.6. In recent years there have been some positive developments, such as the TADS study, IMPACT, SHIFT and the MBT groups for ASPD, which have shown or will show in time the value of well-targeted research. I am keen to build on these and establish a position with collaborating partners in fields of applied research which:

   o Contribute to the evidence base for effective psychosocial interventions.
   o Develop new interventions based on an understanding of the mechanisms involved and test their effectiveness.
   o Complement our existing portfolio in education and clinical work.

1.7. A key challenge will be to develop a strategy as to how we can build up a level of infrastructure to support research work, attract clinicians interested in this area of work and pursue opportunities for research funding and develop further the integration with our research trainings.

2. RESPONDING TO THE CHALLENGE

2.1. We absolutely agree that as a leading NHS provider of mental health services and training, it is essential to the quality of what we provide, to our reputation and ultimately to our survival, that the Tavistock and Portman is actively engaged in research to build the evidence-base (including challenging the existing evidence) and to demonstrate the effectiveness of what we offer.

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2.2. Although we have an effective research management and governance system there has been a failure to align sufficiently our research with our clinical and training endeavours in order to fully develop our potential in each of these spheres.

2.3. Over the last 8 years there have been huge changes in the way in which research in the NHS is funded and delivered and this has presented a significant challenge for all NHS Trusts. The end of the R&D Levy (Culyer funding) and the creation of the National Institute for Health Research (NIHR) made securing funding for clinical research in the NHS highly competitive with the bulk of funding now coming from NIHR directed and commissioned research programmes and NIHR funding partners. This competitive funding environment has seen a change in research culture in the NHS with few trusts being able to support 'own account' research as the focus switches to delivering the national research agenda.

2.4. Income to support research in the NHS is therefore now very clearly linked to NIHR funding. Additional money to support research capability flows to those organisations which are successful in securing NIHR grants, infrastructure funding or senior investigator awards. Attracting this type of funding is a key priority for the Trust as this funding enables 'NHS organisations to create and maintain a sustainable capacity for people and patient based research. It facilitates success in attracting NIHR research grants and other funding, leading to future allocation of Research Capability Funding - a virtuous circle.'

2.5. From languishing at the bottom of the funding pile in the period following the end of the R&D levy and the establishment of NIHR we have succeeded in securing respectable NIHR funding for our size as an NHS provider. Over the last four years we have moved from a position where R&D was a cost pressure on the Trust to one where this is no longer the case.

2.6. We have built effective and productive research partnerships with key academics, particularly Professor Peter Fonagy, and have been involved in a number of NIHR or NIHR partner funded studies (i.e. IMPACT, SHIFT, REDIT, U-Change, FRAMEA). In addition to securing income directly from the DH (Research Capability Funding) we have been successful in securing income from the Clinical Research Network in order to support the involvement of Trust Clinical Directorates in these research studies and to support key members of staff involved in research.

2.7. More recently we have submitted an NIHR programme grant for £2.5 million as part of the NIHR themed call on long-term conditions in childhood in response to the 2012 CMO report 'Our Children Deserve Better: Prevention Pays.' This grant involves collaboration between ourselves, the Institute of Psychiatry, University College London, Liverpool University and Manchester University. If successful the grant will generate a significant amount of additional funding to support research at the Trust.

2.8. So while there have been significant achievements we believe that the scale and reach of our research enterprise is still not sufficiently in line with our aspirations or status as a provider of high quality training and clinical services.

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3. OBSTACLES TO OUR AMBITION

3.1. As an organisation we are too small and do not have academics of sufficient stature to succeed in securing research funding on our own. The era of the clinical academic with relatively modest grant income and publication output is at an end as is the ability of the Trust to fund research such as TADS from clinical and training income alone.

3.2. We have an additional challenge in that our clinical populations are small and contributing effectively to the recruitment of research subjects in large studies has proved difficult both practically and culturally although not impossible. It requires collaboration and partnership with other providers during a time of great turbulence in the commissioning and funding environment.

3.3. There is limited understanding within the Trust of the demands and rigors of developing and delivering research of high enough quality to attract external funding. This gap is then reflected in the quality of research teaching and support for out trainings.

3.4. Some of this reflects a genuine and defensible epistemological and philosophical position about the status afforded to particular kinds of knowledge but we also have a very limited number of individuals with the capacity to teach others about good clinical research which can withstand external scrutiny and challenge.

4. DEVELOPING A STRATEGY

Particularly in such challenging economic circumstances, we must do all we can to maximise our chances of success. Linking up with researchers in other Trusts and relevant academics will clearly enhance our chances of success and existing partnerships via UCLP and other University partners are crucial to this enterprise. We have made a particular commitment to our new academic partner for our training ambitions, the University of Essex, to explore potential research synergies.

We propose a number of elements to our strategy:

4.1. That we demonstrate greater **ambition** but that this is tempered with realism regarding our chances of success. This will mean investing resources in targeting sources of funding where there is reasonable likelihood of success and building the necessary partnerships to create research teams capable of securing external funding.

4.2. That we are more **assertive** in promoting the considerable research output from the Trust both currently and historically.

4.2.1. We have already invested some R&D income in redesigning the Trust website to include a navigation tab on the main website alongside Training and Clinical services. Research, research relevant trainings and innovative clinical services should be coherently organised around three main themes.

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At the moment these are; Psychological Therapies; Child and Adolescent Mental Health; Infancy and Early Years. As a part of developing our strategy over the next few months, we welcome some debate about whether these encompass the right priorities.

4.2.2. Over time specific areas of research expertise can be further promoted by establishing dedicated, visible, research centres with input from Trust staff and key external academics. Examples of potential research centres, some built on existing structures, include: Centre for the Study of Children in Care; Psychological Therapies Research Centre; Infancy and Early Years Research Centre.

4.2.3. Some of the Trust's activity and expertise reside in areas where there is less obvious competition for research and intellectual leadership. Childhood maltreatment is one such area where, in Professor Jonathan Hill, we already have some acknowledged expertise in researching the pathway from early exposure to risk and the development of subsequent emotional, psychological and behavioural difficulties. Charitable funding may be more accessible in this and in related areas.

4.2.4. In the short-term our research activity and information regarding systems for research management and governance in the Trust needs to be more accessible and clearly promoted on the website.

4.3. That there is greater **alignment** with the clinical and training strategy. Research has a significant role in drawing students to us as an educational institution as well as contributing to the rigor and quality of our trainings. In the clinical domain research contributes to developing the evidence base for the effectiveness and cost effectiveness of what we do as well as promoting innovation and the development of new models of intervention.

4.4. That we invest in building our research capacity and capability by inviting key **academics** to engage with us as visiting professors or similar, perhaps linked to the Centres proposed above and offering honorary titles. A limited number of key individuals should be offered funded short sabbaticals or similar to work up research plans.

4.5. That our overall, high level, strategy is to carve out a unique research identity for **applied** clinical research, a 'clinical university for mental health.' This should involve further practical development of our existing relationship with North Thames CLARHC and UCLPartners and would also have strong user involvement. One recent proposal has been that we develop a bid to be a Biomedical Research Unit. http://bit.ly/1zU4bRz. There are currently 4 such units for dementia but none for other aspects of mental health research.

4.6. That, as a matter of urgency, our trainings reflect our commitment to the centrality of research. As an example, we develop cross disciplinary research modules of high quality to identify, encourage and develop young researchers in the Trust and to contribute building research capacity within the NHS.

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5. NEXT STEPS

5.1. We want to invite further discussion and feed-back on these outline proposals from the Board, the Management Team, the R&D Committee, the Clinics Committee (or its heir) and from other stakeholders including people who use our clinical and training services. We would then hope to be able to bring back to the Board early in the New Year a more detailed proposal including a business case for investment and projected income going forward. Many elements of the strategy are about a change in the culture of the organisation for which leadership is required. This, of course, carries a cost but not necessarily in the form of substantial new posts.

Dr Rob Senior, Medical Director
Dr Eilis Kennedy, Director of R&D

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BOARD OF DIRECTORS (PART 1)

Meeting in public
Tuesday 25th November 2014, 14.00 – 16.00
Board Room, Tavistock Centre, 120 Belsize Lane, London NW3 5BA

AGENDA

PRELIMINARIES

1.	**Chair's Opening Remarks** Ms Angela Greatley, Trust Chair		Verbal	-
2.	**Apologies for absence and declarations of interest** Ms Angela Greatley, Trust Chair	To note	Verbal	-
3.	**Minutes of the previous meeting** Ms Angela Greatley, Trust Chair	To approve	Enc.	p.1
3a.	**Outstanding Actions** Ms Angela Greatley, Trust Chair	To note	Enc.	p.11
4.	**Matters arising** Ms Angela Greatley, Trust Chair	To note	Verbal	-

REPORTS & FINANCE

5.	**Trust Chair's and NED's Report, including NED Committee Memberships** Non-Executive Directors as appropriate	To approve	Enc.	p.12
6.	**Chief Executive's Report** Mr Paul Jenkins, Chief Executive	To note	Enc.	p.14
7.	**Finance & Performance Report** Mr Simon Young, Deputy Chief Executive & Director of Finance	To note	Enc.	p.18
8.	**Training and Education Management Board Report** Mr Malcolm Allen, Dean	To note	Enc.	p.29
9.	**SAAMHS Service Line Report - Complex** Mr Marcus Evans, Associate Clinical Director, Complex Needs	To discuss	Enc.	p.41
10.	**CQSG Quarter 2 Report** Dr Rob Senior, Medical Director	To approve	Enc.	p.58

STRATEGY

11.	**Action Plan for addressing Bullying and Harassment** Ms Susan Thomas, Director of Human Resources & Ms Judith Bell, Director Tavistock Consulting	To discuss	Enc.	p.77
12.	**Education and Training: Student Information Management System proposal** Mr Malcolm Allen, Dean	To approve	Enc.	p.81

13.	**Research Strategy Update** Dr Rob Senior, Medical Director	To discuss	Enc.	p.114
PATIENT STORY				
14.	**Patient Story**	To note	Verbal	-
CONCLUSION				
15.	**Any Other Business**		Verbal	-
16.	**Notice of Future Meetings** • Tuesday 2nd December 2014: Leadership Strategic Conference 10.00am to 4.00pm, Danubius Hotel Regents Park. • Thursday 4th December 2014: Council of Governors Meeting, 2pm-5pm, Board Room, Tavistock Centre		Verbal	-