

Board of Directors Part One

Agenda and papers
of a meeting to be held in public

2.00pm–4.30pm
Tuesday 28th July 2015

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

BOARD OF DIRECTORS (PART 1)

Meeting in public
Tuesday 28th July 2015, 14.00 – 16.30
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.10
4.	Matters arising Ms Angela Greatley, Trust Chair	To note	Verbal	-
REPORTS & FINANCE				
5.	Trust Chair's and NEDs' Report Non-Executive Directors as appropriate	To note	Verbal	-
6.	Chief Executive's Report Mr Paul Jenkins, Chief Executive	To note	Enc.	p.11
7.	Finance & Performance Report Mr Simon Young, Deputy Chief Executive & Director of Finance	To note	Enc.	p.13
8.	Training and Education Report Mr Brian Rock, Director of Education & Training; Dean	To note	Enc.	p.24
9.	Service Line Report, Portman Clinic Dr Stan Ruszczyński, Director of Portman Clinic	To note	Enc.	p.28
STRATEGY				
10.	Developing the Medium Term Strategy – Mission, Values and Ambitions. Mr Paul Jenkins, Chief Executive	To approve	Enc.	p.46

11.	Board Assurance Framework Mr Simon Young, Deputy Chief Executive & Director of Finance	To approve	Enc.	p.57
12.	Annual Review of the Operational Risk Register Ms Pat Key, Director of CGF	To approve	Enc.	p.77
13.	Board Objectives Ms Angela Greatley, Chair, and Mr Paul Jenkins, CEO	To approve	Enc.	p.94
14.	Governance Review Mr Paul Jenkins, Chief Executive	To approve	Enc.	p.98
15.	Next Steps for Patient Involvement in the Trust Mr Paul Jenkins	To discuss	Enc.	p.114
16.	Q1 Quality Report Ms Justine McCarthy Woods, Quality Lead	To note	Enc.	p.124
17.	Q1 Governance Statement Mr Simon Young, Deputy CEO and Director of Finance	To approve	Enc.	p.153
CORPORATE GOVERNANCE				
18.	Register of Directors' Interests Mr Gervase Campbell, Trust Secretary	To approve	Enc.	p.157
19.	Update on Freedom To Speak Up and Duty of Candour/FPPT Action Plans Mr Gervase Campbell, Trust Secretary	To note	Enc.	p.164
20.	Terms of Reference of the Management Team, and the Executive Appointment and Remuneration Committee Mr Gervase Campbell, Trust Secretary	To approve	Enc.	p.174
21.	Constitutional Amendments Mr Gervase Campbell, Trust Secretary	To approve	Enc.	p.187
22.	DET Capital Project to Ratify Mr Brian Rock, Director of Education and Training	To approve	Enc.	p.189
CLOSE				
22.	Notice of Future Meetings <ul style="list-style-type: none"> Tuesday 15th September: Director's Conference 12.00 – 5.00pm, Lecture Theatre Thursday 17th September 2015: Council of Governors' Meeting, 2.00pm – 5.00pm, Board Room Tuesday 29th September 2015: Board of Directors' Meeting 2.00pm – 5.00pm, Board Room 		Verbal	-

Board of Directors

Meeting Minutes (Part One) Tuesday 23rd June 2015, 2.00 – 4.40pm

Present:			
Ms Angela Greatley Trust Chair	Ms Jane Gizbert NED	Dr Rita Harris CYAF Director	Mr David Holt NED
Mr Paul Jenkins Chief Executive	Ms Lis Jones Nurse Director	Ms Louise Lyon Director of Q&PE and A&FS	Dr Ian McPherson Non-Executive Director & Vice Chair of Trust
Ms Edna Murphy NED	Mr Brian Rock Director of Education and Training, Dean	Dr Rob Senior Medical Director	Mr Simon Young Deputy CEO & Director of Finance
Attendees:			
Mr Gervase Campbell Trust Secretary (minutes)	Ms Polly Carmichael GIDS Director (item 9)	Ms Claire Shaw Patient Story Lead (item17)	Patients H & I, GIDS (item 17)
Apologies:			
Prof. Dinesh Bhugra NED			

Actions

AP	Item	Action to be taken	Resp	By
1	3	Minor changes to be made to the minutes	GC	Immd.
2	10	Details of Safer Recruitment training to be circulated to the board.	GC	July

1. Trust Chair's Opening Remarks

Ms Greatley opened the meeting.

2. Apologies for Absence and declarations of interest

Apologies as above.

There were no declarations of interest specific to this meeting.

3. Minutes of the Previous Meeting

AP1 The minutes were approved subject to minor amendments

4. Matters Arising

Action points from previous meetings:

AP1 – (minor changes to minutes) – completed.

AP2 – (circulate lessons learned from Essex CAMHS bid – due July

AP3 – (Circulate access agreement) – completed

AP4 – (Update on 'Freedom to Speak Up') – due July

Outstanding action points:

OAP2, 3 – Completed.

There were no further matters arising.

5. Trust Chair and NEDs' Report

Ms Greatley reported that she had attended the NHS Providers event for Chairs and CEOs, and the focus had been on the reality of the financial pressure, and the clear message from government that the NHS would have to manage the £22 billion funding gap by itself.

Dr McPherson reported he had attended the NHS Providers event on NED Challenge, which had been good, and focussed on why NEDs were present on a board and what their role was; he recommended it.

Ms Gizbert reported she had attended the website reference group, and there was good work being done on the Education and Training section, updating it to reflect the work going on in the department.

The Board **noted** the reports.

6. Chief Executive's Report

Mr Jenkins highlighted the work of the Mental Health Taskforce, and noted that the new government seemed to recognise the importance of mental health, and might maintain investment in CAMHS.

He reported that the Trust had agreed in principle to form a partnership with the Anna Freud Centre, UCL Partners and the Dartmouth Centre to promote the development of the Thrive model. For the local implementation sites there was a need to develop a set of guidelines on local autonomy combined with fidelity to the model and consistent measures of outcomes and processes.

The Care Notes system would be going live on the 27th July, with some ongoing risk to be managed, and so fortnightly conversations with the supplier would continue. Mr Holt asked whether there was any possible recourse against the supplier for the delays. Mr Young commented that it was complicated, but they were looking to pursue this in conjunction with the other customers and the head of the procurement consortium.

The Board **noted** the report.

7. Finance & Performance Report

Mr Young reported that the surplus was higher than expected due to underspend in some areas, mostly due to staff vacancies. With FNP he expected that the underspend would be used later in the year, and in GIDS they did have the flexibility to use short term posts towards the end of the year, so would probably come out on budget. However in other services, such as Hackney, although the current vacancies would be filled they were

unlikely to catch up on the underspend.

He noted that the contingency reserve had reduced, in part for technical reasons, but was adequate. The cash position was healthy as we had been paid now for last year's contracts, however many of the commissioners had not yet paid for this year's, and the finance team were working with Commercial with the aim of resolving this in July.

Ms Murphy asked whether the underspend might indicate services weren't being delivered. Mr Young suggested that the GIDS report showed they were able to handle referrals despite never quite having the right staffing levels, but conceded that there were opportunity costs and more could be done if services were fully staffed.

The Board **noted** the report.

8. Training and Education Report

From his report Mr Rock highlighted the work on recruitment and student numbers, which seemed to be roughly consistent with the two years before last. Focus was being placed on following up those who had attended open days or expressed interest without following making an application. They were also following up partially completed applications, and were aware that systems needed to be altered to make it simpler to change course in the middle of the application process.

Mr Holt asked for some clarification of section 6.4, given that he thought was meant to be the year that recruitment issues were resolved, and it didn't seem to be the case that they were on top of the situation. He wondered if there was more that could be done now to get back on track. Mr Young noted that it had been stated in October that we were likely to be behind this year, and Mr Rock explained that they were addressing a cultural change in the ownership of targets, and although they had done a lot of work improving processes, such as running earlier and more frequent open evenings, there were a number of legacy issues that could not all be resolved this year. Ms Gizbert added that she had been working with Ms Laure Thomas on these and the deeper you looked the more issues you found, each of which required investigation, such as the bounce rate on website visits. Ms Murphy commented that it was predictable that many issues would emerge when many difficult changes were being made, and it was encouraging that the priorities were well identified, and staff priorities were aligned with the organisational ones.

The Board **noted** the report.

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

Dr Carmichael presented the report, highlighting that 277 referrals had been received this year already, and there was a 50% increase each year, which was a challenge for the team, and for recruitment.

She noted that being a national service meant they were not able to see their patients all that frequently, and to help manage this they were tightening the referral criteria to ensure risks were being managed locally before cases were taken on. The risk workshops had been very helpful in reminding clinicians that it was impossible to do everything, and so keeping local CAMHS engaged was important.

The Leeds base was growing, which presented challenges with accommodation. Sally Phillips was the Lead in Leeds and was managing an excellent team, including a number of family therapists. An additional problem was keeping the team integrated across the sites, and it was frustrating that the video link still wasn't working.

Research was important as they were the only centre in the UK, and the early intervention work was coming to fruition. They were running lots of CPD events to educate services locally, and developing the website and involving young people using the service in doing this.

Mr Holt asked how they managed the demand whilst ensuring a safe service despite the pressure on clinicians. Dr Carmichael commented that the team was open and were able to speak up about pressures. They were reaching a point where they would have to say enough and she was working on how to convey this to NHS England constructively. Dr Senior added that there was a sense of some escalating risk, not just from work pressure but also in the number of safeguarding and risk concerns that were being brought to him for advice. This was in part due to a lack of containing networks on the ground in some parts of the country, which was being raised with commissioners where it occurred, but meant that in some cases they might need to refuse a referral if they could not be sure of managing it safely. Dr Carmichael added that the input from Tavistock staff outside the team was useful support, e.g. the Case Discussion Forum organised by Ms Lyon.

Mr Rock asked how we could understand the growth, and to anticipate where it might go. Dr Carmichael explained that their Surveillance Study showed the numbers should peak, but it was difficult to know for sure as gender was increasingly on the agenda with young people talking about it more, especially on the web, and identifying themselves in non-binary ways.

Dr Harris noted that the Service Line Report included, for the first time,

'Staff Stories', and she would appreciate feedback from the board on these. Mr Holt commented that they were helpful: very open and honest, and it was good to see they felt confident to put their thoughts in writing.

Mr Jenkins commented that the team were doing great work, and should be very proud. He was impressed by their thoughtful multi-disciplinary and multi-agency approach, and it was fascinating how their work cut through the physical/mental health boundary. The question for the Trust was how to capture that learning more widely. He noted that Dr Carmichael was doing a very good job leading the service, and especially in the media role she had taken on. Communications had improved immensely, and the next step was to be proactive in telling real stories of what it was like for young people to visit the service.

The Board **noted** the report.

10 Annual Safeguarding Report

Ms Greatley thanked Dr Senior and Ms Appleby for the helpful presentation and discussion they had held on safeguarding over lunch. Dr Senior introduced his report by noting that Dr Sarah Helps had taken on the role of adult safeguarding lead enthusiastically, and this was an area the Trust needed to focus some attention on. He explained that DoLs, section 5.2, were the Deprivation of Liberty Safeguards, and linked to the mental capacity act and the care of those who lacked the capacity to make decisions in their own right. He noted that the Trust did not have in-patients and had few patients with cognitive challenges or dementia, but that this might change as we moved towards a community and primary care focus, and it was important that staff were aware of the Act and wider questions of informed consent.

Dr McPherson noted that adult and child safeguarding were treated separately, but there must be some family cases where they both applied. Dr Senior agreed that safeguarding adults at risk applies to some people with mental health issues who were also parents and to the Prevent agenda as well. He noted that he met jointly with both leads, and there was also the safeguarding committee as a joint forum.

Mr Holt queried whether board members needed safer recruitment training, and how the Trust knew who had done it, as it was run by the NSPCC. Dr Senior explained that one member of each interview panel, not necessarily the Chair, needed to have done the training. This meant it would be rare that NEDs were required to do the training, but it would be beneficial for them anyway. It was agreed that Mr Campbell would get the details of the course and how HR managed it and circulate them to the

AP2 board.

The Board **noted** the report.

11 Board Objectives

Ms Greatley introduced the objectives, explaining that they were based on issues from the annual report as well as the two year strategy, and so might need to be updated if the strategy were to change significantly. Mr Jenkins added that sufficient work had been done on the strategy that the objectives for the coming year were unlikely to change now.

The Board discussed the objectives in detail. Suggestions were made for various changes, including a more explicit promotion of the 'Freedom to Speak Up' recommendations and Duty of Candour requirements, as well as a broader attention to quality to include non-clinical. It was agreed that the revised objectives would come to the July board for approval.

The Board **noted** the report.

12 Update on Chair Recruitment

Mr Campbell presented the paper, adding that the advert had now closed, and 36 good applications had been received.

The Board **noted** the report.

13 Identity Badges

Ms Lyon explained that a further paper was planned to come in July for approval, and this paper was to allow an initial discussion of the issues. She noted that although a straw poll had not favoured badges, they were already issued to about 140 staff whose roles took them into the community; badges were now standard within the NHS and other organisations; and recent discussions around safety and being able to demonstrate who staff were had suggested that introducing them more widely would be beneficial. Ms Lyon explained that historically in the Trust badges had been seen as detrimental to the promotion of an ethos of inclusiveness, which was pursued by trying to diminish signs of who was staff, patient or student. Mr Holt commented that patients had the right to have someone who approached them be clearly identified as a staff member, especially on a first visit before going into therapy alone with them. Dr Senior and Dr Harris noted that they had originally supported the egalitarian approach, but had come to feel that it lacked transparency and

it was better to recognise that we are all different and staff need to be identifiable to those they want to help. Ms Murphy noted that attitudes more widely had changed, and badges were common in universities, companies and even for students in schools. Dr McPherson noted communicating to staff the rationale from a clinical perspective would be important to changing the culture if we did proceed, but it was unlikely to be a controversial issue for very long.

Mr Jenkins summarised the discussion, saying that it was the right thing to do and fitted with the Kate Granger initiative, and how we relate to people using our services. So whilst there was a safeguarding aspect it was the cultural goal of remembering we are here to help that was a more important driver.

Ms Greatley added the suggestion that there should be a board at reception with photos and brief details of all the board members.

The Board **agreed** to the roll out of identification badges for all staff.

14 Monitor Self Certificate (2) – Governance Statement

Mr Young explained the requirement for the certificate, and invited the board to approve the statements it contained. Mr Holt questioned whether it was possible to give not-applicable as an answer for 2.8, Mr Young thought that it was probably not an option available, but they would confirm this. Mr Holt asked for more details of whether training for governors needed to be merely offered, or was a requirement. Ms Greatley explained that as governors were elected by their members it was hard to force them to do training, but many did attend courses and so over the whole of the Council there was sufficient knowledge and expertise, which was the aim.

The Board **approved** the statements.

15 Audit Committee Terms of Reference (ToR)

Mr Holt noted that there were only minor changes in the new ToR, mostly to job titles, but the reporting of tender waivers to meetings had been added to the ToR to reflect what had been committee practice for some time.

The Board **approved** the ToR.

16 Scheme of Delegation of Powers Review

Mr Campbell introduced the scheme for review, noting that most changes this year were to job titles. The Board debated the details of the scheme, and sort clarification of some of the areas where they were not clear. With regards to the bank accounts, section 2, Mr Young explained that the SFI made it clear that he operated the accounts within set rules. It was questioned whether for 19c it should in fact be the two directors jointly

authorising, and it was agreed Mr Campbell and Mr Young would check and correct as needed. There were a number of other minor corrections requested.

Mr Rock noted that the scheme would need to be revised when the HR director role changed, and it was agreed that Mr Campbell and Mr Young would revise it whenever a post was removed.

The Board **approved** the scheme, with the changes detailed.

17 Patient Story - GIDS

Ms Greatley welcomed two young people from the GIDS service, Ms H and Mr I, and the board introduced themselves.

Mr I explained that his route to GIDS had been straightforward, with a referral in August 2014 and then initial assessment in November. These had led to a referral to UCLH and the prescription of hormone blockers. Ms H's journey had not been as smooth, as her GP hadn't known how to respond to her, and when she did get referred to CAMHS there had been a long delay with multiple assessments before she was referred on. However, once at the Tavistock things had been clearer and more structured.

Mr I commented that it was easy to find the centre, the receptionist were welcoming, and the clinicians were really nice and made it clear how the visits would work. Ms H agreed that it was a good place to visit, and added that having two clinicians made sessions feel more open and less like interviews. Mr I added that two clinicians meant that the family could be supported too, so they could speak to clinicians separately before coming back together.

Dr Harris asked what their mothers might say about the experience of visiting the Tavistock. Ms H said that her mother had found it helpful, and before visiting they had argued a lot, but the sessions had allowed them to talk about things which had improved their relationship.

Ms Gizbert asked Mr I about the wait before he could come to the Tavistock, and how that had felt. Mr I said that it felt long at the time, and he knew it could have been done faster through school but he hadn't wanted to involve his parents. Looking back on it though, it was ok. Dr McPherson asked how it had been with school, and Ms H said that she had come out first at school and they had agreed she could wear the female uniform, but they had offered no counselling, referral or advice.

Mr Jenkins explained that he attended the GIDS summer event, and wondered if there was more the Trust could do to raise awareness. Ms H said that having stories about what it was like to come to GIDS on the website would be good, with details of what the process was like in practice, as she had assumed that all she would need to do was visit the GP to be prescribed hormones. Mr I added that stories from young people would be better than ones from adults or clinicians.

Mr I and Ms H talked a little about their experiences at school, Mr I explained the difficulties in getting them to use his new name, and Ms H noted that one year they had experimented with gendering all classes, so she had had to drop half her subjects. Dr Carmichael commented that there was a lot of variation across schools, especially over issues such as PE, toilets, and whether they needed to inform parents.

Mr Jenkins asked what they thought could be done to help GPs, whether it was a question of knowledge or attitude. Mr I and Ms H agreed that it was both, that they hadn't known how to react, and then hadn't known what steps or resources were available.

Mr Rock enquired what they had found most helpful here, and what we should do more of. Mr H commented that the young people's groups had been most helpful, teaching him about gender identity and enabling him to make friends where otherwise he would have felt on his own. Ms I commented that young people over 16 shouldn't be made to go on blockers, as it just wasted a year of their transition when they could be on hormones and moving on. Ms I added that she appreciated that the Trust was involving her and the other young people in the service, getting their feedback, and listening to their point of view. She added that they had sat on an interview panel that morning, and it was really good to be on the other side of the table for once.

Ms Greatley and the board all thanked Mr H and Ms I for coming and sharing their stories.

The Board **noted** the stories.

18 Any Other Business & Notice of Future Meetings.

The Board noted the future meetings. It was agreed that Mr Campbell would circulate the dates for the rest of this year and for 2016. There was no other business.

Part one of the meeting closed at 4.40pm.

Outstanding Action Part 1

Action Point No.	Originating Meeting	Agenda Item	Action Required	Director / Manager	Due Date	Progress Update / Comment
6	Feb-15	14. Patient Story Review	Paper on PPI development to come to the board	Paul Jenkins	Jun-15	Completed - on July agenda
3	Mar-15	10. Annual Equalities Report	Arrange a broad equalities/ Time to Change event	Louise Lyon	Sep-15	
4	Mar-15	11. HR Proposal on 360 Feedback	Proposal for 360 to be taken to leadership group	Susan Thomas	Jul-15	Completed - taken to July Leadership Conference
2	Apr-15	6. CEO's Report	Add NEDs to 'Everyone' mailing list	Gervase Campbell	May-15	Completed - relevant emails are being forwarded instead.
3	Apr-15	10. Quality Reports	Circulate further details of waiting time data	Justine McCarthy Woods	May-15	Completed - circulated 2nd June.
4	Apr-15	11. Draft Annual QR	Produce summary sheets for each service	Louise Lyon	Jul-15	
2	May-15	6. CEO's Report	Circulate lessons learnt from Essex CAMHS bid	Paul Jenkins	Jul-15	
4	May-15	17. Freedom to Speak Up Report	Update on FTSU to come to July Board	Gervase Campbell	Jul-15	Completed - on July agenda

Board of Directors : July 2015

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

Chief Executive's Report

1. Two year strategy

- 1.1 I have held a range of consultation meetings with staff, Governors and other stakeholders on the development of the Medium Term strategy for the Trust. A draft Mission and Values statement and set of 5 year ambitions are tabled at this meeting for agreement by the Board of Directors. The full strategy will be presented at the September meeting.

2. Essex Research meeting

- 2.1 On 8th July we held the first joint research meeting at the University of Essex. The meeting was well attended and very positive indicating a strong sense of shared commitment to the partnership and many interesting ideas for joint research.

3. Tottenham Thinking Space

- 3.1 I am very pleased that we have secured a 3 year extension for our Tottenham Thinking Space Service in Haringey.

4. Care Notes

- 4.1 We have continued to work with the supplier to ensure the successful rollout of the Care Notes system on 27th July.
- 4.2 At this stage we are on track for roll out and the supplier was successful on 17th July in securing full roll out approval for their link to the Patient Demographic service.

Paul Jenkins
Chief Executive
20th July 2015

Board of Directors : July 2015

Item : 7

Title : Finance and Performance Report

Summary:

After the three months a surplus of £613k is reported, £772k above the planned deficit of £140k. The main reason for the surplus is the number of vacancies across the organisation.

The current forecast for the year is a surplus of £514k before restructuring.

Analysis by service line will be provided next month.

The cash balance at 30 June was £1,591k.

For : Information.

From : Simon Young, Director of Finance

1. External Assessments

1.1 Monitor

1.1.1 Monitor's assessment on Quarter 4 is awaited. It is expected that our Continuity of Service Risk Rating will remain at 4, and the rating for governance remain green.

1.1.2 The 2015/16 Plan was submitted to Monitor on 30 April. A revised 5 year Plan was not required. The Plan should lead to a Continuity of Service Risk Rating of 3.

2. Finance

2.1 Income and Expenditure 2014/15

2.1.1 After June the trust is reporting a surplus of £613k before restructuring costs, £772k above budget. Income is £30k below budget, and expenditure £783k below budget.

2.1.2 The income shortfall at June of £30k is mainly due to GIDU NPA income over-performance relating 2014/15 and 2015/16 in addition to CAMHS training fees which have been offset by a shortfall on FNP project income, Child Psychology Training Fees and TC consultancy.

2.1.3 Consultancy is £52k below budget, £32k of which is due to TC.

2.1.3.1 Clinical Income was £111k above budget at the end of the quarter which was mainly due to GIDU NPAs. All the main income sources and their variances are discussed in sections 3, 4 and 5.

2.1.4 The favourable expenditure position of £783k below budget was due mainly to the Family Nurse Partnership (FNP) which now has a cumulative under spend of £142k due to vacancies and lower than expected non pay costs. GIDU are under spent £111k and Education and Training by £130k both due to vacancies. Within Complex Needs City & Hackney is also £65k under spent due to vacancies. The remainder of the under spend was mostly vacancies spread across the organisation.

2.1.5 The key financial priorities remain to achieve income budgets; and to identify and implement the future savings required through service redesign.

2.2 Forecast Outturn

2.2.1 The forecast surplus before restructuring of £514k is £464k above budget.

2.2.2 Clinical income is currently predicted to be £363k above budget due City & Hackney final contract value being agreed above the budgeted amount and the Named Patient Agreements (NPA's) over-performing this financial year in addition to late 2014/15 income being received this financial year.

2.2.3 The forecast assumes that the contingency is fully utilised.

2.2.4 At this early stage in the financial year it is difficult to both the Finance

Department and budget holders to make a robust forecast but after discussions with budget holders we have assumed the following.

2.2.4.1 FNP currently predict that they will be £92k below budget on income. FNP expenditure is currently £142k below budget but it is expected to be balanced by the end of the financial year.

2.2.4.2 GIDU income is expected to be £119k above budget due to £36k NPA income relating to 2014/15 and NPA over performance in this financial year. Although GIDU are currently £111k under spent they expect to utilise this under spend on agency staff later in the year.

2.2.4.3 Complex Needs are currently under spent by £94k but this will reduce due to additional resources funded by the higher than anticipated City & Hackney income

2.2.4.4 The Portman Clinic are currently £38k below their expenditure budget and expect this increase to £105k by the end of the year.

2.2.4.5 Commercial Directorate are currently £36k over budget and this is expected to increase to £144k over spent by the end of the financial year due to temporary staffing requirements

2.3 Cash Flow

2.3.1 The actual cash balance at 30 June was £1,591k this is a decrease of £748k in in month and is £2,559 below Plan. The balance was below Plan mainly due to the delay in raising the first two months clinical contract invoices as the contract amounts were not finalised. This has since been rectified and payments were received on 15th July. Capital expenditure is ahead of plan as we completed the modular building earlier than anticipated.

		Cash Flow year-to-date		
		Actual	Plan	Variance
		£000	£000	£000
Opening cash balance		2,761	2,761	0
Operational income received				
	NHS (excl HEE)	4,891	6,838	(1,947)
	General debtors (incl LAs)	2,073	2,565	(492)
	HEE for Training	2,791	2,679	112
	Students and sponsors	538	625	(87)
	Other	0	0	0
		10,293	12,707	(2,414)
Operational expenditure payments				
	Salaries (net)	(4,005)	(4,477)	472
	Tax, NI and Pension	(3,256)	(3,302)	46
	Suppliers	(2,930)	(2,775)	(155)
		(10,191)	(10,554)	363
Capital Expenditure		(1,274)	(765)	(509)
Interest Income		2	1	1
Payments from provisions		0	0	0
PDC Dividend Payments		0	0	0
Closing cash balance		1,591	4,150	(2,559)

2.4 Better Payment Practice Code

2.4.1 The Trust has a target of 95% of invoices to be paid within the terms. During June we achieved 90% (by number) for all invoices. The cumulative total for the year was 91%.

2.5 Statement of Financial Position (aka Balance Sheet) and Capital Expenditure

2.5.1 Appendix E reports the SoFP at 30 June, compared to the Plan figures for the quarter.

2.5.2 Property, Plant and Equipment was £.4m above plan due to the completion of the Modular Building ahead of Plan

2.5.3 Trade and other receivables are £3m over plan and the cash position is £2.5m below Plan due to the late settlement of a number of quarter 1 contract invoices which were received in July 2015. The future timing of payments has been rectified with commissioners.

2.6 Capital Expenditure

2.6.1 Up to 30 June, expenditure on capital projects was £1,273k. This included £831k on the Modular Building which is marginally over budget and £159k on the IDCR project.

2.6.2 The capital budget for the year was £2,370k in total.

Capital Projects 2015/16	Budget 2015/16	Actual YTD June 2015			Spend 2013/14	Spend 2014/15	Cummulative spend to date for total project
	£'000	£'000					
Toilets	100	-					-
Fire door	40	-					-
Boiler at the Portman Clinic	-	18					18
Relocation Project	200	119			12	420	551
Modular Building	825	831				14	845
Building Management system ext	10	-					-
Car Park Extraction Unit	70	-					-
Total Estates	1,620	968			12	500	1,480
IT Infrastructure	350	146					146
IDCR	400	159			-	389	548
Student record system	375						
Total IT	750	305			-	389	694
Total Capital Programme	2,370	1,273			12	889	2,174

3. **Training**

3.1 Income

3.1.1 Training income is £90k below budget in total after three months. Details are in the table below.

3.1.2 FNP income is currently being reported as £51k below budget and is expected to be £205k below target by the end of the year.

3.1.3 The adverse £23k income variance in DET is due to deferred income for LCPPD activity due to take place before the end of this academic year which will give rise to subsequent favourable variances. The HEFCE settlement from Essex is higher than budgeted for AY14/15 but offset by adverse income streams year to date in all areas except CAMHS.

3.1.4 The Education and Training expenditure is currently £130k lower than budget; £65k pay and £65k non-pay. There are a number of vacant posts in Marketing and AV which are now being recruited to. Pay and non-pay underspend to date will be shortly reviewed and is likely to be used to fund short-term support to the department.

3.1.5 The under spend on Junior medical staff is offset by a favourable variance on the expenditure budget.

LDA income (lines 4-7 appendix B)	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Forecast £'000
NHS London Training Contract	1,814	1,814	0	0
Child Psychotherapy Trainees	537	470	-67	0
Junior Medical Staff	232	210	-22	0
Postgraduate Medical and Dental (budget incl. study leave)	21	38	17	0
Sub Total	2,603	2,532	-72	0
Fees and academic income (lines 8-11 Appendix B)				
DET	102	79	-23	68
CAMHS	813	882	69	29
FNP	893	842	-51	-93
SAAMHS	371	367	-3	-49
TC	58	49	-10	-5
Sub Total	2,237	2,219	-18	-49
Grand Total	4,840	4,751	-90	-49

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. The majority of contracts are now block rather than cost and volume. Our commissioners have agreed to review this if there are material activity variances.

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."

4.1.3 The income budget for named patient agreements (NPAs) was increased this year from £131k to £148k. After June actual income is £51k above budget. This is due to £36k from GIDU relating to 2014/15 in addition to continued GIDU over-performance.

4.1.5 Day Unit Income target was increased by £172k in 2015/16 and is on target after June.

	Budget	Actual	Variance	Full year		Comments
	£000	£000	%	Variance based on y-t-d	Predicted variance	
Contracts - base values	3,744	3,849	2.8%	628	139	Contracts are block for 2015/16
NPAs	37	88	137.1%	203	83	Over performed on GIDU
Projects and other	302	273		–	-111	Income matched to costs, so variance is largely offset.
Day Unit	205	205	0.0%	0	0	
FDAC	804	789	-1.9%	-61	0	
Total	5,092	5,203		770	111	

5. **Consultancy**

5.1 TC are £52k behind budgeted target after three months. This consists of expenditure £10k overspent, TC Training Fees £10k below budget and consultancy £32k below budget. TC are currently reviewing and revising their forecast income and expenditure for the rest of the year.

5.2 Departmental consultancy is £20k below budget after June; £12k of the shortfall is within SAMHS.

Carl Doherty
Deputy Director of Finance
20 July 2015

THE TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST				APPENDIX B					
INCOME AND EXPENDITURE REPORT FOR THE FINANCIAL YEAR 2015-16									
All figures £000				June-15			CUMULATIVE		
	BUDGET	ACTUAL	VARIANCE	BUDGET	ACTUAL	VARIANCE	REVISED BUDGET	OPENING BUDGET	FORECAST
INCOME									
1 CENTRAL CLINICAL INCOME	632	629	(4)	1,847	1,881	34	7,389	7,035	7,435
2 CAMHS CLINICAL INCOME	531	561	29	1,686	1,703	17	6,399	6,868	6,427
3 SAAMHS CLINICAL INCOME	296	290	(5)	883	857	(26)	3,368	2,865	3,538
4 GENDER IDENTITY	210	255	45	675	761	86	2,701	2,648	2,820
5 NHS LONDON TRAINING CONTRACT	605	605	0	1,814	1,814	0	7,254	7,254	7,254
6 CHILD PSYCHOTHERAPY TRAINEES	179	157	(22)	537	470	(67)	2,148	2,148	2,148
7 JUNIOR MEDICAL STAFF	77	88	11	232	210	(22)	927	900	839
8 POSTGRADUATE MED & DENT'L EDUC	7	24	17	21	38	17	84	111	153
9 DET TRAINING FEES & ACADEMIC INCOME	34	37	3	102	79	(23)	976	1,373	1,044
10 FAMILY NURSE PARTNERSHIP	298	271	(26)	893	842	(51)	3,574	3,574	3,481
12 CAMHS TRAINING FEES & ACADEMIC INCOME	271	259	(12)	813	882	69	3,392	3,392	3,421
13 SAAMHS TRAINING FEES & ACADEMIC INCOME	124	96	(27)	371	367	(3)	1,758	1,758	1,710
14 TC TRAINING FEES & ACADEMIC INCOME	19	12	(8)	58	49	(10)	272	272	267
15 TC INCOME	76	77	1	228	196	(32)	913	925	881
16 CONSULTANCY INCOME CAMHS	6	2	(5)	19	12	(7)	77	91	34
17 CONSULTANCY INCOME SAAMHS	32	62	30	95	82	(12)	303	624	282
18 R&D	7	12	5	21	14	(8)	83	123	58
19 OTHER INCOME	81	87	6	139	148	9	400	819	424
TOTAL INCOME	3,486	3,525	39	10,435	10,405	(30)	42,018	42,781	42,216
EXPENDITURE									
20 COMPLEX NEEDS	252	228	24	750	656	94	2,728	2,662	2,723
21 PORTMAN CLINIC	124	128	(4)	373	335	38	1,493	1,421	1,388
22 GENDER IDENTITY	171	136	35	539	429	111	2,158	2,079	2,151
23 DEV PSYCHOTHERAPY UNIT	13	17	(4)	38	37	0	106	106	106
24 NON CAMDEN CAMHS	608	604	4	1,829	1,778	51	6,898	7,222	6,888
25 CAMDEN CAMHS	374	357	18	1,129	1,126	3	4,551	4,639	4,504
26 CHILD & FAMILY GENERAL	43	23	21	170	149	22	667	762	594
27 FAMILY NURSE PARTNERSHIP	259	273	(14)	778	636	142	3,112	3,112	3,112
28 JUNIOR MEDICAL STAFF	83	70	12	248	205	43	993	993	860
29 NHS LONDON FUNDED CP TRAINEES	179	141	38	537	489	48	2,148	2,148	2,151
30 TAVISTOCK SESSIONAL CP TRAINEES	2	2	(0)	5	4	1	19	19	16
31 FLEXIBLE TRAINEE DOCTORS & PGMDE	26	20	6	77	49	28	309	309	212
32 EDUCATION & TRAINING	302	252	50	728	598	130	3,581	3,906	3,581
33 VISITING LECTURER FEES	139	142	(3)	416	381	35	1,332	1,332	1,332
34 CAMHS EDUCATION & TRAINING	104	117	(12)	367	367	0	1,548	1,503	1,584
35 SAAMHS EDUCATION & TRAINING	65	65	(1)	244	175	68	1,015	1,015	1,015
36 TC EDUCATION & TRAINING	0	0	(0)	0	0	(0)	0	0	0
37 TC	64	110	(47)	191	201	(10)	765	787	733
38 R&D	17	10	7	50	15	35	201	238	146
39 ESTATES DEPT	172	178	(6)	516	563	(46)	2,026	2,090	2,095
40 FINANCE, ICT & INFORMATICS	219	233	(13)	533	533	(1)	2,131	2,295	2,144
41 TRUST BOARD, CEO, DIRECTOR, GOVERN'S & PPI	87	94	(8)	260	268	(9)	1,038	981	1,039
42 COMMERCIAL DIRECTORATE	(23)	13	(37)	110	146	(36)	439	454	582
43 HUMAN RESOURCES	50	67	(17)	162	171	(9)	607	652	621
44 CLINICAL GOVERNANCE	63	56	7	188	165	23	751	824	751
45 CEA CONTRIBUTION	6	32	(26)	18	43	(26)	70	0	97
46 DEPRECIATION & AMORTISATION	65	57	8	194	170	24	775	775	775
47 VACANCY FACTOR	0	0	0	0	0	0	0	(134)	0
48 PRODUCTIVITY SAVINGS	0	0	0	0	0	0	0	(80)	0
49 INVESTMENT RESERVE	0	0	0	0	0	0	0	0	0
50 CENTRAL RESERVES	23	0	23	23	0	23	90	205	90
TOTAL EXPENDITURE	3,485	3,424	60	10,472	9,689	783	41,552	42,314	41,290
OPERATING SURPLUS/(DEFICIT)	1	101	100	(36)	716	753	466	466	926
51 INTEREST RECEIVABLE	0	1	0	1	3	1	5	5	8
52 DIVIDEND ON PDC	(35)	(47)	(11)	(105)	(105)	0	(421)	(421)	(421)
SURPLUS/(DEFICIT)	(33)	55	89	(140)	613	754	50	50	514
53 RESTRUCTURING COSTS	0	28	(28)	0	28	(28)	0	0	28
SURPLUS/(DEFICIT) AFTER RESTRUCTURING	(33)	27	61	(140)	585	726	50	50	486

[illegible]

STATEMENT OF FINANCIAL POSITION	Plan		Actual		Variance	Appendix E
	31 June 2015 £000	31 June 2015 £000	31 June 2015 £000	31 June 2015 £000		
Non-current assets						
Intangible assets	52	35	(17)			52
Property, plant and equipment	15,347	15,831	484			14,776
Total non-current assets	15,399	15,866	467			14,828
Current assets						
Inventories						
Trade and other receivables	3,621	6,599	2,978			5,479
Cash and cash equivalents	4,150	1,592	(2,558)			2,761
Total current assets	7,771	8,191	420			8,240
Current liabilities						
Trade and other payables	(4,355)	(4,757)	(402)			(5,085)
Provisions	0	(6)	(6)			(6)
Tax payable	(650)	(660)	(10)			(651)
Other liabilities	(3,000)	(2,937)	63			(2,123)
Total current liabilities	(8,005)	(8,360)	(355)			(7,865)
Total assets less current liabilities	15,165	15,697	532			15,203
Non-current liabilities						
Loans	0	0	0			0
Provisions	(65)	(116)	(51)			(117)
Total non-current liabilities	(65)	(116)	(51)			(117)
Total assets employed	15,100	15,581	481			15,086
Financed by (taxpayers' equity)						
Public Dividend Capital	3,474	3,474	0			3,474
Revaluation reserve	8,763	8,764	1			8,763
Income and expenditure reserve	2,863	3,343	480			2,849
Total taxpayers' equity	15,100	15,581	481			15,086

Board of Directors : July 2015

Item : 8

Title: Training & Education Board July 2015 report

Purpose:

To report on issues considered and decisions taken by the Training & Education Programme Management Board at its meeting of 6th July 2015.

This report focuses on the following areas:

- Quality
- Risk
- Finance

For : Noting

From : Brian Rock, Director of Education & Training / Dean of Postgraduate Studies

Training & Education Board report

July 2015

1 Introduction

- 1.1 The Training & Education Programme Management Board (TEPMB) held its tenth meeting on 6th July 2015.

2 Business Design and Office Reconfiguration

- 2.1 Brian Rock presented a report on this item.
- 2.2 The report explained that the report was the result of work completed by John Martin, Programme Director, and others in the training executive to identify issues and set out proposals for change in the department. It included a plan for the reconfiguration of the office space occupied by DET.
- 2.3 The programme board discussed the need for change and the cultural issues within the department and across the trust.
- 2.4 The programme board approved the proposals for the office reconfiguration and a separate paper will be brought to the Trust Board in advance of this meeting to seek their approval.

3 Visitors Programme

- 3.1 Brian Rock presented an update report on this item for which Shirley Borghetti - Hiscock and Bhavna Tailor also attended.
- 3.2 The programme board considered the financial projections for the programme and in particular the additional support involved in managing individual visitors as opposed to groups.
- 3.3 It was suggested that the programme focussed on attracting groups and that it was used as a way of maintaining international relationships.

4 Regional Strategy

- 4.1 Karen Tanner presented a report on this item.
- 4.2 The report detailed the activity across the various regions some of which are better developed than others.
- 4.3 The programme board discussed the need to balance using the contract to encourage growth rather than simply maintaining it.

- 4.4 The use of online course delivery was also considered as a way of meeting more people and as a way of reducing costs to potential students and their employers.

5 Recruitment Update

- 5.1 Laure Thomas presented a report on this item.
- 5.2 Application numbers have continued to rise. Targeted marketing and webinars are taking place for those courses that are a cause for concern.
- 5.3 A new system for managing enquiries is in place which has resulted in an increase in email and telephone enquiries.
- 5.4 Paul Jenkins asked that the programme board continued to be updated
- 5.5
- 5.6 throughout the summer and it was agreed that the weekly recruitment reports would be circulated to the programme board members.

6 ICT Project

- 6.1 Will Bannister presented a report on this item.
- 6.2 The report outlined the current stage of the evaluation process focussing on the issues with one of the parties not being a tier two supplier. Talks are underway with another provider to give them this facility.
- 6.3 Supplier demonstrations are taking place on 13th June and interviews will be taking place in September.
- 6.4 BR explained that a full proposal was unlikely to be able to be presented at the July programme board and it was agreed it would be brought in September.
- 6.5 This paper will include a business case for the expenditure due to the bids financial projections being above the original budget.

7 Two Year Strategy

- 7.1 Paul Jenkins gave an update on this item.
- 7.2 The strategy contains 3 objectives for DET including increasing student numbers, diversifying the training portfolio and increasing national reach.

- 7.3 The programme board discussed the difficulties and ways of meeting these objectives. It was agreed that the programme board felt the strategy was progressing in the right way
- 7.4 It was agreed that the document would be circulated to members of the programme board for their input.

8 Visiting Lecturers

- 8.1 Brian Rock gave an update on this item.
- 8.2 Discussions have been underway with the Trusts solicitor relating to our options in relation to the complaint that has been brought.
- 8.3 A separate paper is being brought to the July Board meeting outlining how the Trust has decided to progress.

Brian Rock

Director of Education & Training / Dean of Postgraduate Studies

Board of Directors : July 2015

Item : 9

Title : Portman Clinic Service Line Report

Purpose:

Service Line Report

This report provides an overview of the work of the Portman Clinic.

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.

For : Discussion

From : Stanley Ruszczynski, Director, Portman Clinic

Service Line Report – Portman Clinic

Executive Summary

1. Introduction

The Portman Clinic offers an assessment and psychotherapeutic treatment service to children, adolescents and adults who are disturbed by their enacted delinquency, criminality and violence and/or by their sexual behaviours which damage others or themselves. Drawing on this clinical experience, the Clinic also offers clinical and organisational consultancy, service development, risk assessments, teaching, training and CPD programmes to colleagues working with similar patients/clients in the social care, mental health and criminal justice services. The Clinic audits its work, undertakes research and produces publications.

The Clinic has two major areas of funding and professional activity. The first is the national clinical contract funded by NHS England, and the second is an overlapping range of consultation and service development activities, and teaching, training and CPD programmes funded through the National Offender Management Service (NOMS) and directly from a variety of commissioning institutions (see below). The financial split between these two areas of activities is approximately 2:1 with very clear growth in the second area.

2. Areas of Risk and/or Concern

- 2.1 The current main area of concern within the Clinic results from the continuing reductions in the funding available to mental health, forensic, social care and criminal justice services, and the resultant need to adapt or restructure the nature of the Portman Clinic and the range of its service and activities. The future of the current National Clinical Contract is uncertain, though the current contract includes a clause requiring that a full 12 months notice is given of the termination of the contract. There are also uncertainties about the future funding available for the commissioning of teaching, training, consultation and service development activities.
- 2.2 The other area of concern is in relation to staff morale with constantly increasing demands and pressures on a small group of colleagues. This concern arises from the result of both the reduction in the size of the staff group over the last few years, and the relentlessness of having to manage cuts by reorganising and restructuring professional activities. There is concern about how quality is maintained across the range of the clinic's activities, and how the smaller and busier staff group is supported to undertake work with disturbing patients and with complex institutions and settings.

3. Proposed Action Plan

- 3.1 The concern in relation to the financial concerns is being managed in a number of ways:
 - **maintaining good relations with current commissioners**
 - **developing presentations of Portman activities to showcase and publicise if/when necessary with local CCGs and other clinical commissioners**
 - **developing new areas of clinical activity and funding**
 - **maintaining good relations with current commissioners of consultancy and service development activities**
 - **pursuing and developing contacts with independent/voluntary/charitable providers of services for patients/clients similar to those of the Portman Clinic**
 - **through the Forensic Portfolio Lead, working with the Trust's DET to design, develop and grow Portman and Trust wide teaching and training activities**
 - **establishing a research function to demonstrate the efficacy of Portman clinical and consultancy/teaching/training activities**
- 3.2 The concerns in relation to staff morale are managed through:
 - **protecting the containment and support provided by a strong team ethic and Clinic-specific organisational structures, by ensuring transparency and staff involvement whenever possible when responding to and implementing changes in work activities and**

professional practices, and by strong local leadership (and very hard work!) from the senior staff group.

- recognising that the nature of all Portman patients (i.e. they enact their disturbances and conflicts in anti-social ways), the fact that treatment is offered rather than only management or institutionalisation, the fact that dissemination of Portman clinical experience and knowledge is mostly through consultative and service development activities rather than didactic teaching, all require a critical mass of more senior clinical staff. These factors contribute in an essential way to the Clinic having a particular, probably unique, place in the mental health, criminal justice and social care domains with the brand name of 'Portman Clinic'. This identity, in itself, functioning to sustain and contain the clinic and its staff.

Main Report

3 Overview of the Service

4.1 Core identity and purpose

- 4.11 The Portman Clinic was set up as the clinical arm of the Institute for the Scientific Treatment of Delinquency, established in 1931, and later called the Institute for the Study and Treatment of Delinquency (ISTD), and became operational when its first patient was seen in 1933. In 1948, with the coming into being of the National Health Service, the Clinic separated from the ISTD and became part of the NHS. In 1970 the Clinic moved to its current location in Fitzjohns Avenue, London, adjacent to the Tavistock Centre which houses the Tavistock Clinic.

During the 1980's the two clinics were both organised under a special sub-committee of the Hampstead Health Authority and whilst maintaining their separate identities, increasingly joined forces, and, as part of the structural changes in the NHS jointly became an NHS Trust in 1994 and then a Foundation Trust in 2006.

- 4.12 The range of work of the Portman Clinic, all rooted in a developmental and psychoanalytic perspective is as outlined below:

- a psychotherapeutic assessment and clinical service, offered to children and adolescents (including their parent(s)/carers) and adults (individuals and couples), currently funded by a national clinical contract
- risk assessment
- teaching, training and CPD programmes,
- institutional and clinical consultancy
- service development
- audit, research and publications

- 4.13 The core activity of the Portman Clinic, in which all its other activities are rooted, is the assessment and psychoanalytic treatment of patients who are disturbed and distressed by the enactment of their delinquent, criminal and violent behaviours or who, as a result of their sexual activities, cause hurt and damage to others and/or to themselves. By acting out their conflicts and difficulties, these patients and offenders often have a disturbing emotional impact on those around them, including their clinicians and the services charged with their care. This psycho-social impact of their conflicts and difficulties needs to be taken very seriously in the delivery of clinical services to these patients, and in the understanding and perspective offered in the teaching, consultancy and service developments activities with colleagues working with similar patients/offenders.

- 4.14 The range of treatments offered to children and adolescents, and their families/carers and to adults includes individual, couple and group treatment, and family/carer intervention in relation to

children and adolescents. Frequency of sessions is mostly once weekly, with a very few patients being seen twice weekly and a few patients being seen intermittently. Treatment tends to be medium to long term. Possible new clinical services currently being discussed, planned and piloted are shorter-term.

- 4.15 Rooted in this in-depth clinical experience with patients, the Portman Clinic provides a range of teaching, training and CPD activities and organisational and clinical consultancy to colleagues in community or institutional settings working with similar patients and offenders, and in the development and delivery of new services. This includes front line practitioners from a variety of mental health, criminal justice and social care settings, their supervisors, service leads and managers, working in community mental health teams, in hostels and day care provision, in the probation service, in low, medium and high secure hospital and in prisons.
- 4.16 The Clinic's third area of activity is audit, research and publication. Though these are essential activities and audits are conducted regularly, the research function has been minimal because staff have needed to focus on income generating activities. (However, see below.) The Portman Clinic's last book publication was in 2014 when it published the third book in its 'Portman Papers' series, titled "*Forensic Group Psychotherapy: the Portman Clinic Approach*", edited by John Woods and Andrew Williams (Karnac Books, 2014). A number of journal papers and book chapters have been published since that time and a book on suicide, co-written by two recently retired Portman clinicians, Rob Hale and Donald Campbell, will be published later this year.

4.20 Overall vision and strategy

- 3.21 Through its clinical activity, the Portman Clinic is committed to continuing to develop an in-depth conceptual and technical understanding of and the capacity to intervene psychotherapeutically with, its particular patient/offender population, and
- 3.22 Through its teaching, training, consultancy and service development activities, and its research and publications, the Portman Clinic is committed to adapting, applying and disseminating its clinical experience and practice-based knowledge to the variety of colleagues working in social care, mental health and criminal justice services, with similar patients/clients, be they in community, residential and/or institutional settings.

4.30 Progress to date and current position

The increasing growth, range and reach of its teaching, training, consultative and service development activities (see below) suggests that the Portman Clinic is successfully adapting and applying knowledge obtained through its core clinical activities, so as it is then found to be of value in community, residential and institutional services offered by a range of sister organisations working in the areas of forensic mental health, anti-social personality disorder services, the criminal justice system, social care and in other related organisations. The recent appointment of a Forensic Portfolio Lead in DET will contribute to the further development and growth of teaching programmes.

The maintenance of the Portman Clinic's clinical activities is absolutely essential to these dissemination activities, and plans are in place to engage with local CCGs should there any threat to the National Clinical Contract. In addition new clinical services and funding are being sought.

5 Clinical Services and Activity Data

The Clinic receives approximately 200 referrals per year, approximately 160 adults and 40 children / adolescents (mostly adolescents). Adult referrals come mostly from secondary care (50%) and primary care (25%). Only 5% of referrals are self referrals. The vast majority of those referred have had a number of previous interventions from mental health services and the criminal justice system. Referrals of children and adolescents come from CAMHS and other mental health providers (34%), from social services (30%) and from Youth Offending services (13%).

The Portman Clinic has three broad 'tickets of entry' for treatment: criminality, violence and sexual perversions. 48% of all adult referrals come with two or three 'tickets of entry'. 21 % of all referrals have all three tickets (examples of these are rape, paedophilia, incest and sexual assault, i.e. all are criminal, violent and sexual).

85% of adult referrals and 81% of child and adolescent referrals are male: men tend to act out their conflict and disturbance in anti-social ways, and so gain a 'ticket of entry' for Portman Clinic services, whilst women tend to express their distress by harming themselves and/or those closest to them such as their children or partners.

Recent audits show that 76% of adult patients stay in treatment for at least two years, 51% stay in treatment for up to 4 years. Some stay in treatment long term, usually as intermittent patients. The 2009 NICE Guidelines on Anti-Social Personality Disorder state that such patients as are seen in the Portman require long term treatment conducted by experienced and supported clinicians.

The Clinic is seeing approximately 120 patients at any one time, of which approximately 85% come from within London. About half are seen individually and half in groups, either symptom specific groups (currently including: a group for patients suffering from paedophilia, an anti-social personality disordered group, and a group for young adults) or in generic groups. The first two of the symptom specific groups are being researched – see below.

The Clinic has recently obtained funding from the Trust's under-spend in 2014-15 to develop two new clinical interventions. One is aimed at young people in danger of becoming entangled in sexually exploitative activities and groups. Together with an external colleague the Clinic will develop a group programme based on therapeutic understandings from mindfulness, mentalisation and psychodynamic principles. This is an innovative development and is a more active therapeutic intervention than the Clinic's standard models, and will be led by the child and adolescent colleagues in the Clinic. The other new venture, in partnership with an independent provider, is aimed at developing a therapeutic intervention for male gang-members serving prison sentences.

5.10 Performance against contracts – current and for next financial year

5.11 The national clinical contract has been frozen over the last three years to just over £1.1m and activity output has been increased by a reduction in the tariff for each patient. Over the previous two years, 2012-14 the Clinic over-performed on its clinical contract to the (planned) level of 6-8%. In the last year, 2014-15, it has performed to 2% under its contract level, partly as a result of a smaller staff group and partly due to staff taking up an increased number of teaching and consulting and service development activities. The contract for 2015-16, has been signed off with a very similar financial envelope to that of last year.

5.2 Description and understanding of under- and over-performance, including planned actions/negotiations and new targets to be set.

The number of referrals and the levels of overperformance show a sustained and continuing demand on Portman clinical services. Meeting this demand and overperformance had to be actively managed. The further reduction in the tariff in the last year, resulting in more patients being seen for the same funding, a smaller staff group and staff using more of their time on an increasing number of dissemination activities has resulted in the difficult task of carefully considering thresholds for the acceptance of referrals for assessment and treatment, which led in 2014-15 to a small underperformance of 2%.

5.3 Waiting times as evidenced by reports and any plans

The Clinic manages to keep its waiting time to within the 11 week period with only extremely rare breaches.

5.4 DNA rate as evidenced by reports and any plans

The Clinic has low DNA rates, in the region of 10%, which is lower than most generic services and significantly lower than in other forensic and PD services. Figures for comparison purposes are extremely difficult to find because DNA rates are affected by many factors, including severity of pathology, seniority/experience of clinician, type of setting, nature of treatment being offered etc. Reports suggest a range of DNA rates of between 7.8% and 34%.

5.5 Dormant case data as evidenced by reports and any plans.

The Clinic has actively managed its dormant cases and they are now at a minimum.

5.6 Ethnicity as compared to local population and national figures.

Ethnicity figures suggest an under-representation of ethnic minority patients but this is in part representative of broader social and cultural issues with regard to which services are made available to/made use of by different ethnic groups.

5.7 Supervision / reflection

See 14.6 below

5 Financial Situation

6.1 Year-to-date financial situation

Please see the service line Report at year end for 2014-15 in Appendix 1

6.2 To include overall financial position of service line / cluster / business unit, subsequently broken down into specific teams / services within that line.

The 2014-15 end of year report shows the Portman Clinic slightly outperforming its £2m income budget (by £60k) and slightly underpaying on its £1.7m operating expenditure by (£70k). These results contributed to a retained surplus at year end of just under £150k. This surplus shows the most recent positive move in the Portman Clinic's annual year-end figures which have moved from deficits of £119k in 2009-10, £302k in 2010-11, £106k in 2011-12, £12k in 2012-13, £11k in 2013-14 to last year's surplus.

Substantial contracts with the probation service in the last two years and from the MBT programme last year, together with the consultancy and PDKUF contracts holding up reasonably well, have contributed to this positive trend. Set against this is the loss of income of approximately £100k per year from court reports which, because of changes in funding, are now not financially viable activities for the Portman Clinic.

6.3 Plans for future developments / changes.

Given the continuous requirement to cut costs, staff numbers have been reduced and salaries for new staff are now at a lower banding. This has raised serious concerns about the future staffing of the Clinic. The demanding and disturbing nature of the patient population being treated and the complexity and toxicity of the institutions being worked with in the dissemination activities, requires in the Clinic staff team a level of training, experience and expertise which is signalled by appropriate salary levels offered to new staff.

With downward pressure on salaries, recruitment of new staff and succession planning is difficult. However, the Clinic has very recently successfully appointed a new staff member from a small list of suitable applicants.

The new staff colleagues who have been appointed over the last few years have already shown enormous potential, but in the short/medium term, relative lack of experience and seniority makes some leadership positions difficult to fill.

6.4 Plans for productivity / service redesign.

The Portman Clinic has been reasonably successful in its drive to improve productivity. It has done this by both diversifying its range of activities, especially in relation to growing its consultation and service development activities and its teaching and training, and by managing to recruit new staff at a lower salary banding. But see 6.3 above. Some degree of service redesign will continue if the Portman Clinic is able to develop some of its new clinical activities, continue to grow its consultative activities and also, with its relationship with DET, to develop its teaching activities.

7 Clinical Quality and Outcome Data

7.1 Description of what has been used and what

Portman clinical services are robustly evaluated regarding their clinical effectiveness, patient safety and patient experience. This has included developing and implementing measures that are sensitive to the specific difficulties of the Clinic patient population, for example the Shedler- Westen Assessment Procedure (SWAP), and the Frequency of Problem Behaviours measure.

Experience of Service

All patients over 18 following assessment and at six-monthly intervals in treatment are asked to complete an Experience of Service Questionnaire (ESQ). Patients under 18 and their carers are asked to complete the Commission for Health Improvement - Experience of Service Questionnaire (CHI-ESQ).

Outcome monitoring

Routine outcome monitoring demonstrating the clinical effectiveness of our treatments is conducted on all patients accepted for treatment. This includes a range of measures, including a patient-reported outcome measure (PROM), clinician reported outcome measures (CROM), and measures done jointly with the clinician and the patient together.

Patients over 18 receive the following measures after assessment and every 6 months in treatment:

- Clinical Outcomes in Routine Evaluation (CORE) – Outcome Measure (PROM)
- CORE Therapy Assessment Form and End of Therapy Form (CROM)
- Shedler-Westen Assessment Procedure-200 (SWAP-200)(clinician-rated personality measure)
- Frequency of Behaviours Outcome measure (jointly done with clinician and patient)

Patients under 18 receive the following measures after assessment and every 6 months in treatment:

- Goal-based measure (measure done jointly with patient and clinician)
- Strengths and Difficulties Questionnaire (PROM)
- Children's Global Assessment Scale (CROM).

Patients in the Mentalisation based treatment for antisocial personality disorder (MBT-ASPD) service receive, with informed consent, a comprehensive battery of measures as this service has been piloted as part of a research project. Service user involvement has been integral to the evaluation of this service, and we have modified elements of the service and its evaluation in response to patient feedback.

8 Feedback

8.1 Given the complex nature of the patient population served by the Clinic, there are remarkably few complaints received and even fewer that become formal matters. Those complaints that are received are dealt with rigorously and sensitively either by the Clinic Director, in liaison with the relevant staff member, and the patient, or, if a formal complaint is made, through the Trust Complaints Procedure.

9 Serious Untoward Incidents and Safety Issues

Details to be added

9.1 Data to date on safety issues and Serious Untoward Incidents (SUIs will have been reported separately to the Board, but should be addressed in this section).

One SUI was dealt with recently when a staff member was confronted by an ex patient who approached him and threw water at him on Finchley Road. The matter was taken up with the police.

10 Clinical Governance and Audit

10.1 To include projects / activities to date.

Regular audits are carried out on

- referral sources
- presenting problems at referral
- engagement by patients treated via the Portman Clinic's MBT for ASPD service
- DNA rates
- Waiting time assessments

11 Education and Training

11.1 Description of range and direction of travel.

To date, most Portman teaching and training activity is delivered through clinical and organisational consultancy within the probation, forensic mental health and Personality Disorder settings rather than through more traditional didactic teaching in the Portman Clinic or Trust. This involves Portman staff going out to host institutions and offering learning opportunities by leading clinical and organisational discussions and programmes with the teams working with forensic patients and offenders. These reflective practice seminars are designed to assist individuals, teams and managers to contain, process and understand the disturbing and often toxic dynamics which inevitably exist in settings and institutions that manage or offer treatment to acting out patients and offenders. The team and the culture of reflection are understood to be the primary therapeutic agents. See 13.10 below.

Alongside these activities the Clinic is increasingly engaged in continuing teaching activities and developing new programmes offered in the Portman Clinic or Trust. See below. The most significant programme launched in the last academic year is D59F, linked with the Trust's D58 programme. This is a BPC accredited forensic psychotherapy programme aimed at colleagues who already have some psychodynamic and forensic training and experience and want to further develop their knowledge and expertise.

11.12 There is ongoing activity in relation to the organisational, administrative and teaching activity related to the national delivery of the Personality Disorder Knowledge and Understanding Framework (PDKUF). The PDKUF is a range of national learning and teaching activities originally designed, developed and produced by the Portman Clinic together with 3 partners (including a service user organisation), addressing the development of services specifically for people designated as suffering from Personality Disorder. One Portman clinician dedicates all her time (0.6 wte) to leading on this area of work, regularly spending time at the Institute of Mental Health, part of the University of Nottingham, which leads on the delivery of the programmes.

11.13 The Portman Clinic has had a contract originally commissioned for 12 months with the 'old' London Probation Trust (LPT), now re-commissioned for a further 12 months by the newly evolving Probation Service (now split into the Community Rehabilitation Companies [CRC] and the National Probation Service [NPS]). This offers clinical supervision (individual and team) and rapid response consultation following untoward incidents, to all probation staff across London. This has been delivered since the early summer of 2013 and is now re-commissioned to continue until at least December 2015.

- 11.14 Predating the 11.13 above, and continuing in parallel, the Portman runs a number of teaching seminars/practice supervision seminars for probation staff from local probation offices using local training funds.
- 11.15 Portman Clinic staff participates in a number of Trust wide courses and trainings as well as offering supervision and consultancy to Tavistock Clinic colleagues. The Trust courses include major contributions to D59c, M34, and supervising staff from Project 507 and M80. In addition, the Portman Clinic itself runs a number of courses, CPD lecture series and seminars. These include D59f (referred to in 11.1), a very well received course on Risk Assessment and Management (also delivered in adapted form in Birmingham and Nottingham), a CPD event targeted at colleagues working with adolescents, a seminar/clinical discussion series at NSCAP in Leeds and a CPD programme aimed at colleagues newly interested in work in forensic and criminal justice settings.
- 11.16 Jointly with the West London Mental Health Trust, the Clinic runs a medical training in forensic psychotherapy. Psychiatrists undertake a 'dual' training in forensic psychiatry and medical psychotherapy and graduate as Consultant Forensic Psychiatrists.
- 11.17 The Portman Clinic has one child and adolescent psychotherapy trainee undertaking the Trust's Child Psychotherapy programme. This is the first time in its history that the Clinic has ever had such a trainee.
- 11.18 The Clinic has recently obtained funding from the Trust's 2014-15 under-spend, to develop an innovative educational programme aimed at teenage girls in danger of becoming involved in street gangs where criminality, drugs and sexual exploitation are highly likely dangers. Together with an independent provider, the Clinic will run events for young people and for staff working with them, based on a theatre production written and performed by young adults. It is planned that this activity may be the beginning of developing more active and new ways of intervening therapeutically with young people in danger of getting caught up in delinquent and criminal cultures. See also final paragraph in 5 above.

11.2 Activity and financial performance against targets

Contracts for institutional and clinical consultancy, for teaching and supervisory activity with the probation service, for the Personality Disorder Knowledge and Understanding programmes and the Mentalisation Based Treatment programmes have all been met for 2014-15 and have been renewed for 2015-16

In comparison with these projects, the targets for Portman Clinic teaching activity have been modest, so the recent developments in this area are to be welcomed as is the very recent appointment of a DET Forensic Portfolio lead whose responsibility includes the development and growth of additional dissemination opportunities and income for the Portman Clinic.

Issues relating to trainees – management, satisfaction etc.

At present the Portman Clinic has a trainee junior doctor undertaking the dual medical forensic psychotherapy training (in collaboration with the West London Mental Health Trust) (see 11.16 above), a trainee child and adolescent psychotherapist undertaking the Trust Child Psychotherapy training (see 11.17 above), and those in the new D59f programme. The latter two are new additions to the life and organisation of the Clinic and represent exciting developments which will grow in future years.

11.4 Conferences

The most recent conference organised by the Portman Clinic was a conference on groups and gangs (March 2014). This went well and is already producing developments and new programmes.

12. Research

12.1 Description of current activity and aspirations

The Portman Clinic employs one staff member in a post specifically designated as a consultant adult psychotherapist/researchers post. Together with other colleagues and an Assistant Psychologists there has been some development in the research mindedness of the clinic resulting, for example, in regular audits. However, securing funding for research is extremely difficult and apart from some internally funded projects there is little research activity in the Clinic.

- 12.11 Agreement has very recently been reached, and the small amount of additional income required has been found from within the Portman Clinic's budget, to develop the current Assistant Psychologist post into a Research Psychologist post. The purpose of this development is to co-ordinate, develop and achieve the publication of a number of audit and research activities which have been taking place in the clinic. In addition the post holder will have the experience and knowledge to make application for research funding. This appointment of a dedicated researcher, is a very significant development in the potential output to come from Portman Clinic .

- 12.12 Regular audits are carried out of both child and adolescent and adult referrals. Other recent audits include recidivism amongst patients in treatment; the nature of requests for advice and consultation from potential referrers as opposed to referral for treatment; looking at referred patients who had major drug and alcohol addictions and were, for this reason, not taken into treatment but encouraged to access addiction services and then be re-referred; an audit in relation to referrals and treatment of female patients; and, at the request of the Department of Health, an outcome audit with multidisciplinary staff teams participating in ward based reflective practice groups, conducted by Portman staff, on seven wards in two medium secure hospitals in south London.

A new audit is currently being designed and piloted looking at the violence and dangerousness amongst those patients referred to the Clinic, with a view to informing future conversations with CCGs thinking about commissioning our clinical services

- 12.13 There are two current research projects. These are:

Evaluation of a Mentalisation Based Treatment group for men with ASPD, in Partnership with Anthony Bateman, Peter Fonagy and colleagues on other sites; and, in partnership with Cardiff University and Grendon Prison, using the Implicit Association Test to test psychoanalytic assumptions about different types of violence enacted by offenders. Funding is being sought for a research project to examine pathways to internet offending.

- 12.14 Recent publications include a book of lectures on violence; a book describing a number of institutional frameworks in community settings supporting work with antisocial patients and their mental health needs; and most recently a book on group psychotherapy. Recent contributions to books and journals include papers/chapters on consultancy, on internet pornography, and on patients' experience of forensic psychotherapy. A new book on suicide will be published at the end of the year.

12.2 Financial reporting

12.3 Future projects / prospects and issues in developing these, e.g. resources

The MBT service for ASPD patients has led to a commission to rollout this service across England and Wales (see 13.31 below). Explicit in this programme is the intention to carry out an RCT research project and work is already underway with Peter Fonagy to develop this proposal and funding has been applied for.

13. Consultancy

13.1 Description of current activity and aspirations

13.11 Many forensic/personality disordered patients and offenders are cared for in institutional settings, in low / medium / high secure hospitals or prisons or, if managed in the community, are often known to a multidisciplinary team. This institutional and team treatment setting for these patients, together with the emotional impact they have on those around them, results in the 'training of choice' often being that of clinical consultancy delivered in the treatment setting and involving the entire multi-disciplinary team. In addition, consulting to the managers and service leads (i.e. organisational consultancy) can protect the institution and the managerial functions from being similarly affected by the inevitable emotional impact of managing and offering treatment to these patients/offenders.

13.12 Currently, such organisational and clinical consultancy is taking place

- in medium and low secure hospitals (including a number of services in London, in Nottingham and Hull)
- in prisons (including Wandsworth, Brixton, Feltham and Pentonville)
- in day care/residential settings (in probation service approved premises across London and in services in Nottingham and Hull),
- in probation teams across London (see 11.13 above),
- in partnership with the London Pathways Project (LPP) which is part of a national project to develop psychological mindedness, specifically in probation setting and especially in relation to personality disorder
- to the wing psychotherapists at Grendon Prison, to the team as a group and to some individuals, which includes joint teaching/CPD activities and a research project (see 12.13 above)..

There is consultative involvement with the Office of the Children's Commissioner in its panels of enquiries relating to sexual exploitation of children in gangs and groups and into family involvement in sexual abuse.

The Clinic, in collaboration with Tavistock Consulting, is currently in discussion with the Home Office about the provision of consultative and other support services to the enquiry being set up in the Home Office focused on the issues of historic child abuse, and related matters, in many and various institutions, including care and education institutions and others.

13.13 Following the provision over the last 3 years in the Clinic of audited and researched Mentalisation Based Treatment (MBT) groups for referred patients designated as Anti-Social Personality Disordered (ASPD), usually violent men in the community and not in secure institutions, the Clinic was commissioned early in 2014, by the National Offender Management Service (NOMS) to oversee and develop an MBT for ASPD patients services in 13 sites located across England and Wales.

This new service, across all the sites, was successfully launched and is being co delivered on each site by a team drawn from psychiatry and the probation service. The Portman Clinic is one of the designated sites but is also overseeing the whole national project. Securing the commission and funding for this national service development is a very significant achievement for the Clinic. The project is funded directly by NHS England and is aimed at designing and developing a therapeutic service for possibly the most difficult patients in the community. As mentioned above, it has been confirmed that funding has been made available for the continuation of this rollout for 2015-16.

13.14 The project has been developed in collaboration with Peter Fonagy and Anthony Bateman (from the Anna Freud Centre and UCL), who designed and developed the original MBT model, initially for patients designated as borderline personality disordered. We have joined together in now developing the treatment model for ASPD patients. The plan is to establish the service across the

13 sites and then to establish an RCT research project. The funding for this research has been applied for and the result of that application should be known in the autumn.

13.2 Financial reporting

13.3 Future projects / prospects and issues in developing these – particularly developments across the Trust.

13.31 As mentioned above, the Portman Clinic was successful in securing funding from the Trust's under-spend in 2014-15 to develop three new projects/activities. The first of these is a new intervention aimed at providing an educative and therapeutic service for men involved in gangs and in prison. A pilot version of the programme has been well received by NOMS and is now being piloted in Grendon Prison.

13.32 The second, again with an external colleague, is a group programme aimed at adolescents, using a combination of mentalisation and mindfulness principles.

13.33 The third project, mentioned above, includes involvement with a theatre company made up of young people, and young writers and directors, who are interested in using the medium of theatre to address some of the highly disturbing increases in gang related activities by girls including sexual exploitation. At present, the Portman clinic is consulting to three independent providers working in this particular area of social concern.

13.4 Developments across the Trust

Two members of part-time Portman Clinic staff are employed part-time in the adolescent and child services in the Trust. Portman staff contribute to a range of teaching programmes in the Trust (see 11.15 above). From the beginning of the contract to deliver supervision to the Probation Service (see 11.13 above), colleagues from Adult Department have been involved. A member of staff from the Adult Department has recently joined the Portman Clinic for one day of the week, contributing to both the clinical and consultative activities of the Portman Clinic. The newly appointed DET Forensic Portfolio lead should play a significant role in both developing Portman specific programmes and other cross-Trust teaching activities.

14. Staffing and HR issues

See Appendix 2 for brief comments from three Portman staff members (one admin, one child psychotherapist and one adult psychotherapist) on the experience of working in the Portman Clinic.

14.1 Information about members, grades, and disciplines.

The clinic has a multidisciplinary staff group made up of colleagues trained and experienced in one of the core NHS disciplines of nursing, social/probation work, psychology and psychiatry. All staff has undertaken further advanced training in child and adolescent psychotherapy, psychoanalytic psychotherapy, psychoanalysis or group psychotherapy.

The Clinic is managed by a Clinic Director and is organised as one team made up of a total of 8.4 permanent wte clinical staff, plus 1 full time medical SpR trainee, 1 full time Assistant Psychologist, 0.9 wte fixed term contract staff (2 people) working on a particular project, plus 2 one day a week honorary staff. This clinical group is supported by an admin group of 1.7 wte and a receptionist, managed by an Administrative Manager.

The Clinic's organisational structure and line of authority is simple. There is a flat hierarchy with the Director of the Clinic being internally supported in his role by Portman Executive Committee, and externally by the Director of Adult and Forensic Services.

- 14.11 As a result of ongoing significant cost reductions made in annual budgets, the Portman's clinical staff group has rapidly fallen in number in the last 5 years. Table 1 below gives the figures for June 2010, March 2014 and current figures (June 2015), showing a reduction of just over 30%.

Table 1: Portman Clinical Staff Group

Clinical Staff	Whole Time Equivalents (WTE)
Consultant Adult Psychotherapists	6.20 (2010) 5.20 (2014) 4.20 (2015)
Consultant Child and Adolescent Psychotherapists	2.60 (2010) 1.75 (2014) 1.60 (2015)
Consultant Psychiatrists in Psychotherapy	3.45 (2010) 2.50 (2014) 2.60 (2015)
Total Clinical Staff	12.25 (2010) 9.45 (2014) 8.40 (2015)

- 14.12 In addition to the permanent staff group shown above, the Clinic employs a part time staff member (0.6 wte) dedicated to the organisation and delivery of the PDKUF programmes, based in Nottingham but delivered in London and other national settings.
- 14.13 The Clinic employs one full time Assistant Psychologist whose primary responsibility is to support the audit and research functions of the Clinic and to provide other support to clinical staff i.e. literature searches. The Assistant does not have clinical responsibilities but meets patients to administer research / audit instruments as appropriate. See 12.11 for very recent developments in relation to this post.
- 14.14 One of the Portman clinical staff group also has two Trust-wide roles, these being, that of Trust Assistant Medical Director and Trust Director of Medical Education.
- 14.15 One Portman clinical staff member also holds a post of 0.2 wte at Broadmoor Hospital and another also holds a post in a local CMHT.
- 14.17 The 8.40 WTE clinical staff group is made up of 15 clinicians. Of these, only 2 are on 2 sessions per week (0.2 wte) and all others are on 5 sessions per week (0.5 wte) or more. The number of staff on less than 0.5 has been actively reduced in the last few years.
- 14.18 The Administrative and secretarial staff of the Portman Clinic is made up of:
- a full-time Admin Manager (who functions as a PA to the Clinic Director and manages the admin staff)
 - a full time Receptionist and appointments secretary
 - 1.7 secretarial/admin staff, supported when necessary by a temporary secretary

. Planned staffing structures

- 14.2 Succession planning
Succession planning has been in place for the last 3 or 4 years with a number of senior staff leaving and retiring to be replaced by younger colleagues, often on a lower pay banding. Another senior staff has just retired but is returning to work on specific projects.
A change will take place when at the end of July 2016, after eleven and a half years in post, the current Clinic Director steps down from his post. Planning for the management of that change will start in the autumn of 2015.
- 14.3 Quality initiatives e.g. supervision groups
See below
- 14.4 Supervision / support / reflective practice and how this is achieved

Given the toxicity and disturbing nature of most of patients dealt with in the Clinic, robust professional structures are in place to support and develop the staff and maintain high quality practice.

- 14.61 All clinical staff are trained and experienced in one of the core disciplines, nursing, social / probation work, psychology or psychiatry, and all have further specialist training as child and adolescent psychotherapists, adult psychoanalytic psychotherapists or psychoanalysts (with a number having trained both as both child and adult psychotherapists).
- 14.63 The clinical work is supported by two obligatory weekly clinical meetings, one supporting on-going individual treatment and the other supporting group treatment; and by a fortnightly meeting where assessments and appropriate disposal of patients following assessment is discussed. There is an obligatory termly extended clinical staff meeting where specific clinical issues are discussed, with staff bringing clinical vignettes for consideration, audit details if they exist of the matters being discussed are made available and there is encouragement to read agreed relevant literature. There is also a voluntary monthly reading seminar.
- 14.64 These systems which support and develop the standard of practice in the clinic are always well attended but, when necessary, staff absent themselves from these meetings to carry out work that cannot be done otherwise. This is perhaps inevitable with an increasing range of dissemination activities being undertaken, but it is of major concern that with fewer staff and increased work loads pressure will be put on staff to absent themselves more often and threaten these 'quality controls'.
- 14.65 The whole Portman staff group meets at least once a term to discuss and decide on policy matters and has an annual whole day Away Day to more fully consider and debate policy issues and the establishment of new projects.
- 14.66 The administrative staff have meetings to discuss details of their own structures and work, and to process the impact of the often very disturbing material they are reading and typing. Any untoward incidents with patients of which they are aware (very rare occurrence), are processed with the support of the Admin Manager and/or the Clinic Director and/or senior staff.

15. Cross-Directorate and Trust

See 13.4 above

15.1 Prospects and challenges

The Portman Clinic has in the last two year been successful in developing and having commissioned two major areas of activity, both of which will continue into the future, though in the current turbulent political environment, there is no guarantee of funding beyond any one year. The two major projects are the national MBT service for ASPD patients and the supervision of staff in the London probation service, as described above. The latter has also led to a greater contribution to the London Pathways Project aimed at increasing psychological mindedness in the probation service (see 11.13 and 13.12 above). These new major contributions to services for offenders and others suffering from personality disorder are in addition to continuing central involvement in the delivery of the Personality Disorder Knowledge and Understanding Framework (PDKUF).

These activities are major projects which have been very important in embedding the Portman Clinic, and the Trust as a whole, in the development of services for offenders and others with personality disorder. All the projects present challenges in delivering the requisite activities across London and across England and Wales but also offer the prospect of being involved into the future in a major area of government activity in relation to developing and delivering services in the area of offender mental health.

The Portman Clinic's involvement in providing teaching and supervisory input to the Probation service must have contributed to our being commissioned by the new probation service developing across the country involving CRCs and the NPS. This should put the Clinic into a strong position with regards to future possibilities of offering teaching, supervision and/or consultation to the new probation structures as they are embedded and developed.

15.2 Any plans

This report as a whole has indicated the plans in place to:

- consolidate current clinical, service development, consultancy and teaching activities, and
- develop new clinical services, design and grow new teaching and training activities, establish new partnerships with independent providers and re-establish a research function
- and support the staff group to do this to a high standard.

Consideration will need to start to be given in the next 6 months to the management of the fact that the current Portman Clinic Director will be stepping down from his role in July 2016.

Stanley Ruszczynski
Director, Portman Clinic
July 2015

Appendix 1

Portman Service Line Report - March 2015 report		
SAAMHS Description	Portman	
	Budget	Actual
INCOME		
<u>DIRECT:</u>		
Portman National Comm	1,230,198	1,221,318
Portman MBT (starts July 14)	301,029	302,000
Portman Ldn Probation, Oxleas	112,000	213,740
<u>TRAINING:</u>		
National Contract	46,230	46,230
Junior Doctors	54,210	55,843
Consultancy	110,000	96,580
PDKUF	101,000	71,930
Buildings	4,272	3,279
	1,958,939	2,010,920
OPERATING EXPENDITURE (EXCL. DEPRECIATION)		
<u>CLINICAL DIRECTORATES</u>		
Portman Central	-1,145,678	-1,071,173
PDKUF	-60,387	-60,320
Portman MBT	-267,779	-261,777
<u>OTHER TRAINING COSTS</u>		
Junior Doctors	-65,744	-62,140
Buildings	-184,556	-195,982
	-1,724,144	-1,651,391
CONTRIBUTION	234,795	359,529
<u>CENTRAL FUNCTIONS</u>		
Income	30,147	47,794
Expenditure	-240,417	-258,415
RETAINED SL SURPLUS	24,525	148,908

Appendix 2

Comments from Portman staff

Jane Delafons – Portman Clinic Manager

I began my work at the Tavistock& Portman NHS Foundation Trust in 2005 in the Clinical Governance office working for the Medical Director. There I learnt a lot about the importance of clinical governance in providing a safe service for patients and it stood me in good stead for moving over to the Portman Clinic in 2009 where confidentiality is of the utmost importance.

My role at the Portman has been wide ranging and challenging on many levels. I began as administration manager and my role was to look after the admin team making sure they were supported with the difficult and sometimes disturbing work they have to type for the clinicians. As they all have to be on reception at varying times, they also need support with the more difficult patients who may need to talk to me separately if they are very distressed. Although this can be challenging, I really enjoy this part of my job – being the person between the patient and the clinician – and it is important for patients to feel contained if they are in crisis or if they want more information about the therapy or help with applying for benefits etc. Sometimes it is helpful for them to be able to speak to someone about the type of therapy (psychoanalytic psychotherapy) who isn't a clinician and working strictly within a certain model.

I took over as Clinic Manager in 2012 and took on other responsibilities such as assisting with recruitment, organising the invoicing and being the PA to the Clinical Director, Stanley Ruszczynski. In this role I can see how wide ranging and complex the issues are we deal with and how well the clinic is managed, especially in the last few years when the financial challenges facing the service have been immense.

I have been constantly amazed at the high standards of work done by both clinicians and admin here at the Portman. The Portman Clinic is a very specialised service seeing patients who often find themselves as outcasts in society and who may have never been able to find help for their behaviours anywhere else. It is therefore a privilege to be part of a clinic which is so dedicated in supporting these patients. I feel proud to be part of such an incredibly thoughtful team of people all working with the same aim – to provide highly skilled and dedicated care for our patients however challenging their behaviours may be.

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Patricia Allen - Child and Adolescent Psychotherapist

I have been working at the Portman Clinic for the last 18 months. My role involves assessing young people for Psychotherapy, seeing young people for weekly, individual Psychotherapy, undertaking risk assessments which are commissioned by local authorities and offering Consultations to other agencies with regard to the impact that working with a young person who is violent and/or sexually harmful to others may be having on a network or an individual worker and how that impact may be managed. I also co-facilitate a weekly workshop for Child Psychotherapy trainees which explores issues around working with violent, delinquent and sexually acting out young people.

The most obvious difference I have found working at the Portman in comparison to other clinics/organisation is that the patients are all complex and risky. The young people referred to us have usually been through the more generic mental health options and have been found to require a more specialist service. I have learned how to assess and help networks manage the risk that these young people pose as both perpetrators and victims. It is only when the risk is being well managed that the young person can embark on Psychotherapy. Working with this patient group is challenging and disturbing. As an organisation the Portman recognises this and provides enough supervision for me to process and understand the disturbance I am working with. As well as weekly, individual supervision we have a weekly clinical meeting and a monthly peer supervision group which provide opportunities to present our patients and support each other.

As the patient group is so risky and unpredictable there are often situations which require me to call on colleagues for advice and support unexpectedly. This is also something which feels to me to be in the fabric of the organisation, that we are available to each other

in times of crisis and that this is a vital part of working in the Portman team.

.....

Cathy Cox – Adult Psychotherapist

I joined the Portman clinic in 2008 having completed my adult psychotherapy training (M1) at the Tavistock Clinic. I started my career aged 18 as a general nurse at UCH and went onto train at The Maudsley as a mental health nurse. I did a number of courses at The Tavistock before I embarked on my adult psychotherapy training whilst holding a staff position in the adolescent department.

The Portman clinic is a fascinating place to work. I work with a very complex patient group who stretch my capacity for managing their disturbance. We, as a staff group, place enormous importance on providing a safe containing structure through our relationship with our clinical colleagues and our clinic administrators, who do an amazing job managing the boundary between the therapists and the patient group. The Portman staff group are extraordinarily generous with their time and minds making the work manageable and, more than that, enjoyable and interesting.

The clinic provides a service to children, adolescents and adults and our Friday morning clinical meeting is attended by all staff so we hear presentations from our colleagues working with all age groups which further enhance our understanding of our patient's backgrounds and the genesis of their difficulties.

My clinical role involves assessing and treating adult patients who present having acted on their sexual, criminal or violent impulses. This makes for very challenging work as the boundary between fantasy and action has been breached. I treat patients in once weekly open ended psychodynamic psychotherapy and in weekly group therapy.

We also do a lot of consultation work with clinicians and teams who are struggling to know how to manage their patients who present with these types of problems or who are concerned about the impact their patients are having on their staff. Many of this patient group are treated within prisons and high or medium secure institutions so we also offer institutional consultation and supervision.

I am also very involved in training. I lead on organising and creating exciting innovative CPD events. I particularly enjoy working collaboratively with external agencies and we have a very exciting event happening in October, 'The Forty Elephants' in collaboration with a young production company Hiypeproductions.

I have also been involved in the creation of (D59F) our Forensic Psychotherapy Training. We are about to go into year 2 and our applications have already tripled which I am delighted about.

The Portman has a close relationship with the NPS and CRC probation services offering training and supervision. I facilitate a supervision group for the LPP (London Pathways Partnership) specialist offender managers and Pathways Psychologists. The London Pathways Partnership (LPP) is part of the implementation of the Offender Personality Disorder strategy, a jointly commissioned project by the Department of Health and the Ministry of Justice – National Offender Management Service. Its aim is to provide a psychologically informed approach, including case identification/screening, case formulation, group and individual case consultation and specialist training, in working with offenders with a personality disorder diagnosis or traits, creating effective therapeutic pathways in custody and in the community.

This is very interesting work and has enhanced my understanding of my patient's relationship with the criminal justice system and creates a real working partnership between the Portman Clinic and London probation and CRC.

July 2015

Board of Directors : July 2015

Item : 10

Title : Developing a medium term Strategy for the Tavistock and Portman NHS Foundation Trust

Purpose:

This paper updates the Board of Directors on the process of developing a medium term strategy for the Trust and seeks their agreement for:

- A revised statement of Mission and Values
- A proposed set of 5 Year Ambitions for the Trust

This report focuses on the following areas:

(delete where not applicable)

- Quality
- Patient / User Experience
- Patient / User Safety
- Risk
- Finance
- Productivity
- Communications

For : Discussion and agreement

From : Paul Jenkins Chief Executive

Developing a medium term Strategy for the Tavistock and Portman NHS Foundation Trust

1. Introduction

1.1 At their May meeting the Board of Directors agreed a consultation document on the development of a medium term strategy for the Trust.

1.2 The strategy will have four levels:

- a revised statement of Mission and Values for the Trust
- a set of 5 Year Ambitions
- more detailed operational objectives for the next 2 years
- a revised set of financial forecasts for the next 2 years

1.3 During June and July we have held an extensive set of consultation meetings on the development of the strategy. This has included two well attended staff meetings, consultation with the Staff Consultative Committee and Council of Governors as well as full discussions at the Directors Conference and most recently at the Leadership Group. There has been good engagement with the strategy process and some very helpful input on issues of detail.

2. Emerging issues

2.1 There has been good recognition of the importance in the current climate of setting a clear sense of direction for the Trust and the need for us to show ambition and relevance at a time of likely change in the provider landscape. There, at the same time, are concerns about the pressure on staff and the need to make clear choices about the prioritisation of resources.

2.2 Given the level of feedback from the consultation and the pressure on the senior team from other initiatives it is not been possible, as originally hoped, to complete all the work on the strategy at this stage. We are therefore asking the Board of Directors , at this stage, to agree two items:

- The revised statement of Mission and Values
- A set of 5 Year Ambitions for the Trust

2.3 Both of these documents are attached at **Annex A**. The Mission and Values statement, in particular, has been a hard document to gain consensus about reflecting the complexity of the organisation's work but it is been a helpful exercise to develop it and I am confident that

the current draft has a good level of buy in and gives a strong sense of our ambition.

- 2.4 In addition the Management Team has agreed a set of 2 year objectives which are attached at **Annex B** which detail the specific actions which will be taken forward to progress our 5 year ambitions. These are offered to the Board of Directors, for comment but not agreement, at this stage.
- 2.5 In the light of feedback from the Board of Directors a more detailed set of plans against each objective will be developed so that the full plan can be brought back for agreement at the Board of Directors in September.
- 2.6 Work has also been taken forward to develop a revised set of financial forecasts for the next two years. Further work is required on these in particular to confirm the balance between contributions from growth and savings required to ensure the Trust can meet efficiency savings and post a balanced budget. The current draft forecasts are attached at **Annex C**.
- 2.7 We are also proposing a closer alignment of the objectives set out in the strategy and Trust's Board Assurance Framework and this is reflected in the draft of the Framework which is tabled for agreement by the Board of Directors at this meeting.

3. Recommendations

- 3.1 The Board of Directors is invited to note progress on the development of a medium term strategy and to agree:
 - The revised statement of Mission and Values
 - A set of 5 Year Ambitions for the Trust
- 3.2 Comments are invited on the list of 2 Year objectives and the draft financial forecasts.

Paul Jenkins
Chief Executive
July 2015

Tavistock and Portman NHS Foundation Trust – Medium Term Strategy

Statement of Mission and Values

Strapline

Innovation in mind

Mission

To make a measurable difference through what we do to the health and wellbeing of individuals and communities.

To be the UK centre of thought leadership and research in the application of psychological and social theory and practice.

To be a pioneer in the development and delivery of effective clinical interventions which improve the mental health and wellbeing of children, young people and adults.

To be a national and international centre of excellence for teaching and education.

To be the champion of psychologically informed practice which improves the quality and efficiency of systems in the NHS and other sectors.

Values

We work with people with lived experience of mental health problems to use their contribution to inform our activities and decision making.

We understand the impact of mental distress on individuals and families and communities and work with the available evidence to make a difference to peoples' lives.

We are passionate about the quality of our work and are always committed to transparency and improvement.

We value all our staff and their wellbeing and foster leadership, innovation and personal accountability in our workforce.

We deliver education and training which meets the evolving needs of individuals and employers.

We embrace diversity and work to make our services and training as accessible as possible.

We are outward facing, make an active contribution to the development of public policy work with others who share our values and can enable us to deliver our mission.

5 Year Ambitions

To develop the Tavistock and Portman's **unique psychological and social approaches** to mental health as we approach the 100th anniversary of the foundation of the Tavistock Clinic.

To be at the cutting edge of the development and dissemination of innovative, **new models of integrated provision** which meet the challenges of the 5 Year Forward View, drawing from our expertise in psychological and social thinking and supporting, through consultancy, the transformation of services.

Clinical services

To maintain and develop **our current portfolio of clinical services for adults and children**, demonstrating the quality and impact of what we deliver and ensuring that people with lived experience of mental health problems are central to our work.

Building on our commitment to quality and innovation, to **double the scale of our clinical services** with a focus on **being a leader in the provision of children and young peoples' and primary and community based mental health services**.

Training and education

To build on our provision of high quality **education and training** with its distinctive focus on reflective practice, experiential learning, and multidisciplinary engagement that best reflects the value, relevance and excellence of our training.

To double our **student numbers** and significantly increase the **volume of our CPD events, diversifying our portfolio beyond postgraduate training and increasing the geographical reach** of our work.

Research and policy impact

To establish ourselves as a nationally and internationally renowned centre of excellence for **research** in child mental health and psychological approaches to the treatment and prevention of mental ill health and the promotion of wellbeing across the lifespan.

To established ourselves as a recognised and influential **thought leader** on relevant public and policy debates.

To extend the **awareness of our brand and activities** and **harness the interest and voice of our alumni**.

Our organisation

To **reinforce our reputation as one of the best places to work in the NHS** and continue to develop the skills and resilience of our **workforce**.

To have enhanced the **capability of our organisation**, improving our use of **information and technology and with a modern set of premises** from which to deliver our activities.

Through contribution from growth, and savings from productivity, to **achieve our annual efficiency** targets and to deliver a sustainable financial future for the organisation.

2 Year Objectives

Service Models and consultancy

With partners to establish Thrive as the leading model for the provision of CAMHS services.

With partners to develop service models such as One Hackney as demonstrator sites for a psycho-social model of integrated care.

To grow our role in consultancy with a particular focus on supporting systems and service transformation.

Services for children, young adults and families

To maintain and develop our existing portfolio of services for children, young adults and families.

To implement a successful first demonstration site for Thrive in Camden.

To win a major CAMHS contract.

To roll out the clinical delivery and training in VIPP for adoptive families to a number of local authority areas.

To develop the work of the FNP National Unit including the development of a sustainable model for the programme.

To extend FDAC successfully to the 4 new areas funded through the DfE grant and secure a sustainable future model for the programme.

Adult and Forensic services

To maintain and develop our existing portfolio of services for adults.

To implement the Camden TAP successfully and to work towards being commissioned to deliver another similar service

To develop clear descriptions of interventions, with practice- based evidence of clinical effectiveness and service user support and to promote these options for patients through the Choice agenda

To maintain our contract for specialist forensic psychotherapy at the current level and develop further applications of the Portman Clinic's approach to support a wider criminal justice workforce nationally through direct clinical service developments, consultation and training.

Education and Training

To increase intake student numbers to 1000 for 2017/8 Academic Year

To diversify training portfolio beyond postgraduate training to support and develop people working in some of the most challenging situations.

To increase the national reach of our training and education offer through the development of regional partnerships and greater use of technology enhanced learning

Research

To develop a faculty of high calibre researchers both within and outside of the Trust by establishing working relationships with senior academics nationally and internationally whose research is linked with the work of the Trust.

To secure further prestigious external grant funding for research, contributing to raising the Trust's profile as a leader nationally and internationally in the clinical and training domains.

Embed research competences across our training portfolios with particular emphasis on our clinical trainings

Quality and patient experience and involvement

To meet and exceed all our external regulatory requirements, including external inspections from CQC and QAA.

To set out an aspirational clinical quality strategy for the whole trust, developed with staff , service users, commissioners and taking into account the regulatory environment

To develop systems for capturing, analysing, reflecting upon and acting upon qualitative and quantitative data to support the implementation of the clinical quality strategy with a particular focus on capturing the experience of people who use our services.

To develop and implement a new strategy for patient involvement which makes the involvement of people with lived experience we drive innovation in the organisation.

Profile and communications

To deliver a significant growth in media coverage and wider public profile for the Trust including the successful delivery of the Century Films project.

To design and implement an alumni communications programme.

To establish the Trust's position as a thought leader on relevant issues.

To have developed and implemented a new Intranet for the Trust.

Workforce

To have designed and implemented a workforce strategy that addresses succession planning, diverse skills and competencies for new models of service as well as sustaining, nurturing and enhancing the specialist expertise in research, training and clinical practice that define the unique psychosocial contribution of the Tavistock and Portman.

To have develop a strategy and introduced new initiatives to support staff wellbeing.

Organisational capability

To have developed and implemented an information and technology strategy for the Trust, securing the successful adoption of new IT systems for clinical services and training and education.

To agree a Full Business case for the best long term accommodation for the Trust's businesses.

Continue to develop our Governance and implement the recommendations of the Governance review.

Finance

Continue steady growth, so as to widen the reach of our influence and leadership and also contribute to the Trust's overall financial position. Minimise reductions in all current income sources.

Identify and implement productivity improvements, to optimise the use of resources in all services and departments.

Surplus before Restruct.	50	160	-340	-130	-444	-100	-698	-15	-1,387	400	300	750	63
Margin			14%							19%	43%		
Inflators/deflators				-2.5%			1.5% Pay	1.5% Non-pay					

Dividend: guesstimate for effect of estate revaluation. Depreciation: estimated effect of full year for additional assets; assume reval offset by longer life.

Summary of changes to surplus:

Note: the main difference from 4% is the gain of around £600k from not applying the tariff deflator to training and other income. Also, changes in depreciation and dividend are not directly related to the tariff calculation.

16/17	Volume reductns	Sub-total	Tariff	QIPP	Cost Inflation	IDCR effects	Sub-total	Volume gains	Savings	17/18
	Clinical							Clinical Educ + Trg		
Clinical	-200	19,102	-478	-85			18,539	8,000		26,539
Educ & Trg		20,885	-522				20,363	700		21,063
Consultancy		1,369					1,369			1,369
Research	83	83					83			83
Other	400	400					400			400
Total Income	-200	41,839	-1,000	-85	0	0	40,754	8,000	700	49,454
Pay	-150	29,586			444		30,030	6,200	300	35,880
Non-pay excl Deprec	-30	10,759			161		10,920	1,200	100	12,070
Depreciation		830					830			830
Dividend		500					500			500
Reserves		125					125			125
Restructuring	0	0					0			0
Other	-4	-4					-4			-4
	-180	41,796	0	0	605	0	42,401	7,400	400	49,401
Surplus before Restruct.	63									
Margin	-20	43	-1,000	-85	-605	0	-1,647	600	300	53
Inflators/deflators	10%		-2.5%		1.5% Pay			8%	43%	
					1.5% Non-pay					

Pay inflation: average 1.5% pay increase (av 3% increments for 50% of staff; 1% increase for others; offset by leavers replaced at lower down their respective scales).

Tariff reduction based on 4.0% efficiency target and projected cost inflation of 1.5%.

The projection assumes that the tariff reduction (or an equivalent reduction for other reasons) is applied to training income this year.

Summary of changes to surplus:

Volume reductions	-20
Annual efficiency requirement	-1,605 (expressed through cost inflation and tariff deflation)
	0
QIPP saving requirement	-85
IDCR annual costs	0
Volume gains	900
Savings	800
	<u>-10</u>

Board of Directors: July 2015

Item : 11

Title : Board Assurance Framework 2015/16

Summary :

The Assurance Framework is attached, identifying key risks to achieving the Trust's strategic objectives as set out in the Medium Term Strategy presented today.

A new format has been adopted. Each risk is presented on a separate page, in section 2. Section 1 gives a summary table.

Updates will be presented every three months; and more frequently if needed.

This report has been reviewed by the Management Team on 9th and 16th July.

For : Approval

From : Deputy Chief Executive and Director of Finance

BAF

Board Assurance Framework 2015/16

1. Introduction

- 1.1 The Board Assurance Framework seeks to identify the key risks that could prevent the Trust from achieving its strategic objectives. For each risk, the framework sets out:
- the controls and processes that are in place to manage and mitigate the risk;
 - the gaps;
 - the independent¹ assurances received by the Board, that support these assessments;
 - the current level of risk, taking into account all the above; and
 - the action plans to reduce the risk further.
- 1.2 At a special session on 27 January facilitated by KPMG, and at the Board meeting on 24 February, it was agreed that the structure and presentation of the BAF may be revised for 2015/16.
- 1.3 This has now been done. In section 2, each risk is presented on a separate page covering the aspects detailed above; the format is partly based on one of the examples presented by KPMG. Section 1 gives a summary table of the risks and their current ratings.
- 1.4 Also at the session on 27 January, Board and Management Team members each identified three key strategic risks, and KPMG summarised the results of this exercise.
- 1.5 A draft list of risks, taking into account the January work and the current work on the Trust's strategy, was presented at the June Board meeting. This list now forms the basis of the new BAF.
- 1.6 The Trust's Operational Risk Register is presented separately to this meeting, for review.
- 1.7 The Medium Term Strategy is also presented separately.

2. Conclusion

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

¹ Where appropriate, this section may include non-independent reports that have given the Board assurance on the management of the risk.

- 2.2 It is proposed that this BAF should return quarterly, in October, January and April, with all risks reviewed and updated by their respective risk owners. The table in section 1 will show the changes in ratings between quarters.
- 2.3 If new risks or other significant changes are identified between these meetings, they will be reported without delay.

Simon Young
Deputy Chief Executive and Director of Finance
13 July 2015

BAF

Board Assurance Framework 2015/16

Section 1

Risk	Current R/A/Y/G	Q1 rating C x L = R	Q2 rating C x L = R	Q3 rating C x L = R	Q4 rating C x L = R
Clinical quality or governance failures – including the risk of serious incidents.		4 x 2 = 8			
Clinical income reduced significantly due to pressure on NHS and local authority budgets.		4 x 3 = 12			
Clinical growth targets not achieved.		3 x 4 = 12			
Education and Training quality failures.		4 x 2 = 8			
Training course numbers reduced, or growth targets not achieved.		3 x 4 = 12			
National Training contract significantly reduced.		5 x 3 = 15			
Loss of workforce engagement / morale / commitment.		4 x 2 = 8			
Loss of workforce skills.		4 x 2 = 8			
Unable to agree or fund relocation / redevelopment plans.		4 x 3 = 12			
IT applications and hardware do not sufficiently support Trust objectives. Loss of access to critical systems.		4 x 3 = 12			
Insufficient management capacity.		4 x 3 = 12			
Damage to the Trust's reputation and brand.		4 x 2 = 8			
Regulatory failure.		5 x 1 = 5			

Risk	Current R/A/Y/G	Q1 rating C x L = R	Q2 rating C x L = R	Q3 rating C x L = R	Q4 rating C x L = R
Savings and growth contribution insufficient.		4 x 4 = 16			
Takeover threat.		5 x 2 = 10			

Notes

- (i) C= consequence. L = likelihood (*allowing for the controls and assurances shown*). R = C x L = risk rating.
- (ii) Rating 15+ = green; 9 – 12 = amber; 5 – 8 = yellow; 1 – 4 = green (in accordance with Trust risk management policy).
- (iii) Section 2 contains a separate table for each risk.

Board Assurance Framework 2015/16

Section 2

<p>RISK: Clinical quality or governance failures – including the risk of serious incidents.</p>	<p><u>Risk Owner:</u> Medical Director Date last reviewed: July 2015</p>
<p><u>Strategic Objectives affected by this risk:</u> Quality and patient experience. Leadership in new models of care. Leadership in children's mental health and development. Development of adult and forensic services.</p>	<p><u>Current risk rating:</u> Consequence 4 x Likelihood 2</p>
<p><u>Controls/Influences (what are we currently doing about this risk?):</u> Director of Quality and Patient Experience leads Quality work-stream reporting to CQSG Committee. Productivity Programme Board reviews savings proposals for quality and safety implications. Continuing development of staff training programmes. Associate Medical Director leads Patient Safety and Risk work-stream.</p>	<p><u>Rationale for current score:</u> The consequence of a serious clinical incident attributable to a failure to comply with appropriate standards of quality or safety is high but there are well-embedded systems in place to provide governance and early warning of system failures.</p>
<p><u>Gaps in controls/influences:</u> Recruitment of key staff with responsibilities for clinical quality data management and reporting.</p>	<p><u>Action plans in response to gaps identified: (with lead and target date)</u> <i>Recruitment of key staff in the quality team is led by the Clinical Governance and Quality Manager. The Quality and Governance Lead takes up her role on September 7th 2015</i></p>
<p><u>Assurance received (independent reports on processes; when; conclusions):</u> Quality Reports and Accounts externally audited and limited assurance on local indicators given by external auditors</p>	

Board Assurance Framework 2015/16

Section 2

<p>RISK: Clinical income reduced significantly due to pressure on NHS and local authority budgets.</p>	<p><u>Strategic Objectives affected by this risk:</u> Leadership in new models of care. Leadership in children's mental health and development. Development of adult and forensic services. Finance – balanced budgets.</p>	<p><u>Risk Owner:</u> Commercial Director Date last reviewed: July 2015</p>
		<p><u>Current risk rating:</u> Consequence 4 x Likelihood 3</p>
<p><u>Controls/Influences (what are we currently doing about this risk?):</u> Regular liaison with commissioners. Continue the development and modernisation of existing services, including the Thrive model for CAMHS. Demonstrate quality and outcomes.</p>	<p><u>Gaps in controls/influences:</u> Full assessment of how to maximise opportunities and mitigate threats presented by Choice has not yet been undertaken. Plan with regard to risks to Portman income not yet in place.</p>	<p><u>Rationale for current score:</u> It is unlikely that the rating can be reduced much further, even with action plans.</p>
		<p><u>Action plans in response to gaps identified: (with lead and target date)</u> Full Choice action plan to be in place in Sept 2015 – Commercial Director Full Portman action plan to be in place in Sept 2015 – Commercial Director</p>

Board Assurance Framework 2015/16

Section 2

RISK: Clinical growth targets not achieved.		Risk Owner: Commercial Director Date last reviewed: July 2015
<p><u>Strategic Objectives</u> affected by this risk:</p> <p>Leadership in new models of care.</p> <p>Leadership in children's mental health and development.</p> <p>Development of adult and forensic services.</p> <p>Finance – balanced budgets.</p> <p><u>Controls/Influences</u> (what are we currently doing about this risk?):</p> <p>Plans updated, agreed and monitored by Strategic and Commercial Programme Board.</p> <p>Development of new service models, including Thrive and TAP.</p> <p><u>Gaps in controls/influences:</u></p> <p>Full action plans not yet in place for selling TAP and FDAC services or for marketing to the criminal justice system.</p> <p>Insufficient prospects to meet the targets.</p> <p><u>Assurance received</u> (independent reports on processes; when; conclusions):</p> <p>Internal Audit of Board Assurance Framework, December 2014, confirmed that the entries for clinical income maintenance and growth were correct; controls were appropriate and were functioning as stated.</p>	<p><u>Current risk rating:</u></p> <p>Consequence 3 x Likelihood 4</p>	12
		<p><u>Rationale for current score:</u></p> <p>The growth target is very high.</p> <p>Currently the income we can secure through current prospects falls short of the target.</p>
		<p><u>Action plans in response to gaps identified:</u> (with lead and target date)</p> <p>TAP plan to be in place Sept 2015</p> <p>FDAC plan to be in place Sept 2015</p> <p>Criminal justice plan to be in place Sept 2015</p> <p>After maximising selling priority products such as FDAC and TAP, to focus on generating further prospects Oct 2015</p>

Board Assurance Framework 2015/16

Section 2

RISK: Education and Training quality failures.	<p><u>Risk Owner:</u> Director of Education and Training.</p> <p>Date last reviewed: July 2015</p>	
<p><u>Strategic Objectives affected by this risk:</u></p> <p>Develop the scope of our training and education work.</p> <p>Increase numbers of students.</p> <p>Raising the profile of the Trust.</p>	<p><u>Current risk rating:</u></p> <p>Consequence 4 x Likelihood 2</p>	8
<p><u>Controls/Influences (what are we currently doing about this risk?):</u></p> <p>Quality governance, supported by and monitored by university partners, and reporting to Training and Education Programme Board.</p> <p>QAA Action Plan is in place, reporting to the TEPMB.</p> <p>Productivity Programme Board reviews savings proposals for quality implications.</p>	<p><u>Rationale for current score:</u></p>	
<p><u>Gaps in controls/influences:</u></p> <p>Academic year 2015/16 we will be working with two University partners which can result in confusion.</p> <p>Increase in student numbers may affect quality of provision.</p>	<p><u>Action plans in response to gaps identified: (with lead and target date)</u></p> <p>Learning and Teaching Committee is being established that will take a role in monitoring quality.</p> <p>Student complaints procedure is currently under review to ensure we are proactive in our response to complaints.</p>	
<p><u>Assurance received (independent reports on processes; when; conclusions):</u></p> <p>University partners have agreed to attend bi-monthly AGQAC meetings.</p> <p>Agreement has been reached to establish a Commitment and Quality Group with the University of Essex.</p>		

Board Assurance Framework 2015/16

Section 2

<p>RISK: Training course numbers reduced, or growth targets not achieved.</p>	<p><u>Risk Owner:</u> Director of Education and Training. Date last reviewed: July 2015</p>
<p><u>Strategic Objectives affected by this risk:</u> Develop the scope of our training and education work. Increase numbers of students. Finance – balanced budgets.</p>	<p><u>Current risk rating:</u> Consequence 3 x Likelihood 4</p>
<p><u>Controls/Influences (what are we currently doing about this risk?):</u> Continue the development and modernisation of existing and new courses. Develop and implement new delivery models. Director of Marketing and Communications appointed. Greater marketing capability and focus. TEL team appointed. Course Development Committee has been established with an approvals and implementation team to ensure we are responsive to new developments. Portfolio managers and Associate Deans provide a stronger link with alignment and delivery to targets. Improved reporting around recruitment targets that allow for targeted action from Marketing and Communications and Associate Deans.</p>	<p><u>Rationale for current score:</u></p>
<p><u>Gaps in controls/influences:</u> Development of new courses including TEL has not progressed as fast as hoped in 2013/14 and 2014/15. Business process review, reported to TEPMB July 2015, identifies needs for improvements. Requirement to review planning cycle to ensure better forward planning. <u>Assurance received (independent reports on processes; when; conclusions):</u> Internal audit of Student Recruitment, 2014/15, amber/green. Director of Marketing and Communications reported to the TEPMB in July that patterns of recruitment were as they had been in previous years with numbers of applications continuing to increase.</p>	<p>Action plans in response to gaps identified: (with lead and target date) Business process review to be completed and implemented.</p>

Board Assurance Framework 2015/16

Section 2

RISK: National Training contract significantly reduced.		<u>Risk Owner:</u> Director of Education and Training. Date last reviewed: July 2015
<u>Strategic Objectives affected by this risk:</u> Develop the scope of our training and education work. Increase numbers of students.		15 <u>Current risk rating:</u> Consequence 5 x Likelihood 3
<u>Controls/Influences (what are we currently doing about this risk?):</u> Continue to develop regional training programme. Regular and active liaison with commissioners including meeting regional directors of education quality. Demonstrate quality and outcomes. Streamlined focus group led by Associate Dean to develop our strategy. Dialogue with HENCEL regarding outcomes is ongoing.	<u>Rationale for current score:</u>	
<u>Gaps in controls/influences:</u> HENCEL have requested a move towards a 50/50 split between training offered in London/South East and the rest of the country, from 70/30. Limited opportunities for growth at associate centre in Bristol. Lack of marketing for associate centres. A national marketing approach is under review.	<u>Action plans in response to gaps identified: (with lead and target date)</u> Associate Dean to continue site visits.	
<u>Assurance received (independent reports on processes; when; conclusions):</u> A report presented to the TEPMB in July indicated that developments in the North West were progressing well and discussions in Essex regarding East Anglia are progressing. Promising developments in Birmingham are underway.		

Board Assurance Framework 2015/16

Section 2

<p>RISK: Loss of workforce engagement / morale / commitment.</p>	<p><u>Risk Owner:</u> Chief Executive Date last reviewed: July 2015</p>
<p><u>Strategic Objectives:</u> Changing the way we work.</p>	<p><u>Current risk rating:</u> Consequence 4 x Likelihood 2</p>
<p><u>Controls/Influences (what are we currently doing about this risk?):</u> Use medium strategy to set clear direction for the organisation. Continuing programmes of consultation and communication with staff including Board lunches and raising concerns initiatives Act on issues from staff survey Develop strategy to support staff wellbeing and positive mental health at work</p>	<p><u>Rationale for current score:</u> Staff survey consistently shows strong commitment to the Trust and its work Survey also indicates growing pressure on staff as resources reduced</p>
<p><u>Gaps in controls/influences:</u> Ongoing pressure to make savings increases pressure on staff</p>	<p><u>Action plans in response to gaps identified:</u> Development of staff wellbeing strategy</p>
<p><u>Assurance received (independent reports on processes; when; conclusions):</u> Staff survey</p>	

Board Assurance Framework 2015/16

Section 2

<p>RISK: Loss of workforce skills.</p>	<p>Risk Owner: Director of HR Date last reviewed: July 2015</p>
<p><u>Strategic Objectives affected by this risk:</u> Changing the way we work.</p>	<p><u>Current risk rating:</u> Consequence 4 x Likelihood 2</p>
<p><u>Controls/Influences (what are we currently doing about this risk?):</u> Employee engagement and employee satisfaction is assessed annually through national survey and thrice a year through the Friends and Family Test. The findings of these surveys and any arising concerns are discussed and addressed with the management team and Unions. For example, the helpline for staff to raise concerns helpline has been introduced. The current Trust HR Strategy includes a focus on effective partnership working and on exploring options (including flexibilities in pay structure) to attract and retain talented staff Up to date employment policies and best practice principles are invoked whilst consulting staff during changes and service re-design, to ensure continuous engagement and foster a sense of fairness and transparency in the process. Besides individual development, emerging Trust-wide team development themes also the in-house training programme. The HEE funding has been put to best use for promotion of multi-professional approaches to workforce development, alongside improved level of access to NHS funded courses for all, and also through identifying CPD training requirements. Succession planning discussions within Directorates are encouraged. Organisational values: work on Value based recruitment is being led by HR in partnership with Unions. This will help create a culture of shared values. Job Descriptions : Managers and Unions are engaged by HR to assess the future skills requirements in job descriptions that cater to the current and future Trust needs</p>	<p><u>Rationale for current score:</u> Skills and experience levels remain high, notwithstanding retirements. Turnover remains low generally. Results from the annual Staff Survey and from the Friends and Family Test remain generally good.</p>
<p><u>Gaps in controls/influences:</u> Work in progress to assess Training Needs Analysis following appraisal exercise (2014).</p>	<p><u>Action plans in response to gaps identified:</u> (with lead and target date)</p>
<p><u>Assurance received (independent reports on processes; when; conclusions):</u></p>	<p>Completion of Training needs analysis and submission of report to staff training committee and the management team – Director of HR, by end of September 2015.</p>

Board Assurance Framework 2015/16

Section 2

RISK: Unable to agree or fund relocation / redevelopment plans.		Risk Owner: Deputy Chief Executive Date last reviewed: July 2015
<u>Strategic Objectives affected by this risk:</u> Changing the way we work.		Current risk rating: Consequence 4 x Likelihood 3
<u>Controls/Influences (what are we currently doing about this risk?):</u> Project Board developing business case, with professional advice. Progress and action plans last reported to the Board in March 2015.		12
		<u>Rationale for current score:</u> Current main building will not facilitate change; and is in need of major work. "Do nothing" is not an option. Good progress but not yet at the stage of firm proposals. Relocation is currently assessed as affordable, but to be confirmed when specific options are available.
<u>Gaps in controls/influences:</u> Options appraisal to be completed, so that preferred option can be identified and progressed. Future movements in property values (for both sale and purchase) uncertain. Plans and timing of possible partners uncertain.		<u>Action plans in response to gaps identified: (with lead and target date)</u> Outline Business Case to Board, September 2015. Deputy Chief Executive
<u>Assurance received (independent reports on processes; when; conclusions):</u> Report from Baker Tilly June 2014 confirmed project management structure functioning satisfactorily; recommendations for revision implemented. Baker Tilly currently engaged to support production of the Outline Business Case to ensure compliance with the Green Book issued by HM Treasury.		

Board Assurance Framework 2015/16

Section 2

<p>RISK: IT applications and hardware do not sufficiently support Trust objectives. Loss of access to critical systems.</p>	<p><u>Risk Owner:</u> Deputy Chief Executive Date last reviewed: July 2015</p>
<p><u>Strategic Objectives affected by this risk:</u> Changing the way we work.</p>	<p><u>Current risk rating:</u> Consequence 4 x Likelihood 3</p>
<p><u>Controls/Influences (what are we currently doing about this risk?):</u> Project Board for CareNotes implementation includes Executive Directors, senior clinicians, and IM&T management. Project board for new DET admin system: progress is currently being reported monthly to the TEPMB. Plan for hardware and network development to be agreed during 2015/16, to include review of resilience.</p>	<p><u>Rationale for current score:</u> Overall strategy and action plan not yet updated and approved.</p>
<p><u>Gaps in controls/influences:</u> CareNotes go-live delayed from 11 May to 27 July. Some milestones missed. Some incidents, though not major, have shown that our systems and network have insufficient resilience. <u>Assurance received (independent reports on processes; when; conclusions):</u> Internal Audit of Board Assurance Framework, March 2015, confirmed that the entries for CareNotes implementation were correct; controls were appropriate and were functioning as stated. Internal Audit of Cyber Security, June 2015, will report to Audit Committee October meeting.</p>	<p><u>Action plans in response to gaps identified: (with lead and target date)</u> Weekly monitoring and planning for CareNotes implementation. Director of IM&T to present priorities and action plan for approval, Nov 2015. Improvements to the network continue to be made as required.</p>

Board Assurance Framework 2015/16

Section 2

RISK: Insufficient management capacity		<p><u>Risk Owner:</u> Chief Executive</p> <p>Date last reviewed: July 2015</p>
<p><u>Strategic Objectives:</u></p> <p>Changing the way we work.</p> <p><u>Controls/Influences (what are we currently doing about this risk?):</u></p> <p>Developing strategy to identify priorities and manage trade offs</p> <p>Streamline decision making processes eg TEPM</p> <p>Use in year surpluses to boost resources</p>	<p><u>Current risk rating:</u></p> <p>Consequence 4 x Likelihood 3</p>	12
	<p><u>Rationale for current score:</u></p> <p>As a small and diverse Trust management resources are spread thinly</p> <p>Need to support growth alongside savings agenda</p>	
<p><u>Gaps in controls/influences:</u> Uncertainty of external environment</p>	<p><u>Action plans in response to gaps identified:</u> Agree priorities and resource implications. Chief Executive, September 2015.</p>	
<p><u>Assurance received (independent reports on processes; when; conclusions):</u></p>		

Board Assurance Framework 2015/16

Section 2

RISK: Damage to the Trust's reputation and brand.		Risk Owner: Chief Executive Date last reviewed: July 2015
<u>Strategic Objectives:</u> Maintaining and developing the Tavistock and Portman's unique tradition of psychosocial approaches to mental health.		Current risk rating: Consequence 4 x Likelihood 2
<u>Controls/Influences (what are we currently doing about this risk?):</u> Strengthening communications and marketing team Focus in strategic plan on building profile, developing links with alumni and developing thought leadership Developing links with stakeholders		Rationale for current score: Generally positive reputation in wider mental health world but not necessarily contemporary
<u>Gaps in controls/influences:</u> Significant change in external environment		Action plans in response to gaps identified: Objectives being developed on profile raising in strategic plan
<u>Assurance received</u>		

Board Assurance Framework 2015/16

Section 2

RISK: Regulatory failure.	Risk Owner: Chief Executive Date last reviewed: July 2015	
<u>Strategic Objectives:</u> Raising the Trust's profile.	<u>Current risk rating:</u> Consequence 5 x Likelihood 1	5
<u>Controls/Influences (what are we currently doing about this risk?):</u> Range of governance processes in place. Programme of work to prepare for CQC inspection	<u>Rationale for current score:</u> Strong current performance	
<u>Gaps in controls/influences:</u> Ongoing pressure for efficiency savings impact on management capacity <u>Assurance received</u> (Clean external audit opinion, May 2015. Internal audit reports during 2014/15, including: <ul style="list-style-type: none"> • Medical revalidation (amber/green) • Safeguarding children (amber/green) • Key financial controls (amber/green) • Information governance (green) • Board Assurance reviews (advisory) Audit Committee effectiveness self-assessment. Board effectiveness review, June 2015.	<u>Action plans in response to gaps identified:</u> Quality and governance objectives in strategic plan	

Board Assurance Framework 2015/16

Section 2

<p>RISK: Savings and growth contribution insufficient.</p>	<p><u>Risk Owner:</u> Deputy Chief Executive Date last reviewed: July 2015</p>
<p><u>Strategic Objectives affected by this risk:</u> Finance – deliver balanced budgets through growth with contribution, and savings.</p>	<p><u>Current risk rating:</u> Consequence 4 x Likelihood 4</p>
<p><u>Controls/Influences (what are we currently doing about this risk?):</u> Projections and action plans to be agreed by Productivity Programme Board. Action plans in place for tendering and other growth opportunities. Growth plans reviewed by Strategic and Commercial Programme Board and Training and Education Programme Management Board.</p>	<p><u>Rationale for current score:</u> Targets outlined for 2016/17 and 2017/18; but plans not yet in place to achieve these.</p>
<p><u>Gaps in controls/influences:</u> Outcome of some tenders will be known late summer / early autumn. Timing for other opportunities not yet confirmed. Work on savings started, but specific plans yet to be agreed. <u>Assurance received (independent reports on processes; when; conclusions):</u> PPB reported to the Board during 2014/15, and we achieved a balanced budget for 2015/16.</p>	<p><u>Action plans in response to gaps identified: (with lead and target date)</u> PPB to agree action plans for growth and savings. Deputy Chief Executive to report on progress in October 2015 and January 2016.</p>

Board Assurance Framework 2015/16

Section 2

<p><u>Strategic Objectives:</u> Maintaining and developing the Tavistock and Portman's unique tradition of psychosocial approaches to mental health.</p>	<p><u>Risk Owner:</u> Chief Executive Date last reviewed: July 2015</p>	
	<p><u>RISK: Takeover threat.</u></p>	<p><u>Current risk rating:</u> Consequence 5 x Likelihood 2</p> <p>10</p>
<p><u>Controls/Influences (what are we currently doing about this risk?):</u> Setting a clear medium strategy for the Trust Demonstrate better Trust's contribution to contemporary issues inc 5 Year Forward View Ensuring the Trust stays in surplus and meets all regulatory requirements Develop strong partnerships with other organisations</p>	<p><u>Rationale for current score:</u> Concern that tradition would be lost if Trust forced to merge Period of major change in the provider landscape</p>	
	<p><u>Action plans in response to gaps identified:</u> Objectives in strategic plan</p>	
<p><u>Gaps in controls/influences:</u> Wider events in sector Significant changes in commissioning intentions</p>		
<p><u>Assurance received</u></p>		

Board of Directors: July 2015

Item : 12

Title : Operational Risk Register Annual Review

Summary:

The Board of Directors are invited to review the full operational risk register on an annual basis. The Board is asked to consider:

1. Does the register provide assurance that risk are accurately described, controlled and rated?
2. Are there any significant operational risks that are missing from the register?
3. The Management Team recommend that project managers who manage local risk registers, *see(iii) below*, are responsible for ensuring that any risk identified that could have a Trust wide impact is escalated to the Trust risk register, does the Board wish to support this recommendation?

Notes:

- i. *The Trust holds one central risk register, due to low number of risks*
- ii. *Risks that have been added and or updated since last review are update are shown in blue*
- iii. *All risks 9+ are reviewed quarterly, and other risk amended as required, with a full review of all risk by each risk lead undertaken in Q1 each year*
- iv. *Risk within key Trust projects e.g. relocation project and the integrated digital records project are not reflected in this register, but are managed within each project. In addition DET and IM and T hold local registers, being escalated up to the Trust risk register.*

For : Approval

From : Director of Corporate Governance and Facilities

Scope	Risk	Controls	Assurance	Gaps	C	L	R	Action Plan	Monitored by	Lead	Target or Review Target/ Review	Update
Financial , new business and business continuity risks												
1	Trust does not achieve CoSRR of at least 3 at each quarter of 2015-16.	Budget presented to Board and approved March 2015, with small surplus and £200k contingency reserve. Cash balance will reduce but liquidity will remain satisfactory.	Board paper set out the factors contributing to this balanced position; and the risks and their mitigation / management. Regular monthly reports will be provided as usual. Surplus in first quarter is well ahead of Plan, though this is expected to reduce later in the year due to (a) the timing of some budgeted costs; and (b) additional non-recurrent expenditure being approved.	As in all years, some income - especially in training and consultancy - is variable and will only be secured in-year.	5	2	10	Productivity Programme Board will continue its work, to find savings for future years and also to increase the contingency for 2015/16.	Board of Directors	Finance Director	quarterly review	Risk reduced to amber in April 2015. Unchanged July. 2015
Business continuity and impact of new business												
2	In the event of a major incident the Trust is unable to deliver services	Business Continuity Plan in place with action cards for Gold, Silver and Bronze Commands Directorate specific Business Continuity Risk Assessments, annually reviewed	Annual revision of published plan Published risk assessments	IT Recovery plan needs updating to include all services.	3	1	3	Revision of IT Recovery Plan to be approved and added to the Business Continuity Plan and Major Incident Plan for Emergency Preparedness Response and Recovery Assurance for NHS ENGLAND in September	Corporate Governance workstream & CQSG	IM&T Director and H&S Manager	Q2 2015-16	Updated June 2015
All services												

Updated June 2015			Updated June 2015		
quarterly review			quarterly review		
Commercial Director			Commercial Director		
SCPb) and Management team					
			To consider this as part of developing the Trust strategy and plans.		
			To review role and needs of contracting team by Aug 2015		
9			8		
3			2		
3			4		
No process for reviewing risk to delivery as a result of cumulative growth.			Contracting capacity required with acquisition of new contracts not fully scoped		
Evidence that decision matrix has been used effectively to inform decision making	completed risk assessments in documentation	Papers and minutes	Evidence of due diligence and monitoring of implementation plan minutes of kick off meetings, email correspondence, papers for BDC, BDIC and MC	copy of plan and progress reports	access to core contract materials as required
Agreed process for consideration of new business (decision matrix) supported by internal subject experts at all stages	risk assessment process in place	SCPb / Management Team / Business Development Meeting scrutiny of decision and bid	Due diligence procedure in operation	implementation plan developed and implemented for each new business acquisition	contracting and invoicing
Risk to delivery of core services as a result of new business acquisitions and/or contract extensions					good working relationships with CSU (single core point of contract)
All new clinical business			Reputational and financial risks to the Trust as a result of failure to meet contract requirements		
3			4		
All new clinical business			All new clinical business		

Clinical Risks									
8	All clinical services	Inaccurate data capture on Rio due to failures of Trust checking data sources (clinical record/Rio) procedures resulting in inaccurate representation of Trust performance to CQC and other assessors	Rio teaching and handbook to support accurate upload of data	Handbook contains clear instructions and screen shots to show how data is to be entered	No comprehensive approach to data quality assurance Action plan to address MHMDS developed but not fully executed	2	4	8	Part of data quality work in progress for IG and to meet demands of external bodies/ Quality Report
									quarterly review
									Clinical Service Directors
									Information Governance workstream & CQSG
									Maintain IG training and promotion of relevant Trust policies and procedures
									Plan to move fully to NHS mail by June 2016 or earlier.
									Liaise with colleagues outside the NHS at the same time, to improve security of communication.
9	All clinical services	Breach of confidential information resulting in harm to patient and/or investigation by the Information Commissioner	Attendance at induction which includes training on confidentiality.	Attendance at induction and inset records held by HR.	e-mail process is found to be too cumbersome by some clinicians, who use fax instead (e.g. info to be sent while visiting a school, to local authority colleagues). Faxes are sent to safe haven locations, but some risks may remain.	3	2	6	
									quarterly review
									SIRO (Finance Director)
									Information Governance workstream & CQSG

13	All clinical services	Inability to account for full assessment/ treatment received by a patient due to incomplete written case record	Rolling case note audit programme. (13/14 programme published June 2013)	Results of case note audit and action planning reported to CG committee.	no gaps currently identified	3	2	6	Rolling programme of case note audits. Roll out of Electronic Patient Records 2015 -16	Patient Safety workstream & CQSG	Medical Director	quarterly review	reviewed June 2014 no change
14	All clinical services	Incident of physical and/or psychological harm to clinical staff due to violence or aggression by patient (outside Day unit)	Emergency number 3333 for access to support for Tavi/Portman MAYBO or in house (H&S Manager) specialist training available for high risk groups/teams On-going clinical risk assessment of patients to anticipate problems and take appropriate action.	Incident reports are followed up when 3333 used in these circumstances. delivery of training in response to request and/or incident analysis identifying 'risk' areas of practice Records audit to show compliance.	no gaps currently identified	3	2	6	Continue to make Lone Working and Personal Safety training available on demand to high risk areas, monitor all reported incidents. Regular attendance by H&S manager to team meetings to discuss concerns	Corp Gov workstream & CQSG	Medical Director	quarterly review	reviewed June 2014, No change

15	All clinical services	Outreach worker harmed by patient/another person in the course of their work	<p>All Trust sites part of rolling annual risk assessment process, which includes lone worker assessments</p> <p>Lone worker procedure and incident reporting presented at induction and INSET, this promotes requirement for case by case risk assessment</p> <p>Personal alarm system provides for 'high risk' staff, together with Personal Safety Training workshops</p>	<p>Risk assessment report for each site in place, which is reviewed quarterly by Estates and Facilities. Reports schedule reviewed quarterly</p> <p>Induction and INSET programmes.</p> <p>Use of alarms monitored by H & S Manager and reported to CGR</p>	<p>3</p> <p>2</p> <p>6</p> <p>Email to all staff with links to the T&P Website for the Lone worker procedures and a Incident form. Continue to offer de-escalation and Personal Safety training to all at risk staff, this will be by managed team including inserts by H & S manager .</p>	Corp Gov workstream & CQSG	Clinical Directors	quarterly review	Updated June 2015 , no change
16	All clinical services	<p>Risk of patient self harming on site and/or requiring rapid transfer to acute care</p>	<p>Rapid transfer procedure and quick check list available for staff</p> <p>Risk assessment during clinical sessions, to support identification of patients 'at risk' of self harm.</p>	<p>incident review each time rapid transfer occurs, with local follow up by risk team if practice does not meet procedure</p> <p>Records audit include assessment of completion of risk assessment during contact with Trust.</p>	<p>3</p> <p>2</p> <p>6</p> <p>Remains under review on a case by case basis</p>	Patient Safety workstream & CQSG	Clinical Services Directors (RH and LL) and SAAMHS Director	quarterly review	June 2015 , No change
17	FNP	FNP is decommissioned in local sites if RCT seen as unfavourable	<p>Detailed plans being developed for RCT communication and to maintain commissioning</p>	<p>Regular reports to FNP Board and to consortium. Weekly NU check in from May. The National Unit has developed a plan to address RCT publication and to maintain commissioning. The RCT report will be available to certain individuals at the National Unit from early June 2015, with actual publication anytime from July 2015 onwards.</p>	<p>4</p> <p>2</p> <p>8</p> <p>Prioritisation of focused NU resource on RCT preparation</p> <p>Monitor, review and revise plan following receipt of RCT report. By June 2015.</p>	FNP Board	Director of CYAF	quarterly review	updated June 2015

[illegible]

Information Governance risks									
		No change June 2015	updated for 2015-16 June 2015						Revised June 2015
		4/9/14 Management Team meeting	31/10/15 (review)						31/10/2015
		Finance Director / SIRO	Finance Director / SIRO						Finance Director
		IG workstream	IG workstream						IG workstream and CQRG
		Students on Research Degrees with registered Thesis have active accounts. All to undertake IG training	Action plan reported to IG workstream and CQSG.						Update IT Recovery Plan by end August 2015 IM&T have implemented a department Risk Register Install fully resilient external links & infrastructure for N3 and ULCC connectivity by December 2015 Review local area network resilience as part of network refresh project by October 2015 and provide recommendations.
		8	6						8
		2	2						2
		4	3						4
		Students to complete IG training							Recovery plan needs updating Full resilience of external links
		Action plan has been reported to the IG lead and workstream. Office 365 has now been installed, and is being made available to all research students.	Compliance to be monitored by IG workstream reporting to CQSG, other workstreams tasked with monitoring relevant parts of the toolkit requirements						Annual audit of our procedures and data restoration tests. Contracts with suppliers for EPR and finance systems.
		Students are aware of their responsibilities for safeguarding such data. The Trust had an action plan to provide a solution for holding such data, and to require all students to use it if they undertake research involving person-identifiable information.	IG delivery plans to be put to the SIRO for approval at the Q1 IG work stream meeting						Back up and restore plans are in place utilising on site backups and cloud based replication for local data. Several key systems (including the Electronic Patient Record (EPR) system and finance systems) are now hosted in the cloud, with suppliers responsible for continuity under strict SLAs. We have limited resilience in our external links
		Research data collected by students on Trust courses may not be held securely, and may include person-identifiable information is not held in line with DPA	Failure to maintain compliance with IG toolkit in 2015-16, resulting in a negative report to CQC and Monitor which could affect ability of Trust to secure future business,						Interruption to Trust system and/or email
		DET & Research	All services						IM and T
		26	27						28

29	Contracts and new business	Failure to include IG clauses in some contracts exposes the Trust to risk of penalties, especially in the event of an information loss incident with such a contractor or commissioner	Commercial Department is maintaining a table of all contracts, identifying whether they include appropriate IG clauses and whether the contract has been concluded and signed. Note also that our commissioners (NHS, LA and private) also have their own IG requirements and processes. The risk of an information loss incident should be relatively small; but in the event of one, the lack of a clause in our contract could be penalised.	This table sent to the IG Lead confirms that most contracts, and all the larger ones, now include this clause and have been signed. For these contracts, this will normally be effective for future years too.	In case any contract were not covered in 2014/15, all contracts should be reviewed again for 2015/16, to ensure that the IG clauses are included.	4	1	4	audit of contracts for 2015-15 to ensure clause included	Finance Director	Commercial Director	ongoing review	updated June 2015
30													
31	Facilities	Staff at risk of harm from patients/strangers due to location and layout of entrance to FDAC CORAM site	Location has CCTV on door, porch lighting and protocol of 2 members of staff to go to door in event of unexpected visitor. Staff have access to Trust mobile phones for use in emergency Lone worker policy promoted and safe working practices assessed and subject to annual review	incident reporting, health and safety annual risk assessment incident reporting	None identified	2	1	2	Staff to continue to be vigilant and have a secure procedure for dealing with uninvited visitors.	Corporate Governance workstream & CQSG	Director of Corp Gov and Facilities	quarterly review	Updated June 2015
32	Facilities	Risk of food poisoning or other environmental	Contracted service with detailed risk arrangements in contract.	Contract records held by Facilities Directorate.	None identified	2	1	2	To continue to monitor standards.	Governance workstream	Director of Corp Gov and Facilities	annual review	June 2015, No changes

Board of Directors : July 2015

Item : 13

Title : Board of Directors Objectives 2015/16

Purpose:

This paper sets out the objectives for the Board of Directors for 2015/16, revised to include the comments from the June board meeting.

The Board is asked to consider and approve these objectives, which will form the basis of individual objectives to be agreed at a later date.

For : Approval

From : Trust Chair

Board Objectives, June 2015

Objective	Details	Review Date
STRATEGY		
Publish refreshed medium term strategy for the Trust	<p>Publish refreshed statement of mission and values.</p> <p>Set ambitions for next five years.</p> <p>Agree detailed roadmap for the next two years.</p> <p>Agree and monitor refreshed BAF which is aligned with the medium term strategy.</p> <p>Agree basis for monitoring progress against the strategy.</p>	July 2015
Oversee development of the Trust's role in children and young peoples' mental health and of existing services in line with new service models.	<p>Oversee strengthening existing provision through introduction of models such as Thrive.</p> <p>Support growth of a leadership role through development of Thrive Partnership.</p> <p>Support securing of opportunities to extend CAMHS service provision.</p> <p>Oversee quality of existing services through scrutiny of CQSG and service line reports.</p>	Ongoing
Oversee develop and improve Adult and Forensic services	<p>Encourage development of services which integrate mental and physical health, building on success of City and Hackney and TAP.</p> <p>Encourage development of services for people with personality disorder</p> <p>Agree strategy for the future of the Portman Clinic</p> <p>Oversee quality of existing services through scrutiny of CQSG and service line reports.</p>	Ongoing
Workforce Development – ensure the Trust has sufficient well trained staff to provide high quality and cost effective services	<p>Engage in a review of staffing structures, ensuring the banding of roles and levels of seniority meet service need and value for money.</p> <p>Ensure training development provision is in place to support succession planning and strategy requirements, and disseminate research findings and best practice.</p> <p>Ensure staffing concerns are listened to and an atmosphere of openness is promoted.</p> <p>Promote the aims of the 'Freedom to Speak Up' review, the Saville enquiry, and the Duty of Candour, with the aim</p>	Autumn 2015

	of encouraging a culture and staff behaviours of openness.	
Oversee the development of the Trust's role in research	Increase our role in delivery of research	Ongoing
Agree an OBC and FBC for the development of our accommodation	Make outline decisions about accommodation options Make final decisions about accommodation options.	September 2015. Spring 2016
PERFORMANCE		
Oversee significant progress in developing the scale and effectiveness of the Trust's Training and Education activities.	Set and monitor targets for growth of student numbers and income. Set plan to increase the national reach of the Trust's education and training work including a robust Regional partnership strategy. Set priorities and targets for new course development. Agree proposals to improve effectiveness and efficiency of the Trust's delivery operations for training and education processes, including marketing, recruitment and technology enhanced learning. Hold Training and Education Programme Board to account for operational delivery of training and education activities.	Ongoing
Encourage a step change in our organisational effectiveness and performance	Oversee effectiveness implementation of Care Notes. Promote the better use of data across the organisation to manage performance and support service development. Support attempts to raise the profile of the organisation and its work including the project with Century Films. Work to ensure engagement with staff and to develop leadership across Trust. Ensure the Trust maintains a green rating from Monitor on Governance.	Ongoing
Oversee the Trust's financial performance and ensure all key financial duties are met.	Oversee delivery of agreed budget for 2015/6. Oversee plans for development of balanced budget for 2016/7 and agreement of medium term financial strategy. Ensure all required financial duties are met	Ongoing

	Maintain a Continuity of Service risk rating of 3 or above	
QUALITY		
Oversee the quality of the Trust's activities.	<p>Oversee Trust's preparation for CQC inspection</p> <p>Encourage staff to raise concerns.</p> <p>Support plans to ensure voice of lived experience and patients more mainstream</p> <p>Challenge the organisation in relation to the contribution it makes to improve the mental health of excluded and vulnerable communities.</p> <p>Hold CQSG to account in its oversight of quality in the organisation.</p> <p>Hold the Training and Education Programme Board to account for quality in T&E, and for preparation for the 2016 QAA visit.</p> <p>Hold all board level committees to account, including Audit, Training and Education, Strategic and Commercial.</p>	Ongoing
GOVERNANCE		
Ensure the BoD supports the recruitment and induction of the new Chair and Governors	<p>Support the CoG led appointment of a new Chair</p> <p>Facilitate an appropriate induction for the new Chair</p> <p>Support elections of new Governors, facilitate induction for them and use joint meetings to develop relationship between board and council.</p>	<p>Summer 2015</p> <p>Autumn 2015</p> <p>Autumn 2015.</p>
Recruit for NED in Spring 2016	Support Governors in recruitment for a new NED in Spring 2016, with a focus on finance/business experience	Spring 2016

Paul Jenkins, CEO
Angela Greatley, Chair
June 2015

Board of Directors : July 2015

Item : 14

Title : Board Governance Review Report

Purpose:

This report presents the findings of the internal review of the Board and Governance, conducted by the Governance Manager, Jonathan McKee.

A draft version of this report was reviewed by the Directors' Conference in June at which it was agreed that the recommendations would be adopted and addressed as part of the Trust's strategic review.

We recommend that:

- the Board accept the recommendations for improvement, and conclude the review.
- the Board agree that as this review of Governance has been rigorous and found no significant problems there is no immediate need to commission a major external review.
- That in 2016/17, after conducting our regular required annual review of the Board, the Board should revisit the question of whether a further review of Governance is required, and if required, whether it should be done internally or externally.

This report focuses on the following areas:

- Risk
- Governance

For : Approval

From : Paul Jenkins, Chief Executive

Board Governance Review Report

Introduction

This report presents the findings of a self-assessment of Board Governance at the Tavistock and Portman NHS Foundation Trust.

Background

Monitor sets out its expectation that trusts carry out a review in the Risk Assessment Framework and the Code of Governance every three years, because...

- 1) ...there is less money in the health economy and funding and commissioning models will change
- 2) ...boards should make their decisions within the context of sound governance and good data
- 3) ...25% of trusts have been the subject of regulatory action since 2008
- 4) ...regular reviews provide some assurance that governance systems and structures are fit for purpose

The Trust had a history and culture of meeting external quality and financial expectations, and this approach remains strong. The Trust has taken its duty to be proactive in areas of scrutiny and governance (eg, scheduling reviews of terms of reference, policies, and commissioning internal and external audits, and applying to become an FT in 2006).

For consistency, the definitions used by Monitor have been used:-

Board governance: being effective, generating confidence with stakeholders, ensuring data on performance are robust.

Board role: set strategy; lead; oversee performance, be accountable.

The review has been undertaken against ten questions suggested by Monitor as the basis for assessing good governance; these are:

- Does the board have a credible strategy to provide high quality, sustainable services to patients and is there a robust plan to deliver?
- Is the board sufficiently aware of potential risks to the quality, sustainability and delivery of current and future services?
- Does the Board have the skills and capability to lead?
- Does the Board shape an open, transparent and quality-focussed culture?

- Does the Board support continuous learning and development across the organisation?
- Are there clear roles and accountabilities in relation to Board governance (including quality governance?)
- Are there clearly defined, well understood, processes for escalating and resolving issues and managing performance?
- Does the Board actively engage patients, staff, governors, and others on quality, operational, and financial performance?
- Is appropriate information on organisational and operational performance being analysed and challenged?
- Is the Board assured of the robustness of information

On considering the findings, the Board should be in a position to either:

- decide whether the self-assessment is a fair and comprehensive expression of the current state of the Trust; or
- decide whether further assessment is indicated.

Method

The Board agreed to set the scope as set out above, exploring the ten questions and using the evidence gathered by having:-

- invited the Chair, the SID, the CEO, Deputy Chair of the Trust, and the Vice Chair of the Council of Governors to give their views in separate semi-structured interviews
- reviewed the list of subjects the Board and its committees discussed in 2014
- reflected on the process observed at a Board meeting (including part 2)
- reviewed standard annual governance activities undertaken as business as usual
- reviewed additional governance activity and reviews from the last few years
- reviewed the composition of the Board, committee structure, and how this compares with elsewhere

The evidence is referenced in appendix 1, the collection was tailored to the Trust. Where evidence has been deemed sufficient and does not fit the guidance it has been accepted for what it is –to do otherwise generates a ‘tick-box’ approach, and given the various regulators propensity for shifting the requirements, the Board is invited to agree that that would not provide good assurance.

The review was facilitated by Jonathan McKee, the Trusts’ Governance Manager in early 2015.

Findings

The findings are discussed here; rag ratings against each of the questions with examples of supporting evidence are listed in appendix 1. A full list of recommendations is given at Appendix 2.

Summary assessment

Overall, the Trust's governance structure and systems are holding up well to the challenges that the Trust faces.

The Board works hard to complete its work and this is demonstrated by good outcomes in the Trust's clinical and education quality, finances, and reputation. The Board should, however, note a number of areas where its performance is relatively weaker, or where action may be required to respond to future challenges and pressures. To address this, recommendations are made to improve and strengthen current practice including:

- strengthening mechanisms for translating Board strategy into operational plans and objectives
- taking the opportunity of the next NED recruitment to increase the representation of individuals with a finance/commercial background, in order to support succession planning
- better publicising Board meetings and strengthening further the transparency of discussions and decision making
- establishing a formal process for clarifying and reviewing committee structures
- giving greater urgency to projects to improve the accessibility and quality of data.

These issues were, in general, already known to Board members and the suggested recommendations can build, in many cases, on a number of initiatives which were already in train.

Looking at the specific criteria for review set out by Monitor the analysis was as follows:

a) Is there a credible strategy and plan to deliver it?

Strengths

The Trust appears to have a credible and realistic strategy. Good efforts have been made to consult stakeholders through the Council of Governors and it seemed to take into account the economic and political realities of the health economy at the time it was written. However, the strategy (reasonably) assumes a steady-state, albeit with well-known financial challenges. There was evidence that people are worried about the effect external pressures might have: these were expressed in terms of abrupt adverse changes in commissioning activity; and the effects changes in the structure of other organisations might have on the Trust. Notwithstanding these issues, the strategy appears credible and has stood the test of time.

Areas for improvement

There was less clarity on the plan to deliver the strategy and on how the Trust strategy drove day to day operational priorities and decision making. Board members questioned felt that reports to the Board did make links to the strategy although specific references in papers were harder to find. Some respondents highlighted a perception of a gap between high-level strategy and what staff understood and did at team level. There is an established process for setting Board objectives and linking these to the objectives of senior executives and NEDS.

The process is, however, less clear as to how these flow into the objectives of teams and individuals across the organisation; a number of initiatives are already in hand to address this.

A new Leadership Conference has been established, in which a range of senior staff join directors discuss strategic objectives and challenges. This seems to have been well-received.

The Chief Executive is launching a process to develop a more detailed two-year strategy, which will result in the addition of more detail in the document and set out how it would be achieved. This is due to be agreed by the Board of Directors, following consultation with key stakeholders, at the July meeting of the Board. It is strongly recommended that, in developing this strategy, attention is given to agreeing a system for regular feedback to the Board and its committees on progress against key objectives and for ensuring that Trust wide objectives flow down formally into team and individual objectives.

b) Does the Board understand and address the risks to realising its strategy?

Strengths

The Board appears to have a strong understanding of the risks facing the organisation, in particular as a result of the wider challenges relating to NHS funding. Potential scenarios through which they might be played out locally were voiced eloquently by those interviewed during this review and were reflected in the Trust's strategy.

There was evidence that the Trust was engaging externally with key stakeholders and building partnerships which might help mitigate those risks. It had also made a strategic investment in marketing and communication expertise with the aim of strengthening its external reputation and promoting the value of its work.

The Board has recently reviewed and improved its management of the Board Assurance Framework with support from the Trust's Auditors.

Areas for improvement

The Board Assurance Framework, while reflecting short term risks well, offers limited scope for giving guidance on longer term funding and sustainability risks, should external forces press for such a change. The potential loss or diminution of the education and training contract, in particular, is recognised as a substantial risk. It is important to be clearer about the Trust's readiness to respond to any sudden and/or significant shortfall in clinical or education funding.

The Board had agreed that the format of the Board Assurance Framework would change, and that as part of this development of the two year strategy the opportunity is taken to fully integrate organisational strategy and risk management, including a clear statement on the Board's appetite for risk. The Board expressed a wish to see strategic risks considered in programme and service line reports.

c) Does the board have the right skills and capability to lead?

Strengths

The Board has broad range of skills with individuals drawn from a wide range of backgrounds. Clinical representation on the Board is strong both amongst executive and non-executive members and the opportunity has been taken, in recent recruitment, to strengthen expertise in relation to training and education and communications.

Areas for improvement

There is no reason to doubt the overall financial competence and skills of the Board but it was noted that that formal professional financial expertise is limited to two individuals: the Finance Director and the Chair of the Audit Committee. There is recognition that, as part of succession planning, this should be addressed and that Board might also benefit from the recruitment of an individual with an explicitly commercial background. It is strongly recommended that this addressed in the next round of NED recruitment.

While the Trust has made some progress in securing greater diversity in the membership of the Board and senior management (in particular in respect of gender), it is recognised that this needs to continue to be a priority.

d) Is the Board open, transparent, and quality focussed?

Strengths

From attending a meeting of the Board there was a clear impression of a good collective approach to the business of the Board, with neither executive nor non-executive 'agendas' or divisions apparent. A member of the Council of Governors routinely attends the meetings, including Part2, and writers of papers also attended for specific parts. The regular inclusion of a Patient Story, where the Board hears from a patient or carer in person or through video or other means, about their experiences of using services at the Trust, has been a very important addition

to the Board's agenda. This could be further strengthened by aligning the story with the regular service line report presented at the Board.

The Chair and Chief Executive produce a summary of key issues discussed at each Board meeting, which is sent to all members of staff shortly after each meeting.

Areas for improvement

It is recommended that greater effort is made to publicise meetings of the Board and to encourage members of the public, staff and stakeholders to attend (it was noted that such attendance has declined from a few years ago when, regularly, a small number of people would attend, including members of the public). This should include publicising dates of meetings in the members' newsletter, promoting meetings on the Trust website, and reminding staff via email. Attending for part of the Board meeting could be used as a training and development opportunity for staff as part of succession planning.

Though a good venue for Board discussion acoustically, there are issues with the accessibility of the Board room (for instance as currently configured it would be difficult to accommodate a wheelchair user who wished to attend). It is recommended that the Board should consider moving meetings to the Lecture Theatre which would provide a more accessible venue.

In the light of efforts to secure stronger outside attendance it is recommended that the Board agenda should remind prospective observers of the opportunity to ask questions.

Staff could be invited to attend meetings to give a 'staff story' much in the same way patients were invited to do, though probably as an alternative rather than in addition.

Informal summaries used for staff on the Board meetings could be used on the Trust website in the news section. It would be useful to explore with stakeholders what appetite there is to use more modern media to disseminate such information.

It is recommended that the Board should consider whether it has the right balance between the number of formal Board meetings and informal strategic sessions.

e) Does the Board support learning and development?

Strengths

This is an area of strength for the Trust with a high level of compliance with mandatory training and 97% of staff in the last year having submitted a PDP. There is evidence for learning at the CQSG, and of innovation in the new services that the Trust has been commissioned to provide.

Areas for improvement

While the overall commitment to training and development for Trust staff is strong there is a case that the Board should consider for how the focus of this could be extended beyond mandatory training to include broader learning and development objectives. The introduction of a thrice yearly Leadership Conference for all with a focus on review and development is a very positive move.

The Trust has been developing a strategy for research. As part of this, the Board may wish to consider the case for creating a separate governance vehicle to oversee this area of work, which would include internal evaluation and audit.

f) Are there clear roles and are there clear lines of accountability?

Strengths

The Board has a good overall system of accountability and while performing well as a unitary Board has a good understanding of the difference between executive and non-executive roles.

The CQSG and Audit committees seem to be well run. The CQSG is not chaired by a NED, which is the most common approach nowadays, but this has been considered and good reasons for this were noted. In 2011, the Board commissioned a substantive review of the discharge of the CQSG's terms of reference for 2015, and the findings have been addressed. The fact that it did this indicates the good practice in the approach to governance.

The Audit Committee considers all financial performance matters and elements of corporate governance too. As this committee remains focussed, and given the absence of any major concerns, there has been no need for it to commission substantive pieces of work in addition to normal activity. It is noted that in some areas, innovative approaches to internal audits came from management (eg asking the Information Commissioner to undertake a free data protection audit) and provided a richer source of evidence.

All Board committees' performance is reviewed annually and the reviews considered by the Board; on the whole these were found to be satisfactory and no substantive changes were indicated (excepting the CQSG, which was reviewed substantively as previously scheduled).

Areas for improvement

The Board has recognised that historically there has been relatively less governance focus on training and education work of the Trust. To address this, the Board agreed the establishment in September 2014 of a Training and Education Programme Board which meets monthly and is chaired by the Chief Executive. The Programme Board includes both Executive and Non-Executive members of the Board and a report on its work is a standard item on the main Board agenda. It has a focus on driving the transformation programme for training and education agreed by the Board but also serves to provide a forum for wider senior oversight of this area of work.

It is accepted that the Board has considered this issue and that a Programme Board provides, at present, the most effective means of securing high level management and governance focus on

this aspect of the Trust's business. It is recommended that this is kept under review and that the Board should consider, in due course, establishing an equivalent to CQSG to oversee quality and performance issues in respect of training and education.

While in general there is evidence that the major IDCR and relocation projects have been well managed, there appeared to be some differences in the visibility of projects and inconsistency in arrangements for monitoring projects' progress more generally. It is recommended that the Board should consider reviewing its approach to the oversight of projects and introducing a common framework for reporting progress. This would facilitate the Board's overall oversight of these areas of work.

While accepting that, given the Trust's size and range of activities, it may be appropriate that there are different governance arrangements for different strands of work it is recommended that it would be helpful if a single document was produced which described these arrangements and that the Board committed to a formal review of arrangements on a biannual basis. Terms of Reference for different groups should be reviewed to ensure, as far as possible, the use of consistent terminology.

g) Processes for managing performance

Strengths

In managing its own performance, there is much evidence that individually and collectively, members and the Board subject themselves to many forms of scrutiny; there appears to be a culture of curiosity and constructive challenge, this was evident at the meeting and in interviews.

The Board's key role in relation to performance is to receive assurance that its strategic objectives are going to be delivered, or that an action plan is in place to mitigate any risks that one or more objectives might not be met. In some areas the CQSG enabled challenges to be addressed with management put in place to support leadership, eg mandatory training, then the Board has been able to receive assurance of progress being made to attain standards, thus raising the standards. In other areas, such as clinical data management, progress has been slower.

Weaknesses

As previously highlighted in respect of Board strategy there would be benefits in strengthening the link between strategy and organisational plans and objectives. This should be a priority in respect of the development of the two year strategy with a clear process for linking Board level objectives with those of teams and individuals.

It was sometimes difficult to understand how mid-year performance reports had enabled the Trust to meet its strategic plan. Reports tended to be based on monthly performance outcomes rather than Board objectives. Clear reference to strategic objectives, and risks thereto, would be helpful. It is also recommended that all key project related risks, as well as being managed within project structures, are also routinely included in the Trust's overall risk register.

h) Does the Board actively engage staff, governors, and stakeholders?

Strengths

The Trust has a well engaged Council of Governors which plays an active role in the business of the Trust, including representation on key committees such as CQSG, and in establishing a programme of engagement with members and external organisations. The Trust has also made significant progress in developing its PPI function to enable this work to happen.

Areas for improvement

There is a shared view that more could be done to develop and further engage the Trust's membership although given the nature of the Trust and the very different constituencies it serves it is not a straightforward task to identify how this might best be achieved.

The Board has already identified that the combination of public engagement and patient involvement activities has served the Trust well but may no longer be fit for purpose and has already started to explore how this will be handled differently with a focus on trying to integrate its patient involvement activities as mainstream clinical activity.

Not all new Board members had attended a Council of Governors meeting by the time of this review, and felt that this left gaps in their knowledge and understanding.

i) Is information on performance challenged?

Strengths

There is a generally strong level of scrutiny of performance. CQSG, in particular, which has representation from both NEDS and Governors, provides an effective addition level of scrutiny of performance in relation to quality.

Areas for improvement

In some areas, a view that the Trust's business is different from other organisations can impede effort to benchmark performance. The Trust has recently joined the NHS Benchmarking Club. While recognising this will be of most relevance in the area of children and young people's work this is an important step forward and it is recommended that the Board consider ways in which benchmarking data can be used to strengthen the scrutiny of performance.

j) Is information robust?

Strengths

Good progress has been made from a low starting point in the use of clinical data to inform decision making (there was much evidence that this had been explored as noted in the preparation of the quality report, and in meetings of the CQSG). The Board had explored the difference between assurance and reassurance and was able to structure discussion on qualitative and quantitative evidence, or recognise where more data would be useful.

The Trust has undertaken a lot of work in recent years to develop the quality of clinical performance data and considerable progress has been made.

The Board has pressed for better outcome monitoring data, and has been blunt in its assessment of progress and has not been shy in challenging certain units which have fallen short of expectations. Executive management has become more assertive in challenging its own performance, and this was evidenced in the MT's challenge to reports for the CQSG where conclusions raised issues. This in turn supported better data reporting through to the Board.

Areas for improvement

Despite recent progress, there is more that could be done to improve the accessibility and analysis of data, which needs to influence strategy and planning in a richer way. This relates both to clinical work and to training and education. A major historic weakness has been the limited use of an electronic patient record system. This is being addressed with the introduction in the summer of the *CareNotes*. Ensuring that the introduction of the system is harnessed effectively to improve the accessibility of information to inform planning and service improvement should be a major priority for the Board.

It is also important that greater priority is given to improving the accessibility and quality of data in respect of training and education. The procurement of a new IT system for the Department of Education and Training, which has commenced, is crucial to this.

Whilst this is potentially an area of strength through several individuals, there was little evidence that the concerns over data management, expressed by several parties, were being addressed in a coherent manner with leadership firmly vested in one person. This was addressed by the appointment of an executive responsible for clinical quality, and the appointment of a new Dean also adds to the possibility that the Trust will be in a position to harness its resources in a more cohesive way. It is recommended that the Board commissions an overall informatics strategy with a clear timetable for how a range of initiatives will contribute to strengthening the data available in the Trust for planning and performance management.

Conclusion

Overall, the Trust's governance structure and systems are holding up well to the challenges that the Trust faces. The Board should, however, note a number of areas where performance is relatively weaker or where action may be required to respond to new and different challenges and pressures. To respond to this recommendations are made in the report to improve and strengthen current practice including:

- reviewing and strengthening mechanisms for translating Board strategy into operational plans and objectives
- working with the Governors to take the opportunity of the next NED recruitment to address issues of succession planning by increasing the representation of individuals with a finance/commercial background.
- Better publicising Board meetings and encouraging attendance from stakeholders.
- establishing a formal process for clarifying and reviewing committee structures
- giving greater urgency to programmes to improve the accessibility and quality of data.

Does the Board need further assessment?

The key phase in Monitor's guidance is "help any reviewer to assess..." so with this in mind, a comprehensive review, which was light-touch, but would put any internal or external reader in possession of the pertinent facts concerning the Trust's governance was undertaken. At the Trust, there is much evidence to support good governance, and where there are gaps, good evidence to show that the gaps are understood and are being addressed. This is not to say there are no outstanding issues, but the few that were found can be considered and addressed without disruption to the work of the Trust.

If the context changes, or there is significant change in the external political or economic environment, the Board can always re-visit its decision.

On conclusion of the review, the Board is invited to consider the following options for concluding the review

1. Accept the recommendations for improvement then conclude the review
2. Accept the recommendations for improvement but repeat once the various changes to the Board have taken effect
3. Accept the recommendations for improvement then undertake the exercise afresh annually or biannually
4. Accept the recommendations for improvement but commission a major review from an external assessor

Appendix 1: Summary of evidence and ratings

The evidence is summarised and presented in the headings based on Monitor's format; where evidence is sound not every detail is captured nor repeated. The ratings have been given as follows:-

Green	Good performance (perhaps with minor suggestions for development)
Yellow	Partially meets standard; improvements are recommended
Amber	Performance is at risk of falling below acceptable standards due to poor governance controls; improvement is required
Red	Does not meet expectations: prompt improvement is necessary to meet standard

	Question	Priority rating	How is the Board assured – evidence for assessment ¹
1.	Does the board have a credible strategy to provide high quality, sustainable services to patients and is there a robust plan to deliver?	Green	<ul style="list-style-type: none"> The Board attends a Council of Governors meeting to explore strategic choices prior to making final decisions The Board uses Monitor's planning tool to structure its plan Staff are briefed by the CEO regularly, and in particular, following Board meetings. Staff are represented on the Council of Governors and the JSCG. The CQC has provided some impetus to refining systematic engagement; this is still being worked-through as set out in the minutes of the Board and the CQSG. The Board has raised standards and is actively engaged in the review of performance against standards
2.	Is the board sufficiently aware of potential risks to the quality, sustainability and delivery of current and future services?	Green	<ul style="list-style-type: none"> The Board is aware of political pressures to merge organisations for reasons of economic convenience; the Trust may face pressures of this sort, but this risk is similar or less than for competitor Trusts. The board tracks performance through reporting

¹

In each case the evidence might be qualitative, quantitative, or both.

			<ul style="list-style-type: none"> • The Board has a risk management system in place and the mechanisms for checking are robust. • The Board receives regular assurance that risk mitigation, action plans, and external requirements are addressed. • Commissioners are engaged by senior management and in membership of the Council of Governors
3.	Does the Board have the skills and capability to lead?		<ul style="list-style-type: none"> • The Trust has developed experience in appointing the Chair and non-executive directors, and has considered skills gaps in the past when appointing new NEDs in order to achieve a good mix • The Board understands where it needs more experience and governors will be asked to address gaps in forthcoming recruitment rounds with a particular focus on formal financial/commercial skills.
4.	Does the Board shape an open, transparent and quality-focussed culture?		<ul style="list-style-type: none"> • Governors articulate their concerns and interests; there is an informal arrangement whereby a governor attends the Board, and vice versa. • Governors serve on a range of Trust committees and project Boards • Users are increasingly found on Trust bodies and working groups • Better data will facilitate transparency and quality development
5.	Does the Board support continuous learning and development across the organisation?		<ul style="list-style-type: none"> • The Board undertakes annual training on risk, and risk scenarios. • The Board notes the ongoing engagement with staff, patients, and stakeholders through formal processes, and takes views into account • There is a long-running cycle considering risk, which was considered appropriately at all levels (though not presented consistently for projects)
6.	Are there clear roles and accountabilities in relation to Board governance		<ul style="list-style-type: none"> • There is a culture of multi-disciplinary governance with no one profession dominating

	(including quality governance?)		<ul style="list-style-type: none"> Committee, working group, project board, and programme board functions are not consistently applied, which results in lack of clarity about task
7.	Are there clearly defined, well understood, processes for escalating and resolving issues and managing performance?		<ul style="list-style-type: none"> The Board receives reports from senior staff who attend the meeting to be questioned The CQSG and Audit committees provide good assurance on a range of clinical quality, financial, and general governance matters.
8.	Does the Board actively engage patients, staff, governors, and others on quality, operational, and financial performance?		<ul style="list-style-type: none"> The Council of Governors is well-briefed by the executive The Board receives reports on clinical outcomes and patient experience; a new approach to reporting through the CQSG will reconcile these two data streams The Trust gets good feedback from staff in the annual staff survey
9.	Is appropriate information on organisational and operational performance being analysed and challenged?		<ul style="list-style-type: none"> There is a proper understanding of the importance of financial stewardship as part of overall governance Some work streams of the CQSG considered related risks at every meeting; there was limited evidence that this happened elsewhere so consistently, though the risk register is reviewed quarterly by all senior staff.
10.	Is the Board assured of the robustness of information?		<ul style="list-style-type: none"> The Board has a good overview of quality metrics and what needs to be done to improve performance in this area Audits were wide ranging and challenging, if few in number. Where a member of senior staff wanted additional audit and where this had not been budgeted for, funds were found to make it happen. More audits would enable to Trust to benchmark its performance against other providers

Appendix 2 : Summary of Recommendations

1. It is strongly recommended that, in developing the Trust's new two year strategy, attention is given to agreeing a system for regular feedback to the Board and its committees on progress against key objectives and for ensuring that Trust wide objectives flow down formally into team and individual objectives.
2. As part of development of the two year strategy, the opportunity is taken to fully integrate organisational strategy and risk management, including a clear statement on the Board's appetite for risk.
3. It is strongly recommended that the recruitment of an individual with an explicitly commercial background be addressed in the next round of NED recruitment.
4. It is recommended that greater effort is made to publicise meetings of the Board and to encourage members of the public, staff, and stakeholders to attend; and that new media are explored to extend dissemination of information
5. It is recommended that the Board agenda should remind prospective observers of the opportunity to ask questions.
6. It is recommended that the Board should consider whether it has the right balance between the number of formal Board meetings and informal strategic sessions.
7. It is recommended that the Board consider, in due course, establishing an equivalent to CQSG to oversee quality and performance issues in respect of training and education.
8. It is recommended that the Board should consider reviewing its approach to the oversight of projects and introducing a common framework for reporting progress, which would include addressing project risks to strategic objectives
9. It is recommended that the Board consider ways in which benchmarking data can be used to strengthen the scrutiny of performance.
10. It is recommended that the Board commissions an overall informatics strategy with a clear timetable for how a range of initiatives will contribute to strengthening the data available in the Trust for planning and performance management.

Board of Directors : July 2015

Item : 15

Title : Next steps for patient involvement in the Trust

Purpose:

This paper updates the Board of Directors on the progress in reviewing the direction of travel for patient involvement work in the Trust. A fuller report and strategy will be produced for the September Board.

This report focuses on the following areas:

(delete where not applicable)

- Quality
- Patient / User Experience

For : Discussion

From : Paul Jenkins Chief Executive

Next steps for patient involvement in the Trust

1. Introduction

- 1.1 Over the last couple of years the Trust has been developing its work in the area of patient involvement. This paper covers some reflections on possible next steps which build on what has already been achieved but look to increase our ambition in the light of the direction set in the "Shaping our Future" . It also takes account of the outcome of a short review of our work undertaken by David Gilbert, a respected patient leader and involvement consultant. David's report is attached at **Annex A**.
- 1.2 In the light of feedback from the Board of Directors it is proposed bringing a fuller report and strategy paper to the September Board alongside the Medium Term Strategy.

2. Current position

- 2.1 David's review involved interviews with members of the PPI team and a number of other key stakeholders. It also included a PPI event on 17th March with a very successful "market stall" presentation of a range of current involvement initiatives in different services.
- 2.2 Reflecting on this work, I have drawn, with others, a number of outline conclusions about our current position. These are:
 - While coming to this agenda relatively late we have made some significant progress. Some of the examples of involvement work highlighted at the PPI event were very impressive. We have an excellent and highly motivated central team.
 - Momentum has been increasing with initiatives such as involving patients on interview panels and patient stories visibly highlighting the benefits of involvement.
 - The nature of our patient population makes recruitment for involvement activities more difficult than it would be other Trusts.
 - Progress is patchy across the Trust. The best examples of involvement are probably in children and young peoples' services and, as yet, we lack a system of accountability for involvement issues within service lines. There is some level of ambivalence in some therapeutic traditions to involvement.

- At the same time we lack momentum and a systematic approach to incorporating lived experience in our training and education work.
- Our Governance arrangements for PPI may need to be reviewed.
- It may be the right to think again about terminology and whether there is a value, in particular in this Trust which does not have a specific population base in the same way as other organisations, in separating work on patient involvement from wider work to engage local communities and other stakeholders.

3. Potential way forward

3.1 Some thought has been given to how we can set a new ambition and take our involvement to the next level. A couple of areas of proposed:

- We invest in building a community of people with lived experience with connections to organisation. This could draw from the model of Recovery Colleges, build on existing initiatives such as the artist in residence and help us make connections to resources in our community. This would help us increase the number of people with lived experience who might be able to involved in our work and, at the same time, support them in developing their skills.
- We make involvement activities mainstream with all service lines accountable for a programme of activities to support involvement of people with lived experience in their work.
- We should reinforce this by building involvement competencies into all relevant job descriptions and extending current initiatives such as the involvement of patients on interview panels and the use of patient stories.
- The Training and Education Programme Board should commission a plan on how we can develop the involvement of people with lived experience as an integral part of our training and education activities.
- In support of this and while retaining a small number of central functions we should refocus the work of the central team on work to facilitate involvement activities by mainstream clinical teams.
- We should stand down the PPI Committee and focus governance and accountability through CQSG and the Board of Directors. At the same time we may need to keep a channel through which to engage with external bodies such as Healthwatch.

- We should consider rebranding our involvement work and making a distinction between involvement work and wider stakeholder and public engagement.

3.2 A fuller plan for this work will be developed for the September Board of Directors meeting.

4. Recommendations

4.1 The Board of Directors is invited to note developments in reviewing our work on patient involvement and offer comments on the proposed direction of travel.

Paul Jenkins
Chief Executive
July 2015

ANNEX A



Tavistock and Portman NHS Foundation Trust Patient and Public Involvement (PPI) Background Paper

Background

The Trust wants to develop the vision for, and refresh, its strategy for its Patient and Public Involvement (PPI) work. This short paper provides some reflections as to how it might do this. These bring together key messages from discussions with key PPI Stakeholders, attendance at the PPI Committee and PPI Team meetings and from the March 17th learning event.

There is much good work to build on, a lot of enthusiasm and expertise, and plenty of good practice examples. At the same time, there are significant challenges. This paper is not intended to portray a comprehensive picture of the Trust's PPI work or provide a systematic framework for the future. Instead they offer one (personal and professional) perspective in order to outline key elements for embedding PPI within the Trust.

1. Developing the strategy

Be clear about what PPI means - There are different interpretations within the Trust (evident during conversations and the learning event) about the meaning and purpose of PPI. Conceptually, there is a need build *shared understanding* of words and meanings – for example, to clarify that involvement can mean an individuals' involvement in their own care (this is one element of the 'patient experience') or be about people's collective involvement in the planning, design and delivery of services (governance or improvement).

Clarify scope and ambition - There is a need to develop *common purpose*. Is the strategy more about working with patients, carers and communities to deliver high quality services (to provide assurance) and/or about improvement (and therefore be geared more to learning for improvement)? It might also be about transforming delivery (changing the way services are provided or generating new ways to meet unmet need). We also heard other ideas, such as developing the Trust's partnerships in the community or providing spaces for health and wellbeing and for patients to support each other.

Define success - Several people have said there is a need to think through more carefully what success might mean over the next, say, five years. In turn, this means being more clear about the vision and direction of the Trust's PPI work. This issue links with developing monitoring and performance management systems and PPI metrics. Though this work did not go into detail on this aspect, DG's work on 'the seven benefits of patient engagement' may aid this thinking (see futurepatientblog.com).

Rebranding - There may be merit in 'reframing PPI'. People said that the traditional notion of PPI may be stale, especially as we move into a digital and Social Media age. Having a clear meaningful strapline (e.g. 'patients as partners for improvement?') and more user-friendly messages about the aims of the work may be useful for patients and staff alike. The event, for example, highlighted the need for a simple slogan to be associated with involvement – 'Help us to help the service' for example.

Leadership and senior team commitment - There might need to be consideration of the roles and responsibilities of the senior management team – what can they do to ensure leadership of this work? How might they model the behaviours and commitments necessary? What can they put in place to do this? But this is more than 'top-level' professional leadership – there may be a need to revisit the sorts of behaviours and cultures necessary throughout the Trust to ensure that 'better relationships' with patients and communities are reflected (see section on 'building capacity of staff').

2. Making sense and making use of data

More effective use of data - There are many examples of good PPI practice across teams and services, and seemingly various methods to gather feedback. But there are some indications that data is not being systematically gathered, analysed and used to inform improvements (at individual, team and corporate level). This may be about communication outwards – that the Trust has not told people (patients, clinicians) what it has done, or that the learning is not being transformed into improvement. There may need to be some mapping or process planning work around what happens to data that is collected and the systems for feeding that into service and quality improvement work. The trust also needs to do more to gather and use data that comes via informal routes (non-clinical staff, everyday conversations between staff and patients/clients, social media and online platforms).

Monitoring and performance management - In order to make PPI 'stick' some said that there need to be clearer and firmer reporting requirements and accountability arrangements. Early suggestions include making PPI part of all internal reports to senior management and/or the Board. How to do this without it being a tick-box exercise, or one that leads to undue burdens on teams seems a significant concerns and is an issue that could be looked at by the Board. During conversations, I also heard about exciting work being done that seeks to bring together clinical outcomes

and patient experience data. This needs to be allied with work to develop relationships with commissioners (around measures of success and incentivisation, building better relationships and joint involvement work).

Demonstrate benefit and impact of PPI - The learning event began the process of articulating the benefits of PPI. Preparation for the CQC inspection process has also helped. Being clear about benefits will be crucial to assuage the concerns of clinicians, demonstrate value for money and making sure PPI is at the core of business and corporate thinking. A more detailed stocktake and ongoing mapping of PPI work, including what's working (in terms of stories of benefits or change) and about the learning (about what helps and gets in the way) should be carried out.

3. Communications

Sharing learning - The event revealed a wide variety of good practice examples, and people were impressed by progress being made and some of the benefits being delivered. It is clear from the event that there is enthusiasm to share learning and have more 'thinking space'. There seemed a genuine willingness to work through some of the challenges to patients/users working together with professionals and staff. This work does seem to aid staff morale and provide a focus on putting the needs of patients at the heart of what the Trust does. More activities to raise awareness of PPI activities should be undertaken.

Raising awareness – Several people have pointed out that the communications team could play a leading role in raising awareness of the good work going on, using newsletters and corporate communications work to provide information about PPI opportunities and demonstrating the benefits of the work. Raising awareness of PPI work to clients (i.e. during treatment) was another idea that came up during the event. Piggy-backing on other events (e.g. World Mental Health Day) seem sensible and worthwhile ideas.

4. Embedded model of PPI

Connection to corporate plans - There is a need to ensure that any PPI strategy is connected with corporate strategies and business plans. Below, are other elements that need to be in place in order to 'embed' or 'mainstream' PPI activities.

Balancing the work across the organisation – Some people at the event noted that more work is going on in children and young people's services than in adult services. More could and should be done in adult services. One idea that came through was to undertake a joint piece of work on PPI on 'transitions' from children to adult services. It is also acknowledged that more PPI work in education and training would be useful (see below).

Support work at different levels – It was noted at the event that some PPI work is better undertaken at team or service level (this came through particularly at the learning event), while other activities require a corporate or thematic cross-cutting approach. Any strategic approach needs to allow and support local activities, but ensure they have corporate support.

Framework and principles – The Trust should ensure that any team or corporate PPI work conforms to good PPI practice principles (such as involving people early and throughout the work, valuing people, supporting staff and patients to be involved, demonstrates and feeds back on impact, etc.). Such principles should be co-produced and provide assurance to the Board about good practice.

Embedding PPI in Teams' work – It is clear that many staff feel under extreme operational pressure and that, for some, PPI may seem an additional burden. The Trust needs to take a sensitive approach to this and to get its communication messages right. In turn, this requires further reflection on, for example, the 'must dos' – is there an expectation that PPI work is to be 'in addition' to clinical work, or part of it? Can it be built into clinical (or educational) time? There is a need for teams to consider these issues too and local leadership (via the developing network of PPI champions) will be key to this. Several people mentioned the need to 'hard-wire' PPI objectives into teams' objectives, job descriptions and personal appraisals. Some people (during the event) thought that having some sort of reflective practice (around PPI) built into corporate and team activities would also be useful.

1000s of everyday conversations - Related to the above is the idea that about the key role of 'everyday conversations' being at the heart of good PPI practice. It might not be so much about developing a PPI 'industry' but about how staff can undertake everyday conversations that can elicit ideas for improvement – this might be a role for non-clinical staff as much as clinical staff. Having 'team time' to devote to PPI - a space to review feedback – as part of, or in addition to clinical meetings is one idea that came up during the learning event.

Rethink the role of the PPI Team – The PPI Team is also stretched. It needs to balance its activities against a growing number of corporate requirements. Meanwhile, there is an awareness that PPI is not just the job of the PPI Team, or of enthusiastic, but often weary, champions. This would entail a reprioritisation of current workload to allow the team to play a more facilitative role, while taking a lead for (some) corporate projects. Resourcing and reporting requirements would need to be considered as a consequence of this. Teams might report PPI work directly through divisions to the Board, rather than via the PPI team.

5. Supporting staff

PPI training for staff – Careful thought needs to be given as to how PPI training could be developed for clinical and non-clinical staff. It might be made mandatory and/or as part of induction. Any training should not just focus on methodologies or

concepts, but cover the ‘embedded model’ along with staff roles and responsibilities. There may need to be dedicated training for PPI team leaders (if the embedded model is adopted) and informal ‘involvement champions’ (i.e. those who have led PPI activities and work showcased during the learning event).

PPI and the therapeutic model – Throughout this work, concerns were raised about how PPI work may run counter to some therapeutic models. This was covered at length during the panel session at the learning event, and it may be worthwhile to build on those discussions to provide a resource that supports PPI work. It may be useful also to undertake further research on this issue in order to better tackle professional concerns.

PPI in Education and Training – Most of the Trust’s PPI activity has been evident in clinical services. There is now an opportunity to pilot a fresh approach to PPI in training and education. Educating a ‘new generation’ of clinicians seems an area where patients can input. The Head of Patient Experience has begun working with the new Dean and with key stakeholders in the Education and Training Division. Unfortunately, in the time available, it was not possible to look more closely at this work. However, one idea would be to identify patients from the ‘people bank’ see below, to (a) draw upon their experiences as input (stories, narratives) for educational sessions (b) support some patients to help design and deliver educational content and/or curricula.

6. Support for patients and the public

Be clear about the need - There is a need to involve a wider range of people in the work, both in providing feedback about experiences and to work in partnership with professionals at a more strategic level (e.g. in improvement, training, governance level)? It might also be about developing new opportunities in the community (e.g. summer clubs) or about patients working as peers (supporting each other). Ultimately, the purpose of creating opportunities and support needs to be clear within the Trust’s vision for PPI.

Practical support – The event revealed many basic principles of engagement around making it easier for people to participate and some of these may be early priorities. These include ensuring benefits are clear, convenient timings for activities, practical support (e.g. crèche), resources and incentives (see below) and providing feedback so that people know their input is used and taken seriously.

The People Bank – The PPI Team and others in the Trust already draw upon a wide range of talented people to input into PPI activity. Now may be the time to formalise support for this work, by developing a bank of people who could be signposted to different opportunities and activities. Practical support, resources and training would be required.

7. Resources

While it is understood that there are significant cost pressures, more investment is needed in PPI. There needs to be exploration of how to fund this work and business cases developed. But in principle, the embedded model would require teams to have a pool of money from which PPI activity could be resourced. In addition, some of the ideas outlined here - The People Bank, PPI education and training activities, corporate improvement projects - also require investment. There also needs to be consideration of a refreshed payment and incentive policy for people involved in this work.

8. Corporate improvement projects

During this work, three main ideas came up about ways to improve patients' experiences – these could include PPI as part of designing and delivering solutions:

- Access and transport – Making it easier for people to come to the Trust or attend community services was mentioned by several people.
- Environment of care – Many people raised the issue of making services more welcoming with possible common spaces for staff and patients.
- Community partnership – Though there was no consensus on the content of such a project, several ideas arose that may align with a more 'outward' looking Trust focus and a desire to involve commissioners, partners and citizens. A public health focus (e.g. around health and wellbeing) might be worth considering.

David Gilbert
April 2015

Board of Directors : July 2015

Item : 16

Title : Quarterly Quality Report 2015-16 , Quarter 1: July 2015

Summary:

The report provides an update of the Key Performance Indicators (KPIs), CQUIN and Quality Indicator targets for Quarter 1, 2015-16. It has been updated to incorporate the new KPI and CQUIN targets for 2015-16 agreed with commissioners and the Quality Indicator targets selected by the Trust. The report combines the performance data reported to the Board and commissioners (CQRG) into a single report.

This report has been reviewed by the following Committee:

- **Management Team, 16th July.**

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:

- Quality
- Patient / User Experience
- Safety

For : Noting

From : Quality Standards and Reports Lead

Tavistock and Portman NHS Foundation Trust

Quarterly Quality Report for Board of Directors & CQRG

Quarter 1: July, 2015/16

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Section One: KPIs for TPFT

Quality Key Performance Indicators – KPIs rolled over from last financial year																
Target	Monitoring	Target %	Progress	% Progress for 2015/16								Actions for Next Quarter				
				Q1		Q2		Q3		Q4						
Waiting Times* Waiting time no more than 11 weeks (77 days from receipt of referral) excluding exceptions where this is outside of the Trust's control.	Quarterly	<77 days	N		%		Q1		Q2		Q3		Q4			
			2	0.5%												
DNA Adult & Forensic DNA rates: Yearly average no larger than 10%.	Quarterly	10%	7%													
Patient Satisfaction Patient Satisfaction: Target 92% or more report satisfied with the service.	Quarterly	92%	N		%		N		%		N		%			
			210	92%												
Personal Development Plan Quality and Development of staff: Target 80% of staff to have a PDP.	Quarterly	80%	99%													
Sickness and Absence Sickness and absence rates. Target: <2% green (2-6% amber, >6% red)	6 monthly	<2%	n/a this quarter													
Trust Service cancellation rates Target: <5% green (5-9% amber, >10% red)	Quarterly	<5%	2.4%													
Staff Training % of staff with up-to-date mandatory training for infection control. Target >95% green. 80-95% is amber < or = 80% red.	Annually	>95%	n/a this quarter													
DBS Checks DBS renewals - Copy of certificate submitted to trust within 1 month of renewal date	Quarterly	100%	Please see 'Enhanced DBS Checks on page 6 for further details'													

*For Quarter 1, there were 9 waiting time breaches, where patients were required to wait eleven weeks or longer for their first appointment. However, only 2 of these breaches related to factors internal to the Trust and represented 0.5% of the total number of patients who were offered a first appointment in Quarter 1.

KPIs for TPFT

Quality Key Performance Indicators																	
Target	Monitoring	Target %	Progress						% Progress for 2015/16				Actions for Next Quarter				
			Q1		Q2		Q3		Q4		Q1	Q2		Q3	Q4		
			N	%	N	%	N	%	N	%							
Explanation of Service Number and % of children who answer certainly agree that they received a clear explanation of service (ESQ)	Quarterly	75%	N	%	N	%	N	%	N	%							
			41	77%													
Care Plans																	
A - % of care plans evidencing co-production with service users	6 monthly	n/a	n/a this quarter														
B - % of care plans evidencing input from primary care (Baseline for 15/16)			n/a this quarter														

KPIs NCL Trusts

Quality Key Performance Indicators											
Target	Monitoring	Target %	Progress				% Progress for 2015/16				Actions for Next Quarter
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
% Response to Complaints* A - 90% of complaints acknowledged within 3 working days.	6 Monthly	>90%	100%								
B - 80% of complaints responded to within 25 working days.			100%								
C - Achieve a downward trajectory of number of complaints that have a concern about staff attitude by end of Quarter 3			n/a this quarter								
D - 100% of upheld complaints identify learning and improvements as a result.			100%								
E - Trends and themes of PALS concerns and complaints identified and published on a quarterly basis.			n/a this quarter								
F - Implementation of actions plan			n/a								
Complaints and Claims A - Provide quarterly complaints and claims update to include: i) no. of complaints where response is outstanding at 3 months and reasons why	Quarterly	n/a	0								
ii) Number of complaints reported to CQC			0								
iii) Numbers of complaints partially and fully upheld by Parliamentary Ombudsman			0								
iv) Number of re-opened complaints.			0								
v) all legal claims acknowledged within 14 days			0								

*In Q1 there were 7 complaints received by the Trust.

KPIs NCL Trusts

Quality Key Performance Indicators												
Target	Monitoring	Target %	Progress				% Progress for 2015/16				Actions for Next Quarter	
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4		
B - Provide bi-annual complaints and claims lessons learnt report with: i) themes of lessons learnt including breakdown of clinical policy/clinical pathway areas where complaints are made ii) detail of actions undertaken as a result of complaints	Quarterly	n/a	n/a this quarter									
			n/a this quarter									
			April 15	May 15	June 15							
Serious Incidents Improvement trajectory agreed for the following: A- % of Serious Incidents (SI) submitted within the designated timescale	Monthly		0	0	0	0						
B - Where SI reports are returned incomplete, % returned complete within 10 working days.	Quarterly	n/a	0									
C - Evidence of implementation of action plans	6 Monthly Audit		n/a this quarter									
D - Organisational learning identified and actions embedded as a result in 100% of SIs.	Q4		n/a									
Safeguarding Completion and submission of the NCL Safeguarding Children and Adult Metrics Return	Quarterly	n/a	Achieved									
Female Genital Mutilation* A - To include FGM as part of mandatory safeguarding training levels 1, 2 & 3, 80% of staff will be trained in safeguarding B - Safeguarding alerts raised and number counted within service in accordance with NICE guidance	Quarterly	80%	L1: n/a	L1: n/a	L1: n/a	L1: n/a						
			L2: 98%	L2:	L2:	L2:						
			L3: 94%	L3:	L3:	L3:						
		n/a	0									

* At levels 2 & 3 of safeguarding training, clinical staff are trained at as basic level of awareness for FGM, as considered appropriate for mental health staff.

Quality Key Performance Indicators											
Target	Monitoring	Target %	Progress				% Progress for 2015/16				Actions for Next Quarter
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Compliance Compliance with relevant standards of the Mental Capacity Act are completed and DOL applications and outcomes. *	Quarterly	n/a	Yes								
Audit of Trust Consent Policy standards To perform an audit on 20 patient notes in Q2.	Q2 Audit	n/a	n/a this quarter								
Assessment Reports Provide CCGs with a copy of all internal process and compliance assessment reports, action plans and progress updates	Quarterly	n/a	Achieved								
Clinical Audit A - Provide CCGs with copy of Trust wide audit program in Q1.	Q1 Audit	n/a	Provided in Q4 14/15								
B - Provide CCGs with bi-annual findings and recommendations of audits carried out, evidence of action plans and Board Involvement	6 Monthly Audit		n/a this quarter								
C - Provide CCGs with copies of Clinical Audit Annual report to include learning the lessons from audit, demonstrating achievement of outcomes	6 Monthly Audit		n/a this quarter								
Reporting on Guidelines Report on compliance with new relevant NICE Clinical Guidelines, Quality Standards and Technology appraisals within 3 months of publication date.	6 Monthly	n/a	n/a this quarter								
Mandatory Training** % of eligible staff are currently compliant on all of their mandatory training	Quarterly	80%	93%								
Enhanced DBS checks Enhanced DBS checks for 100% of all relevant staff including renewals every 3 years for all staff in direct contact with Adult at risk, children and patient data. To include locums, temporary staff and sub-contractors.	Quarterly	100%	98%								

*The Trust to provide eleven MCA training dates to staff over the course of 2015. However, the DOL applications and outcomes is not applicable to the TPFT.

**Please note that INSET/Safeguarding Training figures are reported on page 26.

KPIs NCL Trusts

Quality Key Performance Indicators											
Target	Monitoring	Target %	Progress				% Progress for 2015/16				% Progress for 2015/16
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Staff FFT and Annual Staff Survey To Improve trajectory from 14/15 baseline and provide organisational response to results Last year result: Fully achieved for Q1, Q2 and Q4	Quarterly	n/a	Increase of 32% compared to Q1 14/15*								
Friends and Family Test % of positive responses on the FFT	Quarterly	90%	94%								
Staff Appraisals Number of Staff Appraisals completed	Quarterly	80%	99%								
Staff Absence % Sickness Absence rate less than 2% for all staff groups	Quarterly	<2%	0.6%								
Duty of Candour A - 100% of conversations informing patients and/or family that a patient safety incident have taken place within 10 working days of the incident being reported to local risk management systems for Medium harm, Severe Harm, Death or Profound Psychological Harm categories of incidents; and an apology has been given.	Quarterly	100%	0 Incidents								
B - 100% of incident investigation reports shared within 10 working days of being signed off as complete and the incident closed by the relevant authority for Medium Harm, Severe Harm, Death or Profound Psychological Harm categories of incidents.			0 Incidents								

* Compared to Q1 2014/15, 181 more responses were received for Q1 2015/16 (an increase of 32%).

KPIs Mental Health Trusts

Quality Key Performance Indicators											
Target	Monitoring	Target %	Progress				% Progress for 2015/16				Actions for Next Quarter
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
GP satisfaction with communication received from Trusts > above 60% of GPs who respond to be satisfied with communication from MH Trust Services	Annual	>60%	To be completed in Q4				GP Survey will be undertaken				
Local participation in Suicide Prevention Trust will comply with requirements on Mental Health Trusts outlined in the National Suicide Prevention Strategy (2012)	Quarterly	n/a	Achieved								
Physical Health Care Evidence of physical health addressed across all mental health services	Annual	n/a	n/a this quarter								
Clinical Risk Assessments Annual Audit presented to CQRG	Annual Audit	n/a	n/a this quarter				Audit to be undertaken Q4				
Adherence to Crisis Concordat standards Baseline in 2015/16	Annual	n/a	n/a this quarter								
Crisis Concordat standards - Crisis plan Bi-annual Percentage of patients who have been offered a crisis plan for emergency mental health situations	6 monthly	95%	n/a this quarter								
Equality and Diversity - BME access to 'talking therapies'* Percentage BME access to 'talking therapies' (Baseline in 2015/16)	Quarterly	n/a	April 15 9%	May 15 10%	June 15 9%						
NICE guidance - Bipolar Disorder (CG185, Sept 2014) - CBT/psychological treatment Baseline in 2015/16, Proportion of patients with a diagnosis of bipolar disorder offered CBT/psychological treatment	Quarterly	n/a	0.62% (13 patients)								

* This KPI is looking at reporting the number of BME patients who attend appointments on a monthly basis

Section Two: CQUIN Targets

CQUIN	Detail of indicator	Reported	Performance at Q1	Target %	Progress	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
Children Young Adult and Families (CYAF) (Outcome monitoring)	For 80% of patients (attending CAMHS who qualify for the CQUIN) to complete the Goal-Based Measure (GBM) at the Pre-assessment stage (known as Time 1) and after six months or, if earlier, at the end of therapy/treatment (known as Time 2).	Q1-Q4	n/a this quarter	80%	Q1: T1 forms return rate is 48%. This demonstrates that for 21 patients whose GBM was due in the quarter, 10 staff had completed the T1 form.				
Children Young Adult and Families (CYAF) (Outcome monitoring)	For 75% of patients who complete the Goal-Based Measure (GBM) to achieve an improvement in their score on the GBM, from Time 1 to Time 2, on at least two targets (goals).	Q1-Q4	n/a this quarter	75%	Unable to report in Q1 because Time 2 data not available yet. Progress can only be reported for this indicator from Q3.				
ADULT & Adolescent and Young Adult (Outcome Monitoring)	For the Total CORE scores to indicate an improvement from Pre-assessment (Time 1) to End of Treatment (Time 2) for 50% of patients.	Q1-Q4	64%	50%	Achieved target				

CQUIN Targets

CQUIN	Detail of indicator	Reported	Performance at Q1	Target %	Progress	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
PHYSICAL HEALTH – Smoking Cessation	Smoking status recorded at time of the first assessment appointment for 95% patients age 14 years and above between 1 April 2015 and 31 March 2016	Q1-Q4	n/a as in Q1 Trust finalising the processes for recording this data.	95%	Finalising processes of recording smoking cessation data as part of the assessment process.				
	Very brief advice for 95% of patients recorded as current smoker	Q1-Q4	n/a as the physical health nurse was not in post in Q1.	95%					
	Percentage of patients who are current smokers with a record of initiation of treatment including setting a quit date or receiving Varenicline or NRT or referred for on-going support.	Q1-Q4	n/a as the physical health nurse was not in post in Q1.	n/a					
	Quit attempts, initiation of treatment and referral of patients by Physical Health Practitioner to community stop smoking centres for on-going support.	Q1-Q4	n/a as the physical health nurse was not in post in Q1.	n/a					
	Offer Nicotine Replacement Therapy (NRT) for patients wishing to stop smoking (Prescribing to be a pass through cost to the Trust)	Q1-Q4	n/a as the physical health nurse was not in post in Q1.	n/a					
	Appointment of a BTS clinical champion to promote smoking cessation for patients and staff	Q1-Q4	n/a as the physical health nurse was not in post in Q1.	n/a					
	Pro-active promotion of stop smoking to staff through in-house or local stop smoking service	Q1-Q4	n/a as the physical health nurse was not in post in Q1.	n/a					

Page | 10 *Please note that those patients who have expressed an interest in meeting with the physical health nurse have been put on a Waiting List pending the appointment of the physical health nurse.

CQUIN Targets

CQUIN	Detail of indicator	Reported	Performance at Q1	Target %	Progress	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
PHYSICAL HEALTH – Alcohol Misuse	To ensure the consistent offer of effective, evidence-based screening for increasing risk (hazardous) and high risk (harmful) alcohol consumption to patients presenting with selected conditions in Mental Health Services. Patients (aged 14 years or over).	Q2-Q4	n/a this quarter	n/a	Finalising processes of screening for alcohol misuse as part of the assessment process.				
	To ensure patients screening positive (who score 16 and above for the FAST score) are referred to in-house Physical Health Nurse for a brief intervention and information concerning sensible/safer drinking.	Q2-Q4	n/a this quarter	95%					
	95% of patients screened, referred to the physical health nurse and referred to local alcohol services where GP communication is undertaken within 1 week.	Q2-Q4	n/a this quarter	95%					
	Referrals made to local alcohol services when identified as appropriate by the Physical Health Nurse.	Q2-Q4	n/a this quarter	n/a					
	Trust to implement system of recording instances where patients disclose either: A) Being the victim of violence in relation to alcohol or B) Perpetrating violence in relation to alcohol	Q2-Q4	n/a this quarter	n/a					
			n/a this quarter						

CQUIN Targets

CQUIN	Detail of indicator	Reported	Performance at Q1	Target %	Progress	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
PHYSICAL HEALTH – Domestic Violence	Evidence that there is a domestic violence lead and a domestic violence programme established at the trust. The domestic violence programme is to be supported by a trust wide multi-disciplinary steering group across the trust.	Q1	Achieved.	n/a	We have a named DV lead in place along with a domestic violence training programme.				
	Evidence to be provided of a systematic approach to the identification of domestic violence, support and referral to appropriate services.	Q2	n/a this quarter	n/a	n/a				
	Evidence of roll out of training programmes to front line staff in the identified cohorts. Sample of training plan provided. Training Plan Reviewed and Agreed.	Q3	n/a this quarter	n/a	n/a				
	Further evidence of roll out of training programme in Q4 with further identification that any actions that have been identified from cases that have been referred to MDT have been followed up and completed. Reporting to be built into the CQUIN and shared with primary care. Safety report to be potentially provided for assessment. Numbers and % of staff trained. Evaluation of training programme submitted.	Q4	n/a this quarter	n/a	n/a				

CQUIN Targets

CQUIN	Detail of indicator	Reported	Performance at Q1	Target	Progress	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
Safe and Timely Discharge	Discharge letters for GPs to be sent within 2 weeks of final appointment for planned discharges	Reported in Q3 after completion of audit	n/a this quarter	85%	Training for this target was rolled out in Q1				
	85% Patients discharged from Carenotes within 2 weeks of letter to GP	Reported in Q3 after completion of audit	n/a this quarter	85%	Training for this target was rolled out in Q1				
	Effective discharge plans in place - mandated fields to be added in Carenotes to ensure consistent, quality of information in discharge summaries	Q2	n/a this quarter	n/a					

Portman CQUIN

	Detail of indicator	Reported	Performance at Q1	Target	Progress	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
Demonstrating improvement in outcomes for over 18s (SWAP)	A SWAP will be completed by clinicians for all patients at assessment who are offered treatment. This will be repeated one year from the patient's first treatment attendance to assess a measure of change. The Provider will provide a detailed ongoing analysis of the results.	Q1-Q4	100%	100%	100% of SWAP's completed by clinicians to date.				
Demonstrating improvement in outcomes by measuring reductions in frequency of presenting problem behaviours (PROM)	All patients who are offered treatment will be assessed at the end of the assessment and after 6 months in treatment using the Presenting Problems Monitoring Questionnaire. The Provider will demonstrate a reduction in the number of presenting problems through this tool for 70% or more cases. (Patients presenting with a primary diagnosis of gender dysphoria are excluded as this is not considered an appropriate outcome measure for this cohort of patients).	Q1-Q4	100%	75%	100% of patients with a PROM for Time 1 and Time 2 show an improvement.				

GIDS CQUIN

	Detail of indicator	Reported	Performance at Q1	Target	Progress	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
Clinical Audit	To arrange a clinical audit meeting between April 2015 and January 2016.	Q1-Q4	Achieved	n/a	The date for the workshop has been set as Thursday 28th January 2016				

Section Three: Quality Priorities

Quality Priorities								
Priority	Target	Priority Lead	Monitoring Processes	Evidence Required	Start Date	Achievement Date	Progress	% Progress for 2015/16
								Q1 Q2 Q3 Q4
(1) Outcome Monitoring	1. For 80% of patients (attending CYAF who qualify for the CQUIN) to complete the Goal-Based Measure (GBM) at the Pre-assessment stage (known as Time 1) and after six months or, if earlier, at the end of therapy/treatment (known as Time 2).	Caroline McKenna	Q1/Q2 - OM tracking system Q2 - Carenotes Monitoring of progress by the OM Lead Quarterly progress report Quarterly basis, providing reports to the Patient Experience and Care Quality Committee, the Board of Directors, Camden CCG and our clinical commissioners from other boroughs.	<ul style="list-style-type: none"> OM analysis of the % return rate for Time 1 and Time 2. 	1 April 2015	n/a	Q1: T1 forms return rate is 48%. This demonstrates that for 21 patients whose GBM was due in the quarter, 10 staff had completed the T1 form.	
	2. For 75% of patients who complete the Goal-Based Measure (GBM) to achieve an improvement in their score on the GBM, from Time 1 to Time 2, on at least two targets (goals).			<ul style="list-style-type: none"> OM analysis of the % of patients who achieve an improvement in their score for at least two GBM targets. 	1 April 2015	n/a	Unable to report in Q1 because Time 2 data not available yet. Progress can only be reported for this indicator from Q3.	

Quality Priorities

Quality Priorities											
Priority	Target	Priority Lead	Monitoring Processes	Evidence Required	Start Date	Achievement Date	Progress	% Progress for 2015/16			
								Q1	Q2	Q3	Q4
(1)Outcome Monitoring	3. Adult & AYA Service: For the Total CORE scores to indicate an improvement from Pre-assessment (Time 1) to End of Treatment (Time 2) for 50% of patients.	Michael Mercer	Quarterly basis, providing reports to the Experience and Care Quality Committee, the Board of Directors, Camden CCG and our clinical commissioners from other boroughs.	• OM analysis of the % of service users who achieve an improvement in their score from pre assessment to End of Treatment.	1 April 2015	30 June 2015	Achieved target	64%			
(2) Access to Clinical Services and Health Care Information for Patients and Public	1. PPI team to develop a quarterly PPI newsletter for Trust staff and service users to include updates on patient stories	Sally Hodges		• The PPI team will develop and launch a quarterly PPI newsletter for Trust staff and service users to include updates on patient stories.		30 June 2015	An Adult and a CYAF bulletin flyer is being finalised with Communications. The publication will be published around September 2015.				
	2. PPI Newsletters to be available on the Trust website			•PPI newsletters will be posted on the website.		30 June 2015	The newsletter is accessible on the Trust website.				
	3. Following launch of the newsletter, a Visual Straw Poll to be run on awareness of the newsletters		The evidence will be the results of the Visual Straw Poll.	•A question on the Visual Straw Poll will be used to evaluate awareness and knowledge of the PPI quarterly newsletter.		30 June 2015	A Visual straw poll is currently running on the awareness of the newsletter.				

Quality Priorities

Quality Priorities											
Priority	Target	Priority Lead	Monitoring Processes	Evidence Required	Start Date	Achievement Date	Progress	%Progress for 2015/16			
								Q1	Q2	Q3	Q4
(3) Patient and Public Involvement	1. To provide a service user for every clinical interview panel that requests a service user panel member.	Sally Hodges	<ul style="list-style-type: none">The PPI team will maintain their local spreadsheet containing details of interview panels that have taken place including a service user on the interview panel.	<ul style="list-style-type: none">The PPI team has provided interview panel training sessions for service users who have volunteered to participate and now have a pool of service users who can sit on interview panels.	1 April 2015	30 June 2015	In Q1, 18 Service users were involved in interview panels that requested this.				
	2. To gain feedback from the service users who participate in interview panels. Feedback will be gained regarding three areas: preparation for the panel, participating in the panel and the debrief process. The PPI team will contact every service user who participates on an interview panel.		<ul style="list-style-type: none">We plan to monitor our progress towards achieving these targets on a quarterly basis, providing reports to the Patient and Public Involvement Committee and other various meetings.	<ul style="list-style-type: none">The evidence will be feedback reports maintained by the PPI team. The PPI team will contact service users to ask them about their experience of being on an interview panel.		30 June 2015	Feedback is currently being gained via email, phone and in person. 80% of patients have responded. The comments have been incredibly positive.				

Appendix One: Quality Indicator Performance Supporting Evidence

Waiting Times

QUARTER 1							
	AYAS	Adult	Camden CAMHS	Other CAMHS	Lifespan	Portman	TOTAL
Breaches Cause internal to Tavi	0	0	0	0	1	1	2
Breaches: Cause external to Tavi	3	0	1	0	1	2	7
Total number of breaches	3	0	1	0	2	3	9
Number of 'breaches' shown after data validation shown to be 'no breach'	0	0	5	0	0	0	5
Total number of patients offered a first appointment in the quarter	51	83	181	56	21	31	423
The percentage of patients that are breached in the quarter	5.9%	0.0%	0.6%	0.0%	9.5%	9.7%	2.1%
% of internal breaches	0.0%	0.0%	0.0%	0.0%	4.76%	3.23%	0.5%
% of external breaches	5.9%	0.0%	0.6%	0.0%	4.76%	6.45%	1.7%

Waiting Time Breaches 11+ weeks

Client ID	Service	Team	Purchaser	Referral Date	First Attended Apt	Wait Weeks	Internal / External	Reason for breach
1028118	Adolescent & Young Adult (AYA)	AYA North and West Team	BARNET PCT	20-Jan-2015	15-Apr-2015	12.	External	Patient failed to engage with therapy or take up any appointments offered. As a result, patient file was closed.
1005448	Adolescent & Young Adult (AYA)	AYA Camden Team	CAMDEN PCT	16-Mar-2015	05-Jun-2015	11.43	External	Patient offered appointment however was on holiday, so not available to take up offer of appt. Patient got in contact upon return and was offered another appt. But then Patient DNA'd first appointment.
1029077	Adolescent & Young Adult (AYA)	AYA North and West Team	BARNET PCT	25-Mar-2015	17-Jun-2015	11.86	External	Patient communicated that she had exams so her first appt. had to be postponed.
1015228	Camden CAMHS	South Primary School Service	CAMDEN PCT	20-Jan-2015	29-Apr-2015	13.	External	Delays caused by the difficulty finding a suitable appt. time to discuss the referral with father. In addition, father was busy with a social service investigation so failed to engage with Trust until April.

Waiting Time Breaches 11+ weeks

Client ID	Service	Team	Purchaser	Referral Date	First Attended Appt	Wait Weeks	Internal / External	Reason for breach
028134	Other CAMHS	Lifespan Developmental - Autism	HARINGEY PCT	21-Jan-2015	09-Apr-2015	11.	External	As patient was being seen at UCLH. It was felt by UCLH clinician that patient should continue to be seen at UCLH and then attend assessment for ASD in the lifespan team. So, first appointment was postponed.
1026110	Other CAMHS	Lifespan Developmental - Autism	CITY & HACKNEY PCT	15-Sep-2014	27-Apr-2015	31.86	External	Lifespan Service were waiting to hear whether funding for treatment would be granted by CCG for patient. Funding granted on 27/03/2015
1029083	Other CAMHS	Lifespan Developmental - Autism	BARNET PCT	27-Mar-2015	25-Jun-2015	12.71	Internal	Clinician was due to see patient, however had to cancel for personal reasons. So, an appointment was arranged with another clinician

Trust-wide Waiting Times for Q1 - including Mean and Median data

Service	Total Seen Patients Q1	Median (Weeks)	Average (Weeks)
Adolescent and Young Adult	51	6.71	6.24
Adults	83	6.71	5.85
Camden CAMHS	181	3.57	3.94
Other CAMHS	89	5.00	6.97
Portman	21	4.93	6.15
Total	425	5.00	5.83

Contractually TPFT has agreed to a waiting time no more than 11 weeks (77 days from receipt of referral) for patients. The Gender Identity Development Service (GIDS) waiting time figures are not included as they have a separate target (18 weeks) as part of their National Contract.

DNA Rates

GENERIC & Portman DNA Rates (Total)			
QUARTER 1			
Target <11%	2013/14	2014/15	2015/16
Total 1st appointments attended	352	379	454
Total first appointments DNA's	37	28	36
Total first appointments	389	407	490
% 1st appointments DNA'd	10%	6.9%	7.3%
Total subsequent appointments attended	9266	9722	11310
Total sub. appointments DNA'd	907	830	976
Total subsequent appointments	10173	10552	12286
% DNA subsequent Appointments	9%	7.9%	7.9%
Total % DNA	9%	8%	8%

Adolescent and Young Adult DNA Rates

QUARTER 1			
Target <11%	2013/14	2014/15	2015/16
Total 1st appointments attended	46	44	52
Total first appointments DNA's	6	5	6
Total first appointments	52	49	58
% 1st appointments DNA'd	11.5%	10.2%	10.3%
Total subsequent appointments attended	1105	1072	1128
Total sub. appointments DNA'd	169	234	205
Total subsequent appointments	1274	1306	1333
% DNA subsequent Appointments	13.3%	17.9%	15.4%
Total % DNA	13%	18%	15%

DNA Rates

Adult DNA Rates				
QUARTER 1				
Target <11%	2013/14	2014/15	2015/16	
Total 1st appointments attended	61	55	84	
Total first appointments DNA's	2	6	6	
Total first appointments	63	61	90	
% 1st appointments DNA'd	3.2%	10%	6.7%	
Total subsequent appointments attended	2271	2122	2543	
Total sub. appointments DNA'd	245	158	205	
Total subsequent appointments	2516	2280	2748	
% DNA subsequent Appointments	9.7%	7%	7.5%	
Total % DNA	10%	7%	7%	

Camden CAMHS DNA Rates				
QUARTER 1				
Target <11%	2013/14	2014/15	2015/16	
Total 1st appointments attended	157	188	201	
Total first appointments DNA's	27	16	20	
Total first appointments	184	204	221	
% 1st appointments DNA'd	14.7%	8%	9.0%	
Total subsequent appointments attended	2554	3260	4261	
Total sub. appointments DNA'd	250	260	397	
Total subsequent appointments	2804	3520	4658	
% DNA subsequent Appointments	8.9%	7%	8.5%	
Total % DNA	9%	7%	9%	

DNA Rates

Other CAMHS DNA Rates			
QUARTER 1			
Target <11%	2013/14	2014/15	2015/16
Total 1st appointments attended	56	48	70
Total first appointments DNA's	0	1	3
Total first appointments	56	49	73
% 1st appointments DNA'd	0%	2%	4.1%
Total subsequent appointments attended	2033	1973	1650
Total sub. appointments DNA'd	117	74	55
Total subsequent appointments	2150	2047	1705
% DNA subsequent Appointments	5.4%	4%	3.2%
Total % DNA	5%	4%	3%

Portman DNA Rates			
QUARTER 1			
Target <11%	2013/14	2014/15	2015/16
Total 1st appointments attended	26	33	23
Total first appointments DNA's	2	0	1
Total first appointments	28	33	24
% 1st appointments DNA'd	7%	0%	4.2%
Total subsequent appointments attended	1145	1103	1112
Total sub. appointments DNA'd	107	98	89
Total subsequent appointments	1252	1201	1201
% DNA subsequent Appointments	9%	8%	7.4%
Total % DNA	9%	8%	7%

2. **Patient Satisfaction** – See ESQ Report 2015-2016 Q1. (A hardcopy of this Report can be provided by the Quality Standards and Reports Lead).
3. **Patient Experience** - See Annual PPI Report. (A hardcopy of this Report can be provided by the Quality Standards and Reports Lead, if required.)
4. **Patient Information** - See patient leaflets on Trust Website. (In addition, a hardcopy of these leaflets can be provided by the Quality Standards and Reports Lead, if required.)
5. **Outcome monitoring**- Please refer to CQUIN Targets in Section Two and see 2015-16 CQUINs Outline (A hardcopy of this CQUINs Outline can be provided by Quality Standards and Reports Lead, if required.)
6. **Quality and Development of Staff** - Patient Development Plans (“PDPs”) are managed on an annual cycle with performance reported at end March each year, for implementation over the course of the next year. However, updated figure for Q1 in table below.

Quality and Development of Staff - PDPs:		
Number of staff who require a PDP at 30 th June 2015.	Number of staff with a PDP	% of staff with a PDP
482	479	99%

7. Safety (Children Safeguarding)

Level 1 Safeguarding Training/Adults Risk Training (Which provided at Trust INSET day)				
Quarter	Q1	Q2	Q3	Q4
% of staff whose training is 'in date'	93%			
Narrative	Quarter 1 results			
Total numbers requiring training:	505			
Number of staff trained:	468			
Number of staff NOT trained:	37			
%:	93%			
Rationale (Reason for non-attendance):	3 starters (2015) - missed the first induction date but booked on the second Induction , sick/ booked on course//on annual leave) 28 (9 excused from May INSET Day/returned from MAT/CB/off sick/1 query secondment/2 based elsewhere) 6 new June starters after Trust-wide Induction.			
Level 2 Safeguarding Training				
Quarter	Q1	Q2	Q3	Q4
% of staff whose training is 'in date'	98%			
Narrative	Quarter 1 results			
Total numbers requiring training:	45			
Number of staff trained:	44			
Number of staff NOT trained:	1			
%:	98%			
Rationale (Reason for non-attendance):	Due to attend and scheduled Level 2 training in September.			
Level 3 Safeguarding Training				
Quarter	Q1	Q2	Q3	Q4
% of staff whose training is 'in date'	94%			
Narrative	Quarter 1 results			
Total numbers requiring training:	308			
Number of staff trained:	291			
Number of staff NOT trained:	26			
%:	94%			
Rationale (Reason for non-attendance):	9 new starters (- 1 based in Leeds - 2 booked to attend Dept training in July / 4 returned MAT leave/ DNA's booked July - 1 secondary query raised with CAMHS manager as to the date they will leave the Trust and if that will necessitate attendance). 17 are due for May and June and have not attended but urgent reminders have been sent and have been booked on July and September.			

Justine McCarthy Woods
Quality Standards and Reports Lead
July 2015

Board of Directors : July 2015

Item : 17

Title : Quarter 1 Governance statement

Purpose:

The Board of Directors is asked to approve three elements of the governance statement to be submitted to Monitor for quarter 1:

For Finance

The board anticipates that the trust will continue to maintain a Continuity of Service risk rating of at least 3 over the next 12 months.

For Governance

The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards.

Otherwise

The board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per the Risk Assessment Framework page 21, Diagram 6) which have not already been reported.

At the Management Team on 9 July, members supported all these statements and confirmed that we are not aware of any risk to compliance with any conditions of our licence.

This report focuses on the following areas:

(delete where not applicable)

- Risk
- Finance
- Quality

For : Approval

From : Deputy Chief Executive and Director of Finance

Quarter 1 Governance Statement

1. **Introduction**

- 1.1 Monitor oversees NHS foundation trusts through the terms of our provider licence and through the Risk Assessment Framework.
- 1.2 A key element of the Risk Assessment Framework is the requirement to submit a governance statement each quarter.
- 1.3 This quarter's statement is to be returned to Monitor by 31 July, on the template which also includes the quarterly financial return.

2. **Finance declaration**

- 2.1 In the Trust's Operational Plan submitted to Monitor, the template calculated the following results for the two metrics which comprise the continuity of service risk rating (CoSRR):
 - Our Capital Service Cover rating is projected to be 4 for all quarters of 2015/16.
 - Our Liquidity rating is projected to be 2 for the last three quarters of 2015/16.
- 2.2 Details of the calculations were given at the April meeting.
- 2.3 The two elements are each given a 50% weighting; so based on the ratings predicted, our CoSRR will be 3, which remains satisfactory.
- 2.4 For the Capital Service Cover rating to fall to 3, the Trust's surplus/deficit would have to be some £225k (pro rata) below Plan at some point in the year. If this occurred, the overall rating would still be 3.
- 2.5 For the Liquidity rating to fall to 1, the combination of the Trust's surplus and its capital expenditure would have to be some £500k worse than Plan. This is significantly less likely to occur, and there could be scope to avoid it through delaying capital expenditure if necessary.
- 2.6 We are now required to make a declaration covering the 12 months to June 2016, and so including the first quarter of 2016/17. Financial projections for the medium-term strategy set out the Trust's plans and targets to remain in a satisfactory financial position next year; though the necessary growth and savings have not yet been secured.
- 2.7 Based on the above, we are able to affirm that we anticipate that the trust will continue to maintain a continuity of service risk rating of at least 3 over the next 12 months.

3. **Governance Declaration**

3.1 **Declaration of risks against healthcare targets and indicators**

- 3.1.1 The Monitor template for our quarterly return sets out a list of targets and indicators, in line with the Risk Assessment Framework. The targets and indicators which apply to this Trust are given in the table on the next page.
- 3.1.2 All targets and indicators are being met; and plans are sufficient to ensure that they continue to be met. Further details are given below. The Trust should therefore continue to receive a green governance rating.

Target/Indicator	Weighting	Quarter 1 result	
Data completeness: 97% completeness on all 6 identifiers	0.5	Achieved (see 3.4 below)	0
Compliance with requirements regarding access to healthcare for people with a learning disability	0.5	Achieved (see 3.3. below)	0
Risk of, or actual, failure to deliver Commissioner Requested Services	4.0	No	0
CQC compliance action outstanding	Special	No	0
CQC enforcement action within the last 12 months	Special	No	0
CQC enforcement action (including notices) currently in effect	4.0	No	0
Moderate CQC concerns or impacts regarding the safety of healthcare provision	Special	No	0
Major CQC concerns or impacts regarding the safety of healthcare provision	2.0	No	0
Unable to declare ongoing compliance with minimum standards of CQC registration	Special	No	0
		Total score	0
		Indicative rating	

3.2 **Care Quality Commission registration**

- 3.2.1 The Trust was registered by the CQC on 1 April 2010 with no restrictions. Actions continue to ensure that this status is retained; assurance is considered at the quarterly meetings of the CQSG

Committee.

3.2.2 The Trust remains compliant with the CQC registration requirements.

3.3 Self certification against compliance with requirements regarding access to healthcare for people with a learning disability

3.3.1 The Trust Lead for Vulnerable Adults reviewed the Self certification against compliance with requirements regarding access to healthcare for people with a learning disability in December 2012.

3.3.2 The Trust has continued to develop its services for LD service users, and actively involves users to further refine and tailor provision. For example, the LD team is currently working with service users on an App to act as an adjunct to therapeutic support.

3.4 Data Completeness

3.4.1 The target is 97% completeness on six data identifiers within the Mental Health and Learning Disability Data Set (MHLDDS). Current statistics confirm that we are still meeting and exceeding this target: see table below.

	Month 1, final	Month 2, provisional
Valid NHS number	99.46%	99.34%
Valid Postcode	99.91%	99.30%
Valid Date of Birth	100.00%	100.00%
Valid Organisation code of Commissioner	98.57%	98.55%
Valid Organisation code GP Practice	99.51%	99.21%
Valid Gender	99.91%	99.91%

4. Other matters

4.1 The Trust is required to report any "incidents, events or reports which may reasonably be regarded as raising potential concerns over compliance with [our] licence." The Risk Assessment Framework gives – on page 21 – a non-exhaustive list of examples where such a report would be required, including unplanned significant reduction in income or significant increase in costs; discussions with external auditors which may lead to a qualified audit report; loss of accreditation of a Commissioner Requested Service; adverse report from internal auditors; or patient safety issues which may impact compliance with our licence.

4.2 There are no such matters on which the Trust should make an exception report.

Simon Young
Deputy Chief Executive and Director of Finance
13 July 2015

Board of Directors : July 2015

Item : 18

Title : Corporate Governance – Register of Interests

Purpose:

Please find attached the register of directors' interests. This register ensures there are no material conflicts of interest within the board of directors, and is for the board to approve.

For : Approval

From : Gervase Campbell, Trust Secretary

Register of Directors' Interests 2015/16 – July 2015

1. Introduction

All existing Directors shall declare relevant and material interests forthwith and the Trust shall ensure that those interests are noted in the *Register of Directors' Interests*. Any Directors appointed subsequently shall declare their relevant and material interests on appointment.¹ At the time the interests are declared this shall be recorded in the minutes of the Board of Directors meeting as appropriate. Any changes in interest shall be officially declared at the next meeting of the Board of Directors following the change occurring. It is the obligation of the Director to inform the Trust Secretary in writing within seven days of becoming aware of the existence of a relevant or material interest and the membership.² If a Director has a doubt about the relevance or materiality of any interest this should be discussed with the Trust Chair.³

2. Declaration

Please complete the table below, stating all relevant and material interests. If none are applicable, put "none". Interests which shall be regarded as "relevant and material" and which for the avoidance of doubt should be declared and should be included in the Register of Directors' Interests are:

Disclosure Requirement	Disclosure ⁴
Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those directorships of dormant companies)	Dinesh Bhugra: <ul style="list-style-type: none"> • Director, DKB Consulting • Secretary, Porism Limited
	Jane Gizbert: None
	Angela Greatly: <ul style="list-style-type: none"> • Associate NED at Barts Health, from May 2015 for 6 months.
	Rita Harris: None
	David Holt: <ul style="list-style-type: none"> • Director, Urban Patch Ltd (Consultancy)

¹ Tavistock & Portman NHS Foundation Trust, *Constitution, Election Rules, Standing Orders*, 2014, Annex 5, Paragraph 9.1

² Ibid, Paragraph 9.4

³ Ibid, Paragraph 9.3

⁴ A lack of disclosure from any Director indicates a nil return on the Declaration of Interest

Disclosure Requirement	Disclosure ⁴
	Paul Jenkins: None
	Lis Jones: None
	Louise Lyon: None
	Ian McPherson: None
	Edna Murphy: None
	Brian Rock: None
	Rob Senior: None
	Simon Young: None
	Dinesh Bhugra: None
	Jane Gizbert: None
	Angela Greatly: None
	Rita Harris: None
	David Holt: None
	Paul Jenkins: None
	Lis Jones: <ul style="list-style-type: none"> Lis Jones Associates, Consultancy
Ownership, part-ownership or directorships of private companies, businesses or consultancies likely or possibly seeking to do business with the National Health Service	Louise Lyon: None
	Ian McPherson: None
	Edna Murphy: None
	Brian Rock: None

Disclosure Requirement	Disclosure ⁴
	Rob Senior: None
	Simon Young: None
	Dinesh Bhugra: None
	Jane Gizbert: None
Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the National Health Service	Angela Greatly: None
	Rita Harris: None
	David Holt: None
	Paul Jenkins: None
	Lis Jones: None
	Louise Lyon: None
	Ian McPherson: None
	Edna Murphy: None
	Brian Rock: None
	Rob Senior: None
	Simon Young: None
A position of authority in a charity or voluntary organisation in the field of health and social care	Dinesh Bhugra: <ul style="list-style-type: none"> • Trustee, Care-IF, • Trustee, Sane • President, Mental Health Foundation • President, World Psychiatric Association
	Jane Gizbert:

Disclosure Requirement	Disclosure ⁴
	<ul style="list-style-type: none"> • Director of NICE
	Angela Greatly: None
	Rita Harris: None
	David Holt: <ul style="list-style-type: none"> • NED, Circle Housing, Centra Board
	Paul Jenkins: None
	Lis Jones: <ul style="list-style-type: none"> • Trustee, North London Hospice
	Louise Lyon: <ul style="list-style-type: none"> • Chair of Tavistock Clinic Foundation
	Ian McPherson: <ul style="list-style-type: none"> • Trustee/Director, Centre for Mental Health • Trustee/Director, Mental Health Provider Forum • Trustee/Chair, International Initiative in Mental Health Leadership • Trustee, Birmingham MIND
	Edna Murphy: <ul style="list-style-type: none"> • Faculty Manager, UCL Faculty of Medical Sciences • Magistrate, Cambridge Bench
	Brian Rock: None
	Rob Senior: None
	Simon Young: None
	Dinesh Bhugra: None
	Jane Gizbert: None
	Angela Greatly: None
Any connection with a voluntary or other organisation contracting for National Health Service services or commissioning National Health Service services	

Disclosure Requirement	Disclosure ⁴
	Rita Harris: None
	David Holt: <ul style="list-style-type: none"> Whittington Health NHS Trust, Chair of Audit Committee
	Paul Jenkins: <ul style="list-style-type: none"> Member and previous CEO of Rethink Mental Illness
	Lis Jones: None
	Louise Lyon: None
	Ian McPherson: <ul style="list-style-type: none"> Chair, Improving Health and Wellbeing UK, Director, Community Interest Company 121 Support, Community Interest Company
	Edna Murphy: <ul style="list-style-type: none"> Trustee, Cambridge Youth Music Trustee, Cambridge Project for the Book
	Brian Rock: None
	Rob Senior: <ul style="list-style-type: none"> Married to City & Hackney Clinical Commissioning Group Chair
	Simon Young: None
	Dinesh Bhugra: None
	Jane Gizbert: None
	Angela Greatly: None
	Rita Harris: None
	David Holt:
Any connection with an organisation entity or company considering entering into or having entered into a financial arrangement with the Trust including but not limited to lenders or banks	

Disclosure Requirement	Disclosure ⁴
	<ul style="list-style-type: none"> • Ebbsfleet Development Corporation, Deputy Chair, Chair of Audit Committee
	Paul Jenkins: None
	Lis Jones: None
	Louise Lyon: None
	Ian McPherson: <ul style="list-style-type: none"> • Advisor, Ultrasis plc • Advisor, Handle my Health
	Edna Murphy: None
	Brian Rock: None
	Rob Senior: None
	Simon Young: None

Board of Directors : July 2015

Item : 19

Title : Update on actions plans for the Duty of Candour, Fit and Proper Person Test, and 'Freedom to Speak Up'.

Summary:

This report provides an update on the action plan presented at the February 2015 Board of Directors meeting, and updated at the May meeting.

This report has been reviewed by the following Committees:

- Management Team, July 2015

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:

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

For : Noting

From : Gervase Campbell, Trust Secretary

Update on Action Plans for the Duty of Candour, Fit and Proper Person Test, and Freedom to Speak Up recommendations

1. Introduction

- 1.1 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 came into force in November 2014. From that date the fit and proper person test and the duty of candour applied, whilst all other fundamental standards of care came into force in April 2015.
- 1.2 The Board first considered the Duty of Candour and the Fit and Proper Person Test (FPPT) in October 2014, in February 2015 received an update and action plan, and in May 2015 progress on the action plan was presented.
- 1.3 The 'Freedom to Speak Up' review was published on the 11th February. This is the review that Sir Robert Francis undertook looking at whistleblowing and with the aim of creating a culture of openness and honest reporting within the NHS.
- 1.4 The Board briefly discussed the report in February 2015, when we circulated the letter from David Bennett, Chief Executive of Monitor, to all NHS Managers briefing them on the importance of the report. That letter was also circulated to the Leadership Team to pass on to managers so it could be discussed within teams.
- 1.5 An action plan was presented to the board at their May 2015 meeting.
- 1.6 This report provides an update on progress with the action plans.

2. Action plans for Duty of Candour and FPPT.

- 2.1 Actions were proposed at the Board meeting in February to meet the requirements of the Fit and Proper Person Test and Duty of Candour. Below is an update on progress with those actions:

Action	Due Date	For	Comments
Whistleblowing clause included in contracts	n/a	ST	Completed 2014
Updated whistleblowing policy	n/a	ST	Completed 2014
Board to be updated on progress on DoC	May 2015	GC	Completed May 2015
Annual complaints report at the	April	GC	Completed April 2015

Board to be accompanied by whistleblowing report	2015		
DoC to be included in Trust wide Inductions	Feb 2015	NN	Completed Feb 2015
DoC to be included in INSET training	May 2015	NN	Completed May 2015
DoC to be included in Clinical Inductions	Sept 2015	IH	This will be included in the next clinical induction, in September.
Complaints information posters to be displayed in Trust	Marc h 2015	PK	Completed March 2015
Publishing summary of complaints quarterly	April 2015	PK	Format for informative but anonymised summary report has been agreed, and first quarter report has been published on the website.
'Worries and Concerns' list to inform risk register	April 2015	LL	A message from the CEO has been drafted. This is a response to the worries and concerns list collated earlier this year and will encourage all staff to raise concerns. Methods for capturing concerns raised throughout the year are in development and a repeat exercise , visiting all clinical teams , is planned for when the new Quality and Governance Lead arrives in the autumn
Central 'Action Plan' review committee to be considered	Marc h 2015	RS	We have reviewed the need for an additional system to consider and review progress on action plans arising from SUIs but have concluded that there would be no particular benefit from adding to the existing mechanisms for review via the PSCR work-stream, safe-guarding committee and director level review.
Lessons learnt (from Worries and Concerns, or incident reporting) to be shared via the 'Quality News'	Marc h 2015	LL	Quality News, Safety issue , will be published in July 2015
'Being Open' policy has been updated	n/a	PK	Completed
SUI and Incident Reporting policies have been updated	n/a	PK	Completed.
Bullying and Harassment policy has been updated	Feb 2015	ST	Completed Feb 2015
HR to routinely consider bullying and harassment cases for openness considerations	n/a	ST	Completed
External helpline to consider openness considerations	Feb 2015	ST	Completed. Helpline was put in place in Feb 2015
Training available on managing bullying and harassment to include openness and duty of candour	n/a	ST	Completed

Capability and Disciplinary procedures covers professional standards and the duty of candour	n/a	ST	Completed
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2.1.1 Action plan for Fit and Proper Person Test

Action	Due Date	For	Comments
Pre-employment checks for new directors and members of MT strengthened to meet needs of FPPT	n/a	ST	Completed.
FPPT of current Directors and MT to be done	Sept 2015	ST	FPPT have been done this year for the Chair and all NEDs and will be used to inform the appraisals being conducted now. FPPT for the Executive Directors and members of the management team have been started and will be completed by September.
Appraisals of Directors and MT to cover FPPT	2015	ST	Processes are being put in place to incorporate this within the 2015/16 appraisal cycle.
Directors & MT to sign declaration of good standing	2015	GC	Completed in March 2015
FPPT clause to be included in Dir.'s and MT contracts	2015	ST	Contracts have not yet been revised. Work will be concluded by the end of the year: specific contracts will be issued to NEDs; amendments will be issued to executive directors; and a clause will be incorporated into the contracts of any new appointments.

2.1.2 Further Actions Required for DoC/FPPT

Action	Due Date	For	Comments
Communication and awareness raising required over the Duty of Candour, and also for Raising Concerns and Whistleblowing	June 2015	PJ/AG	Further education and awareness raising for staff is required on Duty of Candour.

3. Freedom to Speak Up Action Plan

- 3.1 An action plan for meeting the recommendations of the 'Freedom to Speak Up' review were presented at the May board. Below is an update on progress with those actions:

Action Plan in Response to the Recommendations of the 'Freedom to Speak Up' Review

Principle	Action	Details	Comments	Action	For	July Update
PRINCIPLE 1: Culture of Safety: Every organisation involved in providing NHS healthcare should actively foster a culture of safety and learning, in which staff feel safe to raise concerns.	1.1	Boards should ensure that progress towards this (culture of safety) is measured, monitored and published regularly	The Trust already has a robust culture, but this is of paramount importance so more can be done to encourage it, and to monitor it.	Sign up to the "Sign Up To Safety" campaign to measure and improve open culture.	LL/ JY	Trust agreed to Sign up to Safety and action plan in process of drafting so as to be relevant and proportionate to the nature of our work
PRINCIPLE 2: Culture of raising concerns: Raising concerns should be a part of the normal routine business of any	2.1	All NHS organisations should have an integrated policy and common procedure for employees to formally report incidents or raise concerns.	Action 2.2 is for NHS England and Monitor to produce a standard integrated policy - wait until this is available to use to integrate our policies. In the meantime, we do have good	Wait for national standard policy to be produced, then review and integrate our policies in line with it.	GC	National policy not yet published.
PRINCIPLE 3: Culture free from bullying: Freedom to speak up about concerns depends on staff being able to work in a culture which is free from bullying and other oppressive behaviours.	3.1	All NHS organisations should be proactive in detecting and changing behaviours which amount, collectively or individually, to bullying or any form of deterrence against reporting incidents and raising concerns.	Board actively responded to B&H result in 2013 Staff Survey by conducting further research, publicising the issue, and introducing B&H helpline.	Continue to monitor B&H in Staff Survey.	ST	Continue to monitor B&H issues in the Trust. First quarter feedback from the independent help line for staff, did not show any concerns were raised. Consultation on Values Based recruitment is currently being had at the JSCC. VBR should help embed Trusts values when it becomes operational
PRINCIPLE 3: Culture free from bullying: Freedom to speak up about concerns depends on staff being able to work in a culture which is free from bullying and other oppressive behaviours.	3.3	Any evidence that bullying has been condoned or covered up should be taken into consideration when assessing whether someone is a fit and proper person to hold a post at director level in an NHS organisation.	Covered by existing FPPT test and references	Complete	n/a	
PRINCIPLE 4: Culture of visible leadership: All employers of NHS staff should demonstrate, through visible leadership at all levels in the organisation, that they welcome and encourage the raising of concerns by staff.	4.1	Employers should ensure and be able to demonstrate that staff have open access to senior leaders in order to raise concerns, informally and formally.	We are a small Trust, and staff do have access to senior managers and the CEO, but we can do more to demonstrate and evidence this.	Work on way to demonstrate that we encourage open access, provide evidence	LL	Staff do have access to senior management.
PRINCIPLE 5: Culture of valuing staff: Employers should show that they value staff who raise concerns, and celebrate the benefits for patients and the public from the improvements made in response to issues.	5.1	Boards should consider and implement ways in which the raising of concerns can be publicly celebrated.	Louise Lyon is working on considering the 'worries and concerns list'. Once this is done feedback can be given to the Trust via Quality News etc.	Raise awareness of importance of raising concerns with email from CEO/Chair, and follow up with reporting on feedback in Quality News.	PI/ LL	Draft message to staff with the CEO for approval

Principle	Action	Details	Comments	Action	For	July Update
PRINCIPLE 6: Culture of reflective practice: There should be opportunities for all staff to engage in regular reflection of concerns in their work.	6.1	All NHS organisations should provide the resources, support and facilities to enable staff to engage in reflective practice with their colleagues and their teams.	This is part of our clinical practice, embodied in supervision meetings for example. We are much better at this than some other Trusts, but there is a perception amongst staff that it is under threat.	This is essential to our clinical excellence, so it must continue to be monitored and protected, and built into all new models of practice.	LL/ RH	All staff have regular clinical supervision. All teams in CYAF are being reviewed as part of service redesign in terms of clinical discussion structures based on staff feedback. Our recent clinical supervision audit showed excellent access to a range of supervision. Protected time for team reflective practice is built in to all models of clinical service delivery
PRINCIPLE 7: Raising and reporting concerns: All NHS organisations should have structures to facilitate both informal and formal raising and resolution of concerns.	7.1	Staff should be encouraged to raise concerns informally and work with colleagues to find solutions.	Raising informal concerns is encouraged and well used. More work may be needed on centrally recording the informal concerns so that issues can be publicised and learning can be shared throughout Trust.	Louise Lyon and CQC group are working on ways to better gather and use informal concerns.	LL	The importance of raising concerns has been stressed throughout the CQC preparation process. The next step is to develop a standard model of requirements for clinical team management so as to embed raising concerns, recording them and responding to them in team practice
PRINCIPLE 7: Raising and reporting concerns: All NHS organisations should have structures to facilitate both informal and formal raising and resolution of concerns.	7.2	All NHS organisations should have a clear process for recording all formal reports of incidents and concerns, and for sharing that record with the person who reported the matter, in line with good practice.	Formal avenues are clear, and in place. Good system in place and working.	none needed	n/a	
PRINCIPLE 8: Investigations: When a formal concern has been raised, there should be prompt, swift, proportionate, fair and blame-free investigations to establish the facts.	8.1	All NHS organisations should devise and implement systems which enable such investigations to be undertaken, where appropriate by external investigators, and have regard to the good practice.	Good system in place and working	none needed	n/a	
PRINCIPLE 9: Mediation and dispute resolution: Consideration should be given at an early stage to the use of expert interventions to resolve conflicts, rebuild trust or support staff who have raised concerns.	9.1	All NHS organisations should have access to resources to deploy alternative dispute resolution techniques, including mediation and reconciliation to: address unresolved disputes between staff or between staff and management as a result of or associated with a report raising a concern; and,	Experience and resources for alternative dispute resolution exist within HR and the Trust more widely. HR and union staff are trained in mediation.	nothing further needed.	n/a	
PRINCIPLE 10: Training: Every member of staff should receive training in their organisation's approach to raising concerns and in receiving and acting on them	10.1	Every NHS organisation should provide training compliant with national standards, based on a curriculum devised by HEE and NHS England in consultation with stakeholders in accordance with good practice.	Specific training course are provided by HR. It will now also be addressed within the incident reporting element of mandatory training (inset and induction).	INSET and Induction presentations to include guidance on raising concerns.	ST	Last Induction included guidance on raising concerns at work. The practice will continue for future INSET and Induction events.

Principle	Action	Details	Comments	Action	For	July Update
PRINCIPLE 11: Support: All NHS organisations should ensure that there is a range of persons to whom concerns can be reported easily and without formality. They should also provide staff who raise concerns with ready access to mentoring, advocacy, advice and counselling	11.1	Boards of NHS organisations should ensure their procedures for raising concerns offer a variety of personnel, internal and external, to support staff who raise concerns including: a) an independent person (a 'Freedom to Speak Up Guardian') appointed by the chief executive	The guidance explains that this should be an internal role that people can turn to as an independent and impartial source of advice. Suggest that we appoint outside the governance structure, so perhaps a HoD or the Director of TC.	CEO to appoint to the role.	PJ	A role description for the FSU Champion has been drafted and the role will be openly advertised within the Trust. No hours or banding are involved in the role initially.
PRINCIPLE 11: Support: All NHS organisations should ensure that there is a range of persons to whom concerns can be reported easily and without formality. They should also provide staff who raise concerns with ready access to mentoring, advocacy, advice and counselling	11.1	b) a nominated non-executive director to receive reports of concerns directly from employees (or from the Freedom to Speak Up Guardian) and to make regular reports to the Board		Suggest Edna Murphy for this role, as she is the NED link to complaints and whistleblowing.	PJ	To be confirmed at July Board
PRINCIPLE 11: Support: All NHS organisations should ensure that there is a range of persons to whom concerns can be reported easily and	11.1	c) at least one nominated executive director to receive and handle concerns		Suggest s Louise Lyon to this role.	PJ	To be confirmed at July Board
PRINCIPLE 11: Support: All NHS organisations should ensure that there is a range of persons to whom concerns can be reported easily and without formality. They should also provide staff who raise concerns with ready access to mentoring, advocacy, advice and counselling	11.1	d) at least one nominated manager in each department to receive reports of concerns	We are a small Trust, and it is unnecessary to have separate appointees for each department. All managers are able to receive reports and escalate or ask advice as needed. In practice this role is already held by the Director of CYAF and the Director of AFS.	Make explicit in the policy the roles of the director of CYAF and the director of AFS, the Director of E&T and the Finance and HR Directors.	GC	Policy will be updated once all the NED and Executive Director roles are formally announced, and the Champion role is advertised.
PRINCIPLE 11: Support: All NHS organisations should ensure that there is a range of persons to whom concerns can be reported easily and	11.1	e) a nominated independent external organisation (such as the Whistleblowing Helpline) for staff	We have two nominated helplines (the NHS and the Public Organisations) in the	nothing further needed.	n/a	
PRINCIPLE 11: Support: All NHS organisations should ensure that there is a range of persons to whom concerns can be reported easily and without formality. They should also provide staff who raise concerns with ready access to mentoring, advocacy, advice and counselling	11.2	All NHS organisations should have access to resources to deploy counselling and other means of addressing stress and reducing the risk of resulting illness after staff have raised a concern	We have our Staff Advice and Consultation Service (SACS) in place.	nothing further needed.	n/a	
PRINCIPLE 12: Support to find alternative employment in the NHS: Where a NHS worker who has raised a concern cannot, as a result, continue in their current employment, the NHS should offer support.	12.2	All NHS organisations should actively support a scheme to help current and former NHS workers whose performance is sound to find alternative employment in the NHS.	No NHS wide scheme exists yet.	Wait for NHS wide scheme to be created.	GC	Waiting for NHS wide scheme.

Principle	Action	Details	Comments	Action	For	July Update
PRINCIPLE 13: Transparency: All NHS organisations should be transparent in the way they exercise their responsibilities in relation to the raising of concerns, including the use of settlement agreements.	13.1	Quality Accounts should include quantitative and qualitative data describing the number of formally reported concerns in addition to incident reports, the action taken in respect of them and feedback on the outcome.	We have very few formal concerns/whistleblowing incidents at present, but there is no reason not to report on them in the annual quality accounts.	Louise Lyon and Justine McCarthy would to include details of formally reported concerns in the next quality accounts.	LL/ JMW	Protocol for reporting on formally reported concerns to be developed
PRINCIPLE 13: Transparency: All NHS organisations should be transparent in the way they exercise their responsibilities in relation to the raising of concerns, including the use of settlement agreements.	13.2	All NHS organisations should be required to report to the National Learning and Reporting System (NLRS), or to the Independent National Officer described in Principle 15, their relevant regulators and their commissioners any formally reported concerns/public interest disclosures or incidences of disputed outcomes to investigations. NLRS or the Independent National Officer should publish regular reports on the performance of organisations with regard to the raising of and acting on public interest concerns; draw out themes that emerge from the reports; and identify good practice.	We already use the NLRS to report incidents (that reach the relevant threshold). There is no reason why we shouldn't also report formally raised concerns (whistleblowing), if this is requested by NLRS.	If NLRS requests this then we will comply and report on formally raised concerns.	PK	Nothing further required
PRINCIPLE 13: Transparency: All NHS organisations should be transparent in the way they exercise their responsibilities in relation to the raising of concerns, including the use of settlement agreements.	13.3	a) CEOs should personally review all settlement agreements made in an employment context that contain confidentiality clauses to satisfy themselves that such clauses are genuinely in the public interest.	We have not used any confidentiality clauses, and do not intend to.	nothing further needed.	n/a	
PRINCIPLE 13: Transparency: All NHS organisations should be transparent in the way they exercise their responsibilities in relation to the raising of concerns, including the use of settlement agreements.	13.3	b) All such settlement agreements should be available for inspection by the CQC as part of their assessment of whether an organisation is well-led.	We have not used any confidentiality clauses, and do not intend to.	nothing further needed.	n/a	
PRINCIPLE 13: Transparency: All NHS organisations should be transparent in the way they exercise their responsibilities in relation to the raising of concerns, including the use of settlement agreements.	13.3	c) If confidentiality clauses are to be included in such settlement agreements for which Treasury approval is required, the trust should be required to demonstrate as part of the approval process that such clauses are in the public interest in that particular case.	We have not used any confidentiality clauses, and do not intend to.	nothing further needed.	n/a	

Principle	Action	Details	Comments	Action	For	July Update
PRINCIPLE 14: Accountability: Everyone should expect to be held accountable for adopting fair, honest and open behaviours and practices when raising or receiving and handling concerns. There should be personal and organisational accountability for: <ul style="list-style-type: none"> poor practice in relation to encouraging the raising of concerns and responding to them the victimisation of workers for making public interest disclosures raising false concerns in bad faith or for personal benefit acting with disrespect or other unreasonable behaviour when raising or responding to concerns inappropriate use of confidentiality clauses. 	14.1	Employers should ensure that staff who are responsible for, participate in, or permit such conduct are liable to appropriate and proportionate disciplinary processes.	This is covered within our Bullying and Harassment procedure, and our Raising Concerns and Whistleblowing policy.	nothing further needed.	n/a	
PRINCIPLE 14: Accountability: Everyone should expect to be held accountable for adopting fair, honest and open behaviours and practices when raising or receiving and handling concerns. There should be personal and organisational accountability for: <ul style="list-style-type: none"> poor practice in relation to encouraging the raising of concerns and responding to them the victimisation of workers for making public interest disclosures raising false concerns in bad faith or for personal benefit acting with disrespect or other unreasonable behaviour when raising or responding to concerns inappropriate use of confidentiality clauses. 	14.2	Trust boards, CQC, Monitor and TDA should have regard to any evidence of responsibility for, participation in or permitting such conduct in any assessment of whether a person is a fit and proper person to hold an appointment as a director or equivalent in accordance with the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014 regulation 5.	Evidence that is available would be discovered via FPPT, references, and interview - but it is a difficult area and it is hard to see how else evidence on the topic could be found.	HR to consider further whether there are other sources of evidence that could be looked at.	ST	Accountability for fair and open behaviours is being observed and monitored for all staff through use of Trust employment policies including updated recruitment practices to ensure that a person is a fit and proper person to hold an appointment in the Trust. The Trust is actively considering the introduction of a 360 degree element to the Trust appraisal system. This will be piloted in Autumn 2015.

Principle	Action	Details	Comments	Action	For	July Update
<p>PRINCIPLE 14: Accountability: Everyone should expect to be held accountable for adopting fair, honest and open behaviours and practices when raising or receiving and handling concerns. There should be personal and organisational accountability for:</p> <ul style="list-style-type: none"> • The poor practice in relation to encouraging the raising of concerns and responding to them • The victimisation of workers for making public interest disclosures • Raising false concerns in bad faith or for personal benefit • Acting with disrespect or other unreasonable behaviour when raising or responding to concerns • Inappropriate use of confidentiality clauses. 	14.3	<p>All organisations associated with the provision, oversight or regulation of healthcare services should have regard to any evidence of poor conduct in relation to staff who have raised concerns when deciding whether it is appropriate to employ any person to a senior management or leadership position and whether the organisation is well-led.</p>	<p>Current recruitment practices should uncover any evidence in this area, but that evidence may not be readily available.</p>	<p>HR to include guidance on questions on experience of raising concerns/whistleblowing in the interview pack for management posts.</p>	ST	<p>The Trust AFC contracts includes a contractual right to raise concerns and the Whistleblowing policy is made available on intranet.</p>
<p>PRINCIPLE 18: Students and trainees: All principles in this report should be applied with necessary adaptations to education and training settings for students and trainees working towards a career in healthcare.</p>	18.2	<p>All training for students and trainees should include training on raising and handling concerns.</p>	<p>Will Bannister confirmed on the 24/4/ that he would get the subject on the agenda of the Training Executive.</p>	<p>E&T executive to consider how to include in courses.</p>	BR	<p>A guide to the Freedom to Speak Up, Whistleblowing and the Duty of Candour has been drafted and once finalised will be made available via Moodle and staff handbooks. Estimated to be completed by Sept 2015.</p>

Board of Directors : July 2015

Item : 20

Title : Terms of Reference of the Management Team and of the Executive Director Appointments and Remuneration Committee

Summary:

The Management Team has reviewed its ToR and proposes some changes to membership and meeting pattern, which are presented for approval.

The Board's Appointment Committee and Remuneration Committee have the same membership so their Terms of Reference have been rewritten as a single document covering both areas, and the Committee named the Executive Director Appointment and Remuneration Committee. The new ToR are presented for approval.

For : Approval

From : Gervase Campbell, Trust Secretary

**Terms of Reference for Approval:
Management Team &
Executive Director Appointment and Remuneration Committee**

1. Introduction

- 1.1 The terms of reference for all board committees are periodically reviewed and updated, and changes need to be approved by the Board.

2. Management Team ToR

- 2.1 The Management Team has reviewed its ToR and proposes some changes to membership and meeting pattern, which are presented for approval.
- 2.2 The Management Team will have a core membership, the Executive Team, comprising the executive board directors, and a wider membership, which adds the Directors of HR, IMT, Marketing and Communications and Commercial. The core members will meet four times a month, the wider membership will meet an additional two times per month.
- 2.3 The Duties and other details of the ToR have not been changed.

3. Executive Directors Appointment and Remuneration Committee

- 3.1 The Board's Appointment Committee and Remuneration Committees have the same membership and related duties, so the two committees have been combined and named the Executive Director Appointment and Remuneration Committee.
- 3.2 The Remuneration part of these ToR is the same as for the previous Remuneration Committee. They continue to include some responsibility outside the executive directors:
- 3.2.1 To approve the ACCEA Local Awards Committee recommendations,
 - 3.2.2 To approve all the performance related pay arrangements in the Trust
 - 3.2.3 to advise on non-board director's pay
- 3.3 The duties within the appointment section of these ToR have been updated with material taken from the NHS Provider's template for this committee.

4. Approval

- 4.1 The Board are asked to approve the Terms of Reference of both these committees.

Gervase Campbell
Trust Secretary
July 2015

MCMC 17 June

Management Team Terms of Reference

Ratified by:	Board of Directors
Date ratified:	<i>July 2015 (tbc)</i>
Name of originator/author:	Paul Jenkins, Committee Chair
Name of responsible committee/individual:	Management Team / Team Chair
Previous Name of Committee	Management Committee until June 2014
Date issued:	July 2007; June 2009; July 2010: June 2014
Review date:	June 2016

Management Team Terms of Reference

1. Constitution

- 1.1 The Board of Directors hereby resolves to establish an advisory committee to advise and support the Chief Executive in his role in the Trust, to be known as the Management Team, previously known as the Management Committee. This Team has no executive powers other than those delegated in these terms of reference.

2. Membership

- 2.1 The Core membership of the Management Team, known as the Executive Team, shall be as follows:

2.1.1 Chief Executive (Committee Chair)

2.1.2 Deputy Chief Executive and Director of Finance

2.1.3 Director of Education and Training

2.1.4 Director of Quality and Patient Experience; Adult and Forensic Services

2.1.5 Medical Director

2.1.6 Director of Children, Young Adults and Families Services

2.1.7 Nurse Director

- 2.2 The Additional membership of the Management Team, shall be as follows:

2.2.1 Commercial Director

2.2.2 Director or Head of Human Resources

2.2.3 Director of IMT

2.2.4 Director of Marketing and Communications

3. Quorum

- 3.1 This shall be at least one third of members.

4. Frequency of meetings

- 4.1 The Executive Team membership of the Management Team will meet formally four times a month. In addition there will be two meetings a month of the full Management Team, the Executive members plus the Additional members, one of which will be formal and one strategic.

5. Agenda & Papers

- 5.1 Meetings of the Management Team will be called by the Team Chair. The agenda will be drafted by the Management Team Secretary and approved by the Chair prior to circulation.
- 5.2 Notification of the meeting, location, time and agenda will be forwarded to Management Team members, and others called to attend, at least three days before the meeting. Supporting papers will also be sent out at this time. If draft minutes from the previous meeting have not been circulated in advance then they will be forwarded to Management Team members at the same time as the agenda.

6. Minutes of the Meeting

- 6.1 The Management Team Secretary will minute proceedings, action points, and resolutions of formal meetings of the Team, including recording names of those present and in attendance.
- 6.2 Strategic meetings, occasional meetings and conferences will not be minuted unless resolutions or action points are to be agreed.
- 6.3 The Chief Executive will highlight pertinent issues and what action has been taken as a result in his reports to the Board of Directors.

7. Authority

- 7.1 The Management Team is constituted to advise the Chief Executive on the conduct and carriage of his role. The Chief Executive holds decision making rights, although in practice these are often delegated to the Management Team. The Management Team therefore gets its authority from the Chief Executive.

MCMC 17 June

8. Duties

- 8.1 The Management Team is the central executive Committee of the Trust.
- 8.2 It advises the Chief Executive on the management of all aspects of the Trust's work.
- 8.3 It is responsible for leading, managing and co-ordinating the Trust's output activities, clinical work, training, consultancy and research, and for ensuring effective liaison and integration between the clinical and non-clinical directorates.
- 8.4 It is responsible for leading and managing the operation of the Trust and its performance in delivering the Operational Plan and Strategic Plan.
- 8.5 It is responsible for developing and proposing strategy to be agreed by the Board of Directors and for leading and delivering the Trust's strategic direction via the Committees that are accountable to the Board of Directors.
- 8.6 It is responsible for reviewing the Trust's management processes and structures and making changes to improve the quality of management.
- 8.7 It is responsible for reviewing changing demands, opportunities and pressures within the NHS and wider environment and leading the Trust's response to these changes.
- 8.8 It is responsible for planning and prioritising to set the annual budget with the Director of Finance and the Chief Executive, for agreement by the Board of Directors.
- 8.9 It is responsible for monitoring the budget on a monthly basis and conducting a mid-year review led by the Director of Finance.
- 8.10 It is responsible for ensuring the Trust's compliance with national standards and the requirements of the Care Quality Commission and other national monitoring bodies.
- 8.11 It has close liaison with other Committees that report to it and will receive regular reports from them. Staff leading in areas of the Trust's work will attend the Committee to report, and to widen consultation. It will need to be responsive to staff and to encourage enterprise and creativity.

9. Other Matters

- 9.1 At least once a year the Management Team will review its own performance, constitution and terms of reference to ensure that it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board of Directors for approval.

10. Reporting

- 10.1 The minutes of the Management Team will be formally recorded by the Secretary and, approved by the Management Team. The Chair shall draw the attention of the Board of Directors to any issues in the minutes that require disclosure or executive action.

11. Support

- 11.1 The Management Team will be supported by a Secretary from the Chief Executive's team.

June 2015

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Executive Appointment and Remuneration Committee

Ratified by:	Board of Directors
Date ratified:	<i>July 2015 (tbc)</i>
Name of originator/author:	Angela Greatley, Committee Chair
Previous Name of Committee	Remuneration and Terms of Service Committee; Appointments Committee
Name of responsible committee/individual:	Angela Greatley, Committee Chair
Date issued:	July 2007; January 2009; June 2009; June 2011
Review date:	July 2016

Executive Appointment and Remuneration and Committee Terms of Reference

12. Constitution

- 12.1 The Board of Directors hereby resolves to establish a standing committee to be known as the Executive Appointment and Remuneration Committee (the Committee). This Committee combines the previous Remuneration Committee and the Appointment Committee. This Committee has no executive powers other than those delegated in these terms of reference.

13. Membership

- 13.1 Membership of the Committee shall be as follows:

13.1.1 All the Non-Executive Directors shall be members

13.1.2 The Chair of the committee shall be the Trust Chair

13.1.3 In addition the Chief Executive will be a member when appointing executive directors other than the CEO.

14. Attendance

- 14.1 Only members of the committee have the right to attend committee meetings, and the authority to vote and determine decisions on behalf of the Committee.

- 14.2 At the invitation of the committee, meetings shall normally be attended by the:

14.2.1 Chief Executive

14.2.2 Director of Human Resources.

- 14.3 Other persons may be invited by the committee to attend a meeting so as to assist in deliberations.

- 14.4 Any non-member, including the secretary to the committee, will be asked to leave the meeting should their own conditions of employment be the subject of discussion.

15. Quorum

- 15.1 This shall be at least three members.

16. Frequency of meetings

- 16.1 The Committee will meet as required, but at least once in each financial year.

17. Agenda & Papers

- 17.1 Meetings of the Committee will be called by the Committee Chair. The agenda will be drafted by the Committee Secretary and approved by the Committee Chair prior to circulation.
- 17.2 Notification of the meeting, location, time and agenda will be forwarded to Committee members, and others called to attend, at least five days before the meeting. Supporting papers will also be sent out at this time. If draft minutes from the previous meeting have not been circulated in advance then they will be forwarded to Committee members at the same time as the agenda.

18. Minutes of the Meeting

- 18.1 The Committee Secretary will minute proceedings, action points, and resolutions of all meetings of the Committee, including recording names of those present and in attendance.
- 18.2 Approved minutes will be forwarded to the Board of Directors for noting.

19. Authority

- 19.1 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek information it requires from any employee, and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised to obtain outside legal advice or other professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary.

20. Main Purpose

- 20.1 To be responsible for identifying and appointing candidates to fill all the executive director positions on the board and for determining their remuneration and other conditions of service.

When appointing the chief executive, the committee shall be the committee described in Schedule 7, 17(3) of the National Health Service Act 2006 (the Act).

When appointing the other executive directors the committee shall be the committee described in Schedule 7, 17(4) of the Act.

21. Remuneration Role

The committee will:

21.1 Establish and keep under review a remuneration policy in respect of executive board directors and other Senior Directors. The remuneration of the Trust Chair and other Non-Executive Directors shall be a matter for the Council of Governors.

21.2 Approve the design of, and determine targets for, any performance related pay schemes operated by the Trust.

21.3 Consider the recommendations of the ACCEA Local Awards Committee approve the implementation of the recommendations.

21.4 Consult the chief executive about proposals relating to the remuneration of the other directors.¹

21.5 In accordance with all relevant laws, regulations and trust policies, decide and keep under review the terms and conditions of office of the trust's executive directors, including:

- Salary, including any performance related pay or bonus;
- Provisions for other benefits, including pensions and cars;
- Allowances;
- Payable expenses;
- Compensation payments.

21.6 In adhering to all relevant laws, regulations and trust policies:

21.6.1 establish levels of remuneration which are sufficient to attract, retain and motivate executive directors of the quality and with the skills and experience required to lead the trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable for the trust;

21.6.2 use national guidance and market benchmarking analysis in the annual determination of remuneration of executive directors [and

¹ Monitor NHS Foundation Trust Code of Governance, E.2, supporting principle

senior managers on locally-determined pay], while ensuring that increases are not made where trust or individual performance do not justify them;

21.6.3 be sensitive to pay and employment conditions elsewhere in the trust.

21.7 Monitor, and assess the output of the evaluation of the performance of individual executive directors, and consider this output when reviewing changes to remuneration levels.

21.8 Advise upon and oversee contractual arrangements for executive directors, including but not limited to termination payments to avoid rewarding poor performance.

22. Appointments Role

The Committee will:

22.1 When a vacancy is identified, evaluate the balance of skills, knowledge and experience on the board, and its diversity, and in the light of this evaluation, prepare a description of the role and capabilities required for the particular appointment. In identifying suitable candidates the committee shall use open advertising or the services of external advisers to facilitate the search; consider candidates from a wide range of backgrounds; and consider candidates on merit against objective criteria.

22.2 Ensure that a proposed executive director's other significant commitments (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the board as they arise.

22.3 Ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported.

22.4 Ensure that proposed appointees are Fit and Proper people for the role, under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

22.5 Consider the re-appointment of any Executive Director at the conclusion of their term of office (if applicable) having given due regard to their performance and ability to continue to contribute to the Board of Directors in the light of the knowledge, skills and experience required.

22.6 Consider any matter relating to the continuation in office of any board executive director including the suspension or termination of service of an individual as an employee of the trust, subject to the provisions of the law and their service contract.

23. Other Matters

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

24. Sources of Information

- 24.1 The Committee will receive and consider sources of information relating to NHS remuneration, provided by the Director of Human Resources or from other sources as required.

25. Reporting

- 25.1 The minutes of the Committee, once approved by the Committee, will be submitted to the Board of Directors for noting. The Committee Chair shall draw the attention of the Board of Directors to any issues in the minutes that require disclosure or executive action.
- 25.2 The Committee will prepare and submit an annual report of the Trust's remuneration practices that will form part of the Trust's Annual Report and ensure each year that it is put to Members at the Annual General Meeting.
- 25.3 The Committee Chair shall attend the Annual General Meeting (AGM) prepared to respond to any Member's questions on the Committee's activities.

26. Support

- 26.1 The Committee will be supported by a Secretary from the Trust Secretary's team.

Board of Directors : July 2015

Item : 21

Title : Constitutional Amendments

Summary:

Constitutional changes need to be approved by the Board of Directors, the Council of Governors and by the Trust members at the Annual General Meeting. Monitor no longer has a role in approving foundation trusts' constitutions.

The changes proposed this year are to reflect the changed job titles of the Executive Directors.

The Board is asked to approve these changes to the Constitution.

For : Approval

From : Trust Secretary

Constitutional Amendments

1. Introduction

- 1.1 Amendments to the Constitution need to be approved by the Board of Directors, the Council of Governors and at the Annual General Meeting. Monitor no longer has a role in approving foundation trusts' constitutions although trusts are still required to forward a copy of their amended constitutions to Monitor for publishing on Monitor's website.

2. Corrections, amendments and additions

- 2.1 Details of the proposed changes are:

Constitutional Amendments

The wording of the proposed constitutional amendments is shown in italics.

19 Board of Directors - Composition

Change the titles of the Executive Directors to reflect the changes made to job titles. The new sentences will read:

19.8

One of the Executive Directors shall be the Director of Children, Young Adults and Family Services (CYAF); this Executive Director will be a non-voting Executive Director.

19.9

One of the Executive Directors shall be the Director of Education and Training/ Dean of Postgraduate Studies.

19.10

One of the Executive Directors shall be the Director of Quality and Patient Experience; Adult and Forensic Services.

Gervase Campbell
Trust Secretary
June 2015

Board of Directors : July 2015

Item : 22

Title : Capital Project: DET reconfiguration

Purpose:

This paper was previously circulated on the 13th July, and the decision made via email on the 16th July 2015 (under BDSO 3.2), to proceed with Phase 1 of the DET reconfiguration capital project.

The board are asked to formally ratify this decision.

This report focuses on the following areas:

(delete where not applicable)

- Risk
- Finance
- Quality

For : Approval

From : Director of Education & training / Dean of Postgraduate Studies

Capital Project: DET reconfiguration

1. **Introduction**

- 1.1 There is a need for significant improvement in the ways we work and our approach to work in the education and training enterprise. This results from a range of strategic drivers primarily in relation to the needed growth of student numbers, the diversification of our training portfolio, and the increase in our regional reach.
- 1.2 The Strategic Transformation Programme (STP) outlined and adopted by the TEMPB reflects the reality of the requirement for significant change in both scope and pace.

2. **Proposed changes**

- 2.1 Over the last 7 weeks our interim Transformation Director, John Martin, has carried out a scoping exercise across our operation aimed at proposing the structural, organisational and administration improvements needed to deliver our ambitious transformation plans and business targets.
- 3. Through an investigative process he has gained a detailed understanding of our current culture and practices, including some distressing evidence of our shortcomings.
- 3.1 Moreover, John has made some precise proposals about opportunities for change and expected benefits, supported by a programme approach to delivering change taking account of our current culture and practices (see Appendix 1).
- 3.2 John will produce a detailed report of his investigation and proposals in mid-July, which will underpin the consultation document that will be circulated to staff in September 2015. This will be presented to the TEMPB at its September meeting before circulation to staff.
- 3.3 At its 6 July 2015 meeting, the Training & Education Programme Management Board (TEPMB) discussed and agreed the need for the proposed changes that are part of the Strategic Transformation Programme. It expressed clear support for these developments, which were seen to address significant cultural issues and needed integration of functions, workflows and communication.

4. **Proposed office reconfiguration**

4.1 The outline issues and proposed changes described in the previous section are intended to achieve the follow benefits:

- Restructure along functional lines rather than product portfolio
- Change the environment to bring people together and encourage direct communication
- Draft clear functional strategies aligned to overall business goals
- Embed a culture of delivery through well founded and managed targets for teams and individuals
- Publish clear service level commitments for students, course tutors, visiting lecturers and other stakeholders, based around measurable deliverables
- Introduce a simple web-based customer relationship management (CRM) process to enable better data and workflow management in support of targets

4.2 There are considerable constraints to achieving this from the current configuration of the office footprint in DET.

4.3 Over time and in particular in the past few months the number of staff working in DET has grown. As it stands 11 more staff than were working in the department in 2014 need to be accommodated this year. This includes new staff, staff due to be recruited and staff that are to be relocated from other floors as they become part of the department (Marketing and Communications). The department also needs to consider the future and additional space that will be needed both for and to support additional students as the Trust hopes to grow.

4.4 While there is no additional space in the building available to DET, and it has been asked to sacrifice space on other floors, it is hoped that by reconfiguring the office space the department can make a better use of the space available to it, create a more welcoming and attractive environment to both staff and students and bring all staff in the department together in one location to enable them to work in a more collaborative way.

4.5 Appendix 2 demonstrates the current room structure of DET while Appendix 3 shows the proposed reconfigured space. This does not include room 234 which has already been converted into a meeting room and shared working space for the department.

- 4.6 As the images show at present the space available to DET is divided into a number of smaller offices which do not allow for flexibility or represent a good use of space. Some staff are in offices that are too small for them while others have excess space. The offices are dark, outdated, and there are not proper storage solutions in place. There is no space for meetings, or for staff to have private conversations with one and other or with students.
- 4.7 As outlined above the current layout of offices has encouraged the department to operate as a series of separate functions. Staff are repeating tasks and not sharing knowledge representing wasted time and missing an opportunity for sharing ideas and good practice. Reconfiguring the offices will allow functions within the department that work together to sit together and share knowledge which could result in finding better ways of working and improving productivity.
- 4.8 It is proposed that the current layout of offices is reconfigured in two phases. The first will address rooms on the east side of the department and will take place in August 2015. The second phase, addressing the west side of the department and creating a student reception area would take place in December 2015.

5. Phase 1

- 5.1 The 4 rooms on the east side of the corridor currently accommodate staff from marketing and communications, the Dean's office, the conference unit, finance, TEL and a learning portfolio developer. It is proposed that all walls on this side of corridor are brought down to create one open plan office.
- 5.2 The majority of the staff currently on this side of the corridor would remain in this shared space with the Dean also moving down to this floor. Finance will eventually move to the West side of the corridor however can be accommodated in room 343 in the interim period.
- 5.3 It is proposed that this work is carried out in August as a number of staff will be away from the office during this time making the reconfiguration simpler. The decision was taken to complete this side of the corridor first due to the amount of work course administrators are undertaking in August and September while preparing for the new term.

6. Phase 2

- 6.1 Phase 2 would address the west side of the corridor. The 2 rooms currently occupied by the course administrators (261/263 and 264 in appendix A)

would be merged into 1 as would the 2 rooms currently occupied by quality (259/260).

- 6.2 Quality will remain in its current space which will also accommodate finance. The other large open plan office shall have a student reception installed and the remaining space shall accommodate the course administrators and registry. Informatics will remain in 268 which will be unchanged.
- 6.3 As well as meeting the practical needs of accommodating staff this new environment will provide a more welcoming environment for students that appears professional, well organised and modern. The inclusion of a student reception offers a number of benefits including;
- Presenting a professional student facing environment with a clear place for students to go when they have queries and a welcoming area for new students.
 - Providing new ways of communicating with students such as video screens detailing events taking place and location of seminars.
 - Reducing the amount of non-essential queries directed at course administrators

7. Concerns

- 7.1 A meeting was held in June with representatives of each of the current rooms providing an opportunity for staff to voice their concerns regarding the proposed reconfiguration and attempt to identify steps that could be taken to address them.
- 7.2 Staff raised concerns relating to privacy/confidential nature of their work, noise, lack of space and poor organisation of previous moves. The department has recognised these concerns and proposed a number of steps to address them.
- 7.3 While it is recognised that both phases of the reconfiguration will take several weeks and will be disruptive there will proper project plans in place to ensure it goes smoothly and staff are able to work. Staff can be accommodated in other parts of the building during the works (such as the library) and plans will be in place to ensure that staff are able to return to their new desks on time and that the necessary resources are in place to enable them to begin work straightaway.

8. Costings

- 8.1 The proposal has been fully developed with the support of our Estates Manager, Paul Waterman, who has provided a comprehensive costing for all the work, including fixtures, fittings and furniture. This is detailed in Appendix 4.
- 8.2 The total costs for Phase 1 are £63,254.90. Phase 2, to be presented for approval in the Autumn is expected to have similar costs.

9. Summary

- 9.1 In summary in order to provide a more professional and welcoming environment to students as well as enabling the department to accommodate all staff the TEPMB is being asked to approve the reconfiguration of DET. This will take place in two phases culminating in two smaller offices, two large open plan offices and a student reception.
- 9.2 Approval is being sought for Phase 1 at this stage.

Brian Rock
Director of Education and Training /Dean of Postgraduate Studies
7 July 2015

Appendix 1

i. Current state & legacy issues

The issues have been grouped in several areas. Included here is one example to illustrate the point but there are several examples to call upon which will be discussed in greater detail when John publishes his report for the Training Executive.

- Lack of administrative leadership
 - Example:** No strategy or targets or culture of performance management for CPD
 - Consequence:** Perception of CPD is down to personal experience and no way of identifying issues, rectifying problems or driving improvement. Also very difficult to forecast results and use outcomes to influence future planning.
Poor performance is rarely identified and definitely not dealt with and conversely, success is rarely celebrated.
- Structure based on 'products' (i.e. course portfolios) rather than function.
 - Example:** 10 course administrators all doing the same cradle-to-grave service
 - Consequence:** 10 generalists. Low specialization, no standardisation, variable service to all internal and external customers, no statistical analysis or strategic planning.
- Deep-rooted cultural divisions
 - Example:** In the absence of formal ways of doing business, the perceptions of teams and their stakeholders misaligned and in some case in conflict.
 - Consequence:** Deteriorating relationships, increased formal labour disputes, dropping performance and productivity and lessening of loyalty. Innovating and delivering change becomes increasingly frustrating.
- Lack of cohesive organisationally aligned strategy
 - Example:** Course administrators set their own agenda, often involving their own unique ways of data collection and management. Also, due to rivalries, they regularly knowingly don't share information for central coordination.
 - Consequence:** ***Very POOR data capture and management***, leading to duplicate/triplicate and higher orders of

replication on student records carrying different statuses and/or course details.
Inability to rely on data analysis and set action plans in motion.
There is evidence of repeated contacts to the spouse of a deceased enquirer and equally, of enquiries not being followed up.

- Few formal processes and procedures
Example: Contracting visiting lecturers have inconsistent or unknown contracts and many delays in paying them.
Consequence: Litigation with unmitigated financial risk if contracts are poor. 3rd parties taking on some in-house strategic activities leading to loss of knowledge and increased costs. Deteriorating relationships could cause interruption in supply.
- Physical barriers reinforcing cultural barriers
Example: Teams split into small spaces hindering communications. Open access to these areas by various stakeholders gives rise to interruption and distraction.
Consequence: Lower productivity, data protection issues, poor service response times, lack of team ethic and cohesion.

ii. Proposed changes

10. **The summary of the proposed changes are set out below. This list is not exhaustive as the scoping work is not yet complete. It will also address processes and accountability for new course and business development and cultural change.**

ID	Description	Complexity	Timescale	Benefits
1	Recruit PMO	LOW	1 MONTH	Coordinate all programme activity ensuring timely delivery and escalations of tasks and issues. Will help keep programme on time and in budget. Can also support ICT deployment where no formal project management skills exist internally

ID	Description	Complexity	Timescale	Benefits
2	Move all enquiry activity prior to application launch into enquiry team as part of enhanced recruitment function reporting to and located with Marketing and Communications	LOW	IMMEDIATE	Better control over data creation and management leading to better targeting and conversion rates. Driving consistency in approach and data centralization will reap immediate and lasting benefits in the ability to drive reliable business critical data analysis for strategic planning.
3	Introduce home-grown enquiry management system /process at low cost with data handling easily transportable to new system	MEDIUM	1 MONTH	Support 1 above. Drive better reporting and therefore tracking against targets
4	Co-locate conference unit and MarComms into one open location	LOW	1.5 MONTHS	Improved communication and co-ordination. Allows shard broadcast of targets and success rates around targets
5	Form a facilities team dedicated to room management across the entire organisation but reporting in DET to co-ordinate on and off-site rooms and resources for all areas. It should also include current AV services and could report in to Head of TEL.	MEDIUM	4 MONTHS	Makes all requests equal (evidence of existing hierarchy in preferencing and usurping rooms currently) Enables active management to deal with issues and risks. Will dedicate time to developing partnerships to share facilities at low cost to expand capacity
6	Formulate functional charters where missing to cover purpose, methodologies and tracking. Delivered by teams themselves through a series of workshops including teams and selected stakeholders	MEDIUM	2 MONTHS	Clear way of defining services to be delivered to whom in which way. Allows all stakeholders to know what service level they can expect. Facilitates the development of professional career paths and allows the organisation to lever skills across functions
7	Introduce 'Behaviour Matrices' to describe the traits of successful teams.	MEDIUM	3 MONTHS	Enables the organisation to embed shared values and record successes and link results to individual performance
8	Introduce department and individual targets across DET coupled to formal management procedure and aligned to Organisational goals.	LOW	3 MONTHS Ready for 2016/17 recruitment cycle	Regular management reporting and warning sign escalation. Allows Exec to formulate and lead remedial action where required, and encourages exec to celebrate success with teams – employee satisfaction and retention impact.

ID	Description	Complexity	Timescale	Benefits
9	Recruit interim Support manager to oversee introduction of performance procedures and to take direct control of Course Admin and Registry and Facilities teams	LOW	3 MONTHS	Enables single point of accountability for measurement and management of individual and organisational performance. This change will drive clarity on where upskilling, individual job alignment, redundancy or recruitment may be required. This role will oversee all operational transition areas
10.	Formalise all working procedures in a version controlled quality manual and introduce annual audits to look for non-compliances	MEDIUM	6 MONTHS	Able to track compliance to results. Also ensures consistency in delivery to all customers. Enable quicker induction for temps and interims or job cover.
11	Full physical integration of DET	MEDIUM	9 MONTHS	Form fully integrated team with operational tasks separated from stakeholder interactions. Supports possibility of building a true 'High Performing Team' with high engagement.

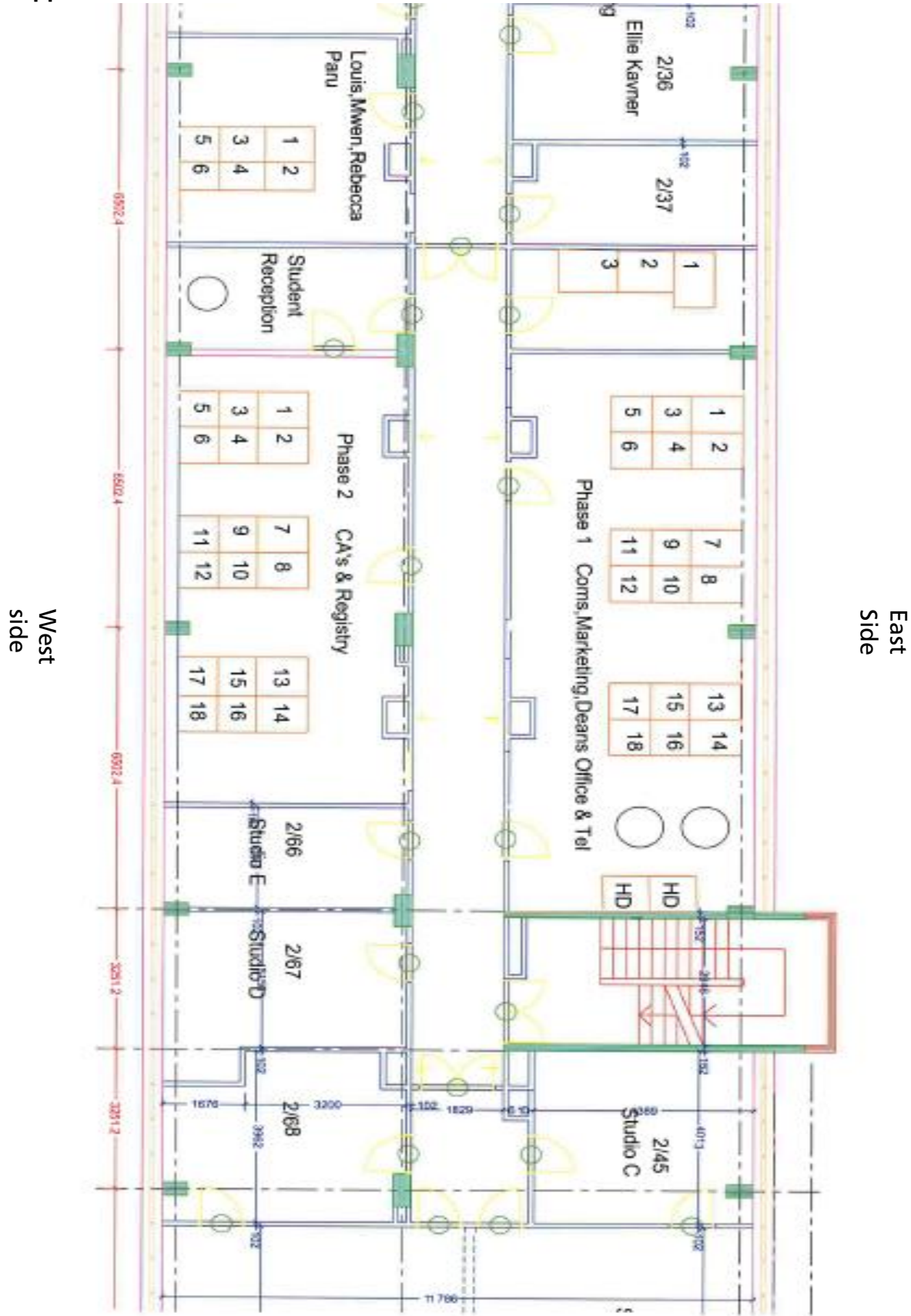
West
side

Architectural floor plan of the second floor. The plan shows a central corridor with rooms on both sides. Rooms include offices (e.g., 2/36, 2/37, 2/38, 2/39, 2/40, 2/43, 2/44), a conference unit, a department of training and postgraduate education, a studio E, a studio D, and a studio C. The plan also shows a staircase and various dimensions.

Rooms and Dimensions:

- 2/36: 102
- 2/37: 102
- 2/38: 102
- 2/39: 102
- 2/40: 102
- 2/43: 102
- 2/44: 102
- 2/45: 102
- 2/68: 102
- 2/67: 102
- 2/66: 102
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- 2/18: 102
- 2/17: 102
- 2/16: 102
- 2/15: 102
- 2/14: 102
- 2/13: 102
- 2/12: 102
- 2/11: 102
- 2/10: 102
- 2/9: 102
- 2/8: 102
- 2/7: 102
- 2/6: 102
- 2/5: 102
- 2/4: 102
- 2/3: 102
- 2/2: 102
- 2/1: 102

Appendix 3



DET: Phase 1
SCOPE OF WORKS

Date : 10 th July 2015

Variations :

BUDGET ESTIMATE		Unit	Labour	Material	Total
Code	Description of work item	M ²	£	£	£
Item					
1	Demolitions,alterartions & strip out				
1.01	Demolish walls and make good				£5,886.00
1.02	Remove ceiling & grids replace				£286.00
1.03	Supply and install new ceiling				£2,896.00
2	Enabling and access works:				
2.01	Protection to site during works				Inc. above
2.02	Clear site on completion of works				Inc. above
2.03					
3	Raised floors				
3.01					
4	Floor finishes				
4.01	Remove existing flooring prepare and make good check level and screed				
4.02	Allow to supply and install new carpet integral skirting and all designated designs				£2,685
5	Wall finishes				
5.01	Apply 1 mist & 2 full coats of acrylic emulsion to walls Lightly sand between coats: See finishes schedule for colours				£838.00
5.02	Glass Partition Create aperture where specified 2Mtr in width and make good				£6,911.00
8	Small power				
8.01	Supply and install floor compartment trunking Connect to island desks Test and issue certification				£4,294
9	Lighting & fittings				
9.01	Allow to take down and dispose of under WEE regs Fit trust issued fittings Test and issue certification				£1,800.00
9.02	Office light fittings				
11	Data and telecommunications;				
11.01	Relocate existing data lines.	18			£720.00
14	Mechanical and air handling				
14.01	Relocate heating pipes into ceiling void				£1,250.00
20	Textiles/Blinds				
	Replace blinds	8			£2,400.00

24	Furniture installation				
	Desks Dual beam monitor arm Floor standing screen etc. see drawing				£18,691.62
SUB - TOTAL					£48,657.62
CONTINGENCY @ 10%					£4,865.76
BUDGET CONSTRUCTION COST					
M&E	N/A				0.00
PROFESSIONAL FEES @ 8.5%					0.00
SUB-TOTAL					
Plus VAT @20%					£9,731.52
TOTAL PROJECT COST					£63,254.90

Variations: