

## Board of Directors Part One

**Agenda and papers**  
of a meeting to be held in public

2.00pm–4.40pm  
Tuesday 23<sup>rd</sup> February 2016

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



## BOARD OF DIRECTORS (PART 1)

Meeting in public  
Tuesday 23<sup>rd</sup> February 2016, 14.00 – 16.30  
Lecture Theatre, Tavistock Centre, 120 Belsize Lane, London NW3 5BA

### AGENDA

PRELIMINARIES				
1.	<b>Chair's Opening Remarks</b> Mr Paul Burstow, Trust Chair		Verbal	-
2.	<b>Apologies for absence and declarations of interest</b> Mr Paul Burstow, Trust Chair	To note	Verbal	-
3.	<b>Minutes of the previous meeting</b> Mr Paul Burstow, Trust Chair	To approve	Enc.	p.1
3a.	<b>Outstanding Actions</b> Mr Paul Burstow, Trust Chair	To note	Enc.	-
4.	<b>Matters arising</b> Mr Paul Burstow, Trust Chair	To note	Verbal	-
REPORTS & FINANCE				
5.	<b>Service User Story</b>	To note	Verbal	-
6.	<b>Service Line Report – Family Drug Alcohol Court (FDAC) and Westminster Family Services (WFS)</b> Mr Steve Bambrough, Associate Clinical Director	To discuss	Enc.	p.9
7.	<b>Trust Chair's and NEDs' Reports</b> Mr Paul Burstow, Trust Chair	To note	Verbal	-
8.	<b>Chief Executive's Report</b> Mr Paul Jenkins, Chief Executive	To note	Late	-
9.	<b>IMT Strategy</b> Mr Toby Avery, Director of IM&T	To approve	Enc.	p.29
10.	<b>CQC Inspection Review</b> Ms Louise Lyon, Director of Quality & Patient Experience	To discuss	Enc.	p.54
11.	<b>Finance and Performance Report</b> Mr Simon Young, Deputy Chief Executive & Director of Finance	To note	Enc.	p.57
12.	<b>CQSG Quarter 3 Report</b> Dr Rob Senior, Medical Director	To discuss	Enc.	p.67
13.	<b>Training and Education Report</b> Mr Brian Rock, Director of Education & Training/Dean	To note	Enc.	p.75

14.	<b>Draft Annual Quality Report</b> Ms Louise Lyon, Director of Quality & Patient Experience Ms Marion Shipman, Associate Director for Quality & Governance	To approve	Enc.	p.80
15.	<b>Corporate Governance - Approval for use of Trust Seal</b> Mr Gervase Campbell, Trust Secretary	To approve	Enc.	p.143
<b>CLOSE</b>				
16.	<b>Notice of Future Meetings</b> <ul style="list-style-type: none"> <li>• Thursday 3<sup>rd</sup> March 2016, Council of Governors' Meeting, 2.00pm – 5.00pm, Board Room</li> <li>• Tuesday 8<sup>th</sup> March 2016: Leadership Conference, 9.00am – 1.00pm, Lecture Theatre</li> <li>• Tuesday 29<sup>th</sup> March 2016: Board of Directors' Meeting, 2.00pm – 5.00pm, Lecture Theatre</li> <li>• Tuesday 12<sup>th</sup> April 2016: Joint Boards' Meeting, 10.00am – 2.00pm, Lecture Theatre</li> </ul>		Verbal	-

## Board of Directors

Meeting Minutes (Part One)  
Tuesday 26<sup>th</sup> January 2016, 2.00 – 4.20pm

<b>Present:</b>			
Mr Paul Burstow Trust Chair	Prof. Dinesh Bhugra NED	Ms Jane Gizbert NED	Dr Sally Hodges 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 NED & Vice Chair of Trust	Ms Edna Murphy NED	Mr Brian Rock Director of E&T/ Dean	Dr Rob Senior Medical Director
Mr Simon Young Deputy CEO & Director of Finance			
<b>Attendees:</b>			
Mr Gervase Campbell Trust Secretary (minutes)	Ms Natalie Baron, Governor	Mr Tim Kent, Service Lead (item 6)	Ms Marion Shipman, Deputy Director of Quality (item 11)
<b>Apologies:</b>			

### Actions

AP	Item	Action to be taken	Resp	By
1	3	Minor amendments to be made to the minutes	GC	Immd.
2	8	Provide briefing on iThrive to directors	PJ	April
3	10	Board to discuss support for carers	PJ	Spring
3	11	Check correct denominator used in calculating bipolar disorder access figures	LL	March

#### 1. Trust Chair's Opening Remarks

Mr Burstow opened the meeting.

#### 2. Apologies for Absence and declarations of interest

Apologies as above. Mr Campbell reported an update to the register of interests:

- Mr David Holt has joined the Planning Inspectorate as NED and Chair of their Audit Committee.

#### 3. Minutes of the Previous Meeting

**AP1** The minutes were approved subject to minor amendments

#### 4. Matters Arising

Action points from previous meetings:

AP1 – (Minutes) – completed.

OAP4 – (team summaries) – completed.

Mr Burstow asked for an update on ligature points. Ms Jones explained that an independent consultant had conducted an audit of the main buildings in the

Autumn, and a proportionate action plan had been developed by Estates and would be reviewed in the CQSG meeting next week. In the meantime certain actions had already been taken, including replacing hooks and window catches. Mr Jenkins added that the second stage would be to review the sites the Trust did not own.

Professor Bhugra asked if the Junior Doctor strike had impacted on services. Mr Jenkins confirmed that there had been very minimal effect.

## **5. Service User Story**

The Board was shown a video presentation on Team Around the Practice (TAP), which explained the service and included comments from patients, GPs, commissioners and clinicians.

## **6. Primary Care Services, PCPCS and TAP – Service Line Report**

Mr Kent introduced his report by speaking about the pressures on GPs, and how the services differed in the two boroughs. He discussed the pressure on the service which resulted from being so visible and accessible, with a porous boundary for referrals, and how they had begun to hold open discussions with their CCG partners about the need to tighten these.

Mr Burstow noted that one benefit of the service was support for the primary care professional teams, and asked whether this was seen as part of the offer. Mr Kent explained that in Camden it was an explicit part of the service whilst in Hackney there was more emphasis on numbers and contributing to IAPT.

Ms Gizbert noted that waiting times constituted a significant risk, and asked whether the practical actions taken were sustainable long term. Mr Kent explained that whilst part of the response was short term they were also allocating their resources to surgeries according to population and speaking to them about limiting the number of referrals. Mr Jenkins commented that he had observed the teams in Hackney directly and via One Hackney, and they had made themselves a valuable and sought out part of the scene and shaped a view of integrated care that gives more weight to psychological issues. Working in this area they found a lot of previously un-met need, and had to strike a balance between openness and restricting access, and the Trust needed to support them in treading that path.

Mr Rock asked about treatment innovation and progress with embedding group approaches. Mr Kent explained that they had made a concerted effort recently, appointed a groups coordinator, had 5 groups running, and were better able to attend to the reasons people had for dropping out.

Mr Holt noted the powerful staff statements which showed their dedication, but given the increasing pressures, asked how we judged when the team had reached its limit? Mr Kent explained that they invested in supervision, which was fundamental to the service, as well as feedback, appraisal, and learning from incidents. Indicators such as sickness rates were positive, and there was good support from colleagues, and an open culture where staff did come and talk to

him. He had recently pulled back on the case load level as there were signs of diminishing returns.

Professor Bhugra commented that he had visited the team before Christmas and they had been incredibly impressive, and clearly enjoying their work, which was a credit to Mr Kent's leadership. He noted that they had won both the BMJ's and the Royal College of Psychiatrists' team awards.

Dr Hodges asked about social prescribing, and Mr Kent noted the Turkish horticultural group had been one of their best innovations, meeting a need not well catered for otherwise, and they were attempting to develop similar projects in collaboration with MIND in Kentish Town and Bloomsbury.

Mr Burstow thanked Mr Kent and the service users who had appeared in the video presentation, and noted that there would be an ongoing discussion in CQSG over how to hold the service and manage risk when the door is open but the resource is constrained.

The Board **noted** the report.

## **7. Trust Chair and NEDs' Reports**

Mr Burstow highlighted the visits he had made since the last meeting, to City and Hackney, the Fitzjohns and Lyndhurst Units, First Steps and the Trauma service. Key points had been the importance of supervision and reflection to enable performance, and the crucial role of interpreters in working with refugees.

Professor Bhugra had represented the Trust at the Cavendish Square meeting, and noted that many Trusts with more SIs have a NED trained to them, and asked whether the Trust should be doing more to support patients and employers overcome the barriers to employment. Mr Burstow suggested that as they were setting NED objectives, there could be a specific one included on SIs.

Ms Gizbert reported that she had sat on the panel assessing website suppliers, and the process had been interesting, and they expected a good outcome.

Mr Holt reported that he had visited the Royal Free pain clinic, where we were not the leading partner, which might have implications for decision making on care pathways – which was a factor to consider in future partnership arrangements.

The Board **noted** the reports.

## **8. Chief Executive's Report**

Mr Jenkins highlighted that at the initial event of the Mental Health Programme for North Central London Dr Senior had jointly presented the strategy, and noted there were opportunities to work creatively to improve pathways.

With FDAC there was some support for a further year of the National Unit, and a

commitment to work longer term to make it the default option for families entering the system.

Mr Avery had presented a comprehensive IMT strategy to the Management Team, and this would come to the Board shortly as a proposal for a two year programme of investment, prioritising areas of risk. One strand of this is the optimisation of Care Notes: there were known issues with the implementation and with changing our culture, and a specific issue with outcome monitoring data that Dr Hodges was addressing urgently. One important area of focus was liaison between clinical staff and IMT, and the appointment of Dr Myooran Canagaratnam would be key to this. Mr Holt commented that IMT had been discussed at the Audit Committee, and they had been impressed by the openness of the report from Mr Avery. It was a key lesson of projects such as Care Notes that sufficient allowance must be made in the budgets for optimisation after systems were introduced.

**AP2**

Dr McPherson noted that iThrive came up a lot in meetings outside the Trust, and it would be helpful to have a briefing on how the Trust is shaping CAMHS development for these situations. Mr Jenkins agreed to provide this.

The Board **noted** the report.

## **9. NHS National Planning Guidance**

Mr Jenkins noted that there was a significant move to place-based planning with outcomes now being addressed through Sustainability and Transformation Plans (STP), and the Trust was likely to fall into the footprint of North Central London. One issue emerging was significant interest in NCL expressing interest for the devolution of tertiary mental health budgets, and the Trust was actively involved in this.

Ms Murphy asked what impact the new focus might have on the Trust's ambitions. Mr Jenkins replied that it would affect the dynamic of whether opportunities were available via the market place or through networks. Dr Senior suggested that there was reduced appetite for putting contracts out to tender in NCL due to the cost, and an increasing spirit of collaboration similar to that seen with stroke care pathways. Dr McPherson asked whether there would be any significant funding for transformation given the financial pressures already present in NCL. Mr Jenkins felt that in 16/17 most of the spending would be towards resolving existing deficits, but that might change afterwards. Mr Burstow noted the interplay between the required one year organisational plans aimed at getting organisations back to balance, and making the changes required of the 5 year STPs, which could be explored further at a Director's Conference.

The Board **noted** the report.

## 10 Draft Clinical Quality Strategy

Ms Lyon introduced the second draft of the strategy, highlighting the changes since it was last presented to the Board, which had been made in consultation with the Quality Stakeholder Group.

Mr Holt noted the number of areas the Trust wanted to improve, and asked where the focus should lie. Ms Lyon suggested that better use of Care Notes and data underpinned all the other objectives, and getting clinicians engaged, and providing feedback to the services via dashboards, were the next steps.

Mr Rock noted that not all the objectives were Trust wide, and they should draw out local objectives and spread the load of development. Ms Lyon explained that they planned to choose four teams to pilot Quality Improvement Programmes (QIP), with the aim of involving team managers closely and aligning closely to their needs and interest.

Mr Burstow asked how the Trust assured itself of the quality of its numerous small teams. Ms Lyon suggested they needed to better embed what they were already doing with outcome measures so performance could be compared and benchmarked, and continue to focus on looking at what patients find useful in their lives. Dr Senior added that for meaningful improvements good data was required so that trends could be identified, and there was a triangle of data, user involvement and staff engagement necessary for good quality.

Mr Burstow noted the demographic of young carers, and suggested that the Board should hold a discussion of our current offer for them, and what good would look like in this area.

AP3

The board **noted** the report.

## 11 Quarter 3 Quality Report

Ms Shipman reported that Care Notes was having an effect on some of the quality outcome measures, and Dr Hodges was looking at these with the Quality Team. She noted that the waiting time breaches (p.114) were improving, but there had been 26 internal breaches, most related to City and Hackney, and this had been picked up by the service.

Mr Jenkins noted that the data quality problems focussed on outcome data, and asked how the Board could be assured that the other indicators were accurately green. Dr Hodges explained that she had been drilling down into outcome forms to address a very specific issue, one which only affected the Outcome Monitoring section of the system. Ms Shipman confirmed that they were testing the data from the rest of the report and the validation work would be completed within a month, and the Q4 data would be in a better position. Mr Young added that outcome monitoring required a complex set of processes that had been disrupted by Care Notes, but that did not affect DNA, attendance and waiting time data in any way, and this all remained robust. Mr Holt noted that the Audit Committee had discussed outcome reporting and it would be the focus of Internal Audit for the coming year, not just because of Care Notes, but also because of the pressures that payment by results might put upon the process. This would give

external assurance on the progress made.

Ms Murphy noted that it would be helpful to include the median as well as average, as the median is what most patients experienced. Ms Shipman agreed they would expand this to more of the measures in the report.

Dr McPherson noted the equality and diversity figures on p.123 were exceptionally good, and asked if we could be confident of them. Ms Shipman explained that a lot of work had been done between Q2 and Q3: they had broken the report down by teams, done a sense check with the leads and she was assured it was accurate. Mr Young added that the Board had seen a more detailed report previously which matched these results, and believed them to be correct. However, he noted they were based on completed surveys and whilst completion rates were improving they were currently not great in some services.

AP4

Dr McPherson queried the bipolar disorder access figures on p.123, which seemed low. The Board discussed whether the wrong denominator had been used in the calculation (total patient numbers, rather than patients diagnosed), and Ms Lyon agreed to look into this and report back to the Board.

Dr Holt asked about the DNA rates, and what could be done to improve them. Ms Shipman explained that the high rates in C&H were in part due to staffing issues and there was a plan to address them, but AYAS worked with young people who were difficult to engage. They already did a lot of work on contacting, and tailoring methods to the individuals, but to continue to have an accessible service they needed to tolerate higher DNA rates. She added that a DNA did not end treatment; patients were followed up and did re-attend.

Mr Holt noted that the Trust achieved the majority of its targets, and wondered if we should be setting ourselves more stringent ones. Dr Hodges noted that all the CAMHS contracts were subject to transformation plans, and an 8 week target had been agreed and was being worked towards, whilst continuing to pick up urgent cases more quickly. Many of the other targets were negotiated with commissioners and were already ambitious and stretching. Mr Jenkins suggested that the Trust should focus on improvements in targets that really matter to patients, and were driven by patient experience. Mr Burstow added that it was a question that referred back to the Quality Strategy and how we could continue to go beyond our current achievements and improve the things that mattered to patients.

The Board **noted** the report.

## 12 Finance and Performance Report

Mr Young reported that the Trust remained ahead of plan, with an expectation that the surplus would reduce to £1/2M by the end of the year. The four major factors in the surplus were: FNP's expenditure remained below budget; GIDS had been understaffed, but was now fully staffed and using additional sessions to catch up on demand; the release of GIDS income from the previous year; and a release of £178k clinical income related to the previous year. Mr Young explained that the Management Team was keen to reinvest the surplus where appropriate,

and IMT was one example of this. However, if it was not possible to do so the surplus was not unreasonable, especially given the restructuring and relocation costs, and the need for a balanced budget.

Mr Holt noted the use of bank and agency staff to cover vacancies, and asked about the quality of these staff. Mr Young explained that they were all administrative staff, none involved clinical posts.

The Board **noted** the report.

### **13 Training and Education Board Report**

Mr Rock highlighted that there had been strong engagement from staff in the consultation over restructuring, and thanks to some voluntary redundancy they had been able to avoid competitive interviews for the new posts and to place staff in posts they had expressed interest in. The climate in the directorate was positive, but they faced challenges ahead.

The student recruitment plan had been presented to the T&E board, and the online portal was now open for applications, though development work was being undertaken at the back end to accommodate the different data requirements of the University of Essex. Mr Burstow asked about the numbers of students who did not enrol (para.4.2), and Mr Rock explained it had been 80 in the last cycle, and following up on these was part of the reason a new Information System was required.

The Board **noted** the report.

### **14 DET Student Information System (SIMS) Full Business Case**

Mr Burstow explained that this item contained commercially sensitive information and so would be considered in part 2 of the meeting.

### **15 Quarter 3 Governance Statements**

Mr Young presented the report, noting that it was similar to previous quarters, but updated with data, and information on Learning and Disability provision in the Lifespan team. The financial position remained 4, and would change over the coming 12 months to level 3.

The Board **approved** the governance statements.

### **16 Emergency Preparedness, Response and Recovery (EPRR) Assurance and Work Plan.**

Dr Senior gave the background to the report, and explained the Trust's contingency plans. He noted the management team had recently held an emergency rehearsal event, and that all the actions in the attached plan were forecast to be completed by year end.

Ms Murphy enquired if the headings were standard, such as the flu requirement. Dr Senior explained that they were, and that they changed in response to events, so if a different pandemic were to arise the Trust would be asked to develop plans in response to it, though many of the actions were generic, such as maintaining contact lists.

The Board **approved** the results of the assessment and the action plan.

#### **17 Any other business**

The Board noted its future meetings.

Part one of the meeting closed at 4.20pm.

## Board of Directors : February 2016

**Item : 6**

**Title :** Service Line Report FDAC London and Westminster Family Services

**Purpose:**

The purpose of this report is to give an update on the London Family Drug and Alcohol Court service (FDAC) and the new contract for the Westminster Family Services.

Please note the WFS service is now named *the Multi-disciplinary Assessment Service* and is jointly commissioned by Westminster and Hammersmith & Fulham

This report has been reviewed by the following Committees:

- Management Team, 9<sup>th</sup> February 2016.

**This report focuses on the following areas:**

- Quality
- Patient / User Experience
- Risk
- Finance

**For :** Noting

**From :** Steve Bambrough, Associate Clinical Director (CAMHS Directorate).

## Service Line Report – FDAC and WFS

### 1. Introduction

- 1.1 The **Family Drug and Alcohol Court (FDAC)** is a specialist clinical team, commissioned on a block contract (due to end March 31<sup>st</sup> 2017) by 6 London Boroughs. The service model is a radical change to the way normal court proceedings work for children at risk, whose parents are alcohol or substance misusers and is also a radical system change to family justice in England.
- 1.2 The team consists of 14 multi-disciplinary staff (10 Trust staff and 4 staff employed by Coram under a Service level Agreement) and a team of volunteer parent mentors. It is delivered under a two year contract with 7 local authorities and the contract lead is the London Borough of Southwark. The total contract value in 2015/16 is £570,544. The unit is contracted to assess and treat a minimum of 46 families per year.
- 1.3 The service has been rigorously independently evaluated by Brunel University and the Nuffield Foundation over 6 years and they reported on their findings in July 2014 - and the evaluation report can be read at [http://www.nuffieldfoundation.org/sites/default/files/files/FDAC\\_evaluation\\_summary\\_findings\\_01\\_05\\_14.pdf](http://www.nuffieldfoundation.org/sites/default/files/files/FDAC_evaluation_summary_findings_01_05_14.pdf)
- 1.4 The **Westminster Family Services** (now named the Multi-disciplinary Assessment Service jointly commissioned by Westminster and Hammersmith & Fulham) is a service which the Trust has been running since 2011 after winning the tender at that time. It was re-tendered with significant alterations, in 2015 and the Trust won this contract. The service is a multi-disciplinary team of 10 staff who undertake parenting assessments and a limited number of brief interventions. The families referred to the service are predominantly already in care proceedings with a view to the future permanent placement of the child/ren.

The contract for Westminster Family Services was placed for tender in June 2015, due to the contract end date being 1 November 2015. The new service specification was for an increased multi-disciplinary components and increased access for clients.

Due to financial pressures in the Councils, the total cost of the service was reduced from the current budget of £860,000 to £550,000, partly due to the new service only including the assessment part of the service and excluding the contact service which was taken in-house by the two Councils, effective from 1 January 2016. Two Trust staff was TUPE transferred to Westminster Council on 1 January 2016. Two employees were TUPE transferred from Hammersmith and Fulham Council to the Trust on 1 January 2016 with a third in April 2016.

- 1.5 The Trust has started a consultation process which ends at the end of February. We have operated within budget for the whole of the contract so far.

Service	2016 budget	2016\17 expenditure as at January 2015
Westminster Family Services	£550,525	Contract is in its first quarter and in an implementation and recruitment phase.
FDAC London	£570,544	£410,348

- 1.6 The Service Line is the Vulnerable Children’s Services and includes First Step, the Young Persons Drug and Alcohol Service and the Fostering, Adoption and Kinship Care team, the FDAC National Unit and the FDAC’s in Milton Keynes and Buckinghamshire and Kent.

## 2. Areas of Risk and Actions

There has been a dramatic drop in numbers being referred to the London FDAC in the next financial year. This is due to Hackney not using the service next year, and Hammersmith & Fulham and Westminster dropping out of the consortium and Camden and Islington developing their own enhanced in-house services. There will be 26 fewer cases in the next financial year (20 as opposed to 46 this year). Meaning a reduction on the current contract value of £317,238.

With the close cooperation of the Trust's commercial directorate, the Trust have been able to include finance from several other sources to increase the value of the contract. This potential income includes ;

- 'Early FDAC' money (held by Southwark for next financial year) ; £100,000
- DfE re-directed money from the National Unit (held by Southwark for next year); £83,900
- Thurrock assessment work (previously with Coram) ; £40,000 (to be confirmed)
- Hadley Trust grant ; £37,000
- Management fee ; £3,200
- Testing clinic ; £10,000

This makes a potential income from other sources of £274,100

The total income including the referred and commissioned 20 cases from 4 London Boroughs at £12,700 each is £254,000. Added to the £274,100, this brings the total budget to £528,100 which is considerably short of the full figure last year of £570,544 (excluding the 'Early FDAC money from the DfE).

- 2.1 **Westminster Family Services** contract came to an end on 1<sup>st</sup> January 2016 and the Trust successfully bid for the Tender in the summer of 2015.
- 2.2 The new contract and service specification removed the contact part of the service (which went in-house to the London Boroughs) and is a 5 year contract.
- 2.3 We are currently in an implementation period until April 1<sup>st</sup> and we need to carry out a consultation process and also recruitment to specific clinical posts

not currently represented. The consultation process started on 27/01/16. The consultation paper has been shared with the Management Team on 26.01.16. The consultation will end after 30 days.

## Main Report ; Multi-disciplinary Assessment Service (Hamm & Fulham and Westminster)

### 3. Overview of the Service

The service provides a comprehensive multi-disciplinary assessment service to family's referred from the two Boroughs, who are either in or on the cusp of care proceedings. The referrals tend to be high risk, involving a combination of mental health problems, domestic abuse, neglect and physical abuse of children.

With the new service specification in the contract, we have been able to increase the service to include domestic abuse and substance misuse expertise. This is a unique clinical team offering the local authority focussed, brief assessments of safeguarding risk and treatability, within very tight timescales. It is hoped that we can use this as a model which we can promote to other local authorities in the future.

### 4. Clinical Services and Activity Data

4.1 Performance data for referral activity for the year 2015 under the old contract ;

Service	Annual target	Q1 actual Referred and accepted	Q2 actual Referred and accepted	Q3 actual referred and accepted	Q4 actual referred and accepted	YTD target	YTD actual
Assessment (total)	60	13	18	14	16	60	61
Parenting Intervention	40	8	4	3	4	40	19
Hours DNA Hours CBC (Includes total for Contact service)		12 DNA 34 CBC	6 DNA 16 CBC	2 DNA 8 CBC	24 DNA 39 CBC		44 DNA 97 CBC

5.

5.1 Performance against contracts – current and for next financial year

The commissioners have conceded that they had significantly underused the intervention part of the service and also the Contact service (which they have now taken in-house). The new service will carry out interventions on a limited number of cases where the evidence based models of intervention that we offer are not available locally.

The Trust is currently agreeing a new set of KPIs and outcome measures for the new contract. We are hoping to convince the Local Authorities of the benefits of undertaking a longer term measure of outcomes for the children who experience the service (2 and 5 years after the service) and assist them in developing an economic cost benefit case for the service model, which will help us adapt the model accordingly to achieve better outcomes for children and parents.

## 5.2 Ethnicity

The ethnicity of the clients referred in the last calendar year are as follows:

- White British ; 26%
- White European ; 8%
- Eastern European ; 4%
- Black Caribbean ; 12%
- Black British ; 13%
- Asian/Asian British ; 6%
- Black African ; 6%
- Somalian ; 2%
- North African ; 2%
- South American ; 4%
- Filipino ; 2%
- Kurdish ; 5%
- Mixed race ; 10%

## 5.3 Supervision / reflection

Within the service, we have developed, in consultation with the staff, a number of opportunities for supervision individually and as a team. In addition to the normal supervision and case management meetings, there is a Multi-Disciplinary meeting every week where staff can bring their cases for focussed and detailed discussion and formulation. This can also happen within the Team Meetings held fortnightly. There is also group supervision and a reflective practice group held monthly.

The service also runs a weekly Mindfulness group for staff and we have invested in the appropriate equipment for this. This group is highly valued by most of the staff.

## 6. Clinical Quality Data and Feedback

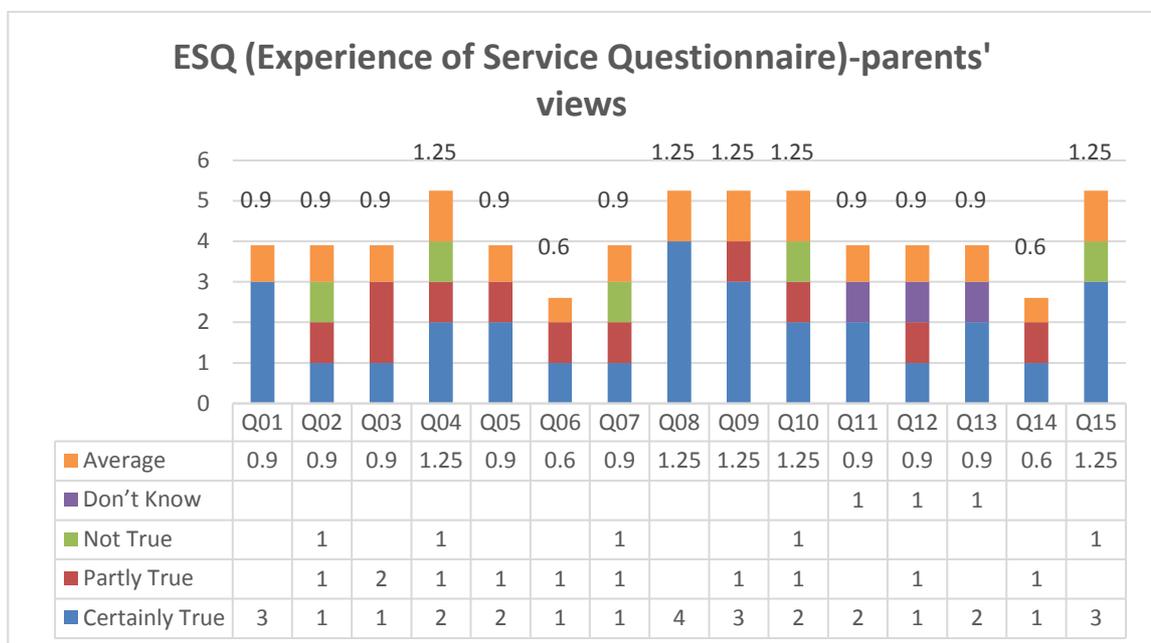
Within the last calendar year, 53% of referred families for assessment were in care proceedings. The remainder were under PLO (pre-proceedings) and we have had several referrals where children were on Child in Need plans.

The Service collected a range of data independent of Commissioner’s requirements during 2013 to 2015. This included ESQs, SDQs, CGAS and PIRGAS, GBM and an experience of contact questionnaire designed for children. I reported on this in the last Service Line report in 2015.

The commissioners were satisfied with the data collected which showed overall that clients were happy with the service delivered. They subsequently asked us to stop the collection of data and to concentrate on KPIs defined in the quarterly monitoring reports, largely on timescales, throughput and numbers of assessments and contacts hours.

We continued to collect ESQs (and SDQs as part of the assessment process) and the children’s ‘contact time’ questionnaire.

The ESQ results are below.



6.1 It is difficult to gather information in a context of care proceedings when the families largely feel compelled to engage and within an adversarial experience. The assessment service has had a very low number of complaints over the past

4 years of the contract, with none in the last year. We are taking these results to the team meeting after the consultation, to discuss and make sense of the ESQ results and any modifications to the assessment process which may give a better experience for the clients.

- 6.2 There have been poor response rates for the ESQs and difficulties in engaging the client group in a user’s feedback group at the centre, despite wide publicity. We have also trialled preventative work and support groups for parents to increase parenting sensitivity but with little take up by clients. We plan to work closer in the new contract with the Trusts PPI to gather better quality service input.
- 6.3 Complaints have all been in relation to the contact service and not in relation to the assessment service.

Below are some feedback examples from clients and social workers in the last six months, left in the compliments and complaints book and suggestion box which we run.

<p>“Thank you so much for all your hard work on the M case. Your proactive approach and your willingness to make a difference to the clients you work with is truly commendable. You have been a big help in so many ways especially during the court hearing. Thanks a lot your efforts are truly appreciated by myself and as well as Judge B.... (From a <i>Senior Practitioner, North East Locality Integrated Children’s Team</i>)</p>
<p>“Thank you for attending the court yesterday and today and further I would like to thank you for your input in re-establishing my parental role in .....’s life. (from a parent undertaking a parenting assessment).</p>
<p>“The new guardian was very complimentary of the assessment you did. She said it was clear and well written.” (from a <i>WCC Senior Practitioner Social Worker</i>).</p>
<p>An ESQ by a parent in a parenting assessment said that she felt the clinician undertaking the assessment had been “Listening. Caring. Trying to reduce issues”.</p>

## 7. Serious Untoward Incidents and Safety Issues

- 7.1 There has been an increase in incidents in the last year with regard to staff safety. This has been as a result of clients becoming verbally abusive and threatening to Local Authority social workers in our building. On several occasions this has also been to staff within the service. These have been reported and action plans drawn up as a result to manage and limit the risks posed by these clients. This has led to several clients not being allowed access

to the premises until specific undertakings about behaviour are agreed, or alternative premises found for the work to be undertaken.

- 7.2 17 incidents in calendar year 2015 – 2 in relation to the assessment service, 3 in relation to building and premises, the rest were in relation to the contact service.

There is evidence to suggest that the Local Authorities have not always been quickly forthcoming in background risk information prior to assessments starting, and also evidence that the Local Authorities are minimising past risk behaviours of clients to assist us accepting referrals. We have now developed a referrals process to deal with this – whereby all relevant risk information (such as Police checks or DVIP reports) is received prior to work beginning.

## **8. Research**

- 8.1 We are aiming to carry out research into the clinical model used in the team and work with the Local Authorities to test longer term outcomes and the value for money of the model. We believe that our model of testing capacity to change and the comprehensive time-limited assessment by the multi-disciplinary team is one which we can market to other areas in the future.

## **9. Staffing and HR issues**

- 9.1 There may need to be an HR lead process this year with regard to harmonisation between those staff brought into the Trust via TUPE in 2011 from Action for Children and the current Trust-contracted staff. There is a discrepancy between staff on different terms and conditions and salaries for similar roles, which the team are likely to challenge this year.
- 9.2 We are very pleased to have contracted the service of Dr Chris Newman, who is a national expert on domestic abuse and will be working with the team one

day per week. This is a very strong addition to the expertise in the Trust on issues of domestic abuse and will be of considerable help in strategies to develop and market our safeguarding model of assessment and intervention in the future.

## **FDAC London**

### **10. Overview of the Service**

10.1 The London Family Drug and Alcohol Court (FDAC) at the Inner London Family Proceedings Court has been running since January 2008 and is the first of its kind outside of the USA. FDAC offers an alternative form of care proceedings for parents and children in those cases where substance misuse is a key factor in the decision to bring proceedings. FDAC uses a problem solving court approach, which aims to help parents control their substance misuse so they can be safely reunited with their children. If that is not possible, we ensure that children are placed permanently with family members or elsewhere as speedily as possible.

The clinical team consists of a team of 14 staff and a team of parent mentors. The model is an integrated legal, social care and health response to care proceedings cases where parental substance misuse is a factor. FDACs take a therapeutic problem-solving approach that aims to achieve long-term improvements for children and parents.

The Department for Education has supported the rollout of the FDAC model, and by the end of March 2016 it is planned that a total of eight FDAC clusters will be in operation, serving 21 local authorities at 12 courts, with more sites in development.

10.2 The overall vision and strategy is for growth of the FDAC model across the country in line with the President of the Family Divisions statements to that effect.

Strategy within London is for ensuring the model survives this year in Central London, waiting for the tender to be advertised this year and by which members of the commissioning consortium. It is possible that the central London service may not be re-tendered in its current form and instead may be commissioned by other London Boroughs (Croydon/Merton/Sutton/Bromley and North or North East London Boroughs).

10.3 Croydon consortium has employed a project manager to begin the feasibility and scoping work in preparation for an FDAC. We have had several meetings with the North/East consortiums and they have asked for our recent Value for Money research to assist them in their decision making.

## **11. Clinical Services and Activity Data**

11.1 Performance against contracts – current and for next financial year

### **Cases referred since 1st April 2015 by borough & type of case**

In the financial year 2015/16 the service was commissioned to take 46 referrals. There are on-going discussions with commissioners (who cannot agree amongst themselves) on the preferred contract currency (average cost per case or a packages model where they are able to choose between pre-proceedings and in-proceedings assessments) and this has not been resolved. See table below for current position at the last Quarter 4 monitoring meeting.

	Total cases	Pre-proceedings only	Pre-proceedings into proceedings	Proceedings only
Camden	7	2	2	3
Islington	4	0	3	1
Westminster	3	0	2	1
Southwark	6	4	2	0
Lambeth	8	2	0	6
Kensington & Chelsea	2	0	0	2
Hackney	0	0	0	0
<b>Totals</b>	<b>30</b>	<b>7</b>	<b>10</b>	<b>13</b>

Southwark, Lambeth, Camden and Islington have indicated they are to commission 20 referrals in the 2016/17 year.

11.2 There is a significant issue with regards to Hackney, who joined the consortium in March 2015 and paid their management fee to join, but then did not make any referrals. The lead commissioner (Southwark) is in a mediation process with Hackney to resolve this dispute and the Trust's commercial directorate are confident that the liability is with Hackney and/or Southwark.

11.3 There are no waiting times at FDAC. Cases are sent through to the court by the commissioning consortium via their legal departments on an agreed schedule.

11.4 Ethnicity ; data collected shows clients referred to FDAC London consisted of the following ethnic breakdown over the previous calendar year ;

- White British ; 32%
- White European ; 16%
- Black Caribbean ; 10%
- Black British ; 14%
- Asian/Asian British ; 10%
- Black African ; 6%

- Somalian ; 4%
- African – Congolese ; 4%
- Ukrainian ; 2%
- Filipino ; 2%

11.5 The team operate a model with different supervision and case management and reflective supervision structures.

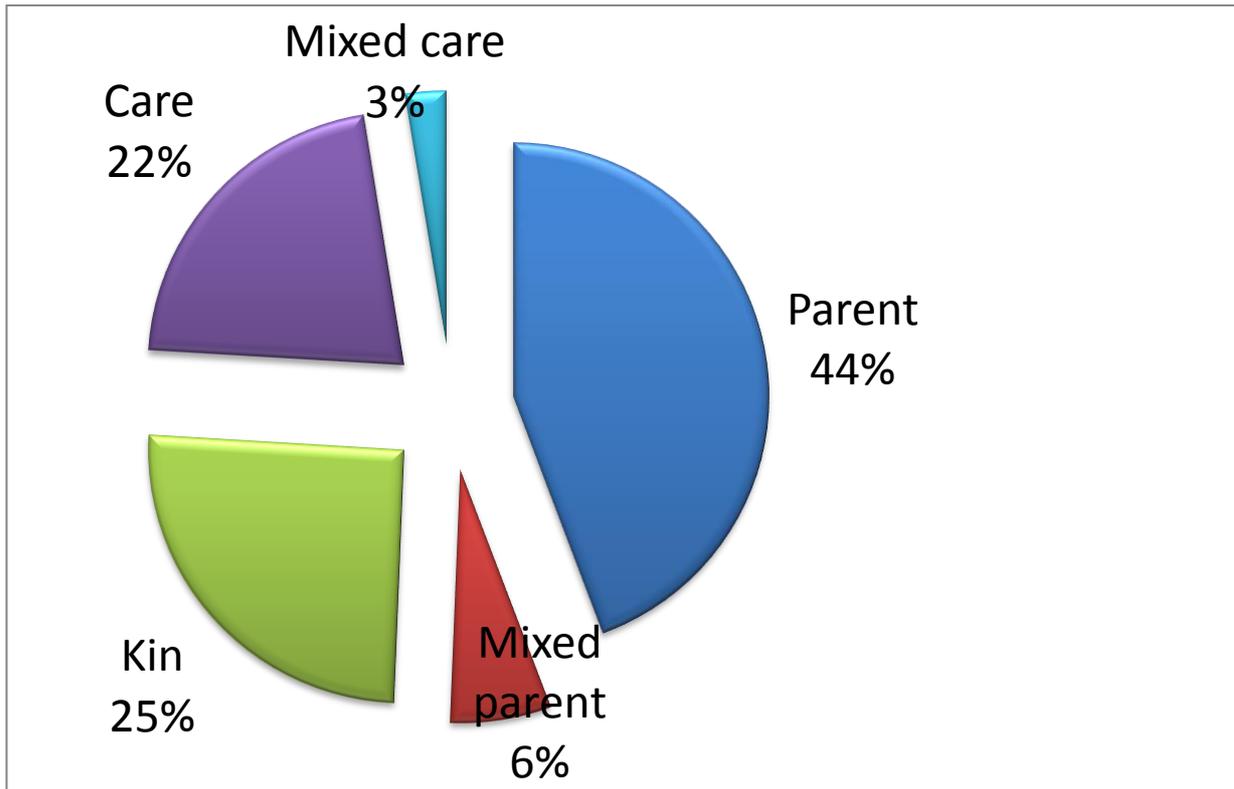
In addition to personal supervision and case management, there are team formulations of risk and treatability for each client and children's needs meeting about each individual child at the start of the work with a family.

The team have weekly team meetings in which cases are discussed and there is a team reflective meeting on a regular basis in which the team work through the difficult feelings generated by the work.

The families have planning meetings with the multi-agency network at planned intervals throughout their time in the FDAC process.

The families receive a number of evidence based interventions regarding domestic abuse (individual and group work), harm minimisation, relapse prevention, CAT, CBT, family therapy, video-interactive guidance, motivational interviewing, and a reflective group for improving parenting.

11.6 Since the Brunel University (for link to research see paragraph 1.3 above), we have continued our internal data analysis to monitor the results since the Brunel evaluation finished. Current data analysis regarding outcomes shows improved percentages in relation to the number of children returning home (44%).



Final Placement at end of proceedings – closed cases 2013 to 2015 calendar years – 79 families/120 children.

This shows consistently high rates of reunification, especially given the high risk and multiple risk profile of the families. In the scope of this updated study we did not have a comparator local authority as the Brunel University/Nuffield research did. The Brunel/Nuffield research shown comparator local authorities not using FDAC had figures of 19% return home for children after proceedings.

## 12. Financial Situation

12.1 The FDAC London service is within budget coming into the final quarter of the year and projecting a small underspend. The situation for the next financial year is very serious, with the reduction in referrals from 46 to 20. This is largely due to Camden and Islington having their own enhanced in-house services, the Tri-Borough having their separate contract for multi-disciplinary services with the Trust, and Hackney refusing to use the service after having committed to purchasing 12 referrals in the current year. New local authorities in London have found obstacles to joining the consortium due to the different London-wide geographical allocation of Family Courts (for example Haringey nor Merton can use the Central family Court where the London FDAC is based).

There are on-going discussions with other potential consortiums in London. The Croydon/Merton/Bromley/Sutton consortium is in advanced stages of scoping and feasibility work and seem very committed to setting up an FDAC in 2016.

We have had several meetings with Haringey/Barnet/Enfield and they have asked for our recent value for money research in order to make their decision about the future.

These developments, if successful, in conjunction with the obstacles around use of specific Family Courts, means there is a possibility that the central London FDAC team will find its future in the North or South London consortiums. This will mean a considerable configuration of the service and premises.

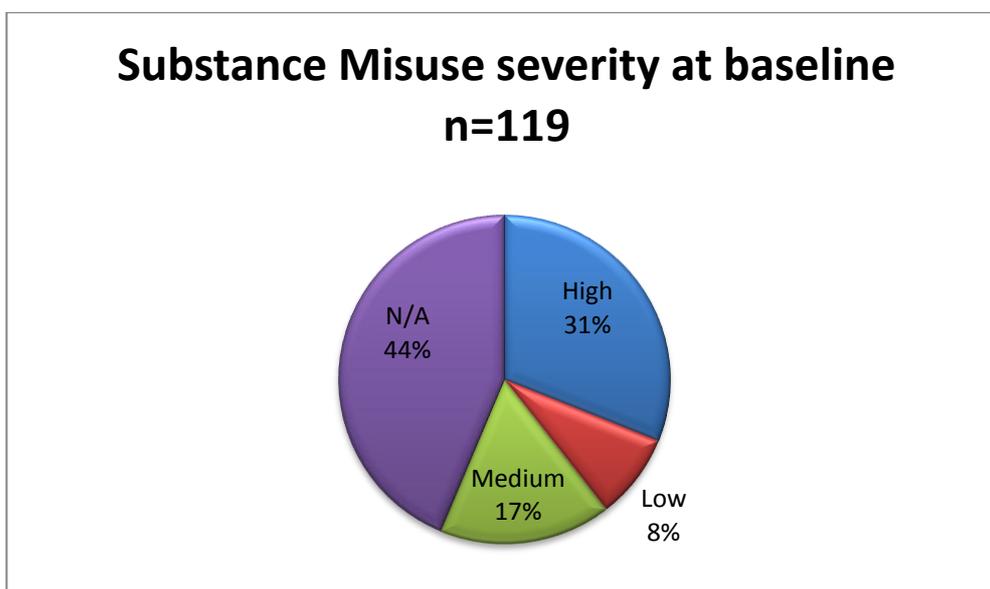
### 13. Clinical Quality and Outcome Data

The service collects a large amount of data relevant to the commissioners' performance indicators, around timescales and throughput of cases. In addition we collect a large amount of data relevant to the performance of the team (reported in the last Service Line report in 2015). It is the plan that all FDAC's will collect the same data in a large data collection project.

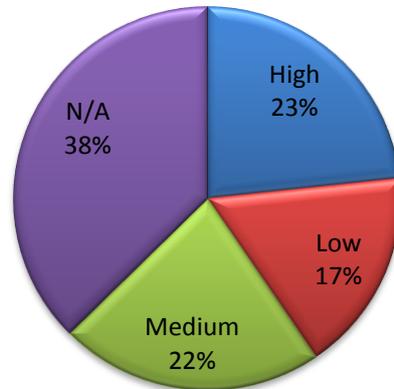
A recent review of baseline assessment data for 189 FDAC parents (77 fathers and 112 mothers) showed that 25% of all parents were looked after as children (no data available for 25 cases) and 31.31% of all mothers were looked after as children.

In relation to presenting problems, we have also analysed the data in order to adapt the service where possible to better meet the needs of the clients referred to the service.

#### Drug and alcohol use

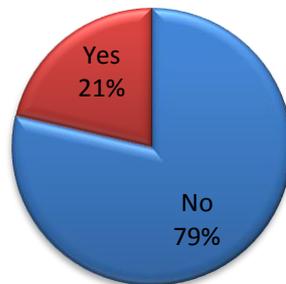


### Alcohol severity at baseline n=163

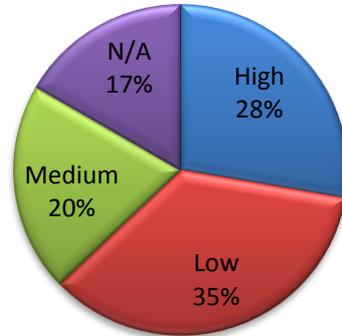


### Forensic Issues

### Known to Criminal Justice System at baseline n=123

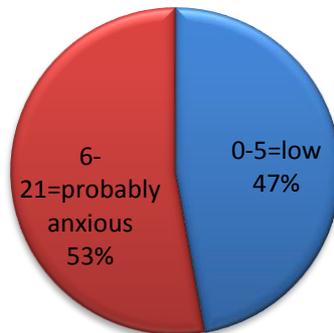


### Current DV risk to mother/child at baseline n=156

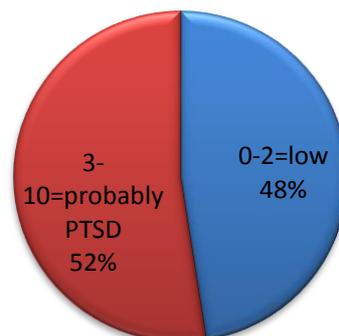


### Mental health

#### GAD-7 scores at baseline n=70

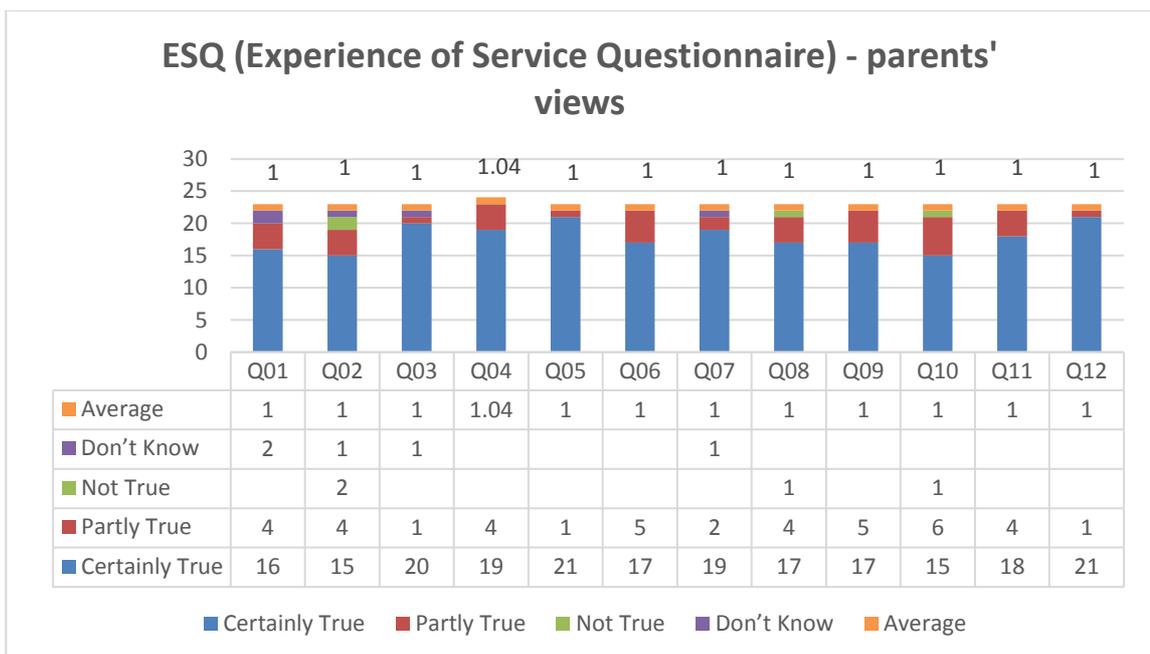


#### Trauma Symptom score at baseline n=70



13.1 With this information we have adapted the screening and assessment process in order to refine our risk assessments. We have included domestic abuse screening and trauma screening for all referrals. This has resulted in us being able to identify issues of domestic abuse and difficulties in engaging in treatment, where this would have been missed previously.

14. Feedback - we routinely collect ESQs for the service.



14.1 Complaints ;

In the 2015 year we have had one complaint which was escalated to the CEOs office. This concerned a client who believed she had not been informed of the decision to remove her child and complained about the lack of support in her assessment, after the court had decided that her child should live elsewhere. The complaint was thoroughly investigated. The outcome showed a high level of input to the client and high quality clinical recording practice and involvement of the parents and agencies in the process of assessment and treatment.

## 15. Clinical Governance

London FDAC was brought onto Carenotes at the launch of the system in 2015. There have been significant difficulties in getting the system operating smoothly in the project offices in Coram. This is partly due to the networking

on the Coram site. Further work and training is planned for the team on this issue.

## 16. Research

There has been significant involvement by the London team in the value for money case for FDAC which was undertaken by a health economist and senior researcher in the Centre for Justice Innovation. The report explores the financial impact of the FDAC model, focussing on the costs and benefits to local authorities and other state stakeholders.

The research uses a “net present value”, in which the value of future savings is lessened to reflect a greater preference to have savings sooner rather than later. This enables the calculation of a single consistent monetary metric – the ‘net present value’. In producing this consistent metric, we have used a rate of 3.5% per annum in line with HM Treasury guidance (‘The Green Book: appraisal and evaluation in central government’). It has not been published yet but its main findings in summary are ;

*“Across the 2014/15 caseload, we estimate that the London FDAC will generate savings of £1.25m to public sector bodies. This implies that, for each £1 spent on FDAC there are gross savings of £2.23, and net savings of £1.23, accruing in net present value terms to public sector bodies over five years.*

*A caseload of 46 implies an average gross saving per case of £27,100. This equates to net savings of around £687,000 after the costs of the FDAC team are taken into account...*

*Savings principally – but not exclusively - accrue from reductions in proceedings costs, the cost of placements, and the reduced level of parents returning to court:*

- *Local authority savings on proceedings-related costs including external assessments and legal costs are around £253,500 across the caseload. This represents an average of £5,510 per case;*
- *Savings in costs related to final care placements over five years are some £792,000 across the caseload - £18,450 per case;*
- *Savings in the cost of parents returning to court either after reunification or with future children are some £93,880 across the caseload - £2,160 per case.*

*Of the total savings of £1.25m (which exclude potential savings possibly of the order of £88,000 to the Legal Aid Agency arising from fewer contested hearings across the caseload), the bulk, £1.13m, accrue to local authorities. This means that if local authorities cover the full costs of FDAC across the caseload they make a net saving of £569,000, averaging £12,360 per case.*

In addition, the London team have also been involved in the work of the University of Lancaster and Dr Karen Broadhurst.

The research has been published in the British Journal of Social Work entitled “Connecting Events in Time to Identify a Hidden Population: Birth Mothers and Their Children in Recurrent Care Proceedings in England” (BJrSW 2015, 45 (8) by Broadhurst et al.

This is part of our on-going work with this difficult to reach population of mothers. With the assistance of this research we were able to attract funding from the DfE via the Innovation Programme to employ clinicians to work specifically with this group of mothers and this funding is available in the 2016/17 year.

### 16.1 Future projects / prospects and issues.

It is likely that the consultation to reduce the size of the current clinical team in line with the budget reductions for the next financial year, will commence in February 10<sup>th</sup> in conjunction with our partners Coram. This will see a reduction in staffing and some potential redundancy, although we are doing all we can to minimise this via redeployments. It is likely that one post in the Coram staff team will be made redundant and some sessions will be reduced in one of the Tavistock posts. Discussions on this are on-going and not finalised at time of writing. A consultation document has been drafted.

Steve Bambrough  
Associate Clinical Director CYAFS  
08.02.16

## Board of Directors : February 2016

**Item : 9**

**Title : IM&T Strategy and Programme Plan**

### **Summary:**

The national strategy for the use of technology within the NHS has become quite clear in the last few years with a target of 2020 set by the Secretary of State for Health for achieving a paperless NHS. This puts a significant amount of focus on the need for a mature and robust IM&T service to deliver this ambition.

The IM&T services at the Tavistock and Portman NHS Foundation Trust have been reviewed and found to have a number of risks following underinvestment in core infrastructure over the last few years. While we have successfully implemented the CareNotes solution for holding our clinical record much of the patient journey continues to be managed on paper. The Department of Education and Training has recently had approval to proceed with procuring a new student management system following years of limited investment.

In short we have some catching up to do if we are to achieve the paperless target we have been set.

To provide the required strategic direction and define the key deliverables needed to achieve this goal while improving the performance and reliability of the existing environment an IM&T Strategy and Programme Plan has been developed. It aims to focus on turning the IM&T environment around within the next 2 years building a platform from which we can deliver excellent and innovative care and training.

The Strategy and Programme Plan have been reviewed by the Management Team and the plan cut from an initial estimated £1.9M Capital and £440K revenue increase to around £1M capital and £330K revenue increase. The first year is heavily loaded due to the "catch-up" required.

At the time of writing the plan was still being reviewed and projects need prioritising. Delivery of this strategy will require board level support for both the projects and investment required.

This report has been reviewed by the following Committees:

- Management Team, 21<sup>st</sup> January 2016

**This report focuses on the following areas:**

- IM&T Strategy
- Risk
- Finance

**For :** Approval

**From :** Director of IM&T

# IM&T Strategy

Building a Platform for Innovation and excellence a 2 year strategy

Toby Avery | November 1, 2015

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## Foreword

I am excited to introduce to you the Tavistock and Portman NHS Foundation Trust's 2 year IM&T Strategy. Over the last few years the Trust has made some significant steps forward in the systems it uses and recognition of the need for IT and Informatics services to be an enabler for more efficient working.

However there have also been a number of challenges around the quality of the services provided and a lack of investment in the underpinning infrastructure. Since joining the Trust in January 2015 I have been able to review the IM&T service recognising what works well and what is not so good. I have begun to make improvements to the way we do things but there is much more needed. The next step is to formalise our approach for the next few years and with the support of the board drive forward the changes needed to provide the technology platforms we need in order to make IT the enabler it should be and allow the innovation many of our clinicians, lecturers, patients, students and administrative staff long for.

My hope is that this strategy will enable just that.

Toby Avery

Director of IM&T

## Executive Summary

### Overview of the IM&T Strategy

This document aims to outline the ambitions of the IM&T Department over the next 2 years to support the Trust's objectives.

The NHS landscape is currently undergoing a significant period of change with cost reduction taking place and the drive for a digital culture with the removal of paper from the NHS being seen as one of the ways we can achieve this reduction.

The Trust is experiencing this "crunch" and is having to respond accordingly with both cost reduction plans and ambitious growth targets combined with the need to relocate in the next 3 – 4 years making the next few years both uncertain and challenging.

At the same time the need to provide high quality and safe care for our patients along with an effective 21<sup>st</sup> Century teaching environment for our students has never been more apparent.

Therefore we have had to develop a strategy that is flexible enough to support and respond to rapid change while continuing to underpin and enable existing services.

To this end we have developed a 2 year ambition and an IM&T vision that focusses on building IM&T maturity, provides a service rather than a product and usability rather than technology.

The aim is that this creates a platform for significant innovation and improvement from year 3. This isn't to say we can't do anything innovative in the next 2 years but simply says that we must first build the foundations on which we can grow.

A relatively short, 2 year, strategy has been adopted to deliver some focused improvements required to enable future growth. The NHS/Trust landscape is changing rapidly as is technology and

having a longer strategy would probably not be productive or provide the focus needed at this stage.

## IM&T 2 Year Ambition

To build a platform for innovation and excellence

## IM&T Vision

To provide customer oriented usable IT and Informatics services that builds on reliable technology solutions and puts the need of the service users and staff at the centre of all we do.

## Where we are now

Over the last 2 years the Trust has implemented its Integrated Digital Care Record (IDCR) project this has delivered the CareNotes system as the Trusts electronic patient record. The implementation of IDCR is a significant milestone for the Trust as for the first time clinical data is recorded and maintained in an electronic system. This is a cultural change that many Trusts went through a number of years ago and has impacted not only the way clinicians work but also the importance of IT as a supporting service.

No longer is IT an ancillary function but it is integral to providing high quality and safe clinical services. This means that we need to consider IT from the ground up ensuring that there are no single points of failure or risks to the service that we are unaware of.

While the Trust has invested significantly into IDCR and supporting devices little has been invested in the the underlying infrastructure at the Tavistock Centre or other sites over recent years and simple organic growth has occurred. This has resulted in an infrastructure that while operating is not designed to provide the performance or resilience that one would expect in a high performing clinical environment. A number of performance issues and failures in 2015 are related to the current state of the infrastructure.

Aspects of IM&T best practice that are now standard across much of the NHS have not been embedded into working practice at the Trust, largely because they have not previously felt to be needed, this leaves us with some catching up to do. Much of this is not in areas that are immediately obvious to users of IM&T services and therefore is often not seen as a priority however it is the foundation of both technical and service management best practice that allows for a reliable and safe environment.

Several internal audits conducted in 2015 have highlighted a number of these areas of best practice as requiring improvement to ensure that appropriate levels of resilience and security are in place.

From a national perspective we have some very clear directives regarding making better use of technology and becoming a "paperless" or "paperlite" environment by 2020. While we have achieved this in terms of our clinical records for the most part we have not yet developed plans to address the inputs and outputs from our clinical systems. These need to be considered.

Another area that has historically lacked investment is the IM&T services for the Directorate of Education and Training. This has resulted in bespoke systems being used that have limited support available and are in some cases hosted on unsupported platforms.

IT security is patchy with some effective tools being in place but lack of management and monitoring to ensure they are functioning appropriately.

While the number of IM&T staff has increased in recent years so has the demand and complexity of the environment this means there is currently very little capacity to support new projects or Trust changes while also delivering day to day activity.

It is also worth considering the organizational culture that appears to struggle to adapt to new technology with take up of CareNotes not being as good as we had hoped.

In summary we have been and are continuing to put more cars (systems like CareNotes and services like TAP, FDAC etc...) on the road while failing to do more than repair the pot holes. The result is that the pot holes become larger and the impact of hitting one more damaging. We now need to rebuild the road with the appropriate capacity for the volume and type of traffic that will be using it.

## Summary of Strategy

We have developed 3 objectives to enable us to achieve our vision of delivering customer oriented usable IT and Informatics services that builds on reliable technology solutions and puts the need of the patient and clinician at the centre of all we do.

These objectives focus on building a platform from which we can innovate and deliver excellent services.

As noted in the previous section the Trust currently has some weaknesses in the underpinning infrastructure and services that are provided which need correcting if we are to provide reliable and safe IT. As a result the objectives that we have identified focus on building a platform from the ground up from which we can depend on.

However it is also understood that we cannot simply stop existing IT projects or slow down business growth therefore we must attempt to build a platform while continuing ongoing work this will be challenging to achieve with current resource and skills. We will therefore need to consider what can be achieved 'in house' and what we will either need to secure temporary resource for or outsource.

You will see in the timeline later in this document that much of the activity required to build the platform is within the first 12 months of the strategy period, this front loads the plan and the costs. However this is needed due to the urgent nature of much of the work. It is likely that other requirements/projects that we are currently unaware of will also emerge and have to be managed.

Throughout the implementation of this strategy we will bear in mind the Trust's plans to relocate in 3-4 years' time. This will impact on the level and type of investment in some of the infrastructure and will lead to an approach that is more cloud based than we have been

previously. This is an approach already being taken by other organisations and it will also make transition to the new building much more seamless.

To deliver this strategy over the next 2 years we will develop a clear IM&T Programme plan that will include both underpinning projects and initiatives that will deliver obvious benefits and changes for the way the Trust works.

To achieve this will require a step change in the way that IM&T works internally and the way the IM&T works with the rest of the Trust. We will need to implement new policies, processes and working styles to enable a collaborative delivery model that supports business as usual activity and the programme of change that we will be undertaking.

We, as an organization, will also need to consider how the culture can be changed to become more engaged with technology development. It is essential that the right support is given from the Board downwards if we are to make the most of the digital opportunities we are now presented with.

## Delivering the strategy

To support the delivery of the IM&T vision for the Trust we have identified 3 strategic objectives that will be delivered over the next 2 years, starting at the bottom and building up we will:

- **Build the Infrastructure Platform** that is usable, reliable and resilient
- **Build the Information Platform** that is simple, accurate and trusted
- **Build the Service Platform** that has the right approach and capabilities

These objectives are intended to build an environment and culture that is focused on meeting the needs of the Trust as a service rather than simply providing hardware and software.

Achieving these objectives is not simply something IM&T will do but rather it is a journey that IM&T will lead on; requiring the support of the wider organization to develop the right systems and services along with realizing the culture change we need to embed.

Once we have achieved these objectives we will be positioned to grow rapidly and respond better to change.

We will focus on the objectives from the ground up, in other words the most important thing for us to get right is the infrastructure that everything else sits on. Therefore this will be our main focus initially.

Service Platform

Information Platform

Infrastructure Platform

## Measuring/monitoring success

It is important that there are some yardsticks in place to measure our success in delivering this strategy. To that end we have identified the following monitoring mechanisms to support our objectives:

- An **IM&T Programme Plan** in place to manage activities and projects prioritised according to Trust goals
- A clear **Financial Plan** being in place and delivering to it
- **Performance Management** in place and monitored for both service provision and compliance activities

An IM&T Steering Committee (IM&T SC) will be established to monitor and manage delivery of these objectives. The IM&T SC will also review the strategy every 6 months to ensure it remains relevant and updated as required.



## Security and Information Governance

Security and Information Governance wrap around all IM&T practice whether this is the delivery of a new solution or day to day business these must be considered.

The threat of cyber-attack and the impact of data loss is growing. In 2015 the Trust has seen a growing volume of cyber-attacks and have had to implement further protective measures to safe guard our services.

As a result security will be at the heart of all we do going forward.

## Aligning IM&T to the Trust's priorities

A number of key drivers have been identified to support the Trust's 5 year ambitions we have linked our IM&T objectives to these drivers as shown on the table below.

The vision is to provide IM&T services that aligns with and supports the Trust's wider ambitions it is therefore critical that thinking is aligned and direction is clear.

Trust Priorities	IM&T Objectives			IM&T Success Measures		
	Build Infrastructure	Build Information	Build Service	Financial Plan	Prioritisation	Management
Efficiency gains	✓	✓	✓	✓	✓	✓
Transform Education	✓	✓	✓	✓	✓	✓
Reputation	✓	✓	✓	✓	✓	✓
Raise Profile	✓	✓	✓	✓	✓	✓
Modernise Systems	✓	✓	✓	✓	✓	✓

## Strategic Context

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### The Trust

The Tavistock and Portman NHS Foundation Trust is a specialist mental health trust focused on psychological, social and developmental approaches to understanding and treating emotional disturbance and mental ill health, and to promoting mental health. It has a national and international reputation based on excellence in service delivery and clinical innovation, and high-quality clinical training and workforce development.

The Trust achieved authorisation as an NHS Foundation Trust in 2006. Prior to this it was the Tavistock and Portman NHS Trust, established in 1994, bringing together the Tavistock Clinic, founded in 1920, and the Portman Clinic, founded in 1933.

As an NHS Mental Health Trust we see ourselves as a public benefit organisation. Our vision is focused on the type of communities and society that we want to contribute to creating and to be a part of. We want to make a positive difference

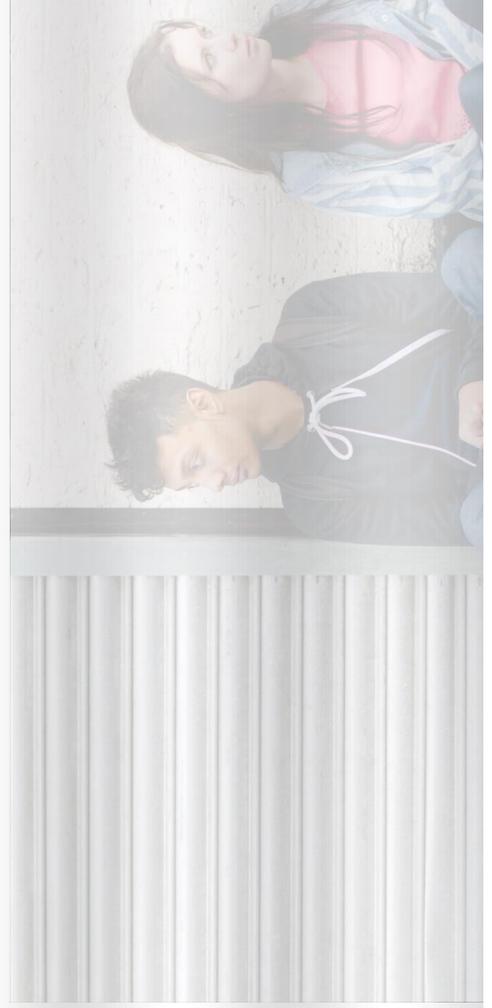
Beyond this, we are an organisation rooted in ideas and in their innovative translation into effective practice. We contribute to the pool of ideas through our own research and development, but are also committed to bringing together the best ideas of the time, old and new, from inside and out, together with the most

gifted and able professionals in our fields of endeavour. We aim to share our ideas and practice through as many routes as possible.

Working alongside others is a key component of our identity. We aim to work in the communities we serve, either as individuals or in teams, listening, learning, sharing, exchanging and working with others as partners.

As a Trust we aim constantly to be evolving in nature and form in relation to the environment in which we work, to ensure that our contribution remains relevant.

The Trust is unusual in the balance of its activities. All of these, however, are closely integrated and share the same underlying values and philosophy. At heart, the Trust is rooted in clinical practice with all activities deriving from the experience of working with patients. The Trust is proud of its history of innovation and excellence, and seeks to build on this in the future. The Trust's two largest areas of activity are patient services, and education and training services.



## The IM&T Strategy in detail

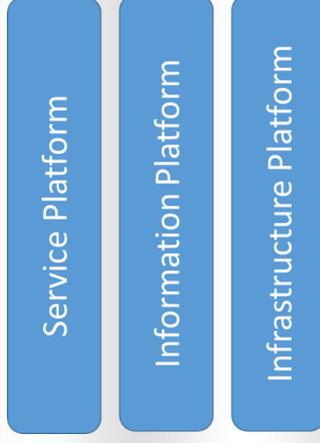
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This section outlines the 3 IM&T strategic objectives and success measures in a bit more detail to define what we need to deliver in the next 2 years.

### Objectives

Starting at the bottom and building up we will:

- **Build the Infrastructure platform** that is usable, reliable and resilient
- **Build the Information platform** that is simple, integrated and accurate
- **Build the service platform** that has the right approach and knowledge



### Success Measures/Monitoring

- An **IM&T Programme Plan** in place to manage activities and projects prioritised according to Trust goals
- A clear **financial plan** being in place and delivering to it
- **Performance management** in place and monitored for both service provision and compliance activities



## Objectives

Build the infrastructure Platform

*Build the infrastructure platform that is usable, reliable and resilient*

IM&T will provide a more strategic joined up approach to investing in IT Infrastructure to ensure that the foundation is in place to support both business as usual activity and the Trust's ambitious growth targets.

### Key priorities

- Build a safe, reliable and resilient infrastructure that supports all trust functions
- Secure systems and data using the latest technology and embedding good practice
- Make better use of contractual arrangements to protect systems and services
- Use the cloud wherever appropriate to increase resilience, deliver greater mobility, reduce the local footprint and prepare for the future
- Support Trust changes through a flexible approach to solutions and delivery

### Key principles

- Take a cost effective approach to procurement
- "Milk" the assets wherever possible e.g. replace desktop PCs every 5 years rather than every 3 years
- Consider security implications always
- Make it usable, engage users wherever appropriate

Some of the specific projects that will be required to achieve this are listed below while a complete list can be seen in the IM&T Programme Plan.

- Refresh the Tavistock Centre Network
- Refresh the Tavistock Centre Firewalls
- Replace the Tavistock Centre Telecoms system
- Implement a robust support contract/contracts for network, security and telecoms
- Migrate to a new Email system that meets the DOH ISB1596 security standard
- Implement a future proof file storage solution to replace the aging 20<sup>th</sup> century solution currently in place
- "Make safe" the Tavistock Centre's infrastructure environments such as the Computer Rooms and Hub Rooms
- Support delivery of directorate projects such as
  - DET Student Information Management System
  - CYAF expansion
  - Estates changes such as GIDS new building in Leeds



PAGE 10

## Build the Information Platform

*Build the information platform that is simple, integrated and accurate*

IM&T will develop its Informatics service building upon the work already done to provide the information that Trust needs to meet statutory, contractual and operational requirements. This will be achieved through several key priorities over the next 2 years to work towards the government paper light targets:

- Optimise the use of CareNotes
  - Ensuring the system is capable of capturing data requirements
  - Improving data quality through education and training in collaboration with the Quality Team
  - Enable CareNotes Mobile functionality where appropriate
  - Work with teams to ensure they have the right devices, forms etc... available to enable the most efficient work practices
  - Ensure all clinical documentation is digital in line with national directives
- Build a simple self-service reporting platform that delivers reports to agreed specifications
- Build a Trust dashboard for monitoring reporting activity and performance
- Provide support to services to enable better performance management
- Preparation for integration of CareNotes with other systems including e-referrals in support of national directives such as the Personalised health and care 2020 framework

To achieve these targets we will need to work closely with the quality team, contracts team and service leads to ensure we are delivering the services required.

Recognising the Directorate of Education and Training (DET) has not had the same level of attention over recent years regarding its informatics function IM&T will work with DET to help develop their systems, services and structure to support the needs of the business going forward.

We will support for example:

- Developing the staffing and structure to provide support for DET systems
- "Shoring up" of existing DET systems
- Procurement and implementation of a new Student Information Management System
- Development of Trust website and Intranet



While our focus is often on the “front line” services we provide we mustn't forget about the central services that support the organization and our service users.

While Finance has a fairly stable outsourced system currently the payroll function will be changing supplier in 2016 and this may require new systems and ways of working. External drivers may also see the requirement for new solutions to support things like payment by results.

HR currently use the outsourced electronic staff record system; while this meets the need there is probably room for improvement and opportunity to expand the use of this system that may need to be investigated.

DET already provide online services through Moodle and other platforms for students but there is currently no equivalent for patients. The Secretary of State for Health stated in October 2015 that by 2018 all patients will be able to access and update their own health information. We need to understand what this means to us and how we should respond to it. There are many other opportunities arising for how we can better engage with our patients through technology and we need to decide our approach.

There are also likely to be other initiatives that need to be investigated and considered such as video conferencing, telemedicine and e-learning opportunities. These have the potential to change the way we provide services across the organization and create interesting new possibilities.

## Build the Service Platform

*Build the service platform that has the right approach and knowledge*

This objective is concerned with developing and delivering a mature and professional IM&T service with appropriate levels of best practice and customer service in place.

The IM&T Department has very little formal "best practice" in place at present and to deliver the first 2 objectives and maintain standards we will need to change the way we do things. This journey has begun already with the implementation of a dedicated Helpdesk function and associated processes but there is more to do if IM&T is to provide a truly customer centred service.

Building the service platform will require a change in thinking from both the IM&T team and the wider Trust. Demand on IM&T services is rising which means more efficient ways of operating need to be implemented as an instant response to complex issues is not always possible.

Implementing a best practice approach such as the IT Infrastructure Library (ITIL) approach to IT Service Management helps manage this tension. However it does require that customers recognise and adopt new ways of interfacing with IM&T, these cultural changes must have continuous board level support if they are to be embedded and deliver the benefits desired.

Key ITIL processes that need to be implemented over the next 2 years are:

- IT Incident management processes need to be embedded including new ways of accessing the Helpdesk such as self-service call logging

- Change management processes need to be implemented across all IT related changes to support a safe and controlled environment
- Configuration (asset) management will be implemented to support better control of the IT estate from both a support perspective and a financial asset management perspective
- Software Asset Management will be implemented to ensure legal compliance and financial efficiency with regards software licensing
- Service Level management will be implemented so that we can monitor performance of IM&T services against agreed targets

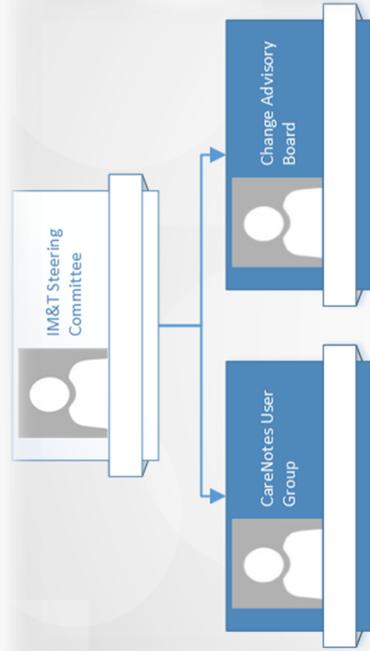
We must also ensure that staff are properly developed to deliver and support the increasingly complex systems we are required to use. Therefore we will aim to send staff on the appropriate technical and personal development courses to assist with service delivery.



## Measuring/Monitoring success

Now that IM&T is such an integral function it is important that the appropriate governance structure is in place to support the delivery of the strategy and monitor performance of the department.

To achieve this I am proposing a number of new groups led by the IM&T Steering Committee the structure is shown below.



The IM&T Steering Committee is envisioned to be a strategic group with high level representation from across the Trust that has the authority to make strategic decisions concerning the implementation of IM&T strategy and projects.

The IM&T SC will monitor performance against the IM&T Programme Plan and agreed IM&T service levels.

The group will also act as the IT Security Forum and provide oversight and guidance on security matters for the Trust.

While the terms of reference have not yet been agreed it is suggested that membership would include executive and non-executive directors and representation from all key Trust functions. The Deputy Chief Executive has been proposed as the chairperson for this committee.

Two other groups will report into the IM&T SC these are:

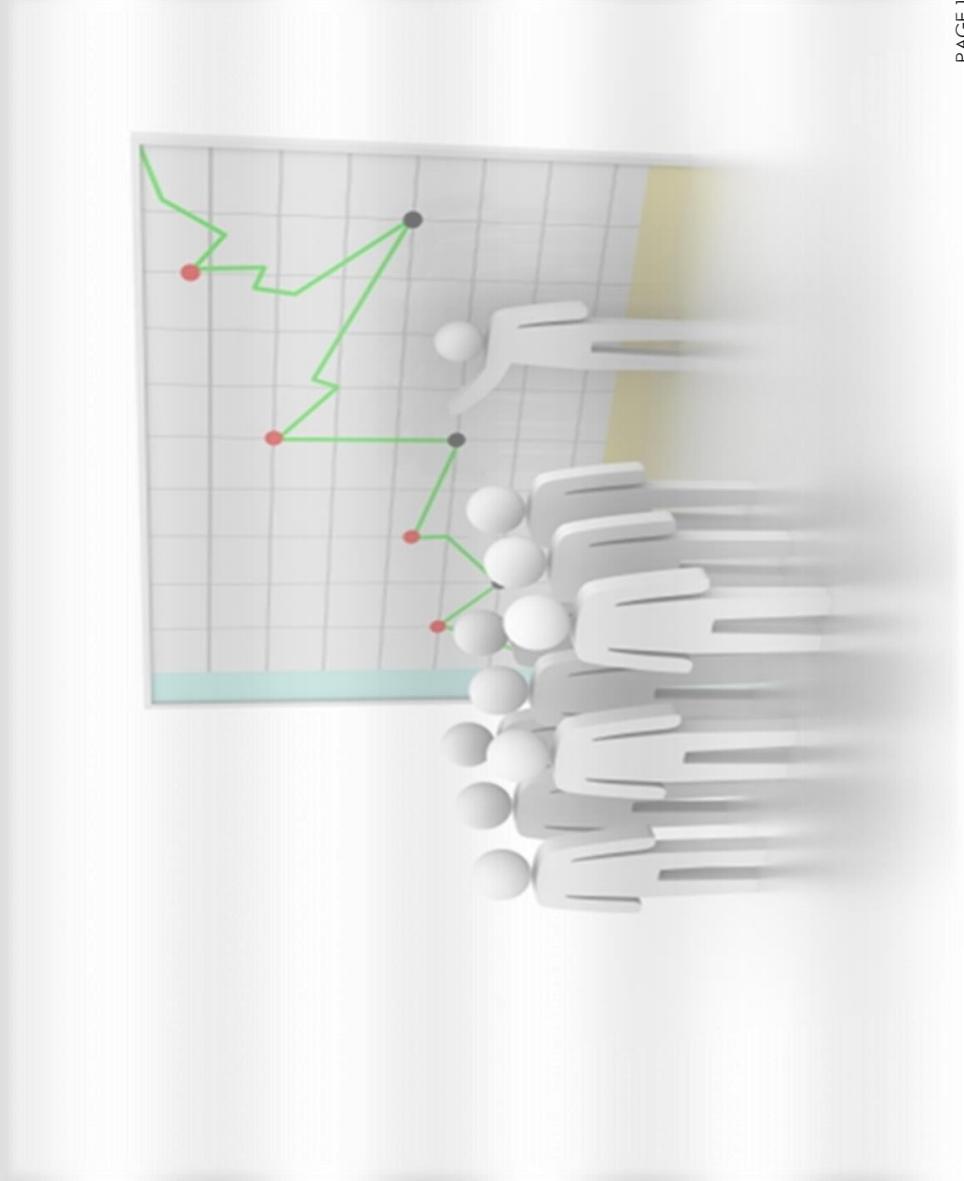
1. The CareNotes User Group chaired by the Lead for the Development of Clinical Applications of IM&T (CCIO). This group will be monitoring uptake and improvement of CareNotes and associated systems and helping to ensure benefits are achieved.
2. The Change Advisory Board. This group will approve significant changes to the IM&T environment providing appropriate levels of control and safety. Examples may include new functionality being deployed in CareNotes or a server upgrade. Their job is not to decide whether the change is appropriate but rather whether all due consideration has been taken to ensure implementation is safe



## Performance Management

Business as usual performance management will be implemented in line with ITIL principles and monitored by the IM&T SC for both service provision and compliance activities.

- Service Levels will be proposed by IM&T and the Chief Clinical Information Officer and submitted to the IM&T SC for approval
- A customer satisfaction survey will be implemented
- Bi-monthly reports will be presented to the IM&T SC on performance against agreed targets
- Supplier Management will be implemented for agreed contracts



## Security

Although not a specific objective good IT security must be a practice embedded into all aspects of the IM&T Strategy and wrap around everything that we do.

The global risk of cyber-attack is growing on a daily basis with an estimated annual cost of £27 Billion in the UK alone. The NHS is not immune to these attacks with security experts indicating a patient record having a \$50 value on the "dark web".

The Trust has been subjected to a number of attacks in 2015 with the most significant resulting in the website being unavailable for several days. Current security systems are preventing around 100,000 pieces of SPAM and 4,000 viruses per month in the second half of 2015 however we know that a growing amount of SPAM and potentially viruses are getting through our first line of defense.



We therefore have to improve the technological solutions in place, provide better monitoring and ensure we have appropriate plans in place to respond to attack.

As well as the technological solutions it is essential that the human element is also addressed through greater awareness, training and best practice being implemented.

This added but essential requirement will increase the workload on an already ambitious plan and this will need to be monitored and responded to as appropriate.

Several actions have already been identified to improve our security stance:

- Upgrading existing security tools to ensure they are supported and as effective as possible.
- Add security responsibilities to all staff job descriptions.
- Implement regular awareness exercises.
- Implement best practice security principles for managing IT systems such as the principle of least privilege.
- Improved asset management.

Innovation and excellence has to be built on a platform that is robust, reliable and secure therefore it is essential for both the fulfillment of this strategy and the confidence of our patients that we invest appropriately in IT security.

## The End Result

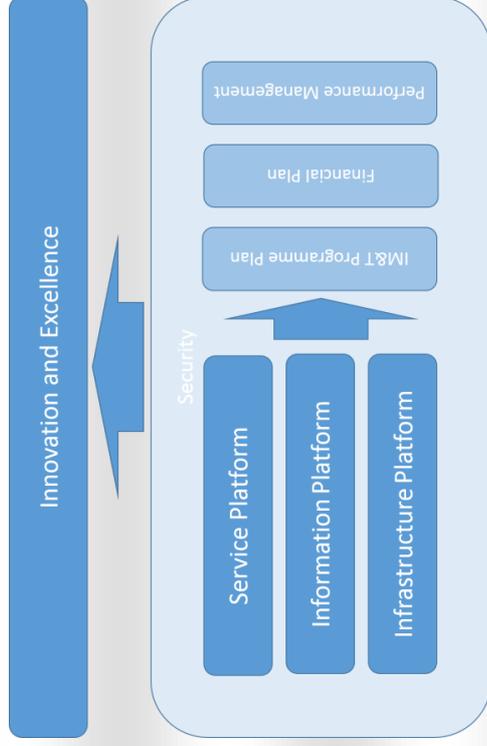
The idea of this strategy is to build a platform from which we can meet the needs of the Trust now and in the future. This requires getting all the right building blocks in place from a technical, procedural and people perspective.

There are a lot of things that we must do in order to provide a safe and reliable IT environment and there are other things we must do to meet the information needs of the Trust and national directives.

To achieve this goal is going to require significant commitment and investment over the next 2 years but by fulfilling this strategy we will have built the IM&T platform needed in the 21<sup>st</sup> Century.

Many of the changes will be invisible to staff as they are behind the scenes however they should result in the following benefits:

- Reduced downtime
- More reliable IT services
- Reduced risk
- More usable IT
- Improved customer service and expectation management
- Reporting that can be relied upon



## Implementation of the IM&T Strategy

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Implementing a strategy of this scale is not going to be straightforward and there are certain risks.

The support of the Trust Board is essential for success along with the recognition that we can't do it all at once.

We will need to use the Management Team and IM&T Steering Committee to help prioritise projects within the Programme Plan and agree funding.

Probably the biggest risk within the IM&T Department is limited capacity and expertise to deliver these projects as well as day to day activities. While it is possible to get agency staff in to deliver specific pieces of work this limits the in-house development of staff and their ability to support the system implemented. It is often not cost effective as 6 months at agency rates could easily cost more than 1 year of a permanent staff member.

Currently the IM&T Department is struggling to deliver on the existing workload and lacks senior technical expertise, project management expertise and change management capacity. Without addressing this it will be difficult to deliver this strategy.

To this end we will review the current IM&T structure against current and projected workload and recommend a pragmatic approach for ensuring the right capacity and expertise of staff.

**Capital Costs (K) inc VAT**

	2015/16	2016/17				2017/18
	Q4	Q1	Q2	Q3	Q4	Q1-4
Period Total	£66	£366	£150	£105	£30	£335
<b>Annual Total</b>	<b>£66</b>	<b>£651</b>				<b>£335</b>
<b>Grand Total</b>	<b>£1,052</b>					

**Revenue Costs (K) inc VAT in additional to existing revenue spend**

	2015/16	2016/17				2017/18	2018/19
	Q4	Q1	Q2	Q3	Q4	Q1-4	Q1-4
Period Total	£20	£330				£285	£185
<b>Annual Total</b>	<b>£20</b>	<b>£330</b>				<b>£285</b>	<b>£185</b>

nb. Depreciation not calculated

ID	TITLE <i>Heading in the Business Plan</i>	SUMMARY <i>Edit &amp; use as description in Bus Plan</i>	JUSTIFICATION FOR PROJECT	CONSEQUENCES OF NOT DOING	Year 1 (16/17)				Year 2(17/18)				Notes				
					Year 0 (15/16)				Year 1 (16/17)					Year 2(17/18)			
					Q4	Q1	Q2	Q3	Q4	Q1-4	Q1-4	Q1-4		Q1-4	Estimated Revenue Cost per annum (additional)	Priority	
CAPITAL COST (K) inc VAT	Estimated CAPITAL COST (K) inc VAT	CAPITAL COST (K) inc VAT	CAPITAL COST (K) inc VAT	CAPITAL COST (K) inc VAT	CAPITAL COST (K) inc VAT	CAPITAL COST (K) inc VAT	CAPITAL COST (K) inc VAT	CAPITAL COST (K) inc VAT	CAPITAL COST (K) inc VAT	Estimated Revenue Cost per annum (additional)	Priority						
<b>Building the Infrastructure</b>																	
1	Network Replacement	Tavi Centre full network replacement which will include redesign.	Essential infrastructure needs to be up to date and in support to enable business activity	Reduced availability and reliability of network, inability to fix as out of support.	110					20	40	Critical	Cost should be quite accurate				
2	Phone System Replacement	Tavi Centre and other connected sites full replacement of phone system	Essential infrastructure needs to be up to date and in support to enable business activity	Reduced availability and reliability of phones, inability to fix as out of support.						85	20	Critical	Year 1 basic upgrade to supported level (cost indicative). Year 2 upgrade handsets and OS to latest level (cost estimated) Support cost is minus current cost				
3	Email Migration	Scope email migration and implement along with appropriate solution for services that should not sit here.	Current email system is out of date and providing poor performance. Requires accrediting to ISO15396 standard.	Blocked from sending secure email, interruption to business activity due to poorly performing system.	75					20	50	Critical	Revenue cost total is circa £100k but total shown assumes cancellation of existing contracts for EA and Proofpoint				
7	Data Leak Prevention	Implement and test DLP solution across all outbound data flows	Implement DLP on email service	Increased risk of data loss through email	5					0	0	Critical	This may be possible to complete in house but may need some professional services support @ £1k/day				
8	N3 Network enhanced resilience	N3 links and underlying network infra such as firewalls	To provide increased resilience for N3 connected clinical systems by using commercial cloud services	Risk of loss of access to CareNotes is greater.		10				0	5	Nice to have					
9	ULCC resilience	Install resilient ULCC network connection	To provide increased resilience for remote connectivity to clinical systems by providing a second link	Risk of loss of access to CareNotes is greater for remote users	5					0	6	Critical	Revenue cost of circa £8k				
10	Firewall replacement	Replace as end of life and redesign to provide greater resilience	Essential infrastructure needs to be up to date and in support to enable business activity	Reduced availability and reliability of network, inability to fix as out of support. Greater risk of malicious penetration.			30			0	2	Critical					
15	Audio Visual Refresh	Replace all computers supporting AV functions. Seminar Rooms to have internet only access and meeting rooms to have corporate network access	Laptop replacement only		15					0	0	Business Development	Possibly funded from DET revenue				
16	Active Directory review	To review AD structure, accounts etc... and tidy up	Active directory has many accounts for staff who have left this poses a licensing challenge and makes it more complex to administer. It has grown organically and would benefit a review against best practice	Potential for greater licence charges, change failure due to complexity, best practice not adhered to could increase security risk		5				0	0	Critical	Cost for 1 month agency @ £250/day				
17	Estates changes e.g. Leeds, FDAC Kent, Westminster, Amphil etc...	A marker for the various Estates changes that come up throughout the year	Required for service continuity		?						?	Business Development	Its expected that there will be increased costs for services in these sites, implementation costs unknown Estate budget				
18	IT estates review and correction	Audit of existing IT facilities e.g. Computer Room and Hub Rooms to ensure they are safe and secure, corrective action where not. Includes power supply review.	Essential to keep IT provision reliable and secure The current power situation is not satisfactory as it presents both a fire risk and a resilience risk	Downtime of critical IT systems	124					30	10	Critical	£104 from supplier estimated £24 for Tavi direct work through Estates Revenue for maintenance, year 2 further works should be completed on other hub rooms.				
20	PC and other device replacement programme	Replace all PCs older than 3 years	To ensure all equipment within warranty and performing to standard	Reduced productivity due to breakages	25		25			30	105	Critical	Based on replacing approximately 1/5 the estate per year on a 5 year cycle. PCs replaced at 5 years old. Inc £3k for resource				
21	Storage improvement	Implement future proof storage solution	Ensure storage capacity and resilience for the future	Insufficient capacity and resilience						25	0	Critical	Assumes c365 agreed this is implementation cost only				
<b>Building the Information</b>					66	249	150	55	30	285	133						
26	CRM	Implement a CRM system to support DET business functions	???		10					0	5	Business Development	This is a complete guess it could be a bit more or less				
29	Patient portal							50			10	Business Development	This is likely to incur an ongoing monthly cost as well as implementation cost as estimated.				
32	DET Existing systems improvement	Existing systems need to be made safe until new SIMS system is implemented and fully functional	Essential to keep existing systems running for maintaining services provision	Loss of income and reputation	10						5	Critical	Needs investigating - a nominal amount as a placeholder				
42	Digital patient journey (Paperless 2020)	Implement: 1. e-referral system 2. e-discharge letters, care plan etc	Reduce paper and increase efficiency	Greater wastage and not aligned with government targets						50	?	Critical					
43	Clinical System Optimisation	Optimise the clinical systems for best use including reporting systems	Increase efficiency, quality, reporting, management, performance etc...	Failure to deliver benefits from systems	23						0	Critical	Senior PM 1 day/week @ £450/day to drive both cultural and technical change				
44	Data Warehouse Optimisation	Develop warehouse to provide management information from clinical data to support decision making and research	Support clinical decision making thru better use of data	Significant senior informatics focus will be required to deliver this	0						0	Critical					

ID	TITLE <i>Heading in the Business Plan</i>	SUMMARY <i>Edit &amp; use as description in Bus Plan</i>	JUSTIFICATION FOR PROJECT	CONSEQUENCES OF NOT DOING	Year 0 (15/16)				Year 1 (16/17)				Year 2(17/18)		Notes		
					Q4				Q1				Q1-4				
					CAPITAL COST (K) inc VAT	Estimated CAPITAL COST (K) inc VAT		Estimated Revenue Cost per annum (additional)	Priority								
45	Reporting optimisation	Reporting information, performance management, dashboards, quality etc...	Support management decision making and performance monitoring	Unable to effectively manage performance possibility for financial loss					50						10	Business Development	Estimate cost of dashboard tool may be significantly more or we may choose not to utilise a tool and provide a more basic embedded tool.
46	DATIX	Datix risk/incident mgmt system	Support better management of incidents and risks						24						12	Business Development	Estimated cost awaiting quotes
47	CareNotes integration with external systems	Enable communication and record sharing with commissioners and other providers	Support new, lenders and improved clinical processes	Commissioners are looking for providers that are able to integrate with other systems for data sharing, therefore it could mean we lose opportunities					?						?	Business Development	Unable to estimate a cost until further work is carried out
48	Patient Engagement Site (Interactive WiFi portal)	Interactive means of engaging patients via connection to the Trust WiFi linking to videos, CBT, FFT, other support media etc...							?						?	Business Development	Unable to estimate a cost until further work is carried out
<b>Building the Service</b>									117	0	50	0	50	0	42		
53	Implementation of Incident Management process	Developing and implementing the processes to run the department more effectively and resolve some of the existing compliance and service issues							0						0	Business Development	Time from in house teams required to develop and embed processes
54	Implementation of Change Management processes	Developing and implementing the processes to run the department more effectively and resolve some of the existing compliance and service issues							0						0	Business Development	Time from in house teams required to develop and embed processes
55	Implementation of Configuration Management processes	Developing and implementing the processes to run the department more effectively and resolve some of the existing compliance and service issues							0						0	Critical	Time from in house teams required to develop and embed processes
56	Implementation of Service Level Management processes	Developing and implementing the processes to run the department more effectively and resolve some of the existing compliance and service issues							0						0	Business Development	Time from in house teams required to develop and embed processes
57	Implement Cyber security incident procedures	Develop and implement procedures for managing cyber security incidents	Action required from cyber security audit	Increased risk of security breach resulting in loss of services					0						0	Critical	Time from in house teams required to develop and embed processes
58	Implement IT DR audit recommendations	Implement recommendations coming out of the IT DR audit	Actions required from audit	Risk around system availability					0	0	0	0	0	0	0	Critical	Time from in house teams required to develop and embed processes
<b>Resources</b>									0	0	0	0	0	0	0		
59	Senior technical project resource	Senior technical resource required to support delivery of infrastructure projects	Insufficient expertise and capacity will hinder delivery of priority projects	Failure to deliver projects effectively											50	Critical	Based on band 7 FTC for 2 years
60	Project Management resource	Project management resource required to support delivery of agreed plan	IM&T staff do not have the expertise or capacity to manage projects a volume of work to progress over the next 2 years structured project management is key.	Failure to deliver projects effectively											50	Critical	Based on band 7 FTC for 2 years
61	Change Management resource	Change Management resource to support embedding of good practice in support of the CareNotes optimisation project	Optimisation and culture change takes time and focus to deliver. Dedicated resource to achieve this is key	Optimisation won't be fully embedded or achieved if focussed effort is not given to it.											45	Business Development	Based on band 6 FTC for 1 year
62	Review IM&T structure and implement changes as required	IM&T has grown over recent months and demand has grown. We need to consider whether the structure and skill mix is appropriate for the services that we must deliver.	Required to ensure the correct support is in place to deliver the IM&T strategy	Failure to do so may impact negatively on the strategy.												Nice to have	
63	Additional desktop support temporary	Deliver replacement PCs and additional devices Feb-Mar 16													20	Critical	Only Q4 15/16 so excluded from total
<b>Total Grand Total</b>					66	0	366	150	105	30	335	0	145	330			



## Board of Directors:

**Item:** 10

**Title:** Care Quality Commission Inspection, January 2016

**Purpose:**

This brief paper gives an overview of the onsite visit of the Care Quality Commission (CQC) inspection team over the week beginning January 25<sup>th</sup> 2016.

The visit went largely to plan and there was good engagement from staff across the Trust which was much appreciated by the inspection team.

The team gave informal headline feedback at the end of the week. The formal report , including our CQC rating will be published in April 2016

**This report focuses on the following areas:**

- Quality

**For:** Noting

**From :** Louise Lyon, Director of Quality and Patient Experience/  
Director of Adult and Forensic Services

## CARE QUALITY COMMISSION INSPECTION

1. The Care Quality Commission (CQC) team arrived in the Trust on Monday January 25<sup>th</sup> 2016. There were 27 inspectors in total and the team, which included mental health professionals and people with lived experience, was led by Judith Edwards and chaired by Professor Tim Kendall.
2. Paul Jenkins met the inspection team, with colleagues, on January 25<sup>th</sup> to deliver a short presentation, which set out who we are, why we are unique, our strengths and where we see some of our challenges. A short Q&A session followed; the inspection team were interested in hearing more about workplace equality, staff well-being, our quality improvement work and how we action plan following feedback from patients, staff and other key stakeholders.
3. Over the following three days, the inspection team spent time with the Gender Identity Development Service, the Refugee Service, the Family Mental Health Service, Camden North and South, the Adolescent and Young Adult Service, City and Hackney Primary Care Psychotherapy Consultation Service, the Portman Clinic, and the Fitzjohn's Trauma and Lyndhurst Units.
4. They ran two focus groups for clinical staff and one for clinical trainees. They joined the Children, Young Adults and Families' administrative staff meeting.
5. The inspectors met with patients from across all our services, individually - either face-to-face or over the phone - or in groups. They attended the adult reference group, the pizza and chat session and attended a Governors' briefing session in the run-up to their inspection.
6. The inspectors attended our Board of Directors meeting and met individually with some Board members and with senior staff leading on various areas of our work such as HR, Safeguarding, Patient and Public Involvement, Equalities and Freedom to Speak Up.
7. We set up a CQC Hub in the IT training suite at the Tavistock Centre to offer guidance and advice for anyone with questions before, during, or after the inspection. We invited teams to send in a summary of the themes that came up in their meetings with the inspectors. The hub also provided an informal opportunity to debrief and share experiences. Daily updates from Paul Jenkins were sent out by email throughout the inspection week. There was a striking sense of everyone coming together, approaching the inspection positively and being very accommodating to the inspection team.
8. Overall we had a positive interaction with the inspectors, who found the information we had been sharing in the run up to the inspection week helpful.
9. Discussions with inspectors largely concerned how we embed new and existing practice to deliver quality, effective services and they were interested in how we learn and adapt as an organisation. We were pleased that we were able to draw on some very pertinent examples, which the inspectors are always keen to hear. They were interested in how we use evidence, for example how we demonstrate the impact supervision and case discussion has on clinical delivery.

10. On the last day of the week, Friday 29<sup>th</sup> January, the inspection team informally shared some headline findings with us. Their first message conveyed their appreciation for the exemplary way in which staff and trainees across the organisation had engaged with the Inspection. They particularly commented on how quickly staff had responded to requests for information and how open everyone had been to the issues that had been raised with them.
11. Secondly, the team particularly wanted to commend the clear evidence they found in all teams of the caring values and behaviours of staff, both clinical and non-clinical, and the sense of commitment they had to the people who used their services. While no surprise to us, it was very pleasing to hear the emphasis they put on this message.
12. The team commented on the breadth of good practice they saw in individual teams and across the organisation. They particularly drew out our focus on supervision and training, partnership working, patient and public involvement, safeguarding and meeting the needs of the populations we serve.
13. The team did highlight areas where we could improve. Many of these aligned with areas where we have already identified the need for further work. A consistent theme, however, was the opportunity for us to develop a more systematic approach to quality improvement across the organisation. They also touched on some of the current issues around Care Notes and the waiting times in some services. We acknowledged the need to address these issues.
14. In due course, we will have to develop an action plan to respond to areas they have identified. Meanwhile it is worth noting that staff across the Trust worked hard both in preparation for the visit and during the inspection week. It will be important to build on the sense of common purpose in taking forward our plans for clinical quality development.
15. The CQC team will prepare a report, which will go through their internal quality monitoring and moderating procedures. We will receive a draft copy of the report towards the end of March for us to correct any inaccuracies. The final report is likely to be published in early April 2016. The report will give us an overall rating (Outstanding, Good, Requires Improvement, Inadequate) along with a summary of areas in which we do well and those in which improvement will be required.

Louise Lyon,  
February 2016



## Board of Directors : February 2016

**Item :** 11

**Title :** Finance and Performance Report

### **Summary:**

After ten months the Trust has a surplus of £1,734k before restructuring, £1,530k above the planned surplus of £204k.

In January, the surplus before restructuring was £169k. There were 42 wte vacancies across the organisation, but these were covered by 29 bank staff and 14 agency staff. The favourable variance on expenditure was offset by shortfalls on income.

The current forecast for the year is a surplus of £1,220k before restructuring or £718k after restructuring.

The cash balance at 31 January was £5,642k, but this will reduce by year-end.

This report was reviewed by the Executive Management Team on 16 February.

**For :** Information.

**From :** Simon Young, Director of Finance

## 1. **External Assessments**

### 1.1 **Monitor**

1.1.1 Monitor's assessment on Quarter 2 confirmed that our Financial Sustainability Risk Rating (FSRR) is 4, and the rating for governance is green. We are now required to complete a monthly Monitor return; for the December submission the FSRR remained 4: our formal Quarter 3 ratings are awaited.

## 2. **Planning**

2.1 The draft operational plan for 2016/17 was submitted to Monitor on 8 February with a target surplus of £300k. Copies of this draft have been circulated to members. The full budget will be presented for approval at the March meeting, and will form the basis for the final operational plan due to be submitted in 11 April. Management Team are reviewing the current draft of the budget this week, and an update will be provided at the meeting.

2.2 The plan is set in the context of the local health and care system for the five boroughs of North Central London, for which a five year Sustainability and Transformation Plan (STP), covering the period October 2016 to March 2021, is being developed. The financial challenge for North Central London over this period is considerable.

2.3 As part of the work to develop the STP, a North Central London Mental Health Programme has been established. The programme will identify and address areas where there is potential to strengthen progress across the sector towards achieving the triple aim<sup>1</sup> as set out in the Forward View. As part of this, the Trust will continue to work closely with commissioners, partner mental health Trusts and acute and primary care services.

## 3. **Finance**

### 3.1 **Income and Expenditure 2015/16**

3.1.1 After January the trust is reporting a surplus of £1,734k before restructuring costs, £1,530k above budget. Income is £116k below budget, and expenditure £1,641k below budget.

3.1.2 The income shortfall at January of £116k is due to shortfalls on Training £203k and Consultancy £229k which is partially offset by a Clinical surplus of £201k.

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<sup>1</sup> Better health; transformed quality of care delivery; and sustainable finances

- 3.1.2.1 Training is £203k below plan due to Portfolio Fee income being £85k below plan and a £75k shortfall on FNP project income.
- 3.1.2.2 Consultancy is £229k below budget, £145k of which is due to TC.
- 3.1.2.3 Clinical Income was £201k above budget at the end of January which was mainly due to the release of a provision of £145k from 2014/15 for potential non-payment of GIDU over performances and £133k for Gloucester House due to high pupil numbers which has been offset by the FDAC service as there is a dispute over case provision. All the main income sources and their variances are discussed in sections 3, 4 and 5.
- 3.1.3 The favourable expenditure position of £1,641k below budget was due mainly to the following areas.
- 3.1.3.1 Family Nurse Partnership (FNP) has a cumulative under spend of £412k due to £144k vacancies (4.52 WTE) and lower than expected non pay costs of £268k. This is forecast to reduce to a £297k under spend by the end of the financial year.
- 3.1.3.2 GIDS are under spent £196k cumulatively; but as discussed at previous meetings, vacant posts have now been filled and the Unit is currently overspending due to employing additional staff or sessions on a temporary basis. There are also additional non-pay costs, including costs of the move to new premises in Leeds. The under spend is expected to reduce to £133k by the end of the financial year.
- 3.1.3.3 Education and Training is under spent by £163k on pay which includes £110k from E-learning (3.00 WTE); this under spend is anticipated to reduce to £88k by year end. The Portfolios are also £168k under spent on pay due to previous vacancies and this is expected to be £132k below budget at the end of the year.
- 3.1.3.4 Complex Needs is under spent £116k on pay cumulatively, due vacancies earlier in the year. The One Hackney project is £146k under spent on pay.
- 3.1.3.5 Portman is £174k under budget on pay: this is due to additional budget for the increased Probation Service income, and a vacant consultant post (0.70 wte).

## 3.2 Forecast Outturn

- 3.2.1 The forecast surplus allowing for restructuring costs of £502k is £744k, which is £694k above budget.
- 3.2.2 Clinical income is currently predicted to be £308k above budget due to GIDS over performance on NPAs and Gloucester House over performance, offsetting the provision for under performance on the FDAC Service.

- 3.2.3 There is also a release of a provision of £145k on Clinical Income relating to previous years.
- 3.2.4 Training Portfolio income is forecast to be £171k below plan for this financial year due to student numbers being below target. Further detail is in 3.1.3
- 3.2.5 Visiting Lecturer costs are forecast to be £102k below budget.
- 3.2.6 TC expect their income to be £800k which is £113k below target. To offset this loss they forecast their expenditure will be £116k under spent. The current position is less favourable than this, so an improvement is needed in the final quarter.
- 3.2.7 The Portman Clinic are currently £199k below their expenditure budget and expect this increase to £223k by the end of the year.
- 3.2.8 Commercial Directorate are currently £90k over budget and this is expected to increase to £94k over spent by the end of the financial year due to temporary staffing requirements.
- 3.2.9 The forecast assumes that £319k of the contingency remains unutilised.

### 3.3 Cash Flow (Appendix D)

- 3.3.1 The actual cash balance at 31 January was £5,642k this is an increase of £1,338k in month and is £1,516k above Plan.
- 3.3.2 The balance was above Plan mainly due to the size of the surplus in addition to over performance payments from this year and last from GIDU. Capital expenditure is £495k below Plan.

	Actual £000	Plan £000	Variance £000
Opening cash balance	2,761	2,761	0
Operational income received			
NHS (excl HEE)	15,471	15,017	454
General debtors (incl LAs)	10,385	10,654	(269)
HEE for Training	11,395	10,494	901
Students and sponsors	2,374	2,825	(451)
Other	0	0	0
	<b>39,625</b>	38,990	635
Operational expenditure payments			
Salaries (net)	(15,039)	(15,283)	244
Tax, NI and Pension	(10,809)	(11,174)	365
Suppliers	(8,996)	(8,752)	(245)
	<b>(34,844)</b>	(35,209)	364
Capital Expenditure	(1,715)	(2,210)	495
Interest Income	9	4	5
Payments from provisions	0	0	0
PDC Dividend Payments	(194)	(211)	17
Closing cash balance	<b>5,642</b>	4,126	1,516

### 3.4 **Better Payment Practice Code**

3.4.1 The Trust has a target of 95% of invoices to be paid within the terms. During January we achieved 88% (by number) for all invoices. The cumulative total for the year was 89%.

### 3.5 **Capital Expenditure**

3.5.1 Up to 31 January, expenditure on capital projects was £1,715k. This included £894k on the Modular Building and £268k on the IDCR project.

3.5.2 The capital budget for the year was £2,433k in total and in September the Board approved a further £500k to take the Relocation/Refurbishment project up to Full Business Case. The forecast for the year is shown on the table below, totalling £2,275k.

Capital Projects 2015/16	Budget 2015/16	Actual YTD January 2016	Forecast 2015/16	Spend 2013/14	Spend 2014/15	Total Project	
						Spend to date	Budget to date
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Toilets	100	60	100			60	100
Fire door	40	8	40			8	40
Boiler at the Portman Clinic	-	23	23			23	25
Relocation Project up to OBC	200	200	200	12	420	632	600
Relocation Project up to FBC	500	76	240			76	500
Modular Building	825	894	894		14	908	925
DET refurbishment	63	26	63			26	63
Building Management system ext	10	-	10			-	10
Car Park Extraction Unit	70	-	70			-	70
<b>Total Estates</b>	<b>1,808</b>	<b>1,287</b>	<b>1,640</b>	<b>12</b>	<b>434</b>	<b>1,733</b>	<b>2,333</b>
IT Infrastructure	350	160	235			160	350
IDCR	400	268	350	-	389	657	789
Student record system	375		50			-	375
<b>Total IT</b>	<b>1,125</b>	<b>428</b>	<b>635</b>	<b>-</b>	<b>389</b>	<b>817</b>	<b>1,514</b>
<b>Total Capital Programme</b>	<b>2,933</b>	<b>1,715</b>	<b>2,275</b>	<b>12</b>	<b>823</b>	<b>2,550</b>	<b>3,847</b>

## 4. **Training**

### 4.1 **Income**

4.1.1 Training income is £203k below budget in total after ten months.

4.1.2 FNP income is currently being reported as £75k below budget and is expected to be £117k below target by the end of the year.

4.1.3 Training income is significantly below Plan. Recruitment to the new academic year 2015-16 has reached 77% of target, with 484 students compared to the target of 630. This is 5% up on last year. The academic year 2015-16 fee

income is forecast £465k below Plan; £271k (7/12ths) of this in this financial year. Overall student numbers are 98 below plan (5% above target). Enrolment into all years at Associate Centres is 219, just ahead of the target of 215.

4.1.4 Short courses activity is currently £95k below Plan, and forecast to reach in the region of £147k below the full year Plan of £585k. This is due to a number of CPD's and conferences not attracting the level of attendance when compared with previous years. A number of new short courses are being developed to subject areas more aligned with the HEE strategic priorities.

4.1.5 Training expenditure is currently £691k lower than budget for all areas.

4.1.5.1 The majority of this is within FNP at £412k.

4.1.5.2 The Department of Education and Training is £21k below budget mainly due to a number of key posts being vacant to date. Some short-term posts have been and are being recruited to

4.1.5.3 The Portfolio budgets are £175k under spent as some posts have only just been filled following later than planned recruitment to Portfolio Manager posts which in turn has result in delays in filling the course team posts. A review of all staff sessions of clinical/training posts is taking place as part of the budget setting process.

## 5. **Patient Services**

### 5.1 Activity and Income

5.1.1 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.

5.1.2 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."

5.1.3 The income budget for named patient agreements (NPAs) was increased this year from £131k to £148k. After January actual income is £80k above budget. This is due to £36k from GIDU relating to 2014/15 in addition to continued GIDU over-performance.

5.1.4 Day Unit Income target was increased by £172k in 2015/16 and is £133k above target after January.

	Budget	Actual	Variance	Full year		Comments
	£000	£000	%	Variance based on y-t-d	Predicted variance	
Contracts - base values	14,230	14,317	0.6%	104	144	Release of prior year credit
NPAs	124	204	64.9%	96	116	Over performed on GIDU
Projects and other	843	808		-	-5	Income matched to costs, so variance is largely offset.
Day Unit	683	816	19.4%	159	159	
FDAC	2,016	1,911	-5.2%	-126	-106	FDAC dispute
Total	17,896	18,056		233	308	

## 6. **Consultancy**

6.1 TC are £73k behind budgeted target after ten months. This consists of expenditure £59k underspent and consultancy income £134k below budget. TC have reviewed their forecast income and expenditure for the rest of the year and estimate income to be £113k below target and expenditure to be £116k under spent.

6.2 Departmental consultancy is £84k below budget after December; £49k of the shortfall is within Adults and Forensic Services.

Carl Doherty  
Deputy Director of Finance  
16 February 2016

THE TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST				APPENDIX A				
INCOME AND EXPENDITURE REPORT FOR THE FINANCIAL YEAR 2015-16								
		Jan-16						
	BUDGET	ACTUAL	VARIANCE	BUDGET	ACTUAL	VARIANCE	REVISD	
	£000'S	£000'S	£000'S	£000'S	£000'S	£000'S	BUDGET	
							£000	
							FORECAST	
							OUTTURN	
							£000	
<b>INCOME</b>								
1 CLINICAL	2,388	2,491	103	17,982	18,182	201	20,674	19,416
2 TRAINING	1,640	1,723	83	16,844	16,642	(203)	20,187	20,783
3 CONSULTANCY	99	66	(33)	1,040	811	(229)	1,238	1,640
4 RESEARCH	7	9	2	69	65	(5)	83	123
5 OTHER	83	144	60	500	620	120	667	819
<b>TOTAL INCOME</b>	<b>4,217</b>	<b>4,432</b>	<b>216</b>	<b>36,435</b>	<b>36,319</b>	<b>(116)</b>	<b>42,848</b>	<b>42,781</b>
<b>OPERATING EXPENDITURE (EXCL. DEPRECIATION)</b>								
6 CLINICAL DIRECTORATES	2,273	2,286	(14)	16,417	15,526	891	18,864	18,891
7 OTHER TRAINING COSTS	1,069	1,164	(95)	11,589	10,898	691	13,873	14,337
8 OTHER CONSULTANCY COSTS	64	56	8	637	578	59	765	787
9 CENTRAL FUNCTIONS	710	648	62	6,281	6,552	(271)	7,724	7,535
10 TOTAL RESERVES	27	0	27	266	0	266	319	(9)
<b>TOTAL EXPENDITURE</b>	<b>4,142</b>	<b>4,154</b>	<b>(12)</b>	<b>35,191</b>	<b>33,555</b>	<b>1,636</b>	<b>41,546</b>	<b>41,539</b>
<b>EBITDA</b>	<b>75</b>	<b>278</b>	<b>203</b>	<b>1,244</b>	<b>2,765</b>	<b>1,520</b>	<b>1,302</b>	<b>1,241</b>
<b>ADD:-</b>								
11 BANK INTEREST RECEIVED	0	1	(1)	4	9	(5)	5	5
<b>LESS:-</b>								
12 DEPRECIATION & AMORTISATION	112	75	37	694	689	5	836	775
13 FINANCE COSTS	0	0	0	0	0	0	0	0
14 DIVIDEND	35	35	0	351	351	0	421	421
<b>SURPLUS BEFORE RESTRUCTURING COSTS</b>	<b>(72)</b>	<b>169</b>	<b>240</b>	<b>204</b>	<b>1,734</b>	<b>1,530</b>	<b>50</b>	<b>50</b>
15 RESTRUCTURING COSTS	0	147	(147)	0	293	(293)	0	0
<b>SURPLUS/(DEFICIT) AFTER RESTRUCTURING</b>	<b>(72)</b>	<b>22</b>	<b>94</b>	<b>204</b>	<b>1,441</b>	<b>1,237</b>	<b>50</b>	<b>50</b>
<b>EBITDA AS % OF INCOME</b>								
	1.8%	6.3%		3.4%	7.6%		3.0%	2.9%
								5.8%

	All figures £000										
	Jan-16			CUMULATIVE			FORECAST FOR FULL YEAR				
	BUDGET	ACTUAL	VARIANCE	BUDGET	ACTUAL	VARIANCE	OPENING BUDGET	REVISED BUDGET	FORECAST	VARIANCE FROM REV BUDGET	
<b>INCOME</b>											
1	CENTRAL CLINICAL INCOME	617	771	154	6,170	6,330	161	7,035	7,404	7,701	297
2	CYAF CLINICAL INCOME	506	441	(65)	5,058	5,085	27	6,868	5,990	5,973	(17)
3	AFS CLINICAL INCOME	1,035	1,093	58	4,255	4,209	(45)	2,865	4,322	4,265	(58)
4	GENDER IDENTITY	229	185	(44)	2,499	2,558	59	2,648	2,957	3,043	85
5	NHS LONDON TRAINING CONTRACT	605	605	0	6,045	6,045	0	7,254	7,254	7,254	0
6	CHILD PSYCHOTHERAPY TRAINEES	179	236	57	1,790	1,823	33	2,148	2,148	2,188	40
7	JUNIOR MEDICAL STAFF	71	79	8	710	761	51	900	852	851	(1)
8	POSTGRADUATE MED & DENT'L EDUC	7	8	1	70	27	(42)	111	84	79	(5)
9	PORTFOLIO FEE INCOME	461	474	13	4,375	4,290	(85)	5,422	5,298	5,127	(171)
10	DET TRAINING FEES & ACADEMIC INCOME	20	51	31	875	811	(64)	1,373	976	889	(87)
11	FAMILY NURSE PARTNERSHIP	298	290	(7)	2,978	2,903	(75)	3,574	3,574	3,456	(117)
12	TC INCOME	76	44	(32)	761	616	(145)	925	913	787	(126)
13	CONSULTANCY INCOME CYAF	6	3	(3)	64	29	(35)	91	77	29	(48)
14	CONSULTANCY INCOME AFS	17	18	2	215	166	(49)	624	248	200	(48)
15	R&D	7	9	2	69	65	(5)	123	83	73	(10)
16	OTHER INCOME	83	144	60	500	620	120	819	667	778	111
	<b>TOTAL INCOME</b>	<b>4,217</b>	<b>4,432</b>	<b>216</b>	<b>36,435</b>	<b>36,319</b>	<b>(116)</b>	<b>42,781</b>	<b>42,848</b>	<b>42,693</b>	<b>(156)</b>
<b>EXPENDITURE</b>											
17	COMPLEX NEEDS	971	920	51	3,516	3,185	331	2,662	3,456	3,083	373
18	PORTMAN CLINIC	142	140	2	1,337	1,138	199	1,421	1,605	1,382	223
19	GENDER IDENTITY	183	221	(39)	1,826	1,630	196	2,079	2,191	2,058	133
20	DEV PSYCHOTHERAPY UNIT	8	61	(54)	91	154	(64)	106	106	203	(97)
21	NON CAMDEN CAMHS	531	479	53	5,322	5,113	209	7,222	6,267	6,152	115
22	CAMDEN CAMHS	376	384	(8)	3,796	3,691	105	4,639	4,549	4,446	103
23	CHILD & FAMILY GENERAL	62	82	(20)	529	615	(85)	762	691	805	(115)
24	FAMILY NURSE PARTNERSHIP	211	218	(6)	2,545	2,133	412	3,112	3,051	2,754	297
25	JUNIOR MEDICAL STAFF	83	58	24	828	722	106	993	993	887	107
26	NHS LONDON FUNDED CP TRAINEES	179	180	(1)	1,790	1,818	(28)	2,148	2,148	2,181	(33)
27	TAVISTOCK SESSIONAL CP TRAINEES	2	1	0	15	12	3	19	19	15	4
28	FLEXIBLE TRAINEE DOCTORS & PGMDE	20	21	(2)	195	178	18	309	234	213	21
29	EDUCATION & TRAINING	251	308	(56)	3,053	3,032	21	3,906	3,619	3,699	(81)
30	VISITING LECTURER FEES	111	154	(42)	1,109	1,103	6	1,332	1,332	1,231	102
31	CYAF EDUCATION & TRAINING	39	47	(8)	351	407	(56)	1,503	429	555	(126)
32	ADULT EDUCATION & TRAINING	30	18	12	273	238	35	1,015	334	288	46
33	PORTFOLIOS	143	160	(17)	1,428	1,253	175	0	1,714	1,577	137
33	TC EDUCATION & TRAINING	0	(0)	0	0	3	(3)	0	0	3	(3)
34	TC	64	56	8	637	578	59	787	765	654	111
35	R&D	17	28	(11)	168	106	61	238	201	131	71
36	ESTATES DEPT	221	272	(51)	1,703	1,983	(281)	2,090	2,166	2,490	(324)
37	FINANCE, ICT & INFORMATICS	172	130	42	1,768	1,793	(25)	2,295	2,113	2,147	(34)
38	TRUST BOARD, CEO, DIRECTOR, GOVERNS & PPI	139	128	11	1,023	1,024	(1)	981	1,302	1,305	(2)
39	COMMERCIAL DIRECTORATE	37	45	(8)	376	466	(90)	454	449	543	(94)
40	HUMAN RESOURCES	51	49	2	512	542	(30)	652	614	650	(36)
41	CLINICAL GOVERNANCE	67	63	4	673	617	56	824	808	750	58
42	CEA CONTRIBUTION	6	(67)	73	59	21	38	0	70	25	45
43	DEPRECIATION & AMORTISATION	112	75	37	694	689	5	775	836	836	0
44	VACANCY FACTOR	0	0	0	0	0	0	(134)	0	0	0
45	PRODUCTIVITY SAVINGS	0	0	0	0	0	0	(80)	0	0	0
46	INVESTMENT RESERVE	0	0	0	0	0	0	0	0	0	0
47	CENTRAL RESERVES	27	0	27	266	0	266	205	319	0	319
	<b>TOTAL EXPENDITURE</b>	<b>4,255</b>	<b>4,230</b>	<b>25</b>	<b>35,885</b>	<b>34,244</b>	<b>1,641</b>	<b>42,314</b>	<b>42,382</b>	<b>41,060</b>	<b>1,322</b>
	<b>OPERATING SURPLUS/(DEFICIT)</b>	<b>(38)</b>	<b>203</b>	<b>241</b>	<b>551</b>	<b>2,076</b>	<b>1,525</b>	<b>466</b>	<b>466</b>	<b>1,632</b>	<b>1,166</b>
48	INTEREST RECEIVABLE	0	1	1	4	9	5	5	5	9	4
49	DIVIDEND ON PDC	(35)	(35)	0	(351)	(351)	0	(421)	(421)	(421)	0
	<b>SURPLUS/(DEFICIT)</b>	<b>(72)</b>	<b>169</b>	<b>241</b>	<b>204</b>	<b>1,734</b>	<b>1,530</b>	<b>50</b>	<b>50</b>	<b>1,220</b>	<b>1,170</b>
50	RESTRUCTURING COSTS	0	147	(147)	0	293	(293)	0	0	502	(502)
	<b>SURPLUS/(DEFICIT) AFTER RESTRUCTURING</b>	<b>(72)</b>	<b>22</b>	<b>95</b>	<b>204</b>	<b>1,441</b>	<b>1,237</b>	<b>50</b>	<b>50</b>	<b>718</b>	<b>668</b>



## Board of Directors : February 2016

**Item** : 12

**Title** : CQSG Committee Report, Q3, 2015/16

### **Purpose:**

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

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

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

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

### **This report focuses on the following areas:**

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

**For** : Discussion

**From** : Rob Senior, CQSG Chair

## Clinical Quality, Safety, and Governance Committee

Notes from a meeting held at 11:00, Tuesday 2<sup>nd</sup> February 2016, Boardroom

Members	Present?
Rob Senior, Medical Director (& CQSGC Chair)	Y
Paul Burstow, Trust Chair	Y
Dinesh Bhugra, Non-Executive Director	-
Anthony Levy, Public Governor	Y
George Wilkinson, Public Governor	Y
Paul Jenkins, Chief Executive	Y
Simon Young, Senior Information Risk Owner	Y
Louise Lyon, Quality, Patient Experience and Adult & Forensic Director	Y
Sally Hodges, CYAF Director	Y
<b>In attendance</b>	
Caroline McKenna, CO & CA Lead	Y
Jessica Yakeley, PSCR Lead	Y
Elisa Reyes Simpson, Associate Dean for Academic Governance and Quality Assurance	Y
Marion Shipman, Associate Director Quality and Governance	Y
Jonathan McKee, Governance Manager (& CQSGC Secretary)	Y

AP	Item	Action to be taken	By	Deadline
5	5 (c)	<i>A report assuring the CQSGC that the EMT is actively monitoring the implementation of users-on-interview panels initiative by reviewing the proportion of panels conforming with the standard [via the CQPE work stream report]</i>	LL	31.1.16
1	4	The Training and Education Programme Management Board is to consider further proposals to ensure compliance with governance of trainees' mandatory training	PJ	31.3.16
2	5 (a)	<i>Generate robust clinical data quality reports enabling management of team or individual clinician practice [via CQPE work stream report]</i>	MS, LL	31.3.16
3	5 (a)	<i>A recent audit had showed that not all clinicians were adding a scanned copy of the prescription in to the IDCR; this needs to be followed-up at team level [via PSCR work stream report]</i>	RS, LL	31.3.16

Items in italics should be reported through the respective work streams.

<b>Preliminaries</b>		<b>Action</b>
<b>1</b>	<b>Chair's opening remarks</b>	
	Everyone was welcomed, especially George Wilkinson attending for the first time, and Sally Hodges attending for the first time in role as CYAF Director.	

CQSG Jan 15 **A**  
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	Rob Senior again reminded work stream leads to respond to prompts to update the action tracker in good time so that the action table could be updated before sending it out; he also apologised for the lateness and quality of some of the papers.	
<b>3</b>	<b>Notes from the last meeting</b>  These were accepted as a true record.	
<b>4</b>	<p><b>Matters arising</b></p> <p>Elisa Reyes-Simpson reported that DET was leading on the management of trainees' mandatory training, having introduced a 'governance passport' at the beginning of the year, without which students will not be issued with honorary contracts (a pre-requisite for clinical placements at the Trust). The Training and Education Programme Management Board is to consider further proposals to ensure compliance with governance in this area.</p> <p>CGR, CQPE and PSCR leads should include consider evidence that clinical trainees were considered in all routine reports and provide assurance of this in their respective CQSG reports.</p> <p>On further consideration, it was decided that the Internal Auditors were not best placed to review NICE guideline compliance; an <i>ad hoc</i> Trust audit will be undertaken instead. The committee was not content that NICE guidelines are ignored and directed that, even if they only applied in part, any exceptions in practice be documented with rationale.</p> <p><b><u>CQC update</u></b></p> <p>A new model inspection/visit was undertaken in January. Preliminary feedback from the inspectors highlighted many positive things and some challenges the majority of which the Trust recognised and is working to improve its performance in those areas. The full report is expected in April. The EMT will review the CQC report, and consider the findings of the CQSG's Annual Report to the Board, together, to ensure the alignment of management and assurance work.</p>	1PJ
<b>5</b>	<b>Reports from work stream leads</b>	
	<b>a) Information Governance</b>  Simon Young presented his previously circulated report and highlighted:	



with a third sector organisations and indicated some confusion about lines of responsibility and communication.

As noted in the IG report above, this is not a new problem, and whilst the incident had been resolved, and the relationship with the partner in question had been clarified, it was incumbent on prospective promoters of new enterprises to engage will colleagues in the governance teams at the earliest possible stage so that safe structures could be put in place to reduce risk to patients

- Similarly, this approach needs to be extended to, and by, DET
- The SI action tracker was attached to provide assurance of progress
- The numbers of complaints had fallen overall but more shortcomings on the part of the Trust were being acknowledged. The duty of candour was seen as helpful overall
- All but one member of staff was receiving clinical supervision

#### The committee

- ❖ Was concerned that personal confidential information might be shared without due controls, and that this should be considered as part of the review of third sector working
- ❖ Expected that better assessment and recording of risks be included in case files where indicated
- ❖ Noted a variety of means of capturing informal feedback were in place; positive messages from ESQ returns were also collected and fed back to teams
  - Julia Smith to be asked to review existing partnership agreements to ensure that all managers involved in governance had confirmed that the respective agreements had been assessed for conformance with the various safety controls
  - Louise Lyon to engage with Voluntary Action Camden to explore an approach that would be meet the respective organisations' needs when working with one or more third sector parties

The committee accepted the report as assurance on performance or as satisfactory progress towards attaining assurance where action plans were in place; subject to the directions given to be addressed on the work stream action tracker, the proposed green rating was confirmed.

#### *ii) Terms of reference*

Minor changes to the terms of reference were proposed, including establishing the work stream as a body that met quarterly. The committee agreed the changes should be put to the Board for ratification.

### c) Clinical Quality and Patient Experience

Louise Lyon presented her previously circulated report and highlighted:

#### Clinical outcomes

- A range of technical, clinical practice, data management, and personnel issues had come together to cause a decline in the number of forms completed, and the mis-labelling of various pieces of data. As a result, reporting outputs had been compromised and that data quality, therefore, was not yet of satisfactory quality
- Patients do not always complete forms in the way the Trust would like and this made processing such data a challenge as subsequent comparisons were difficult
- The Trust has fallen behind on CQUINS, and is not likely to reach targets in several areas by the end of March

The committee

- ❖ Looked for a prompt resolution of training issues
- ❖ Was concerned that a further vacancy was imminent in the Data Quality Team as a member of staff had just resigned; it would not be possible to recruit in time to prevent a gap between appointments
- ❖ Noted that work was underway to improve clinical data quality but that there remained much to be done
- ❖ Accepted that the radical change to both data systems and to electronic record systems would take time to work through and noted that a project to address this had been commissioned

The committee accepted the report as assurance on performance or as progress towards attaining assurance where action plans were in place. A red rating was allocated.

#### Clinical audit

- The CQC took an interest in this area and are likely to mention it in their report
- A report on audits will be included in the next CQPE report

The committee accepted the report as assurance on performance or as satisfactory progress towards attaining assurance where action plans were in place. An amber rating was allocated.

	<p><b>PPI/ patient experience</b> CGR, CQPE and PSCR leads should include consider evidence that patient/ user experience of services was considered in all applicable routine reports and provide assurance of this in their respective CQSG reports.</p> <p>The committee accepted the report as assurance on performance or as satisfactory progress towards attaining assurance where action plans were in place. A green rating was allocated.</p> <p>The committee noted assurance from the Chief Executive that data quality, care quality, CareNotes, and patient experience were to be organisational priorities for 2016/17.</p>	
	<p><b>d) Corporate Governance and Risk</b></p> <p>Marion Shipman presented her previously circulated report and highlighted:-</p> <ul style="list-style-type: none"> <li>• A risk had been missed from the report (GID waiting times) but was being addressed</li> </ul> <p>The committee</p> <ul style="list-style-type: none"> <li>❖ was concerned that PCPCS waiting times were not equivalent to those in primary care and that this risk would need to be addressed to the satisfaction of the referring GPs, and noted that this would remain on the risk register until a resolution was effected</li> <li>❖ noted that the previously allocated item on the monitoring of users on interview panels had not been "closed". Louise Lyon confirmed that this had been transferred to her work stream, though no data was available on this occasion; a section will be included in the Q4 report.</li> <li>❖ Was concerned about the risk to the FNP service due to staff turnover; this is being addressed at the FNP Board and was assured that this would not have wider implications for the Trust.</li> </ul> <p>The committee accepted the report as assurance on performance or as satisfactory progress towards attaining assurance where action plans were in place. The proposed green rating was confirmed.</p>	
	<p><b>Conclusion</b></p>	
	<p><b>6 Any other business</b></p>	
	<p>Work stream leads were reminded about the annual review of the CQSGC which would be considered at the next meeting.</p>	
	<p><b>7 Notice of future meetings</b></p>	

	11am, Tuesday 3rd May 11am, Tuesday 6th September 11am, Tuesday 1st November	

## Board of Directors : February 2016

**Item :** 13

**Title :** Education and Training Programme Management Board Report

**Purpose:**

To update on issues in the Education & Training Service Line. To report on issues considered and decisions taken by the Training & Education Programme Management Board at its meeting of 1<sup>st</sup> February 2016

**This report focuses on the following areas:**

- Quality
- Risk
- Finance
- Productivity
- Communications

**For :** Noting

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

## Department of Education and Training Board Report

### 1. Introduction

1.1 The Training and Education Programme Management Board met on Monday 1<sup>st</sup> February 2016 and discussed the following areas.

### 2. Student Recruitment

2.1 Laure Thomas, Director of Marketing & Communications, provided an update on student recruitment.

2.2 She advised the programme board that applications for the 2016/17 academic year were now open and that applications had already been received.

2.3 The recent January 2016 open evening was well attended.

2.4 The discussion focussed largely on the systems issues that the team currently faced and how this would potentially prohibit them for accurately assessing application numbers and for ensuring that those that were incomplete were not simply duplicate records. Paul Jenkins asked that a process was drawn up that outlined how applications were going to be monitored. This will be presented at the next TEPMB in March 2016.

2.5 The programme board also discussed targets and the capability of faculty to meet these with competing demands on their time. It was acknowledged that change will be needed while recognising that some of the growth required will be happening nationally rather than on site.

### 3. DET Restructure

3.1 Brian Rock updated the programme board on the progress of the departmental restructure, which had on balance gone well. Most of the first preferences of staff were accommodated.

3.2 He advised that Beverley Nicholson had been brought into the team as Interim Operational Development Lead. She will be working closely with John Martin, Programme Director, to bring about the changes required as well as developing standard operating

procedures, shared service charters, and KPI's.

#### **4. Strategic Transformation Plan Review**

- 4.1 Brian Rock brought an update of the strategic transformation plan to the programme board.
- 4.2 The group acknowledged the significant amount of work that had gone into bringing about the changes this year from when the plan was first presented at the TEPMB in 2014.

#### **5. Financial Plan and Fee Review**

- 5.1 Bhavna Tailor attended for this item and explained the paper she had brought to the programme board.
- 5.2 There is a 2% productivity saving to be made in the next financial year.
- 5.3 The programme board discussed the fee review that had taken place and it was explained that in most cases any fee increase/decrease was in relation to the pricing of our competitors.
- 5.4 The group also discussed the importance of us remaining accessible to students and the need to consider bursaries and other ways of supporting those unable to pay fees.

#### **6. Regional Strategy**

- 6.1 Brian Rock spoke to this item and explained that we were continuing to develop our regional relationships.
- 6.2 This requires attention to both our existing regional partnerships and our new partnerships.
- 6.3 There had been encouraging developments with our partners in the North. Work was underway to engage other existing partners beyond the course level.
- 6.4 It needed to be recognised that prospective partner organisations are also faced with immense challenges and pressures and can be preoccupied with other issues that reduce their time and focus on partnerships with us. However the establishment of the Commercial Engagement & Development Unit (CEDU) puts us in a stronger position to identify and engage with new partnerships.

## **7. Letters of Recognition**

- 7.1 Fiona Hartnett brought a paper on a review of the system of letters of recognition.
- 7.2 These have in the past been used as a way of the Trust promoting its work and model of thinking in other parts of the world.
- 7.3 There have been historical issues or poor monitoring of the issuing of these letters, a lack of contractual support and no clear definition as to the obligations of the Trust. Presently, without closer scrutiny and investment of resource in terms of management time and oversight, these letters of recognition potentially place the Trust at risk though this is viewed as small. However the benefit to the Trust with the resources required means that it unlikely to be something we wish to invest in at the present in light of our other more pressing priorities.
- 7.4 The programme board discussed the issues and agreed that the Trust would cease to offer the letters. All those currently holding a letter will be communicated with to this effect.

## **8. Graduation**

- 8.1 Brian Rock advised the programme board that plans for graduation were progressing well and that the honorary doctorate nominations have now been confirmed.
- 8.2 There had been some issues with the venue (around disabled access) and with data integrity but these had been addressed and resolved to a good outcome.

## **9. QAA Action Plan**

- 9.1 Louis Taussig attended for this item and updated the programme board on the QAA risk register ahead of their visit in April.
- 9.2 The group discussed the needs to the team on their visit and also stressed the importance of communicating this visit both within the directorate and across the wider Trust.
- 9.3 This visit holds as much importance for the organisation as the CQC visit. There was a commitment from the TEPMB for support to be given to the QAA steering committee to ensure as far as possible that this was a successful inspection.

9.4 Louise Lyon has been immensely helpful to the QAA steering committee in sharing her knowledge from the leadership of the CQC visit.

## 10. Information Governance for Clinical Trainees

10.1 Elisa Reyes-Simpson presented a paper on this item.

10.2 It is important for the Board to note that there has been a significant improvement in the management of these requirements through the creation of a 'Governance Passport' centrally managed within DET.

10.3 She explained to the programme board that while the majority of trainees had completed their training a number still had not.

10.4 It was agreed that further discussion should take place with clinical directorates with regards to this and that risk training should be part of the clinical governance passport going forward.

10.5 An update will be brought to next month's programme board.

## 11. ICT Project

11.1 Brian Rock advised that both suppliers had been informed of the outcome of the procurement process and that we were currently in the standstill period.

**Brian Rock**

**Director of Education and Training/Dean of Postgraduate Studies**

**15<sup>th</sup> February 2016**



## Board of Directors : February 2016

**Item :** 14

**Title :** Draft Annual Trust Quality Report

### **Summary:**

This is a first draft of the annual Quality Report. It has been prepared in accordance with Monitor's annual reporting guidance for 2014/15 which incorporates the Quality Accounts regulatory requirements. The final report forms part of the Annual Report.

The Monitor consultation for quality reports 2015/16 has just completed but not yet finalised. There were no additional requirements in the consultation document requiring amendment to the Trust report.

The Quality Accounts reporting arrangements 2015/16 asked Trusts to consider adding the following information:

- How we are implementing the Duty of Candour;
- Our patient safety improvement plan as part of the Sign up to Safety campaign;
- Our most recent NHS Staff surgery results for indicators KF19 and KF27;
- CQC rating grid along with plans to address any areas that require improvement or are inadequate. Where no rating exists yet then Trust own views are requested. Information on all the additional areas above will be included in the final Quality Report.

As per previous annual Quality Reports vignettes of information will be included on various services and issues. The report for 2015/16 will include information on: Lifespan, TAPS; TADS (research); PPI and CareNotes.

The Board of Directors is asked to note the quality priorities for 2016/17. A summary of these can be found on page 11 (section 2.1.2), with details in the following pages.

**This report focuses on the following areas:**

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

**For :** Noting

**From :** Marion Shipman, Associate Director Quality and Governance

# Quality Report

2014/2015

2015/16



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## Introduction

The Tavistock and Portman NHS Foundation Trust (the Trust) is a specialist mental health Trust which provides psychological, social and developmental approaches to understanding and treating emotional disturbance and mental ill health, and to promoting mental well-being. It has a national and international reputation based on excellence in service delivery, clinical innovation, and high-quality clinical training and workforce development.

The Trust provides specialist out-patient services, both on site and in many different community settings, offering assessment and treatment, and a full range of psychological therapies for patients of all ages. In addition, in Camden it provides an integrated health and social care service for children and families. The Trust does not provide in-patient treatment, but has a specific expertise in providing assessment and therapy for complex cases including forensic cases. It offers expert court reporting services for individual and family cases.

It has a national role in providing mental health training, where its training programmes are closely integrated with clinical work and taught by experienced clinicians. One of its strategic objectives is that trainees and staff should reflect the multi-cultural balance of the communities where the Trust provides services. A key to the effectiveness and high quality of its training programmes are its educational and research links with its university partners, University of East London, the University of Essex and Middlesex University.

### Core Purpose

The Trust is committed to improving mental health and emotional well-being. We believe that high-quality mental health services should be available to all who need them. Our contribution is distinctive in the importance we attach to social experience at all stages of people's lives, and our focus on psychological and developmental approaches to the prevention and treatment of mental ill health. We make this contribution through:

- Providing relevant and effective patient services for children and families, young people and adults, ensuring that those who need our services can access them easily.
- Providing education and training aimed at building an effective and sustainable NHS and Social Care workforce and at improving public understanding of mental health.
- Undertaking research and consultancy aimed at improving knowledge and practice and supporting innovation.

- Working actively with stakeholders to advance the quality of mental health and mental health care, and to advance awareness of the personal, social and economic benefits associated with psychological therapies.

[consider adding Trust objectives, mission and values in this section]

DRAFT

## Part 1: Statement on Quality from the Chief Executive [draft]

The annual quality account report is an important way for the Trust to report on quality and show improvements in the services we deliver to local communities and stakeholders. Embedded within the Trust is a genuine desire to improve each year the quality of our services across a number of broad headings, including the experience that our patients have of the way they are dealt with by our administrative teams and by our clinical staff. The way we collect, report and use information about the outcome of patients' treatment.

We are committed to driving improvement and a culture of excellence throughout the organisation, as demonstrated by some key achievements in quality over the past year. You will find details in the next section and throughout the report.

Our continued effort and commitment to improve quality has resulted in positive outcomes for our Quality Priorities for 2015/16 namely, for demonstrating the effectiveness of our clinical services; for us improving access to information about our clinical services for patients and for the emphasis we have placed on hearing the patient's voice. You can read about more about these achievements in Part 2.

Our Council of Governors is fully committed to quality agenda. One of the major roles of the Council of Governors during 2015/16 has been to ensure that they are fully involved in both contributing to and monitoring the Trust's quality agenda. The influence of the Council of Governors is interwoven in all the key decision making processes and they do this in a variety of ways including visiting and where possible observing the work of the different departments and services and attending Trust Board Meetings. In particular, the Governors Clinical Quality Meetings continue to provide an important forum for Governors and key Trust staff to focus on the quality agenda for the Trust and ways for improving quality.

We continue to be fully committed to improving quality across every aspect of the Trust's work, building further on what we have achieved this year. Our on-going consultation throughout the year with a variety of stakeholders has provided us with valuable feedback and ideas both for establishing our priorities for next year and for exploring the ways we can raise the bar on the targets we set.

In this report you will find details about our progress towards our priority areas as well as information relating to our wider quality programme. Some of the information is, of necessity, in rather complex technical form, but I hope the glossary will make it more accessible. However, if there are any aspects on which you would like more information and explanation, please contact Marion Shipman (Associate

Director Quality and Governance) at [mshipman@tavi-port.nhs.uk](mailto:mshipman@tavi-port.nhs.uk), who will be delighted to help you.

I confirm that I have read this Quality Report which has been prepared on my behalf. I have ensured that, whenever possible, the report contains data that has been verified and/or previously published in the form of reports to the Board of Directors and confirm that to the best of my knowledge the information contained in this report is accurate.

Signature to be added once drafted and approved

Paul Jenkins  
Chief Executive

DRAFT

## 1.1. Achievements in Quality

We are proud to report that, in addition to our Quality Priorities, during the year 2015/16 we achieved the following:

- City and Hackney Primary Care Psychotherapy Consultation Service, was named BMJ's 2015 Mental Health Team of the Year. The service was established at the request of GPs in Hackney and since it started, it's continued developing it to meet the needs local GPs identify for their patients. The service's achievements are based on partnership working with commissioners, GPs and patients. This is a prestigious award and so is a great acknowledgement of the excellent, innovative work undertaken by this service.
- We were successful in our bid to provide a brand new service in Camden. The Team around the Practice (TAP) is partly based on our award winning City and Hackney Primary Care Psychotherapy Consultation Service model. Provided in partnership with Mind in Camden, the service opened in July 2015. It will offer a range of tailored interventions to support a busy primary care workforce.
- In April, The Trust held a Patient & Public Involvement (PPI) event. David Gilbert, an expert in PPI, opened the day and a number of our PPI Champions spoke too. The event gave us an opportunity to find out more about best practice initiatives across other health trusts occurring elsewhere and to discuss the barriers to engagement and how these can be overcome. A fruitful discussion followed about our own PPI agenda and future planning.
- At the start of April, a new FDAC opened its doors in Sussex. The Family Drug and Alcohol Court sees parents who are subject to care proceedings offered intensive help to tackle substance abuse. The scheme, which first launched in London seven years ago, has helped to increase the proportion of parents who are able to continue caring for their children.
- Our Family Drug and Alcohol Court (FDAC) featured in the law section of the Observer in May 2015. The article explores some of the successes and challenges FDAC has faced with a particular focus on a two case studies who have been through the family drug and alcohol court.
- As a Stonewall Health Champion we have made a commitment to ensure that the clinical and training services we provide are accessible and that we're a supportive, open employer who promises a fair, accessible place to

work. As part of this programme, the Trust held a training session in order to discuss Lesbian, Gay, Bisexual and Transgender (LGBT) issues in the workplace. The session was held on 24 April and was well attended.

- The Trust welcomes the Family Nurse Partnership (FNP) national unit who moved into the new modular building at the Tavistock Centre site in May. The Trust held an event to mark the opening of the new building with our FNP colleagues.

DRAFT

## 1.2 Overview of Quality Indicators 2015/16 [to be updated]

The following table includes a summary of some of the Trust's quality priority achievements with the RAG status\*, along with the page number where the quality indicator and achievement are explained in greater detail.

Target	RAG Status*	Achievement	Page Number
<b>Child and Adolescent Mental Health Service Outcome Monitoring Programme</b>			
For 75 % of patients to complete the Goal-Based Measure (GBM) at Time 1 and Time 2 (ideally with at least 2 targets).	Yellow	73%	15
For 75% of patients to achieve an improvement in their score on the GBM, from Time 1 to Time 2, on 2 targets (goals).	Green	75%	15
<b>Adult Outcome Monitoring Programme</b>			
For the Total CORE scores to indicate an improvement from Pre-assessment (Time 1) to End of Treatment (Time 2) for 50% of patients.	Green	53%	16
<b>Access to Clinical Service and Health Care Information for Patients and Public</b>			
To ensure that information from the patient story is on the patient section of the website.	Green	Achieved	17
To run a Visual Straw Poll on awareness of the patient stories.	Green	Achieved	17
Based on the feedback from the Visual Straw Poll, to revise the communications campaign to publicise patient stories if necessary.	Green	Achieved	17
<b>Patient and Public Involvement</b>			
To run at least two staff trainings on having services users on panels.	Green	Achieved	19
To have at least three interviews with service users on the panel.	Green	Achieved	19
To take a minimum of three real patient stories to the Trust Board in one of the following ways: a patient visiting the Board, the Board seeing a video or a transcript of the description of the journey.	Green	Achieved	19

<b>Patient Safety Indicators</b>			
NHS Litigation Authority Level		Level 2 achieved Feb 2011	35
Patient Safety Incidents		15	37
Monitoring of Adult Safeguard Alerts		0	38
Safeguarding of Children – Level 1 Training		97%	40
Safeguarding of Children – Level 2 Training		100%	
Safeguarding of Children – Level 3 Training		94%	
<b>Clinical Effectiveness Indicators</b>			
Monitor number of staff with PDPs		97.5%	44
<b>Patient Experience Indicators</b>			
Complaints received		14	46
<b>Patient Satisfaction</b>			
Percentage of patients that rated the overall help they had received as good:			46
Quarter 1		93%	
Quarter 2		92%	
Quarter 3		91%	
Quarter 4		93%	
<b>Did Not Attend Rate</b>			
Trust Wide – First Attendances		7.8%	48
Trust Wide – Subsequent Appointments		7.7%	48
<b>Waiting Time Breaches**</b>			
Trust Wide – Number of patients waiting for first appointment for 11 or more weeks		36	50
Internal Causes		13	
External Causes		23	
Trust Wide – Percentage of patients waiting for first appointment for 11 or more weeks		1.9%	50
Internal Causes		0.7%	
External Causes		1.2%	
<b>Other Achievements</b>			
IG Assessment Report overall score		96%	32
<b>Maintaining a High Quality, Effective Workforce</b>			
Attendance at Trust Wide Induction Days		90%	38
Completion of Local Induction		98%	39
Attendance at Mandatory INSET Training		98%	39

\*Traffic light system for indicating the status of the target using Red (remedial action required to achieve target), Amber (target not achieved but action being taken or situation being monitored) and Green (target reached and/or when the Trust performed well).

\*\*Please note that our patient administration system (PAS) is a 'live system' and therefore with data cleansing and the addition of missing data taking place after quarter end, the final outturn figures for DNA and waiting time may be slightly different to quarterly performance figures published in year.

## Part 2: Priorities for Improvement and Statements of Assurance from the Board

### 2.1 Our quality priorities for 2016/17

The priorities for 2016/17 which are set out in this report have been arranged under the three broad headings which, put together, provide the national definition of quality in NHS services: patient safety, clinical effectiveness and patient experience. Progress on achievement of these priorities will be reported in next year's Quality Accounts.

#### 2.1.1 How we choose our priorities

In looking forward and setting our goals for next year, our choice of quality priorities has been based on wide consultation with a range of stakeholders over the last year. We have chosen those priorities which reflect the main messages from these consultations, continuing to focus on measurable outcomes from our interventions, focusing on improving the physical as well as mental health of our patients, improving the identification and management of patients where there is evidence of domestic abuse or violence, and ensuring that there is increased awareness and levels of engagement for service users.

Camden CCG (Clinical Commissioning Group, see Glossary) and our clinical commissioners from other boroughs have played a key role in determining our priorities through review of the 2015/16 targets and detailed discussion to agree CQUIN targets for 2016/17.

Our Quality Stakeholders Group has been actively and effectively involved in providing consultation on clinical quality priorities and indicators. This group includes patient, Governor and non-executive director representatives along with the Patient and Public Involvement (PPI) Lead, Associate Director Quality and Governance and is chaired by the Quality and Patient Experience Director. The Governors Clinical Quality Group has played a key role in helping us to think about some our quality priorities for next year.

#### 2.1.2 Our quality priorities for 2016/17

##### Patient Safety

Priority 1: Improving the physical health of patients receiving treatment

Priority 2: Identifying and managing issues of domestic abuse and violence

### Clinical Effectiveness

Priority 3: Child and adolescent mental health service (CYAF) outcome monitoring programme

Priority 4: Young adult and adult outcome monitoring programme

Priority 5: Increase use of clinical audit and quality improvement methodologies across the Trust to support improvements in services

### Patient Experience

Priority 6: Improve awareness and levels of engagement for service users: 'Word of Mouth' project

Priority 7: Patient involvement with physical healthcare 'Wellbeing' project

Priority 8: ESQ data developments – integrating the use of ESQ data to improve services

### Patient Safety

#### Priority 1: Improving the physical health of patients receiving treatment

We have agreed with our commissioners, as part of our CQUIN targets for 2016/17, to establish a 'wellbeing' programme covering a number of public health issues including smoking, alcohol, healthy eating and fitness. This is in addition to developing further the provision of individual support for staff and patients around smoking cessation and alcohol use. This priority is also one of the Trust's Sign up to Safety goals.

#### 1. Improving the physical health of patients receiving treatment

##### Targets for 2016/17 [TBC]

This priority continues but with new elements from last year

1. Further develop the provision of ongoing individual support for staff and patients around smoking cessation and alcohol use
2. Further develop the provision of ongoing individual support for staff and patients around smoking cessation and alcohol use

### Measure Overview

We plan to use a number of different measures to evidence compliance with the targets including the development and dissemination of wellbeing patient and staff information; development of a wellbeing programme which is then evaluated by attendees; evidence on ongoing individual support for staff and patients; staff training to deliver Brief Advice for smoking and alcohol and ongoing monitoring to embed the use of physical health forms.

**How we will collect the data for this target**

To be updated

**Monitoring our Progress**

We will monitor our progress towards achieving our physical health targets on a quarterly basis, providing reports to the Patient Safety and Clinical Risk Workstream, the Clinical Quality Safety and Governance Committee, the Board of Directors, Camden CCG and our clinical commissioners from other boroughs. The Physical Healthcare Specialist Practitioner for the Trust will ensure that action plans are in place when expected levels of assurance are not achieved.

**Priority 2: Improving and managing issues of domestic abuse and violence**

We have agreed with our commissioners, as part of our CQUIN targets for 2016/17, to embed the domestic abuse and violence programme established in 2015/16. This priority is also one of the Trust’s Sign up to Safety goals.

<b>2. Identifying and managing issues of domestic abuse and violence</b>	
<b>Targets for 2016/17 [TBC]</b>	This priority continues from last year
1.	
2.	

**Measure Overview**

TBC – to build on CQUIN work for 2015/16

**How we will collect the data for this target**

To be updated

**Monitoring our Progress**

We will monitor our progress towards achieving our domestic abuse and violence targets on a quarterly basis, providing reports to the Patient Safety and Clinical Risk Workstream, the Clinical Quality Safety and Governance Committee, the Board of Directors, Camden CCG and our clinical commissioners from other boroughs. The

Lead for Domestic Abuse and Violence for the Trust will ensure that action plans are in place when expected levels of assurance are not achieved.

## Clinical Effectiveness

### Priority 3: Child, Adolescent and Young Adult (CYAF) Mental Health Service Outcome Monitoring Programme

To be updated

#### 3. Child, Adolescent and Young Adult Mental Health Service Outcome Monitoring Programme

##### Targets for 2016/17 [TBC]

This priority continues but with new elements from last year

1. For xx% of patients (attending CYAF) 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).
2. For xx% 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).
3. ?add specific target for Young Adult Outcome Data?
4. Improve access to patient and team level data - developing a dashboard to provide 'real-time' data which is reviewed by teams to improve services.

## Measure Overview

For our Child, Young Adult and Family Mental Health Services (CYAF), we plan to use the Goal-Based Measure again this year. This is a commonly used measure in CYAF and we will be building further on the knowledge we have gained since 2012, with patients previously referred to the service. The Goal-Based Measure enables us to know what the patient or service user wants to achieve (their goal or aim) and to focus on what is important to them.

As clinicians we want to follow this up to know if patients think they have been helped by particular interventions/treatments and to make adjustments to the way we work depending on this feedback.

## How we will collect the data for this target

To be updated

### Monitoring our Progress

A new patient system (Carenotes) implemented during 2015-16 replaced the previous outcome monitoring tracking system in use. The new system identifies when patients and clinicians are due to be issued with outcome monitoring forms, and provides a clear way to record and track when these forms have been completed.

We will monitor our progress towards achieving our outcome monitoring targets on a quarterly basis, providing reports to the Clinical Quality and Patient Experience Workstream, the Clinical Quality Safety and Governance Committee, the Board of Directors, Camden CCG and our clinical commissioners from other boroughs. The Lead for Outcome Monitoring in CYAF will ensure that action plans are in place when expected levels of assurance are not achieved.

#### Priority 4: Adult Outcome Monitoring Programme

For 2016/17, we plan to continue to focus on evaluating the change for adult patients (over 25 years of age) from the pre-assessment phase to the End of Treatment.

#### 4. Adult Outcome Monitoring Programme

##### Target for 2016/17 TBC

This priority continues but with new elements from last year.

1. For the Total CORE scores to indicate an improvement from Pre-assessment (Time 1) to End of Treatment (Time 2) for xx% of patients.

#### Measure Overview

As described in Part xxx, the CORE Clinical Outcomes for Routine Evaluation system was designed to provide a routine outcome measuring system for psychological therapies. The 34 items of the measure covers four dimensions: subjective well-being, problems/symptoms, life functioning and risk/harm.

#### How we will collect the data for this target

To be updated

#### Monitoring our Progress

A new patient system (Carenotes) implemented during 2015-16 replaced the previous outcome monitoring tracking system in use. The new system identifies when patients and clinicians are due to be issued with outcome monitoring forms, and provides a clear way to record and track when these forms have been completed.

We will monitor our progress towards achieving our outcome monitoring targets on a quarterly basis, providing reports to the Clinical Quality and Patient Experience Workstream, the Clinical Quality Safety and Governance Committee, the Board of Directors, Camden CCG and our clinical commissioners from other boroughs. The Lead for Outcome Monitoring in CYAF will ensure that action plans are in place when expected levels of assurance are not achieved.

#### Priority 5: Clinical audit and quality improvement developments

For 2016/17, we plan to increase the use of clinical audit and quality improvement methodologies across the Trust to support improvements in services. The Trust has recently introduced a tool for assessing the impact of service developments and improvements

#### 5. Clinical audit and quality improvement developments

##### Target for 2016/17 TBC

This is a new priority

1.

### Measure Overview

To be updated

### How we will collect the data for this target

To be updated

### Monitoring our Progress

To be updated

DRAFT

**Patient Experience Involvement**

**Priority 6: Word of Mouth Project**

The decision was taken to replace the Trust PPI committee meetings with a steering group of interested stakeholders, called the 'Word of Mouth' (WoM) Steering Group. The group will lead on providing direction, focus and support in providing activities and resources for the WoM project.

6. 'Word of Mouth' project	
<b>Targets for 2016/17</b>	This is a new priority
1. Develop a plan for raising awareness and levels of engagement for service users	
2. Raise awareness among staff both at the Tavistock Centre and external sites to promote active engagement with the project	
3. Following launch of the newsletter, a Visual Straw Poll to be run on awareness of the newsletters	

**Measure Overview**

To be updated

**How we will collect the data for this target**

To be updated

**Monitoring our Progress**

To be updated

**Priority 7: Patient involvement with physical healthcare – ‘Wellbeing’ project**

To support delivery of the physical healthcare ‘wellbeing’ project, Priority 1 above.

7. Patient involvement with physical healthcare – ‘Wellbeing’ project	
Targets for 2016/17	This is a new priority
1. Develop a plan for raising awareness and levels of engagement for service users in the physical health ‘wellbeing’ programme	
2. Raise awareness among staff both at the Tavistock Centre and external sites to promote active engagement with the physical health ‘wellbeing’ project	

**Measure Overview**

To be updated

**How we will collect the data for this target**

To be updated

**Monitoring our Progress**

To be updated

DRAFT

Draft Quality Accounts

**Priority 8: ESQ data developments – integrating the use of ESQ data to improve services**

To be updated

8. ESQ data developments – integrating the use of ESQ data to improve services	
<b>Targets for 2016/17</b>	This is a new priority
1. Establish quarterly analysis of team level ESQ data	
2. Disseminate the analysis to teams, discussing and agreeing actions as required	
3. Establish regular feedback mechanisms for patients and staff	

**Measure Overview**

To be updated

**How we will collect the data for this target**

To be updated

**Monitoring our Progress**

To be updated

## Insert- TADS

### TADS - Tavistock Adult Depression Study

#### What is the project?

The Tavistock Adult Depression Study (TADS) aims to produce findings which develop:

- Specific understanding of how effective this form of treatment is in improving long-term treatment-resistant depression
- A deeper understanding of the nature of this condition and of how it can be improved
- A deeper understanding of the way in which this therapy works.

The findings of TADS will contribute to the development of evidence-based medicine (EBM) in respect of the most common mental disorder. They will help the National Institute of Health & Clinical Excellence (NICE) as it further develops its recommendations for the treatment of depression.

#### Who is the service for?

This study aims to help individuals with depression whose condition has not been satisfactorily improved by previous treatments. These treatments may include medication, psychological therapy or both.

The study is evaluating the role of psychoanalytic psychotherapy as a treatment for this condition. The treatment is weekly and it lasts for eighteen months.

#### Outcomes

#### Quotes

## 2.2 Statements of Assurance from the Board

This section contains the statutory statements concerning the quality of services provided by the Tavistock and Portman NHS Foundation Trust. These are common to all quality accounts and can be used to compare us with other organisations.

### A review of our services

During the reporting period the Tavistock and Portman NHS Foundation Trust provided and /or sub-contracted six relevant health services.

The Tavistock and Portman NHS Foundation Trust has reviewed all the data available to them on the quality of care in [number] of these relevant health services.

The income generated by the relevant health services reviewed in 2015/16 represents xxx % of the total income generated from the provision of relevant health services by The Tavistock and Portman NHS Foundation Trust for 2015/16.

### Participation in Clinical Audits and National Confidential Enquiries [information to be updated]

During 2015/16 [1] national clinical audit and [number] national confidential enquiries covered relevant health services that The Tavistock and Portman NHS Foundation Trust provides.

During that period The Tavistock and Portman NHS Foundation Trust participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that The Tavistock and Portman NHS Foundation Trust was eligible to participate in during 2015/16 are as follows:

- National Audit into Psychological Therapies
- Confidential Inquiry into Homicide and Suicide
- Confidential Inquiry into Maternal Deaths

The national clinical audits and national confidential enquiries that The Tavistock and Portman NHS Foundation Trust participated in during 2015/16 are as follows:

- National Audit into Psychological Therapies

- Confidential Inquiry into Homicide and Suicide
- Confidential Inquiry into Maternal Deaths

The national clinical audits and national confidential enquires that The Tavistock and Portman NHS Foundation Trust participated in, and for which data collection was completed during 2015/16, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

- **Confidential inquiry into Homicide and Suicide:** we responded to one request for a review report of an adult male who had taken his life. The male had been seen at the Trust.
- **Confidential Inquiry into Maternal Deaths:** the auditors did not approach the Trust to complete an audit form in 2015/16
- **National Audit into Psychological Therapies:** no data collection was required in 2015/16, the Trust received a copy of the second report of this audit in 2013

The Trust received and reviewed the report of the National Confidential Inquiry into Homicides and Suicides in 2015/16 and in response The Tavistock and Portman NHS Foundation Trust has produced the following documents for staff to improve the quality of healthcare provided: 'Prevention of suicide procedure' and 'Assessment and management of self harm procedure', both which will be circulated to staff, available on the Trust Website and promoted at mandatory training events and at team meetings.

The reports of **nine** local clinical audits were reviewed by the provider in 2015/16 and The Tavistock and Portman NHS Foundation Trust has plans in place to improve care as a result of the learning from these audits.

Audit topics included compliance with case note standards involving 3 audits and one re-audit; audit of patients attending the Fitzjohns unit; audit of prescribing practice in children and adolescent services; audit of care in the FAKCT (Fostering Adoption & Kinship Care Team); audit of care in the EIS (Early Intervention Service); audit of care of patients receiving intensive treatment in the Adolescent and Young Adult Service

Actions include:

- Continued improvement in record keeping
- Use the initial learning from audit of adult 'intermittent therapy' service along side other data to inform service redesign work in Adult services.

- Learning from the 'prescribing audit' will inform development of the electronic records format which will be rolled out in 2016/17.
- Further changes to information collected at assessment to ensure key data is available (e.g. inclusion of 'duration' as a standard question in Fitzjohns unit assessments).

## Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by The Tavistock and Portman NHS Foundation Trust in 2015/16 that were recruited during that period to participate in research approved by a research ethics committee was 282. Throughout the year, the Trust has been involved in 5 studies; 3 were funded (of which 0 were commercial trials), and 2 were unfunded.

## The use of the CQUIN Framework

A proportion of The Tavistock and Portman NHS Foundation Trust income in 2015/16 was conditional on achieving quality improvement and innovation goals agreed between The Tavistock and Portman NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2015/16 and for the following 12 month period is available electronically at <http://www.tavistockandportman.nhs.uk/about-us/governance/commissioning-quality-and-innovation-cquin>

The total financial value for the 2015/16 CQUIN was £249,156 and The Tavistock and Portman NHS Foundation Trust expects to receive £244,522. (The Trust received £257,775 in 2013/14).

## Registration with the Care Quality Commission (CQC) and Periodic/Special Reviews

The Tavistock and Portman NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is full registration without conditions, for a single regulated activity "treatment of disease, disorder or injury".

The Care Quality Commission has not taken enforcement action against The Tavistock and Portman NHS Foundation Trust during 2015/16.

The Tavistock and Portman NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during 2015/16.

In January 2016 the Trust underwent a routine inspection by the Care Quality Commission (CQC). We continue to hold full registration with the CQC without restriction. The full report is due in April and available on the CQC website, [www.cqc.org.uk](http://www.cqc.org.uk) when published.

[add ratings grid as per Quality Account requirements 2015/16]

### Information on the Quality of Data

The Tavistock and Portman NHS Foundation Trust did not submit records during 2015/16 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. This is because The Tavistock and Portman NHS Foundation Trust is not a Consultant-led, nor an in-patient service.

The Tavistock and Portman NHS Foundation Trust Information Governance Assessment Report overall score for 2015/16 was 96% and was graded green.

The Tavistock and Portman NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2015/16 by the Audit Commission.

### Information on the Quality of Data

- The Quality Team was established last year with a remit to ensure that effective processes and procedures are in place across the Trust including outreach services, to ensure we meet our local and nationally agreed targets. The team continues to promote the Trust's quality agenda with a robust campaign of posters, training and events, highlighting our current CQUIN and KPIs (Key Performance Indicators) and the work required to achieve them. The team meets weekly to address any data quality issues, particularly around Outcome Monitoring, and other operational issues.
- Members of the Quality Team meet with department managers on a monthly basis to review service/team performance in relation to CQUINs, KPIs and any locally-agreed targets. Where targets are identified to be weak or insufficient, action plans and strategies can be discussed and tabled, so that improvements can be made in time to achieve the targets for quarterly reporting.
- In order to provide assurance to the Trust's Quality and Patient Experience Director and Trust Board, a senior committee has been established, the Data

Analysis and Reporting Committee (DARC) to look at clinical data in line with the Trust's overall strategic plans and to enable the Trust to benchmark services both internally and externally. This committee meets quarterly.

- The recent installation of the electronic patient administration system, CareNotes, has helped towards streamlining the Trust's data collection and enables the Quality Team to swiftly report on pertinent clinical and care data.

## 2.3 Reporting against core indicators

Since 2012/13 NHS foundation Trusts have been required to report performance against a core set of indicators using data made available to the Trust by the Health and Social Care Information Centre (HSCIC)\*.

As specified by Monitor:

'For each indicator the number, percentage, value, score or rate (as applicable) for at least the last two reporting periods should be presented in a table. In addition, where the required data is made available by the HSCIC, a comparison should be made of the numbers, percentages, values, scores or rates of each of the NHS foundation Trust's indicators with:

- the national average for the same and
- those NHS Trusts and NHS foundation Trusts with the highest and lowest for the same.'

However, the majority of the indicators included in this section ("Reporting against core indicators") are not relevant to the Trust.

**Core Indicator No. 22** covers 'The Trust's 'Patient experience of community mental health services' indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.'

Although, we have reported on patient satisfaction elsewhere in the Quality Report on page xx, the questions included in the Experience of Service Questionnaire (ESQ), which we use with patients we see in the Trust to obtain feedback on their experience of our services, cannot be directly compared with the questions derived from the Annual Report on Patient Experience from community mental health services.

However, we believe that with the positive feedback we have received from patients in 2015/16 (93% of patients in Quarter 1; 92% of patients in Quarter 2; 91% of patients in Quarter 3 and 93% of patients in Quarter 4 rated the help they had received from the Trust as 'good') means that we would score very positively for patient experience when compared to other mental health Trusts.

**Core Indicator No. 25** covers "The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death". Again, the data for this indicator can be found elsewhere in the Quality Report on page xx.

\*Please refer to pp13-16 of "Detailed requirements for quality reports 2014/15" ([www.gov.uk/monitor](http://www.gov.uk/monitor))

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## Insert- TAPS

### Team around the practice (TAP)

#### What is the project?

TAP is a new service provided by Tavistock & Portman NHS Foundation Trust and MIND in Camden. We provide emotional and practical support to patients registered with a GP in Camden. TAP is loosely based on our award winning City and Hackney model, provided in partnership with Mind in Camden, the service opened in July 2015.

#### Who is the service for?

The TAP service is for those who are experiencing difficulties like depression, anxiety, stress, social isolation, problems in relationships, and physical health difficulties such as persistent pain. Sometimes these problems can make it hard to manage life demands and can cause people to feel overwhelmed, stuck or unable to cope.

The service is open to those who are 18 years and over and registered with a Camden GP. TAP offers a confidential and safe environment and aim to see patients in their own GP practice. If this is not possible, the patient is able to be seen at a closer practice.

#### Outcomes

#### Quotes

## Part 3: Review of quality performance

### Review of progress made against last year's priorities

This section contains information relevant to the quality of relevant services provided by The Tavistock and Portman NHS Foundation Trust during 2015/16 based on performance in 2015/16 against indicators selected by the Board in consultation with stakeholders.

#### 3.1 Quality of Care Overview: Performance against selected indicators

This includes an overview of the quality of care offered by the Trust based on our performance on a number of quality indicators within the three quality domains of patient safety, clinical effectiveness and patient experience. Where possible, we have included historical data demonstrating how we have performed at different times and also, where available, included benchmark data so we can show how we have performed in relation to other Trusts. These indicators include those reported in the 2013/14 and 2014/15 Quality Reports along with metrics that reflect our quality priorities for 2015/16. In this section, we have highlighted other indicators outside of our quality priorities that the Trust is keen to monitor and improve.

The Trust Board, the Clinical Quality Safety and Governance Committee (CQSG), along with Camden CCG and our clinical commissioners from other boroughs have played a key role in monitoring our performance on these key quality indicators during 2015/16.

**Add picture here**

## Patient Safety Indicators

### Patient Safety Incidents

Indicator	2013/2014	2014/2015	2015/2016
Patient Safety Incidents	42	15	22

### What are we measuring?

The Trust records all reported incidents on a spreadsheet in order to support the management of, monitoring and learning from all types of untoward incident. In addition, patient safety incidents are uploaded to the National Reporting and Learning System (NRLS) for further monitoring and inter-Trust comparisons which promote understanding and learning. The NRLS definition of an incident that must be uploaded is as follows:

'A patient safety incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care.'

The Trust has a low rate of '*patient safety*' incidents due to the nature of its patient services, (we provide psychological therapies, we do not undertake any physical interventions, and are an out-patient service only). All 22 incidents reported in 2015/16 were in the "no harm/low harm" category, and were therefore rated as suitable for local review only.

Most of the reportable incidents relate to 'pupil on pupil' behaviour incidents i.e. when one pupil physically or emotionally 'attacks' another pupil which occurred in the Trust's Specialist Children's Day Unit, which is a school for children with emotional difficulties and challenging behaviour. Under the NRLS these are classed as patient to patient incidents and are therefore reportable.

During the year the Trust did investigate a small number of serious patient incidents [state number] (for example, suicide of patients known to or being treated by the Trust). These incidents are not included in the above data as in these cases the patients were also known to another Mental Health Trust, which undertook the role of lead investigator. [update]

We have robust processes in place to capture incidents, and staff are reminded of the importance of incident reporting at induction and mandatory training events. However, there are risks at every Trust relating to the completeness of data collected for all incidents (regardless of their severity) as it relies on staff making the effort to report (often for this Trust very minor events). Whilst we

continue to provide training to staff and there are various policies in place relating to incident reporting, this does not provide full assurance that all incidents are reported. We believe this position is in line with all other Trusts.

### Being Open and Duty of Candour

**Add information on this.** Duty of candour fields have been added to the incident spreadsheet and is followed up with staff where there is moderate to severe harm. Requirements are covered in all Trust induction and training (INSET) days. Information on compliance is also included within the Trust Quarterly Quality News.

### Monitoring Child and Adult Safeguarding

Indicator	2013/2014	2014/2015	2015/2016
Monitoring Child and Adult Safeguarding Alerts	0	2*	58 (as of Q3)

#### What are we measuring?

**Trust staff have made one safeguarding enquiry to the local authority in Q4.** Staff consultations regarding safeguarding issues continue to be raised at the rate of about one per week. Staff are thoughtful and increasingly aware of the ten adult safeguarding categories and the range of ways in which these can present. In house level 2 and 3 adult safeguarding training is being developed and trialled. The new adult safeguarding policy has been launched. In 2015/16, **57 children identified and 1 adult safeguarding referrals were made.**

### Attendance at Trust-wide Induction Days

Indicator	2013/2014	2014/2015	2015/2016
Attendance at Trust Wide Induction Days	94%	90%	89% (subject to change)

#### Measure Overview

This measure monitors staff attendance at mandatory Trust-wide induction, which all new staff are required to attend, when they first join the Trust. The Trust schedules this induction event on a rolling basis to new staff at least three times a year. As part of this Induction, staff are provided with an introduction to the work of the Trust and introduction to the Trust's approach to risk management and incident reporting; health and safety; infection control, confidentiality and information governance; Caldicott principles; safeguarding of children and counter

fraud awareness, to ensure that all new staff are able to provide a safe and good quality service to service users.

### Targets and Achievements

89% of staff joining the Trust in 2015/16 attended the Trust-wide induction and the Trust will continue to monitor the attendance at mandatory training events, aiming to maintain a high level of attendance.

#### Local Induction

Indicator	2013/2014	2014/2015	2015/2016
Completion of Local Induction	97%	98%	88%

#### Measure Overview

The Trust provides all new staff with a local induction checklist in their first week of employment. This checklist needs to be completed within two weeks of commencing employment with line managers and a copy returned to Human Resources. This checklist is required by Human Resources to verify that the new staff member has completed their local induction.

This measure monitors the completion and return of the local induction checklist by new staff. The local induction process covers all local policies and procedures in place in individual service areas/directorates and ensures new staff are aware of all terms and conditions of employment, mandatory training requirements and arrangements in place locally that impact on working arrangements within the Trust.

### Targets and Achievements

It is important that all new staff undertake a local induction with the appropriate manager, in order to ensure that staff are aware of policies and procedures that apply locally within their service area/directorate, and so that staff newly recruited to the Trust are able to provide a relevant, safe and good quality service to patients.

We are very pleased to report that we received ...% returned forms to show that the local induction had been completed by almost all of staff joining the Trust in 2015/16.

## Attendance at Mandatory INSET Training

Indicator	2013/2014	2014/2015	2015/2016
Attendance at Mandatory INSET Training*	95%	98%	96%

\*Staff are expected to attend training every two years. In order to achieve this 100% attendance is expected over a two year period. Therefore, the figure reported shows the % of staff up to date with mandatory training at 31 March 2016.

### Measure Overview

This measure monitors staff attendance at mandatory INSET training. The Trust provides the main mandatory training through an In-Service Education and Training (INSET) day, which all staff are required to attend once every two years. During this training day, staff receive training updates in risk management and assessment, health and safety, infection control, confidentiality, equality and diversity, information governance, safeguarding children and adults and fire safety.

### Targets and Achievements

It is important that staff remain up to date with developments in each of these areas, to ensure that they are able to provide a safe and good quality service to service users.

We can report that 96% of our staff who were required to attend INSET training had done so within the previous two years and that the attendance rate has improved further since last year.

### Safeguarding of Children and Adult

Indicator	2013/2014	2014/2015	2015/2016
Safeguarding of Children & Adult – Level 1 Training	94%	97%	91% (subject to change)
Safeguarding of Children – Level 2 Training	88%	100%	97% (subject to change)
Safeguarding of Children – Level 3 Training	89%	94%	89% (subject to change)

\*All staff receive level 1 training as part of mandatory INSET training.

\*\* Adult L1 Safeguarding introduced in 2015/16

### What are we measuring?

All staff receive Level 1 training as part of mandatory INSET training and must complete this training every 2 years.

All clinical staff, who are not in contact with children and young people and do not fulfil requirement for level 3, are required to attend Level 2 training. This training must be completed every 3 years. **Currently level 2 and 3 Adult safeguarding Training is being developed.** [ update required]

To ensure that as a Trust we are protecting children and young people who may be at risk from abuse or neglect, the Trust has made it mandatory for all clinical staff in Child and Adolescent services and other clinical services working predominantly with children, young people and parents to receive Level 3 Safeguarding of Children training once every three years.

### Targets and Achievements

The Trust places great importance on all staff receiving relevant safeguarding training and so we are very pleased that when compared with last year there has been an improvement in attendance for all three levels of Child Safeguarding training. By March 2016 91% of staff received Level 1 training and 97% of staff attended Level 2 training. In addition, 89% of staff requiring Level 3 training had attended this training

### Infection Control

Due to the types of treatment offered (talking therapies) this Trust is at very low risk of cross infection. All public areas are cleaned to a high standard by internal cleaning staff. Toilets and washrooms are stocked with soap and paper towels and we have alcohol hand gel available for staff and public use in public areas of the Trust (e.g. at the entrance to the lifts in the Tavistock Centre).

The Trust organised on site access to flu vaccination for staff in the autumn of 2015.

Update on personal responsibility for reducing the risk of cross infection is raised at induction and biennial INSET training.

**Staff Survey** [This section needs to be updated with the 2015 national staff survey results. Use graphs / bullet points etc. More visual with benchmarking.]

### Introduction

The National NHS Staff Survey is completed by staff annually and took place between October and December 2015. The Trust's results from this year's survey continue to be positive overall and indicate that staff still consider the Trust to be a good employer.

### Summary of Performance

Some of the key highlights from the Staff Survey are summarised below:

The Trust's overall staff engagement score is once again higher than the national average (national average is 3.72 and the Trusts score is **3.97**, measured on a scale of 1 – 5, 5 being highly engaged and 1 poorly engaged) and also better than the Trust's score of 3.91 in 2013.

Some of the other areas where the Trust received the best scores include:-

- *Staff recommending the Trust as a place to work and receive treatment*
- *Low numbers of staff experiencing harassment, bullying and abuse from patients, public and staff*
- *Staff witnessing errors, near misses and incidents*
- *Staff job satisfaction*
- *Staff feeling pressure to attend work while unwell*
- *Staff feeling their roles make a difference to patients*

There are, however, a number of areas where the Trust still needs to improve, some of which are highlighted below:

- *staff indicating that they are working extra hours*

We believe that this is linked with the very positive score we received for 'staff job satisfaction' and 'staff feeling their roles make a difference to patients' with us having a very committed and engaged staff group. Notwithstanding this, there is on-going work within the Trust to improve job planning which forms part of the annual appraisal process, so that staff can work together with managers to ensure that they are making effective use of their working time and so reduce the number of staff who work extra hours.

- *staff receiving health and safety and equality and diversity training*

The National NHS Staff Survey includes questions about 'annual training' in these areas. However, as the Trust provides refresher training for all staff every two years, it means that performance against this indicator for the Staff Survey will be low (compared to other Trusts). Nevertheless, although equality and diversity training is offered to staff throughout the year, in addition to the mandatory Induction and INSET day training (which includes health and safety and equality and diversity training). In the future the Trust plans to mainstream equalities training with a focus on increasing staff attendance.

- *staff experiencing discrimination at work and equal opportunities in career progression or promotion*

To address some of the concerns raised by staff regarding experiencing discrimination at work, the Trust will consider providing regular diversity training sessions at team meetings and raise awareness through use of email alerts, briefing hand-outs, flyers and awareness sessions, either in teams or at directorate meetings. In addition, the current strategies and interventions to support and assist staff in reporting bullying, harassment or discrimination will be promoted further. Regarding equal opportunities in career progression or promotion, the Trust will review ethnicity statistics and data relating to staff promotions and staff progression and if disparities exist, devise an action plan to address these. If no disparities exist, ensure Trust data on promotions and appointments is shared regularly with staff, in order to address this perception.

Staff response rates have also reduced further this year from 47% in 2013 to 38% in this survey, (202 out of 535 staff); this is below the national average of 42%.

The reasons for this are not entirely clear, but possibly related to the fact that this year, for the first time, the Staff Survey was run via an online confidential survey system, where staff were sent a code and a link to access the survey via email. Whereas in previous years staff were required to complete a paper (hardcopy) survey which possibly might have been more difficult to overlook than the electronic staff survey used this year.

The three priorities for the coming year identified by the Trust's Management Team, some of which has been informed by the findings from the Staff Survey include the following:

1. Continuing to tackle issues of bullying and harassment.
2. Mainstreaming equalities training with a focus on increasing staff attendance.
3. Ensuring that improvements continue in internal communication processes to ensure that staff are informed of and able to contribute to developments across the Trust.

A copy of the 2015 National NHS staff survey for The Tavistock and Portman NHS Foundation Trust is available at ....

## Clinical Effectiveness Indicators

### Monitor number of staff with Personal Development Plans (PDPs)

Indicator	2013/2014	2014/2015	2015/2016
Monitor number of staff with Personal Development Plans	96%	97.5%	8 received so far – approx 480 to be received by end of Q4

#### What are we measuring?

Through appraisal and the agreement of Personal Development Plans (PDP) we aim to support our staff to maintain and develop their skills. It also provides an opportunity for staff and their managers to identify ways for the staff member to develop new skills, so as to enable them to take on new roles within the organisation, as appropriate. A Personal Development Plan also provides evidence that an appraisal has taken place. In addition, the information gathered from this process helps to highlight staff requirements for training and is used to plan the Trust Staff Training Programme for the up-coming year.

The data collection period for Personal Development Plans takes place from January to March each year. However, it is important to note that the staff group who have not completed a PDP include those staff who are on a career break or sick leave, new starters, or those who have not submitted their PDPs by the Trust deadline.

#### Targets and Achievements

We are very pleased to report that ...% of staff had attended an appraisal meeting with their manager and agreed and completed a PDP for the upcoming year by the 31 March 2016 deadline. [state whether improvement from last year]

## Range of Psychological Therapies [update this section. ?include]

Over the years, the Trust has increased the range of psychological therapies available, which enables us to offer treatment to a greater range of patients, and to offer a greater choice of treatments to all of our patients. We have established expertise in systemic psychotherapy and psychoanalytical psychotherapy for patients of all ages and continue to support staff development and innovative applications of these models. This is in addition, to Group Psychotherapy, Couples Therapy and therapeutic work with parents.

Over the last year we have continued to strengthen our capacity to offer a range of interventions through a staff training and supervision programme. Staff have been supported to train in VIPP (Video Interaction to Promote Positive Parenting). A group of staff from across the Trust have been developing their skills in mindfulness based interventions and are now providing colleagues with opportunities to learn about this approach.

We have continued to support training in Interpersonal Therapy (IPT) through which a number of staff across the Trust have completed practitioner level training and a smaller number have achieved supervisor status. We continue to offer specialist supervision and training in Cognitive Behaviour Therapy (CBT) for CAMHS staff and specialist supervision and training for CBT for Post Traumatic Stress Disorder for the Adult and Adolescent Trauma Service. An increasing number of staff have been trained in Eye Movement Desensitisation and Reprocessing (EMDR) for children with Post Traumatic Stress Disorders.

Over the last year 12 staff members have been trained in EMDR for over 18s. This training was provided in response to an increased identified need for this form of intervention. In addition, a group of staff have been trained in Dynamic Interpersonal Therapy (DIT), now recognised as an approved treatment within the Improving Access to Psychological Therapies Programme. This innovative therapy was developed by a member of our staff in partnership with colleagues at the Anna Freud Centre, London. Further applications of the model are in development such as a version adapted for adolescents and young adults. We continue to develop our work in a range of other models including Relationship Development Intervention (RDI) and Mentalisation Based Therapy (MBT).

Our priority for the coming year (**confirm for 2016/17**) remains to continue to train staff to increase their capacity to identify and present treatment choices, taking into account relevant NICE guidance where available.

## Clinical Outcome Monitoring

## Priority 1: Outcome Monitoring – Child and Adolescent Mental Health Service (CAMHS)

1. Child and Adolescent Mental Health Service Outcome Monitoring Programme			
Targets for 2015/16	2013/2014	2014/2015	2015/2016
1. For 80% of patients (attending CAMHS who qualify for the CQUIN) to complete the Goal-Based Measure (GBM) at Time 1 and after six months or, if earlier, at the end of therapy/treatment (known as Time 2).	79%	73%	
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).	73%	75%***	

\*The 2013/14 target was increased to 75%, from 70% in 2012/13.

\*\*The 2013/14 target was increased to achieving an improvement on at least two targets instead of at least one target in 2012/13.

\*\*\* For 2014/15 when those patients who only set one goal at Time 1 and who improved on that one goal are included, the improvement rate increases to 82%.

### What did we measure

xxxx

### Targets and Achievements [to be updated]

1. Unfortunately, this year we fell slightly short of the target of 75%, by achieving 73% for the return rate of forms for the Goal-Based Measure completed by patients/service users, in conjunction with clinicians, at both Time 1 and Time 2.
2. However, we are very pleased to have achieved the target, for 75% of patients to achieve an improvement in their score on the GBM, from Time 1 to Time 2, on 2 targets (goals), which is an improvement on last year when we achieved 73%. This is an important target as it enables us to demonstrate positive changes for patients as a consequence of the psychological intervention and/or treatment they have received from the Trust.

## Priority 2: Outcome Monitoring – Adult Service

2. Adult Outcome Monitoring Programme			
Targets for 2015/16	2013/2014	2014/2015	2015/2016
1. For the Total CORE scores to indicate	*	53%	

an improvement from Pre-assessment (Time 1) to End of Treatment (Time 2) for 50% of patients.

\*No comparable targets existed for the previous years, so therefore cannot be compared.

## What did we measure

XXXX

## Targets and Achievements **[to be updated]**

For the Adult Service, for Target 1, Time 1 refers to the Pre-assessment stage, where the patient is given the CORE form to complete before they are seen for the first time. Then, the patient is asked to complete this form again at the End of Treatment stage (Time 2).

We are pleased to report that we exceeded our target, as 53% of patients who completed the CORE forms at Time 1 and Time 2 showed an improvement in their Total CORE score from the Pre-assessment to the End of Treatment stage. Again, we consider this to be a very positive result as it enables us to demonstrate positive changes for patients as a consequence of the psychological intervention and/or treatment they have received from the Trust\*\*.

## Patient Experience Indicators

### Priority 3: Access to clinical service and health care information for patients and the public

#### 3. Access to Clinical Service and Health Care Information for Patients and Public

Targets for 2015/16	2015/16 Outcome
1. PPI team to develop a quarterly PPI newsletter for Trust staff and service users to include updates on patient stories	The target was achieved.
2. PPI Newsletters to be available on the Trust website	The target was achieved.
3. Following launch of the newsletter, a Visual Straw Poll to be run on awareness of the newsletters	The target was achieved.

## Targets and Achievements

**Target 1:** Achieved. An Adult newsletter and Child and Adolescent newsletter has been created and published in each quarter. Articles in the newsletters have consistently been reporting on patient and public projects and initiatives that have taken place during the previous quarter, where some articles also included patient quotes of the events.

In each newsletter upcoming events and projects have been advertised in a 'What's On' section. Articles in the newsletters further describe the events or projects. And, the PPI team's contact details are also included in the newsletters in order to enable new patients, parents/carers and the public to get more information and/or to become involved.

Finally, the Patient Stories project has also been made a priority by having it advertised and described in the newsletters. Again, the PPI team's contact details were available so that people using our services can find out more information and/or get involved in telling their story to the Board.

**Target 2:** Achieved. PPI Newsletters are available on the Trust website.

**Target 3:** Achieved. A Visual Straw Poll was placed in the general and adolescent waiting rooms. The question asked was "Have you read our involvement flyer?" The collated information is as follows; Yes 60, No 77 and I'd like to (please take one) as 34.

In addition to publishing the newsletters on the Tavistock and Portman website, the newsletters were also printed and distributed in all the waiting rooms in the Tavistock Centre. The Adult and Child and Adolescent newsletters were also emailed to respective client contact distributions lists. Finally, feedback on the Adult newsletter was also asked from service users who attend the Adult Reference Group.

## Priority 4: Patient and Public Involvement

4. Patient and Public Involvement	
Targets for 2015/16	2015/16 Outcome
1. To provide a service user for every clinical interview panel that requests a service user panel member.	The target was achieved.
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.	The target was achieved.

### Targets and Achievements

**Target 1:** Achieved. Anthony Newell, a PPI staff member, has been successfully trained in facilitating the service user panel training sessions. The interview training sessions took place on the 21<sup>st</sup> of May 2015 and 28<sup>th</sup> January 2016, where both sessions were well attended.

There has been one group Information Governance (IG) training on the 26<sup>th</sup> November 2015 where six service users were trained. Other service users have been consistently asked to arrive early on their interview panel day in order to complete their IG training before their interview panel starts. A member of the PPI team supports the service user to complete their Information Governance training.

When staff request service users in a timely manner, the PPI endeavor to arrange a service user representative for the panel. In regards to this reports respective dates, 49 service users representative have been participating on various interview panels across a variety of services.

**Target 2:** Achieved. After each panel, service user representatives are asked for feedback either in person, over the phone or email. In regards to the reporting period, we have received feedback from 70% of service user representatives who have participated on panels. Overall, the feedback has mostly been positive. Where feedback has been constructive or negative, the PPI team have followed up with the necessary actions and have informed the service user representative of these actions.

### Complaints Received

Indicator	2013/2014	2014/2015	2015/2016
Complaints received	12	14	21

### What are we measuring?

The Trust has a Complaints Policy and Procedure in place that meets the requirements of the Local Authority and NHS Complaints (England) 2009 Regulations. As in previous years the number of formal complaints received by the Trust in 2015/16 remains low at 21 although this represents a rise in complaints from previous years, 12 in 2013/14 and 14 in 2014/15. This may be due to patients feeling more able to raise issues with us.

All but one of the formal complaints received relate to aspects of clinical care, appointment times and delays in referral. One complaint related to facilities.

In order to maintain confidentiality of the complainants, given the small numbers of complaints, the Trust does not provide the details of these complaints. Each complaint was investigated under the Trust's complaints procedure and a letter of response was sent by the Chief Executive to each complainant. During the year there were no complaints referred to the Mental Health Ombudsman.

We endeavour to learn from each and every complaint, regardless of whether it is upheld or not. In particular, each complaint gives us some better understanding of the experience of our services for service users, a critical contribution to all of our service development. In addition, for 2016/17 the Trust is committed to ensure that all staff are fully aware of the different ways that patients can raise concerns and we have recently launched a short guidance note for staff to help them support their patients with raising concerns. We have also ensured that information on how to raise a complaint is in all patient waiting areas.

### Patient Satisfaction

Indicator	Q1	Q2	Q3	Q4
Patient rating of help received as good	92%	94%	92%	

The Trust has formally been exempted from the NHS National Mental Health Patient Survey which is targeted at patients who have received inpatient care. For eleven years, up until 2011 we conducted our own annual patient survey which incorporated relevant questions from the national survey and questions developed by patients. However the return rate for questionnaires was very low and therefore in 2011 the Trust discontinued using its own survey and started to use feedback received from the Experience of Service Questionnaire (CHI-ESQ) to report on the quality of the patient experience on a quarterly basis. The ESQ was chosen because it was already being used as a core part of the Trust's outcome monitoring, and so we anticipated obtaining reasonable return rates to enable us to meaningfully interpret the feedback. We took the standard ESQ form and added some additional questions.

## Targets and Achievements

Results from the Experience of Service Questionnaire found that 92% of patients in Quarter 1 (April to June 2015), 94% of patients in Quarter 2 (July to September 2015) and 92% of patients in Quarter 3 (October to December 2015) and ...% of patients in Quarter 4 (January to March 2016) rated the help they had received from the Trust as 'good'.

For this financial year, this patient satisfaction target was also a CQUINs Target for CAMHS, please see table below for the quarterly patient satisfaction percentages:

Indicator	Q1	Q2	Q3	Q4
CAMHS Number of service users reporting satisfaction with the service (rated the help they had received from the Trust as 'good'.)	77%	97%	80%	

Compared to other Trusts using the Patient Survey, our results reveal a consistently high level of patient satisfaction with our Trust's facilities and services. This includes clinical services and staff along with reception and security staff and anyone else who the patient has interacted with during their visit. Feedback from patients has provided us with an understanding of areas we need to work to improve for the year ahead. We will continue to work with the clinical directorates to improve patient satisfaction with the explanation they receive regarding help available at the Trust. This includes the verbal and written information they receive prior to their first visit to the Trust, as well as involvement of patients in decisions about their care and treatment.

### Did Not Attend Rates (1,2)

Indicator	2013/14	2014/15	2015/2016
<b>Trust-wide</b>			
First Attendance	10.3%	7.8%	
Subsequent Appointments	8.7%	7.7%	
<b>Adolescent and Young Adult</b>			
First Attendance	7.7%	8.9%	
Subsequent Appointments	14.3%	14.8%	
<b>Adult</b>			
First Attendance	7.5%	8.5%	
Subsequent Appointments	9.1%	7.3%	
<b>Camden Child and Adolescent Mental Health Service (Camden CAMHS)</b>			
First Attendance	14.1%	8.8%	

Subsequent Appointments	8.1%	7.1%	
<b>Developmental (including Learning and Complex Disability Service)</b>			
First Attendance	2.0%	5.7%	
Subsequent Appointments	6.9%	7.3%	
<b>Portman</b>			
First Attendance	7.9%	2.7%	
Subsequent Appointments	9.1%	8.3%	
<b>Other Child and Adolescent Mental Health Service (Other CAMHS)</b>			
First Attendance	6.4%	3.8%	
Subsequent Appointments	5.8%	4.1%	

1. Please note that our patient administration system (PAS) is a 'live system' and therefore with data cleansing and the addition of missing data taking place after quarter end, the final outturn figures for DNA and waiting time may be slightly different to quarterly performance figures published in year.
2. DNA figures for the City & Hackney Primary Care Psychotherapy Consultation Service (PCPCS) have not been included due to a different DNA target being agreed with the City and Hackney (PCPCS) and their commissioners.

## What are we measuring?

The Trust monitors the outcome of all patient appointments, specifically those appointments where the patient Did Not Attend (DNA) without informing us prior to their appointment. We consider this important, so that we can work to improve the engagement of patients, in addition to minimising where possible wasted NHS time.

## Targets and Achievements [\[to update this section\]](#)

We are very pleased to report that there has been a decrease in the Trust-wide DNA rates both for first attendances and for subsequent/follow-up appointments, compared with last year. Namely, there has been a decrease in DNA rates for first attendances (7.8%) compared with 2013/14 (10.3%) and a decrease in DNA rates for subsequent/follow-up appointments (7.7%) compared with 2013/14 (8.7%).

We believe that this has been as a consequence of the on-going and concerted efforts undertaken by all services to reduce the number of appointments patients fail to attend. For example, by offering a greater choice concerning the times and location of appointments; emailing patients and sending them text reminders for their appointments, or phoning patients ahead of appointments as required. By comparison, the average DNA rate reported for mental health Trusts is around 14%.<sup>3</sup>

As DNA rates can be regarded as a proxy indicator of patient's satisfaction with their care, the lower than average DNA rate for the Trust can be considered positively. For example, for some patients not attending appointments can be a way of expressing their dissatisfaction with their treatment. However, it can also be the case, for those patients who have benefited from treatment that they feel there is less need to

continue with their treatment, as is the case for some patients who stop taking their medication when they start to improve. However, this is only one of the indicators that we consider for patient satisfaction, which needs to be considered along with other feedback obtained from patients, described elsewhere in this report.

It is important to note that the Trust reports DNAs that are recorded on our electronic administrative data base Rio. Information is uploaded onto Rio by administrators who rely on clinicians to inform them of the outcome for each patient. On occasions data validation audits have demonstrated that we were unable to review a paper entry that linked to the Rio record of DNA. This is as a result of a number of different paper sources of data being used (e.g. clinical records; diary sheets and emails to administrators). We have added this comment to our report to show the steps we take to validate data. We continue to impress on staff the importance of making a record in the paper file for each appointment whether or not the patient attends. However, currently the Trust is in the process of moving to an Integrated Digital Care Record (IDCR) namely Carenotes, which will reduce the number of steps to recording DNA (i.e. the clinician will record outcome directly) and we anticipate that our data reliability will be increased.

3. Mental Health Benchmarking Club, April 2010, Audit Commission: <http://www.nhsbenchmarking.nhs.uk/index.php>

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## Waiting Times

Indicator	2013/2014	2014/2015	2015/2016
<b>Trust Wide – Number of patients waiting for first appointment for 11 or more weeks</b>	65	36	
Internal Causes	18	13	
External Causes	47	23	
Unknown Causes	N/A	N/A	
<b>Trust Wide – Percentage of patients waiting for first appointment for 11 or more weeks</b>	4.1%	1.9%	
Internal Causes	1.1%	0.7%	
External Causes	2.9%	1.2%	
Unknown Causes	N/A	N/A	

### What are we measuring? [\[to update\]](#)

The Trust monitors waiting times on an on-going basis, seeking to reduce the length of time that patients have to wait, especially those who are close to our target time of eleven weeks.

Prior to their first appointment, patients will be contacted and offered two possible appointments, and invited to choose one of these appointments. If neither appointment is convenient for the patient, they will be offered an alternative appointment with the same therapist where possible. This system on the whole helps to facilitate patients engaging with the service. The majority of patients are seen within eleven weeks of the Trust receiving the referral.

During 2015/16, 36 (1.9%) patients had to wait for eleven weeks or longer for their first appointment. Clinical and administrative staff work hard to minimise the length of time that patients have to wait before they are seen and we are pleased to report that this is a significant improvement on the 65 (4.1%) figure from 2013/14. There were both factors external to the Trust, concerning 23 (1.2%) patients, and internal to the Trust, for 13 (0.7%) patients, which contributed to these delays. The Trust waiting times, will continue to be monitored and improved where possible, especially for internal delays.

To help address the breaches of the eleven week target, at the end of each quarter a list is drawn up for each service of those patients who had to wait eleven weeks or longer for their first appointment, together with reasons for this. The services where the breach has occurred are requested to develop an action plan to address the delay(s) and to help prevent further breaches.

### 3.2 Performance against relevant Indicators and Thresholds

The majority of the mental health indicators set out in the Compliance Framework/Risk assessment framework are not applicable to The Tavistock and Portman NHS Foundation Trust, as they relate to inpatient and/or medical consultant lead services which the Trust does not provide. However, the 'mental health identifiers' (NHS number; date of birth; postcode; current gender; Registered General Medical Practice organisation code, and Commissioner organisation code) apply to the Trust and in 2015/16 by achieving 99% data completeness for these mental health identifiers, the Trust exceeded the 97% threshold for completeness of data.

The Trust complies with requirements regarding access to healthcare for people with a learning disability.

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## Lifespan Service

### What is the service?

Lifespan Service offers multi-modal assessment and treatment which has been developed in line with published practice and evidence and through many years of clinical practice at the Tavistock Clinic. We offer a range of therapeutic approaches for children, young people and adults with ASDs, learning and complex disabilities and their families and wider educational social networks.

### Who is the service for?

We are an all-age service, and accept referrals of children, adolescents and adults with ASDs and LDs. The service focuses on providing therapy for those with learning disabilities, neurodevelopmental difficulties, brain injury, sensory and other neurological and neuropsychological difficulties, emotional difficulties such as depression, anxiety, difficulties with sleeping and eating and those who are bereaved, emotionally related behavioural problems, difficulties with interpersonal and family relationships and difficulties related to different stages of development through the lifespan.

### Outcomes

### Quotes

## Part 4: Annexes

### 4.1 Statements from Camden Clinical Commissioning Group (CCG), Governors, Camden Healthwatch, Overview and Scrutiny Committees (OSCs), and response from Trust.

#### Comments from Camden Clinical Commissioning Group (CCG)

##### Trust Response:

#### Comments from our Governors

##### Trust Response:

#### Joint statement by Camden Healthwatch and the Camden Health and Adult Social Care Scrutiny Committee

##### Trust Response:

### 4.2 Statement of Directors' Responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16 and supporting

guidance

- The content of the Quality Report is not inconsistent with internal and external sources of information including:
  - o Board minutes and papers for the period April 2014 to May 2015.
  - o Papers relating to Quality reported to the board over the period April 2014 to May 2015.
  - o Feedback from commissioners dated 14 May 2015.
  - o Feedback from governors dated 11 May 2015.
  - o Feedback from local Healthwatch organisations dated 18 May 2015.
  - o Feedback from Overview and Scrutiny Committee dated 18 May 2015.
  - o The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009. We have produced an annual complaints report dated April 2015 covering 2015/16, which was presented to the Board in April 2015.
  - o The 2014 national staff survey, received by the Trust in February 2015.
  - o The Head of Internal Audit's annual opinion over the trust's control environment dated 20 May 2015.
  - o CQC Intelligent Monitoring Report dated 4 March 2015
- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- The performance information reported in the Quality Report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- The Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at [www.monitor.gov.uk/annualreportingmanual](http://www.monitor.gov.uk/annualreportingmanual)) as well as the standards to support data quality for the preparation of the Quality Report (available at [www.monitor.gov.uk/annualreportingmanual](http://www.monitor.gov.uk/annualreportingmanual)).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

NB: sign and date in any colour ink except black

.....Date.....Chairman

.....Date.....Chief Executive

### 4.3 Independent Auditors Report

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## Appendix – Glossary of Key Data Items

**Barnet Young People’s Drug and Alcohol Service (YPDAS)** - This service operates in the London Borough of Barnet to provide support to young people relating to drug and alcohol misuse. They provide counselling, drug treatment, family therapy and health assessments, following NHS confidentiality and patient care guidance.

**Black and Minority Ethnic (BME) Groups Engagement** - We plan to improve our engagement with local black and minority ethnic groups, by establishing contact with Voluntary Action Camden and other black and minority ethnic community groups based in Camden.

**CCG (Clinical Commissioning Group)** - CCGs are new organisations created under the Health and Social Care Act 2012. CCGs are independent statutory bodies, governed by members who are the GP practices in their area. A CCG has control of the local health care budget and 'buys' local healthcare services on behalf of the local population. Some of the functions a CCG carries out replace those of Primary Care Trusts that were officially abolished on 31 March 2013, such as the commissioning of community and secondary care. Responsibilities for commissioning primary care transferred to the newly established organisation, NHS England.

**Care Quality Commission** – This is the independent regulator of health and social care in England. It registers, and will license, providers of care services, requiring they meet essential standards of quality and safety, and monitors these providers to ensure they continue to meet these standards.

**City and Hackney Primary Care Psychotherapy Consultation Service (PCPCS)** - The City and Hackney Primary Care Psychotherapy Consultation Service offers talking therapies to adults aged 18 or over living in the City of London or London Borough of Hackney. Clinicians typically see patients who are experiencing problems such as depression, anxiety, stress, panic, isolation, loss of sleep or persistent physical pain or disability. It is an inclusive service, seeing people from a diverse range of backgrounds. Depending on the individual needs clinicians will work with the individual, a couple, and a family or in a group of 8-12 others.

**Clinical Outcome Monitoring** - In “talking therapies” is used as a way of evaluating the effectiveness of the therapeutic intervention and to demonstrate clinical effectiveness.

**Clinical Outcomes for Routine Evaluation** - The 34 items of the measure covers four dimensions, subjective well-being, problems/symptoms, life functioning and risk/harm.

**Commission for Health Improvement Experience of Service Questionnaire** - This captures parent, adolescent and child views related to their experience of service.

**CQUIN (Commissioning for Quality and Innovation payment framework)** - This enables commissioners to reward excellence by linking a proportion of the Trust's income to the achievement of local quality improvement goals.

**Complaints Received** - This refers to formal complaints that are received by the Trust. These complaints are all managed in line with the Trust's complaints policy.

**Did Not Attend (DNA) Rates** - The DNA rate is measured for the first appointment offered to a patient and then for all subsequent appointments. There is a 10% upper limit in place for the Trust, which is the quality standard outlined in our patient services contract.

The DNA Rate is based on the individual appointments attended. For example, if a family of three is due to attend an appointment but two, rather than three, family members attend, the appointment will still be marked as attended. However, for Group Therapy the attendance of each individual will be noted as they are counted as individual appointments.

DNA rates are important to the Trust as they can be regarded as a proxy indicator of patient's satisfaction with their care.

**Family Nurse Partnership National Unit (FNP NU)** - The Family Nurse Partnership is a voluntary home visiting programme for first time young mothers, aged 19 or under. A specially trained family nurse visits the young mother regularly, from early in pregnancy until the child is two. Fathers are also encouraged to be involved in the visits if mothers are happy for them to be. The programme aims to improve pregnancy outcomes, to improve child health and development and to improve the parents' economic self-sufficiency. It is underpinned by an internationally recognised evidence base, which shows it can improve health, social and educational outcomes in the short, medium and long term, while also providing cost benefits.

**Goal-Based Measure** - These are the goals identified by the child/young person/family/carers in conjunction with the clinician, where they enable the child/carer etc to compare how far they feel that they have moved towards achieving a goal from the beginning (Time 1) to the End of Treatment (either at Time 2 at 6 months, or at a later point in time).

**Infection Control** - This refers to the steps taken to maintain high standards of cleanliness in all parts of the building, and to reduce the risk of infections.

**Information Governance** - Is the way organisations 'process' or handle information. It covers personal information, for example relating to patients/service users and employees, and corporate information, for example financial and accounting records.

Information Governance provides a way for employees to deal consistently with the many different rules about how information is handled, for example those included in The Data Protection Act 1998, The Confidentiality NHS Code of Practice and The Freedom of Information Act 2000.

**Information Governance Assessment Report** - The Trust is required to carry out a self-assessment of their compliance against the Information Governance requirements.

The purpose of the assessment is to enable organisations to measure their compliance against the central guidance and to see whether information is handled correctly and protected from unauthorised access, loss, damage and destruction.

Where partial or non-compliance is revealed, organisations must take appropriate measures, (for example, assign responsibility, put in place policies, procedures, processes and guidance for staff), with the aim of making cultural changes and raising information governance standards through year on year improvements.

The ultimate aim is to demonstrate that the organisation can be trusted to maintain the confidentiality and security of personal information. This in-turn increases public confidence that 'the NHS' and its partners can be trusted with personal data.

**Information Governance Toolkit** - Is a performance tool produced by the Department of Health. It draws together the legal rules and central guidance included in the various Acts and presents them in one place as a set of information governance requirements.

**INSET (In-Service Education and Training/Mandatory Training)** - The Trust recognises that it has an obligation to ensure delivery of adequate and appropriate training to all staff groups, that will satisfy statutory requirements and requirements set out by the NHS bodies, in particular the NHS Litigation Authority and the Care Quality Commission Standards for Better Health. It is a requirement for staff to attend this training once every 2 years.

**LGBT** - Lesbian, Gay, Bisexual, and Transgender community.

**Local Induction** - It is the responsibility of the line manager to ensure that new members of staff (including those transferring to new employment within the Trust, and staff on fixed-term contracts and secondments) have an effective induction within their new department. The Trust has prepared a Guidance and checklist of topics that the line manager must cover with the new staff member.

**Monitoring of Adult Safeguards** - This refers to the safeguarding of vulnerable adults (over the age of 16), by identifying and reporting those adults who might be at risk of physical or psychological abuse or exploitation.

The abuse, unnecessary harm or distress can be physical, sexual, psychological, financial or as the result of neglect. It may be intentional or unintentional and can be a single act, temporary or occur over a period of time.

**Mystery Shoppers** – These are service users or volunteers who make contact with the Trust via phone, email or who visit the building or our website, in order to evaluate how accessible our services are, the quality of our information and how responsive we are to requests. The mystery shoppers then provide feedback about their experiences and recommendations for any improvements they consider we could usefully make.

**National Clinical Audits** - Are designed to improve patient care and outcomes across a wide range of medical, surgical and mental health conditions. Its purpose is to engage all healthcare professionals across England and Wales in systematic evaluation of their clinical practice against standards and to support and encourage improvement and deliver better outcomes in the quality of treatment and care.

**National Confidential Enquiries** - Are designed to detect areas of deficiency in clinical practice and devise recommendations to resolve these. Enquiries can also propose areas for future research programmes. Most confidential enquiries to date are related to investigating deaths and to establish whether anything could have been done to prevent the deaths through better clinical care.

The confidential enquiry process goes beyond an audit, where the details of each death or incident are critically reviewed by a team of experts to establish whether clinical standards were met (similar to the audit process), but also to ascertain whether the right clinical decisions were made in the circumstances.

Confidential enquiries are “confidential” in that details of the patients/cases remain anonymous, though reports of overall findings are published.

The process of conducting a national confidential enquiry process usually includes a National Advisory Body appointed by ministers, guiding, overseeing and co-ordinating the Enquiry, as well as receiving, reporting and disseminating the findings along with recommendations for action.

**NHS Litigation Authority (NHSLA)** - The NHSLA operate a risk pooling system into which Trust contribute on annual basis and it indemnifies NHS bodies in respect of both clinical negligence and non-clinical risks and manages claims and litigation under both headings. The Authority also has risk management programmes in place against which NHS Trusts are assessed.

**NHS Litigation Authority Level** - The NHSLA has a statutory role "to manage and raise the standards of risk management throughout the NHS" which is mainly carried out through regular assessments, ranging from annually to every three years, against defined standards developed to reflect the risk profiles of the various types of healthcare organisations. Compliance with the standards can be achieved at three levels, which lead to a corresponding discount in contributions to the NHSLA schemes.

There are 50 standards to achieve covering the categories of governance, workforce, safe environment, clinical and learning from experience. Level 1 assesses that the policies around each standard are in place, level 2 ensures that processes around each policy are in place and level 3 ensure compliance with both the policies and processes for each of the individual standards.

**Patient Administration System (PAS)** - This is the patient administration system using RiO, which is a 'live system' for storing information electronically from patient records.

**Participation in Clinical Research** - The number of patients receiving NHS services provided or sub-contracted by the Trust that were recruited during the year to participate in research approved by a research ethics committee.

**Patient Feedback** - The Trust does not participate in the NHS Patients Survey but conducts its own survey annually, as it has been exempted by the Care Quality Commission from using the NHS Patient Survey, with the recognition that the nature of the services provided by the Trust differ to other mental health Trusts.

There are various other methods used to obtain feedback from patients, including small scale surveys and audits (such as the Children's Survey, the Ground Floor Environment Survey, the Website Survey), the suggestions box, feedback to the PALS officer and informal feedback to clinicians and administrators.

**Patient Forums/Discussion Groups** – These meetings aim to increase the opportunities for patients, members and the public to obtain information, and to engage in discussions about topics, such as therapy - how it can help, and issues such as confidentiality. In turn, the feedback to the Trust generated by these meetings is used to improve the quality of our clinical services.

**Patient Safety Incidents** – This relates to incidents involving patient safety which are reportable to the National Patient Safety Agency database National Reporting and Learning System.

**Percentage Attendance** – The number of staff members who have attended the training or completed the inductions (Trust-wide and Local) as a percentage of those staff required to attend training or complete the inductions. Human Resources (Staff Training) record attendance at all mandatory training events and inductions using the Electronic Staff Record.

**Periodic/Special Reviews - The Care Quality Commission** conducts special reviews and surveys, which can take the form of unplanned visits to the Trust, to assess the safety and quality of mental health care that people receive and to identify where and how improvements can be made.

**Personal Development Plans** - Through appraisal and the agreement of a Personal Development Plan for each member of staff we aim to support our staff to maintain and develop their skills. A Personal Development Plan also provides evidence that an appraisal has taken place.

**Range of Psychological Therapies** - This refers to the range of psychological therapies available within the Trust, which enables us to offer treatment to a greater range of patients, and also offer a greater choice of treatments to our patients.

**Return rate** - The number of questionnaires returned by patients and clinicians as a percentage of the total number of questionnaires distributed.

**SAAMHS** - Specialist Adolescent Adult Mental Health Service. This includes the Portman Clinic, Adolescent and Young Adult Service and the Adult Service.

**Safeguarding of Children Level 3** - The Trust has made it mandatory for all clinical staff from Child and Adolescent Mental Health Services, GIDS, Portman Child and Adolescent Service and the Adolescent and Young Adult Directorate to be trained in Safeguarding of Children Level 3, where staff are required to attend Level 3 training every 3 years. (In addition, all other Trust staff regularly attend Safeguarding of Children Training, including Level 1 and 2 training.)

The training ensures that Trust staff working with children and young people are competent and confident in carrying out their responsibilities for safeguarding and promoting children's and young people's welfare, such as the roles and functions of agencies; the responsibilities associated with protecting children/young people and good practice in working with parents. The Level 3 training is modeled on the core competencies as outlined in the 'Safeguarding Children and Young People: Roles and Competencies for Health Care Staff' (Intercollegiate Document 2010); Working Together to Safeguard Children, 2010; the London Child Protection Procedures 4th Ed, 2010; NICE Clinical Guidance 2009: 'When to Suspect Child Maltreatment'.

**Specific Treatment Modalities Leaflets** - These leaflets provide patients with detailed information on the different treatment modalities offered by the Trust, to facilitate patients making informed choices and decisions about their treatment.

**Stakeholder Quality Meetings** - These include consultation meetings with stakeholders (Patient and Public Involvement representatives), Non-Executive Directors and a Governor, and the separate meeting with governors. The purpose of these meetings is to contribute to the process of setting quality priorities and to help improve other aspects of quality within the Trust.

**Time 1** - Typically, patients are asked to complete a questionnaire during the initial stages of assessment and treatment, or prior to their first appointment.

**Time 2** - Patients are again asked to complete a questionnaire at the end of assessment and treatment. The therapist will also complete a questionnaire at Time 2 of the assessment and/or treatment stage.

Our goal is to improve our Time 2 return rates, which will enable us to begin to evaluate pre- and post- assessment/treatment changes, and provide the necessary information for us to determine our clinical effectiveness.

**Trust-wide Induction** – This is a Trust-wide induction event for new staff, which is held 3 times each year. All new staff (clinical and non-clinical) receive an invitation to the event with their offer of employment letter, which makes clear that they are required to attend this induction as part of their employment by the Trust.

**Trust Membership** - As a foundation Trust we are accountable to the people we serve. Our membership is made up of our patients and their families, our students, our staff and our local communities. Members have a say in how we do things, getting involved in a variety of ways and letting us know their views. Our members elect Governors to represent their views at independent Boards where

decisions about what we do and how we do it are made. This way we can respond to the needs of the people we serve.

**Waiting Times** - The Trust has a policy that patients should not wait longer than 11 weeks for an appointment from the date the referral letter is received by the Trust to the date of the first appointment attended by the patient.

However, if the patient has been offered an appointment but then cancelled or did not attend, the date of this appointment is then used as the starting point until first attended appointment.

The Trust monitors waiting times on an on-going basis, seeking to reduce the length of time that patients have to wait, especially beyond eleven weeks. A list of breached first appointments is issued at the end of each quarter for each service, together with reasons for the long wait and, if appropriate, the actions to be taken to prevent recurrence.

DRAFT



## Board of Directors : May 2015

**Item :** 15

**Title :** Corporate Governance: Use of Trust Seal

**Purpose:**

This report requests approval for the use of the Trust seal, in signing the agreement for the Multi-Disciplinary Family Assessment Service commissioned by Westminster, Hammersmith & Fulham

**For :** Approval

**From :** Gervase Campbell, Trust Secretary

## Corporate Governance Report – Use of Trust Seal

### 1. Use of the Trust Seal

- 1.1 The Trust's constitution states that the Board of Directors is responsible for approving use of the Trust Seal before it is affixed to any document. Where it is not possible to get approval in advance, the use must be reported to the Board of Directors at their next meeting.
- 1.2 The Board are asked to approve the Sealing of an agreement with the London Borough of Hammersmith and Fulham and the City of Westminster for the provision of the Westminster, Hammersmith and Fulham Multi-Disciplinary Family Assessment Service from 1<sup>st</sup> January 2016 to 31<sup>st</sup> December 2020.
- 1.3 It was reported to the Board in November 2015 that we had been awarded the contract.
- 1.4 The contract itself was agreed by the usual management processes; it is coming to the Board because Westminster requested we seal the contract as a deed.
- 1.5 The Board are asked to approve this use of the Trust Seal.

Gervase Campbell  
Trust Secretary  
February 2015

**BOARD OF DIRECTORS (PART 1)**

Meeting in public

Tuesday 23<sup>rd</sup> February 2016, 14.00 – 16.30

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

**AGENDA**

<b>PRELIMINARIES</b>				
<b>1.</b>	<b>Chair's Opening Remarks</b> Mr Paul Burstow, Trust Chair		Verbal	-
<b>2.</b>	<b>Apologies for absence and declarations of interest</b> Mr Paul Burstow, Trust Chair	To note	Verbal	-
<b>3.</b>	<b>Minutes of the previous meeting</b> Mr Paul Burstow, Trust Chair	To approve	Enc.	p.1
<b>3a.</b>	<b>Outstanding Actions</b> Mr Paul Burstow, Trust Chair	To note	Enc.	-
<b>4.</b>	<b>Matters arising</b> Mr Paul Burstow, Trust Chair	To note	Verbal	-
<b>REPORTS &amp; FINANCE</b>				
<b>5.</b>	<b>Service User Story</b>	To note	Verbal	-
<b>6.</b>	<b>Service Line Report – Family Drug Alcohol Court (FDAC) and Westminster Family Services (WFS)</b> Mr Steve Bambrough, Associate Clinical Director	To discuss	Enc.	p.9
<b>7.</b>	<b>Trust Chair's and NEDs' Reports</b> Mr Paul Burstow, Trust Chair	To note	Verbal	-
<b>8.</b>	<b>Chief Executive's Report</b> Mr Paul Jenkins, Chief Executive	To note	Late	-
<b>9.</b>	<b>IMT Strategy</b> Mr Toby Avery, Director of IM&T	To approve	Enc.	p.29
<b>10.</b>	<b>CQC Inspection Review</b> Ms Louise Lyon, Director of Quality & Patient Experience	To discuss	Enc.	p.54
<b>11.</b>	<b>Finance and Performance Report</b> Mr Simon Young, Deputy Chief Executive & Director of Finance	To note	Enc.	p.57
<b>12.</b>	<b>CQSG Quarter 3 Report</b> Dr Rob Senior, Medical Director	To discuss	Enc.	p.67
<b>13.</b>	<b>Training and Education Report</b> Mr Brian Rock, Director of Education & Training/Dean	To note	Enc.	p.75

<b>14.</b>	<b>Draft Annual Quality Report</b> Ms Louise Lyon, Director of Quality & Patient Experience Ms Marion Shipman, Associate Director for Quality & Governance	To approve	Enc.	p.80
<b>15.</b>	<b>Corporate Governance - Approval for use of Trust Seal</b> Mr Gervase Campbell, Trust Secretary	To approve	Enc.	p.143
<b>CLOSE</b>				
<b>16.</b>	<b>Notice of Future Meetings</b> <ul style="list-style-type: none"> <li>• Thursday 3<sup>rd</sup> March 2016, Council of Governors' Meeting, 2.00pm – 5.00pm, Board Room</li> <li>• Tuesday 8<sup>th</sup> March 2016: Leadership Conference, 9.00am – 1.00pm, Lecture Theatre</li> <li>• Tuesday 29<sup>th</sup> March 2016: Board of Directors' Meeting, 2.00pm – 5.00pm, Lecture Theatre</li> <li>• Tuesday 12<sup>th</sup> April 2016: Joint Boards' Meeting, 10.00am – 2.00pm, Lecture Theatre</li> </ul>		Verbal	-